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Technical Assistance to the Uganda AIDS Commission for Operationallisation of the Performance Monitoring and Management Plan

Technical Assistance to the Uganda AIDS Commission for Operationallisation of the Performance Monitoring and Management Plan

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The Inter-religious Council of Uganda
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Acronyms

ACAO	Assistant Chief Administrative Officer
ACE	AIDS Capacity Enhancement Project
ACP	AIDS Control Programme
ADP	AIDS Development Partner
AIDS	Acquired Immuno-Deficiency Syndrome
AIS	AIDS Indicator Survey
AMREF	African Medical and Research Foundation
ART	Anti-retroviral Therapy
ASO	AIDS Service Organization
CAO	Chief Administrative Officer
CBO	Community-based Organization
CBSO	Community-based Services Officer
CCT	Centre Coordinating Tutor
CD4+	Lymphocytes with the CD4 Marker
CDC	Centers for Disease Control and Prevention
CDO	Community Development Officer
CSF	Civil Society Fund
CSO	Civil Society Organization
DAC	District HIV/AIDS Committee
DANIDA	Danish Agency for International Development
DEO	District Education Officer
DFP	District Focal Person
DAT	District HIV/AIDS Team
DHE	District Health Educator
DHO	District Health Officer
DHT	District Health Team
DIS	District Inspector of Schools
DTLS	District TB/Leprosy Supervisor
DTPC	District Technical Planning Committee
EMIS	Education Management Information System
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSD	Health Sub-district
IDI	Infectious Disease Institute
IEC	Information, Education and Communication
JCRC	Joint Clinical Research Centre
LOGICS	Local Government Information System
LQAS	Lot Quality Assessment Sample
M&E	Monitoring and Evaluation
MARPs	Most-At-Risk Populations
MIS	Management Information System
MoES	Ministry of Education and Sports
MoGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health

NAFOPHANU	National Forum of People Living with HIV/AIDS Networks in Uganda
NDA	National Drug Authority
NGO	Non-Governmental Organization
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
PHA	People with HIV/AIDS
PHC	Primary Health Care
PMMP	Performance Monitoring and Management Plan
PMTCT	Prevention of Mother-to-Child Transmission
PREFA	Protecting Families Against AIDS
RC	Resource Centre
TASO	The AIDS Support Organization
TA	Technical Assistance
TB	Tuberculosis
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UBTS	Uganda Blood Transfusion Service
UDHS	Uganda Demographic Health Survey
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASO	Uganda Network of AIDS Service Organizations
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

Executive Summary

Background

The Uganda AIDS Commission (UAC) has committed to roll-out and make operational a new National Performance Monitoring and Management Plan (PMMP) to monitor and evaluate the national response to the HIV/AIDS epidemic. The PMMP has at its core the collection and processing of 58 national indicators, 47 district output indicators, and 22 outcome indicators covering prevention, care, and treatment and social support. The roll-out of this system is challenging because at least seven organizations must collaborate at the national level, and appropriate staff at the district level need to be in place and trained in new procedures of data collection. In addition, these data are to be supplied to district planning organizations that may or may not be functioning and the cooperation of civil society organizations (CSOs) is necessary even though their participation is entirely voluntary. The Population Council and Makerere University School of Public Health (MUSPH) were funded by USAID/Uganda to assist the UAC in assessing these challenges and determining appropriate procedures for creating a successful roll-out of the new PMMP system. This final report focuses on recommendations for the successful completion of the roll-out. A full description of the challenges to be overcome with these recommendations was presented in the third interim report (Appendix 11).

Objectives

The specific objectives of this assistance were to:

1. Review and document operating monitoring and evaluation (M&E) systems for the national and district level response, in relation to the PMMP.
2. Identify best practices, gaps, challenges and solutions to operationallise the PMMP.
3. Describe a system and critical linkages required to make the PMMP operational.
4. Document requirements and propose an evidence based capacity building strategy to operationallise the PMMP.
5. Develop a training guide and plans necessary to implement the national capacity building strategy necessary to roll-out the PMMP to all 90[1] districts.
6. Develop cost estimates for the national roll-out of the PMMP.

Methodology

The assessment team used a “systems analysis model” that followed-up the different processes needed to make the PMMP indicators operational and described how these processes are related to each other at three levels—national, district, and CSO. Initially, the team conducted a document review in order to evaluate and determine responsibility for each

[1] Currently there are 80 districts involved in the national roll-out. The government has approved 14 new districts, but they are all not likely to start in the next fiscal year. Therefore 90 was chosen as an estimate of the number of districts that will be involved in the upcoming fiscal year.

indicator of the PMMP and to link these to the available management information systems at district and sector levels. Next, the team gathered information from a number of key informants during visits to various stakeholders, starting with the UAC, UNAIDS, and the Ministry of Health (MoH). The team then visited and revisited over 10 additional organizations at the national and district levels holding meetings and focus group discussions on key issues and developed recommendations for PMMP implementation at the national and CSO levels. Working with the District Monitoring Tool supplied by the UAC, the team then developed a training guide for district level staff development. Working collaboratively with the UAC staff, the team developed a training plan and carried out a pretest of a training programme based on the training guide and plan in the three districts where an assessment had previously taken place. This experience, including visiting the three districts for assessments and pre-testing the training guide and training plan, provided an empirical basis for developing recommendations for the development of a staff development plan capable of successfully rolling-out the PMMP to all of Uganda's 90 districts in a 5- to 15-week period. The team then estimated the costs of this staff development plan and provided recommendations for technical assistance necessary for implementing the plan.

Operationallising the PMMP at the National Level

As a result of meetings with key informants, the team developed a series of 12 recommendations for operationallising the PMMP at the national level. These recommendations, which can be found in the body of this report, emphasize the need for the UAC to take an active role in prompting the different stakeholders by officially asking for the needed information and following up communications until it is provided. In summary these recommendations include: increasing engagement with stakeholders; creating reporting schedules; providing clear reporting mechanisms; specifying who should provide information; following-up with sector persons; developing a spreadsheet that automatically indicates which indicators are out of date; participating in the design of national surveys; and working with the MoH to develop a strategy for national level surveys. National level CSOs also have an important role to play in the PMMP. The team recommends that these CSOs be encouraged to report to the line sectors, regardless of their reporting obligations to funding partners. They also need to encourage their district level offices to share information and report to district planning staff.

Training and PMMP Implementation at the District Level

The team proposes a relatively quick and efficient plan that will result in the complete national roll-out of the PMMP at the district level in a 5- to 15-week period. This plan relies on: four to ten teams of trainers with three trainers per team; training of 12 staff from each district in a three-day training programme that emphasizes hands on experience and active participation focused on achieving specified skills; each training team conducts two training programmes per week. This training programme will require a coordinating unit that will manage scheduling of training, invitations to participants, transport of trainers and arrangements for participants, logistics, funding of allowances, venues, production of training materials, any changes in plans and follow-up communications/visits that may prove necessary to strengthen reporting, coordination, and use of data at the district level. This is a large and crucial coordinating activity that the team feels will benefit from technical

assistance with planning, implementation, and follow-up, which should be developed as a UAC or donor-funded project. Despite providing some introductory training on district level outcome indicators, the team found that district personnel in all three districts believed they could collect such indicators only if provided substantial resources, including funds, centrally developed survey instruments, and technical assistance for sampling, training of interviewers, data analysis, writing, and use of reports. In view of this substantial challenge to implementing this component of the PMMP, the team recommends that the UAC postpone attempts to collect this information and rely on national-level indicators.

Cost Estimates for the Roll-Out

The total estimated cost of the PMMP roll-out is US$2,709,215. Details of these costs are in the budgets (Appendices 1, 2, 3, and 4). This amount covers costs of implementing the capacity building for district teams, conducting the Lot Quality Assessment Sample (LQAS) surveys at district level, and support to the national levels (sectors and the UAC) in operationallising the PMMP. It does not include costs for technical assistance to UAC to assist with the roll-out.

1.0 Introduction

1.1 Monitoring the National Response

The Uganda AIDS Commission (UAC) is the Government of Uganda body mandated to oversee, plan, and coordinate HIV prevention and control activities of the nation. The mission of the UAC is to provide overall leadership in the coordination and management of the HIV/AIDS national response. As part of the efforts to achieve effective coordination, the UAC has developed a National HIV/AIDS Strategic Plan (NSP), a national M&E plan—the Performance Monitoring and Management Plan (PMMP)—and an operational guide for the PMMP. While the NSP has been launched, dissemination of the PMMP has only recently begun. The national roll-out of the PMMP has not yet begun except for piloting activities carried out by this project team in three districts.

The UAC adopted a national PMMP to track the performance of the national response to the HIV/AIDS epidemic. The PMMP is divided into the national and district level components. The national level component consists of 58 indicators, while the district response consists of 47 output indicators and 29 outcome indicators. The 58 indicators at the national level are intended to monitor the national level response and are therefore described as “outcome indicators”. The 47 indicators for the district level are “output indicators” aimed at monitoring the service delivery outputs from the districts (Appendix 8). These are required to be updated on a quarterly basis by districts and are meant to inform their planning and decision-making. There are also 29 indicators for monitoring district level outcomes, and these are aligned with the national level outcome indicators. Districts are supposed to use these latter indicators to monitor key outcomes at the district level. A PMMP operations handbook has been prepared, spelling out the detailed indicator definitions and the mechanisms by which these indicators can be collected at the district level.

The PMMP was developed by a consortium of stakeholders including representatives from the various sectors, agencies, and CSOs involved in HIV/AIDS interventions at policy and operational levels of the country. It therefore represents a consensus of stakeholders on what will be the key benchmarks for monitoring the national response and it implies a commitment by the different stakeholders to fulfill their obligations in contributing to the monitoring process. This is in line with the principle of “the three ones:”

- **One** agreed HIV/AIDS **action framework** that provides the basis for coordinating the work of all partners;
- **One** national AIDS **coordinating authority**, with a broad-based multi-sectoral mandate; and
- **One** agreed **monitoring and evaluation system**.

The UAC is not an implementing agency. Its role is to oversee and coordinate the national response. The UAC can help, request, resource, advocate, sensitize, guide, and support national-level and district staff to implement the PMMP guidelines. One of its main commitments is to standardize reporting. It does not wish to set up a parallel system for data collection and reporting. The approach therefore is to build on existing information systems at sector and district levels. The UAC system may not capture comprehensive data, but success in influencing stakeholders to use monitoring information will be a significant

achievement. The UAC is also clear in its observation that it has no direct mandate to run an operational level information system and therefore has to partner with sectors to monitor the national response.

The UAC wants to prioritize engagement at two levels: the sectors and the districts. The districts are responsible for actual implementation of HIV-related services, while the sectors are responsible for technical oversight and policy formulation. As such, the districts and sectors have a key role in ensuring availability of monitoring information, collating this information, and aggregating it so that it can be reviewed both at the district and the national levels. All other stakeholders are expected to channel their issues, including plans, interventions, and outputs, through the sectors and the districts; this also applies to civil society organizations (CSOs). The midterm review of the NSP is expected in December 2009, and the UAC hopes that by that time, the PMMP should have at least been disseminated to stakeholders.

1.2 Objectives of the Technical Assistance

This report presents a summary of key findings from the assessment of sectors, AIDS development partners (ADPs), CSOs, and the districts. It focuses on the team's recommendations for operationallising the PMMP at all levels. It includes specific recommendations regarding a staff development programme to operationallise the district reporting and data use in all 90 districts. Broad areas of support were included in the scope of work (SOW) for this project, including database development and management, capacity building of the UAC M&E staff, and operationallising the PMMP through stakeholder meetings, curriculum development, training, and reporting. In collaboration with the UAC and USAID, the team specified these broad areas into the following specific objectives:

1. Review and document operating M&E systems for the national and district level response, in relation to the PMMP.
2. Identify best practices, gaps, and challenges for PMMP operationallisation.
3. Describe a system and critical linkages required to make the PMMP operational.
4. Document requirements and propose evidence-based capacity building strategies that will successfully operationallise the PMMP nationwide.
5. Develop a training guide and plans necessary to implement the national capacity building strategy necessary to roll-out the PMMP to all 90 districts.
6. Estimate the costs associated with the national roll-out of the PMMP.

2.0 Methodology

2.1 Data Collection Methods for the Assessment Phases

The team generated information for this report from a number of key informants interviewed in the assessment of the situation, existing challenges, and approaches to overcoming these challenges at the national and district levels. This information provides a foundation for developing an overall framework for the necessary linkages in operationallising the PMMP. The assessment involved visits to stakeholders from different agencies. The team started with a meeting with the UAC and a technical meeting with UNAIDS and the MoH. The team then set up a schedule of visits and re-visits to different agencies, and held meetings and focus group discussions with key resource persons. Prior to each meeting, team meetings were held during which key issues for discussion with the particular agency were agreed upon.

The assessment was conducted using a "systems analysis model" that followed-up the different processes needed in making the PMMP indicators operational and described how these processes are related to each other. The table below provides a summary of the key information sources.

Table 1 Key information sources used in preparation of this report

National level

1. The Uganda AIDS Commission, M&E Section
2. The AIDS Control Programme (ACP), Ministry of Health
3. The Resource Centre, Ministry of Health
4. The Ministry of Gender, Labour, and Social Development (MoGLSD)
5. The Ministry of Education and Sports (MoES)
6. Uganda Bureau of Statistics (UBOS)
7. Uganda Network of AIDS Service Organizations (UNASO)
8. The AIDS Support Organization (TASO)
9. The AIDS Information Centre
10. Joint Clinical Research Centre (JCRC)
11. The Inter-religious Council of Uganda
12. UNAIDS
13. Document Review—the PMMP
14. Document Review—the NSP
15. Document Review—the Health Management Information System (HMIS) Manual
16. Meetings with AIDS Capacity Enhancement Project (ACE)
17. Meetings with Infotronics
18. Meetings with the National Committee on M&E
19. Synthesis meetings of the assessment team

District level (3 districts)

1. The District Health Officers (DHOs) and the District Health Teams (DHTs)
2. Focal persons for specific programmes (anti-retroviral therapy [ART], prevention of mother-to-child transmission [PMTCT], HIV counseling and testing [HCT]/lab, tuberculosis [TB]/leprosy, and condoms)
3. The Chief Administrative Officers (CAOs) or Assistant Chief Administrative Officer (ACAOs) of Health
4. The District Planners and their teams
5. The District Education Officers (DEOs) and their teams
6. The District CSOs and their teams
7. Representatives of CSOs
8. District hospitals, health centre III and IV teams

2.2 Developing and Pre-testing Training Plans and Materials

After assessing the situation at the district level in three districts, determining the challenges and possible solutions to these challenges, the team developed a district training guide and a training plan based on the guide (Appendix 9). Both the training guide and plans were pre-tested in three districts. The pretest experiences resulted in recommendations for adjustments to the training guide and the training plans, and the development of recommendations for how training the staff in all 90 districts can be accomplished.

2.3 Data Management and Analysis

After each initial assessment meeting, team members wrote summary minutes of the discussions and key observations. The team reviewed these minutes frequently, along with the results of the team's document review while seeking an overview and understanding of the issues and a consensus on final recommendations for how the national and district programmes can be implemented. Data on the progress of the training pretests were reviewed informally in a dynamic process of faculty discussions during travel, training breaks, reviews of the training evaluation forms, and afterwards. The team consolidated these recommendations into a report on the lessons of the initial training programme at Kumi and Mukono-the first two district training programmes. These reports were circulated for comments among all team members and the UAC staff. The final decisions on these training plans were made collaboratively with the UAC.

2.4 Limitations

The district analysis and the resulting training plans were based on the team's analysis of the situations in three districts selected to represent different regions, relationships to urban centers, experiences with development programmes, and other features (Appendix 7). Visits were limited to three districts based on the available resources for the assessment and training. This small convenience sample may not be representative of the districts as a whole.

Not all features of the training could be pretested because the training teams were not supplied with all of the appropriate tools necessary to conduct training using e-forms. An extra day of training was added to allow this material to be covered, but it has not been pretested.

3.0 Findings and Recommendations for Making the PMMP Operational

3.1 Recommendations on Linkages with Sectors

The diagnosis of responsibilities for specific indicators of the PMMP and the description of the situation at the national, CSO, and district levels has been extensively documented in all previous interim reports (Appendices 10 and 11). Rather than repeat that analysis of findings, including the challenges uncovered, it will merely be stated that there are a large number of challenges at every level and that the team developed recommendations that address them all. If these recommended actions are followed, the team believes that a functioning PMMP system will be rolled-out and set in operation. The following section presents the recommendations.

3.1.1 Recommendations on linkages with the Ministry of Health and proposed actions

1. The UAC and MoH should agree on a schedule, with key dates and a budget for collection of data and information required for the updates of PMMP indicators. Such a plan could be funded through the UAC partnership fund or other available and reliable sources, in addition to the funding sources within the Ministry.
2. Indicators that require periodic surveys should be updated as and when new information is available, and the UAC naturally should be part of the planning process for these surveys. For other indicators that do not require surveys (e.g., those updated from ACP programme reports, the Resource Centre, the National Drug Authority [NDA] and Uganda Blood Transfusion Service [UBTS]), the UAC should communicate to stakeholders the suggested reporting mechanism and a list of key dates. For those that have to be updated on an annual basis, we propose 1 July as the reporting date.
3. For all indicators, a five-year schedule should be drawn indicating the datelines. If data on an indicator is not available at the time it is scheduled to be updated, then the update should reflect the most recent estimate available and indicate that this information is not up-to-date. The recipient database should be able to indicate the due dates for each of these indicators, the date when they were last updated, and if they are out of date, indicate by how many months.
4. The reporting mechanisms and contact points need to be clearly articulated.
5. The MoH is set to review the HMIS in 2009. This provides an opportunity for negotiations to see if additional district-level outputs can be integrated, so that data sourcing mechanisms are as lean as possible.
6. Most-at-risk populations (MARPs) Surveys, Condom Availability Surveys, and People Living with HIV/AIDS (PLHA) Surveys could be merged into one survey to reduce the number of surveys that need to be conducted in the five-year cycles. Some aspects of these surveys could be merged with the AIDS Indicator Survey (AIS) or the Uganda Demographic Health Survey (UDHS), with oversampling of the specific populations.

7. Resources for surveys that are not funded should be mobilized through the partnership fund under the UAC as per the indicator update schedule and resources disbursed to MoH for implementation.

3.1.2 Recommendations on linkages with other agencies and sectors

1. The UAC needs to conduct follow-up round-table discussions with the MoGLSD and the MoES, and to negotiate mechanisms through which the indicators expected from them will be serviced on an annual basis. The focus should be on integrating the PMMP indicators in their respective MIS.
2. Since the MoGLSD is developing a HIV/AIDS M&E system, now is the time to negotiate inclusion of the indicators that the UAC would like to collect, both at national and district levels.
3. Since the MoES has a sectoral MIS, the negotiations should focus on how the required indicators at national and district levels can be integrated into the routine reporting tools.
4. The Ministry of Local Government is already running the Local Government Information System (LOGICS). The UAC should conduct harmonization meetings and engage the Ministry of Local Government to include the HIV Monitoring Indicators for the district level (both output and outcome indicators), but especially focusing on the HIV Coordination Index, which currently does not seem to be under any sectoral MIS.
5. As the UAC focuses on engaging the districts and sectors to provide up-to-date data, it needs to develop its own plan for updating the five indicators that the PMMP stipulates will be directly updated by the UAC.

3.1.3 Overall recommendations for operationallising the PMMP at national level

Almost all the key informants from the different agencies agree that the UAC should actively engage the different stakeholders to provide the required monitoring information. The UAC should prompt the different stakeholders by officially asking for the needed information and following them up until they provide the information. Unlike routine reporting, monitoring information, by definition, requires active sourcing from the people being monitored. The team recommends that the UAC:

1. Increase its engagement with stakeholder agencies and sectors (specifically the MoH and line agencies, the Ministry of Gender, Labour and Social Development, the Ministry of Education and Sports, and the Ministry of Local Government) to provide the required monitoring information and scheduled indicator updates during biannual, annual, and other stakeholders' meetings. This should be done through a series of harmonization and micro-planning meetings with the Sector Focal Persons and key persons in coordination of the sector monitoring activities. In these meetings, the UAC and sectors should agree on a mechanism for information sharing.
2. Create a schedule for updates of the national level indicators clearly indicating the date, month, and year on which each indicator needs to be updated and disseminate it to the stakeholders (for consistency with the major national survey cycles and programme reporting cycles).

3. Disaggregate and categorize the 58 impact indicators of the PMMP by their expected sources and modes of collection (we have provided this categorization in the Appendix 8) and disseminate this to the actual persons responsible for providing this information in the sectors; this should take the form of an official communication, so that reporting requirements are formalized.
4. Develop a list of contact persons who should provide the updated information, and specify who should contact them and the information exchange mechanisms that should be used.
5. Articulate a clear reporting mechanism and circulate a reporting blank or reporting forms for the indicators for which the sector is responsible and specify who fill them at sector level and how they should be relayed to a central monitoring database.
6. Conduct regular follow-up of the Sector Focal Persons who are expected to play an active role in coordination of the sourcing activities for the PMMP indicators within the respective stakeholder sectors, based on the five-year schedule.
7. Engage Sector Focal Persons to follow-up the relevant desk officers responsible for indicators that need to be updated on an annual basis (those from programme reports and sectoral MISs).
8. Develop an automated spreadsheet that shows the status of each of the indicators, when it was last updated and when it is due for updating. The system should be able to flag when the indicator is outdated. It should be maintained by the UAC M&E Coordinator. If data on an indicator is not available at the time it is scheduled to be updated, then the update should reflect the most recent estimate available and indicate that this information is not up-to-date. The recipient database should be able to indicate the due date for each indicator, the date when each was last updated, and, if out of date, indicate by how many months.
9. Participate in the design, conduct, and analysis of assessment activities for indicators that are to be collected in scheduled national surveys (e.g., the UDHS, AIS) to ensure that PMMP indicators are incorporated within their protocols, with adequate disaggregation of information as specified in the PMMP.
10. Conduct discussions with ADPs and sectors to negotiate resources for those surveys where resources are not guaranteed (e.g., MARPs and PHA Surveys). In order to do this, the UAC needs to have estimates of the cost of these additional surveys for a five-year period.
11. Update its portion of the 58 indicators, i.e., the five indicators that it plans to up-date annually.
12. Work with the MoH and UBOS to develop a strategy for national level surveys. Where possible, aspects of these surveys should be integrated in other existing surveys. However, the UAC should engage the line sectors and ADPs to identify resources to sustain and regularize these surveys.

3.2 Recommendations on Gaining CSO Involvement at the National and District Levels

3.2.1 Recommendations on integrating national level CSO into the M&E loop

1. A CSO subcommittee of the National M&E Committee should be formed to ensure inclusion of national-level CSOs in the national-level monitoring activities. The subcommittee will coordinate their M&E activities and promote information sharing between the private and public sectors. The committee should convene a meeting with the major national-level CSOs to agree on the modalities for capturing data from the CSOs as part of the monitoring of the national response.
2. As much as non-governmental organizations (NGOs) are being funded by ADP, they have a duty to be accountable to their line sectors at the national level. National-level CSOs should therefore be engaged to report to their line sectors, and there ought to be a national-level policy and deliberate action within the Ministries to develop this information loop. This should be implemented through a series of harmonization meetings with the national-level CSOs, sponsored by the UAC, but convened by the line Sector Focal Persons.
3. For national-level CSOs that implement district-level operations, reports for the district-level service delivery points should be channeled to the District Health Offices and the aggregated reports should clearly indicate to the Ministry of Health the part of their output that was reported through the district system and the part that was not.

3.2.2 Recommendations on integrating district level CSOs into the M&E system

1. District-level CSOs should be coordinated at the district, and therefore report their data and information through the line departments in the district. For example, health facility-based, district-level CSOs should report to the Health Office, while community-based CSOs should report to the Community-Based Services Department in the district.
2. UAC should develop a simple data capture form for the district-level CSOs.
3. Consideration should be given to the adoption of data collection tools developed by the M&E agency for the Civil Society Fund (CSF) to collect output data from CSOs at district level and integrate it into the district M&E report.

3.3 Recommendations on Linkages with Districts

3.3.1 Recommendations on strengthening HIV coordination at district level

1. In order to promote a multi-sectoral intervention, the District Planning Unit should be the lead agency at the district level to coordinate the HIV monitoring activities, regardless of the department that hosts the District HIV Focal Person. The planning unit is best suited to leverage the different sectors in developing a multi-sectoral HIV/AIDS plan. It is also the one best suited to mobilize the different sectors to provide M&E data and to present it to the District HIV/AIDS Committee (DAC) meetings. The HIV Focal Persons should work closely with the planning unit in convening and conducting the DAC.

2. In the absence of external support to the HIV/AIDS plan, the District Planning Unit should provide a line in its annual budget to facilitate HIV coordination activities (e.g., meetings of the DAC as well as supportive supervision, collection of monitoring information).
3. In the absence of external funding for coordination activities, the District Planning Unit, or the department that hosts the HIV Focal Person, should include in its annual work plan a budget line for coordination of HIV activities.

3.3.2 Recommendations for operationallising the quarterly monitoring of HIV outputs in the districts

1. There are four main stakeholder departments that should be brought on-board in completing the quarterly sector progress reports in the districts. The District HIV/AIDS Focal Persons should focus on these four departments in order to pool the minimum information required for monitoring the district level outputs.
    a. The District Health Office
    b. The District Education Office
    c. The District Community-based Services Office
    d. The District Planning Unit and Administration
2. There is a minimum of 14 core district officers or Focal Persons required for all the different pieces of information contained in the quarterly sector progress report to be filled. These are the (those denoted with asterisk are key participants):
    a. Under the District Health Office
        - District Health Educator*
        - District HMIS Focal Person*
        - District TB/Leprosy Supervisor*
        - District PMTCT Focal Person*
        - District HCT Focal Person*
        - District ART Coordinator*
        - District Condom Coordinator
    b. Under the District Education Office
        - District Inspector of Schools*
        - District Education Officer
    c. Under the District Community-based Services Office
        - District Community-based Services Officer (CBSO)*
        - District Probation and Welfare Officer
    d .Under the Office of the Chief Administrative Officer and the District Planning Unit
        - District Focal Person (DFP)* (regardless of the department to which they are attached, they require a close linkage with the planning unit and administration)
        - District Planner
        - ACAO in-charge of health*
3. An "active surveillance approach" is necessary for the above resource persons to actively seek out this information from the relevant sectors on a periodic basis from available information sources. The DFP should engage the critical officers on a quarterly basis to seek their input into the report.

4. For indicators that do not currently have a mechanism for routine information collection, the line ministries should develop protocols, tools, and a strategy for collecting the required information. Specifically, these include the following:
    a. MoH
        - Development of a protocol/tool for collection of non-facility-based information and data on community-based service and social intervention activities, like information, education, and communication (IEC).
        - Adoption of the data collection tools developed by the M&E Agency for collection of non-facility-based HIV/AIDS data from CSOs.
    b. UAC
        - Development of protocols and tools for collecting data and information for measurement/calculation/estimation of HIV/AIDS allocations and spending at national and district levels.
        - Development of a tool for measurement of capacity for M&E at the district level.
        - Adoption of the data collection tools developed by the M&E Agency for collection of non-facility-based HIV/AIDS data from CSO.

    This implies therefore that the sectors have to be conversant with the district level output indicators and they have to be actively involved in supporting the districts to monitor their local HIV outputs.

5. When the quarterly sector report has been completed, the HIV Focal Person, in liaison with the District Planning Unit, should then convene the DAC to discuss the report. Thereafter the report should be shared with line sectors (especially the Ministry of Health, the Ministry of Gender, Labour, and Social Development, the Ministry of Education and Sports, and the Ministry of Local Government). Quarterly reporting to the sectors should be to the Sector Focal Persons. A copy of the district quarterly report should be sent directly to the UAC.

6. Information and communication technology capacity at the districts and the line sectors should be built, and the relevant software and database installed, so that these reports can be sent electronically. At the district level, the HIV Focal Person should be responsible for entering the quarterly monitoring information into the district database, and a computer with the database should be provided in the District Planning Unit for this purpose. At the sector level, the Sector Focal Persons should be responsible for updating the database. At UAC, the M&E Unit should maintain the central database that receives updated information from the districts and sectors.

7. As planned, the districts should be assisted to establish and maintain a database of these monitoring reports, so that any agency seeking this type of information can access it easily. The database should be updated by the HIV Focal Person and should be part of the information system in the District Planning Unit. Once established, the UAC should conduct a follow-up evaluation to assess how well the districts are generating and using monitoring information and to provide further assistance as may be necessary.

8. In order for the information generation, use, and sharing loop to be successful, there have to be key dates institutionalized for: completing the tool on a quarterly basis, discussing the information in the DAC, sharing this information with the sectors, and the sectors sharing the aggregated district information with the UAC.

9. Because the UAC is a major stakeholder in monitoring the district response, all districts should send a copy of their monitoring reports to the UAC at the time they send the report to the line sectors.
10. There is need to train a critical number of the key stakeholders in monitoring the district level response. Details of this are described in the training plan.

3.3.3 Recommendations on operationallising the monitoring of district level outcomes

1. The UAC should develop a standard protocol to measure the district specific HIV/AIDS programme performance in the future. The LQAS methodology is recommended for all districts.
2. The UAC should mobilise resources to fund and roll-out the community level surveys to all districts in a phased manner starting with districts where capacity has been identified. Capacity building of districts in the implementation of the community surveys should be part of the roll-out plan to be implemented in the future.
3. The different periodic surveys expected for monitoring HIV-related outcomes at the district level should be integrated into one survey, conducted at least once in the next five years. Emphasis should be placed on making the LQAS methodology as simple as possible so that districts are able to conduct them more regularly (e.g. annually). LQAS, if simplified, can be conducted annually. However, the assessment team notes that capacity for these surveys is still lacking in many districts. For this reason it is recommended that LQAS surveys be conducted once in five years as a minimum for monitoring HIV-related outcomes. Districts that have capacity and additional support should conduct annual LQAS surveys. The surveys could be more frequent for other socio-economic and development issues and if resources are available.
4. Districts should be provided technical support to design and implement community-level HIV/AIDS surveys. This support should include some financial resources, central design of instruments, and substantial technical assistance on sampling, training, data analysis, and use.
5. Districts need to be guided on how they can raise funds for these surveys, budget for them, and make them a routine information management tool in their medium-term planning cycles.
6. In the absence of the substantial resources required to implement district-level monitoring of outcome indicators, the UAC should postpone attempts to collect this information from districts and instead rely on national level indicators. However, different development partners will be in a position to conduct LQAS surveys in their areas of operation.
7. USAID is planning to conduct about 40 LQAS surveys at the district level in the near future. Different development partners have also conducted LQAS surveys in different districts in line with their operational objectives. We propose that the LQAS surveys conducted by different development partners and agencies should be coordinated and aligned. They should follow a similar protocol and data collection tool that is standard and captures all the PMMP indicators.

3.4 Recommendations on Training and Capacity Development for Sectors and Districts

3.4.1 Training of the district HIV/AIDS monitoring teams

In order to build a critical mass of resource persons who can operationallise the PMMP at the district level, we recommend that all districts receive training specifically in the output indicators.

Format for the training: We recommend that each district be trained on its own, using an apprenticeship format. Although this format (Appendix 9) of training is more costly in terms of resources, it is preferred in comparison to the workshop format[2] because:

- It will allow a hands on approach in which the district teams can collect actual data as a means of trying out the new quarterly monitoring report.
- It allows for training of more people at a time.
- The target trainees are mostly heads of departments, hence they are busy people; if a workshop format is implemented where they have to be away from their district, many are likely to send their assistants rather than attending themselves.

We therefore recommend that a total of 90 training programmes (if we factor in some of the 14 new districts to be created next financial year) be conducted.

Number and composition of training teams: We recommend that the UAC develop between four and ten national training teams, each with three trainers with experience in both training activities and the PMMP. The number of teams would be based on UAC's desired speed for the roll-out and its ability to support the teams. At least one team member should be a regular staff member of the UAC, and at least one team member should be from one of the three sectors that have a strong stake in the PMMP.

- The primary responsibilities of two of these staff are to conduct the training.
- The responsibility of the third staff is to manage all materials, logistic, and financial arrangements during the training programmes.

Each team could cover two districts per week. Depending on the number of teams, the trainings could be conducted over a 5- to 15-week period, with breaks to be determined as appropriate.

Length of each training programme: Each training programme will last three days utilizing the training guide and training plan (Appendix 9). The basic training will last one day, followed by actual data collection and feedback over one day. Thereafter, the database training shall follow for about one day. This will require hands-on practice with computers.

Active, participant-oriented training: As is clear from a review of the training guide, training plan, and the annexed reports, trainers will place a strong emphasis on participant-oriented, active exercises and direct, hands-on, real field data collection and computer experiences.

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[2] Workshop format implies inviting people from several locations and training them together.

Additionally, participant reviews of information in small group discussions and plenary reports will replace lecturing.

Required training materials: Each training team will carry to each district the following materials:

- 15 copies of the training guide
- 15 copies of the training schedule
- 15 copies of the training evaluation form
- 15 copies of the district quarterly monitoring tool
- Newsprint, marking pens, and masking tape
- 2 laptops
- The database software developed by Infotronics
- Each training team requires a vehicle and a driver

Number, representation, and positions of trainees: Twelve district-level staff from each district will be invited to each district-based training. The invited participants will represent the District Health Office, the District Education Office, the District Community-based Service Office, and the District Planning Unit and Administration. Specific positions of invitees will be:

a. Health Department
    1. District Health Educator
    2. District HMIS Focal Person
    3. District TB/Leprosy Supervisor
    4. District PMTCT Focal Person
    5. District HCT Focal Person
    6. District ART Coordinator

c. Education Department
    1. District Education Officer
    2. District Inspector of Schools

d. Community-based Services Department
    1. District Community-based Services Officer
    2. District Probation and Welfare Officer

e. Administration and Planning Unit
    1. District HIV Focal Person (or District Planner if the Focal Person is not in the Planning Unit)
    2. ACAO In-charge of Health

Evaluation of training: All training programmes will be evaluated with the training evaluation form, which may be upgraded as experience suggests. Possible changes in training plans will be made based on these evaluations. The receipt of quarterly reports from districts and the quality of those reports will serve as the most appropriate longer-term indicator of the level of success achieved with the training (see Appendix 6 for an example).

Coordination of training: This training programme will require a coordinating unit that will manage scheduling of training, invitations to participants, transport arrangements for participants, logistics, funding of allowances, venues, and production of training materials.

Follow-up of training: The Training Coordination Unit will work collaboratively with the M&E unit to review quarterly reports received, and provide feedback and suggestions to individual district staff to improve the quality of their reporting.

Technical assistance: This is a large and crucial coordinating activity that will benefit from technical assistance with planning, implementation, and follow-up, which should be developed as a UAC or donor-funded project.

3.4.2 Capacity building for the sectors

We recommend that the sectors be engaged through meetings and discussions rather than a formal training. The UAC should therefore conduct a series of meetings with the Sector Focal Persons and other key officers responsible for collation of the different indicators required for the national level monitoring (Appendix 5).

3.4.3 Long-term capacity building

The proposed district training is not an M&E course; rather, it is specific to the PMMP output indicators. In order to build longer-term capacity for M&E for district and sector teams, we propose that a credible training institution be facilitated to develop a full-fledged certificate course in M&E to be offered either as a short-term modular course or a short-term distance learning course for district and sector officers who are critical to the monitoring of social and development programmes. District teams should then be facilitated to undertake this course in a phased manner, over a medium-term time frame.

4.0 Estimated Cost of the PMMP Operationallisation

The estimated cost of operationallising the PMMP is appended together with a budget justification (Appendices 1, 2, 3 and 4). These costs are itemized as follows:

District Level

Support to PMMP output indicator scale-up to the districts Includes:	**US$**	**1,098,315**
Conducting a training/apprenticeship programme for PMMP operationallisation: • Logistics (Venue, transport refund for participants, food and beverages, hired consultant trainers, transportation for trainers, computer hire) • Printing of training materials and other materials (Apprenticeship/indicator training manual, e-database/software training manual, file folders, participant name tags, markers, pens, masking tape) • Printing copies of PMMP, NSP, and PMMP operational manual	US$	527,715
Producing district quarterly report on output indicators: • Support on HMIS (Data collection of all reports from all health units, data entry, analysis of HIV/AIDS HMIS) • Supporting collection and analysis of data (TB, IEC, education, orphans, and management indicators, support the writing and production of the overall district quarterly report on HIV/AIDS)	US$	156,600
Half day meeting to present and share the district HIV/AIDS report with all district level stake holders • Venue, meals, day allowance for personal support from the UAC, transport team from the UAC	US$	414,000
Support to district level surveys for the outcome indicators Includes:	**US$**	**1,392,300**
• Training materials (Venue, transport refund for trainees, stationery, meals)	US$	225,000
• Survey costs (Transport during data collection within the data collector's allowances/wages, questionnaires)	US$	296,100
• Central level costs for provision of technical support (Trainers' per diem, per diem for driver, transportation of trainers)	US$	385,200
• Data entry and analysis (Manual data tallying, district level data analysis and report writing, computerized data entry, further data cleaning and aggregated analysis at the UAC)	US$	486,000

National Level

Support to roll-out activities at the national level	**US$**	**218,600**
Includes:		
Support to harmonization activities at sector level	US$	175,000
• Production of the national quarterly report on output indicators: MOH (Provide support for reviewing data and reports, writing progress output report, and hold validation meeting)	US$	19,600
• Production of the quarterly report on education and orphans (Support integrating PMMP indicators within EMIS, support reviewing EMIS and orphan data and analysis for PMMP indicators)	US$	8,400
• Production of six months report on management indicator by the UAC (Compiling and analysis of available data on management PMMP indicators, produce quarterly report)	US$	0
• Annual status report of PMMP outcome indicators (Review and compile status report)	US$	6,000
• Reviewing of the overall national report on PMMP indicators (Writing and production of an overall semi-annual report, meeting to discuss semi-annual report, writing annual national report, meeting to discuss annual report)	US$	9,600
Total estimated cost of the PMMP operationallisation	**US$**	**2,709,215**

5.0 Discussion

Population Council, MUSPH, and the UAC staff have collaborated on conducting an analysis of factors influencing the roll-out of the UAC's PMMP at the national, CSO, and district levels. Challenges have been explored in-depth at all levels, and recommendations for addressing the challenges have been proposed and reported previously in the detailed interim project reports. This final report has focused on a summary of these recommendations, which have been updated by the empirical experience gained in conducting training in the three pilot districts and the presentation of the recommendations on training and estimated costs for the PMMP roll-out. In addition, at the request of the UAC M&E technical working group for the purposes of their action planning, we have proposed next steps for following up the recommendations of this report (see Appendix 12).

The roll-out will require careful planning and technical oversight, as well as resource inputs, in order for it to be successfully accomplished. The team anticipates that many district participants will be able to submit quarterly reports after the training programme. However, it is likely that these reports will not be complete and without mistakes. It is thus important to continue to provide feedback to each district, distribute overview communications covering patterns of issues needing attention, and possibly arranging revisits to poorly performing districts. The extent of these activities can only be known after the programme starts and quarterly reports arrive. It is recommended that before the UAC undertakes the roll-out, efforts are made to organise staff and prepare the training unit, and arrange for technical assistance for this unit. The team recommends that technical assistance be provided from an agency familiar with the PMMP and the training plan.

While the UAC would like there to be individual district surveys for the collection of the district outcome indicators, it is the team's opinion that it is unlikely that these indicators can be collected at the district level in the near future and will require substantial funding, technical assistance, and development of instruments before this activity can begin. Recognizing these difficulties and the already challenging aspects of what is being required of district-level personnel in the PMMP roll-out, the team is unanimous in recommending that training and expectations on this component should be underemphasized in training. National-level indicators from the Demographic and Health Surveys should be relied upon until the district-level phase-in can begin sometime in the future, after the quarterly reporting system is well-functioning.

In sum, during the period of October 2008 to September 2009, staff of the Population Council, MUSPH, and the UAC have worked collaboratively to accomplish the objectives of this project. The project team reviewed and documented the existing operating M&E systems for the national- and district-level response and identified changes necessary for the roll-out of the PMMP. The team involved many key informants from a variety of organizations and conducted extensive and detailed analysis of gaps, challenges, solutions, and critical linkages required to operationallise the PMMP. The team documented requirements, developed a training guide to meet those requirements, and proposed an evidence-based national capacity building strategy to operationallise the PMMP in 90 districts. Finally, the team developed cost estimates for the national roll-out of the PMMP. Recommendations have been provided in this final report on all aspects of the national, CSO, and district-level functioning of the PMMP. What is required now is for these recommendations to be acted upon.

Appendix 1: Budget for the District Level PMMP Scale-Up

Costing for Both District Output and Outcome Indicators in 90 Districts						
Measuring of district specific/level outcome indicators—Every five years	**Unit cost US$, 2,000Ug/US$**	**Qty/No. of participants**	**No. of days**	**Number of clusters trained (Five districts per cluster)**	**Number of times (Once in five years)**	**Total cost (for 90 districts)**
Training materials						
Venue	100	1	5	18	1	9,000
Transport refund for trainees	10	75	5	18	1	67,500
Stationary	750	1	1	18	1	13,500
Meals	20	75	5	18	1	135,000
Survey costs						
Transport during data collection within the district*	30	38	5	18	1	102,600
Data collector's allowances/wages	50	15	5	18	1	67,500
Questionnaires	10	700	1	18	1	126,000
Central level costs for provision of technical support						
Trainers' per diem—during training	250	5	15	18	1	337,500
Per diem for driver	50	1	15	18	1	13,500
Transport trainers—vehicle hire	100	1	15	18	1	27,000
Fuel for hired vehicle	400			18	1	7,200
Data entry and analysis						
Data tallying (capture/entry), done manually	50	75	5	18	1	337,500
District level data analysis and report writing	50	5	5	18	1	22,500
Computerized data entry	20	10	10	18	1	36,000
Further data cleaning and aggregated analysis at the UAC**	250	3	40	3	1	90,000
					Total 1	**1,392,300**

*Assume a pair (38) pays US$30 per day for transport within a supervision area

**Data analysis and cleaning will be done in groups of 30 districts therefore three clusters

Operationallisation of PMMP at District Level					
Training/apprenticeship programme for PMMP operationallisation	**Unit cost**	**Qty/No. of participants**	**No. of days**	**No. of districts**	**Total**
Logistics					
Venue hire	100	1	3	90	27,000
Transport refund for participants	20	12	3	90	64,800
Meals (breakfast, break tea, lunch, drinking water)	20	12	3	90	64,800
Hired consultant trainers	250	3	3	90	202,500
Per diem for consultant trainers (3) and driver (1)	50	4	3	90	54,000
Transport trainers—vehicle hire	100	1	4	90	36,000
Fuel for hired vehicle	200	1	1	90	18,000
Computer hire (three laptops to be hired)	60	1	3	90	16,200
				Sub-total	**483,300**
Printing of training materials					
Apprenticeship/indicator training manual	10	15	1	90	13,500
E-database/Software training manual	5	15	1	90	6,750
Other materials					
File folders	1	15	1	90	1,350
Participant name tags	1	15	1	90	675
Markers (packet)	7	1	1	90	630
Pens	7	1	1	90	630
Masking tape	7	1	1	90	630
				Sub-total	**24,165**
Printing copies of PMMP, NSP, and PMMP operational manual					
PMMP	5	15	1	90	6,750
NSP	5	15	1	90	6,750
PMMP operational manual	5	15	1	90	6,750
				Sub-total	**20,250**

Producing district quarterly report on output indicators					
Support on HMIS					
Data collection of all reports from all health units (including HIV,TB)	10	1	60	90	54,000
Data entry, including cleaning	10	1	60	90	54,000
Analysis of HIV/AIDS HMIS	10	1	4	90	3,600
				Sub-total	**111,600**
Supporting collection and analysis of data					
TB	10	1	32	90	28,800
IEC	10	1	10	90	9,000
Education, orphans, and management indicators	10	1	3	90	2,700
Support the writing and production of the overall district quarterly report on HIV/AIDS	10	1	5	90	4,500
				Sub-total	**45,000**
Half day meeting to present and share the district HIV/AIDS report with all district level stake holders					
Venue	100	1	4	90	36,000
Meals	20	40	4	90	288,000
Day allowance for personal support from the UAC	100	3	2	90	54,000
Transport for team from the UAC	200	1	2	90	36,000
				Subtotal	**414,000**
				Total 2	**1,098,315**

	90 districts	**One district**
Outcome indicator survey cost	1,392,300	15,470
District PMMP roll-out cost	1,098,315	12,203.50
Grand total	**2,490,615**	**27,673.50**

Appendix 2: Budget Justification for the District Level PMMP Scale Up

Activities shall be implemented in 90 districts. All costs have been calculated to cover the 90 districts.

A. Measuring of District Specific/Level Outcome Indicators

This activity will be conducted once every five years. There will be collection of survey data, manual data tallying and analysis (at the district level). Subsequently, data will be entered electronically at the district level, through their planning units. Technical support will be provided at various levels of the activity implementation.

This activity will be conducted in clusters of five districts each; hence a total of 18 clusters will be trained, in order to cover the 90 districts.

Note: The column “Number of times (once in five years)” represents how often the LQAS will be conducted in the interval of five years. It was previous thought that the UAC would have surveys conducted twice i.e. at 2.5 years, but this seemed too expensive. We therefore have a one in this column to further specify that the surveys will be conducted once every five years.

Specific costs involved in this activity will include:

- The LQAS has a standard procedure for the sample size determination, training, and analysis. Every district is divided up into supervision areas, where on average a district can have seven such areas at county or sub-county level. Each supervision area provides two field workers for training, data collection and analysis. This implies that each district will have fourteen individuals, in addition to a supervisor making a total of 15 people per district. Each supervision area will have to provide nineteen questionnaires (respondents) for the survey, which is equivalent to 133 (approximately 140) participants.
- Training is conducted in clusters of districts, and the suggested manageable number participants should not exceed 80, implying five districts can form clusters for this purpose. With the 90 districts in Uganda, this boils down to eighteen such clusters. This description forms the basis for this outcome indicator survey budgeting approach.

i) Training

A 5 day training in data collection methods will be conducted for 75 prospective data collectors, 15 drawn from each of the 5 districts to be trained at a given time. Overall, a total of 18 clusters of 5 districts will be trained. The participants will be provided with break tea and lunch. A venue will be hired at a rate of US$100/day for the 5 training days per group to be trained. All trainees will receive a US$10 transport refund per day to facilitate their travel to and from the training venue. Stationery for this training will include sample questionnaires, flip charts, pens, markers, note books, file folders, etc.

ii) **Survey**

Fifteen data collectors per district will be hired to collect survey data. These will be paid a daily allowance of US$50 during this period. Each pair of data collectors within a supervision area will require transport to and from the data collection sites. Approximately 140 questionnaires will be printed for each district, for use in data collection. The estimated cost of printing shall be US$10 per questionnaire.

iii) **LQAS data entry and analysis**

All the trained data collectors will participate in manual data analysis, interpretation and writing of the district-specific report. For this task, each participant will be paid US$50 per day. Data analysis and report writing will take a period of five days to complete. In addition to the hand tabulation, the districts shall also do computer data entry and analysis. This will be done by the District Planning Unit. The UAC will produce the data entry screens and send to all districts. Districts will need two people for data entry for ten days, to do double entry for purposes of quality control. Each data entry person will be paid US$20 per day. The district statistician will do the data analysis. Once data has been entered, data will be sent to the UAC, for further cleaning and aggregated analysis. The UAC will need 40 days to clean and analyze the data for a group of 30 districts. This will need one data analyst and two assistants, who will be paid at consultant rate.

iv) **Central level costs for provision of technical support**

This will include per-diem for a district trainer to provide support supervision/technical support for the period during data collection, data analysis and report writing. Each district will contribute one trainer. A per-diem rate of US$250/day will be offered. Each trainer will be engaged for a total period of 15 days, 5 of which are for the training period, 5 for data collection and 5 for data analysis and report writing. A vehicle will be hired to transport the trainers at a rate of US$100/day, for the total duration of 15 days. Fuel for the hired vehicle has also been included. The driver will be paid a per-diem at a rate of US$50/day for the 15 days.

Budget justifications below give details for an individual district

B. Producing District Quarterly Report on Output Indicators

Although data collection, analysis and report writing will be done on a quarterly basis, the budgeting has been done based on a full year i.e. annualized. Also, we note that this is support to the districts to ensure that these data are regularly and continuously provided.

i) Support on HMIS

a. **Data collection of all reports from all health units (including HIV, TB)**: The District HMIS Focal Person will collect HMIS reports from all health units. It will take five (5) person days per month for 12 months. The costs involved include communication costs to all health units to submit their reports and this will be a contribution to the costs involved in collecting HMIS data.

b. **Supporting the District HMIS Focal Person to enter data from HMIS health facility reports**: Five (5) person days per month for 12 months. The costs involved cover an allowance, which is a contribution to ensure that HMIS data is entered and analyzed.

c. **Supporting the analysis of HIV/AIDS HMIS data**: One (1) person day per quarter will be dedicated to the analysis of the HMIS data for the district PMMP indicators to facilitate producing of the district HIV/AIDS report.

d. **Supporting the collection and analysis of data on TB**: Approximately eight (8) days every quarter will be used to collect and analyze TB data collected from all district TB treatment centers. Each activity day, the TB Focal Person will be provided with US$10 to facilitate travel and communication with the health units.

e. **Supporting collection and analysis of data and information on IEC**: Ten (10) person days. This will be support to the District Health Educator to collect data on all district IEC PMMP indicators. This will be on the assumption that MOH /ACP develops data using IEC data collection tools which currently do not exist. The funds will be budgeted for under the district HIV/AIDS work plan.

f. **Supporting collection and analysis of data on education, orphans, and management indicators**: The District Education Office, the Probation Officer and District Planner will be supported with US$10 each for one day to collect the required data on the PMMP indicators.

g. **Supporting the writing and production of the overall district report on HIV/AIDS for the quarter**: One person at the district will be assigned to put together all the data and information generated on HIV/AIDS and produce a district HIV/AIDS report. This will take about five (5) days to complete and facilitation of US$10 will be provided per day.

h. **Support ½ day meeting to present and share the district HIV/AIDS report with all district level stakeholders**: The meeting will be convened by the District HIV/AIDS Focal Person, as part of the routine district HIV/AIDS Coordination meeting. During the meeting the district stakeholders will discuss and validate the district HIV/AIDS report before submission to the UAC. The costs will be for communication to invite the stakeholders, coffee /tea during the meeting as well as transport refund to the members. Personnel from the UAC will provide support during these meetings. They will be provided with transport from Kampala and day allowance.

C. Operationallisation of PMMP at district level

This training budget has done with the assumption that the UAC does not have sufficient staff to handle this massive task, and will therefore need to depend on hired labor or consultants to accomplish this task. It is important that this training need not be done annually. However, annual supervision will be needed and possibly provided by the resource center of the Ministry of health, MoH, which is the primary recipients and users of the HMIS data. So such supervision costs will be budgeted under the national level indicator budgets.

i) Training/apprenticeship programme for PMMP operationallisation

A 3 day training for 12 participants to engage in operationallisation of PMMP at district level will be conducted within each district. To accomplish this training, we shall hire a venue at which to train, at a rate of US$100/day. Participants will be provided with meals and a transport refund for the days attended. Three trainers will be hired at a rate of US$250/day. They will be provided with transportation to the training site, using a hired vehicle. Fuel required for this vehicle for the four days (three days of training and a last day of travel) has been estimated to cost US$200.

All participants will have an opportunity to use the computers in small groups. For this purpose, three laptops will be hired for the total duration of training.

ii) Printing of training materials

15 copies of the Apprenticeship/Indicator Training Manual (80 pages), and 15 copies of the E-database/Software Training manual will be printed at a cost of US$10 and US$5 per manual respectively.

Other materials required for the training will include pens, markers, participant tags, file folders, masking tape etc.

D. Printing copies of PMMP, NSP and PMMP Operational manual

Each district will receive printed copies of the PMMP, NSP and PMMP Operational manuals. Fifteen copies of each will be provided, at an approximate cost of US$5 per copy. These manuals will be used by the 12 trainees and the trainers. Copies used by the trainers will be left at the district libraries/DHO office as reference copies.

In the long run, the UAC may need to do printing of these manuals in bulk in order to save on printing costs. However, we budget for individual and not bulk printing.

Appendix 3: Budget for Support to National Level Activities

	Activity	Unit cost US$, 2000Ug/US$	Duration/ Quantity	Total Cost
Activity 1.1	**Support to harmonisation activities at sector level**			
i)	Ministry of Health (ACP, Resource Centre and HMIS, UBOS, UBTS, NTLP, NDA)	1,000	75	75,000
ii)	Ministry of Education and Sports including support to district	1,000	20	20,000
iii)	Ministry of Gender, Labour, and Social Development	1,000	20	20,000
iv)	Ministry of Local Government	1,000	20	20,000
v)	National-level CSO coordination	1,000	20	20,000
vi)	Overall coordination of stakeholders	1,000	20	20,000
				175,000
Activity 1.2	**Production of the national quarterly report on output indicators: MOH**			
i)	Support reviewing of HMIS data at the Resource Centre / MOH for ten (10) man days to produce national report on the PMMP output indicators generated through the HMIS from all the districts	300	40	12,000
ii)	Support reviewing of programme reports on PMTCT, HCT, STI, ART, TB & Blood Bank at MOH for two (2) man days for a semi-annual report	300	8	2,400
iii)	Support the MOH/AIDS Control Programme to write the six (6) months progress output report, using data from HMIS and Programme reports: Four (4) man days	300	16	4,800
iv)	Support MOH / ACP to hold a half-day validation meeting for the six months report with staff of the Resource Centre and ACP, TB, and STD Programme staff. (Funds are for stationary and photocopying ($100) and tea/coffee during the meeting, twice a year)	200	2	400
	Total number of days required: 66 days for which the RC will secure short term technical support			
				19,600
Activity 1.3	**Production of the quarterly report on education and orphans**			
i)	Support MOES, MOLGSD to integrate PMMP indicators in the EMIS			
ii)	Support reviewing EMIS data and analysis for the PMMP indicators - by the MOES 3 for days every six months	300	20	6,000

	Activity	Unit cost US$, 2000Ug/US$	Duration/ Quantity	Total Cost
iii)	Support reviewing of orphan data and analysis for the PMMP indicators by the OVC Secretariat for 2 days every six months	300	8	2,400
				8,400
Activity 1.4	**Production of six months report on management indicator by UAC**			
i)	Compiling, analysis of available data on management indicators for PMMP: This will be done by the M&E Coordinator at UAC for 2 man days at no additional cost	-	-	-
ii)	Production of quarterly report on management indicator by UAC : This will be done by the UAC M&E Coordinator at no additional cost	-	-	-
				0
Activity 1.5	**Annual status report of PMMP outcome indicators**			
i)	Review and compile a status report on all PMMP outcome indicators by UAC	300	20	6,000
				6,000
Activity 1.6	**Reviewing of the overall national report on PMMP indicators**			
i)	Writing and production of an overall semi-annual report covering activities 1.1 to 1.4 above by UAC: five (5) man days	300	5	1,500
ii)	Semi-annual review meeting by the M&E National Technical Working Group: The report will be presented to the M&E technical working group for consensus before publication	300	5	1,500
iii)	Writing of an annual national report on all PMMP indicators by UAC: 20 man days	300	20	6,000
iv)	Reviewing of the annual national report by the M&E Technical Working Group before it is published: This will be a half-day meeting of the M&E sub committee, organized by UAC, at UAC	300	2	600
				9,600
Sub Total: National Level Costs				**218,600**

Appendix 4: Budget Justification for Support to National Level Activities

Activity 1.1 Support to harmonization activities at sector level

Six sectors/agencies shall be supported directly to harmonize their sector monitoring priorities with the PMMP. These shall include:

1. The Ministry of Health
2. The Ministry of Education and Sports
3. The Ministry of Gender, Labour and Social Development
4. The Ministry of Local Government
5. National-level CSO Coordination activities
6. The Uganda AIDS Commission in coordinating other agencies

Activities shall include retreats, seminars, support to districts, and planning meetings for national-level survey indicator harmonization.

Activity 1.2 Production of the national quarterly report on output indicators: MOH

i) **Support the Resource Centre/MOH to review HMIS data:** This activity will take ten (10) person days. It is aimed at producing a national report on the PMMP output indicators generated through the HMIS from all the districts. Currently districts are reporting on PMMP district level output indicators to MOH/RC. The RC is not currently analyzing and producing reports on PMMP indicators. The RC will need financial support for short-term technical support on a semi-annual basis, and 20 person days will be required for a whole year to produce the national report.

ii) **Program report review**: This is support to ACP /MOH to review programme reports on PMTCT, HCT, STI, ART, TB and Blood Bank at MOH for two (2) person days for a semi-annual report. Quarterly and annual programme reports will be reviewed to obtain information and data on PMMP health sector indicators which has not been collected through the HMIS. The reports will be obtained from the respective programme managers.

iii) **Support MOH/ACP to write the six months progress output report**: Once data from HMIS and from Programme Reports has been obtained and analyzed, a report will be produced to provide the status of health sector PMMP output indicators. This is a five (5) person days activity.

iv) **Report validation**: To be done with staff of the Resource Centre and ACP, TB and STD Programme staff for one (1) person day. The validation will ensure quality and accuracy of the report on PMMP indicators. The costs are for stationery, photocopying, and tea/coffee during the meeting. The meetings will be at MOH.

Activity 1.3 Production of the quarterly report on education, and orphans

i) **Support MOE to review EMIS data and analysis for the PMMP indicators**: This is aimed at obtaining data and information on the status of the education sector PMMP output indicators from all the districts. It is a three (3) person days activity.

ii) **Support to OVC Secretariat /MOGLSG to review orphan data and analysis for the PMMP indicators:** This will involve reviewing the OVC Secretariat IMS and reports to establish the status of the OVC PMMP output indicators. It is a two (2) person days activity.

Activity 1.4 Production of quarterly report on management indicator by the UAC

i) **Compiling and analyzing of available data on management indicators for PMMP**: This will be done by the M&E Coordinator at the UAC at no extra cost for two (2) person days.

ii) **Production of quarterly report on management indicator by the UAC**: This will be done by the UAC M&E Coordinator at no additional cost.

Activity 1.5 Annual status report of PMMP outcome indicators

Review and compiling of a status report on all PMMP outcome indicators by the UAC: This will be done by reviewing survey reports (UDHS, IAS, Condom survey, PHA survey and other available reports). It will also include undertaking further analysis of the survey data to obtain information on those indicators that may not have been covered by the published reports. This will therefore involve hiring of a consultant to undertake further analysis, review of available survey reports and produce status report on all PMMP outcome indicators. It is ten (10) person days activity.

Activity 1.6 Review of the overall national report

i) **Writing and production of an overall semi-annual report covering activities 1.1 to 1.4 above by the UAC**: This activity will put together all the sectoral reports and produce a national consolidated report for the quarter. The quarter report will then be the national status report on HIV/AIDS based on the PMMP. This will require five (5) person days.

ii) **Semi-annual review meeting by the M&E National Technical Working Group**: The report will be presented to the M&E technical working group for consensus before publication.

iii) **Writing of an annual national report on all PMMP indicators by the UAC**: This will be the overall national report on all PMMP indicators produced at the end of each year of implementation. The report will provide annual status of the national HIV/AIDS report. This will require 20 person days.

iv) **Reviewing of the annual national report by the M&E Technical Working Group**: This is to be done before the report is published. It will be a half-day meeting of the M&E subcommittee, organised by the UAC at the UAC. The costs will mainly be communication or invitation of members for the meeting, printing costs for about 20 copies of the reports and tea/coffee served during the meeting.

Appendix 5: Sample Sector Report, Ministry of Health

Summary of the findings on sector output indicators from HMIS as on 10 September 2009

Sector output indicators for MOH

Program area

A. **IEC/BCC programme area**: All indicators not captured in the HMIS. However, it can be obtained from health promotion department

B. **Condoms programme area**:
   1) Number of peer educators trained in life skills(condom education): not captured in the HMIS *
   2) Number of condom service outlets: it is not captured*
   3) Number of condoms received: it is not captured*
   4) Number of condoms dispensed at service outlet is captured but only disaggregated for corps and health units not for free and social marketing*
      - **Data for July–Oct 2008 (Quarter I)—Corps = 458,266 and Units = 991,782**

C. **PMTCT programme area**
   1) Number of pregnant women counseled, tested and given results for HIV
      - Captured as number of pregnant women tested *
      - Most recent data available is for **April–June (Quarter 4) = 204,631**

   2) Number of pregnant women positive for HIV: it is captured:
      - **Most recent data available is for April–June = 12,365**

   3) Number of pregnant women given ARVs for prophylaxis(PMTCT: it is captured
      - **Most recent data available is for April–June = 13,352**

   4) Number of pregnant women given ARVs for treatment: it is captured
      - **Most recent data available is for April–June = 2,863**

   5) Number of deliveries that are to HIV-positive mothers in the district: it is captured
      - **Most recent data available is for Oct-Nov 2008 = 4,578**

   6) Number of deliveries (mothers) that are HIV-positive who swallowed ARVs for prophylaxis : it is captured
      - **Most recent data available is for Oct-Nov 2008 = 4,937**

7) Number of live births to HIV-positive mothers: it is captured without disaggregation for sex*
   - **Most recent data available is for Oct–Nov 2008 = 5,894**

8) Number of (babies born to HIV-positive mothers) given ARVs for prophylaxis: it is captured without disaggregation for sex*
   - Available data is **for Oct–Nov 2008 = 3,486**

9) Number of PMTCT static service outlets
   - Not captured in the HMIS but it could be obtained from the vertical programs

D. HCT programme area

1) Number of individuals-HIV counseled (first time): it is captured and disaggregated for sex and age but it is not indicated whether it is first time or not. We also noted that children 0 to 4 years old are not counseled and also the age range captured in the HMIS is from 5 to 17 years old not 5 to 18 years old* as indicated on the forms
   - **Data for Jan–March 2009**

   5–17 years old: Females = 21,514 and Males = 14,021
   18+ years: Females = 170,873 and Males = 83,982

2) Number of couples-HIV counseled (first time): not captured *

3) Number of individuals-HIV tested (from laboratory register): it is captured and disaggregated for sex and age
   - **Data for Jan–March 2009**

   0–4 years old: Females = 5,021 and Males = 4,537
   5–17 years: Females = 21,397 and Males = 12,214
   18+ years: Females = 163,181 and Males = 79,910

4) Number of individuals received HIV results: it is captured and disaggregated for sex
   - **Data for Jan–March 2009**

   0–4 years old: Females = 3,879 and Males = 12,441
   5–17 years old: Females = 20,747 and Males = 12,297
   18+ years old: Females = 157,996 and Males = 77,562

5) Number of individuals HIV-positive (from Laboratory register): it is captured and disaggregated for sex
   - **Data for Jan–March 2009**

   0–4 years old: Females = 530 and Males = 529
   5–17 years old: Females = 1,828 and Males = 4,947
   18+ years: Females = 23,224 and Males = 11,082

6) Number of health units reporting stock out of HIV testing kits: it is captured but not disaggregated by the level of facility*
   - **Data for Jan–March 2009**

   Stock out of screening HIV testing kits = 214
   Stock out of confirmatory HIV testing kits = 178
   Stock out of tie-breaker HIV testing kits = 209
   However, it was noted that many districts don't report that section.

7) Number of HCT outreach activities: they capture number of HCT activities planned and number of HCT outreach activities carried out*
   - **Data for Jan–March 2009**

   Planned: 2,390
   Carried out: 1,220

8) Number of HCT static service outlets disaggregated by facility level
   - **Not captured in the HMIS but could be obtained from the vertical programme**

E. ART programme area

1) Number of individuals eligible for ART: it is captured and disaggregated
   - **Data for Jan–March 2009**

   0–4 years old: Females = 244 and Males = 204
   5–17 years old: Females = 515 and Males = 424
   18+ years old: Females = 7,089 and Males = 4,603

2) Number of individuals started on ART: it is captured and disaggregated
   - **Data for Jan–March 2009**

   0–4 years old: Females = 100 and Males = 89
   5–17 years: Females = 212 and Males = 145
   18+ years: Females = 6,035 and Males = 3,498

3) Number of ART outlets
   - **Not captured in the HMIS but it can be got from the vertical programme (ART)***

4) Number of individuals HIV-positive cases started on CTX (Cotrimoxazole) prophylaxis: it is captured and disaggregated
   - **Data for Jan–March 2009**

   0–4 years old: Females = 527 and Males = 503
   5–17 years old: Females = 1,256 and Males = 817
   18+ years old: Females = 20,509 and Males = 9,964

5) Number of health units reporting stock out of Cotrimoxazole tablets disaggregated for the level of facility: it is not captured*

F. HIV/TB programme area

1) Number of HIV-positive persons screened for TB
   - Not captured*

2) Number of HIV-positive individuals with confirmed TB
   - **Data for Jan–March 2009**

   0–4 years old: Female = 40 and Males = 41
   5–17 years old: Females=127 and Males = 82
   18+ years old: Females = 2,249 and Males = 1,229

3) Number of registered TB patients tested for HIV
   - Not captured but it can be got from the National TB programme*

4) Number of registered TB patients positive for HIV:
   - **Not** captured but it can be got from the National TB programme*

* Means it is not captured or the indicator captured is not exactly the same

Appendix 6: Sample District Quarterly Report, Mukono District

District HIV and AIDS Collation Report Form

Uganda AIDS Commission Secretariat
General District Progress Report Format

(This report is to be filled in by the District HIV and AIDS Focal Person)

(Please attach signed minutes of the DAC meeting)

UAC Mission : Provide overall leadership in the coordination and management of an effective HIV/AIDS National Response.

UAC Vision : Realization of "a population free of HIV/AIDS and its effects"

Purpose of the Information Collection : *Gather information from the central government to enable the UAC assess the progress made in implementing the NSP and advise on necessary adjustments in the hope of attaining the set targets.*

Name of the District :

Reporting Quarter :	**Q1 (J-S)**	**Q2 (O-D)**	**Q3 (J-M)**	**Q4 (A-J)**
Financial Year :	**2008/09**	**2009/10**	**2010/11**	**2011/12**

Name of the HIV/AIDS Focal Person : **Dr Kkonde Anthony**

Signature of the HIV/AIDS Focal Person : ____________________

Title of the HIV/AIDS Focal Person : **Dep District Health Officer**

Telephone : 0772 - 402784 **E-mail :** ____________________

Signature of the Chief Administrative Officer : ____________________

Date of Submission : **6/8/2009**

Program Area : IEC/BCC

Disaggregated by :

PMMP Indicator			Actual			Target	
			Produced	Disseminated	Cumulative	Quarter	Annual
Number of IEC materials produced and disseminated	*Abstinence & Faithfulness (AB)*	**Print**					
		Poster	0				
		Leaflet	0				
		Newspaper Supplement	0				
		Newspaper Advert	0				
		T-Shirts	0				
		Caps	0				
		Badges	0				
		Billboard	0				
		Audiovisual					
		Music , Dance and Drama	0				
		TV Talk Show	0				
		TV Spot Message	0				
		Radio Talk Show	0				
		Radio Spot	0				
		Videos/ Films/ Documentaries	0				
		Rallies	0				
Number of IEC materials produced and disseminated	*Condom Promotion*	**Print**					
		Poster	0				
		Leaflet	0				
		Newspaper Supplement	0				

		Newspaper Advert	0				
		T-Shirts	0				
		Caps	0				
		Badges	0				
		Billboard	0				
		Audiovisual					
		Music , Dance and Drama	0				
		TV Talk Show	0				
		TV Spot Message	0				
		Radio Talk Show	0				
		Radio Spot	0				
		Videos/ Documentaries	0				
		Rallies	0				
Number of IEC materials produced and disseminated	*PMTCT*	**Print**					
		Poster	0				
		Leaflet	0				
		Newspaper Supplement	0				
		Newspaper Advert	0				
		T-Shirts	0				
		Caps	0				
		Badges	0				
		Billboard	0				
		Audiovisual					
		Music , Dance and Drama	0				
		TV Talk Show	0				
		TV Spot Message	0				

		Radio Talk Show	0				
		Radio Spot	0				
		Videos/ Films/ Documentaries	0				
		Rallies	0				
Number of IEC materials produced and disseminated	*STI Prevention and Management*	**Print**					
		Poster	0				
		Leaflet	0				
		Newspaper Supplement	0				
		Newspaper Advert					
		T-Shirts	0				
		Caps	0				
		Badges	0				
		Billboard	0				
		Audiovisual					
		Music , Dance and Drama	0				
		TV Talk Show	0				
		TV Spot Message	0				
		Radio Talk Show	0				
		Radio Spot	0				
		Videos/ Films/ Documentaries	0				
		Rallies	0				
Number of IEC materials produced and disseminated	*Basic Medical Care and Support for PHA's*	**Print**					
		Poster	0				
		Leaflet	0				
		Newspaper Supplement	0				
		Newspaper Advert	0				

		T-Shirts	0				
		Caps	0				
		Badges	0				
		Billboard	0				
		Audiovisual					
		Music , Dance and Drama	0				
		TV Talk Show	0				
		TV Spot Message	0				
		Radio Talk Show	0				
		Radio Spot	0				
		Videos/ Films/ Documentaries	0				
		Rallies	0				
Number of IEC materials produced and disseminated	*ART*	**Print**					
		Poster	0				
		Leaflet	0				
		Newspaper Supplement	0				
		Newspaper Advert	0				
		T-Shirts	0				
		Caps	0				
		Badges	0				
		Billboard	0				
		Audiovisual					
		Music , Dance and Drama	0				
		TV Talk Show	0				
		TV Spot Message	0				
		Radio Talk Show	0				

		Radio Spot	0				
		Videos/ Films/ Documentaries	0				
		Rallies	0				
Number of IEC materials produced and disseminated	*TB/HIV*	**Print**					
		Poster	0				
		Leaflet	0				
		Newspaper Supplement	0				
		Newspaper Advert	0				
		T-Shirts	0				
		Caps	0				
		Badges	0				
		Billboard	0				
		Audiovisual					
		Music , Dance and Drama	0				
		TV Talk Show	0				
		TV Spot Message	0				
		Radio Talk Show	0				
		Radio Spot	0				
		Videos/ Films/ Documentaries	0				
		Rallies	0				
Number of IEC materials produced and disseminated	*Social Support*	**Print**					
		Poster	0				
		Leaflet	0				
		Newspaper Supplement	0				
		Newspaper Advert	0				
		T-Shirts	0				

		Caps	0				
		Badges	0				
		Billboard	0				
		Audiovisual					
		Music , Dance and Drama	0				
		TV Talk Show	0				
		TV Spot Message	0				
		Radio Talk Show	0				
		Radio Spot	0				
		Videos/ Films/ Documentaries	0				
		Rallies	0				

PMMP Indicator		*Actual*		*Target*	
		Number	*Cumulative*	*Quarter*	*Annual*
Number of trainers for youth out of school trained in Life Skills	*Female*	0			
	Male	0			
Number of peer educators trained in Life Skills education for youth out of school	*Female*	0			
	Male	0			
Number of young people reached by Life Skills education in out of school settings	*Female*	0			
	Male	0			

Program Area: Condoms

Disaggregated by:

PMMP Indicator		*Actual*		*Target*	
		Number	*Cumulative*	*Quarter*	*Annual*
Number of peer educators trained in Life Skills (condom) education	*Female*	10			
	Male	20			
Number of condom service outlets		307			
Number of condoms received		90,000			
Number of condoms dispensed at service outlet	*Free*	57,312			
	Social marketing	0			
Number of condoms dispensed by CORPs					

Program Area: PMTCT

Disaggregated by:

PMMP Indicator	*Actual*		*Target*	
	Number	*Cumulative*	*Quarter*	*Annual*
Number of pregnant women counselled, tested and given results for HIV	6,812			
Number of pregnant women positive for HIV	404			
Number of pregnant women given ARVs for prophylaxis (PMTCT)	328			
Number of women given ARVs for treatment	43			

PMMP Indicator	*Actual*		*Target*	
	Number	*Cumulative*	*Quarter*	*Annual*
Number of deliveries that are to HIV-positive mothers in the district	279			
Number of deliveries (mothers) that are HIV-positive who swallowed ARVs for Prophylaxis	241			

PMMP Indicator		*Actual*		*Target*	
		Number	*Cumulative*	*Quarter*	*Annual*
Number of live births to HIV-positive mothers	*Female*				
	Male				
Number of (babies born to HIV-positive mothers) given ARVs for Prophylaxis	*Female*				
	Male				

		Actual			*Target*
		Public	*Private*	*Total*	*Annual*
Number of PMTCT static service outlets	*Hospitals*	1	5	6	
	HC IV	3	1	4	
	HC III	21	3	24	
	HC II	1	0	1	

Program Area: HCT

Disaggregated by :

PMMP Indicator			*Actual*		*Target*	
			Number	*Cumulative*	*Quarter*	*Annual*
Number of individuals—HIV counseled [First Time]	*0–4 years old*	*Female*	0			
		Male	0			
	5–17 years old	*Female*	112			
		Male	56			
	18+ years old	*Female*	3,991			
		Male	2,539			
Number of couples—HIV counseled [First Time]						
Number of individuals—HIV tested (from laboratory register)	*0–4 years old*	*Female*	0			
		Male	0			
	5–17 years old	*Female*	112			
		Male	56			
	18+ years old	*Female*	3,991			
		Male	2,539			

Number of individuals received HIV results	*0–4 years old*	*Female*	0			
		Male	0			
	5–17 years old	*Female*	112			
		Male	56			
	18+ years old	*Female*	3,991			
		Male	2,539			
Number of individuals HIV-positive (from laboratory register)	*0–4 years old*	*Female*	0			
		Male	0			
	5–17 years old	*Female*	9			
		Male	4			
	18+ years old	*Female*	631			
		Male	451			

		Stock out screening HIV testing kits	***Stock out confirmatory HIV testing kits***	***Stock out tie-breaker HIV testing kits***
Number of health units reporting stock out of HIV testing kits	*Hospitals*	0		
	HC IV	0		
	HC III	0		
	HC II	0		

PMMP Indicator	***Actual***		***Target***	
	Number	***Cumulative***	***Quarter***	***Annual***
Number of HCT outreach activities	55 (Health centre II)			

PMMP Indicator (Annual)		*Actual*			*Target*
		Public	*Private*	*Total*	*Annual*
Number of HCT static service outlets	*Hospitals*	1	5	6	
	HC IV	3	1	4	
	HC III	24	3	27	
	HC II	0	0	0	

Program Area: ART

Disaggregated by :

PMMP Indicator			*Actual*		*Target*	
			Number	*Cumulative*	*Quarter*	*Annual*
Number of individuals eligible for ART	*0–4 years old*	*Female*	4			
		Male	2			
	5–17 years old	*Female*	56			
		Male	71			
	18+ years old	*Female*	638			
		Male	100			
Number of individuals started on ART	*0–4 years old*	*Female*	7			
		Male	3			
	5–17 years old	*Female*	72			
		Male	83			
	18+ years old	*Female*	1,119			
		Male	431			

PMMP Indicator (Annual)		*Actual*			*Target*
		Public	*Private*	*Total*	*Annual*
Number of ART outlets	*Hospitals*	1	5	6	
	HC IV	3	1	4	
	HC III	0	3	3	
	HC II	0	0	0	

Program Area: Care

Disaggregated by :

PMMP Indicator			*Actual*		*Target*	
			Number	*Cumulative*	*Quarter*	*Annual*
Number of individuals HIV-positive cases started on CTX (Cotrimoxazole) prophylaxis	*0–4 years old*	*Female*	44			
		Male	43			
	5–17 years old	*Female*	231			
		Male	226			
	18+ years old	*Female*	3,381			
		Male	263			
Number of health units reporting stock out of Cotrimoxazole tablets	*District hospital*		0	-		
	HC IV		0	-		
	HC III		0			
	HCII		0			

Program Area : HIV/TB						
Disaggregated by :						
PMMP Indicator			***Actual***		***Target***	
			Number	***Cumulative***	***Quarter***	***Annual***
Number of HIV-positive persons screened for TB	*Female*		0			
	Male		0			
Number of HIV-positive individuals with confirmed TB	*0–4 years old*	*Female*	0			
		Male	0			
	5–17 years old	*Female*	0			
		Male	0			
	18+ years old	*Female*	6			
		Male	10			
Number of registered TB patients tested for HIV	*Female*		65			
	Male		125			
Number of registered TB patients positive for HIV	*Female*		44			
	Male		66			

Program Area : HIV/TB Care

Disaggregated by :

PMMP Indicator			*Actual*		*Target*	
			Number	*Cumulative*	*Quarter*	*Annual*
Number of individuals HIV-positive cases started on CTX (Cotrimoxazole) prophylaxis	*0–4 years old*	*Female*	4			
		Male	5			
	5–17 years old	*Female*	11			
		Male	7			
	18+ years old	*Female*	143			
		Male	114			

Program Area : Education

Disaggregated by :

PMMP Indicator		*Actual*		*Target*	
		Number	*Cumulative*	*Quarter*	*Annual*
Number of teachers trained in Life Skills in the past academic year	*Primary*	3,644			
	Secondary	0			
	Tertiary	0			
Number of schools with teachers trained in Life Skills and who have taught it in the past academic year	*Primary*	386			
	Secondary	172			
	Tertiary	0			
Number of young people reached by Life skills education in schools	*Female*	159,030			
	Male	139,070			
	Tertiary	0			

Program Area : Education—Orphans

Disaggregated by :

PMMP Indicator			*Actual*		*Target*	
			Number	*Cumulative*	*Quarter*	*Annual*
Number of orphans in school	*Female - Primary*	*Mother Deceased*	0		-	
		Father Deceased	0		-	
		Both Deceased	25,395		-	
	Male - Primary	*Mother Deceased*	0		-	
		Father Deceased	0		-	
		Both Deceased	24,970		-	
	Female - Secondary	*Mother Deceased*	0			
		Father Deceased	0			
		Both Deceased	0			
	Male - Secondary	*Mother Deceased*	0			
		Father Deceased	0			
		Both Deceased	0			

PMMP Indicator		*Actual*		*Target*	
		Number	*Cumulative*	*Quarter*	*Annual*
Number of service outlets for orphans (Service = psychosocial, material, agricultural, education, legal, IGA, medical)		0		-	
Number of orphans and vulnerable children served/reached	*Female*	0		-	
	Male	0			

Management|: This section is to be filled in annually (response areas highlighted in light gray)

Management of the HIV/AIDS response, measures all different areas of support and coordination of HIV/AIDS in the district. This will include planning, budgeting, resource mobilization, coordination, advocacy, information management and M&E

Program Area : Planning and Budgeting

Disaggregated by :

PMMP Indicator	*Actual*		*Target*
	Number	*Cumulative*	*Annual*
Amount of HIV/AIDS funds received by the district Local Government (From both government and NGOs)	2,000,000/=		
Amount of district local government funds spent on HIV/AIDS	2,000,000/=		
Total amount of funds received by CSOs operating within the district	0		
Total number of LG personnel trained and available to carry out planning work	0		
Total number of CSOs that have undergone capacity building in planning and budgeting	0		
		Yes	**No**
Does the district have an up-to-date strategic plan in line with NSP		Yes	
Is there integration of the district HIV/AIDS strategic plan into the District Development Plan		Yes	
Is there an annual HIV/AIDS plan in line with the National Priority Action Plan		Yes	

Program Area : Coordination

Disaggregated by :

PMMP Indicator	Actual		Target
	Number	Cumulative	Annual
No of CSO stakeholders districts sitting on the District AIDS Taskforce	3%		
Percentage of CSO stakeholders sitting on the DAC	30%		
Number of meeting meetings held by the District AIDS Taskforce	1		
Number of DAC supervision visits held in the past 12 months	1		
Number of meeting meetings held by the DAC	1		
Number of meeting meetings held by the sub-county AIDS Taskforce	0		
Number of meeting meetings held by the sub-county AIDS Committee	0		
-	Yes	No	
Did the district hold an annual District AIDS partnership forum	Yes		
Does the district have District AIDS Focal Person	Yes		
	Number	Cumulative	
Number of community-based organisations in the district receiving support for HIV/AIDS interventions			

Program Area: Advocacy

Disaggregated by:

	Yes	No
Was the candle light memorial observed this year?		No
Was World AIDS day observed?	Yes	
Was the Philly Lutaaya day observed this year?		No

Program Area: Information Management and M&E				
Disaggregated by:				
			Yes	**No**
Does the district have an information unit containing HIV/AIDS information?			Yes	No
Is the District M&E system in line with the PMMP				No
Have all district quarterly HIV/AIDS reports been submitted				No
Have all district monthly sector HIV/AIDS reports been submitted to the sector?				No
	Prevention	**Treatment**	**Social Support**	**Total**
How many agencies are providing HIV/AIDS services in the district (By type)	2	6	2	10
How many district personnel have been trained in information management and M&E and are available to carry out M&E activities	0	0	0	0
How many CSOs have undergone capacity building in information management and M&E	0	0	0	0

Research

Provide a list any HIV/AIDS research going on in the district (by programme area, title, organization).

NIL					

Appendix 7: District Specific Findings

A7.1 Kiboga District

Coordination of HIV/AIDS Activities

HIV/AIDS Focal Person

The district has two HIV Focal Persons; the one described as “non-technical” is responsible for the overall coordination of HIV/AIDS activities, while the one designated as “technical” is primarily responsible for HIV treatment activities (i.e., ART Focal Person). The overall HIV Focal Person is appointed by the CAO and is currently the district population officer. Previously, the Focal Persons came from different offices as follows:

- Current: District Population Officer
- Previous: Medical Officer In-charge of a health sub-district
- Previous: Medical Officer In-charge of a health sub-district
- Previous: District Population Officer

The coordination therefore seems to be alternating between the Health Sub-district (HSD) heads and the District Planning Unit. The roles of the HIV Focal Persons have been stipulated. They include strengthening coordination and participatory planning.

Functionality: The current HIV Focal Person was described as functional and active. He regularly consults his peers at the district level. According to the key informants we talked to in Kiboga, effective coordination of these activities depends on two main variables:

- The personality and attitude of the individual appointed (whether they are active, committed and able to provide leadership and to mobilize others).
- The department and office responsible for the coordination.

According to the key informants, any officer from the four key departments that has a strong stake in HIV activities (Planning Unit, Health, Community-based Services and Education) can be effective in coordinating HIV activities; however, officers from other departments may not be effective. It was also noted that the planning unit is the strongest link for HIV coordination activities, because it has a wide spectrum of resource persons with the expertise, and it relates with all departments. Quoting the ACAO:

> *“Coordination of HIV activities would be best done in the planning unit; that way, people would cease to view HIV as solely a health issue but as a social issue. The planning unit can convene other departments.”*

Oversight and planning

The ACAO In-charge of Health is responsible for overall oversight for HIV activities and chairs the DAC meetings.

District HIV/AIDS plan

The district has prepared a HIV/AIDS “strategic plan” and different partners were brought together under the DAC to commit to different activities in the plan. During the plan negotiation, some activities were taken up by different partners including CSOs. However, many other activities in the plan still do not have specified sources of funding, e.g., World AIDS Day activities.

DAC and DAT

In Kiboga, the DAC meets every quarter, and there was evidence for this in the minutes. The agenda of the DAC normally includes review of activities implemented by the different sectors on a quarterly basis and discussion of a way forward (normally involving presentation of activities for the following quarter). The DAC meetings are supported by Protecting Families Against AIDS (PREFA), while the DAT is supported by African Medical and Research Foundation (AMREF). According to the ACAO, even without financial support, the DAC can be functional, since the committee consists of technical people, whose regular role is to coordinate such services, and its activities could be integrated into the District Technical Planning Committee (DTPC). However, the DAT would not be functional. The district received reference materials from the UAC.

Challenges related to coordination of HIV activities

- Funding for the DAC and coordination activities is inconsistent.
- Joint monitoring activities are not currently undertaken. The district lacks a mechanism for coordinating joint monitoring and reporting. District partnership workshops, though highly recommended, are not implemented because of lack of funds.
- There are many players involved in many activities, many of them non-facility based.
- Some departments were reported as not active including Works and Water, Forestry, Finance and the Forces—according to the CAO, these departments tend to look at HIV as a health problem. The more active ones are Health, Administration/Planning Unit, Education, Community-based Services and Production.
- Sub-county HIV/AIDS committees were formed in all sub-counties but are not functional.

District Health Office

There is a HIV Focal Person “technical” who is responsible for coordinating ART (in principle, the ART Coordinator). There is also a PMTCT Focal Person, and the district laboratory Focal Person is the designated HIV Counseling and Testing Focal Person. There is no designated “condom coordinator,” but condom activities are overseen by the district health educator. In general, the district health office seemed to be in a position to collect most of the information needed. However, the process required collation of information from different sources.

HIV activities are implemented at static and outreach points. Static activities are facility-based, and the information generated is sent through the routine reporting mechanisms. However, HIV outreach activities are concentrated at the HSD level (i.e., VCT and ART). Outputs for these activities are therefore reflected in the reports for the HC IVs and hospitals.

The district receives support from several partners involved in HIV activities; some of these provide direct budget support to the District Health Office, while others provide allowances to health unit teams for outreach activities. They include:

- Infectious Disease Institute (IDI)—which supports HIV testing and treatment activities through the HSDs
- Baylor College—which supports HIV testing and treatment activities for children through the HSDs
- PREFA—which supports PMTCT
- AMREF—which supports HCT activities for HSDs and health units and has provided computers to all health centres levels III and IV
- TB CAP Project—which supports TB and TB-HIV integration activities

- RC—which supports HCT and treatment in specific health units

These agencies work through the existing structures, and their outputs are reflected in the routine reports. However, they also require parallel reports in form of summaries, which puts additional burden on the health workers.

We found that Lwamata Health Centre III did not have an official VCT register and was using improvised registers in the form of counter books. However, Bukomero Health Centre has a VCT register, based in the laboratory. In Lwamata Health Centre, there was also a book that contained client forms in form of vouchers that capture background information. A piece of the form is supposed to be torn off and given to the client. This VCT voucher book was not found in Bukomero.

There were standard PMTCT registers from the Ministry of Health provided under PREFA support. Two PMTCT reports were generated every month—one to the PMTCT Focal Person and the other as part of the HMIS report. There were also standard registers for the ART programme including a pre-ART register and an ART register. A dual report had to be prepared (HMIS and ART). There is also a bi-monthly report used for requisitioning for drugs. This form also captures some information on ART outputs. The HCT programme, however, did not have a parallel reporting system, and all HCT information was reported through HMIS.

Challenges within the health department

- Staffing is very low, and health workers have a large burden of work; for some activities, e.g., ART, there are too many details that need to be recorded for each client.
- TB/HIV collaboration activities are minimal; however, with the new project (TB-CAP), it is hoped that integrated services will improve.
- The district has only three records assistants, and these cadres can only be at the HSD level. Health unit in-charges therefore have the additional responsibility of collating the different reports. At the moment, some health units have to make a minimum of five reports:
  - Monthly HMIS report
  - ART report
  - PMTCT report
  - TB CAP report
  - IDI or Baylor or AMREF report
- Health units lack stationery for making the monthly reports; as a result, they have to photocopy the forms. Some use the older forms that have not been updated. The lack of HMIS reporting forms is therefore a major challenge to reporting.
- While records systems at the HC IVs and hospitals are strong, records at lower health units are lacking.
- There is a dual data capture system for VCT, creating double work for the people involved. Data is first captured on a lab form and then into a lab register. This system had been abandoned in some health units, which were using only the register.
- Reporting is often late.
- Some health units were given computers but no printers. Some have computers but no power. The computer at Bukomero HC IV had crashed because of viruses, and staff seemed not to know who should fix it.

Planning Unit and Administration

There is an assistant chief administrative officer in-charge of health. According to the DHT and ACO Health, the district has never conducted any surveys for HIV/AIDS. However, they noted that:

- The district has the technical capacity to implement the surveys—the technocrats are there, but the districts lack resources.
- Districts need their specific prevalence rates and other behavioural indicators.

Community-based Services Department

The Community-based Services Department does not have a routine management information system and can therefore not track HIV IEC activities and mitigation activities implemented in communities. Current information is only available for two of 14 sub-counties where the district has a PHA project, and the information is activity-based. The Community-based Services Department also has an Orphan Programme that has just started. The district received support from the Ministry of Gender and Save the Children to conduct a mapping exercise for CBOs and CSOs involved in orphan activities. This was a one-off activity, but according to the Community-based Services Officer, this programme will be continuous.

In terms of coordination of CSOs, the Community-based Services Department is expected to register all CBOs and CSOs operating in the district, which it does. However, this is a one-off registration, and CSOs are not required to report routinely.

Challenges within the community department

- There is no management information system for regularly tracking non-facility-based HIV activities both at the district and CSO level.
- There are no reporting forms from the Ministry of Gender.

CSOs

CSOs that support facility-based services

There were many CSOs involved in HIV/AIDS services. CSOs and CBOs are required to register with the Community-based Services Department, but it is a one-off registration, and they are not required to renew regularly. In terms of providing information to the district, the Community-based Services Officer noted that CSOs do not regularly report to districts—they only report when called upon to provide specific information. However, the Community-based Services Officer also notes that some of the national-level CSOs are well organised and are able to report to the district if engaged. It is the community-level CBOs that may not be in position to report consistently.

CSOs that support prevention and livelihood activities

The CSOs have an NGO forum that is supposed to be used as a platform to share information on their activities. However, there is no reporting system for their activities. Since their activities are diverse and cross-cutting, setting up a reporting mechanism would require a simple data capture tool that attempts to standardize their reporting.

The Education Department

The Education Department has an EMIS. Schools are supposed to report on a monthly basis on about five parameters: enrollment, teachers, activities in line with government programs (co-curricular, HIV/AIDS and environmental education), and UPE Funds. Schools are also required to report at the end of every term, covering programs implemented during the term. There is also a statistical monitoring tool that is used to conduct annual surveys in schools.

There is a parallel reporting system that is implemented through "centre coordinating tutors," which coordinate activities in a cluster of schools and report directly to the tutor colleges.

Challenges in the Education Department

- EMIS is not currently being used to capture the required information; schools have not been guided on the indicators and how they can capture this information regularly.

A7.2 Kumi District

District Level

The district has an HIV Focal Person that is appointed by the CAO and is from the health sector. The routine functions of the HIV Focal Person include planning for the HIV/AIDS activities; coordination of HIV activities in the district; and monitoring and evaluation of HIV-related activities. The Focal Person has never been trained but has a background in HIV-related activities. The previous Focal Person was the district population officer.

ACAO in-charge of health

The district has a DAC, and the District HIV Focal Person works closely with the DAC as the committee secretary. The DAC is supposed to meet quarterly; however, it has only met once in the last six months (September 2008). The DAC is composed of the CAO (the chairperson), heads of departments and different CSOs actively involved in the HIV-related activities, and a representative of people living with HIV/AIDS.

District AIDS coordination index (measure of the level of district integration and coordination)

There is an up-to-date District HIV/AIDS Plan in draft form submitted to the Uganda AIDS Commission, and the district HIV Focal Person has the data. The District HIV/AIDS Plan is integrated into the District Development Plan (DDP) through the planning unit, which makes the development plan. However, DAC is not currently active and last met in April 2007. The only supportive supervision at the district and in the community is carried out in the health department.

Challenges faced by the DAC

- Capacity building is needed among DAC members, e.g., in data analysis.
- Equipment is lacking, especially a computer; the existing one has many programs and users.
- Data collection is expensive; there is need for monetary facilitation.
- A storage facility for the data collected is not adequate.

DHT composition

The DHT is composed of: health officer, educator, HMIS Focal Person, TB/leprosy supervisor, ART coordinator, HIV Focal Person, and PMTCT coordinator. However, the district health educator also works as the HIV Focal Person, condom coordinator, and PMTCT and HCT Focal Person.

Information flow from the lower health units to the district

The lower health units fill the HMIS form with information extracted from the various registers. For example, these include the integrated maternity register (PMTCT data) and HCT registers (counselling data). These reports are sent to the HSD and the DHO's office, where the HMIS Focal Person collates these data on a monthly basis. Samples of the reports and registers shown to the research team were currently up-to-date. The HMIS is able to compare reports compiled by the HSDs.

Challenges in HIV coordination at district

The key challenges mentioned by most the DHT members with respect to their responsibilities included irregular meetings with other partners involved in HIV-related activities in the district, lack of facilitation for supportive supervision of HIV-related activities, failure of partners in HIV work to share information with the DHT, and lack of commitment by CSOs. Data quality is poor at times because of inadequate staffing, negative attitudes of health workers towards completing HMIS forms, inadequately trained record assistants to fill the forms, and of lack equipment such as computers to ease their work. They also have minimal or no supportive supervision from the HMIS Focal Person because of limited resources and lack of facilitation for lower health units to ensure regular and on-time submission of the monthly reports. There is potential for non-reporting or even double counting of figures when CSOs make their independent report submission. Statistics that require surveys are not available because of lack of funding; yet human resources to conduct such surveys can be obtained.

Recommendations

Training: Refresher courses on HMIS, records assistants and all staff involved in the recording of data.

Logistics: Buy and install computers at the HSD (initially) or HC III-IV to speed up reporting.

Staff recruitment: The HIV Focal Person needs to be recruited for this purpose instead of burdening one person with all the responsibilities as in Kumi. It is critical to harmonize the various reporting forms so that data recorders at the lower levels do not have to duplicate reports for the various partners.

Departments

Education sector

This sector mainly uses the Annual National Statistical Forms from the MoES, but collects little information on HIV/AIDS. Data from these school surveys are sent to the planning unit of MoES, but the district receives minimal feedback; when it does, feedback is inconsistent with what is observed, for example, with regard to the number of schools. In order to improve and speed up monitoring, the DEO has hired an NGO—BILL Africa—to conduct data entry at the district level so that it can use the information at the district level. The current EMIS is not yet upgraded, and was last used in 1997, but is no longer standard. Data on orphans, vulnerable children and number of pupils with HIV/AIDS is not available, but could be obtained from the Centre Coordinating Tutor (CCT) of the PEARS project.

Challenges: Inconsistent statistics between statistical reports from the central MoES and analysis from the districts, lack of tools (these come late from the MoES), and lack of technical skills to conduct the analysis.

Solutions: Training in analysis, and tools available for data collection in time.

District Community Development

This department deals with youth, in cases where HIV activities are integrated with other income generation activities and training. The targeted groups include youth (married, non-married, in and out of school), and child mothers usually supported in reproductive health issues as well. Details on the number of youth groups, and individuals in each group and the types of support given are available. A report about youth activities is sent to the MoGLSD on a quarterly basis using a data tool designed within the district.

Orphan statistics are usually collected using a biannual survey that collects cross-cutting information. The department has little information on orphans, but most of it can be obtained from CSOs involved in OVC activities.

Challenges: CBOs are supposed to write and submit reports to the district, but they do not do so, which hinders the district's ability to monitor the activities. Currently there is no M&E system in place, i.e., there is no mechanism for data collection to coordinate activities. For example, two CSOs support the same orphans with the same items, and there are few staff to coordinate all the needed activities.

Solutions: Build the capacity of the district to implement a monitoring and evaluation system on OVC, and also identify a Focal Person in charge of data collection on OVC, for example transport and equipment.

The District Planning Unit

There is a district technical planning committee, with a Focal Person in charge of HIV/AIDS. All departmental heads have to plan for HIV/AIDS activities in their sectors, which are integrated in the district plan. Lower local government committees have been set up, and their plans are forwarded to the planning committee of the district.

Challenges: Data collection is a challenge because of a lack of harmonized data collection instruments, as all stakeholders tend to have their own data needs. Information on OVC is scarce. The education sector sends all the data to the Ministry of Education; none is left at the district. Yet, these data are needed for planning. Some indicators are set at the national level, yet they may not be applicable in a particular district, and no capacity building on M&E has been done, despite the fact that there was a capacity grant awarded.

Community Level

AIDS-related CSOs (community development officer)

The district does not have a comprehensive list of AIDS-related CSOs that operate in it. Although there is a registration requirement with the district, registration is not universal. Also, many of the CSOs do not provide regular reports of their activities to the district. However, some do at the quarterly or semi-annual basis using their reporting formats.

A.7.3 Mukono District

An assessment of the functionality of the M&E system for HIV/AIDS in Mukono District was held 14–16 April 2009. The purpose was to: i) assess the monitoring and evaluation systems at district level; ii) assess the extent and capacity of the district M&E systems to collect PMMP indicators; iii) identify PMMP indicators that are not collected or are problematic to collect; iv) identify general data collection challenges; and v) note opportunities to improve data collection and collation in relation to PMMP indicators.

HIV/AIDS M&E System

The M&E system for Mukono district consists of the following:

- Health management information system (HMIS) for the health sector HIV/AIDS indicators
- PMTCT monitoring forms from the AIDS Control/STD Programme/MOH
- PMTCT reporting forms for the EGPAF project
- ART reporting forms for the MOH
- ART reporting forms to Joint Clinical Research Center (harmonized with MOH ART reporting forms)
- ART reporting forms to Mildmay (also harmonized with MOH ART forms)
- Reporting forms for the Inter-religious Council of Uganda (not harmonized with MOH reporting forms
- HIV-QUAL for HIV status monitoring by CDC at Nagalama hospital
- LQAS (Lot Quality Assurance Survey) monitoring and evaluation of HIV/AIDS outcomes (carried out in 2004 and 2006 funded by the AIDS Control Project)

M&E Plan for HIV/AIDS

Mukono district has no documented cost plan and budget for HIV/AIDS, including defined goals and objectives for M&E of HIV/AIDS at the district level. It was observed by the district team that the district has no incentive to make plans. The district has made several plans that have not been funded. These include but are not limited to: HIV/AIDS Strategic Plan 2006/7 – 2010/2011, Mukono District Integrated Strategic Plan for Orphans and Other Vulnerable Children, 2008 – 2013, and Global Fund Proposals. All these have not been funded.

> "*We are tired of making plans that have no resources for implementation."*
>
> —District HIV/AIDS Focal Person, Mukono District

There are also no M&E plans for the various vertical programmes. The HMIS activities and budget are integrated into the overall district health annual plan and budget, both at district and health facility levels. Activities for HMIS are funded from the primary health care (PHC) conditional budget. Data collection is on a monthly basis, and timelines for reporting by the health units also exist. However information was not provided as to how much is allocated for HMIS activities.

Data Collection and Collation

HMIS and PMMP indicators

The HMIS is the main collection and collation system of health and AIDS indicator data. The health facilities collect data and submit reports to the health sub-districts. The HMIS Focal Person is responsible for collating all the information from the health sub-districts reports and compiles the information into one HMIS 105 report to be submitted to the MOH. The HMIS reports from the health sub-districts are sent to the district in a timely manner by the set deadline of the fifth of every month.

The district PMMP output indicators that are collected in the HMIS were readily available and were complete except for indicators on HCT outreach, which were usually not filled out in the report, and the condom dispensation indicators.

Other parallel systems

ART and PMTCT have a parallel reporting system to the MOH. RC, Mildmay and EGPAF projects use the reporting forms for the MOH but do not report their data directly to the district.

Other surveys

None of the PMMP outcome indicators are collected in any routine system; however, some baseline data was collected on behavior change indicators, through the LQAS survey in 2006. The district submitted a proposal to carry out a similar survey to Uganda AIDS commission in 2007 with funding from Global Fund, but that proposal was not funded.

Functionality of HMIS

Strengths	Weakness
▪ Functional with all data collection instruments already designed, available, and tested. ▪ Activities are integrated in the district annual work plan and budgeted at the district and health facility level. ▪ Financed through PHC conditional grant, which is a more sustainable mechanism. ▪ Reporting by the districts is one of the criteria for assessing the district performance for the national league table. This motivates districts to collect and report through HMIS. ▪ Release of funds for health facilities by Mukono district is tagged to HMIS reporting. Health facilities are required to report to the district by the 10th of the next month or else they miss out on PHC funding. ▪ Mukono district developed a chart for monitoring HMIS reporting by each health facility. This enables the HMIS officer to know which health facility has not reported, for appropriate action by the DHO. ▪ Health unit in-charges have been made accountable for the completeness and accuracy	▪ Priority is on reporting with limited emphasis on analysis and utilization of data. Among the health facilities visited, only Naggalama hospital showed any analyzed HMIS data that informs the report presented to the hospital board every three months. ▪ No analysis currently being done for the HIV/AIDS indicators in HMIS. The DHO admitted that he had not taken interest in the analysis of the HIV/AIDS HMIS data. His interest has largely been in MCH and reproductive health. Therefore, there are no HIV/AIDS programme reports produced from HMIS to inform planning and management decision. ▪ No supervision of HMIS from the MOH to the district. ▪ No feedback provided to the district on HMIS reports submitted to the MOH. ▪ The post of the bio-statistician is in the district establishment. However, it is not filled due to wage bill constraints. This limits the district capacity for collection and

of HMIS data from their health facilities. The in-charges have to own the report, which therefore ensures data quality. ▪ When a report is submitted to the district, it is checked by the nursing officer for completeness and quality. When gaps are identified, it is sent back to the in-charge. ▪ Mukono district discusses key HMIS findings during DHTM meetings. Currently, there is interest in the analysis of maternal health and child health data, reproductive health, and OPD attendance. ▪ The HMIS officer is equipped with a computer and has skills in the analysis of HMIS data using Excel. ▪ On average 70 of the 77 (90%) functional public and PNFP health facilities produce and submit HMIS reports on a monthly basis to the district. ▪ Mukono district has integrated HMIS supervision into the overall district health supervision check list. HMIS is among the support services supervised on a quarterly basis by the supervision teams.	analysis of data. ▪ Records assistants at health facility level have no medical orientation, yet the registers are written in medical language. ▪ Only one individual officer is managing HMIS data at the district level. The absence of the HMIS officer creates a gap in the management of HMIS at district level.
Opportunities	**Threats**
The MOH has carried out an assessment of the functionality of HMIS and based on the findings, improves on the effectiveness and efficiency of HMIS.	

Data storage: All HMIS reports are entered in the computer and consolidated into a district report. Hard copies of district reports submitted to MOH are also kept in a district file. A file with all district reports for 2008 was available. However, the system did not contain an electronic backup of the HMIS data. This poses a challenge in case of computer breakdown or loss.

Data utilization of collected information at the district level: Utilization of data at the district is generally low for monitoring and evaluating district progress of their programs. This is because of limited technical skills and time constraints to analyze and interpret data. However, on a small scale some data are analyzed, e.g., monitoring trends of pregnant mothers testing for HIV and receiving PMTCT services. There has not been much emphasis in analyzing HCT and ART data. The results of small scale analysis are shared in the district health quarterly meetings.

Other challenges to data utilization include: lack of M&E systems for the HIV programs; lack of a designated person in charge of M&E at the district; and lack of a district bio-statistician because of funding limitations.

Challenges in data collection at the district level:

- Timeliness may occasionally be hampered because of stock-outs of HMIS reporting forms.
- Accuracy may be affected because of lack of trained data assistants/records personnel at the districts. There is a high turnover of trained records personnel, which creates a gap from time to time.
- Accuracy may also be affected by the lack proper training of record assistants, who are required to make summaries of the data after collection.
- Some forms are filled in using medical language. Yet the person to go through them has no medical background.
- M&E requires funding, which is not available, and the funding at the district has been reduced every year, so priority is given to other areas.
- Manual handling of data is difficult; errors are more likely with manual handling of data—need to computerize data collation using simple standardized systems.
- Lack of transport in collection of data—for example, on condom distribution in the communities— which causes delays and affects timeliness and completeness of data.

DAC Overview

It is meant to:

- Integrate HIV component in the development plan of the district.
- Incorporate HIV at all levels of local government from sub-county to district level.
- Ensure timely accountability for funding on HIV areas.
- Provide technical support, i.e., spearheads the HIV committee at the district.
- Hold regular meeting of the DAC members.

Members of DAC committee include the following:

- Chief administrative officer
- All heads of department
- NGO representatives active in HIV/AIDS issues
- Representative of people living with HIV
- Faith-based organization representative

DAC meetings

The DAC in Mukono is supposed to meet on a quarterly basis but has been inactive. The last formal meeting was last held in April 2006. This is because there has not been any funding for activities. The DAC activities were previously supported by the AIDS control project, but it ended in 2006.

Support to the DAC

AIDS commission does not currently support DAC. Recently UgSh 125,000,000 from the district funds was budgeted to revive the activities of the DAC this year. There is need for the AIDS Commission to support DAC activities regularly.

District Planning Unit

There is a district technical planning committee with a Focal Person in charge of HIV/AIDS. A monitoring plan is in place with each sector supposed to provide sector specific information on a quarterly

basis to feed into the central system, although sometimes this does not happen regularly. All departmental heads have to plan for HIV/AIDS activities in their sectors, and these then are integrated in the district plan.

Challenges involved in data collection in the planning department

- There is no harmonized tool to collect data by all the stakeholders, and therefore departments may not know what to collect. For example, from the community development department, there is very scant data on OVC.
- The education sector sends all the data to the parent ministry, and none is left at the district, yet it is needed for planning.
- Some indicators may be set at the national level, yet they are not applicable in a particular district.
- No capacity building on M&E has been done, yet there need for these skills with changing data needs.

District AIDS coordination index (measure of the level of district integration and coordination)

Up-to-date district HIV/AIDS plan: draft submitted to Uganda AIDS commission; the district HIV Focal Person has the data.

Up-to-date district HIV/AIDS plan integrated in to DDP: data exists; the planning unit makes the development plan.

Quarterly DAC meetings held: No data because no DAC meetings have taken place for the last two years.

Quarterly DAC support supervision carried out: DAC is supposed to give support supervision at the district and in the community; there is no motivation to do this without support.

Quarterly district HIV/AIDS report available and sent to the UAC: This is not being done, but can be enforced if the UAC supports activities regularly.

Appendix 8: Matrices for Evaluation of the PMMP Indicators

A. Evaluating the sourcing mechanisms for the district level monitoring indicators

A1. Evaluation of the output indicators for monitoring the district response

Category and Indicator	Primary Source	Indicator Focal Person	Key Information System	Alternative Sources	Challenges	Recommendation
IEC (BCC)						
Number of IEC materials produced and disseminated (by type-poster, leaflet, newspaper supplement etc)	Not routinely captured in any system	DHE	DHE from activity reports. However, many IEC activities are being implemented without the knowledge of the DHE. The DHE will only capture what is implemented by the district departments and what is reported to the district by CSOs	Many CSOs also distribute IEC materials	• In Kumi, there is a log-book where in-coming and issued IEC materials are logged (in DHE's Office); however, the register not specific to HIV; however this practice is not there in other districts • In Kiboga, bulk IEC materials are delivered to the stores if they have a delivery note, but smaller amounts are taken to the DHE, who distributes randomly • The indicator was in the old HMIS form but has been removed from the new one • Districts do not routinely produce IEC materials; they are usually involved in distribution	• Indicators should refer to distribution rather than production • Indicator needs to specify 'IEC materials for HIV' • If this indicator is to be effectively reported on, the realistic approach is to monitor the items as they are issued at the DHE or District store; but this requires streamlining the stock control system for IEC materials • Collation of information for IEC materials distributed by CSOs is not feasible

Number of radio programmes	Not captured routinely but district have planned radio programmes	DHE			• Radio messaging is not routinely coordinated under on e focal office • There is no log that registers radio programmes or spots	• It is possible for the DHE to have a log that tracks these outputs; however, indicator definition needs to be made more specific; do spots mean themes or each time a theme is run? It also needs to be indicated whether these are HIV specific
Number of radio spots						
Number of young people reached by Life Skills education in-out of school settings	These are non-facility based indicators; Activities are ubiquitous with many implementers; Information not captured at any level	CBSO	Not routinely captured in any information system		• Districts conduct these activities but not on a regular basis • The indicators are not routinely captured because IEC activities are not coordinated • Some CSOs conduct these activities but CSO reporting is not done • Lack of coordination for different actors in Life Skills education; data capture not streamlined • There are many actors but districts have no coordination mechanism to monitor these activities	• Collection of this information would only be possible is there is a management information system and a system for coordination of the activities of the Community Based Services Department
Number of trainers for out-of-school youth trained in Life Planning Skills						
Number of peer educators trained in HIV/AIDS and Life Skills						

Condom Services						
Number of condoms dispensed at service delivery outlets (free/social marketing)	Not currently captured at the service delivery points	Condom Coordinator; Health Educator	Condom information captured in HMIS Monthly reports but is specific to FP; Recording of stocks received and issued out done at the district drug stores or the coordinators		• Information on indicator not collected at health units • Social marketing agencies do not report to districts	• It is feasible to collect and report on this indicator at the health centers • HMIS monthly report needs to have a section that captures condoms distributed at service outlets at points other than FP; this is possible if it is made a requirement that stock cards are completed • Practically, it is hard to collate information from social marketing activities
Number of condoms dispensed by Community Resource Persons (CORPs)	Not currently captured at the service delivery points	Condom Coordinator; Health Educator	Health units routinely issue condoms to community resource persons and some CSOs but do not capture the information	In Kumi, CSOs involved in condom distribution are required to report numbers dispensed and the demographics of recipients	• Service delivery points do not have a recording systems for condoms issued in this way; information not routinely collected • Much of the dispensing is done by volunteers who at times do not record • In Kiboga and Mukono condom distribution to the non-facility based community outlets (Bars, Toilets, Boda-boda stages etc) is random and not recorded	• It is possible to collect this information if it is made part of HMIS; however, indicator definition should refer to those issued to CORPS by the health facility • It is also possible to obtain this information from the CSOs routine reports • It is possible to register these outlets and the number of condoms distributed in this mode; this can be captured in the stock cards

Number of condom service outlets	Not captured	Condom Focal Person				• Official outlets should be defined at the district level including facility and non facility based and updated by the CFP
PMTCT						
Number of deliveries that are HIV-positive in the unit (Males/Females)	These indicators are Integrated Maternity Register at HC III and above	HMIS Focal Person; PMTCT Focal Person	Collected routinely in HMIS; but not disaggregated for sex in the monthly summary	Also captured routinely in PMTCT reporting system; but not disaggregated for sex in the monthly summary	• In Kumi, HIV Focal person coordinates all HIV activities (HCT, PMTCT, ART, Condoms and H/Education) • Current summaries do not disaggregate indicator for sex	• The PMTCT monthly reporting form can be modified to include sex disaggregation for this indicator • Can the UAC live with the non disaggregated data for now? What is the PH importance of this disaggregated by sex?
Number of deliveries that are HIV-positive who swallowed ARVs (Males and Females)						
Number of live births to HIV-positive mothers (Males and Females)						
Number of babies born to HIV-positive mothers given ARVs (male and Female)						
Number of pregnant women tested for HIV	These indicators are Integrated ANC Register	HMIS Focal Person; PMTCT Focal Person	Collected routinely in HMIS	Also captured routinely in PMTCT reporting system;	• Information on this indicator is readily available	
Number of pregnant women positive for HIV						
Number of pregnant women given ARVs for prophylaxis						
Number of PMTCT static service outlets (Type of facility, sub-county, county)	DHO's Office	DHO; PMTCT Focal Person				

HCT						
Number of individuals (0–4/5–17/18+ years old) HIV counseled (male/female)	HCT Register at service delivery points	HCT Focal Person; HMIS Focal Person	Captured routinely in HMIS and adequately disaggregated			• Indicator is readily available
Number of individuals (0–4/5–17/18+ years old) HIV tested (from laboratory register) (male/female)	Laboratory Register HCT Register	HCT Focal Person; Laboratory Focal Person	HMIS and HCT records system; fully disaggregated		• The HIV counseling and testing cards were not available in most health units and even where available, were not in use • In Kiboga, some government health units did not have the official HCT register and used improvised counter-books and entries did not tally with official • In Kiboga, some H/centers use only the HCT register for their routine testing activities and not the lab register • Some CSOs providing HCT on outreach basis do not share at all the information with the districts (AIC in Mukono)	• Standards for HCT recording need to be strengthened so that all health units follow the right procedure • Distribution of HCT registers should be consistent and countrywide for all health units that offer HCT
Number of individuals (0–4/5–17/18+ years old) received HIV results (male/female)						
Number of individuals (0–4/5–17/18+ years old) HIV-positive (from laboratory register) (male/female)						

Stock out (< 1 week/≥ 1 week) screening HIV testing kits	Stock cards in health units	HMIS Focal Person	HMIS		• Readily available	
Stock out (< 1 week/≥ 1 week) confirmatory HIV testing kits						
Stock out (< 1 week/≥ 1 week) tie-breaker HIV testing kits						
Number of HCT outreach activities planned for the month			This indicator is available in the HMIS 123 but one district is using a different version for the form that does not have it	Some districts are using a different version of HMIS that does not have this indicator		• All districts should use the same HMIS; the ministry should ensure that all districts have the latest versions of the HMIS whenever it is updated; district HMIS FPs should ensure that all health units are using the same monthly report form
Number of HCT outreach activities conducted for the month						
Number of HCT static service outlets (type of facility/sub-county/county)	District Health Office and health centers	DHO; HCT Focal Person; Laboratory Focal Person	Management information		• Focal persons not updating this information	• This information can be obtained by regularly updating the health facility inventories

ART						
Number of individuals (0–4/5–17/18+ years old) eligible for ART (male and female)	ART Register in health units	ART Focal Person	HMIS	This information is extensively collected and readily available There is a vertical ART reporting system that goes to ACP There is also an ART for accountability and drug requisitions decentralized to Health units	• Some CSOs providing ART on outreach basis do not share at all the information with the districts (TASO in Kumi, Kiboga)	
Number of individuals (0–4/5–17/18+ years old) started on ART (male and female)						
Number of ART outlets (Type of facility/sub-county/county)	DHOs office	DHO		Not routinely captured	• Can be readily updated by the DHOs	
Care						
Number of individuals (0–4/5–17/18+ years old) HIV-positive cases started on Cotrimoxazole prophylaxis (male and female)	Pre-ART Register	HMIS Focal Person; ART Focal Person	HMIS		• Readily available • However, CSOs that provide outreach services but without reporting to the districts may lead to the under estimation of this indicator (TASO-Kumi)	
Stock out (< 1 week/≥ 1 week) Cotrimoxazole tablets	Stock cards in health units	HMIS Focal Person	HMIS		• Readily available	

HIV/TB						
Number of TB registered patients tested for HIV (male/female)	TB/Leprosy Register	DTLS	TB and Leprosy Reporting system; indicator not in HMIS			
Number of TB patients positive for HIV						
Number of HIV-positive persons screened for TB (male/female)	Not captured	ART Focal Person	This indicator is not captured in ART	In districts with the TB-CAP programme, these indicators are captured in their vertical reporting system; however, TB CAP is a project and does not cover all districts	• This indicator is not captured in any register; it is only captured in the HIV Care/ART cards and this is not summarized in any summary; there are only specific agencies that capture it e.g., IRCU Kumi	• ART register and the HMIS reporting form needs to be updated to include this indicator
Number of individuals (0–4/5–17/18+ years old) HIV-positive cases with confirmed TB (male and female)	In pre-ART register		HMIS		• Readily available	

Education						
Number of schools with teachers trained in Life Planning Skills and who have taught it in the past academic year (primary/secondary)	Not routinely captured	DEO DHI	Could be part of the EMIS under the term report (the EMIS has a monthly, termly and annual report); but not currently captured	Districts are required to conduct an annual survey for schools in which management and enrollment information is collected; Schools are also supposed to present monthly reports for UPE accountability but also report on government programmes (including); there is also a termly report; however these indicators are not part of the assessment	• Under PIASCY two teachers per school are supposed to be trained as trainers of trainers; however, their outputs in training other teachers are reported to the CCTs who then report to the Tutor Colleges' principals which then report to MoES; no linkage with the district EMIS • Started as a pilot project, that later became a programme for the entire country; however, it is still viewed as a project and programme activities are not always covered or complete • Districts stopped using the electronic EMIS form in 2006 (introduced 1997); it was cumbersome to use; districts fell back to the paper-based report; also report that they do not receive any feedback on the reports they receive • District school inventories are inconsistent with what the MoES records	• According to the DEOs, it is possible to integrate this information into the EMIS, so that it is updated on a regular basis • However, the most realistic timeframe for updating them is on a 'termly' and annual basis • This information could be made part of the 'statistical tool' that is used to update school information on an annual basis; they can also be incorporated into the termly report
Number of teachers trained in Life Planning Skills in the past academic year						
Number of young people reached by Life Skills education in schools						

Orphans						
Number of orphans in school	Currently captured annually from schools	DEO	Part of the EMIS annual statistical form	Some CSOs have lists of orphans sponsored in school; however, with no information management system for CSO activities, such sources are not likely to give a complete district picture	• This information is part of the statistical tool	• Can be obtained from the annual surveys using the statistical tools • Termly reports may also be modified to capture this information
Number of service outlets for orphans (Service = psychosocial, materials, agricultural, education among others)	Not routinely captured	CBSO	No information management system for this	CSO departments have no developed MIS for this; however, the districts have been facilitated under a project to conduct a one off mapping of CSOs	• CSOs are required to be registered by the district, mainly in the Community Development Office. While community departments in some districts register all CSOs (e.g., Kiboga), they only do so once at the time of entry; other districts do not register them, while others only give clearance from specific offices (e.g., security offices, political leaders etc.) • Sometimes districts are requested to provide reports on the status of specific activities by the Ministry; it is then that the CDOs seek out for this information; this reporting is ad hoc	• Community departments should develop a system to monitor CSOs involved in livelihood intervention for vulnerable groups including orphans • Ministry of gender should develop a simple data capture tool that districts can issue to CSOs for them to regularly report on OVC related activities
Number of orphans and vulnerable children served/reached						

Management						
Amount allocated and percentage of district government funds spent on HIV in the last financial year	Finance Department	District Planner	Could be collated by the HIV Focal Person from the financial reports; however, the indicator is too non-specific; what of the mainstream activities like PMTCT and HCT? How is the financial cost of this imputed?; need to focus the indicator			• Orientation of the HIV Focal Person
Number of local government personnel trained and available to carry out M&E activities	District Planning Unit	District Planner	Indicator is non-specific; does not indicate the level and whether they are expected to operate as a team			• Orientation of the HIV Focal Person
District AIDS Coordination Index (measure of the level of district integration and coordination)	District Planning Unit	Substantive HIV Focal Person	Can be computed by the HIV Focal Person but they need training in how to do it			• Orientation of the HIV Focal Person
Number of community based organizations in district receiving support for HIV/AIDS interventions	District Planning Unit	Substantive HIV Focal Person	HIV Focal Person should be able to provide this information readily			• Orientation of the HIV Focal Person

A2. Evaluation of the Outcome Indicators for Monitoring the District Response

A) Prevention

i) Behavioural Change

Indicator	PMMP Indicator # (see Chapter 5)	Source	Alternative source	Challenges	Recommendations
Percentage of young people aged 15–24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	Adapted from #5	Require periodic surveys but are not currently collected	UDHS AIS	• Availability of resources to conduct periodic surveys in districts • None of the 3 districts visited conduct any periodic surveys • Quality of the surveys if conducted • Availability of a protocol for district level surveys • How do districts obtain ethical clearance for research on human subjects?	• All these indicators require periodic surveys • Districts should be encouraged to initiate these surveys • Districts should be encouraged to budget for these surveys in their coordination activities
Median age at which young people aged 15–24 had first penetrative sex.	See #8		UDHS AIS		
Percentage of young people aged 15–24 years reporting the use of a condom during sexual intercourse with a non-regular sexual partner.	Adapted from #10		UDHS AIS		
Percentage of young people aged 15–24 years who used a condom in the last of act of sexual intercourse.	Complementary to #10		UDHS AIS		
Percentage of sexually active people (women 15–49 years and men 15–54 years) who both correctly identify ways of preventing sexual transmission of HIV who reject major misconceptions about HIV transmission.	Adapted from #5		UDHS AIS		

Percentage of sexually active people (women 15–49 years and men 15–54 years) who had sex with a non-regular partner on the last 12 months.	Adapted from #9		UDHS AIS		
Percentage of sexually active people (women 15–49 years and men 15–54 years) who have ever used a condom.	Complementary to #10 and 12		UDHS AIS		
Percentage of sexually active people (women 15–49 years and men 15–54 years) who had used a condom during sex with a non-regular partner in the last 12 months.	Complementary to #10		UDHS AIS		
Percentage of sexually active people (women 15–49 years and men 15–54 years) who had used a condom in the last act of sexual intercourse with a non-regular partner.	Complementary to #10		UDHS AIS		
Percentage of schools in the district with teachers who have been trained in life skills based HIV/AIDS education and who taught it in the last academic year.	Adapted from #16	Collected by but not reported	UDHS AIS		• DEO should request Centre Coordinating Tutors to report information monthly

ii) PMTCT

Indicator	PMMP Indicator # (see Chapter 5)	Source	Alternative Source	Challenges	Recommendations
Percentage of women with children aged 0–11 months who know that HIV/AIDS can be transmitted from mother to child.	Not collected	Require periodic surveys but not currently collected		• As above	• All these indicators require periodic surveys • Districts should be encouraged to

Percentage of women with children aged 0–11 months who know that HIV transmission from the mother to child can be reduced.	Not collected				initiate these surveys in order to get district specific information • Districts should be encouraged to budget for these surveys in their coordination activities
Percentage of women aged 15–49 and men aged 15–54 who know about PMTCT.	Not collected				
Percentage of women with children aged 0–11 months who were counselled about PMTCT and to take an HIV test during an antenatal care visit.	Not collected	This information is currently collected in the PMTCT records system. The PMTCT Focal Person should collate this information on an annual basis and update the indicator as needed			• It is possible for districts to collate this information from the PMTCT registers • PMTCT focal persons need to be oriented
Percentage of women with children aged 0–11 months who were counselled for VCT/PMTCT services who tested for HIV.	Not collected				
Percentage of women with children aged 0–11 months who delivered their babies in health facility or with a clinician.	Not collected				
Number /percentage of hospitals and health centre IVs in the district providing at least the minimum package of PMTCT services.	Available in DHO's but not reported				
Number and percentage of HIV positive pregnant women in the district receiving a complete course of ARV prophylaxis to reduce the risk of MTCT.	Collected, but not reported Integrated ANC register				

iii) Sexually Transmitted Infections					
Indicator		**Source**	**Alternative source**	**Challenges**	**Recommendations**
Percentage of sexually active people (women 15–49 years, men 15–54 years, youths 15–24 years) who both correctly identify common symptoms of STIs.		Not collected		• Challenges as noted before, relating to surveys	• These indicators require surveys • Recommendations as above
Percentage of sexually active people (women 15–49 years, men 15–54 years, youths 15–24 years) who correctly identify at least two ways of preventing transmission of HIV.		Not collected			

iv) HCT					
Indicator		**Source**	**Alternative source**	**Challenges**	**Recommendations**
Percentage of women aged 15–49 and men aged 15–54 who know at least two benefits of VCT.		Not collected			• Survey • Can include indicator in UDHS
Percentage of women aged 15–49 and men aged 15–54 who have ever voluntarily requested an HIV test, received the test, and received the results.		Not collected			• Survey • Can include indicator in UDHS

B) Social Support					
i) Care and Support for People Living with HIV/AIDS					
Indicator	**Source**		**Alternative source**	**Challenges**	**Recommendations**
Percentage of PHAs registered with service organisations supported for income generating activities.		Not currently collected	Some CSOs have these data, but not reported to district	• Challenges relate to the capacity of	• These indicators require special PHA

Percentage of PHAs registered with service organisations who received material support in the last 12 months.				districts to conduct PHA surveys as noted earlier	surveys at the district level • Districts need to be guided on how to conduct PHA surveys • Districts need to be guided on how resources can be obtained for these surveys
Percentage of PHAs registered with service organisations who received psycho social support in the past 3 months.					
Percentage of PHAs who correctly identified at least two safe coping mechanisms to live positively with HIV/AIDS.					
ii) Orphan Development, Care and Support					
Indicator		**Source**	**Alternative source**	**Challenges**	**Recommendations**
Percentage of orphans that received medical care in the last one month of all orphans who required medical care.		Not collected		• Challenges relate to the capacity of districts to conduct orphan surveys as noted earlier	• Districts should be guided on how to set up a coordination mechanism and information system for these aspects of orphan care • Districts should be guided on how to conduct special surveys for orphans
Percentage of orphans who received educational support in the last year.			Some CSOs offer this support		
Percentage of orphans who attended five days of school in the preceding week.					
Percentage of orphans who have received psychosocial support in the last month.					
Percentage of orphans who received material support in the last 12 months.					

Percentage of orphans who received food support in the last 12 months.					
Ratio of current school attendance among OVC and non-OVC age 6–14 years.					• Districts should oriented on how to enrich the annual statistical surveys in schools

C) Care and Treatment					
i) ART					
Indicator		**Source**	**Alternative source**	**Challenges**	**Recommendations**
Number/percentage of people with advanced HIV infection in the district receiving antiretroviral combination therapy in past year.		Collected, but not reported			• Should be compiled from monthly HMIS
Number/percentage of hospitals and health centre IV s providing ART.		Not reported, but can be sourced from the DHOs' office			
ii) Opportunistic infections					
Indicator		**Source**	**Alternative source**	**Challenges**	**Recommendations**
Percentage of PHAs registered with service organisations who required medical care in the last month and received it.		Not collected	Some CSOs can provide		• Survey of CSOs

B. Evaluation of the National Level Indicators

B1. Indicators for which the Ministry of Health is expected to take the lead

No.	Indicator	Baseline	Year of baseline data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
Source: Updated annually from programme reports and the health facility database							
1	Annual number/ incidence rate of new HIV infections	134,500/0.85%	2006	112,430/0.66%	100,000/0.51%	Need triangulation of various methods and standardisation of procedure. Impact indicator	Can be determined by the ACP
17	Percentage of HIV-infected infants born to HIV positive mothers	30%	Estimate without significant intervention	22.50%	15%	Formula based estimate. UNGASS impact indicator	Can be determined from the PMTCT Programme reports; however, the most recent data available is for October–November 2008
19	Percentage of pregnant women tested for HIV during pregnancy	24%	2005/06	50%	80%		Can be determined from the PMTCT Programme reports; however, the most recent data available is for April to June 2009
28	Current number/ percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	91,500 (39%)	2006	135,000 (51%)	240,000 (67%)	UNGASS indicator. Not cumulative	Can be determined from the ART Programme; Most recent data available is from January to March 2009
30	Percentage of HIV infected among newly registered TB cases	60%	2006	40%	30%	UNGASS indicator	Not captured in Resource centre summary; Can be obtained from the national TB and Leprosy programme
49	Percentage of health facilities from HC III and above that are providing HCT	42%	2006/07	60%	100%		Not captured in HMIS; should be provided by the vertical programme in the ACP (HCT)
50	Percentage of health facilities from HC IV and above that are providing ART	57%	2006/07	80%	100%		Not captured in HMIS; should be provided by the vertical programme in the ACP (ART)

No.	Indicator	Baseline	Year of baseline data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
Source: Updated annually from ANC Sentinel Surveillance							
2	Percentage of pregnant women aged 15–49 years attending ANC clinics who are HIV-infected	Urban: 7.1% Rural: 5.5%	2005	Urban:7.6 % Rural: 6.0%	Urban: 7.8% Rural: 6.2 %	Modified MDG and UNGASS Indicator. Impact indicator	Can be captured from the PMTCT Programme reports in the ACP
Source: Updated every 2 ½ years from Most-At-Risk Population (MARP) Surveys							
4	Percentage of MARPs who are HIV-infected	47.2% (CSWs)	2003	40%	30%	UNGASS indicator. Impact indicator	Subject to availability of funds for conducting the MARPs; Protocols are available but resources are not guaranteed. These indicators can also be integrated in the National Sero-Behavioural survey, with over-sampling of the populations of interest
6	Percentage of MARPs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	82.6% cited two preventive practices	2003	85%	90%		
33	Percentage of MARPs that have received an HIV test in the last 12 months and who know the results	49.3% CSWs had ever had VCT	2003	62%	73.50%	UNGASS indicator	
Source: Updated every 2 ½ years from PHA Behaviour Surveys							
13	Percentage of PHAs who know their status reporting consistent use of condoms in the past 12 months	54.5% (UAC-LQAS)	2006	80%	90%	Measures prevention with positives	Subject to availability of funds for conducting the PHA surveys
29	Number/percentage of PHAs receiving co-trimoxazole	150,000/15%	2006	30%	60%		
37	Percentage of PHAs whose households received nutritional support in past 12 months	26.9% PHAs in past 3 months (UAC-LQAS)	2006	40%	60%		

No.	Indicator	Baseline	Year of baseline data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
38	Percentage of PHAs whose households received psychosocial support in past 12 months	86.3% PHAs in past 3 months (UAC-LQAS)	2006	95%	95%		
42	Percentage of households of people living with HIV/AIDS that have benefited from IGAs in last year	41.2% (UAC-LQAS)	2006	60%	80%		
Source: Updated every 2 ½ years from Health Facility Surveys like the SPA							
22	Percentage of ART sites that provided PEP during the past 12 months	TBD	2007	80%	100%		Subject to the availability of funds for conducting the Service Provision Assessment (SPA)
23	Proportion of STI patients that are appropriately managed in PHC facilities according to national guidelines	36%	2005	54%	70%		
24	Percentage of STI patients who are appropriately counselled on condom use, partner referral and also provided or referred for PMTCT	10%	2005	30%	50%		
27	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	TBD	2007	85%	90%	A cohort analysis with health facility surveys; UNGASS indicator. Impact indicator	
31	Percentage of health units with capacity to provide a minimum palliative care package	TBD	2007/8	80% of HC IVs & hospitals	90% of HC IVs & hospitals	Minimum is HCT, TB diagnosis (smear) and treatment, oral morphine & Co-trimoxazole prophylaxis	

No.	Indicator	Baseline	Year of baseline data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
34	Percentage of facilities providing care and treatment integrated with prevention with positives (PWP)	TBD	2007/8	50%	100%		
35	Number of trained PWP persons at HC-IV and community levels	TBD	2007/8	At least 2 per HC-IV	At least 4 per HC-IV		
36	Percentage of health facilities with or linked to operational HBC services	TBD	2007/8	60%	80%		
Source: Updated annually from the National Drug Authority							
14	Number/percentage of condoms of need distributed in the past 12 months by public and private sector	73 million male condoms/38%	2006	151 million male condoms/72%	181 million male condoms/80%	Not cumulative	Can be provided by the NDA
Source: Updated annually from Condom Availability Surveys							
15	Percentage of randomly selected retail outlets and service delivery points that have condoms in stock at time of survey	TBD	2007/8	75%	90%		Subject to the availability of funds; can be integrated with the Service Provision Assessment (SPA)
Source: Updated annually from the Uganda Blood Transfusion Service Programme Reports							
20	Number/percentage of donated blood units in the country that have been adequately screened for HIV according to national or WHO guidelines during the past 12 months	122,442/100 %	2006	314,000/100%	403,000/100%	Annual	UNGASS indicator. Not cumulative
21	Percentage of donated blood units that were found to be HIV positive	1.50%	2006	1.00%	0.75%	Measures quality of selection of donors and potential significance of not testing blood	

B2. Indicators expected from both the Ministry of Health and UBOS through National Surveys and Census Data

No.	Indicator	Baseline	Year of baseline data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
Source: AIS every 2 ½ years							
3	Percentage of adults aged 15–49 yrs old who are HIV positive; by gender and age	6.40%	2004/05	6.9%	7.1%	Impact indicator	Subject to the availability of funds for conducting the National Sero-behavioural survey every 5 years; the last survey was conducted in 2004; The survey planned for 2009 has not yet been undertaken because of resource constraints.
26	Percentage of males circumcised (Disaggregate by age group, facility based/traditional, when)	25%	2006	35%	50%		
25	Prevalence of HSV II among 15–49 year olds	44%	2004/05	31%	25%		
Source: AIS and the UDHS every 2 ½ to 5 years							
5	Percentage of adults aged 15–49 and young people aged 15–24 years who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission	15–49: Males 42%	2004/05	15–49: Males 50%	15–49: Males 63%	MDG and UNGASS indicator	Subject to the availability of funds for conducting the UDHS and the National Sero-behavioural survey every 5 years; the last UDHS was conducted in 2005; the ACP needs to integrate these indicators into the UDHS and AIS
		15–49: Females 31.3%		15–49: Females 42%	15–49: Females 52%		
		15–24: Males 38.2%		15–24: Males 52%	15–24: Males 64%		
		15–24: Females 31.9%		15–24: Females 37%	15–24: Females 52%		
7	Percentage of young women and men aged 15–24 years who have had sex before the age of 15 years	15–24: Males 12.2%	2006	15–24: Males 10%	15–24: Males 7%	UNGASS indicator	
		15–24: Females 15.5%		15–24: Females 10%	15–24: Females 7%		
		15–19: Males 13.9%		15–19: Males 12%	15–19: Males 8%		

No.	Indicator	Baseline	Year of baseline data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
		15–19: Females 11.8%		15–19: Females 9%	15–19: Females 6%		
		20–24: Males 9.6%		20–24: Males 8%	20–24: Males 5.5%		
		20–24: Females 19.7%		20–24: Females 13%	20–24: Females 8.5%		
8	*Alternate 7*. Median age at which young people aged 15–24 years first have penetrative sex	Males 19.1 Females 18.3	2004/05	Males 19.5 Females 18.6	Males 20 Females 19 years		
9	Percentage of adults aged 15–49 years who have had sex with a non-marital, non-cohabiting sexual partner in last 12 months	Males 36.2% Females 15.9%	2006	Males 28% Females 11%	Males 19% Females 8%		
10	Percentage of adults aged 15–49 years who have had sex with a non-marital, non-cohabiting sexual partner in last 12 months and used a condom at last higher risk sex	Males 57.4% Females 34.9%	2006	Males 66% Females 58%	Males 73% Females 70%		
11	Percentage of adults aged 15–49 years who have had sex with more than one sexual partner in the last 12 months	Males 28.7% Females 2.4%	2006	Males 22% Females 2%	Males 15% Females 1%	UNGASS Indicator	

No.	Indicator	Baseline	Year of baseline data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
12	Percentage of adults aged 15–49 years who have had sex with more than one sexual partner in last 12 months and report using a condom at last sexual intercourse	Males 20.4% Females 23.9%	2006	Males 30% Females 35%	Males 50% Females 50%	UNGASS Indicator	
32	Percentage of women and men aged 15–49 who got counselling and an HIV test in the last 12 months and who know their results	Men: 4%	2004/05	10%	15%	UNGASS indicator	
39	Percentage of OVCs whose households received emotional support in past 12 months	0.9%	2006	5%	10%		
Source: Either the census, or the UDHS or the AIS every 5 to 10 years							
41	Ratio of current school attendance among orphans vs. non-orphans, aged 10–14	0.9%	2004/05	0.95	1	MDG and UNGASS indicator	Subject to availability of funds to conduct the UDHS regularly (every 5 years) and the census; UBOS should be engaged to incorporate them into the census
43	Percentage of orphans and vulnerable children (under 18) whose households received free basic external support in caring for the children in the last 12 months	10.7%	2006	20%	30%	UNGASS indicator	

B3. Indicators expected from the Ministry of Education and Sports

No.	Indicator	Baseline	Year of baseline data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
Source: Annually from the Education Management Information System							
16	Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year	TBD	2007	90%	95%	UNGASS indicator. Not yet integrated into EMIS.	Ministry of Education and Sports has a Sectoral MIS; Need to support the Ministry to strengthen the MIS and to incorporate the indicator

B4. Indicators expected from the Ministry of Gender, Labour and Social Welfare

No.	Indicator	Baseline	Year of baseline data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
Source: Special Surveys of disadvantaged groups every 2 ½ years							
40	Percentage of disadvantaged groups that have received vocational education in the past 12 months	TBD	2007/08	5%	10%	Disaggregated by OVCs, PHAs, IDPs, PWDs, etc.	Subject to availability for resources and commitment by the Ministry of Gender Labour and Social Welfare

B5. Indicators that should be sourced by the Uganda AIDS Commission

No.	Indicator	Baseline	Year of baseline data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
Source: Annual workplace surveys							
44	Number/percentage of 30 largest employers in the country that have HIV/AIDS workplace policies and programmes	25 out 30 largest companies (83.3%)	2006	90%	96%	Not cumulative	UAC should develop a mechanism for collection of this information
Source: UAC Programme Reports including the National HIV Status Report, Desk Reviews and Key Informants							
45	UAC management index	TBD	2007/8	90%	95%		UAC has already developed the index but should develop a mechanism for collation of district reports to compute the indicator on an annual basis

No.	Indicator	Baseline	Year of baseline data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
46	National Composite Policy Index	67.5 of 100 points	2005	75%	85%	UNGASS. Indicator. A measure of national commitment and action as well as policy development and implementation status	UAC should develop the index
Source: National HIV/AIDS Stakeholders' service mapping atlas							
47	Percentage of districts with functional District AIDS Committees	89.20%	2005	97%	100%		UAC should be able to compute this annually; attention should be paid to the new districts as they are being formed
Source: Networks of AIDS Service Organisations and PHA Networks (NAPOPHANU and UNASO)							
48	Percentage of districts with a functional PHA network	TBD	2007/8	50%	80%	Functional PHA network is one with registered members affiliated to all PHA associations in District, has met 12 times in past 12 months and is represented in DAC. Measures GIPA	UAC should describe a mechanism for collation of this indicator

Appendix 9: HIV/AIDS Performance Measurement and Management Plan: Training Manual for District HIV/AIDS Monitoring Teams

National Performance Measurement and Management Plan:

Training Manual

September
2009

Uganda AIDS Commission

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HIV/AIDS PERFORMANCE MEASUREMENT AND MANAGEMENT PLAN

TRAINING MANUAL FOR DISTRICT HIV/AIDS MONITORING TEAMS

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Signed

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Director General,
Uganda AIDS Commission

List of Acronyms and Abbreviations

ACAO	Assistant Chief Administrative Officer
AIDS	Acquired Immuno-deficiency Syndrome
ART	Anti-retroviral Therapy
CAO	Chief Administrative Officer
CSO	Civil Society Organization
DEO	District Education Officer
DAC	District HIV/AIDS Committee
DAT	District HIV/AIDS Taskforce
DHE	District Health Educator
DHO	District Health Officer
DIS	District Inspector of Schools
EMIS	Education Management Information System
HIV	Human Immuno-deficiency Virus
HCT	HIV Counseling and Testing
HMIS	Health Management Information System
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MIS	Management Information System
MoES	Ministry of Education and Sports
MoGLSD	Ministry of Gender, Labour and Social Development
NGO	Non-governmental Organization
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
PHA	People with HIV/AIDS
PMMP	Performance Measurement and Management Plan
PMTCT	Prevention of Mother-to-Child Transmission
UAC	Uganda AIDS Commission
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development

Purpose of the District Training

The goal is to train district multi-sectoral teams to source, collate and transfer Performance Measurement and Management Plan (PMMP) indicators to the Uganda AIDS Commission (UAC), line ministries and other stakeholders in order to strengthen the monitoring of the HIV/AIDS National Response.

Training Objectives

1. Identify the basic components of the National Strategic Plan for HIV/AIDS response.
2. Explain basic monitoring and evaluation (M&E) concepts.
3. Identify district PMMP output indicators.
4. Collect and collate the district PMMP output indicators.
5. Demonstrate how to capture data into an electronic database and transfer it to the UAC and other stakeholders.
6. Generate basic reports from output indicators for district use.
7. Emphasize the importance of multi-sectoral approach in the coordination of the district HIV/AIDS response.

Training Curriculum

General Specifications

Title: District PMMP output indicator training

Duration of the training: Three days

Training format: This manual can be used in two different training formats:

1. An apprenticeship format in which each district is trained individually, in which case the venue is at the district.
    - This format carries the advantage that the districts will be able to generate the required data for at least one quarter, during the actual training.
    - It has the disadvantage that it requires more resources and time to cover all the districts.
2. A workshop format in which three to five districts are trained together, at a venue away from the participating districts.
    - This format has the advantage that it is less expensive and would cover all the districts in a shorter time.
    - However, district teams may not have the data at hand to complete at least one report during the training.

Participants: There are four main stakeholder departments that should participate in this training:

a. District Health Office
b. District Education Office
c. District Community-based Services Office
d. Office of the Chief Administrative Officer and the District Planning Unit

In order to create a critical number of resource persons in the district who are capable of collecting and collating the monitoring information, it is desirable that a minimum of 8 people and an optimum number of 12 people participate in this training, selected from the 4 departments as follows:

a. District Health Office (six representatives if an apprenticeship format is used and two representatives if a workshop format is preferred)
b. District Education Office (At least two representatives)
c. District Community-based Services Office (At least two representatives)

d. Office of the Chief Administrative Officer and the District Planning Unit (At least two representatives)

Participants should be selected from the following officers:

a. Under the District Health Office
   i. District Health Educator (DHE)
   ii. District Health Management Information System (HMIS) Focal Person
   iii. District TB/Leprosy Supervisor
   iv. District Prevention of Mother-to-Child Transmission (PMTCT) Focal Person
   v. District HIV Counseling and Testing (HCT) Focal Person
   vi. District Anti-Retroviral Therapy (ART) Coordinator
   vii. District Condom Coordinator

b. Under the District Education Office
   i. District Inspector of Schools (DIS)
   ii. District Education Officer (DEO)

c. Under the District Community-based Services Office
   i. District Community-based Services Officer
   ii. District Probation and Welfare Officer

d. Under the Office of the Chief Administrative Officer and the District Planning Unit
   i. District HIV/AIDS Focal Person (regardless of which department they are attached to, they require a close linkage with the planning unit and administration)
   ii. District Planner
   iii. ACAO In-charge of Health

The recommended number of participants per district is 10 officers, including the following:

1. District Health Educator
2. District HMIS Focal Person
3. District TB/Leprosy Supervisor
4. District PMTCT Focal Person
5. District HCT Focal Person
6. District ART Coordinator
7. District Inspector of Schools
8. District Community-based Services Officer
9. District HIV Focal Person
10. The ACAO In-charge of Health

Training outline, description and time allocation

Session	Outline	Description	Methods/ Mode of delivery	Time allocated
0	Introduction and participant expectations of the training	• Registration • Opening remarks • Participants expectations • Logistics/housekeeping • Training overview	Didactic and group discussions	60 minutes
1	Overview of National Strategic Plan (NSP)	• Description NSP • Priority areas of NSP • Multi-sectoral response	Didactic and group discussions	45 minutes
2	Overview of M&E	• Definition of M&E, supervision and its related terms • Development of indicators	Didactic and group discussions	60 minutes
3	Overview of PMMP	• Definition of PMMP • Components of PMMP • Sources of PMMP indicators • Specific objectives of PMMP indicators • Types of PMMP indicators	Didactic	60 minutes
4	Coordinating HIV/AIDS activities and monitoring in the districts	• Multi-sectoral response at district level • Organizational requirement for effective coordination • Role of civil society organization (CSO) • Integration of CSO outputs into district M&E system	Group discussions	120 minutes
5	Monitoring district output indicators	• Describe the 47 output indicators by department • Group exercise by primary sources department	Group discussions	120 minutes
6	Data collection tools and e-database	• Data collection tools • Overview of e-database • Field exercise of data collection at district departments • Demonstration of data capture • Demonstration of data transfer* (***may need internet***)	Group discussions and practical demonstration	6 hours

Session	Outline	Description	Methods/ Mode of delivery	Time allocated
7	Generation of progress reports and their use at the district	• Practical on e-report generations • Presentation and interpretation of reports • Identification of use of reports in the districts	Group discussions practical demonstration	3 hours
	Closing/wrap up	• Post-training evaluation • Remarks	Facilitator led, individual	60 minutes

The Facilitators

Each training programme should be facilitated by at least two individuals. One of the facilitators should be conversant with the e-data base software. Both facilitators should have a good understanding of the HMIS and PMMP indicators.

Recommended Background Reading Materials

- National HIV/AIDS Strategic Plan 2007/8-2011/12
- National Strategic Plan Guide
- National PMMP for the NSP 2007/8-2011/12
- PMMP Operational Handbook
- National PMMP Standard Forms Book
- PMMP Computer Training Manual

Required Resources

- Training manual, plans, Evaluation Form, and District Tool
- Marking pens, masking tape, flipcharts and writing pads
- Computers (laptops or desktops) and the database software
- LCD projector (beamer)

PART A

FRAMEWORK FOR MONITORING AND EVALUATION OF HIV/AIDS IN UGANDA

Session 1: Overview of the National Strategic Plan

1.1 Introduction to the National HIV/AIDS Strategic Plan

The Uganda AIDS Commission is the statutory body mandated to coordinate HIV prevention activities in Uganda. The UAC is a coordinating agency rather than an implementing agency.

Its role is to oversee the national response and to guide stakeholders in implementation of HIV activities in accordance with the National Strategy for HIV Prevention and Control.

In order to facilitate this, the Commission develops a 5-year **National Strategic Plan (NSP)** for HIV/AIDS interventions. The current strategic plan spells out activities for 2007/08 to 2011/12.

Priority Areas for the NSP (2007/08 – 20011/012)

In each strategic planning cycle, the NSP identifies priority areas for the national response.

The NSP identified four areas; three priorities for service for the national response in the current plan period and one cross-cutting area.

They are:

- Prevention
- Care and treatment
- Social support, and
- Strengthening systems for service delivery.

The specific areas of focus under each of these service areas are as follows:

Prevention

- Prevention of sexual transmission of HIV
- PMTCT
- Blood transfusion safety
- Universal precautions and post exposure prophylaxis
- Management of sexually transmitted infections

Care and treatment

- ART
- HIV/ADS counselling and testing
- Opportunistic infections prophylaxis
- Home-based care

Social support

- Psychosocial support for people with HIV/AIDS (PHA) and orphans and vulnerable children (OVC)
- Formal and informal education for vulnerable groups
- Community empowerment
- Basic social needs
- Legal, social and community safety nets

In addition to the three priority service delivery areas, the NSP focuses on *"strengthening systems for the delivery of services that increase access to and improve the quality of services for people infected and affected by HIV."*

These systems consist of:

- Institutional arrangements and human resource requirements
- Infrastructure requirements
- Research and development
- Resource mobilisation and management
- Monitoring and evaluation

1.2 Multi-sectoral Response to HIV/AIDS at District Level

HIV/AIDS is a broad social issue. Because of this, the Government of Uganda emphasises a "multi-sectoral response." This implies that all sectors have a role to play in HIV prevention, care and mitigation.

All sectors therefore should:

- Have HIV/AIDS prevention, care and mitigation activities in their strategic and operational plans.
- Mainstream these activities into their day-to-day operations.

The coming together of different sectors and stakeholders in implementing HIV activities is called the "*multi-sectoral HIV/AIDS response*." There are two important levels in the multi-sectoral response: <u>the sectors</u> (or line ministries) and <u>the districts</u>. As such, the districts and sectors have a key role in ensuring availability of monitoring information, collating this information and aggregating it so that it can be used for performance improvement.

1.3 Group Activity: Roles of the Different Departments in HIV/AIDS

The purpose of this exercise is for the participants to brainstorm on the roles of the different departments in the HIV/AIDS response. Instructions: Now face the person next to you and discuss the role of the following district departments in HIV prevention, care and treatment of HIV.

Table 1 Roles of the different departments in HIV/AIDS

Sector	Role of department at district level
Health	
Local Government and Administration	
Water	
Works, Engineering and Transport	
Gender and Social Welfare	
Community Development	
Finance, Planning and Budgeting	
Information	
Education	
Agriculture and Production	
Industrial and Manufacturing	
Environment	
Civil Society	

Session 2: Overview of Supervision, Monitoring and Evaluation

2.1 What is Supervision, Monitoring and Evaluation?

Distinction between supervision, monitoring and evaluation

Supervision, monitoring and evaluation are very important aspects of programme implementation. Managers and leaders may not know if activities are achieving expected results if they do not monitor them. Confusion between supervision, monitoring and evaluation is common. There is a simple distinction between them that may be helpful.

Supervision means that the managers or leaders conduct continuous checks on the **quality of activities** as they are being implemented.

- The supervisor operates at activity level and helps the implementer by showing them how to do things better. Supervision is continuous and supports the implementers in improving the way they deliver actual services.
- The key words here are “**quality of activities”**.

Monitoring means that the managers or leaders conduct a periodic assessment of whether the desired **outputs** have been realised, and whether the implementers have made the best use of scarce resources (**processes**).

- Monitoring is therefore done periodically e. g., quarterly, while supervision is part and parcel of implementation. Monitoring involves checking on the “extent of attainment of desired outputs” from the activities.
- The key word here is **‘outputs’**.

Evaluation on the other hand refers to a periodic assessment of the extent of attainment of desired **outcomes** and **impacts** of an intervention.

- Evaluation is therefore done on a “termly basis.” Evaluation of a strategic plan can be done either half way the strategic plan period (mid-term evaluation) or at the end of the plan period (end-of-term evaluation).
- The key words here are **‘outcomes and impacts’**.

2.2 Assessment in M&E

What do we assess for in supervision, monitoring and evaluation?

We assess for:

- Extent to which the planned **activities** have been implemented and their quality **(supervision)**.
- Extent of attainment of desired **outputs** and the efficiency of the processes involved **(monitoring)**.
- Extent of attainment of the desired **outcomes** and **impacts** **(evaluation)**.

How do we measure the extent of attainment of desired outputs, outcomes and impacts?

We use "**indicators**".

<u>What is an indicator?</u>

- An indicator is something that shows the extent of attainment of desired results.
- It is a reference measure that enables us to quantify to what extent we have achieved the results.

<u>How do we set the indicators?</u> We set indicators based at five main levels:

1. Whether the planned activities have been implemented *(input indicators).*
2. Whether the implemented activities have been implemented properly and efficiently *(process indicators).*
3. The immediate results of project or programme **activities** *(output indicators).*
4. The attainment of project or programme **objectives** *(outcome indicators).*
5. The attainment of the project or programme **goal** *(impact indicators).*

To obtain indicators, we convert the project goal, the project objectives and the results of project activities into things that can be measured.

NB:
Process indicators are used mainly in supportive supervision, but can be used in monitoring.

Impacts may take a longer time to be realised, sometimes beyond the strategic plan period.

The key types of indicators needed in monitoring and evaluation are therefore:

- Output indicators (mainly in monitoring)
- Outcome indicators (mainly in evaluation)

The major levels are[3]: inputs—processes—outputs—outcomes—impacts

Table 2: Monitoring and evaluation results chain

	Results Level	Description
Supervision	**Inputs**	Inputs are resources put into a project or programme, i.e. the people, training, equipment, facilities and other resources used to implement the planned activities.
Monitoring	**Processes**	The quality of activities and the efficiency with which scarce resources are used
	Outputs	Direct results of project inputs, achieved through the completion of activities/processes. Outputs are the tangible products (including services) of a programme or project that are necessary to achieve the desired programme or project outcomes. Outputs relate to the completion (rather than the conduct) of activities and are the type of results over which managers have a high degree of influence.
Evaluation	**Outcomes**	Outcomes are changes in behaviours or skills, e. g., safer HIV prevention practices and increased ability to cope with and ameliorate the consequences of AIDS. Outcomes are brought about by the combination of target group action in response to project outputs, e.g. through using or responding to quality, economical, accessible and widespread services.
	Impacts	Impacts are higher order outcomes, such as major health effects, e.g., decreased HIV incidence (transmission) and prevalence as well as improved quality of life of the affected and infected.

[3] Note that the terminology used here is that agreed by the M&E committee of the UAC and HIV/AIDS Partnership. Terminologies for these same concepts, e.g., among the different AIDS development partners and even between government agencies may vary.

Session 3: Overview of the National Performance Measurement and Management Plan

3.1 What is the PMMP?

The UAC's mandate to coordinate the monitoring and evaluation of the national HIV/AIDS response is contained in the UAC Parliamentary Statute of 1992 and the draft National Policy on HIV/AIDS. One of the UAC's main commitments is to standardize monitoring and evaluation of HIV activities at the different levels of implementation.

This is in line with the three principles now termed as *"the three-ones*:"

- ***One*** agreed HIV/AIDS ***action framework*** that provides the basis for coordinating the work of all partners;
- ***One*** national AIDS ***coordinating authority***, with a broad-based multi-sectoral mandate; and
- ***One*** agreed ***monitoring and evaluation system***.

To fulfil its mandate and to facilitate the monitoring of HIV/AIDS activities at the national and local levels, the UAC, together with different stakeholders, and guided by UNAIDS, developed the National **Performance Measurement and Management Plan**.

Components of the PMMP

This HIV/AIDS PMMP consists of a number of components:

- An M&E Unit at the UAC and M&E system documentation;
- **One set of national HIV/AIDS indicators**;
- National strategic plan;
- Strategic information flow from districts to national and international levels and back to district levels;
- An information management system;
- Supervision and data auditing; and
- Harmonised capacity building in M&E.

The PMMP therefore has a set of indicators for monitoring the multi-sectoral HIV/AIDS response.

3.2 Sources of PMMP Indicators

The UAC does not wish to set up a parallel system for data collection but to build on existing information systems at sector and district levels.

The PMMP operational handbook states clearly that *"the PMMP will use existing structures both at the central government and at the local government levels."* PMMP information is supposed to be provided routinely by the different stakeholders in HIV/AIDS based on a monitoring and evaluation cycle.

The Uganda AIDS Commission has prioritized engagement at two levels:

1. At the national level, the UAC engages with the ministries (Also called the sectors). These are responsible for policy formulation and technical oversight for line sector activities
2. At the district level, the UAC engages with the district departments (through their line sectors). These are responsible for actual service delivery and contact with the communities.

From the PMMP

The goal of the PMMP is to ensure collection and reporting of all national level HIV/AIDS indicators. The purpose of the PMMP is to guide coordinated and efficient collection, collation, analysis, interpretation and dissemination of information for HIV/AIDS programmes. This PMMP is designed to serve as a guide for baseline and subsequent annual reports on national and district indicators for HIV/AIDS in Uganda and for biennial reports to the United Nations.

Annual reports will form the basis of discussion for the HIV/AIDS Joint Annual Review (JAR) where undertakings or priorities for action will be decided upon for the next year. In addition to the PMMP, the national performance measurement and management system is constituted by a monitoring and evaluation unit at the Uganda AIDS Commission, a National Strategic Plan for HIV/AIDS activities in Uganda, an overall national data collection and analysis plan and a dissemination plan.

The PMM information on HIV/AIDS activities in the district will be captured through flow channels that follow the national/local government structures. These are based on the mandates for the UAC, sector and district directorates/departments.

The UAC is responsible for the multi-sectoral coordination of monitoring and evaluation of HIV/AIDS activities. Sectors are responsible for quality assurance, sector M&E, policy guidance and technical support supervision. Districts, meanwhile, are responsible for implementation.

Data will flow from the communities and facilities through the district local governments to the relevant sectors and converge at the multi-sectoral level. At the district local government level, multi-sectoral reports will be prepared for discussion by the District AIDS Committees (DACs).

Feedback will be made to the districts by the sectors and data will be shared at national level during the joint annual review of AIDS activities with a presentation of the national HIV/AIDS status report by the UAC.

Monitoring will be carried out through sector management information systems and evaluations.

3.3 Specific Objectives of the PMMP

The specific objectives of the PMMP are:

- Direct gathering of information that is useful in monitoring and evaluating implementation of NSP for HIV/AIDS.
- Guide in development and strengthening of the stakeholders' M&E systems.
- Assist all HIV/AIDS stakeholders in conceptualising a coordinated Performance Measurement and Management System for the national HIV/AIDS response.
- Increase the understanding of trends and explaining of changes in the levels of HIV/AIDS prevalence over time.
- Promote utilisation of M&E data in planning.
- Generate an information base for Uganda's timely reporting on its UNGASS commitment and MDG targets.

Expected outputs of implementation of the PMMP are:

- Quality and timely reporting by the UAC and all programme implementers.
- Strengthened M&E systems.
- An up-to-date documentation and information centre.
- A M&E dissemination strategy.
- A list of strategic indicators developed and reviewed based on existing and emerging issues.

3.4 Types of Indicators for Monitoring HIV/AIDS at the Priority Levels in Uganda

The PMMP describes three main types of indicators:

1. **National Level Outcome Indicators:** There are **58 national outcome indicators** to be used to monitor outcomes of the National Response. The Ministries and responsible agencies at national level are supposed to provide this information. Some information requires collation of programme reports and routine reports from the districts. However, some of it requires collection of additional information that is not captured in routine management information systems in the sectors and a re-alignment of sectoral monitoring priorities. In fact, some indicators require surveys.
2. **District Level Outcome Indicators:** There are **29 district outcome indicators** to be used to monitor outcomes of the District Response. The different district departments are supposed to collate this information **periodically.** Most of the indicators require a special survey at the district level. There is need for the UAC to coordinate the planning and implementation of these special surveys. The UAC is to solicit and provide technical support on the agreed special surveys to be carried out. A few of them require collation of information from existing information management systems
3. **District Level Output Indicators:** There are **47 output indicators** to be used to monitor the HIV related activities in the districts. The different district departments are supposed to collate this information on a **quarterly** basis. Most of the indicators require collation of information from existing management information systems in the different departments. For example, the Education Information System, Community Information System, etc. However, some departments do not have a management information system or some indicators are not collected routinely. Districts should establish mechanisms for collection of the PMM indicators that are not collected routinely.

From the PMMP Operational Handbook

Ministries, districts and most other organisations have their own functioning M&E systems that they use to collect data about their activities, including HIV/AIDS-related activities. If the organisation's data collection format (which is part of its M&E system) is aligned to accommodate National HIV/AIDS PMM system reporting, the responsibility to report data to the National HIV/AIDS PMM system will not involve any new data collection. If this is the situation in your sector/ministry/district/organisation, then the requirements for reporting to the National HIV/AIDS PMM system should imply very minimal costs and effort from your Sector/Ministry/District/Organisation.

To eliminate any costs that HIV/AIDS implementers may incur in terms of National HIV/AIDS PMM system reporting, the UAC will print and distribute Sector/Ministry reporting formats, which will eliminate the need to photocopy or reproduce the National HIV/AIDS PMM system report form when reporting to the UAC.

PART B

MONITORING THE DISTRICT LEVEL OUTPUTS

Session 4: Coordinating HIV/AIDS Activities and Monitoring in the Districts

4.1 Multi-sectoral Stakeholders in Collation of Information for the Quarterly Report

Evaluation of the 47 output indicators for quarterly progress report indicates that in order for this information to be successfully compiled, there are **four** main district departments that should participate actively:

1. District Health Office
2. District Education Office
3. District Community-based Services Office
4. District Planning Unit and Administration

With regard to providing specific information on each of the indicators, there is a minimum of **15 Focal Persons** required for all the different pieces of information in the quarterly progress report to be filled:

Under the District Health Office

1. District Health Officer (DHO)*[4]
2. District Health Educator*
3. District HMIS Focal Person*
4. District TB/Leprosy Supervisor*
5. District PMTCT Focal Person*
6. District HCT Focal Person*
7. District ART Coordinator*
8. District Condom Coordinator

Under the District Education Office

9. District Inspector of Schools*
10. District Education Officer

Under the District Community-based Services Office

11. District Community-based Services Officer*
12. District Probation and Welfare Officer

Under the Office of the Chief Administrative Officer and the District Planning Unit

13. District HIV Focal Person* (regardless of which department they are attached to, they require a close linkage with the planning unit and administration)

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[4] An asterisk (*) indicates core persons

14. District Planner*
15. ACAO In-charge of Health*

4.2 Recommended Approach to Coordination of Information Collation

1. The District HIV/AIDS Focal Persons should prioritize these four departments in compiling the quarterly progress report.
2. The HIV Focal Persons should link up with the 15 Focal Persons on a quarterly basis, with a blank reporting form for them to fill the respective sections.
3. An "active surveillance approach" is recommended in which the Focal Person makes a quarterly round of visits to all the focal officers to seek their input.

4.3 Organisational Requirements for Effective Coordination of HIV/AIDS Activities

In line with their roles in the decentralized system in Uganda, districts should know that it is their mandate to provide HIV/AIDS services at the primary care level. Overall coordination of the HIV response in the district is the responsibility of the **Chief Administrative Officer**, who in turn appoints the **District HIV Focal Person from the district senior staff members.**

District HIV/AIDS Focal Person

All districts are required to have a District HIV Focal Person (DFP) who coordinates the multi-sectoral response on a day-to-day basis. The District HIV Focal Person is responsible for technical oversight for planning, implementation and monitoring of HIV/AIDS activities in the district. The level of commitment of the HIV Focal Person is crucial to all processes.

District HIV/AIDS Strategic Plan

Stakeholder departments in the districts should develop a single, multi-sectoral district HIV/AIDS strategic plan that is in line with the NSP. The plan should be integrated in the overall District Development Plan (DDP) and the district annual work plans and budgets and it should reflect the different sectoral HIV/AIDS interventions. It is the responsibility of the DAC to ensure that the plan is up-dated on a regular basis.

Role of the District Planning Unit

The planning unit often prepares the district plan by combining the sectoral plans using a coding system based on the Local Government Integrated Financial Management System (IFMS). This central coordinating role of the planning unit has important implications for HIV/AIDS planning.

The District Planning Units should therefore work very closely with the designated HIV Focal Person and the DAC to:

- Mainstream the sectoral HIV/AIDS plans into the District Development Plan.
- Provide support in getting the different sectors to play their part in collecting the HIV monitoring outputs and outcomes, taking advantage of the existing structures like the District Technical Planning Committee.
- Provide support in managing the electronic HIV/AIDS database.

DAC and DAT

The districts should also have a **District HIV/AIDS Committee (DAC)**, and a **District HIV/AIDS Taskforce (DAT)**. Similar structures are also prescribed at sub-county and lower levels. The DAC should be composed of a multi-sectoral team of technical heads of departments and some CSO representatives. Districts also ought to have a forum that unites the HIV/AIDS-related CSOs operating there. The DAC is required to meet at least once every quarter and deliberate the status of HIV/AIDS service delivery **outputs** so as to improve performance in the following quarter.

Progress Reports

There is a lot of information collected by different stakeholders in the district HIV/AIDS response.

The role of the DAC is to pool and collate this information, from all its various sources, formal and informal, and to provide an up-to-date progress report.

DAC needs to discuss the report on the various output indicators and forward it Chief Administrative Officer (CAO) through the Focal Person for submission to the UAC.

- The primary objective of these monitoring reports is to facilitate performance improvement so as to bolster the district HIV/AIDS response.
- These status reports should therefore be discussed in the regular DAC meetings as a basis for improving service delivery.

- As a secondary objective, these reports ought to be shared with the relevant sectors and stakeholders at national level, so that information from the districts can be aggregated into a national database.

In the next session, we describe the indicators contained in this report.

4.4 Importance of CSOs in the District Response

At the district level, there are many organizations, of various sizes, and many of them are not officially monitored by the DACs. They are involved in different activities related to the NSP. Some are involved in prevention, some are involved in care and others are involved in social support. However, many CSOs do not routinely report to districts and because of this, their outputs are not properly monitored. To leave them out of the district system would mean under-counting of the district response.

4.5 Integration and Monitoring the CSO Outputs at the District Level

District level CSOs should be coordinated at the district, and therefore should report their data and information through the district.

All AIDS related CSOs operating service delivery points at the district level (including CBOs) should be appropriately registered by the district authorities. Districts should develop a reporting mechanism through which CSOs can provide feed-back on their outputs. The line department responsible for coordination of CSOs should engage CSOs to report. The UAC is planning to support districts by developing a simple reporting tool for CSOs

4.6 General Discussion

- How can districts improve the coordination of HIV/AIDS related CSOs operating in their area?
- How can outputs from HIV/AIDS related interventions by CSOs be integrated into the district information management systems?

Session 5: Monitoring the District Level Outputs

5.1 District Level Output Indicators

Districts are expected to collect output information on a quarterly basis. Previously, the quarterly reports in the districts were not based on any standard format and were mainly in narrative form. Therefore, the quarterly meetings of the DAC did not discuss outputs. The PMMP now prescribes the output indicators that should be used to monitor the district response.

They are listed as follows:

Table 3 List of district level output indicators

No	Indicator
Category 1: Led by the Health Department	
Information, Education and Communication (IEC) (i.e. Behaviour Change Communication)	
1	Number of IEC materials produced and disseminated *(by type-poster, leaflet, newspaper supplement etc)*
2	Number of radio programmes
3	Number of radio spots
4	Number of young people reached by Life Skills education in out-of-school settings
5	Number of trainers for youth out of school trained in Life Planning Skills
6	Number of peer educators trained in HIV/AIDS and Life Skills
Condom Services	
7	Number of condoms dispensed at service delivery outlets *(Free/Social Marketing)*
8	Number of condoms dispensed by Community Resource Persons *(CORPs)*
9	Number of condom service outlets
PMTCT	
10	Number of deliveries that are HIV-positive in the unit *(Males/Females)*
11	Number of deliveries that are HIV-positive who swallowed ARVs *(Males and Females)*
12	Number of live births to HIV-positive mothers *(Males and Females)*
13	Number of babies born to HIV-positive mothers given ARVs *(Male and*

No	Indicator
	Female)
14	Number of pregnant women tested for HIV
15	Number of pregnant women positive for HIV
16	Number of pregnant women given ARVs for prophylaxis *(PMTCT)*
17	Number of PMTCT static service outlets *(type of facility, sub-county, county)*
HCT	
18	Number of individuals (0–4/5–17/18+ years old) HIV counselled *(Male/Female)**
19	Number of individuals (0–4/5–17/18+ years old) HIV tested *(from laboratory register) (Male/Female)**
20	Number of individuals (0–4/5–17/18+ years old) received HIV results *(Male/Female)**
21	Number of individuals (0–4/5–17/18+ years old) HIV-positive *(from laboratory register) (Male/Female)**
22	Stock out (< 1 week/≥ 1 week) screening HIV testing kits**
23	Stock out (< 1 week/≥ 1 week) confirmatory HIV testing kits**
24	Stock out (< 1 week/≥ 1 week) tie-breaker HIV testing kits**
25	Number of HCT outreach activities planned for the month
26	Number of HCT outreach activities conducted for the month
27	Number of HCT static service outlets *(type of facility/sub-county/county)*
ART	
28	Number of individuals (0–4/5–17/18+ years old) eligible for ART *(Male and Female)*
29	Number of individuals (0–4/5–17/18+ years old) started on ART *(Male and Female)**
30	Number of ART Outlets *(type of facility/sub-county/county)*
Care	
32	Number of individuals (0-4 years/5-18 years/19+ years) HIV-positive cases started on Cotrimoxazole prophylaxis *(Male and Female)**
33	Stock out (< 1 week/≥ 1 week) Cotrimoxazole tablets**
HIV/TB	
34	Number of TB registered patients tested for HIV *(Male/Female)*
35	Number of TB patients positive for HIV

No	Indicator
36	Number of HIV-positive persons screened for TB *(Male/Female)*
37	Number of individuals (0–4/5–17/18+ years old) HIV-positive cases with confirmed TB *(Male and Female)**
Category 2: Led by the Education Department	
Education	
38	Number of schools with teachers trained in Life Planning Skills and who have taught it in the past academic year *(Primary/Secondary)*
39	Number of teachers trained in Life Planning Skills in the past academic year
40	Number of young people reached by Life Skills education in schools
Category 3: Led by the Community-based Services Department	
Orphans	
41	Number of orphans in school
42	Number of service outlets for orphans *(service = psychosocial, materials, agricultural, education among others)*
43	Number of orphans and vulnerable children served/reached
Category 4: Led by Administration, Planning and Finance	
Management	
44	Amount allocated and percentage of district government funds spent on HIV in the last financial year
45	Number of local government personnel trained and available to carry out M&E activities
46	District AIDS Coordination Index *(measure of the level of district integration and coordination) (This is a composite indicator of six other indicators*
	Planning:
	Up-to-date District HIV/AIDS Plan—Yes = 1, No = 0
	Plan Integrated into District Development Plan—Yes = 1, No = 0
	Coordination:
	DAC meetings held in past three months—Yes = 1, No = 0
	DAC support supervision carried out in past three months—Yes = 1, No = 0
	Reporting:
	Quarterly district HIV/AIDS report available and sent to the UAC— Yes = 1, No = 0
	Monthly district sector management information system (MIS) reports

No	Indicator	
	available and sent to Ministry/ sector, e.g., HMIS	
		Health—Yes =1, No = 0
		Education—Yes = 1, No = 0
		Gender, Labour and Social Development—Yes =1, No = 0
	Total score = 7	
47	Number of community-based organizations (CBOs) in district receiving support for HIV/AIDS interventions	

*All indicators initially defined with age categories 18+ yrs have been revised to >18 yrs for clarity
** All indicators with drug or testing kit stock out initially defined as <1 week/ >1 week have been revised to <1 week/ ≥1 week for clarity

5.2 Key Assumptions

- Information is already collected somewhere within the information management system of the different district departments.
- That information on each indicator can be summarised on a quarterly basis from the Information system from which is generated in the respective district departments.
- For information not routinely collected, the line department will establish mechanisms for its collection.
- Different departments will play their role in collating the monitoring indicators expected from them.
- The HIV Focal Person will coordinate the departments to compile the quarterly progress report.

5.3 Group Activity: Evaluating the Mechanisms for Sourcing the District Level Output Indicators

Instructions for group work

- Form four groups based on your departments in the districts and the four categories of indicators above.
- Each group should discuss each of the indicators in their category.
- Since the health department has many indicators, this group should form three sub-groups.
- For each indicator, answer the following questions:

- Who is the primary focal point for this indicator? (By this we do not mean the person who collects the information in the field, but the person who is best placed to lead others in compiling existing information the indicator is updated; or who can initiate its collection in case it is not routinely collected)
- Is the indicator currently captured in any information management system by the district? If not, is it captured in any routine reports?
- What is the primary source and alternative sources of this indicator? Are there alternative information sources for the indicator?
- What challenges are you likely to face in compiling information on this indicator and how might these challenges be overcome?

Group 1: Will discuss the indicators expected from the Health Department

- Group one should form three sub-groups.
- Each sub-group will discuss a section of the output indicators.
- Use the worksheets provided to summarise your observations.

Sub-group A: IEC (behaviour change communication [BCC]) and condom services

Table 4a: IEC (BCC) and condom services output indicators

No	Indicator	Focal Person	Is it currently captured?	Primary source and alternatives	Challenges in collating this information	Suggested ways to overcome the challenges
IEC (BCC)						
1	Number of IEC materials produced and disseminated *(by type-poster, leaflet, newspaper supplement etc)*					
2	Number of radio programmes					
3	Number of radio spots					
4	Number of young people reached by Life Skills education in out-of-school settings					
5	Number of trainers for youth out of school trained in Life Planning Skills					

No	Indicator	Focal Person	Is it currently captured?	Primary source and alternatives	Challenges in collating this information	Suggested ways to overcome the challenges
6	Number of peer educators trained in HIV/AIDS and Life Skills					
Condom Services						
7	Number of condoms dispensed at service delivery outlets *(Free/ social Marketing)*					
8	Number of condoms dispensed by Community Resource Persons *(CORPs)*					
9	Number of condom service outlets					

Sub-group B: PMTCT and HCT

Table 4b: PMTCT and HCT output indicators

No	Indicator	Focal Person	Is it currently captured?	Primary source and alternatives	Challenges in collating this information	Suggested ways to overcome the challenges
PMTCT						
10	Number of deliveries that are HIV-positive in the unit *(Males/ Females)*					

No	Indicator	Focal Person	Is it currently captured?	Primary source and alternatives	Challenges in collating this information	Suggested ways to overcome the challenges
11	Number of deliveries that are HIV-positive who swallowed ARVs *(Males and Females)*					
12	Number of live births to HIV-positive mothers *(Males and Females)*					
13	Number of babies born to HIV-positive mothers given ARVs *(Male and Female)*					
14	Number of pregnant women tested for HIV					
15	Number of pregnant women positive for HIV					
16	Number of pregnant women given ARVs for prophylaxis *(PMTCT)*					
17	Number of PMTCT static service outlets *(Type of facility, sub-county, county)*					
HCT						
18	Number of individuals (0–4/5–17/18+ years old) HIV counselled *(Male/Female)*					

No	Indicator	Focal Person	Is it currently captured?	Primary source and alternatives	Challenges in collating this information	Suggested ways to overcome the challenges
19	Number of individuals (0–4/5–17/18+ years old) HIV tested *(from laboratory register) (Male/Female)*					
20	Number of individuals (0–4/5–17/18+ years old) received HIV results *(Male/female)*					
21	Number of individuals (0–4/5–17/18+ years old) HIV-positive *(from laboratory register) (Male/Female)*					
22	Stock out (< 1 week/≥ 1 week) screening HIV testing kits					
23	Stock out (< 1 week/≥ 1 week) confirmatory HIV testing kits					
24	Stock out (< 1 week/≥ 1 week) tie-breaker HIV testing kits					
25	Number of HCT outreach activities planned for the month					
26	Number of HCT outreach activities conducted for the month					

No	Indicator	Focal Person	Is it currently captured?	Primary source and alternatives	Challenges in collating this information	Suggested ways to overcome the challenges
27	Number of HCT static service outlets *(type of facility/ sub-county/ county)*					

Sub-group C: ART, Care and HIV/TB

Table 4c: ART, Care and HIV/TB

No	Indicator	Focal Person	Is it currently captured?	Primary source and alternatives	Challenges in collating this information	Suggested ways to overcome the challenges
ART						
28	Number of individuals (0–4/5–17/18+ years old) eligible for ART *(Male and Female)*					
29	Number of individuals (0–4/5–17/18+ years old) started on ART *(Male and Female)*					
30	Number of ART Outlets *(Type of facility/ sub-county/ county)*					

No	Indicator	Focal Person	Is it currently captured?	Primary source and alternatives	Challenges in collating this information	Suggested ways to overcome the challenges
Care						
32	Number of individuals (0–4/5–17/18+ years old) HIV-positive cases started on Cotrimoxazole prophylaxis *(Male and Female)*					
33	Stock out (< 1 week/≥ 1 week) Cotrimoxazole tablets					
HIV/TB						
34	Number of TB registered patients tested for HIV *(Male/Female)*					
35	Number of TB patients positive for HIV					
36	Number of HIV-positive persons screened for TB *(Male/Female)*					
37	Number of individuals (0–4/5–17/18+ years old) HIV-positive cases with confirmed TB *(Male and Female)*					

Group 2: Will discuss the indicators expected from the Education Department

Table 5: Education Department output indicators

No	Indicator	Focal Person	Is it currently captured?	Primary source and alternatives	Challenges to collating this information	Suggested ways to overcome the challenges
Education						
38	Number of schools with teachers trained in Life Planning Skills and who have taught it in the past academic year *(Primary/ Secondary)*					
39	Number of teachers trained in Life Planning Skills in the past academic year					
40	Number of young people reached by Life Skills education in schools					

Group 3: Will discuss the indicators expected from the Community-based Services Department

Table 6: Community-based Services Department output indicators

No	Indicator	Focal Person	Is it currently captured?	Primary source and alternatives	Challenges to collating of this information	Suggested ways to overcome the challenges
Orphans						
41	Number of orphans in school					
42	Number of service outlets for orphans *(Service= Psychosocial, Materials, Agricultural, Education among others)*					
43	Number of orphans and vulnerable children served/reached					

Group 4: Will discuss the Indicators expected from the Administration and Planning Department

Table 7: Administration and Planning Department output indicators

No	Indicator	Focal Person	Is it currently captured?	Primary source and alternatives	Challenges to collating this information	Suggested ways to overcome the challenges
Management						
44	Amount allocated and percentage of district government funds spent on HIV in the last financial year					
45	Number of local government personnel trained and available to carry out M&E activities					
46	District AIDS Coordination Index *(measure of the level of district integration and coordination) (This is a composite indicator of six other indicators)*					
	Up-to-date District HIV/AIDS Plan *(Yes = 1, No = 0)*					

	Plan integrated into District Development Plan *(Yes = 1, No = 0)*					
	DAC meetings held in past three months *(Yes = 1, No = 0)*					
	DAC support supervision carried out in past three months *(Yes = 1, No = 0)*					
	Quarterly district HIV/AIDS report available and sent to the UAC (Yes = 1, No = 0)					
	Monthly district sector MIS reports available and sent to Ministry/sector, e.g., HMIS					
	Monthly HMIS reports available and sent to Ministry of Health (Yes = 1, No = 0)					

	Monthly Education Management Information System (EMIS) reports available and sent to Ministry of Education (Yes = 1, No = 0)					
	Monthly sector reports available and sent to Ministry of Gender, Labour and Social Development (MoGLSD) (Yes =1, No = 0)					
47	Number of CBOs in district receiving support for HIV/AIDS interventions					

Plenary Session and Feedback:
Let us now have a plenary session and feed-back on your findings

Session 6: Introduction to the District Data Collection Tools and Electronic Database

The Uganda AIDS Commission has developed a reporting format to help districts in compiling the "Quarterly District Progress Report." In this session, we shall go through the reporting format and discuss its content. The format is available as an MS Excel blank form; an electronic copy will be provided to you.

Please refer to **Appendix A** of this booklet.

[**Note to the facilitator:** *The facilitator should go through the items in the reporting format, clarify issues and re-enforce their linkage to the PMMP district level output indicators*]

6.1 Overview of the E-database

The Uganda AIDS Commission has developed an electronic database to support the management of data from the quarterly progress reports.

The database should be updated by the HIV Focal Person upon completion of the quarterly report. It should be part of the information systems in the district, and will be hosted by the District Planning Unit. The database will also be web-based, so that when information is entered, it can be simultaneously shared with the line sectors and the UAC. For districts that do not have internet services, the districts will be able to up-load the data to the web-site when they access the internet. Once established, the UAC should conduct a follow-up evaluation to assess how well the districts are generating and using monitoring information. We shall now go into a brief-practical session to demonstrate how we can navigate and use the web-site.

Demonstration:

Facilitators should now demonstrate how the web-based portal can be used and how monitoring information can be up-loaded.

Session 7: Generating Progress Reports for District Use

The output indicators are based on routine HIV/AIDS service delivery activities in the different district departments and CSOs.

Therefore, they are supposed to be collated from:

- Existing information management systems within the different departments in the districts.
- For indicators that do not currently have a mechanism for routine information collection, the district departments (supported by their line Ministries) should develop alternative methods and a strategy for their collation, including:
  - A strategy for collation of information on non-facility-based interventions like:
    - IEC activities (Health Department)
    - Orphan activities (Community-based Services and Education Department)
  - A simple reporting tool for the major CSOs involved in HIV/AIDS service delivery in the district should be developed.

7.1 Information Management, Use and Dissemination

Once the quarterly sector report has been completed, the DAC should then meet to discuss it. The DAC should base on the report to recommend improvements in performance. Thereafter the report should be shared with line sectors (especially the AIDS Control Programme in the Ministry of Health, the Ministry of Gender, Labour and Social Welfare and the Ministry of Education and Sports [MoES]) as well as the Uganda AIDS Commission. Because the UAC is a major stakeholder in monitoring the district response, all districts should send a copy of their monitoring reports to the UAC at the time they send the report to the line sectors.

The districts should have key dates institutionalized for these events:

- Key dates for completing the tool on a quarterly basis.
- Key dates for discussing the information in the DAC.
- Key dates for sharing this information with the line Ministries and the UAC.

Appendix 1: District Output Indicator Tools

District HIV and AIDS Collation Report Form

Uganda AIDS Commission Secretariat

General District Progress Report Format

(This report is to be filled in by the District HIV and AIDS Focal Person)

(Please attach signed minutes of the DAC meeting)

UAC Mission: To provide overall leadership in the coordination and management of an effective HIV/AIDS National Response.

UAC Vision: Realization of "a population free of HIV/AIDS and its effects"

Purpose of the Information Collection: *To gather information from the central government to enable the UAC assess the progress made in implementing the NSP and advice on necessary adjustments in the hope of attaining the set targets.*

Name of the District:

Reporting Quarter:	**Q1 (J-S)**	**Q2 (O-D)**	**Q3 (J-M)**	**Q4 (A-J)**
Financial Year:	**2008/09**	**2009/10**	**2010/11**	**2011/12**

Name of the HIV/AIDS Focal Person: ______________________________

Signature of the HIV/AIDS Focal Person: ______________________________

Title of the HIV/AIDS Focal Person: ______________________________

Telephone: ______________ **E-mail :** ______________

Date of Submission: ______________________________

Signature of the Chief Administrative Officer: ______________________________

OUTPUTS FOR DISTRICT LEVEL

IEC/BCC

Disaggregated by:

PMMP Indicator			***Actual***			***Target***	
			Produced	***Disseminated***	***Cumulative***	***Quarter***	***Annual***
Number of IEC materials produced and disseminated	*Abstinence & Faithfulness (AB)*	**Print**					
		Poster					
		Leaflet					
		Newspaper Supplement					
		Newspaper Advert					
		T-Shirts					
		Caps					
		Badges					
		Billboard					
		Audiovisual					
		Music, Dance and Drama					
		TV Talk Show					
		TV Spot Message					
		Radio Talk Show					
		Radio Spot					
		Videos/Films/ Documentaries					
		Rallies					

PMMP Indicator			Actual			Target	
			Produced	Disseminated	Cumulative	Quarter	Annual
Number of IEC materials produced and disseminated	*Condom Promotion*	**Print**					
		Poster					
		Leaflet					
		Newspaper Supplement					
		Newspaper Advert					
		T-Shirts					
		Caps					
		Badges					
		Billboard					
		Audiovisual					
		Music, Dance and Drama					
		TV Talk Show					
		TV Spot Message					
		Radio Talk Show					
		Radio Spot					
		Videos/Documentaries					
		Rallies					
Number of IEC materials produced and disseminated	*PMTCT*	**Print**					
		Poster					
		Leaflet					
		Newspaper Supplement					
		Newspaper Advert					
		T-Shirts					
		Caps					
		Badges					
		Billboard					

PMMP Indicator			Actual			Target	
			Produced	Disseminated	Cumulative	Quarter	Annual
		Audiovisual					
		Music, Dance and Drama					
		TV Talk Show					
		TV Spot Message					
		Radio Talk Show					
		Radio Spot					
		Videos/ Films/ Documentaries					
		Rallies					
Number of IEC materials produced and disseminated	*STI Prevention and Management*	**Print**					
		Poster					
		Leaflet					
		Newspaper Supplement					
		Newspaper Advert					
		T-Shirts					
		Caps					
		Badges					
		Billboard					
		Audiovisual					
		Music , Dance and Drama					
		TV Talk Show					
		TV Spot Message					
		Radio Talk Show					
		Radio Spot					
		Videos/ Films/ Documentaries					
		Rallies					

PMMP Indicator			***Actual***			***Target***	
			Produced	***Disseminated***	***Cumulative***	***Quarter***	***Annual***
Number of IEC materials produced and disseminated	*Basic Medical Care and Support for PHAs*	**Print**					
		Poster					
		Leaflet					
		Newspaper Supplement					
		Newspaper Advert					
		T-Shirts					
		Caps					
		Badges					
		Billboard					
		Audiovisual					
		Music, Dance and Drama					
		TV Talk Show					
		TV Spot Message					
		Radio Talk Show					
		Radio Spot					
		Videos/ Films/ Documentaries					
		Rallies					
Number of IEC materials produced and disseminated	*ART*	**Print**					
		Poster					
		Leaflet					
		Newspaper Supplement					
		Newspaper Advert					
		T-Shirts					
		Caps					

PMMP Indicator			***Actual***			***Target***	
			Produced	***Disseminated***	***Cumulative***	***Quarter***	***Annual***
		Badges					
		Billboard					
		Audiovisual					
		Music, Dance and Drama					
		TV Talk Show					
		TV Spot Message					
		Radio Talk Show					
		Radio Spot					
		Videos/ Films/ Documentaries					
		Rallies					
Number of IEC materials produced and disseminated	*TB/HIV*	**Print**					
		Poster					
		Leaflet					
		Newspaper Supplement					
		Newspaper Advert					
		T-Shirts					
		Caps					
		Badges					
		Billboard					
		Audiovisual					
		Music, Dance and Drama					
		TV Talk Show					
		TV Spot Message					
		Radio Talk Show					
		Radio Spot					
		Videos/ Films/ Documentaries					

PMMP Indicator			Actual			Target	
			Produced	Disseminated	Cumulative	Quarter	Annual
		Rallies					
Number of IEC materials produced and disseminated	*Social Support*	**Print**					
		Poster					
		Leaflet					
		Newspaper Supplement					
		Newspaper Advert					
		T-Shirts					
		Caps					
		Badges					
		Billboard					
		Audiovisual					
		Music, Dance and Drama					
		TV Talk Show					
		TV Spot Message					
		Radio Talk Show					
		Radio Spot					
		Videos/ Films/ Documentaries					
		Rallies					

PMMP Indicator | Actual | Target

		Number	Cumulative	Quarter	Annual
Number of trainers for youth out-of-school trained in Life Skills	*Female*				
	Male				
Number of peer educators trained in Life Skills education for youth out of school	*Female*				
	Male				
Number of young people reached by Life Skills education in out-of-school settings	*Female*				
	Male				

Condoms

Disaggregated by:

PMMP Indicator		***Actual***		***Target***	
		Number	***Cumulative***	***Quarter***	***Annual***
Number of peer educators trained in Life Skills (condom) education	*Female*				
	Male				
Number of condom service outlets					
Number of condoms received					
Number of condoms dispensed at service outlet	*Free*				
	Social marketing				
Number of condoms dispensed by (CORPs)					

PMTCT				
Disaggregated by:				
PMMP Indicator	***Actual***		***Target***	
	Number	***Cumulative***	***Quarter***	***Annual***
Number of pregnant women counseled, tested and given results for HIV				
Number of pregnant women positive for HIV				
Number of pregnant women given ARVs for prophylaxis (PMTCT)				
Number of women given ARVs for treatment				
Number of deliveries that are to HIV-positive mothers in the district				
Number of deliveries by HIV-positive mothers who swallowed ARVs for Prophylaxis				

PMMP Indicator		***Actual***		***Target***	
		Number	***Cumulative***	***Quarter***	***Annual***
Number of live births to HIV-positive mothers	*Female*				
	Male				
Number of (babies born to HIV-positive mothers) given ARVs for Prophylaxis	*Female*				
	Male				

PMMP Indicator		***Actual***			***Target***
		Public	***Private***	***Total***	***Annual***
Number of PMTCT static service outlets	*Hospitals*				
	HC IV				
	HC III				
	HC II				

HCT

Disaggregated by:

PMMP Indicator			*Actual*		*Target*	
			Number	*Cumulative*	*Quarter*	*Annual*
Number of individuals HIV counseled [First Time]	*0–4 years old*	*Female*				
		Male				
	5–17 years old	*Female*				
		Male				
	18+ years old	*Female*				
		Male				
Number of couples HIV counseled [First Time]						
Number of individuals HIV tested (from laboratory register)	*0–4 years old*	*Female*				
		Male				
	5–17 years old	*Female*				
		Male				
	18+ years old	*Female*				
		Male				
Number of individuals received HIV results	*0–4 years old*	*Female*				
		Male				
	5–17 years old	*Female*				
		Male				
	18+ years old	*Female*				
		Male				
Number of individuals HIV-positive (from laboratory register)	*0–4 years old*	*Female*				
		Male				
	5–17 years old	*Female*				
		Male				
	18+ years old	*Female*				
		Male				

PMMP Indicator		***Stock out screening HIV testing kits***	***Stock out confirmatory HIV testing kits***	***Stock out tie-breaker HIV testing kits***
Number of health units reporting stock out of HIV testing kits	*Hospitals*			
	HC IV			
	HC III			
	HC II			

PMMP Indicator	***Actual***		***Target***	
	Number	***Cumulative***	***Quarter***	***Annual***
Number of HCT outreach activities				

PMMP Indicator (Annual)		***Actual***			***Target***
		Public	***Private***	***Total***	***Annual***
Number of HCT static service outlets	*Hospitals*				
	HC IV				
	HC III				
	HC II				

ART

Disaggregated by:

PMMP Indicator			***Actual***		***Target***	
			Number	***Cumulative***	***Quarter***	***Annual***
Number of individuals eligible for ART	*0–4 years old*	*Female*				
		Male				
	5–17 years old	*Female*				
		Male				
	18+ years old	*Female*				
		Male				
Number of individuals started on ART	*0–4 years old*	*Female*				
		Male				
	5–17 years old	*Female*				
		Male				
	18+ years old	*Female*				
		Male				

PMMP Indicator (Annual)		***Actual***			***Target***
		Public	***Private***	***Total***	***Annual***
Number of ART outlets	*Hospitals*				
	HC IV				
	HC III				
	HC II				

Care

Disaggregated by:

PMMP Indicator			***Actual***		***Target***	
			Number	***Cumulative***	***Quarter***	***Annual***
Number of individuals HIV-positive cases started on CTX (Cotrimoxazole) prophylaxis	*0–4 years old*	*Female*				
		Male				
	5–17 years old	*Female*				
		Male				
	18+ years old	*Female*				
		Male				
Number of health units reporting stock out of Cotrimoxazole tablets	*District hospital*					
	HC IV					
	HC III					
	HC II					

HIV/TB

Disaggregated by:

PMMP Indicator			*Actual*		*Target*	
			Number	*Cumulative*	*Quarter*	*Annual*
Number of HIV-positive persons screened for TB	*Female*					
	Male					
Number of HIV-positive individuals with confirmed TB	*0–4 years old*	*Female*				
		Male				
	5–17 years old	*Female*				
		Male				
	18+ years old	*Female*				
		Male				
Number of registered TB patients tested for HIV	*Female*					
	Male					
Number of registered TB patients positive for HIV	*Female*					
	Male					

HIV/TB Care

Disaggregated by:

PMMP Indicator			*Actual*		*Target*	
			Number	*Cumulative*	*Quarter*	*Annual*
Number of individuals HIV-positive cases started on CTX (Cotrimoxazole) prophylaxis	*0–4 years old*	*Female*				
		Male				
	5–17 years old	*Female*				
		Male				
	18+ years old	*Female*				
		Male				

Education

Disaggregated by:

PMMP Indicator		*Actual*		*Target*	
		Number	*Cumulative*	*Quarter*	*Annual*
Number of teachers trained in Life Skills in the past academic year	*Primary*				
	Secondary				
	Tertiary				
Number of schools with teachers trained in Life Skills and who have taught it in the past academic year	*Primary*				
	Secondary				
	Tertiary				
Number of young people reached by Life Skills education in schools	*Female*				
	Male				
	Tertiary				

Education—Orphans

Disaggregated by:

PMMP Indicator			***Actual***		***Target***	
			Number	***Cumulative***	***Quarter***	***Annual***
Number of orphans in school	*Female - Primary*	*Mother Deceased*				
		Father Deceased				
		Both Deceased				
	Male - Primary	*Mother Deceased*				
		Father Deceased				
		Both Deceased				
	Female - Secondary	*Mother Deceased*				
		Father Deceased				
		Both Deceased				
	Male - Secondary	*Mother Deceased*				
		Father Deceased				
		Both Deceased				

PMMP Indicator		***Actual***		***Target***	
		Number	***Cumulative***	***Quarter***	***Annual***
Number of service outlets for orphans (*Service = psychosocial, material, agricultural, education, legal, IGA, medical*)					
Number of orphans and vulnerable children served/reached	*Female*				
	Male				

Management: This section is to be filled in annually

Management of the HIV/AIDS response measures all different areas of support and coordination of HIV/AIDS in the district. This will include planning, budgeting, resource mobilization, coordination, advocacy, information management and M&E.

Planning and Budgeting			
Disaggregated by:			
PMMP Indicator	***Actual***		***Target***
	Number	***Cumulative***	***Annual***
Amount of HIV/AIDS funds received by the district local government *(from both government and non-governmental organizations [NGOs])*			
Amount of district local government funds spent on HIV/AIDS			
Total amount of funds received by CSOs operating within the district			
Total number of LG personnel trained and available to carry out planning work			
Total number of CSOs that have undergone capacity building in planning and budgeting			
		Yes	***No***
Does the district have an up to date strategic plan in line with NSP			
Is there integration of the district HIV/AIDS strategic plan into the District Development Plan			
Is there an annual HIV/AIDS plan in line with the National Priority Action Plan			

Coordination

Disaggregated by:

PMMP Indicator	*Actual*		*Target*
	Number	*Cumulative*	*Annual*
No of CSO stakeholders districts sitting on the District AIDS Taskforce			
Percentage of CSO stakeholders sitting on the DAC			
Number of meeting meetings held by the District AIDS Taskforce			
Number of DAC supervision visits held in the past 12 months			
Number of meeting meetings held by the DAC			
Number of meeting meetings held by the sub-county AIDS Taskforce			
Number of meeting meetings held by the sub-county AIDS Committee			

	Yes	*No*
Did the district hold an annual District AIDS partnership forum		
Does the district have District AIDS Focal Person		

	Number	*Cumulative*
Number of CBOs in the district receiving support for HIV/AIDS interventions		

Advocacy

Disaggregated by:

	Yes	*No*
Was the candle light memorial observed this year?		
Was World AIDS day observed?		
Was the Philly Lutaaya day observed this year?		

Information Management and M&E				
Disaggregated by:				
			Yes	***No***
Does the district have an information unit containing HIV/AIDS information?				
Is the District M&E system in line with the PMMP				
Have all district quarterly HIV/AIDS reports been submitted				
Have all district monthly sector HIV/AIDS reports been submitted to the sector?				
	Prevention	***Treatment***	***Social support***	***Total***
How many agencies are providing HIV/AIDS services in the district (*By type*)				
How many district personnel have been trained in information management and M&E and are available to carry out M&E activities				
How many CSOs have undergone capacity building in Information management and M&E				

Research

Provide a list of any HIV/AIDS research going on in the district (By programme area, title, organization)

Appendix 2: Frequently Asked Questions for Further Discussion

1. How can the data sharing among the departments at the district levels?
2. Will the districts get feedback from the data sent to the UAC?
3. How can the collected data be analysed in places where there are limited computers?
4. In case there is no statistician to support the analysis process for report generation, what options are available?
5. Since the indicators required in the PMMP may be slightly different from the MoH indicators, should PMMP indicators be sent to MoH as well?

Appendix 10: First and Second Interim Report of the Assessment Phase

Technical Assistance to the Uganda AIDS Commission for the Operationallisation of the PMMP

1st and 2nd Interim Report Covering the period October 2008 to February 2009: Challenges and Pre-requisites for Making the PMMP Operational

Reference: USAID/Uganda HIV/AIDS Evaluation, Assessment, and Formative Research
Contract No. GHH-I-02-07-00034-00

Contractor: The Population Council
Sub-contractor: Makerere University School of Public Health

(February 2009)

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The Uganda AIDS Commission, M&E Team
The ACP, Ministry of Health
The Resource Centre, Ministry of Health
The Ministry of Gender, Labour and Social Development
The Ministry of Education and Sports
UBOS
UNASO
TASO
The AIDS Information Centre
JCRC
The Inter-religious Council of Uganda
UNAIDS
ACE
Infotronics

List of Acronyms and Abbreviations

ACE	AIDS Capacity Enhancement Project
ADP	AIDS Development Partner
AIDS	Acquired Immuno-Deficiency Syndrome
ART	Anti-Retroviral Therapy
ASO	AIDS Service Organization
CAO	Chief Administrative Officer
CD4+	Lymphocytes with the CD4 Marker
CDC	Centres for Disease Control
CDO	Community Development Officer
CSF	Civil Society Fund
CSO	Civil Society Organization
DANIDA	Danish Agency for International Development
DEO	District Education Officer
DHAC	District HIV/AIDS Committee
DHAT	District HIV/AIDS Team
DHE	District Health Educator
DHO	District Health Officer
DIS	District Inspector of Schools
DTLS	District TB and Leprosy Supervisor
EMIS	Education Management Information System
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
IEC	Information, Education and Communication
JCRC	Joint Clinical Research Centre
M&E	Monitoring and Evaluation
MARPS	Most-At-Risk Population Surveys
MEEPP	Monitoring and Evaluation of Emergency Plan Progress Project
MIS	Management Information System
MISs	Management Information Systems
MoES	Ministry of Education and Sports
MoGLSD	Ministry of Gender, Labour and Social Development
NAFOPHANU	National Forum of People Living with HIV/AIDS Networks in Uganda
NDA	National Drug Authority
NGO	Non-Governmental Organization
NSP	National Strategic Plan
OVCs	Orphans and Vulnerable Children
PEPFAR	Presidential Emergency Plan for AIDS Relief
PHA	People with HIV/AIDS
PMMP	Performance Measurement and Monitoring Plan
PMTCT	Prevention of Mother to Child Transmission
SPA	Service Provision Assessment
TASO	The AIDS Support Organization
TB	Tuberculosis
ToT	Training of Trainers
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UBTS	Uganda Blood Transfusion Service
UNAIDS	United Nations joint Action on AIDS
UNASO	Uganda Network of AIDS Service Organizations
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing

1.0 Background
1.1 The UAC and Monitoring the National Response

The PMMP is divided into the National and District level components. The national level component consists of 58 indicators while the district response consists of about 50 indicators. The 58 indicators at national level are intended to monitor the national level response and are therefore described as 'impact indicators'. The 50 indicators for the district level are 'output indicators' aimed at monitoring the service delivery outputs from the districts. These are required to be up-dated on a quarterly basis by districts to inform their planning and decision-making.

The UAC emphasizes that it is not an implementing agency. Its role is to oversee and coordinate the national response. UAC can help, request, resource, advocate, sensitize, guide and support district staff to implement the PMMP guidelines. One of their main commitments is to standardize reporting. It does not wish to set up a parallel system for data collection and reporting. Its approach therefore is to build on existing information systems at sector and district level. The UAC system may not capture comprehensive data, but if it can succeed in the objective of getting stakeholders to use monitoring information, then significant ground will have been covered. The UAC is also clear in its observation that they have no direct mandate to run an operational level information system and therefore has to partner with sectors to monitor the national response.

The UAC wants to prioritize engagement at two levels: the sectors and the districts. All other players are expected to channel their issues through the sectors and the districts, including the civil society organizations (CSOs or ASOs). The Midterm Review of the NSP is expected in December 2009 and the UAC hopes that by that time, the NSP should have at-least been disseminated to stakeholders.

1.2 Objective of the Assessment

This report presents a summary of key findings from the first part of the assessment phase (Sectors and ADPs) and the second phase (CSO) as part of the assignment to provide technical support to UAC in operationallising the PMMP. The objective therefore is to:

- Review and document operating M&E systems for the national response, in relation to the PMMP
- Identify best practices, gaps and challenges for PMMP operationalisation
- Describe a system and critical linkages required to make PMMP operational
- Document requirements and propose a plan for the PMMP operationalisation

1.3 Methods, Information Sources and Data Presentation

This information has been generated from a number of key informants that we talked to in the first part of the assessment, and provides a backbone on which we shall build subsequent reports and from which we shall develop an overall framework for the necessary linkages in operationallising the PMMP. The assessment involved visits to different stakeholders from different agencies. We started with a debriefing meeting with UAC and a technical meeting with the UNAIDS. We then set up a schedule of visits and re-visits to different agencies. The debriefing sessions were in the form of meetings and prior to each meeting, we had a team meeting in which we agreed on key issues for discussion with the particular agency. After each meeting, a summary of the observations was made. These minutes have been used as the basis for compiling this report. In addition, we conducted a document review, the purpose being to evaluate each indicator of the PMMP and to link these to the available MISs at district and sector level.

The assessment was conducted using a 'systems analysis model' that followed-up the different processes needed in making the PMMP indicators operational, and described how these processes are related to each other. The table below provides a summary of the key information sources:

Table 1: Key Information Sources Used in Preparation of this Report

1.	The Uganda AIDS Commission, M&E
2.	The ACP, Ministry of Health
3.	The Resource Centre, Ministry of Health
4.	The Ministry of Gender, Labour and Social Development
5.	The Ministry of Education and Sports
6.	UBOS
7.	UNASO
8.	TASO
9.	The AIDS Information Centre
10.	JCRC
11	The Inter-religious Council of Uganda
12.	UNAIDS
13.	Document Review – the PMMP
14.	Document Review – the NSP
15.	Document Review – the HMIS Manual
16.	Meetings with ACE
17.	Meetings with Infotronics
18.	Synthesis meetings of the assessment team

Each section of this report is organized in three tiers: observations, challenges and recommendations. We present our findings in three broad contexts:

- Monitoring the National Level Response,
- Monitoring the District Level Response, and
- Monitoring the Civil Society Response.

2.0 Monitoring the National Response
2.1 What is Expected at the National Level

The National level response will be monitored on the basis of the 58 impact indicators of the PMMP. A breakdown of these indicators by responsible agency shows that there are six categories of agencies which are supposed to provide leadership in up-dating this information, and it is these agencies that the UAC should engage with directly. They include:

I) *Ministry of Health (MoH),*
II) *Ministry of Health together with the Uganda Bureau of Statistics (UBOS),*
III) *Ministry of Education and Sports (MoES),*
IV) *The Ministry of Gender, Labour and Social Development (MoGLSD),*
V) *The Uganda Blood Transfusion Service (UBTS)*
VI) *UAC itself*

For each of these stakeholders, there is a shortlist of indicators they need to provide; each of these has different sourcing mechanisms and periodicity of collection. Below is a summary of the different categorizations:

Table 2: Categories of PMMP National Level Indicators by Responsible Agency and Means of Collection

A. Indicators for which the Ministry of Health is expected to be the source
1. Indicators to be updated annually from Programme Reports and the Health Facility Database *(7 Indicators)* 2. Indicators to be up-dated annually from ANC Sentinel Surveillance *(1 Indicator)* 3. Indicators to be up-dated every 2 ½ years from Most-At-Risk Population Surveys (MARPS) *(3 Indicators)* 4. Indicators to be up-dated every 2 ½ Years from PHA Behaviour Surveys *(5 Indicators)* 5. Indicators to be up-dated every 2 ½ years from Health Facility Surveys like the SPA *(8 Indicators)* 6. Indicators to be updated annually from the National Drug Authority *(1 Indicator)* 7. Indicators to be up-dated annually from Condom Availability Surveys *(1 Indicator)*
B. Indicators expected from both the Ministry of Health and UBOS through National Surveys and Census Data
1. Indicators expected from the AIS every 2 ½ Years *(3 Indicators)* 2. Indicators expected from both the AIS and the UDHS every 2 ½ to 5 Years *(10 Indicators)* 3. Indicators expected from either the Census, the UDHS or the AIS every 5 to 10 years *(3 Indicators)*
C. Indicators expected from the Ministry of Education and Sports
1. Indicators to be sourced annually from the Education Management Information System (EMIS) *(1 Indicator)*
D. Indicators Expected from the Uganda Blood Transfusion Service
1. Indicators to be sourced annually from the Uganda Blood Transfusion Service Programme Reports *(2 Indicators)*
E. Indicators expected from the Ministry of Gender, Labour and Social Welfare
1. Indicators to be sourced from Special Surveys in disadvantaged groups every 2 ½ Years *(1 Indicator)*
F. Indicators that the Uganda AIDS Commission should Source
1. Indicators to be sourced from annual workplace surveys *(1 Indicator)* 2. Indicators to be sourced from UAC Programme Reports including the National HIV Status Report, Desk Reviews and Key Informants *(2 Indicators)* 3. Indicators to be sourced from the National HIV/AIDS Stakeholders' service mapping atlas *(1 Indicator)* 4. Indicators to be sourced from networks of AIDS Service Organisations and PHA Networks (NAPOPHANU and UNASO) *(1 Indicator)*

* Source: The PMMP

The UAC expects to receive regular updates on the 58 'impact' indicators of the PMMP from the line sectors and partners at national level, *some annually, some after every two to three years and some after four to five years.* The key challenge is in getting the different sectors to collect this information at the required times and provide the needed up-dates to the UAC. For this purpose, an M&E unit was established at the UAC to coordinate the information management process, including negotiations with the relevant stakeholders and sectors. At the national level, the UAC observes that it is the sectors' responsibility to solicit information from the different stakeholders, i.e. the districts, national level CSOs and AIDS Development partners, so that information from the different management information systems is aggregated into sectoral data-bases.

2.1.1General Challenges in Operationallising the National Response:

- Some sectors have not set up MISs that tap into district level interventions, and as such, they do not routinely collect sector specific HIV/AIDS related information from the districts. Examples include the Ministry of Gender which is still developing an M&E system.
- Sectors such as Education have not integrated HIV/AIDS indicators in their MIS.
- Sectoral MISs themselves are not designed to provide all the monitoring information that the UAC needs. On the other hand, sectoral MIS are designed for purposes other than monitoring. In order to collect all the monitoring information needed, sectors have to triangulate information from multiple sources.
- Implementation of HIV/AIDS is multi-sectoral; therefore collection of data for the PMMP indicators will depend on the good will of the relevant sectors. Priority is given to the primary data collection needs of the sector and HIV/AIDS is considered secondary.
- There is no routine operating information management system for community based, behavioral and social interventions like IEC, OVC and condom use, to routinely provide data on non-health-unit-based indictors. Implementation of such interventions is also diverse, with many actors, and without a central implementing agency that can report on indicators related to the intervention.
- The culture of information collation from different sources has not yet taken root in districts; districts have not yet learnt to move beyond MISs to actual monitoring and data collation so that information can be used for planning.
- There is limited or a lack of resources to support scheduled data collection activities. No sector presented an approved M&E annual plan and budget for the PMMP indicators.

The assessment of the national level information mechanisms focused on six sectoral partners from whom the PMMP expects to receive up-dated information and information on how they will relate to a common information system for monitoring the PMMP impacts. These six sectoral partners included: selected sectors (the Ministry of Health and its association with UBOS, the Ministry of Education and Sports and the Ministry of Gender, Labour and Social Welfare), the UBTS and the UAC.

2.2 Assessment of Capacities for Stakeholder Agencies

2.2.1 The Ministry of Health

The main task of the Ministry of Health is to provide leadership for the public health response to HIV/AIDS and in doing this the sector has worked closely with different partners. According to the ACP, the Ministry's position in the HIV/AIDS intervention provides many opportunities, but also a number of challenges. The Ministry has a surveillance system and Working Group, responsible for

monitoring the 'public health response', and Uganda AIDS Commission is represented on this working group. This provides an opportunity for the UAC to inject its agenda in the Ministry's operations and to negotiate for information.

According to the PMMP indicator categories, the Ministry of Health is responsible for providing information on 42 of the 58 indicators. The PMMP stipulates 10 sources for these indicators, including:

- Programme reports and health facility inventory
- ANC surveillance
- Most At Risk Populations Surveys
- PHA Behaviour surveys
- Health Facility Surveys
- Reports from the NDA
- Condom Availability Surveys
- AIDS Indicator Surveys
- Demographic and Health Surveys (together with UBOS), and
- The Census (together with UBOS).

Some of these indicators require annual up-dates (especially those based on reports) while the surveys are expected every 2 ½ to 5 years. Based on our discussions with the ACP, the feasibility of obtaining information from these sources is evaluated as follows:

1) ***Programme Reports:*** The ACP has an epidemiology, surveillance and monitoring unit and a programme coordinator for each of the major interventions (VCT/HCT, ART, and PMTCT, IEC /BCC and condom promotion). These receive reports from implementing sites in the public health system and facility based PNFP partners affiliated with the national programmes. They have an inventory of all these units and run a vertical management information system that is supplemental to the HMIS and is based on the VCT/HCT, ART and PMTCT registers. However, some aspects of these services are also captured in the HMIS monthly reporting forms from national level CSOs which are less integrated into the system. In general, seven PMMP indicators are supposed to be generated from programme reports and the health facility inventory. There is also one indicator (on condom procurement) that is expected from the NDA and two indicators expected from the Uganda Blood Transfusion Service. Our initial assessment is that it is possible for information on these indicators to be captured from the programme reports. However, the extent to which these indicators are captured in the current programme reports at the Ministry represents an information gap that will be established and reported in subsequent reports.
2) ***Annual Sentinel Surveillance:*** These ANC based surveillance activities have been on-going since 1989. In the pre-ART Phase (before 2000), this data was relatively easy to interpret. However, since ARVs became widely available, adjustments have to be conducted to make the data less confounded. The data can also be disaggregated by age-group and it provides a proxy for determination of incidence. The data also allows annual estimates and projections, using software like Spectrum and EPP. There is one PMMP indicator that will be up-dated annually from these sources and according to the Ministry they are ready to provide this information. However, it should be noted that the last publication of the surveillance report was in 2002. The reason for this break in analysis is an information gap that will be established and reported in the subsequent report.
3) ***Population Based Surveys:***
    a. ***The UDHS and the Census:*** The Ministry of Health, the Uganda Bureau of Statistics and Macro International have been conducting the Uganda Demographic and Health Survey (UDHS) under the MEASURE DHS Project, supported by USAID. The UDHS is expected to

provide information for at least 13 impact indicators of the PMMP. It has been conducted fairly regularly, 2.5 to five year cycles, and it is hoped that they will be sustained over the next two decades. Censuses are also expected every 10 years – UBOS takes the lead on these. It is expected that the subsequent UDHSs will include HIV testing and behavioural assessment.

b. ***The AIS:*** Under the MEASURE DHS Project, the Ministry of Health plans to conduct regular AIDS Indicator Surveys every five years. The last one was conducted in 2004 and another one is planned for May 2009. The AISs are expected to provide information for about 13 indicators of the PMMP, 10 of them intersecting with those expected from the UDHS. The up-coming survey is expected to include additional biomarkers, including CD4+ counts and incidence.

These two types of population surveys are fairly predictable and it is hoped that the relevant indicators will be available when updates are needed. With both the AIS and UDHS, 13 impact and outcome indicators can be updated every 2.5 years. The Ministry also has stipulated forums and mechanisms for disseminating the findings from such types of surveys. However, two main challenges are foreseen: whether these surveys will be conducted regularly, according to schedule, and the large amount of resources needed to conduct them.

4) ***On-going Cohort Studies:*** The Ministry also receives information from partners undertaking cohort studies, including the Rakai Cohort and the Medical Research Council Cohort in Masaka. According to the MoH, these types of studies provide good information; however, the information is not generallizable to the whole country. There are no PMMP indicators that are required from such studies but they can be used to estimate other indicators.

5) ***Other surveys:*** There are a number of other surveys that the Ministry conducts or partners to conduct. However, the ACP is specific in its observation that these surveys are non-routine, irregular and may only happen if resources are available. These include:

   a. ***Health Facility Surveys:*** Recently, a Service Provision Assessment (SPA) was conducted under the MEASURE DHS Project and the results disseminated in September 2008. The SPA has some service delivery indicators related to ART, PMTCT and HIV/AIDS services coverage. However, health facility surveys are not routine because of inadequacy of resources. This is likely to impact on the UAC's ability to up-date eight indicators whose frequency is supposed to be every 2 .5 years.
   b. ***Condom Availability Surveys:*** Modules and protocols are in place but the Ministry has no resources to conduct the surveys on an annual basis. This is likely to impact on the UAC's ability to up-date one PMMP indicator.
   c. ***People with HIV/AIDS Surveys:*** There is no official PHA survey that has been carried out in the country so far. However, the protocols are available and it is the resources that are lacking. This is likely to impact on the UAC's ability to up-date five indicators.
   d. ***MARPS:*** Protocols are available, targeting special groups like commercial sex workers and fishing communities. However, the resources are not available to ensure that these surveys are conducted routinely. Therefore they are undertaken as and when resources are available. This is likely to impact on the UAC's ability to up-date three indicators.

The Ministry of Health notes that for the majority of the indicators of the PMMP, information can be provided, and opportunities have improved for information gathering. MOH also emphasized that UAC should assist the sectors in mobilizing resources for information collection activities for which the sectors do not currently have the resources. Table 3 below provides a summary of the Ministry's

readiness and realities with regard to the suggested sources of information for the indicators it has been assigned:

Table 3: Summary Evaluation of the Stipulated Information Sources for the PMMP Indicators Expected from the MoH

Stipulated MoH Source	Evaluation	Frequency / Regularity , and Date of last report	Regularity Rating
Programme reports and health facility inventory	Information readily available but needs to be extracted; UAC needs to describe a clear reporting mechanism	Annual; these reports are produced on a quarterly basis	Strong
ANC surveillance	On-going and information is available; of late, there have been some delays in processing this information	Annual; last report was in 2002	Strong
Most-At-Risk Populations Surveys	Protocols available but no resources to make these surveys routine		Not guaranteed*
PHA Behaviour surveys	No national PHA survey to-date, but protocols are available; resources are needed		Weak*
Health Facility Surveys	Not regular at the moment; a recent SPA was conducted and the information released in August 2007; they are often broad in scope; resources needed if they are to be regularized		Not guaranteed*
Reports from the NDA	Information readily available		Strong
Condom Availability Surveys	No resources to conduct them every year; but protocols are available		Not guaranteed*
AIDS Indicator Surveys	Have become relatively regular and are a good opportunity; plans to estimate incidence and additional bio-markers	Five years , last is of the 2004 survey	Strong
Demographic and Health Surveys (together with UBOS)	Have become relatively regular and are a good opportunity; plans to include HIV testing in the subsequent ones	Every five years, last report is of 2006 survey	Strong
The Census (together with UBOS)	Occurs once in 10 years and it has a broad range of issues but it is regular and offers an opportunity		Strong

* Activities for which further negotiations and resources are needed

The ACP/Ministry of Health is also the sector-level supervisor for the district health HIV/AIDS response. Data for monitoring the 50 output level indicators is in principle supposed to be aggregated at this level (for the indicators relevant to the District Health Office) and shared with partners including the UAC.

Challenges in PMMP Operationallisation at MoH Level

- TASO, which is a major national level CSO that provides care and support health services, is not effectively integrated in the MoH reporting mechanism.
- HMIS does not capture all the district level parameters that the UAC would like to be captured; specifically, information on IEC activities and livelihood interventions are not captured. HMIS only captures health-unit-based-data.
- Because the HMIS alone cannot meet all the information needs for monitoring the health sector response, there are parallel MISs for specific programmes like PMTCT, ART and VCT. The challenge is in making these systems complementary.
- Even the UDHS and AIS that are conducted fairly routinely and provide information on the bulk of the indicators are supported under a project mode. Their long-term sustainability is not guaranteed. In addition, they may not be strictly regular according to the five-year schedule (AIS) and five-year schedule (for the UDHS) as indicated in the PMMP. Development partners (USAID/CDC) have funded these surveys.
- There are four types of surveys for which the Ministry of Health acknowledges that it does not have the resources to ensure that they are conducted regularly: *The health facility surveys, the condom availability surveys, PHA surveys and MARPS*. A decision has to be taken on how information for these indicators will be up-dated, or how resources will be generated to conduct these surveys, or whether remedial surveys can be conducted by any stakeholder that has the funds. If all these mechanisms fail, there ought to be a system for making estimates for the indicators, using alternative approaches.
- Even for the larger and more regular surveys (UDHS and AIS), sometimes the information provided is not adequately disaggregated to provide the sub-group estimates that the PMMP requires. However, the Ministry of Health advises that specific information can be provided if the UAC works together with the MoH during the design of the surveys.
- Who should elicit the indicator up-dating process? One of the key issues in operationallising the PMMP is that up-date information needs to be sourced and relayed as per the specified schedules for each indicator. This implies that there has to be someone dedicated to implementing the following tasks:
  - Reminding the stakeholders that a given indicator is due for up-dating
  - Negotiating with the stakeholders for inclusion of the indicator in any assessments
  - Mobilising resources required to facilitate such assessments
  - For impact indicators that are collected from programme reports, following-up the sectors to see that they can aggregate and share this information.

Recommendations on Linkages with the Ministry of Health

1. The UAC and MOH should agree on a schedule and budget for collection of data and information required for the scheduled updates of PMMP indicators. Such a plan could be funded through though the UAC partnership fund of other available and reliable sources, in addition to the funding sources within the Ministry. The reporting mechanisms and contact points need to be clearly articulated.
2. The Ministry of Health also proposes that indicators that require periodic surveys should be up-dated 'as an when new information is available' and that the UAC should naturally be part of the planning process for these surveys.
3. The Ministry of Health proposes that for other indicators that do not require surveys (e.g. those updated from programme reports, the NDA and UBTS), the UAC should communicate to stakeholders the suggested reporting mechanism and a list of key dates.
4. For indicators that have to be up-dated on an annual basis, we propose the 1st of July as the reporting date. For indicators that require periodic up-dates, a five-year schedule should be drawn indicating the datelines. The Ministry of Health also advises that if data on an indicator is

not available at the time it is scheduled to be updated, then the update should reflect the most recent estimate available and indicate that this information is not up-to-date.

5 The Ministry of Health is set to review the HMIS this year. This provides an opportunity for negotiations to see if additional district level outputs can be integrated, so that data sourcing mechanisms are as lean as possible.

2.2.2 Other Sectors and Agencies that Should Provide Information at the National Level

The Ministry of Gender, Labour and Social Welfare: This sector mainly engages in social support for OVCs. The activities are facilitated through project funds from the Core Initiative and Civil Society Fund granted by the UAC. Technical service organizations which are identified at the district level coordinate the work of the CBOs which are given the funds. At the district level, the line department falls in the Community Based Services Department, which is often headed by the Community Development Officer and has a 'District Gender Officer' and a 'Probation and Welfare Officer'. The sector also has an HIV/AIDS desk which is responsible mainly for general advocacy activities but does not collect any data. The MoGLSD is currently in the process of developing an M&E system which will be used to gather the HIV/AIDS program data. The information gathered to date is all aggregated by district and is not reported based on indicators. The information generated is mainly shared through their multi-sectoral coordination meeting on a quarterly basis. The MoGLSD expressed willingness to share the data they will generate once they have their M&E system in place. The MoGLSD recommends that the planned M&E system should be feasible to implement without increasing the burden of paper work of the personnel at the district level.

With regard to the PMMP, the MoGLSD is expected to service one indicator: *'Percentage of disadvantaged groups that have received vocational education'* and the means of collection is supposed to be through special surveys that should be conducted annually. We noted however that these surveys are not conducted routinely and have to be negotiated. The HIV/AIDS desk does not currently collect monitoring information and there was no plan to collect such data.

With support from Core, through the OVC Secretariat, the MoGLSD has developed an MIS. The MIS provides an opportunity for incorporation of the needed parameters.

The Ministry of Education and Sports: The Ministry of Education and Sports runs an information system called the Education Management Information System (EMIS). This is linked to the districts through the District Education Offices and is used to aggregate a range of information on the functions and outputs of schools. The Ministry is expected to provide information for one PMMP indicator at national level, i.e. *'Percentage of schools that provided life-skills based HIV/AIDS education'* and the indicator should be up-dated annually. The key challenge noted is that the EMIS has not yet incorporated this indicator in routinely collected data.

The Uganda Blood Transfusion Service: The UBTS is supposed to provide information on two blood related indicators. Our assessment shows that the UBTS has the capacity to provide this information and all the UAC needs to do is to establish an information linkage and agree on an up-dating schedule for the indicators; information is expected on an annual basis.

Indicators that the UAC is required to source directly: According to the PMMP, the UAC itself is supposed to source information on five indicators, including conducting annual workplace surveys, and analyzing information from programme reports (including the national HIV status report) and Key Informant Interviews. The UAC is also supposed to source information from the HIV

stakeholders' service map and up-date it regularly, and it should also link up with NAPOPHANU and UNASO to up-date one indicator. These indicators are all supposed to be up-dated annually. We hope to provide information in the next interim report on whether the UAC has up-dated these five indicators.

Recommendations on Linkages with Other Agencies and Sectors

1 The UAC needs to conduct follow-up round table discussions with the Ministry of Gender and the Ministry of Education to and negotiate mechanisms with which the indicators expected from them will be serviced on an annual basis. The focus should be on integrating the PMMP indicators in their respective MIS.
2 Since the Ministry of Gender is developing a HIV/AIDS M&E system, now is the time to negotiate inclusion of the indicators that UAC would like to collect, both at National and District levels.
3 Since the Ministry of Education has an already an existing sectoral MIS, the negotiations should focus on how the required indicators at national and district level can be integrated into the routine reporting tools.
4 UAC should establish a communication link with UBTS so that a mechanism for up-dating its two indicators in put in place.
5 As the UAC focuses on engaging the districts and sectors to provide up-date data, it needs to develop its own plan for up-dating the five indicators that the PMMP stipulates will be directly up-dated at the UAC level.

2.2.3 Proposed Strategies by UNAIDS

We conducted a debriefing meeting with the technical team at UNAIDS. In summary, UNAIDS provided the following technical points in the overall direction that the PMMP operationallisation should be taking:

a) **Time frame for operationallising the PMMP:** UNAIDS presented the view that there is no way that the PMMP can be operationallised nationwide in a short period of time. The job is not merely technical; it also requires considerable negotiations. However, there can be short term studies and analyses to assess progress in implementation.
b) **Need for common tools:** Different agencies and sectors at the district and national level have different tools and reporting formats. Emphasis should be placed on the fact that while MIS tools can differ, monitoring tools should be harmonized since the intervention goals are the same even across different stakeholders. UNAIDS hopes that a common monitoring tool can be developed that meets the needs of different stakeholders, including donors.
c) **Value of inter-sectoral collaboration:** All contributors and partners should be involved in joint work planning and joint review mechanisms with an emphasis on quality control. At the moment, sectors and partners are all working parallel to each other in a fragmented approach – this is what has made the development of simple inter-sectoral monitoring mechanisms appear complex. However, building a sustainable inter-sectoral response requires significant investment in capacity building.
d) **To the extent possible, do not create a new system:** We need to emphasize collating what is captured in existing systems rather than creating new systems which will be resisted and that this is monitoring information and not the routine MISs.
e) **Compiled data from sectors can be a quality check:** UAC should compare the same data from different sources and investigate differences that are found.
f) **UAC has reporting requirements:** The M&E system should assist UAC to fulfil its various annual and biannual reporting requirements.

g) **Monitoring ART resistance:** UNAIDS staff feel that the development of resistance to ART is a serious issue that requires constant monitoring on a quarterly or semi-annual basis. They feel that this activity was left out overall in the PMMP and are of the view that it is a fundable by the Global Fund and that our team should recommend this activity.
h) **Development of data-bases**: The PMMP operationallisation team needs to work hand-in-hand with the consultants engaged in developing the Monitoring Database.
i) **Feasibility of PMMP timelines**: UNAIDS indicated that, in their opinion, the PMMP reporting timelines are feasible.
j) **LQS surveys, UAMIS, and CRIS**: LQS surveys are being limited to districts that can afford to implement them. Macro International is preparing to conduct a UAMIS survey with staff in Uganda at this moment. How CRIS will be integrated with the data-base under construction is under negotiation. Again, UNAIDS emphasizes that use of the existing data bases at the district level is sustainable.

The team will examine and evaluate all the above strategies in the subsequent report.

2.2.4 Overall Recommendations for Operationallising the PMMP at Sector Level

Almost all the Key Informants from the different agencies agree that the UAC should actively engage the different stakeholders to provide the required monitoring information. The UAC should prompt the different stakeholders by officially asking for the needed information and following them up until they provide the information. Unlike routine reporting, monitoring information by definition requires active sourcing from the people being monitored.

The UAC should:

1 Increase its engagement with stakeholder agencies and sectors to provide the required monitoring information for the PMMP.
2 Break-down and categorize the 58 impact indicators of the PMMP by their expected sources and modes of collection (we have provided this break-down in the appendices) and disseminate this to the actual persons responsible for providing this information in the sectors.
3 Create a five-year schedule for indicator updates clearly indicating the date, month and year on which each indicator needs to be up-dated and disseminate it to the stakeholders. This should translate into a plan with a budget, indicating the source of financing for the activities that will lead to collection of data on the PMMP indicators.
4 Conduct round-table discussions with the stakeholders to agree on the schedule and mechanisms for indicator up-dates.
5 Articulate a clear reporting plan that includes a schedule with key dates for each sector responsible for providing up-date information and circulate a reporting blank for the indicators for which the sector is responsible.
6 Make a list of actual contact persons who should provide the update information, and articulate who should contact them and the information exchange mechanisms that should be used.
7 Actively engage the relevant desk officers responsible for indicators that need to be up-dated on an annual basis (those from programme reports and sectoral MISs).
8 Participate in the design, conduct and analysis of assessment activities for indicators that are to be collected in scheduled national surveys (e.g. the UDHS, AIS) and provide information on the level of disaggregation that it needs for particular indicators.
9 Conduct discussions with ADPs and sectors to negotiate resources for those surveys where resources are not guaranteed (e.g. MARPS and PHA surveys). In order to do this, the UAC needs to have estimates of the cost of these additional surveys for a five-year period.

10	Indicators that require periodic surveys should be up-dated as and when new information is available.
11	In the subsequent report, we shall provide an assessment of the UAC capacity needs in terms of describing the actual human resources needed for liaison activities for data extraction from the sectors.
12	The UAC should have an automated spread-sheet that shows the status of each of the indicators, when it was last updated and when it is due for up-dating. The system should be able to raise a red flag when the indicator is out-dated. It should be maintained by the M&E coordinator.
13	The UAC itself should up-date its portion of the 58 indicators, i.e. the five indicators that it should up-date annually.

3.0 Preliminary Observations on Monitoring the District HIV Response

We conducted a preliminary assessment of the critical linkages for operationallisation of the monitoring activities at the district level. In this section, we present highlights of the key issues that emerged from discussions with central key informants from sectors and national level CSOs. We note however that we shall endeavor to validate these findings during our district visits.

3. 1 Expectations on Coordinating Structures in Districts

According to the Uganda AIDS Commission, the districts know that it is their mandate to provide HIV/AIDS services at the primary care levels and almost all districts now have a HIV Focal Person. The UAC has disseminated the recommended structure for organization of the district HIV/AIDS response.

All districts are expected to have a District HIV Focal Person (D-HIVFP) and a District HIV/AIDS Committee, the 'DHAC'. The DHAC should be composed of a multi-sectoral team of technical heads of departments and selected NGO representatives. Also, the district ought to have a forum that unites the AIDS-related CSOs operating there.

Overall coordination of the HIV response in the district is the responsibility of the Chief Administrative Officer, who in turn appoints the HIV Focal Person. The District HIV Focal Person is responsible for technical oversight for planning, implementation and monitoring of HIV/AIDS activities in the district. He/she is also responsible for putting in place a system with which the different stakeholders in HIV/AIDS interventions are coordinated through a single, multi-sectoral district HIV/AIDS plan that is in line with the NSP.

All districts are expected to have a District HIV/AIDS plan. The plan should be integrated within the overall District Development Plan and the District Annual Work Plan and Budget and it should reflect the different sectoral HIV/AIDS interventions. In the broader framework, the plan should also have an appendix that shows a summary of intervention areas and activities for the key civil service organizations involved in the district response and those that receive support from the district. It is the overall responsibility of the District HIV Focal Person and the DHAC to ensure that there is a multi-sectoral HIV/AIDS plan in the district, and it is his/her responsibility to ensure that the plan is up-dated on a regular basis.

All districts have planning units responsible for preparation of the District Development and Annual plans. The planning unit often prepares the district plan by combining the sectoral plans into a common coding system based on the Local Government Integrated Financial Management System (IFMS). This central coordinating role of the planning unit has important implications for HIV/AIDS planning.

3.1.1 Preliminary Observations on Challenges in HIV Coordination at District Level

- While the District HIV Focal Person is essential to effective coordination of HIV/AIDS activities, the office is mostly an informal one. The position was established to promote a multi-sectoral approach to coordination of HIV/AIDS related activities. However, because of the informal nature of the position, different districts appoint different cadres to the position. In many districts, the District Health Officer has been appointed. Some Health Officers have further delegated the function to another cadre, most commonly one of the

Medical Officers. In other districts, it is the ACAO in charge of Health, or the District Planning Officer that holds this position. For some districts an officer within the district planning unit has been appointed (e.g. the population officer, or the district statistician). In others still, the position is coordinated by the District Community Development Office, or the Production Coordinator.

- We also noted that for some districts, the HIV Focal Person is appointed by the CAO, while for others, the appointment is by the Chairman LC V. For some districts, a politician from the District Local Council, rather than a technical officer had been appointed to the position – there were even reports that teachers or heads of Civil Society Organizations were appointed in some of the districts. Whether this is an actual challenge to the operationallisation of the PMMP is an issue we shall validate when we conduct the district assessments.
- While this flexibility is important for promotion of a multi-sectoral response, there is also need for uniformity in the standard for the person appointed to this position across all districts. The diverse persons have different capacities, and some cannot effectively influence planning, or leverage the different departments to a common coordination effort. The situation is further complicated when a focal person leaves the district. The fact that the position is not attached to a particular office means that a detailed handover has to be conducted whenever the focal person changes. In general, these are preliminary observations based on information from central key informants and we shall endeavor to validate them when we visit the sampled districts.

Together with a team from the Uganda AIDS Commission, we conducted a SWOT analysis of the key issues affecting the district in relation to their responsibility in providing HIV/AIDS services:

Table 4: SWOT Analysis of Key Issues Affecting the Districts

Strengths	• The district structures will always be there • Districts are closer to the beneficiary populations • Districts have different sectors that can spearhead the sectoral interventions • Districts already have existing capacity for HIV/AIDS service delivery
Weaknesses	• Many districts have not yet built optimum capacity to meet their obligations under decentralization; different districts have different capacities • Varying levels of commitment from serving officers • Frequent attrition of human resources, including HIV Focal persons • Weak collaborative activities between sectors • Imbalances in sectoral capacity; some sectors have more capacity than others • Political interference in selection of Focal persons • Non-functional DHACs; • Activities of CSOs are not adequately incorporated into district MISs
Opportunities	• Some Management Information Systems already exist • Most of the information needed for district level monitoring is already collected either in routine MISs (e.g. HMIS) or in activity reports • There are existing focal persons for the different intervention areas • Districts have the legal mandate to implement and monitor services at their level • HIV activities tend to have better funding compared to other health and social challenges

Threats	• Rapid formation of new districts • Some DHACs only function when there is a project • Wrong expectations that there will always be external funding for HIV activities

3.1.2Preliminary Recommendations on Strengthening HIV Coordination at District Level

1 Having to deal with different offices in different districts creates a situation in which communication channels are variable and may result in coordination challenges. Some Key Informants (especially UNASO) noted that for proper continuity of HIV/AIDS coordination activities at the district level, the Focal Person ought to be situated in the same department for all districts. This way, the responsibility can be effectively integrated into the day-to-day expectations from that particular department, making the head of the department ultimately accountable. Even the UAC feels that focus should be on the District Planning Unit as the best point for coordination of the multi-sectoral response. On the other hand, some key informants observed that the issue should not be about which office coordinates, but more on how the district focal person can work with the planning unit and other departments to facilitate the PMMP. We recommend therefore that the issue of coordination arrangements should be assessed further when we conduct the district visits.

2 In order to promote a multi-sectoral intervention, many key informants noted that the District Planning Unit under the Office of the Chief Administrative Officer should play a key role in bringing the different departments together. The planning unit is the one best suited to leverage the different sectors in developing a multi-sectoral HIV/AIDS plan. It is also the one best suited to mobilize the different sectors to provide M&E data and to convene the regular DHAC meetings. Therefore, regardless of where the focal person is situated, the District Planning Units should take play a more active role in coordinating the collation of monitoring information for the multi-sectoral response.

3 Within the designated department, the Head of Department could delegate one of the team members to be the HIV/Focal person. However, the overall responsibility for ensuring continuity in the coordination activities should rest under the Head of this Department.

4 All District HIV Focal persons should receive terms of reference and clear specification of duties and responsibilities as well as a specification of their linkage with the different sectors and the District Planning Unit as well as their reporting relationships; these should be part and parcel of the outputs expected from their work at all times.

3.2 Expectations on Monitoring Activities and Information Collection

Quarterly Monitoring Reports: The DHAC is expected to meet at least once every quarter and deliberate on the HIV/AIDS situation in the district and the status of HIV/AIDS service delivery so as to lay strategies for the following quarter. In order for these coordination functions to be effective, the DHAC should be able to collect routine monitoring information on the progress of attainment of key results stipulated in the district HIV/AIDS plan and to use this information for planning. There is a lot of information collected by different stakeholders in the district HIV/AIDS response. The role of the DHAC is to pool and collate this information, from all its various sources formal and informal, to provide an up-to date picture in form of a status report. The primary objective of these monitoring reports is to facilitate performance improvement so as to bolster the district HIV/AIDS response. These status reports should be discussed in the regular DHAC meetings as a basis for improving service delivery. As a secondary objective, these reports ought to be shared with the relevant sectors

and stakeholders at national level, so that information from the districts can be aggregated into a national data-base. During the district visits, the team will establish what is required for this to function.

Reporting Lines: As already noted the information generated from the monitoring reports should be used as a basis for performance improvement and should form the agenda for the quarterly coordination meetings of the DHAC – this is the primary reason why it should be collected. However, the UAC would like the districts to regularly share this information, so that the district response can be monitored at higher levels. Therefore, during the district visits, the team will review, examine and establish the requirements for the above to happen.

3.2.1 Preliminary Observations on Sourcing the Information Required for Monitoring the District Response

We conducted a preliminary evaluation of the different indicators expected to be used by districts in monitoring their own response and the mechanisms for their collection. The landscape and sources of this information differ slightly from sector to sector within the district. The matrices below provide a summary of the salient observations by sector:

The District Health Office

The District Health Office is responsible for over 70% of the output indicators for monitoring the district response. The bulk of this information is already collected at the service delivery points and is part of the HMIS. However, there are some indicators that are not routinely collected, but can be up-dated through the regular activity reports produced by the relevant desk officers. In general, the matrix below provides a preliminary evaluation of the output indicators expected from the health sector.

Table 5: Preliminary evaluation of sources for indicators expected from the District Health Office

Sub-Area	Proposed Point of Contact	Source of Information	Evaluation of the means of information extraction
IEC/BCC: This area has a total of 9 indicators categorized as follows:			
Number and type of IEC activities, including print media, radio programmes and spots run by the district in a quarter *(3 Indicators)*	District Health Educator	Aggregation of activity reports at the district level	The DHE should be in position to provide this information. However, it should be noted that they are multiple stakeholders who are implementing the IEC activities, sometimes without the knowledge of the DHE. Therefore information on this indicator will mainly be for activities implemented by district department, and those NGOs that submit reports to the DHE on IEC /BCC.
Outputs from life skills education activities including training of trainers, peer educators and beneficiary youth *(3 Indicators)*	District Health Educator	Aggregation of activity reports at the district level; District health educator should liaise with HSD health educators	The DHE should be in position to provide this information but needs to liaise with HSD health educators and the community development department. It should also be noted that there many actors implementing life skills using different approaches,

Sub-Area	Proposed Point of Contact	Source of Information	Evaluation of the means of information extraction
			The DHE is likely to capture those implemented by district departments and those who report the DHE'S office.
Condom distribution activities in the communities *(2 Indicators)*	HMIS Focal Person	The HMIS Monthly report form (HMIS 105) has a section that summarizes condom distribution info	The HMIS form is well disaggregated to capture information on condoms distributed at the health unit and those distributed by corps.
			HMIS does not capture information on: condom distribution by social marketing but it is possible to obtain this information; the DHE can source this info from activity reports; they also need to liaise with CSOs (if any) involved in this kind of work in their districts.
PMTCT/HCT/ART: A total of 23 areas categorized as follows:			
PMTCT service delivery Outputs *(9 Indicators)*	HMIS Focal Person	The HMIS Monthly report form (HMIS 105)	HMIS covers 5 of the 9 indicators
	PMTCT Focal Person	PMTCT reports and The PMTCT Register	4 indicators require additional collation of information from the parallel PMTCT reporting system.
HCT service delivery outputs *(11 Indicators)*	HMIS Focal Person	The HMIS Monthly report	The HMIS is adequately disaggregated to capture all this information for all sub-groups except for one indicator: [number of 'couples' counseled]; *need to discuss how this data will be captured; or the better to collate for sex-ratios among first time testers.*
ARV service delivery outputs *(3 Indicators)*	HMIS Focal Person	The HMIS Monthly report	The HMIS captures information an all these indicators.
HIV/TB and HIV Care: These areas have a total of 6 output indicators categorized as follows:			
TB patients tested for HIV and those that are positive for HIV *(2 Indicators)*	District TB/Leprosy Focal Person	District TB reports	The two indicators are not captured in the HMIS and need to be collated from the TB reports.
HIV positive persons screened for TB and those with confirmed TB *(2 Indicators)*	HMIS Focal Person	The HMIS Monthly report	One of the two indicators (HIV positive persons screened for TB) is not in the HMIS; there is need to discuss how it will be captured.
HIV care *(2 Indicators)*	HMIS Focal Person	The HMIS Monthly report	These indicators are effectively covered in the HMIS.

These observations will be evaluated during the district visits.

The District Education Office

There are three indicators expected from the education department – all focus on capacity for life-skills education in schools as well as the outputs in terms of number of in-school young people reached with life-skills training.

The matrix below summarizes our preliminary evaluation:

Table 6: Preliminary evaluation of sources for indicators expected from the District Education office

Sub-Area	Proposed Point of Contact	Source of Information	Evaluation of the means of information extraction
Numbers of teachers trained in life skills, number of schools with trained teachers and number of in-school young people reached with this training	DEO/District Inspector of Schools	Aggregation of reports from head-teachers; activity reports from trainings	This information can be sourced from the education department; however, the current EIS and reporting tools do not capture it.

These observations will be evaluated during the district visits.

The District Community Based Services Office

Three indicators are expected from this department, covering the orphan situation in the district. Our preliminary evaluation of the sources is presented in the table below:

Table 7: Preliminary evaluation of sources for indicators expected from District Community Based Services Office

Sub-Area	Proposed Point of Contact	Source of Information	Evaluation of the means of information extraction
Number of orphans in schools (disaggregated by single or double orphanhood and level)	DEO/District Inspector of Schools	EMIS	We shall assess if the EMIS captures this information.
Number of service outlets for orphans and number of orphans reached with services	CDO/District Probation and Welfare Officer	Strong need to liaise with Civil Society Organizations and to strengthen the Education MIS	Since it is not feasible and sustainable to conduct quarterly surveys, do districts have an up-to-date orphan's data base? While the department can attempt to source for this information, what will be obtained will only be an estimate; it is better to focus on the number of orphans reached with particular services; we shall also assess whether the planned OVC MIS attempts to capture this information.

These observations will be evaluated during the district visits.

The District Planning Unit

The CAO's office (Administration) is expected to collect routine information on the available capacity for coordination of HIV/AIDS activities and the status of implementation of activities, in collaboration with the District Planning Unit and the Finance Department. The District Planning Unit could take on the lead in updating these indicators. The matrix below provides a preliminary evaluation of sources for these indicators:

Table 8: Preliminary evaluation of sources for indicators expected from Administration and the Planning Unit

Sub-Area	Proposed Point of Contact	Source of Information	Evaluation of the means of information extraction
Amount of local government funds allocated and spent in HIV/AIDS activities and capacity for M&E	District Planner/HIV FP	District annual planning documents and quarterly reports; need to liaise with sectors to capture sectoral data	The focus should be on the actual amount allocated and spent from the local government. Need to clarify whether local government funding includes central level grants.
Number of CBOs receiving support for HIV/AIDS interventions	District Planner/HIV FP		This can be up-dated from activity reports and the district plan; the challenge here is that many CSO receive support for HIV/AIDS activities without knowledge of the district local government.
The District AIDS Coordination Index	District Planner/HIV FP	The HIV-FP needs to liaise with sectors to capture information on sectoral MIS reporting	This can be computed by the HIV FP; however, it requires training of the FP and also requires sector visits to check on the status of reporting.

These observations will be evaluated during the district visits.

3.2.2 Preliminary Observations on Challenges in Sourcing Monitoring Information in the Districts

- Because different sectors in the districts tend to run parallel management information systems, there is usually no single management information system at the Districts. Even the District Information Office does not operate an inter-sectoral surveillance system.
- Management Information Systems do not capture some key service delivery data, especially on social interventions like IEC and OVC support. This is because there are not specific static points in which these services are delivered; some of them are one-off operations conducted periodically.
- According to the UAC, one of the key gaps at the district level is the use of information for monitoring and planning. This is partly brought about by the absence of a standard tool that can be used to summarize service delivery outputs from the different sectoral interventions into a routine multi-sectoral report that can be used to inform decision-making. Because of this, districts rarely produce any monitoring reports for the district HIV/AIDS response, and they often do not use performance-based information for planning. In order to promote utilization of monitoring information for HIV interventions at the district level, the UAC is in the process of developing a 'data collation tool' that translates the PMMP output indicators for monitoring district response into a quarterly evaluation form. The tool presupposes that, through the different sectoral MISs, districts collect various types HIV/AIDS related service delivery information, either routinely or non-routinely at the operational levels. Much of this information is available with the different stakeholders and the only problem is that it is not regularly collated and summarized into progress reports. The tool also pre-supposes that different sectors should be able to provide parts of the information that is needed to complete the tool; all that is needed is the extraction of the relevant information from the service delivery points and the leadership necessary for this.

- Challenges in operationallising this information loop can be summarized in four questions:
    1. *How do we get the HIV Focal person to actively seek out this information and leverage the input from the different sectors?*
    2. *How do we get the different sectors and the stakeholders within the sectors to collate the necessary data and fill out their section of the report on a regular basis?*
    3. *How do we get the DHAC to meet regularly, to own the information and to use this information for planning?*
    4. *How do we get this information effectively shared with sectors, partners, ministries and the UAC?*

Whether these challenges actually affect PMMP Operationallisation at the district level shall be evaluated in the district visits.

3.3.3 UAC Plans to Support Districts

The Uganda AIDS Commission is clear in its recommendation that establishment of a monitoring system should be based on information systems that are already in the districts and not by setting up parallel reporting systems. Therefore, the tool should only be used in extracting information that has been collected using other existing mechanisms in the districts, and the information should be used primarily for planning.

To improve capacity for data management and use, the UAC is planning to mentor the districts and establish a HIV/AIDS data base. Once the quarterly monitoring information has been collected, it should be used to update the data-base, and discussed in the DHAC. After the DHAC deliberations, an up-date of the monitoring information should be sent to the line sector ministries and as well copied to the UAC.

3.2.6 Preliminary Recommendations on What Needs to be Done to Operationallise the Monitoring Activities in Districts

1 Our evaluation of the 50 output indicators for monitoring the district response, and the draft 'collation tool' developed by UAC indicates that in order for this information to be successfully extracted routinely, there are four main stakeholder departments that should be brought on board in completing the quarterly sector progress reports in the districts:

1. The District Health Office
2. The District Education Office
3. The District Community Development Office
4. The District Planning Unit under the CAO's Office

2 With regard to providing specific information on each of the indicators, our analysis indicates that there is a minimum of 10 core officers required for all the different pieces of information contained in the Quarterly Sector Progress Report to be filled. These are:

b. Under the District Health Office
    i. The District Health Educator*
    ii. The District HMIS Focal Person*
    iii. The District PMTCT Focal Person*
    iv. The District HCT Focal Person
    v. The District TB/Leprosy Supervisor*
    vi. The District Condom Coordinator
    vii. The District ART Coordinator

c. Under the District Education Office

    i. The District Inspector of Schools*
d. Under the District Community Based Services Office
    i. The District Probation and Welfare Officer*
e. Under the Office of the Chief Administrative Officer/District Planning Unit
    i. The DHIVFP*

3 In order to extract the information needed to fill out the HIV/AIDS Quarterly progress report, the team recommends an 'active surveillance approach' in which one or a few people actively seek out this information from the relevant sectors on a periodic basis. By implication therefore, the district HIV Focal Person should make a quarterly round of visits to all the critical officers, to seek their input into the report.
4 Once the quarterly sector report has been completed, the DHAC can then be called to discuss it, and thereafter the report should be shared with line sectors (especially the AIDS Control Programme) and the Uganda AIDS Commission.
5 As planned, the districts should be assisted to establish and maintain a data-base of these monitoring reports, so that any agency seeking this type of information can access it easily. The data-base should be up-dated by the HIV Focal Person and should be part of the information systems in the District Planning Unit. Once established, the UAC should conduct a follow-up evaluation to assess how well the districts are generating and using monitoring information.
6 In order for the information generation, use and sharing loop to be successful, there have to be key dates institutionalized for these events: *key dates for completing the tool on a quarterly basis, key dates for discussing the information in the DHAC, key dates for sharing this information with the sectors and key dates for the sectors to share the aggregated district information with UAC.*
7 Because the UAC is a major stakeholder in monitoring the district response, the consultants feel that it is appropriate for districts to send a copy of their monitoring reports to the UAC at the time they send the report to the line sectors.

3.3 Preliminary Observations on Training Needs

In this section, we present initial observations and a scenario plan for full-scale roll out of the PMMP. These are only preliminary observations that will be validated when we visit the districts.

We propose that in order to build the necessary capacity for M&E in the districts, the UAC should training a critical mass of resource persons at the district level to build capacity for M&E and to roll out the planned district level monitoring system. In order to build effective team work and in order for the districts to promote inter-sectoral collaboration in monitoring the district level response, resource persons from the districts should be trained in a workshop format which includes working in district teams.

By the end of the workshops, each district should have developed a plan for collecting their monitoring information, clearly indicating the key dates and key resource persons in the loop. In the same training, district teams should be trained on how to operate the new data-base.

In order for the proposed systems to take root country-wide, these trainings should cascade to cover *all the 80 districts in the country – some key informants were clear in their observation that the time has passed for piloting*. However, a countrywide roll-out implies a significant investment for which resources may not be readily available. We therefore propose three training plans, depending on the availability of logistics and funds. All plans are designed to cover the entire country and not selected districts. These are only preliminary proposals and we shall validate them during and after the district visits.

3.3.1 Plan A: Adequate Resources Available

Our assessment indicates that a minimum of six officials need to be trained in each district to build a critical alliance for a multi-sectoral approach to monitoring in the districts. They include:

- Two Representatives from the District Health Office (the District Health Educator and the HMIS Focal Person)
- A Representative from the Education Department (the District Inspector of Schools)
- A representative from the Community Development Office (the Probation and Welfare officer)
- A representative from the District Planning Unit under the Office of the CAO (the designated District HIV-Focal Person
- A representative of the CSOs in the district (a CSO that represents other CSOs in the district)

These should be designated as the 'district HIV/AIDS Monitoring team'. They could be trained in 12 workshops of seven districts teams each (42 participants per training). The workshops can be organized at regional level, in four regions, so that each region runs four workshops; invitations should insist that only complete teams will be trained. If resources are available, this is the most recommended number of people that need to be trained to promote team-work and ownership of the monitoring process. However, training six people in 80 districts requires a significant investment of time and resources.

Evaluation: This 'district HIV/AIDS Monitoring team' should be part of, and report to, the DHAC. The benefit of training a team of six is that it fosters multi-sectoral representation in monitoring the response. It also ensures that the critical sectors are involved and can work together to develop the monitoring plan. We believe that with the selection of the right persons, this investment would be worth-while in terms of building long-term institutional linkages for monitoring the district response. However, training six people in 80 districts requires a significant investment of time and resources and this is why we propose training plans B and C.

3.3.2 Plan B: Resources Inadequate to Train the Critical Mass of People at the District

Resources may not be available to allow training of six people per district. In such a scenario, the focus would be on training at least four people per district including one representative each from:

- the District Health Office (The DHE)
- the Education Department (The DIS)
- the District Planning Unit (the designated HIV Focal person)
- the Community Development Office

These could be trained in eight workshops of 10 district each (40 people). These workshops can also be organized at regional level (two workshops per region).

Evaluation: Training the four people would ensure that the four critical sectors are represented, and there would be a reasonable degree of a multi-sectoral representation. However, the Health Office alone has at least four stakeholders that need to feed into the monitoring system and training only one person is likely to be inadequate. In addition, the civil society agencies would not be represented.

3.3.3 Plan C: Very Limited Training Resources Available

Resources may not even be adequate to allow training of four people per district. In such a scenario, the minimum number of people we recommend for the training is two per district, including one representative from:

- The District Health Office (the DHE)
- The District Planning unit (the designated HIV Focal person)

These could be trained in four workshops of 20 districts each. The workshops can be organized at regional level (one workshop per region).

Evaluation: Training only two people will not build a multi-sectoral coalition at the district level. There is also the risk that these two people may not have the leverage needed to cascade the skills to others.

Validation of these proposals: The above observations and proposed training plans are only preliminary and will be validated when we conduct the district visits. During the district visits, we shall further evaluate the minimum number of people that need to be trained, the training needs and suitable methods of training and support supervision needs. We shall also assess the staffing gaps and other capacity needs at districts likely to impact on the completeness of monitoring information.

3.3.4 Preliminary Proposals on Training of Trainers

We propose a team of at least eight national trainers to run these workshops. These can work in pairs to conduct the regional trainings. The trainers should be persons either from the UAC or linked to it. They should be ready to set of time to conduct the trainings at regional level.

3.3.5 Preliminary Proposals on Development of Training Guide and Plan

Part of our terms of reference is to develop a training guide for the district teams. This will be developed in the next phase of the technical support, starting this month. We would like it to be developed in sync with the data-base development team, so that aspects of the data-base are included. We propose the following modules for the three-day course:

Table 9: Preliminary proposals on training areas for districts

Day 1
Training Opening
Module 1: Overview of the NSP
Module 2: Introduction to Monitoring, Evaluation and Supervision
Module 3: Overview of the PMMP
Day 2
Module 4: Monitoring the National Response
Module 5: Monitoring the District Response
Module 6: The District HIV/AIDS Data base
Day 3
Module 7: Practicum: The District HIV/AIDS Data Base
Module 8: Information use for decision making
Module 9: Practicum: Developing a District M&E strategy for HIV/AIDS

In addition to the training guide, we shall develop a training plan that details the resources needed for the training cascade to districts. T his will be after agreeing on the number of persons that need to be trained from each district.

3.3.6 Other Issues to Note about the Training

Alternative approaches to cascading the capacity development process to all districts: The costs of sending training teams to each of the 10 districts are prohibitive, and this approach may not be feasible. On the other hand, we could train only the district HIV focal persons, with the hope that they will disseminate this information to other team members. However, this approach does not build teamwork, and we shall not be certain that the Focal Persons will perform.

Availability of resources: The UNAIDS technical team feels that resources are widely available to support activities related to the roll-out of the PMMP. However, available funds often tend to be used for start-up activities, like ToTs rather than for training of all line staff. UNAIDS indicated a willingness to help bring all funding agencies together and help distribute components in need of funding support. They felt that USG, including USAIDS and CDC, would be supportive of continuing efforts on the PMMP, especially in providing additional support to capacity building.

Importance of supervision for assuring data quality: According to the UNAIDS, it will be important for key actors to go out to the districts regularly as a team to supervise quality of data and reporting. Without credibility that comes from supervision, no one will use the data. UNAIDS recommends that the UAC should be assisted to develop protocols for assuring data quality as part of the operationallisation process.

4.0 Monitoring the Civil Society Response
4.1 National Level ASOs

There are many national level ASOs running HIV/AIDS services that are preventive, curative or rehabilitative. By the nature of their scope of work, many of these agencies generate significant amounts of service delivery data – some of them even have a network of district or regional branches. However, the mechanisms for integrating this data into the public health information systems are largely inadequate. The UAC itself argues that its main focus is on districts and sectors and not ASOs. However, because these agencies are responsible for a significant portion of AIDS service delivery in the country, excluding them from the aggregated outputs generated from the districts would imply significant undercounting of the overall response – even if the district output indicators are mainly meant for the districts to monitor their own response, ignoring the outputs from ASOs – especially the national level ASOs would significantly undercount the force of the national response at output level. Yet our assessment indicated that there were no clear mechanisms to coordinate these agencies, let alone to standardize the kind of reporting mechanisms they use. According to the ACP Ministry of Health, some of these agencies provide summaries for specific outputs to the vertical programmes in the ACP; examples of these include ART services (for agencies affiliated to the national ART Programme) and VCT (for those affiliated to the national VCT programme) – others do not. In general, CSOs generate many other outputs that could be equated to those expected from the districts, e.g. some are involved in PMTCT, others in IEC/BCC, life skills education, in and out of school and orphan care, and to ignore them would imply that the observed response is weaker than the actual response – a lot of the HIV interventions in the country are run as vertical programmes in the PNFP sector.

4.1.1 Description of the Context in Selected National Level CSOs

The diverse characteristics of these agencies are summarized in our assessment of six such organizations:

TASO

TASO is a national level ASO with 12 service delivery centres, including a training unit. Their service delivery scope includes treatment, care, support and preventive activities. They collect a large amount of data at their service centres, and all aggregated information is channeled to the head-quarters. They reportedly have over 20 reporting tools specifically designed for their services and do not use the national reporting tools. According to the Key Informant to whom we spoke, their data collection system is 'fairly reliable'. Apart from generating the reports, there was evidence that they used this information for planning, resource mobilization and advocacy. In terms of reporting, they often prepare reports that aggregate the information from different centres and programmes. According to them, they *'report to any person who relates to them'*. TASO reports that there was a 'one-off' request from UAC in form of an e-mail that asked for a list of service delivery outputs to be provided; however, this was a one-time event and these requests have not been repeated since. On the other hand, the vertical programmes in the ACP have been seeking specific information routinely, but by telephone, e.g. number of people that received ART. TASO reports that a person from the ACP often calls them and requests for an itinerary of outputs – these communications are mostly informal, and information is given over the telephone. It seemed to us that the ACP could obtain a more comprehensive dossier of service delivery information if they actively sought it.

They noted that since the agency is almost purely donor funded, they have no obligations to report to the public MIS and vertical reporting mechanisms but are willing to give information to anyone who needs it. TASO notes that they provide regular reports to their donors *(a long list of ADPs*

including CDC/PEPFAR/MEEP for the ART programme only, DANIDA, Global Fund, the Civil Society Fund-CSF for the palliative care programme only and USAID for the preventive programme only). However, each funder received a report covering outputs for only the project they fund. The reports are also mostly in form of summaries.

According to TASO, the ADPs to which they submit this information are better placed to provide feed-back to the sectors and to the UAC in case they needed the information. TASO also notes that for organizations that receive funding through the Civil Society Fund, the UAC has a direct mandate to receive monitoring data from them because it is the one that coordinates the fund.

JCRC

The JCRC is a parastatal agency involved in providing the entire range of HIV/AIDS services except for PMTCT. At the JCRC head-quarters, they provide care and support, VCT, ART and adherence monitoring, training, IEC and other preventive activities. The JCRC also runs five regional centres of excellence attached to the Regional Referral Hospitals. They provide care and treatment facilities, laboratory services and VCT. In addition, there are several district level health facilities affiliated with the JCRC. These are public or PNFP facilities that provide care and treatment for PLWHAs. The service delivery points collect routine treatment information from patients, using a general patients' tool *similar to that used by the MoH line facilities*. In addition, they run registers in different categories, including pre-ART, ART, VCT in the VCT supported sites and referral forms: *In all these, the JCRC uses similar registers to those used by the Ministry of Health*, and this is one major point of difference with other agencies in the same category. The sites are often required to provide monthly reports, which are then aggregated into semi-annual reports. However, the key informants we talked to noted that the monthly reports often incomplete and untimely. Supported health units in the districts are required to report through routine HMIS in their districts, but they also send summaries to the centres of excellence and then to the head-quarters. JCRC reports mainly cover the area of care and treatment (especially ART). The head-quarters prepares bi-annual and annual reports that are sent to the donors and to key partners. They reportedly send bi-annual reports to the AIDS Control Programme of the Ministry of Health, disaggregated to indicate data from the Centres of Excellence (TREAT and Cash and Carry Categories) and that from government health centres supported by the JCRC. The purpose of the disaggregation is so that there is no double counting of clients as a result of the fact that the district level supported health units also report through the HMIS and the vertical reporting systems of the MoH ART programme. However, there are also problems with over-counting patients who change treatment plans from the MoH system to JCRC and vice-versa. The JCRC notes that reports from its centres of excellence are of good quality and are timely and accurate. However, reports from the supported health units have variable quality and most of them are not timely – it is for this reason that the JCRC changed its policy from quarterly reporting to bi-annual reports. On the other hand, the JCRC sends a summary report to its funders (PEPFAR) under their MIS the MEEP. According to the JCRC, other partners can then access the information from the MEEP.

The AIDS Information Centre

The AIC is mainly involved in prevention and VCT activities, as well as post-test mitigation activities. They run eight branches in different parts of the country. However, under a memorandum of understanding with the Ministry of Health, they also provide support to about 169 affiliated health centres. Their reporting relationships mirror those already described for the JCRC.

The Inter-Religious Council of Uganda

IRCU is a secretariat that brings together five main religious denominations for a common cause of fighting and prevention of HIV/AIDS. IRCU works as a coordination platform to spearhead its country

wide activities through two main programs, one of which is the HIV/AIDS program. This program runs activities in three thematic areas: namely prevention, care and treatment, and psychosocial support of OVCs. The HIV/AIDS program activities are spread in 32 districts and are conducted through identified faith-based health facilities. IRCU collects routine information on all three thematic areas using specifically developed tools. At district level, IRCU has trained and pays two focal persons whose responsibility is to manually complete the data registers on a monthly basis.

IRCU has a well designed data collection system where all the data from the 32 districts is entered and collated centrally at the IRCU secretariat. The collated program data is transferred into a database that was developed by MEEP. A report is generated semi-annually and sent to USAID, PEPFAR and any other interested stakeholders. It was pointed out that reports are not routinely shared with the MOH or UAC except on request. IRCU only focuses on reporting deadlines of the donor agencies from which their funding support is obtained. However, they expressed great willingness to share any data they generate with both UAC and MOH if requested.

IRCU faces difficulties in motivating the staff at the health facility to collect the data they need. Sustainability of the financial incentives for the staff to collect and complete data in a timely manner is a potential challenge in the absence of donor funding. To overcome this challenge IRCU has started to solicit the local support and contributions of participating religious groups towards this cause. Like TASO, the IRCU notes that information from national level CSOs should be accessed through the donor run information systems, to avoid dual reporting (for the IRCU, it should be through MEEP).

National Level Networks that Coordinate other Service Providers

There are also some national level agencies whose role is to coordinate networks of service providers in different constituencies. Some of these include:

a. ***UNASO:*** This is a national network of AIDS service organizations operating at the national and district level. It exists to coordinate, represent and build capacity (organizational development) for the ASOs as well as to provide advocacy and raise concerns on their behalf on issues concerning them. At the district level, they have district networks of ASOs, and there is usually one lead ASO as a point of contact. Membership is by registration. The networks current coverage is country wide, although organizational structures have been set up in 43 districts. Some of the newer districts are still part of the older districts. Member ASOs are involved in diverse HIV related activities, but mostly in prevention, care and support. The network only admits registered CSOs. In Uganda, CSOs are supposed to be registered either at the national level (NGOs) or at the district level (CBOs). To-date, the network has 1,693 member organizations, 60% of which are CBOs. UNASO does not collect routine service delivery data from organizations. It only maintains a resister of member organizations showing 'who does what where.' In addition, it collects information on organizational capacity and capacity building activities.
b. ***NAPOPHANU:*** This is a national network of ASOs involved in mitigating the issues of people living with HIV/AIDS. Like UNASO, it is also a networking organization and does not collect or aggregate service delivery data. It keeps a register of member organizations and provides advocacy and capacity building services.

4.1.2 Summary of Challenges in Coordinating National Level CSOs

According to several Key Informants, and especially the ACP/Ministry of Health, the coordination of information from these organizations is liable to a number of challenges because:

- They are often structured differently, both organizationally and in terms of service delivery.

- Some of them have branches in districts or at regional levels; in such arrangements, some agencies provide reports through the district health system, while some do not; others provide reports to the District Health Offices, but also send a summary of their aggregated outputs to the ACP/MoH.
- National level ASOs tend to provide reports only in form of summaries, and in diverse formats, making their integration into national information systems difficult, and disaggregation impossible.
- Many of these agencies have complex bureaucracies; even with the current policy on collaboration with the PNFP sector, many are largely autonomous. They often have agency specific procedures, sometimes driven by the funders; we noted that many of these agencies channel their reports for specific service delivery outputs to specific management information systems run by the respective funders. Examples of the funders include USAID, DANIDA, Irish Aid, PEPFAR and CDC; examples of the respective MISs include MEEP and the CSF system.
- Some of them have multiple funders, each covering a specific project in their service delivery spectrum, and each requiring a different approach to reporting.
- Because of the project nature of their work, some of their activities vary from year to year, although they often have some core activities.
- Even for vertical programmes that have a monitoring and coordination desk within the ACP or other relevant sectors, some of these agencies use the official forms used in the vertical reporting mechanisms for these programmes; e.g. some of the agencies use the official ART reporting forms while others do not; in addition, compliance to reporting varies from regular in some agencies to no information shared at all; some say they run their own ART programmes, not part of the national response; some report monthly, others quarterly, and others once in six months or less frequently.

4.1.3 Recommendations on Integrating National Level CSO into the M&E Loop

1 A national committee for these agencies should be formed; the committee should include the ADPs to which their information flows. The committee can be used to coordinate their activities and to promote negotiations and information sharing; many key informants note that it is within the mandate of the UAC to cause this coordination mechanism. It is through this mechanism that the UAC can leverage a common approach to reporting. The UAC and MOH should convene a meeting with the major national level CSO to agree on the modalities for capturing data from the CSO as part the monitoring of the national response.

2 For agencies that report to ADP specific management information systems under specific funding arrangements, the recommended approach is that the ADPs should be the ones to report to the line sectors; this will prevent duplication of reports. The ACP/MoH should seek aggregated data at these levels and the UAC should work with these agencies to try and develop a reasonable level of harmony in reporting.

3 Much as NGOs are being funded by ADP, they have a duty to be accountable to the people they are serving. NGO /CSO should consider it to be their primary responsibility to report to Government, and not only ADP. It should be the NGO and not the ADPs to report to the relevant Government institution.

4 For agencies that run district level operations, reports for the district level service delivery points should be channeled to the District Health Offices, and the aggregated reports should clearly indicate to the Ministry of Health the part of their outputs that was reported through the district system and the part that was not.

4.2 District Level ASOs

At the district level, there are many organizations, of various sizes, and many of them are not officially monitored by the DHACs. However, UNASO recommends that all AIDS related CSOs operating service delivery points at the district level (including CBOs) should be appropriately registered by the district authorities. UNASO also recommends that for those agencies that have the capacity, e.g. those running health units), there should be a reporting mechanism that connects them to the District HIV Focal person, and to the HMIS in the District Health Office. However, this is not occurring because the coordination of HIV/AIDS services in districts is still poor according to UNASO.

Based on their experience operating in districts, UNASO observes that the general status of HIV/AIDS coordination in the districts in poor. UNASO notes that most DHACs and DHATs only exist in writing and they do not meet at all. In many districts, the DHAC is viewed as separate from the District Technical Planning Committee, yet a large part of their membership is similar. However, the biggest challenge facing districts is in operationallising their broad mandate for service delivery – districts are often lax in creating an organizational vision for their activities and do not appear to 'own their HIV intervention'. Focal persons are often ill-supervised and are not checked for outputs. In many cases, this cannot even be done because their duties and responsibilities have not been stipulated as part of their terms of service. All these problems are attributed to three gaps: lack of capacity, lack of commitment, and inadequately developed systems. In addition, UNASO observes that because of the previous project models that arose as a result of the MAPs and CHAI Projects, districts developed a mentality that HIV/AIDS is a Uganda AIDS Commission issue and always expected vertical funding for these activities; when these projects closed, the DHACs became dormant –clearly pointing to low perceived ownership of their response. UNASO even suggests that if resources were available, a full position of HIV Focal Person should be created in the civil service structure of the districts, with a clear scope of work and terms of reference.

4.2.1 Recommendations for Integrating District Level CSOs into the Information Loop

1. District level CSOs should be coordinated at the district, and therefore report their data and information through the district.
2. The UAC should work together with the ACP to develop a simple tool that can be used to capture key outputs from registered CSOs in the districts, on a quarterly basis. The NGOs should be able to use similar tools to those that are being used at the district level. This is when information and data from NGOs can be integrated and aggregated into a district report.
3. In order for the monitoring information at the districts to be complete, there has to be strong and deliberate action to integrate district level CSOs into the management information systems at the districts. We shall attempt to validate the feasibility of this during the district visits.

5.0 Summary

The proposed approach to operationallising the PMMP is tiered at three levels: monitoring the national response, monitoring the district response and monitoring the civil society response. This report presents preliminary findings from the assessment phase of the consultancy for support to the UAC in operationallisation of the PMMP.

At the national level, the Uganda AIDS Commission needs to identify the contact persons in the six agencies that are required to provide the up-date information on the 58 indicators and disseminate to them their scope of indicators. It should then hold negotiation meetings to come up with a common agreement on how these indicators will be up-dated. For indicators that require updating on an annual basis (e.g. those from programme reports), the UAC needs to work with the contact persons in these agencies to articulate a clear reporting mechanism; for indicators that require national surveys that are predictable (e.g. the UDHS and AIS), the UAC should be part of the planning processes for these surveys to negotiate for inclusion of the indicators of interest and should establish a mechanism for up-dating these indicators once the surveys have been conducted. For indicators that require special surveys (e.g. MARPS or PHA surveys), the UAC should negotiate with the responsible agencies on how resources can be mobilized for these special surveys to be conducted. In addition to these processes, the UAC should negotiate with the Ministry of Education and the Ministry of Gender, so that some PMMP output indicators can be incorporated into their sectoral MISs under development. There are also one or two output indicators that can be added to the HMIS, and the UAC can take the opportunity of the planned review of the HMIS this year to negotiate for these. The UAC should appoint a liaison officer responsible for actively searching for up-date information from where it is expected. This officer should maintain a simple spread sheet that shows the current status of each of the indicators.

At the district level, the UAC should press for uniformity in coordination of HIV services, so that a department or unit in the district is accountable for coordinating the multi-sectoral response, rather than an individual. All districts should have a similar coordinating department and the HIV-Focal Person should come from this department. To foster a multi-sectoral response, there seems to be agreement that the District Planning Unit would be more appropriate for this, and the HIV-Focal Person should be appointed form one of the officers there – this officer should receive clear terms of reference and a scope of work, so that they are accountable; they should report to the head of the unit, who then reports to the CAO. The UAC should also build multi-sectoral M&E coalitions in the districts, composed of a critical number of sector representatives that can collect the required monitoring information. It should develop and disseminate an electronic interface that can help districts to translate the written reports into an electronic storage system, and it should articulate a mechanism for information use as well as the stakeholders in the information sharing loop. If the district data-bases become credible, then sectors shall be more included to tap into them. The UAC should conduct a series of trainings to cascade the capacity building process to all 80 districts – the training should be for 'district teams' rather than individuals, so that a multi-sectoral M&E alliance is created among sectors. The critical number of members on the district M&E teams should be about six, representing the critical sectors involved in sourcing the required information. The UAC should then describe a mechanism of initial follow-up to the districts to support them.

Monitoring the CSO response is a much larger challenge. There seems to be a consensus that district level CSOs should be monitored at district level. Mechanisms for tapping into their outputs should be developed – probably through a reporting tool; this intervention may wait until the next NSP. However, national level CSOs may be contributing a significant promotion of the HIV/AIDS outputs, and ignoring them may selectively undercount some services. Yet coordinating them is an up-hill

task because each agency seems to have its own processes and reporting lines. Since most of these agencies report to their funders, one mechanism for tapping into this information source would be to negotiate with the ADP-MISs for greater sharing of their aggregated outputs. The ADPs can then over time be encouraged to develop a relatively uniform reporting format for extracting monitoring information from their MISs, although they can maintain their reporting requirements from the CSOs they assist.

Appendix 1: Evaluating the Sourcing Mechanisms for the District Level Output Indicators

Category and Indicator	Source and Comments
IEC (BCC)	
Number of IEC materials produced and disseminated (by type-poster, leaflet, newspaper supplement etc)	DHE from activity reports. However, many IEC activities are being implemented without the knowledge of the DHE. The DHE will only capture what is implemented by the district departments and what is reported to the district
Number of Radio programmes	
Number of radio spots	
Number of young people reached by life skills education in out of school settings	
Number of trainers for youth out of school trained in Life planning skills	
Number of peer educators trained in HIV/AIDS and Life skills	
Number of condoms dispensed at service delivery outlet (Free/Social Marketing)	HMIS for free condoms
	Collaboration with relevant CSOs for socially marketed condoms
Number of condoms dispensed by Community Resource Persons (CORPs)	HMIS
Number of condom service outlets	HMIS
PMTCT	
Number of deliveries that are HIV Positive in the unit (Males/Females)	PMTCT Focal Persons from the PMTCT Reporting mechanism
Number of deliveries that are HIV Positive who swallowed ARVs (Males and Females)	PMTCT Focal Persons from the PMTCT Reporting mechanism
Number of Live births to HIV positive mothers (Male s and Females)	PMTCT Focal Persons from the PMTCT Reporting mechanism
Number of babies born to HIV positive mothers given ARVs (male and Female)	PMTCT Focal Persons from the PMTCT Reporting mechanism
Number of pregnant women tested for HIV	HMIS
Number of pregnant women positive for HIV	HMIS
Number of pregnant women given ARVs for prophylaxis (PMTCT)	HMIS
Number of PMTCT static service outlets (Type of facility, sub-county, county)	HMIS
HCT	
Number of individuals (5 years/5-18 years/18+ years) HIV counseled (male/Female)	HMIS
Number of couples counseled	This indicator is not in the HMIS and will present problems in sourcing because it requires back collation of information from registers; however, it could be collated from the vertical VCT reporting mechanism
Number of individuals (5 years/5-18 years/18+ years) HIV tested (from laboratory register) (Male/Female)	HMIS
Number of individuals (5 years/5-18 years/18+ years) received HIV results (Male/female)	HMIS
Number of individuals (5 years/5-18 years/18+ years) HIV positive (from laboratory register) (Male/Female)	HMIS
Stock out (< 1 week/> 1 week) screening HIV testing kits	HMIS
Stock out (< 1 week/> 1 week) confirmatory HIV testing kits	HMIS
Stock out (< 1 week/> 1 week) tie-breaker HIV testing kits	HMIS
Number of HCT outreach activities planned for the month	HMIS
Number of HCT outreach activities conducted for the month	HMIS
Number of HCT static service outlets (type of facility/sub-	HMIS

Category and Indicator	Source and Comments
county/county)	
ART	
Number of individuals (5 years/5-18 years/18+ years) eligible for ART (Male and Female)	HMIS
Number of individuals (5 years/5-18 years/18+ years) started on ART (Male and Female)	HMIS
Number of ART Outlets (Type of facility/sub-county/county	HMIS
Care	
Number of individuals (5 years/5-18 years/18+ years) HIV Positive cases started on Cotrimoxazole prophylaxis (Male and Female)	HMIS
Stock out (< 1 week/> 1 week) Cotrimoxazole tablets	HMIS
HIV/TB	
Number of TB registered patients tested for HIV (Male/Female)	TB and Leprosy Coordinator; not captured in HMIS
Number of TB patients positive for HIV	TB and Leprosy Coordinator; not captured in HMIS
Number of HIV Positive persons screened for TB (Male/Female)	HMIS
Number of individuals (5 years/5-18 years/18+ years) HIV positive cases with confirmed TB (Male and Female)	HMIS
Education	
Number of schools with teachers trained in Life Planning Skills and who have taught it in the past academic year (Primary/Secondary)	Could be part of the EMIS; but not routinely captured as yet
Number of teachers trained in Life Planning skills in the past academic year	Could be part of the programme reports by the DIS
Number of young people reached by Life Skills education in schools	Could be part of the EMIS; but not routinely captured as yet
Orphans	
Number of orphans in school	Could be part of the EMIS
Number of service outlets for orphans (Service= Psychosocial, Materials, Agricultural, Education among others)	To be validated in the district visits
Number of orphans and vulnerable children served/reached	To be validated in the district visits
Management	
Amount allocated and percentage of district Government funds spent on HIV in the last financial year	Could be collated by the HIV Focal person from the Financial reports; however, the indicator is too non-specific; what of the mainstream activities like PMTCT and HCT? How is the financial cost of this imputed; need to focus the indicator
Number of local government personnel trained and available to carry out M&E activities	This indicator is non-specific; it does not indicate the level and whether they are expected to operate as a team
District AIDS Coordination Index (measure of the level of district integration and coordination)	Can be computed by the HIV Focal person but they need training in how to do it
Number of community based organizations in district receiving support for HIV/AIDS interventions	The HIV Focal person should be able to provide this information readily

Appendix 2: National HIV/AIDS PMMP Indicator Matrix Organized by Responsible Agency

NB: (Cut-outs of these blanks should be disseminated to the sectors and used to guide the negotiations)

A. Indicators for which the Ministry of Health is expected to be the source

No.	Indicator	Baseline	Year of Baseline Data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
Source: To be updated annually from Programme Reports and the Health Facility Database							
1	Annual number/incidence rate of new HIV infections	134,500/ 0.85%	2006	112,430/ 0.66%	100,000/ 0.51%	Need triangulation of various methods and standardisation of procedure. Impact indicator	
17	Percentage of HIV-infected infants born to HIV positive mothers	30%	Estimate without significant intervention	22.50%	15%	Formula based estimate. UNGASS impact indicator	
19	Percentage of pregnant women tested for HIV during pregnancy	24%	2005/06	50%	80%		
28	Current Number/Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	91,500 (39%)	2006	135,000 (51%)	240,000 (67%)	UNGASS indicator. Not cumulative	
30	Percentage of HIV infected among newly registered TB cases	60%	2006	40%	30%	UNGASS indicator	
49	Percentage of health facilities from HC III and above that are providing HCT	42%	2006/07	60%	100%		
50	Percentage of health	57%	2006/07	80%	100%		

No.	Indicator	Baseline	Year of Baseline Data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
	facilities from HC IV and above that are providing ART						
Source: To be up-dated annually from ANC Sentinel Surveillance							
2	Percentage of pregnant women aged 15-49 years attending ANC clinics who are HIV-infected	Urban: 7.1% Rural: 5.5%	2005	Urban:7.6 % Rural: 6.0%	Urban: 7.8% Rural: 6.2 %	Modified MDG and UNGASS Indicator. Impact indicator	
Source: To be up-dated every 2 ½ years from Most-At-Risk Population Surveys (MARPS)							
4	Percentage of [most-at-risk population(s)] who are HIV-infected	47.2% (CSWs)	2003	40%	30%	UNGASS indicator. Impact indicator	
6	Percentage of Most-at-Risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	82.6% cited two preventive practices	2003	85%	90%		
33	Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	49.3% CSWs had ever had VCT	2003	62%	73.50%	UNGASS indicator	

No.	Indicator	Baseline	Year of Baseline Data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
Source: To be up-dated every 2 ½ Years from PHA Behaviour Surveys							
13	Percentage of PHAs who know their status reporting consistent use of condoms in the past 12 months	54.5% (UAC-LQAS)	2006	80%	90%	Measures prevention with positives	
29	Number/Percentage of PHAs receiving co-trimoxazole	150,000/ 15%	2006	30%	60%		
37	Percentage of PHAs whose households received nutritional support in past 12 months	26.9% PHAs in past 3 months (UAC-LQAS)	2006	40%	60%		
38	Percentage of PHAs whose households received psychosocial support in past 12 months	86.3% PHAs in past 3 months (UAC-LQAS)	2006	95%	95%		
42	Percentage of households of people living with HIV/AIDS that have benefited from IGAs in last year.	41.2% (UAC-LQAS)	2006	60%	80%		
Source: To be up-dated every 2 ½ years from Health Facility Surveys like the SPA							
22	Percentage of ART sites that provided PEP during the past 12 months	TBD	2007	80%	100%		

No.	Indicator	Baseline	Year of Baseline Data	Targets for mid-term- end of 2009	Targets for 2011/12	Comments	Evaluation
23	Proportion of STI patients that are appropriately managed in PHC facilities according to national guidelines.	36%	2005	54%	70%		
24	Percentage of STI patients who are appropriately counselled on condom use, partner referral and also provided or referred for PMTCT	10%	2005	30%	50%		
27	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	TBD	2007	85%	90%	A cohort analysis with health facility surveys; UNGASS indicator. Impact indicator	
31	Percentage of health units with capacity to provide a minimum palliative care package	TBD	2007/8	80% of HC IVs & Hospitals	90% of HC IVs & Hospitals	Minimum is HCT, TB diagnosis (smear) and treatment, oral morphine & Co-trimoxazole prophylaxis	
34	Percentage of facilities providing care and treatment integrated with prevention with positives (PWP)	TBD	2007/8	50%	100%		
35	Number of trained PWP persons at HC-IV and community levels	TBD	2007/8	At least 2 per HC-IV	At least 4 per HC-IV		

No.	Indicator	Baseline	Year of Baseline Data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
36	Percentage of health facilities with or linked to operational HBC services	TBD	2007/8	60%	80%		
Source: To be updated annually from the National Drug Authority							
14	Number/Percentage of condoms of need distributed in the past 12 months by Public and Private sector	73 million male condoms /38%	2006	151 million male condoms /72%	181 million male condoms /80%	Not cumulative	
Source: To be up-dated annually from Condom Availability Surveys							
15	Percentage of randomly selected retail outlets and service delivery points that have condoms in stock at time of the survey	TBD	2007/8	75%	90%		

B. Indicators Expected from both the Ministry of Health and UBOS through National Surveys and Census Data

No.	Indicator	Baseline	Year of Baseline Data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
Source: The AIS every 2 ½ Years							
3	Percentage of adults aged 15-49 yrs old who are HIV positive; by gender and age	6.40%	2004/05	6.9%	7.1%	Impact indicator	

No.	Indicator	Baseline	Year of Baseline Data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
26	Percentage of males circumcised (Disaggregate by age group, facility based/traditional, when)	25%	2006	35%	50%		
25	Prevalence of HSV II among 15-49 year olds	44%	2004/05	31%	25%		
Source: From Both the AIS and the UDHS every 2 ½ to 5 Years							
5	Percentage of adults aged 15-49 and young people aged 15-24 years who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission	15-49: Males 42%	2004/05	15-49: Males 50%	15-49: Males 63%	MDG and UNGASS Indicator.	
		15-49: Females 31.3%		15-49: Females 42%	15-49: Females 52%		
		15-24: Males 38.2%		15-24: Males 52%	15-24: Males 64%		
		15-24: Females 31.9%		15-24: Females 37%	15-24: Females 52%		
7	Percentage of young women and men aged 15-24 years who have had sex before the age of 15 years	15-24: Males 12.2%	2006	15-24: Males 10%	15-24: Males 7%	UNGASS Indicator.	
		15-24: Females 15.5%		15-24: Females 10%	15-24: Females 7%		
		15-19: Males 13.9%		15-19: Males 12%	15-19: Males 8%		
		15-19: Females 11.8%		15-19: Females 9%	15-19: Females 6%		
		20-24: Males 9.6%		20-24: Males 8%	20-24: Males 5.5%		
		20-24: Females 19.7%		20-24: Females 13%	20-24: Females 8.5%		
8	*Alternate 7.* Median age at which young people aged 15-24 years first have penetrative sex.	Males 19.1	2004/05	Males 19.5	Males 20		
		Females 18.3		Females 18.6	Females 19 years		

No.	Indicator	Baseline	Year of Baseline Data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
9	Percentage of adults aged 15-49 years who have had sex with a non-marital, non-cohabiting sexual partner in last 12 months	Males 36.2% Females 15.9%	2006	Males 28% Females 11%	Males 19% Females 8%		
10	Percentage of adults aged 15-49 years who have had sex with a non-marital, non-cohabiting sexual partner in last 12 months and used a condom at last higher risk sex	Males 57.4% Females 34.9%	2006	Males 66% Females 58%	Males 73% Females 70%		
11	Percentage of adults aged 15-49 years who have had sex with more than one sexual partner in the last 12 months	Males 28.7% Females 2.4%	2006	Males 22% Females 2%	Males 15% Females 1%	UNGASS Indicator	
12	Percentage of adults aged 15-49 years who have had sex with more than one sexual partner in last 12 months and report using a condom at last sexual intercourse	Males 20.4% Females 23.9%	2006	Males 30% Females 35%	Males 50% Females 50%	UNGASS Indicator	

No.	Indicator	Baseline	Year of Baseline Data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
32	Percentage of women and men aged 15-49 who got counselling and an HIV test in the last 12 months and who know their results.	Men: 4%	2004/05	10%	15%	UNGASS indicator	
39	Percentage of OVCs whose households received emotional support in past 12 months	0.9%	2006	5%	10%		
Source: Either the census, or the UDHS or the AIS every 5 to 10 years							
41	Ratio of current school attendance among orphans vs. non-orphans, aged 10-14	0.9	2004/05	0.95	1	MDG and UNGASS indicator	
43	Percentage of orphans and vulnerable children (Under 18) whose households received free basic external support in caring for the children in the last 12 months	10.7%	2006	20%	30%	UNGASS indicator	

C. Indicators expected from the Ministry of Education and Sports

No.	Indicator	Baseline	Year of Baseline Data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
Source: Annually from The Education Management Information System							
16	Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year	TBD	2007	90%	95%	UNGASS indicator. Not yet integrated into EMIS.	

D. Indicators Expected from the Uganda Blood Transfusion Service

No.	Indicator	Baseline	Year of Baseline Data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
Source: Annually from the Uganda Blood Transfusion Service Programme Reports							
20	Number/percentage of donated blood units in the country that have been adequately screened for HIV according to national or WHO guidelines during the past 12 months	122,442 /100%	2006	314,000/ 100%	403,000/ 100%	Annual	UNGASS indicator. Not cumulative
21	Percentage of donated blood units that were found to be HIV positive	1.50%	2006	1.00%	0.75%	Measures quality of selection of donors and potential significance of not testing blood	

E. Indicators expected from the Ministry of Gender, Labour and Social Welfare

No.	Indicator	Baseline	Year of Baseline Data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
Source: From Special Surveys of disadvantaged groups every 2 ½ Years							
40	Percentage of disadvantaged groups that have received vocational education in the past 12 months	TBD	2007/08	5%	10%	Disaggregated by OVCs, PHAs, IDPs, PWDs, etc.	

F. Indicators that should be Sourced by the Uganda AIDS Commission

No.	Indicator	Baseline	Year of Baseline Data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
Source: From annual workplace surveys							
44	Number/Percentage of 30 largest employers in the country that have HIV/AIDS workplace policies and programmes	25 out 30 largest companies (83.3%)	2006	90%	96%	Not cumulative	
Source: From UAC Programme Reports including the National HIV Status Report, Desk Reviews and Key Informants							
45	UAC management index	TBD	2007/8	90%	95%		
46	National Composite Policy Index	67.5 of 100 points	2005	75%	85%	UNGASS. Indicator. A measure of national commitment and action as well as policy development and implementation status	
Source: From the National HIV/AIDS Stakeholders' service mapping atlas							
47	Percentage of districts with functional District AIDS Committees	89.20%	2005	97%	100%		

No.	Indicator	Baseline	Year of Baseline Data	Targets for mid-term-end of 2009	Targets for 2011/12	Comments	Evaluation
Source: From networks of AIDS Service Organisations and PHA Networks (NAPOPHANU and UNASO)							
48	The Percentage of districts with a functional PHA network	TBD	2007/8	50%	80%	Functional PHA network is one with registered members affiliated to all PHA associations in District, has met 12 times in past 12 months and is represented in DAC. Measures GIPA	

Appendix 11: Third Interim Report of the Assessment Phase

Technical Assistance to the Uganda AIDS Commission for the Operationallisation of the PMMP

3rd Interim Report

Challenges and Recommendations for Making the PMMP Operational

(October 2008 to June 2009)

Reference: USAID/Uganda HIV/AIDS Evaluation, Assessment, and Formative Research
Contract No. GHH-I-02-07-00034-00

Contractor: The Population Council
Sub-contractor: Makerere University School of Public Health

(June 2009)

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UNAIDS
ACE
Infotronics
The District Health Teams, Kiboga, Mukono, Kumi
The District Planning Units, Kiboga, Mukono, Kumi
The District Community Based Services Department, Kiboga, Mukono, Kumi
The District Health Offices

List of Acronyms and Abbreviations

ACE	AIDS Capacity Enhancement Project
ADP	AIDS Development Partner
AIDS	Acquired Immuno-Deficiency Syndrome
ART	Anti-Retroviral Therapy
ASO	AIDS Service Organization
CAO	Chief Administrative Officer
CCT	Centre Coordinating Tutor
CD4+	Lymphocytes with the CD4 Marker
CDC	Centres for Disease Control
CDO	Community Development Officer
CSF	Civil Society Fund
CSO	Civil Society Organization
DANIDA	Danish Agency for International Development
DEO	District Education Officer
DAC	District HIV/AIDS Committee
DAT	District HIV/AIDS Team
DHE	District Health Educator
DHO	District Health Officer
DIS	District Inspector of Schools
DTLS	District TB and Leprosy Supervisor
EMIS	Education Management Information System
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
IEC	Information, Education and Communication
JCRC	Joint Clinical Research Centre
M&E	Monitoring and Evaluation
MARPS	Most-At-Risk Population Surveys
MEEPP	Monitoring and Evaluation of Emergency Plan Progress Project
MIS	Management Information System
MISs	Management Information Systems
MoES	Ministry of Education and Sports
MoGLSD	Ministry of Gender, Labour and Social Development
NAFOPHANU	National Forum of People Living with HIV/AIDS Networks in Uganda
NDA	National Drug Authority
NGO	Non-Governmental Organization
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
PEPFAR	Presidential Emergency Plan for AIDS Relief
PHA	People with HIV/AIDS
PMMP	Performance Measurement and Monitoring Plan
PMTCT	Prevention of Mother to Child Transmission
SPA	Service Provision Assessment
TASO	The AIDS Support Organization
TB	Tuberculosis
ToT	Training of Trainers
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UBTS	Uganda Blood Transfusion Service
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASO	Uganda Network of AIDS Service Organizations

USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing

1.0 Background

1.1 Monitoring the National Response

The PMMP is divided into the National and District level components. The national level component consists of 58 indicators while the district response consists of about 50 output indicators and about 30 outcome indicators. The 58 indicators at national level are intended to monitor the national level response and are therefore described as 'outcome indicators'. The 50 indicators for the district level are 'output indicators' aimed at monitoring the service delivery outputs from the districts. These are required to be up-dated on a quarterly basis by districts and are meant to inform their planning and decision-making. There are also 29 indicators for monitoring district level outcomes and these are aligned with the national level outcome indicators. Districts are supposed to use these latter indicators to monitor key outcomes at the district level. A PMMP Operations hand-book has been prepared, spelling out the detailed indicator definitions and the mechanisms by which these indicators can be collected at the district level.

The PMMP was developed by a consortium of stakeholders including representatives from the various sectors, agencies and CSOs involved in HIV/AIDS interventions at policy and operational levels on the country. It therefore represents a consensus of stakeholders on what will be the key benchmarks for monitoring the national response and it implies a commitment by the different stakeholders to fulfill their obligations in contributing to the monitoring process. This is in line with the principles now termed as 'the three ones':

- ***One*** agreed HIV/AIDS ***action framework*** that provides the basis for coordinating the work of all partners;
- ***One*** national AIDS ***coordinating authority***, with a broad-based multi-sectoral mandate; and
- ***One*** agreed ***monitoring and evaluation system***.

Quoting the PMMP Document:

"The National Performance Measurement and Management Plan (PMMP) for the NSP is a major step in ensuring that there is one country-level monitoring and evaluation system. Its development has built on lessons from the assessment of the previous National Monitoring and Evaluation Framework for HIV/AIDS. The PMMP outlines how the Government of Uganda plans to track the performance of the National Strategic Plan (NSP) for HIV/AIDS activities 2007/08 to 2011/12. To ensure its operationallisation, it is accompanied by an operational handbook. The NSP identified the following priority service areas in the national response:

Prevention:

- Prevention of sexual transmission of HIV; Prevention of Mother To Child Transmission; Blood transfusion safety, Universal precautions and PEP; and management of Sexually Transmitted Infections;

Care and treatment

- ART; HIV/ADS Counselling and Testing; Opportunistic infections prophylaxis; and Home Based Care;

Social support

- Psychosocial support for PLWHAs and OVC; Formal and informal education for vulnerable groups; Community empowerment; Basic social needs; and Legal, social and community safety nets.

In addition to the three priority service delivery areas, the NSP focuses on strengthening systems for the delivery of services that increase access to and improve the quality of services for people infected and affected by HIV. These systems consist of:

- Institutional arrangements and human resource requirements; Infrastructure requirements; Research and development; Resource mobilisation and management; and Monitoring and evaluation.

The PMMP recognises the focus areas of the NSP and has therefore included more indicators on prevention, especially for monitoring the most-at-risk populations, as well as more indicators to track systems management and strengthening for HIV/AIDS service delivery. The goal of the PMMP is to ensure collection and reporting of all national level HIV/AIDS indicators. The purpose of the PMMP is to guide coordinated and efficient collection, collation, analysis, interpretation and dissemination of information for HIV/AIDS programmes. This PMMP is designed to serve as a guide for baseline and subsequent annual reports on national and district indicators for HIV/AIDS in Uganda and for biennial reports to the United Nations. Annual reports will form the basis of discussion for the HIV/AIDS Joint Annual Review (JAR) where undertakings or priorities for action will be decided upon for the next year. In addition to the PMMP, the national performance measurement and management system is constituted by a Monitoring and Evaluation unit at the Uganda AIDS Commission, a National Strategic Plan for HIV/AIDS activities in Uganda, an overall national data collection and analysis plan and a dissemination plan.

The PMM information on HIV/AIDS activities in the district will be captured through flow channels that follow the National/Local Government structures. These are based on the mandates for the UAC, sector and district directorates/departments. The UAC is responsible for the multi-sectoral coordination of Monitoring and Evaluation of HIV/AIDS activities. Sectors are responsible for quality assurance, sector M&E, policy guidance and technical support supervision. Districts, meanwhile, are responsible for implementation. Data will flow from the communities and facilities through the District local governments to the relevant sectors and converge at the multi-sectoral level. At the District Local Government level, multi-sectoral reports will be prepared for discussion by the District AIDS Committees (DACs). Feedback will be made to the districts by the sectors and data will be shared at national level during the Joint Annual Review of AIDS activities with a presentation of the National HIV/AIDS status report by the UAC. Monitoring will be carried out through sector management information systems and evaluations will include the Uganda Demographic and Health Survey, AIDS Indicator Survey, Antenatal clinic sentinel surveillance, Most-At-Risk-Population Surveys, cohort analyses of patients on ARVs as well as longitudinal studies for determination of HIV incidence".

The UAC is not an implementing agency. Its role is to oversee and coordinate the national response. The UAC can help, request, resource, advocate, sensitize, guide and support district staff to implement the PMMP guidelines. One of their main commitments is to standardize reporting. It does not wish to set up a parallel system for data collection and reporting. Its approach therefore is to build on existing information systems at sector and district level. The UAC system may not capture comprehensive data, but if it can succeed in the objective of getting stakeholders to use monitoring information, then significant ground will have been covered. The UAC is also clear in its observation that it has no direct mandate to run an operational level information system and therefore has to partner with sectors to monitor the national response.

The UAC wants to prioritize engagement at two levels: the sectors and the districts. The districts are responsible for actual implementation of HIV related services while the sectors are responsible for technical oversight and policy formulation. As such, the districts and sectors have a key role in ensuring availability of monitoring information, collation of this information and aggregating it so that it can be visualized at the national level. All other stakeholders are expected to channel their issues, including plans, interventions and outputs through the sectors and the districts and this

applies also to the civil society organizations (CSOs or ASOs). The Midterm Review of the NSP is expected in December 2009 and the UAC hopes that by that time, the NSP should have at-least been disseminated to stakeholders.

1.2 Objective of the Assessment

This report presents a summary of key findings from the first part of the assessment phase (Sectors and ADPs), the second phase (CSOs) and the third phase (the districts) as part of the assignment to provide technical support to the UAC in Operationallising the PMMP. The specific objectives of the assessment phase therefore were to:

- Review and document operating M&E systems for the national and district level response, in relation to the PMMP
- Identify best practices, gaps and challenges for PMMP Operationallisation
- Describe a system and critical linkages required to make PMMP operational
- Document requirements and propose an evidence based capacity building strategy for the PMMP Operationallisation

1.3 Methods, Information Sources and Data Presentation

This information has been generated from a number of key informants that we talked to in the three phases of the assessment, and provides a foundation for developing an overall framework for the necessary linkages in operationallising the PMMP. The assessment involved visits to stakeholders from different agencies. We started with a meeting with the UAC and a technical meeting with the UNAIDS. We then set up a schedule of visits and re-visits to different agencies in which we held meetings and focus group discussions with key resource persons. Prior to each meeting, we had a team meeting in which we agreed on key issues for discussion with the particular agency. After each meeting, a summary of the discussions and key observations was made. These minutes have been used as the basis for compiling this report. In addition, we conducted a document review, in order to evaluate each indicator of the PMMP and to link these to the available MISs at district and sector levels.

The assessment was conducted using a 'systems analysis model' that followed-up the different processes needed in making the PMMP indicators operational, and described how these processes are related to each other. The table below provides a summary of the key information sources:

Table 1: Key Information Sources Used in Preparation of this Report

National Level	
1.	The Uganda AIDS Commission, M&E
2.	The ACP, Ministry of Health
3.	The Resource Centre, Ministry of Health
4.	The Ministry of Gender, Labour and Social Development
5.	The Ministry of Education and Sports
6.	UBOS
7.	UNASO
8.	TASO
9.	The AIDS Information Centre
10.	JCRC
11	The Inter-religious Council of Uganda
12.	UNAIDS
13.	Document Review – the PMMP
14.	Document Review – the NSP
15.	Document Review – the HMIS Manual

16.	Meetings with ACE
17.	Meetings with Infotronics
18.	Synthesis meetings of the assessment team
District Level (3 Districts)	
1.	The DHOs and the DHTs
2.	Focal persons for specific programmes (ART, PMTCT, HCT/Lab, TB/Leprosy Condoms
2.	The CAOs or ACAOs health
3.	The District Planners and their teams
4.	The DEOs and their teams
5.	The District CBSOs and their teams
6.	Representatives of CSOs
7.	District Hospitals, Health centre III and IV Teams

Each section of this report is organized in three tiers: observations, challenges and recommendations. We present our findings in three broad contexts:

- Monitoring the National Level Response
- Monitoring the District Level Response, and
- Monitoring the Civil Society Response.

2.0 Monitoring the National Response

2.1 What is expected at the national level

The National level response will be monitored on the basis of the 58 impact indicators of the PMMP. A breakdown of these indicators by responsible agency shows that there are five categories of agencies which are supposed to provide leadership in up-dating this information and it is these agencies that the UAC should engage with directly. They include:

I) *Ministry of Health (MoH),*
II) *Ministry of Health together with the Uganda Bureau of Statistics (UBOS),*
III) *Ministry of Education and Sports (MoES),*
IV) *The Ministry of Gender, Labour and Social Development (MoGLSD),*
V) *The UAC itself*

For each of these stakeholders, there is a shortlist of indicators they need to provide; each of these has different sourcing mechanisms and periodicity of collection. Below is a summary of the different categorizations (Details are provided in Appendix 2):

Table 2: Categories of PMMP National Level Indicators by Responsible Agency and Means of Collection

A. Indicators for which the Ministry of Health is expected to be the source
1. Indicators to be updated annually from Programme Reports and the Health Facility Database *(7 Indicators)* 2. Indicators to be up-dated annually from ANC Sentinel Surveillance *(1 Indicator)* 3. Indicators to be up-dated every 2 ½ years from Most-At-Risk Population Surveys (MARPS) *(3 Indicators)* 4. Indicators to be up-dated every 2 ½ Years from PHA Behaviour Surveys *(5 Indicators)* 5. Indicators to be up-dated every 2 ½ years from Health Facility Surveys like the SPA *(8 Indicators)* 6. Indicators to be updated annually from the National Drug Authority *(1 Indicator)* 7. Indicators to be up-dated annually from Condom Availability Surveys *(1 Indicator)* 8. Indicators to be sourced annually from the Uganda Blood Transfusion Service Programme Reports *(2 Indicators)*
B. Indicators expected from both the Ministry of Health and UBOS through National Surveys and Census Data
1. Indicators expected from the AIS every 2 ½ Years *(3 Indicators)* 2. Indicators expected from both the AIS and the UDHS every 2 ½ to 5 Years *(10 Indicators)* 3. Indicators expected from either the Census, the UDHS or the AIS every 5 to 10 years *(3 Indicators)*
C. Indicators expected from the Ministry of Education and Sports
1. Indicators to be sourced annually from the Education Management Information System (EMIS) *(1 Indicator)*
D. Indicators expected from the Ministry of Gender, Labour and Social Welfare
1. Indicators to be sourced from Special Surveys in disadvantaged groups every 2 ½ Years *(1 Indicator)*
E. Indicators that the Uganda AIDS Commission should Source
1. Indicators to be sourced from annual workplace surveys *(1 Indicator)* 2. Indicators to be sourced from the UAC Programme Reports including the National HIV Status Report, Desk Reviews and Key Informants *(2 Indicators)* 3. Indicators to be sourced from the National HIV/AIDS Stakeholders' service mapping atlas *(1 Indicator)* 4. Indicators to be sourced from networks of AIDS Service Organisations and PHA Networks (NAPOPHANU and UNASO) *(1 Indicator)*

* Source: The PMMP

The UAC expects to receive updates on the 58 'impact' indicators of the PMMP from the line sectors and partners at national level, *some annually, some after every 2-3 years and some after 4 to 5*

years. The PMMP lists 24 specific events that constitute a 5 year workplan for operationallising the monitoring information at national level. These are summarised in the table below:

Table 3: PMMP Workplan 2007/08-2011/12

No.	Activity	2007/08	2008/09	2009/10	2010/11	2011/12	Responsible	Unit cost (US$)
1	UASR consultants and consultations	X	X	X	X	X	UAC	60,000/yr
2	SPR	X	X	X	X	X	Sectors	-
3	SBAASR		X		X		UAC/Sectors	500,000/survey
4	UDHS				X		UBOS/MoH	
5	AIS	X					MoH/UBOS	1.41 million/survey
6	ANC-SS	X	X	X	X	X	MoH/UBOS	360,000
7	LQAS					X	UBOS/UAC	11,000/district
8	Incidence studies	X	X	X	X	X	MoH/SPH	
9	MARPS	X			X		MoH	150,000/survey
10	CAS	X	X	X	X	X	MoH	20,000/survey
11	ART cohort data collection, entry, analysis & report	X	X	X	X	X	MoH	500,000/yr
12	Health Facility Surveys	X		X		X	MoH	300,000/yr
13	PHA behaviour and service survey	X		X		X	MoH	500,000/yr
14	Website hosting of database	X	X	X	X	X	UAC	1,200/yr
15	Supportive supervision costs	X	X	X	X	X	UAC	30,000/yr
16	Database & web based Information system development costs	X					UAC	32,500 lump sum
17	Printing PMM system documents	X	X	X	X	X	UAC	20,000/yr
18	Costs of PMMP advocacy workshops	X	X	X	X	X	UAC	200,000/yr
19	Cost to disseminate information to stakeholders at JAR workshops	X	X	X	X	X	UAC	600,000/yr
20	M&E sub committee meetings	X	X	X	X	X	UAC	2,000/yr
21	National PMM system capacity building costs	X	X	X	X	X	UAC	40,000/yr
22	UNGASS report consensus meetings for composite score calculation	X		X		X	UAC	20,000
23	Partnership Forum	X	X	X	X	X	UAC	600,000/yr
24	Mid-term Review and end term evaluation			X		X	UAC	500,000/review
	Total budget (US$ millions)	4.8	2.5	3.8	7.5	3.8		22.8 million*

AIS - AIDS Indicator Survey
ANC-SS - Antenatal Clinic Sentinel surveillance
CAS - Condom availability survey
LQAS - Districts Lot Quality and Assurance Sample Surveys
MARPS - Most at Risk Population Surveys
SBAASR - Sector Based Assessment of AIDS Spending

The key challenge is to get the different sectors to commit to collect this information at the required times and provide the needed up-dates to the UAC. For this purpose, an M&E unit was established at the UAC to coordinate the information management process, including negotiations with the relevant stakeholders and sectors. At the national level, the UAC observes that it is the sectors'

responsibility to solicit information from the different stakeholders i.e. the districts, national level CSOs and AIDS Development partners, so that information from the different management information systems is aggregated into sectoral data-bases.

2.1.1General Challenges in operationallising the national response

- The PMMP specifies that monitoring information will be collected through sectoral Management Information Systems (MISs) at national level and these should be linked to district level MISs; however, some sectors have not set up Management Information Systems that tap into district level interventions, and as such, they do not routinely collect sector specific HIV/AIDS related information from the districts. Examples include the Ministry of Gender which is still developing an M&E system.
- Sectors like Education have not yet integrated the HIV/AIDS indicators stipulated in the PMMP into their Management Information System.
- Sectoral MISs themselves are not designed to provide all the monitoring information needed to inform the PMMP. On the other hand, sectoral MISs are designed for purposes other than monitoring. In order to collect all the monitoring information needed, sectors have to triangulate information from multiple sources.
- Implementation of HIV/AIDS is multi-sectoral; therefore collection of data for the PMMP indicators will depend on the good will of the relevant sectors. Priority is given to the primary data collection needs of the sector and HIV/AIDS is considered secondary.
- There are no routine information systems for capturing outputs from community-based behavioral and social interventions (like IEC, OVC and condom use) that are non-health-unit-based indictors. Implementation of such interventions is also diverse, with many actors, and without a central implementing agency that can report on indicators related to the interventions.
- The system of information collation from different sources has not yet been institutionalized at the national level; Sectors have not yet moved beyond MISs to actual monitoring and data collation so that information can be used for planning.
- There is limited or lack of resources to support scheduled data collection activities. No sector presented an approved M&E annual plan and budget for the PMMP indicators.
- There are Sector HIV Focal Persons that were identified following the guidelines for HIV Coordination that were disseminated by the UAC. However, these Sector HIV Focal Persons were not providing adequate support to districts in operationallising the district monitoring functions.

2.2 Assessment of Capacities for Stakeholder Agencies at National Level

The assessment of the national level information mechanisms focused on five sectoral partners from whom the PMMP is required to receive up-dated information and information on how they will relate to a common information system for monitoring the PMMP impacts. These six sectoral partners include: selected sectors (the Ministry of Health and its association with the Uganda Bureau of Statistics, the National Drug Authority and the Uganda Blood Transfusion Service), the Ministry of Education and Sports and the Ministry of Gender, Labour and Social Welfare), and the UAC. This section summarizes the sector specific findings and challenges in operationallising the PMMP.

2.2.1 The Ministry of Health

The main task of the Ministry of Health is to provide leadership for the public health response to HIV/AIDS and in doing this the sector has worked closely with different partners. According to the ACP, the Ministry's position in the HIV/AIDS intervention provides many opportunities, but also a number of challenges. The Ministry has a surveillance system and Working Group responsible for monitoring the 'public health response' and Uganda AIDS Commission is represented on this working group. This provides an opportunity for the UAC to inject its agenda in the Ministry's operations and to negotiate for information.

Based on the PMMP indicator categories, the Ministry of Health is responsible for providing information on 42 of the 58 national level indicators. The PMMP stipulates 10 sources for these indicators, including:

1. Programme reports and health facility inventory
2. Reports from the UBTS
3. Reports from the NDA
4. ANC surveillance
5. Most-At-Risk Populations Surveys (MARPS)
6. PHA Behaviour surveys
7. Health Facility Surveys
8. Condom Availability Surveys
9. AIDS Indicator Surveys
10. Demographic and Health Surveys (together with UBOS), and
11. The Census (together with UBOS).

Some of these indicators require annual up-dates (especially those based on reports) while the surveys are expected every 2 ½ to 5 years. Based on our discussions with the ACP, the feasibility of obtaining information from these sources is evaluated as follows:

1) ***Programme Reports:*** In general, seven PMMP indicators are supposed to be generated from programme reports and the health facility inventory. There is also one indicator (on condom procurement) that is expected from the NDA and two indicators expected from the Uganda Blood Transfusion Service. Our initial assessment is that it is possible for information on these indicators to be captured from the programme reports.
   The ACP: The ACP has an epidemiology, surveillance and monitoring unit and a programme coordinator for each of the major interventions (VCT/HCT, ART, and PMTCT, IEC /BCC and condom promotion). These receive reports from implementing sites in the public health system and facility based PNFP partners affiliated with the national programmes. They have an inventory of all these units and run a vertical management information system that is supplemental to the HMIS and is based on the VCT/HCT, ART and PMTCT registers.
   The Resource Centre and HMIS: The majority of the HIV output indicators are also captured in the HMIS monthly reporting forms and the HMIS should provide a good information base. The HMIS has been revised over the last 10 years to incorporate more of the programme indicators.
   The Uganda Blood Transfusion Service: The UBTS is expected to provide information on two blood related indicators. Our assessment shows that the UBTS has the capacity to provide this information and all the UAC needs to do is to establish an information linkage and agree on an up-dating schedule for the indicators; information is expected on an annual basis.

2) ***Annual Sentinel Surveillance:*** These ANC based surveillance activities have been on-going since 1989. In the pre-ART Phase (before 2000), this data was relatively easy to interpret. However, since ARVs became widely available, adjustments have to be conducted to make the data less confounded because average duration with the disease has changed. The data can also be disaggregated by age-group and it provides a proxy for determination of incidence. The data also allows annual estimates and projections, using software like Spectrum and EPP. There is one PMMP indicator that will be up-dated annually from these sources and according to the Ministry they are ready to provide this information. However, it should be noted that the last publication of the surveillance report was in 2002. The reason for this break in analysis is an information gap that will be established and discussed in the subsequent report.

3) ***Population Based Surveys:***

   a. ***The UDHS and the Census:*** The Ministry of Health, the Uganda Bureau of Statistics and Macro International have been conducting the Uganda Demographic and Health Survey (UDHS) under the MEASURE DHS Project, supported by USAID. The UDHS is expected to provide information for at least 13 impact indicators of the PMMP. It has been conducted fairly regularly, in 4 to 5 year cycles, and it is hoped that they will be sustained over the next two decades. Censuses are also expected every 10 years – UBOS takes the lead on these. It is expected that the subsequent UDHSs will include HIV testing and behavioural assessment.
   b. ***The AIS:*** Under the MEASURE DHS Project, the Ministry of Health plans to conduct regular AIDS Indicator Surveys every five years. The last one was conducted in 2004 and another one is planned for May 2009. The AISs are expected to provide information for about 13 indicators of the PMMP, 10 of them intersecting with those expected from the UDHS. The up-coming survey is expected to include additional biomarkers, including CD4+ counts and incidence.

   These two types of population surveys are fairly predictable and it is hoped that the relevant indicators will be available when updates are needed. With both the AIS and UDHS, 13 impact and outcome indicators can be updated every 2.5 years. The Ministry also has stipulated fora and mechanisms for disseminating the findings from such types of surveys. However, two main challenges are foreseen: whether these surveys will be conducted regularly and according to schedule, and the large amount of resources needed to conduct them.

4) ***On-going Cohort Studies:*** The Ministry also receives information from partners undertaking cohort studies, including the Rakai Cohort and the Medical Research Council Cohort in Masaka. According to the MoH, these types of studies provide good information; however, the information is not generalisable to the whole country. There are no PMMP indicators that are required from such studies but they can be used to estimate other indicators.

5) ***Other surveys:*** There are a number of other surveys that the Ministry of Health or partners conduct. However, the ACP is specific in its observation that these surveys are non-routine, irregular and may only happen if resources are available. These include:

   a. ***Health Facility Surveys:*** Recently, a Service Provision Assessment (SPA) was conducted under the MEASURE DHS Project and the results disseminated in September 2008. The SPA has some service delivery indicators related to ART, PMTCT and HIV/AIDS services coverage. However, health facility surveys are not routine because of inadequate resources. This is likely to impact the UAC's ability to up-date eight indicators whose frequency is supposed to be every 2 .5 years.
   b. ***Condom Availability Surveys:*** Modules and protocols are in place but the Ministry has no resources to conduct the surveys on an annual basis. This is likely to impact on the UAC's ability to up-date one PMMP indicator.
   c. ***People with HIV/AIDS Surveys:*** There is no official PHA survey that has been carried out in the country so far. However, the protocols are available and it is the resources that are lacking. This is likely to impact on the UAC's ability to up-date five indicators.
   d. ***MARPS:*** Protocols are available, targeting special groups like commercial sex workers and fishing communities. However, the resources are not available to ensure that these surveys are conducted routinely. Therefore they are undertaken as and when resources are available. This is likely to impact on the UAC's ability to up-date three indicators.

The Ministry of Health notes that for the majority of the indicators of the PMMP, information can be provided, and opportunities have improved for information gathering. MOH also emphasized that the UAC should assist the sectors in mobilizing resources for information collection activities for which the sectors do not currently have the resources. Table 3 below provides a summary of the Ministry's readiness and realities with regard to the suggested sources of information for the indicators it has been assigned:

Table 4: Summary Evaluation of the Stipulated Information Sources for the PMMP Indicators Expected from the MoH

Stipulated MoH Source	Evaluation	Frequency / Regularity , and Date of last report	Regularity Rating
Programme reports and health facility inventory	Information readily available but needs to be extracted; the UAC needs to describe a clear reporting mechanism	Annual; these reports are produced on a quarterly basis	Strong
ANC surveillance	On-going and information is available; of late, there have been some delays in processing this information	Annual; last report was in 2002	Strong
Most-At-Risk Populations Surveys	Protocols available but no resources to make these surveys routine		Not guaranteed*
PHA Behaviour surveys	No national PHA survey to-date, but protocols are available; resources are needed		Weak*
Health Facility Surveys	Not regular at the moment; a recent SPA was conducted and the information released in August 2007; they are often broad in scope; resources needed if they are to be regularized		Not guaranteed*
Reports from the NDA	Information is available and reports can be sourced		Strong
Reports from the UBTS	Information is available and reports can be sourced		Strong
Condom Availability Surveys	No resources to conduct them every year; but protocols are available		Not guaranteed*
AIDS Indicator Surveys	Have become relatively regular and are a good opportunity; plans to estimate incidence and additional bio-markers	Five years , last is of the 2004 survey	Strong
Demographic and Health Surveys (together with UBOS)	Have become relatively regular and are a good opportunity; plans to include HIV testing in the subsequent ones	Every Five years, last report is of 2006 survey	Strong

The Census (together with UBOS)	Occurs once in 10 years and it has a broad range of issues but it is regular and offers an opportunity		Strong

* Activities for which further negotiations and resources are needed

The ACP/Ministry of Health is also the sector-level supervisor for the district health HIV/AIDS response. Data for monitoring the 50 output level indicators is in principle supposed to be aggregated at this level (for the indicators relevant to the District Health Office) and shared with partners including the UAC.

Challenges in PMMP Operationallisation at MoH Level

- Several key informants noted the challenges related to the completeness and accuracy of HMIS data.
- Because the HMIS alone cannot meet all the information needs for monitoring the health sector response, there are parallel MISs for specific programmes like PMTCT, ART and VCT. The challenge is in making these systems complementary and creating links for collation of this information into a common monitoring report.
- The HMIS only captures health-unit-based-data and as such does not capture all the district level outputs expected in the PMMP; specifically, information on IEC activities and livelihood interventions are not captured.
- While several national level indicators are expected from the UDHS and AIS, these surveys have been conducted under a project mode for the last two decades. Their long-term sustainability is not guaranteed. In addition, they may not be strictly regular according to the 5-year schedule (AIS) and 5-year schedule (for the UDHS) as indicated in the PMMP. Development partners (USAID/CDC) have funded these surveys.
- There are four types of surveys for which the Ministry of Health acknowledges that it does not have the resources to ensure that they are conducted regularly: *The health facility surveys, the condom availability surveys, PHA surveys and MARPS*. A decision has to be taken on how information for these indicators will be up-dated, or how resources will be generated to conduct these surveys, or whether remedial surveys can be conducted by any stakeholder that has the funds. If all these mechanisms fail, there ought to be a system for making estimates for the indicators, using alternative approaches.
- The PMMP proposes at-least 6 different types of surveys to be conducted under the health sector and conducting all these surveys in a 5 year cycle is very costly (some surveys like the condom availability surveys are expected in an annual basis); some of these surveys could be merged.
- Even for the larger and more regular surveys (UDHS and AIS), sometimes the information provided is not adequately disaggregated to provide the sub-group estimates that the PMMP requires. However, the Ministry of Health advises that specific information can be provided if the UAC works together with the MoH during the design of the surveys.
- Another key challenge is defining who should elicit the indicator up-dating process? One of the key issues in operationallising the PMMP is that up-date information needs to be sourced and relayed as per the specified schedules for each indicator. This implies that there has to be someone dedicated to implementing the following tasks:
    - Reminding the stakeholders that a given indicator is due for up-dating
    - Negotiating with the stakeholders for inclusion of the indicator in any assessments
    - Mobilize resources required to facilitate such assessments
    - For impact indicators that are collected from programme reports, following-up the sectors to see that they can aggregate and share this information.

There also ought to be a schedule and dates for each of the stated activities and due dates for each indicator, as a basis for the reporting.

Recommendations on linkages with the Ministry of Health

1 The UAC and MOH should agree on a schedule, with key dates and a budget for collection of data and information required for the updates of PMMP indicators. Such a plan could be funded through though the UAC partnership fund of other available and reliable sources, in addition to the funding sources within the Ministry.
2 Indicators that require periodic surveys should be up-dated 'as and when new information is available' and that the UAC naturally should be part of the planning process for these surveys;
3 For other indicators that do not require surveys (e.g. those updated from ACP programme reports, the Resource Centre, the NDA and UBTS), the UAC should communicate to stakeholders the suggested reporting mechanism and a list of key dates. For those that have to be up-dated on an annual basis, we propose the 1st of July as the reporting date.
4 For all indicators, a 5-year schedule should be drawn indicating the datelines. If data on an indicator is not available at the time it is scheduled to be updated, then the update should reflect the most recent estimate available and indicate that this information is not up-to-date. The recipient data-base should be able to indicate the due dates for each of these indicators, the date when they were last updated and if they are out of date, indicate by how many months
5 The reporting mechanisms and contact points need to be clearly articulated.
6 The Ministry of Health is set to review the HMIS this year. This provides an opportunity for negotiations to see if additional district level outputs can be integrated, so that data sourcing mechanisms are as lean as possible.
7 MARPS Surveys, Condom Availability Surveys and PHA Surveys could be merged into one survey so as to reduce on the number of surveys that need to be conducted in the 5 year cycles. Some aspects of these surveys could be merged with the AIS or the UDHS, with oversampling of the specific populations.

2.2.2 Other Sectors and agencies that should provide information at the National Level

The Ministry of Gender, Labour and Social Welfare: This sector mainly engages in social support for OVC. The activities are facilitated through project funds from the Core Initiative and Civil Society Fund granted by the UAC. Technical service organizations which are identified at the district level coordinate the work of the CBOs which are given the funds. At the district level, the line department falls in the Community Based Services Department, which is often headed by the Community Development Officer and has a 'District Gender Officer' and a 'Probation and Welfare Officer.' The sector also has an HIV/AIDS desk which is responsible mainly for general advocacy activities but does not collect any data. The MOGLSD is currently in the process of developing an M&E system which will be used to gather the HIV/AIDS programme data. The information gathered to date is all aggregated by district and is not reported based on indicators. The information generated is mainly shared through their multi-sectoral coordination meeting on a quarterly basis. MOGLSD expressed willingness to share the data they will generate once they have their M&E system in place. The MoGLSD recommends that the planned M&E system should be feasible to implement without increasing the burden of paper work of the personnel at the district level.

With regard to the PMMP, the Ministry of Gender, Labour and Social Development is expected to service one indicator: *'Percentage of disadvantaged groups that have received vocational education'* and the means of collection is supposed to be through special surveys that should be conducted annually. We noted however that these surveys are not conducted routinely and have to be negotiated. The HIV/AIDS desk does not currently collect monitoring information and there was no plan to collect such data.

Through the OVC Secretariat, the MGLSD has developed an MIS. The MIS provides an opportunity for incorporation of the needed parameters.

The Ministry of Education and Sports: The Ministry of Education and Sports implements an information system called the Education Management Information System (EMIS). This is linked to the districts through the District Education Offices and is used to aggregate a range of information on the functions and outputs of schools. The Ministry is expected to provide information for one PMMP indicator at national level i.e. *'Percentage of schools that provided life-skills based HIV/AIDS education'* and the indicator is expected to be up-dated annually. The key challenge noted is that the EMIS has not yet incorporated this indicator in routinely collected data.

Indicators that the UAC is required to source directly: According to the PMMP, the UAC itself is supposed to source information on five indicators, including conducting annual workplace surveys, and analyzing information from programme reports (including the national HIV status report) and Key Informant Interviews. The UAC is also supposed to source information from the HIV stakeholders' service map and up-date it regularly and it should also link up with NAPOPHANU and UNASO to up-date one indicator. These indicators are all supposed to be up-dated annually. We hope to provide information in the next interim report on whether the UAC has up-dated these five indicators.

Recommendations on linkages with other agencies and sectors

1 The UAC needs to conduct follow-up round-table discussions with the Ministry of Gender and the Ministry of Education, to and negotiate mechanisms with which the indicators expected from them will be serviced on an annual basis. The focus should be on integrating the PMMP indicators in their respective MIS.
2 Since the Ministry of Gender is developing a HIV/AIDS M&E system, now is the time to negotiate inclusion of the indicators that the UAC would like to collect, both at National and District levels.
3 Since the Ministry of Education has an already existing sectoral MIS, the negotiations should focus on how the required indicators at national and district level can be integrated into the routine reporting tools.
4 As the UAC focuses on engaging the districts and sectors to provide up-date data, it needs to develop its own plan for up-dating the 5 indicators that the PMMP stipulates will be directly up-dated by the UAC.

2.2.3 Proposed strategies by UNAIDS

We conducted a debriefing meeting with the technical team at UNAIDS. In summary, UNAIDS provided the following technical points in the overall direction that the PMMP operationallisation should take:

a) **Time frame for operationallising the PMMP:** UNAIDS presented the view that there is no way that the PMMP can be operationallized nationwide in a short period of time. The job is not merely technical; it also requires considerable negotiations. However, there can be short term studies and analyses to assess progress in implementation.
b) **Need for common tools:** Different agencies and sectors at the district and national level have different tools and reporting formats. Emphasis should be placed on the fact that while MIS tools can differ, monitoring tools should be harmonized since the intervention goals are the same even across different stakeholders. UNAIDS hopes that a common monitoring tool can be developed that meets the needs of different stakeholders, including donors.
c) **Value of inter-sectoral collaboration:** All contributors and partners should be involved in joint work planning and joint review mechanisms with an emphasis on quality control. At the moment, Sectors and Partners are all working parallel to each other in a fragmented

approach – this is what has made the development of simple inter-sectoral monitoring mechanisms appear complex. However, building a sustainable inter-sectoral response requires significant investment in capacity building.

d) **To the extent possible, do not create a new system:** We need to emphasize collating what is captured in existing systems rather than creating new systems, which will be resisted, and that this is monitoring information and not the routine MISs.
e) **Compiled data from sectors can be a quality check:** The UAC should compare the same data from different sources and investigate differences that are found.
f) **The UAC has reporting requirements:** The M&E system should assist the UAC to fulfill its various annual and biannual reporting requirements.
g) **Monitoring ART resistance:** UNAIDS staff feel that the development of resistance to ART is a serious issue that requires constant monitoring on a quarterly or semi-annual basis. They feel that this activity was left out of the PMMP. UNAIDS staff are of the view that the monitoring of this important information can be supported by the Global Fund and that our team should recommend this activity.
h) **Development of data-bases**: The PMMP operationallisation team needs to work hand-in-hand with the consultants engaged in developing the Monitoring Database.
i) **Feasibility of PMMP timelines**: UNAIDS staff indicated that, in their opinion, the PMMP reporting timelines are feasible.
j) **LQS surveys, UAMIS, and CRIS**: LQS surveys are being limited to districts that can afford to implement them. Macro International is preparing to conduct a UAMIS survey with staff in Uganda at this moment. How CRIS will be integrated with the data-base under construction is under negotiation. Again, UNAIDS emphasizes that use of the existing data bases at the district level is sustainable.

The team will examine and evaluate all the above strategies in the subsequent report.

2.2.4 Overall Recommendations for Operationallising the PMMP at National Level

Almost all the Key Informants from the different agencies agree that the UAC should actively engage the different stakeholders to provide the required monitoring information. The UAC should prompt the different stakeholders by officially asking for the needed information and following them up until they provide the information. Unlike routine reporting, monitoring information by definition requires active sourcing from the people being monitored.

The UAC should:

1 Increase its engagement with stakeholder agencies and sectors to provide the required monitoring information for the PMMP. This should be done through annual workshops and biannual meetings for stakeholders and sector HIV focal persons. In these meetings, the UAC and Sectors should agree on:
   a. *A mechanism for information sharing.*
   b. *Development of Sector MISs for the Education Sector and the Ministry of Gender*

2 Create a schedule for indicator updates clearly indicating the date, month and year on which each indicator needs to be up-dated and disseminate it to the stakeholders (For consistency with the major national survey cycles).
   a. *Indicators that require periodic surveys should be up-dated 'as and when new information is available'*
   b. *For other indicators that do not require surveys (e.g. those updated from ACP programme reports, the Resource Centre, the NDA and UBTS), the UAC should communicate to stakeholders the suggested reporting mechanism and a list of key dates.*
   c. *For those that have to be up-dated on an annual basis, we propose the 1st of July should be the reporting date (Corresponding with the start of the reporting year).*

    d. *For all indicators, a 5-year schedule should be drawn indicating the datelines for updating the information*

3. Break-down and categorize the 58 impact indicators of the PMMP by their expected sources and modes of collection (we have provided this categorization in the appendices) and disseminate this to the actual persons responsible for providing this information in the sectors.
4. Articulate a clear reporting mechanism and circulate a reporting blank or reporting forms for the indicators for which the sector is responsible and specify who fill them at sector level and how they should be relayed to a central monitoring data-base
5. Make a list of contact persons who should provide the update information, and articulate who should contact them and the information exchange mechanisms that should be used.
6. Regular follow-up of the Sector Focal Persons to play a more active role in coordination of the sourcing activities for the PMMP indicators within the respective stakeholder sectors, based on the 5 year schedule
7. Engage Sector Focal Persons to follow-up the relevant desk officers responsible for indicators that need to be up-dated on an annual basis (those from programme reports and sectoral MISs).
8. Develop an automated spreadsheet that shows the status of each of the indicators, when it was last updated and when it is due for up-dating. The system should be able to raise a red flag when the indicator is out-dated. It should be maintained by the M&E coordinator. If data on an indicator is not available at the time it is scheduled to be updated, then the update should reflect the most recent estimate available and indicate that this information is not up-to-date. The recipient data-base should be able to indicate the due dates for each indicator, the date when they were last updated and if they are out of date, indicate by how many months
9. Participate in the design, conduct and analysis of assessment activities for indicators that are to be collected in scheduled national surveys (e.g. the UDHS, AIS) to ensure that PMMP indicators are incorporated within their protocols, with adequate disaggregation of information as specified in the PMMP
10. Conduct discussions with ADPs and sectors to negotiate resources for those surveys where resources are not guaranteed (e.g. MARPS and PHA surveys). In order to do this, the UAC needs to have estimates of the cost of these additional surveys for a 5-year period.
11. Up-date its portion of the 58 indicators i.e. the 5 indicators that it plans to up-date annually.
12. Work with the Ministry of Health to develop a strategy for national level surveys. The proposed surveys in the PMMP are many and could be merged because of resource limitations. MARPS, PHA and Condom Availability Surveys could be merged into one survey or some aspects incorporated in the AIDS Indicator survey and the UDHS (with oversampling of the target populations), to reduce on the number of separate surveys that need to be conducted

3.0 Monitoring the District HIV Response

We conducted an assessment of the critical linkages for operationallisation of the monitoring activities at the district level. The assessment was carried out in 3 districts: Mukono, Kumi and Kiboga. These districts were selected based on the need to balance: region, size of the district, rural/urban setting and whether the district was new or old. At the districts, we held meetings with the District Health Team, the District Education Officer, the District Planners and HIV Focal Persons, the District Community Development Officers and the ACAO in-charge of health. In this section, we present highlights of the most important findings that emerged from discussions with key informants from the districts.

3.1 Expectations on Coordinating Structures in Districts

According to the Uganda AIDS Commission, the districts know that it is their mandate to provide HIV/AIDS services at the primary care level and almost all districts now have a HIV Focal Person. The UAC has disseminated the recommended structure for organization of the district HIV/AIDS response.

All districts are expected to have a District HIV Focal Person (D-HIVFP), a District AIDS Committee (DAC), and a District AIDS Taskforce (DAT). The DAC should be composed of a multi-sectoral team of technical heads of departments and selected NGO representatives. Also, the district ought to have a forum that unites the AIDS-related CSOs operating there.

Overall coordination of the HIV response in the district is the responsibility of the Chief Administrative Officer, who in turn appoints the HIV Focal Person. The District HIV Focal Person is responsible for technical oversight for planning, implementation and monitoring of HIV/AIDS activities in the district. He/she is also responsible for putting in place a system with which the different stakeholders in HIV/AIDS interventions are coordinated through a single, multi-sectoral district HIV/AIDS plan that is in line with the NSP.

All districts are expected to have a District HIV/AIDS plan. The plan should be integrated within the overall District Development Plan and the District Annual Work Plan and Budget and it should reflect the different sectoral HIV/AIDS interventions. It is the overall responsibility of the District HIV Focal Person and the DAC to ensure that there is a multi-sectoral HIV/AIDS plan in the district, and it is the responsibility of the DAC to ensure that the plan is up-dated on a regular basis.

All districts have planning units responsible for preparation of the District Development and Annual plans. The planning unit often prepares the district plan by combining the sectoral plans into a common coding system based on the Local Government Integrated Financial Management System (IFMS). This central coordinating role of the planning unit has important implications for HIV/AIDS planning.

3.1.1 Current Status of Coordinating Structures in the Districts

The 3 districts that we assessed all had HIV Focal Persons. The focal persons come from different departments but they were leaning more towards the health department (in two of the three districts, the Focal Persons were from the Health Office, while in one district, the focal person was from the District Planning Unit).

All the 3 districts we visited had a DAC. However there were variations in the level of functionality of the DACs. In Kiboga district, the DAC was active and there was evidence that it meets regularly on a quarterly basis. In Kiboga, the DAT was also active and met on a quarterly basis. However, we noted that DACs were functional in districts which received funds to facilitate their activities. In Kiboga, DAC activities were funded by PREFA and the DAT was funded by AFREF under the Malaria, AIDS and

TB (MAT) Project. However even Kiboga notes that before AMREF came is, the structures were there but were not active, and this was attributed to lack of facilitation. It seems then that districts do not allocate funds for the functioning of these committees. In Kiboga District, Sub-county

With regard to planning, the three district districts had an integrated HIV/AIDS plan that was multi-sectoral. In most districts, these planned are 'pooled together' within the planning unit, and are negotiated in the District Technical Planning committee. Different sectors had their own sectoral plans and districts had to pool these together into a common plan. This further emphasises the role of the planning unit in collating the multi-sectoral plan.

In Kiboga, the district has prepared a HIV/AIDS 'strategic plan' and different partners where brought together under the DAC to commit to different activities in the plan. During the plan negotiation, some activities were taken up by different partners including CSOs. However, many other activities in the plan still do not have specified sources of funding. An example was the World AIDS Day activities. It is worth noting that Kiboga District was not part of the CHAI and MAPS project supported district; the fact that they have a plan demonstrates that districts are capable of developing multi-sectoral plans when guided. The challenge however is in making these plans operational and obtaining the funds needed for coordination activities.

3.1.2 Challenges in HIV Coordination at district level

- While the District HIV Focal Person is essential to effective coordination of HIV/AIDS activities, the office is mostly an informal one. The focal persons expressed that this is an additional responsibility assigned on top of their other work. In Mukono, the Deputy DHO was the HIV Focal Person; in Kumi, the DHE was the HIV Focal Person the Condom Coordinator as well as the HCT Focal Person. Some Focal Persons noted that because the work of the HIV focal person is an additional responsibility, it is not given first priority until other responsibilities are fulfilled. They noted that they act as volunteers because they do not receive additional pay for the work. In Mukono, the HIV Focal person tends to get more active when there are HIV specific projects that come up, e.g. the HIV quality assurance survey.
- The position was established to promote a multi-sectoral approach to coordination of HIV/AIDS related activities. However, because of the informal nature of the position, different districts appoint different cadres to the position. In two districts (Kumi and Mukono) the coordinator was a member of the DHT while in Kiboga it was the District Population Officer in the Planning Unit.
- We also noted that in all three districts, the HIV Focal Person is appointed by the CAO; however, in some districts, the CAO gives the responsibility to a Head of Department who then delegates to a member of their team. In 2 of the 3 districts, the HIV Focal Persons were from the health department
- According to the Key informants we talked to in Kiboga, effective coordination of these activities depends on two main variables:
  - The personality and attitude of the individual appointed (whether they are active, committed and able to provide leadership and to mobilize others)
  - The department and office responsible for the coordination (according to Kiboga)
- Kiboga District has had the experience of HIV Focal Persons alternating between the Health Department and the District Planning Unit. With regard to the best department for coordinating HIV activities, key informants from Kiboga noted that any officer from the four key departments that have a strong stake in HIV activities (Planning Unit, Health, Community Based Services and Education) can be effective in coordinating HIV activities; however, officers from other departments like Works, Production, etc may not be effective.

- It was also noted however that the planning unit is the strongest link for HIV coordination activities, because it has a wide spectrum of resource persons with the expertise and it relates with all departments. Quoting the ACAO:

  > *"Coordination of HIV activities would be best done in the planning unit; that way, people would cease to view HIV as solely a health issue but as a social issue. The planning unit can convene other departments" (ACAO Kiboga)*

- Lack of funding to implement HIV/AIDS plans at district level is a major challenge and this is especially so for the coordination activities. In Kiboga, where the DAC and DAT were active, they received funding support from outside sources, all of them CSOs. While it would be expected that the department that coordinates HIV/AIDS activities would provide a budget line for coordination, this is not the case. Districts even expect that the funds for their plans would be provided externally. According to the DHIV Focal Person Mukono:

  > *"there was no incentive to make any more HIV/AIDS plans because we have made many plans that have not been funded; e.g. we made a HIV/AIDS strategic plan 2006-2011, Mukono district strategic plan for orphans and vulnerable children, and also proposals to Global Fund; all these plans have not been funded. We are tired of making plans that have no resources for implementation."*

3.1.2 Recommendations on strengthening HIV Coordination at district level

1 Departments with a high stake in HIV activities should take the lead in the coordination of HIV activities and the focal person may be effective if appointed from any of these (Health, Education, Community Based Services, and Planning).

2 In order to promote a multi-sectoral intervention, the District Planning Unit should play a key role in bringing the different departments together. The planning unit is the one best suited to leverage the different sectors in developing a multi-sectoral HIV/AIDS plan. It is also the one best suited to mobilize the different sectors to provide M&E data and to convene the regular DAC meetings. Therefore, regardless of where the focal person is situated, the District Planning Units should take a more active role in coordinating the collation of monitoring information for the multi-sectoral response and development of the district HIV/AIDS plan. The HIV Focal Persons should therefore work closely with the planning unit.

3 In the absence of external support to the HIV/AIDS plan, the department hosting the HIV Focal person should provide a budget line to facilitate HIV coordination activities (e.g. meetings of the DAC as well as supportive supervision, collection of monitoring information.

4 All District HIV Focal persons should receive terms of reference and clear specification of duties and responsibilities as well as a specification of their linkage with the different sectors and the District Planning Unit as well as their reporting relationships; these should be part and parcel of the outputs expected from their work at all times. These should b e specified in their appointment letter from the Chief Administrative Officer.

5 In the absence of external funding for coordination activities, the district planning unit or the department that hosts the HIV Focal Person should set in its annual workplan a budget line for coordination of HIV activities.

3.2 Expectations on monitoring activities and information use

The DAC is expected to meet at least once every quarter and deliberate on the HIV/AIDS situation in the district and the status of HIV/AIDS service delivery so as to develop strategies for the following quarter. In order for these coordination functions to be effective, the DAC should be able to collect routine monitoring information on the progress in key results stipulated in the district HIV/AIDS plan

and to use this information for planning. There is a lot of information collected by different stakeholders in the district HIV/AIDS response. The role of the DAC is to pool and collate this information, from all its various sources, formal and informal, and to provide an up-to date status report. The primary objective of these monitoring reports is to facilitate performance improvement so as to bolster the district HIV/AIDS response. These status reports should be discussed in the regular DAC meetings as a basis for improving service delivery. As a secondary objective, these reports ought to be shared with the relevant sectors and stakeholders at national level, so that information from the districts can be aggregated into a national data-base.

3.2.1 Mechanisms for Sourcing the PMMP Output Indicators at the District Level

We assessed the different indicators expected to be used by districts in monitoring their own response and the mechanisms for their collection. The landscape and sources of this information differ slightly from sector to sector within the districts. The matrices below provide a summary of the salient observations by sector:

The District Health Office

The District Health Office is responsible for over 70% of the output indicators for monitoring the district response. The bulk of this information is already collected at the service delivery points (health units) and is part of the HMIS. However, there are some indicators that are not routinely collected, but can be up-dated through the regular activity reports produced by the relevant desk officers. In general, the matrix below provides an evaluation of the output indicators expected from the health sector.

Table 5: Evaluation of sources for indicators expected from the District Health Office

Sub-Area	Proposed Point of Contact	Source of Information	Evaluation of the means of information extraction
IEC/BCC: This area has a total of 9 indicators categorized as follows:			
Number and type of IEC activities, including print media *(1 Indicators)*	District Health Educator	DHE's Records and District Stores	Current system for tracking HIV IEC materials is informal. All districts should have a stock control system for IEC, supervised by the DHE
Radio programmes and spots run by the district in a quarter *(2 Indicators)*	District Health Educator but collaboration with the Information Officer	DHE's and Information Officers' Records	The DHE should be in position to provide this information but should collaborate with the District information Office. As a pre-requisite, there needs to be a log-book in which all radio programmes and spots that are run b y the districts are captured.
Outputs from life skills education activities including training of trainers, peer educators and beneficiary youth *(3 Indicators)*	CBSO, in collaboration with CSOs and District Health Educator	CBSO and DHEs activity reports	These activities are not routine; they are carried out by multiple interest groups and there is not centralized coordinating entity. In order for these activities to be collated, someone needs to be given the responsibility (especially the CBSO); he/she should liaise with the DHE, DRHFP and CSOs to generate a good estimate for these activities on a quarterly basis. The

<table>
<tr><th colspan="2">Sub-Area</th><th>Proposed Point of Contact</th><th>Source of Information</th><th>Evaluation of the means of information extraction</th></tr>
<tr><td colspan="2"></td><td></td><td></td><td>other option is to focus on only the activities run by the district at the risk of undercounting the CSO input.</td></tr>
<tr><td colspan="2" rowspan="3">Condom distribution activities in the communities (at health units, service outlets and Commercial marketing activities)
(2 Indicators)</td><td rowspan="3">Condom Coordinators and HMIS Focal Person and DHE</td><td rowspan="3">HMIS, Condom Records</td><td>Health unit information possible after modifying HMIS Monthly reporting form to include condoms distributed at points other than family planning</td></tr>
<tr><td>For condoms distributed centrally to service points other than health centers, DHEs need to maintain a stock control system</td></tr>
<tr><td>Socially marketed condoms will be difficult to monitor at the district level</td></tr>
<tr><td colspan="5">**PMTCT/HCT/ART:** A total of 23 areas categorized as follows:</td></tr>
<tr><td rowspan="3">PMTCT service delivery Outputs
(8 Indicators)</td><td>Deliveries HIV Positive and those who took ART (2)</td><td>HMIS Focal Person; PMTCT Focal person</td><td>The HMIS Monthly report form (HMIS 123 and Parallel PMTCT Report</td><td>HMIS and PMTCT Report readily covers these</td></tr>
<tr><td>Live births to positives and live births that took ART (2)</td><td>HMIS Focal Person; PMTCT Focal person</td><td>The HMIS Monthly report form (HMIS 123 and Parallel PMTCT Report</td><td>HMIS and PMTCT Report readily covers these but they are not disaggregated by sex in either report; we recommend that disaggregation of these indicator by sex be abandoned</td></tr>
<tr><td>No. of pregnant women tested, number positive, number given ART Prophylaxis (3)</td><td>HMIS Focal person and PMTCT Focal Person</td><td>HMIS reports and PMTCT Reports</td><td>Readily available</td></tr>
<tr><td colspan="2">Number of PMTCT, HCT, ART service outlets (3)</td><td>DHO</td><td>Health unit inventory at the district</td><td>These are management indicators that should available in the health unit inventory at the district and are not expected to change every quarter.</td></tr>
<tr><td colspan="2">HCT service delivery outputs
(10 Indicators)</td><td>HMIS Focal Person and HCT Focal Person</td><td>The HMIS Monthly report</td><td>The HMIS adequately captures all this information, adequately disaggregated</td></tr>
<tr><td colspan="2">ARV service delivery outputs
(2 Indicators)</td><td>HMIS Focal Person and ART Focal Person</td><td>The HMIS Monthly report and ART Parallel reporting system</td><td>The HMIS captures information an all these indicators</td></tr>
<tr><td colspan="5">**HIV/TB and HIV Care:** These areas have a total of 6 output indicators categorized as follows:</td></tr>
<tr><td colspan="2">TB patients tested for HIV and those that are positive for HIV *(2 Indicators)*</td><td>District TB/Leprosy Focal Person</td><td>District TB reports</td><td>The two indicators are not captured in the HMIS and need to be collated from the TB reports</td></tr>
<tr><td colspan="2">HIV Positive persons screened for TB and those with confirmed TB
(2 Indicators)</td><td>HMIS Focal Person</td><td>The HMIS Monthly report</td><td>One of the two indicators (HIV Positive persons screened for TB) is not in the HMIS but the other one on confirmed TB is in HMIS; the indicator is in the pre-ART register; HMIS needs to be updated to include this indicator</td></tr>
</table>

Sub-Area	Proposed Point of Contact	Source of Information	Evaluation of the means of information extraction
HIV care *(2 Indicators)*	HMIS Focal Person	The HMIS Monthly report	These indicators are effectively covered in the HMIS

Challenges in Sourcing Output Indicators expected from the Health Department

- Non facility-based information e.g. IEC, is not currently collected or coordinated in the districts and is therefore difficult to capture; the District Health Educators need to be oriented on the need to capture this information, so that they develop a mechanism for collation of this information from their activity reports and from other channels that can provide this information at the district level.
- Although over 70% of the PMMP district level output indicators expected from the health department are captured in the HMIS, some districts still use the older HMIS forms which lack some of the indicators.
- There is wide spread lack of stationery in the lower level health units; they have to photocopy the HMIS reporting forms and at times they lack the funds to purchase paper.
- Some health units lack the official registers, e.g. HCT registers are lacking in many health units; because of this, some health units (e.g. in Kiboga) use improvised counter-books where the entries are not standard and vary from one health unit to another. The Distribution of official registers from the Ministry of Health is ad-hoc in some cases, especially where CSOs are involved in supporting particular HIV programmes. There does not seem to be an official system for acquiring new registers through the district health office. Statements like "this register was brought in by PREFA" or "this register was brought in by AMREF" were common in the districts.
- Unlike PMTCT, the HCT Programme had a dual recording system at the service delivery points. There is a lab form that contains patient information and a results voucher. There is also an official register called the 'lab register'. Information is supposed to be transcribed from the form to the register. Some health units have abandoned the lab forms and use only the register (e.g. Lwamata HC II Kiboga).
- There is wide spread lack of records assistants. Kiboga district for instance has only 3 RAs who are at HSD level. Many are not trained, are not computer literate and have to compute summaries manually; not only does their lack of skill complicate their work but it introduces delays and errors especially at the HSD level.
- Health units are grossly understaffed. The same people have to provide services, undertake outreaches and then collate the reports. The multiplicity of reports further complicates their work. An example is Kiboga District. The district receives support from several partners involved in HIV activities and some of these provide direct budget support to the District Health Office while others provide allowances to health unit teams for outreach activities. Health unit in-charges therefore have the additional responsibility of collating the different reports. At the moment, some health units have to make a minimum of 5 reports: The monthly HMIS report, the ART report, the PMTCT report, the TB CAP report, the IDI or Baylor or AMREF Report
- CSOs do not routinely report to the district; as a result, there is under-reporting for the specific activities in which they are involved.

The District Education Office

There are three indicators expected from the education department – all focus on capacity for life-skills education in schools as well as the outputs in terms of number of in-school young people reached with life-skills training. The matrix below summarizes our preliminary evaluation:

Table 6: Evaluation of sources for indicators expected from the District Education office

Sub-Area	Proposed Point of Contact	Source of Information	Evaluation of the means of information extraction
Numbers of teachers trained in life skills, number of schools with trained teachers and number of in-school young people reached with this training	DEO/District Inspector of Schools in collaboration with the Center Coordinating Tutors (CCTs)	Termly and Annual Report (Using the Statistical Tool)	According to the DEOs, this information can b e obtained periodically; however, the information is not demanded at the district and is therefore not collected routinely; the computer based EMIS collapsed. The school Termly reporting form needs to integrate these indicators and it should re-vamped so that information is provided regularly; DEOs need to be oriented into summarizing all the school information into a common Termly report
			The annual statistical report also needs to be summarised at the district level and used to collect this information
Number of orphans in schools (disaggregated by single or double orphanhood and level)	DEO/District Inspector of Schools	EMIS	We shall assess if the EMIS captures this information

Challenges in Sourcing the Output Indicators expected from the Education Department

- Available reporting mechanisms like the Term and annual statistical report have not been adequately used to capture routine HIV/AIDS information.
- Summaries of information are lacking at the district level; piles of school reports are sent to the MOE planning unit without a unified district report. Districts do not get feed-back from the Ministry on their performance; districts need to do their own summaries.
- The Education Management Information System (EMIS) is less well developed that the health management information system. There is need to integrate HIV/AIDS information into the routine information management systems, and to operationallize the information generation processes on a routine process.
- There is general lack of coordination of HIV programmes in schools. Different projects tend to implement different programmes in schools without involvement of the district departments. Some of these are one off activities. There are therefore many on-going activities that are not documented.

The District Community Based Services Office

Three indicators are expected from this department, covering the orphan situation in the district. Our preliminary evaluation of the sources is presented in the table below:

Table 7: Evaluation of sources for indicators expected from District Community Based Services Office

Sub-Area	Proposed Point of Contact	Source of Information	Evaluation of the means of information extraction
Number of service outlets for orphans and number of orphans reached with services	CBSO/District Probation and Welfare Officer	Strong need to liaise with CSO and to develop a MIS for the entire sector at district level	There is a multiplicity of actors, but no coordination mechanism. The different activities are difficult to quantify at the moment. Some services are duplicated with some CSOs supporting the same children. CSOs do not report routinely. In order for this information loop to function, there is need to establish a formal information management system that effectively links with the different stakeholders including CSOs, and to operationalise it

Challenges in sourcing the output indicators expected from the Community Based Services Department

- There is a multiplicity of actors in orphan care and welfare in the districts including CSOs. However there is no systematic coordination of their activities
- The Community Development Officers do not collect any routine information and there is no management information system.
- There is no reporting form for Community Development Officers' activities.
- In some districts, mapping exercises have been conducted but these are one off events; there is need for mechanisms for routinely updating this information.

The District Planning Unit, Administration and Finance

The CAO's office (Administration) is expected to collect routine information on the available capacity for coordination of HIV/AIDS activities and the status of implementation of activities, in collaboration with the District Planning Unit and the Finance Department. The District Planning Unit could take on the lead in updating these indicators. The matrix below provides a preliminary evaluation of sources for these indicators:

Table 8: Evaluation of sources for indicators expected from Administration and the Planning Unit

Sub-Area	Proposed Point of Contact	Source of Information	Evaluation of the means of information extraction
Amount of local government funds allocated and spent in HIV/AIDS activities (1 Indicator)	District Planner/HIV FP	District Annual planning documents and quarterly reports;	District Planners and the HIV Focal persons need to liaise with sectors to capture sectoral data; there is need to focus on IEC activities because all services in district are integrated and one cannot tease out those for HIV.
Capacity for M&E (1 Indicator)	District Planner/HIV FP in collaboration with sector heads and Principle Personnel Officers	Human resource records	The District HIV Focal person should source for this information from sector heads and Personnel Officers
Number of CBOs receiving support for HIV/AIDS interventions	HIV FP in collaboration with CBSO		Districts do not routinely support CSOs; the indicator may be redundant
The District AIDS Coordination Index	District Planner/HIV FP	The HIV-FP needs to liaise with sectors to capture information on sectoral MIS reporting	This can be computed by the HIV FP. However, it requires training of the FP and also requires sector visits to check on the status of reporting.

Challenges in sourcing the output indicators expected from the District Planning Unit, the HIV Focal Person and Administration

- Capacity for joint HIV Monitoring is weak or non-existent. Joint monitoring activities are not currently undertaken because districts lack a mechanism for coordinating joint monitoring and reporting.
- HIV activities are integrated into general service delivery systems and it is difficult to tease out specific funding for HIV. The indicator should refer to specific activities e.g. funding for HIV Coordination and funding for IEC, to make this more measurable.
- Information on CBOs and CSOs operating in HIV is not regularly up-dated. District partnership workshops are not implemented because of lack of funds. Because of this, it is difficult to keep track of CSO support.

3.2.2 Collation of information from different departments into a common report

This does not currently exist in all district visited. The closest to this was in Kiboga, where sector heads are requested to present a summary of activities undertaken in a quarter and activities planned for the next quarter. This however demonstrates that it is possible for different sector heads to provide reports and shows that the planned collation tool being prepared by the UAC/ACE/Infotronics will be relevant.

3.2.3 Summary of Challenges Related to Collation of District Level Output Indicators

- There are no joint monitoring activities for HIV activities between sectors in the districts. The
- Some sectors do not have MISs e.g. Community Based Services; even the stakeholders that they are supposed to generate information from (especially CSOs) do not report routinely to them
- Departments do not capture some key service delivery data, especially on social interventions that are non-facility based like IEC and OVC support. There are multiple actors in these services and in most cases there is no central coordinating authority
- According to the UAC, one of the key gaps at the district level is the use of information for monitoring and planning. This is partly brought about by the absence of a cross-cutting tool that can be used to summarize service delivery outputs from the different sectoral interventions into a routine multi-sectoral report that can be used to inform decision-making. Because of this, districts rarely produce any monitoring reports for the district HIV/AIDS response, and they often do not use performance-based information for planning. In order to promote utilization of monitoring information for HIV interventions at the district level, the UAC is in the process of developing a 'data collation tool' that translates the PMMP output indicators for monitoring district response into a quarterly evaluation form. The tool presupposes that, through the different sectoral MISs, districts collect various types HIV/AIDS related service delivery information, either routinely or non-routinely at the operational levels. Much of this information is available with the different stakeholders and the only problem is that it is not regularly collated and summarized into progress reports. The tool also pre-supposes that different sectors should be able to provide parts of the information that is needed to complete the tool; all that is needed is the extraction of the relevant information from the service delivery points and the leadership necessary for this.
- There are capacity gaps in joint monitoring and evaluation; the different sector heads are not adequately sensitized in the need and mechanisms for joint monitoring of HIV/AIDS activities. As a result, existing systems are ad hoc and information shared in the routine technical planning committee meetings does not include review of targets for HIV outputs and outcomes.
- Challenges in operationallising this information loop can be summarized in four questions:
    1. *How do we get the HIV Focal person to actively seek out this information and leverage the input from the different sectors?*
    2. *How do we get the different departments and the stakeholders within the sectors to collate the information from routine activities and fill out their section of the report on a regular basis?*
    3. *How do we get the district to conduct periodic surveys for indicators that are not routinely collected, especially on the outcome indicators?*
    4. *How do we get the DAC to meet regularly, to own the information and to use this information for planning?*
    5. *How do we get this information effectively shared with sectors, partners, ministries and the UAC?*

Whether these challenges actually affect PMMP Operationallisation at the district level shall be evaluated in the district visits.

3.2.4 Sourcing the PMMP Outcome Indicators at the District Level

None of the district level outcome indicators are provided in any of routine information management systems existing in the districts. An assessment of these indicators shows that in order for districts to be able to capture this information, the following data collection activities need to be institutionalized:

1. Periodic surveys on KAP at the community level
    a. Behavioural Indicators
    b. STD Indicators
2. Special surveys for PHAs (Indicators for Care and Support of PHAs)
3. Special surveys for Orphans (Indicators for Care and support of orphans)
4. Collation of information from the PMTCT reports

Challenges in sourcing the District level Outcome Indicators

- None of the outcome indicators are captured in routine information systems and they require re-orientation of the district system and the particular focal persons to be able to provide this information
- The majority of indicators require special surveys and none of the districts visited conducts these surveys regularly
- The sources of funds for these surveys was not clear in these districts visited; districts reported that they have the technical capacity but do not have the funds to conduct the surveys
- The assessment team also has the concern that if each district develops their own protocols, the quality and consistency of surveys may be compromised.

3.2.5 The UAC plans to support districts

The Uganda AIDS Commission is clear in its recommendation that establishment of a monitoring system should be based on information systems that are already in the districts and not by setting up parallel reporting systems. Therefore, the tool should only be used in extracting information that has been collected using other existing mechanisms in the districts, and the information should be used primarily for planning.

To improve capacity for data management and use, the UAC is planning to mentor the districts and establish a HIV/AIDS data base. Once the quarterly monitoring information has been collected, it should be used to update the data-base, and discussed in the DAC. After the DAC deliberations, an up-date of the monitoring information should be sent to the line sector ministries and as well copied to the UAC.

3.2.6 Recommendations on what needs to be done to operationallize HIV monitoring activities in districts

Recommendations on District Level Output Indicators

1 Our evaluation of the 50 output indicators and the Outcome Indicators for monitoring the district response, and the draft 'collation tool' developed by the UAC indicates that in order for this information to be successfully extracted routinely, there are four main stakeholder departments that should be brought on board in completing the quarterly sector progress reports in the districts:

1. The District Health Office
2. The District Education Office
3. The District Community Based Services Office
4. The District Planning Unit and Administration

The HIV Focal persons should focus on these four departments in order to pool the minimum information required for monitoring the district level outputs

2 With regard to providing specific information on each of the indicators, our analysis indicates that there is a minimum of 15 core officers or focal persons required for all the different pieces of information contained in the Quarterly Sector Progress Report to be filled. These are:

a. *Under the District Health Office*
   i. The District Health Educator*
   ii. The District HMIS Focal Person*
   iii. The District TB/Leprosy Supervisor*
   iv. The District PMTCT Focal Person*
   v. The District HCT Focal Person*
   vi. The District ART Coordinator*
   vii. The District Condom Coordinator

b. *Under the District Education Office*
   i. The District Inspector of Schools*
   ii. The District Education Officer

c. *Under the District Community Based Services Office*
   i. The District Community Based Services Officer*
   ii. The District Probation and Welfare Officer

d. *Under the Office of the Chief Administrative Officer and the District Planning Unit*
   i. The DHIVFP* (regardless of which department they are attached to, they require a close linkage with the planning unit and administration)
   ii. The District Planner
   iii. The ACAO in-charge of health*

The HIV Focal persons should link up with these persons in a quarterly basis, with a reporting blank, to solicit for the required monitoring information.

3 We recommend an 'active surveillance approach' in which the above team of resource persons actively seeks out this information from the relevant sectors on a periodic basis, from available information sources. The district HIV Focal Person should make a quarterly round of visits to all the critical officers, to seek their input into the report.

4 For indicators that do not currently have a mechanism for routine information collection, districts should develop a strategy for establishment of the information systems required for collection of this information, guided by the UAC M&E team.

5 Once the quarterly sector report has been completed, the DAC should then be called to discuss it, and thereafter the report should be shared with line sectors (especially the AIDS Control Programme, the Ministry of Gender and the Ministry of Education) and the Uganda AIDS Commission

6 As planned, the districts should be assisted to establish and maintain a data base of these monitoring reports, so that any agency seeking this type of information can access it easily. The data-base should be up-dated by the HIV Focal Person and should be part of the information systems in the District Planning Unit. Once established, the UAC should conduct a follow-up evaluation to assess how well the districts are generating and using monitoring information

7 In order for the information generation, use and sharing loop to be successful, there have to be key dates institutionalized for these events: *key dates for completing the tool on a quarterly basis, key dates for discussing the information in the DAC, key dates for sharing this information with the sectors and key dates for the sectors to share the aggregated district information with the UAC.*

8 Because the UAC is a major stakeholder in monitoring the district response, all districts should send a copy of their monitoring reports to the UAC at the time they send the report to the line sectors.

9 There is need to train a critical number of the key stakeholders in monitoring the district level response. Details of this are described in the training plan.

Recommendations on District Level Outcome Indicators

10 District HIV Monitoring teams should be oriented on how to measure HIV related outcomes

11 Districts teams should be trained on how to organize and conduct behavioural and access surveys

12 The different periodic surveys expected at the district level should be integrated into one survey, conducted after every 2 ½ years

13 Districts should be given technical support in the development of standard guidelines and protocols, so that information generated from districts surveys in credible and consistent across districts.

14 Districts need to be guided on how they can raise funds for these surveys, budget for them and make them a routine information management tool in their medium term planning cycles

4.0 Monitoring the Civil Society Response

4.1 National Level ASOs

There are many national level ASOs running HIV/AIDS services that are preventive, curative or rehabilitative. By the nature of their scope of work, many of these agencies generate significant amounts of service delivery data – some of them even have a network of district or regional branches. However, the mechanisms for integrating this data into the public health information systems are largely inadequate. The UAC itself argues that its main focus is on districts and sectors and not ASOs. However, because these agencies are responsible for a significant portion of AIDS service delivery in the country, excluding them from the aggregated outputs generated from the districts would imply significant undercounting of the overall response – even if the district output indicators are mainly meant for the districts to monitor their own response, ignoring the outputs from ASOs – especially the national level ASOs would significantly undercount the force of the national response at output level. Yet our assessment indicated that there were no clear mechanisms to coordinate these agencies, let alone to standardize the kind of reporting mechanisms they use. According to the ACP Ministry of Health, some of these agencies provide summaries for specific outputs to the vertical programmes in the ACP; examples of these include ART services (for agencies affiliated to the national ART Programme) and VCT (for those affiliated to the national VCT programme) – others do not. In general, CSOs generate many other outputs that could be equated to those expected from the districts e.g. some are involved in PMTCT, others in IEC/BCC, Life Skills education, in and out of school and orphan care and to ignore them would imply that the observed response is weaker than the actual response – a lot of the HIV interventions in the country are run as vertical programmes in the PNFP sector.

4.1.1 Description of the context in selected National Level CSOs

The diverse characteristics of these agencies are summarized in our assessment of six such organizations:

TASO

TASO is a national level ASO with 12 service delivery centres, including a training unit. Their service delivery scope includes treatment, care, support and preventive activities. They collect a large amount of data at their service centres and all aggregated information is channeled to the head-quarter. They reportedly have over 20 reporting tools specifically designed for their services and do not use the national reporting tools. According to the Key Informant we spoke to, their data collection system is 'fairly reliable'. Apart from generating the reports, there was evidence that they used this information for planning, resource mobilization and advocacy. In terms of reporting, they often prepare reports that aggregate the information from different centres and programmes. According to them, they *'report to any person who relates to them'*. TASO reports that there was a 'one-off' request from the UAC in form of an e-mail that asked for a list of service delivery outputs to be provided; however, this was a one-time event and these requests have not been repeated since. On the other hand, the vertical programmes in the ACP have been seeking specific information routinely, but by telephone e.g. number of people that received ART. TASO reports that a person from the ACP often calls them and requests for an itinerary of outputs – These communications are mostly informal and information is given over the telephone. It seemed to us that the ACP could obtain a more comprehensive dossier of service delivery information if they actively sought it.

They noted that since the agency is almost purely donor funded, they have no obligations to report to the public MIS and vertical reporting mechanisms but are willing to give information to anyone who needs it. TASO notes that they provide regular reports to their donors *(a long list of ADPs including CDC/PEPFAR/MEEP for the ART programme only, DANIDA, Global Fund, the Civil Society Fund-CSF for the palliative care programme only and USAID for the preventive programme only)*.

However, each funder received a report covering outputs for only the project they fund. The reports are also mostly in form of summaries.

According to TASO, the ADPs to which they submit this information are better placed to provide feed-back to the sectors and to the UAC in case they needed the information. TASO also notes that for organizations that receive funding through the Civil Society Fund, the UAC has a direct mandate to receive monitoring data from them because it is the one that coordinates the fund.

JCRC

The JCRC is a parastatal agency involved in providing the entire range of HIV/AIDS services except for PMTCT. At the JCRC head-quarters, they provide care and support, VCT, ART and adherence monitoring, training, IEC and other preventive activities. The JCRC also runs five regional centres of excellence attached to the Regional Referral Hospitals. They provide care and treatment facilities, laboratory services and VCT. In addition, there are several district level health facilities affiliated to the JCRC. These are public or PNFP facilities that provide care and treatment for PLWHAs. The service delivery points collect routine treatment information from patients, using a general patients' tool *similar to that used by the MoH line facilities*. In addition, they run registers in different categories, including Pre-ART, ART, VCT in the VCT supported sites and referral forms: *In all these, the JCRC uses similar registers to those used by the Ministry of Health* and this is one major point of difference with other agencies in the same category. The sites are often required to provide monthly reports, which are then aggregated into semi-annual reports. However, the key informants we talked to noted that the monthly reports often incomplete and untimely. Supported health units in the districts are required to report through routine HMIS in their districts, but they also send summaries to the centres of excellence and then to the head-quarters. JCRC reports mainly cover the area of care and treatment (especially ART).The head-quarter prepares bi-annual and annual reports that are sent to the donors and to key partners. They reportedly send bi-annual reports to the AIDS Control Programme of the Ministry of Health, disaggregated to indicate data from the Centres of Excellence (TREAT and Cash and Carry Categories) and that from government health centres supported by the JCRC. The purpose of the disaggregation is so that there is no double counting of clients as a result of the fact that the district level supported health units also report through the HMIS and the vertical reporting systems of the MoH ART programme. However, there are also problems with over-counting patients who change treatment plans from the MoH system to JCRC and vice-versa. The JCRC notes that reports from its centres of excellence are of good quality and are timely and accurate. However, reports from the supported health units have variable quality and most of them are not timely – it is for this reason that the JCRC changed its policy from quarterly reporting to bi-annual reports. On the other hand, the JCRC sends a summary report to its funders (PEPFAR) under their MIS the MEEP. According to the JCRC, other partners can then access the information from the MEEP.

The AIDS Information Centre

The AIC is mainly involved in prevention and VCT activities, as well as post-test mitigation activities. They run eight branches in different parts of the country. However, under a memorandum of understanding with the Ministry of Health, they also provide support to about 169 affiliated health centres. Their reporting relationships mirror those already described for the JCRC.

The Inter-Religious Council of Uganda

IRCU is a secretariat that brings together 5 main religious denominations for a common cause of fighting and prevention of HIV/AIDS. IRCU works as a coordination platform to spearhead its country wide activities through 2 main programs, one of which is the HIV/AIDS programme. This programme runs activities in 3 thematic areas namely prevention, care & treatment, and psychosocial support of OVC. The HIV/AIDS programme activities are spread in 32 districts and are conducted through identified faith-based health facilities. IRCU collects routine information on all 3 thematic areas using

specifically developed tools. At district level, IRCU has trained and pays two focal persons whose responsibility is to manually complete the data registers on a monthly basis.
IRCU has a well designed data collection system where all the data from the 32 districts is entered and collated centrally at the IRCU secretariat. The collated programme data is transferred into a database that was developed by MEEP. A report is generated semi-annually and sent to USAID, PEPFAR and any other interested stakeholders. It was pointed out that reports are not routinely shared with the MOH or the UAC except on request. IRCU only focuses on reporting deadlines of the donor agencies from which their funding support is obtained. However, they expressed great willingness to share any data they generate with both the UAC and MOH if requested.

IRCU faces difficulties in motivating the staff at the health facility to collect the data they need Sustainability of the financial incentives for the staff to collect and complete data in a timely manner is a potential challenge in the absence of donor funding. To overcome this challenge IRCU has started to solicit the local support and contributions of participating religious groups towards this cause. Like TASO, the IRCU notes that information from national level CSOs should be accessed through the donor run information systems, to avoid dual reporting (for the IRCU, it should be through MEEP)

National level networks that coordinate other service providers

There are also some national level agencies whose role is to coordinate networks of service providers in different constituencies. Some of these include:

a. ***UNASO:*** This is a national network of AIDS Service organizations operating at the national and district level. It exists to coordinate, represent and build capacity (organizational development) for the ASOs as well as to provide advocacy and raise concerns on their behalf on issues concerning them. At the district level, they have district networks of ASOs, and there is usually one lead ASO as a point of contact. Membership is by registration. The networks current coverage is country wide, although organizational structures have been set up in 43 districts. Some of the newer districts are still part of the older districts. Member ASOs are involved in diverse HIV related activities, but mostly in prevention, care and support. The network only admits registered CSOs. In Uganda, CSOs are supposed to be registered either at the national level (NGOs) or at the district level (CBOs). To-date, the network as 1,693 member organizations, 60% of which are CBOs. UNASO does not collect routine service delivery data from organizations. It only maintains a resister of member organizations showing 'who does what where?' In addition, it collects information on organizational capacity and capacity building activities.
b. ***NAPOPHANU:*** This is a national network of ASOs involved in mitigating the issues of People Living with HIV/AIDS. Like UNASO, it is also a networking organization and does not collect or aggregate service delivery data. It keeps a register of member organizations and provides advocacy and capacity building services.

4.1.2 Summary of challenges in coordinating National Level CSOs

According to several Key Informants, and especially the ACP/Ministry of Health, the coordination of information from these organizations is liable to a number of challenges because:

1 They are often structured differently, both organizationally and in terms of service delivery
2 Some of them have branches in districts or at regional levels; in such arrangements, some agencies provide reports through the district health system, while some do not; others provide reports to the District Health Offices, but also send a summary of their aggregated outputs to the ACP/MoH.
3 National level ASOs tend to provide reports only in form of summaries, in diverse formats, making their integration into national information systems difficult, and disaggregation impossible

4 Many of these agencies have complex bureaucracies; even with the current policy on collaboration with the PNFP sector, many are largely autonomous; they often have agency specific procedures, sometimes driven by the funders; we noted that many of these agencies channel their reports for specific service delivery outputs to specific Management Information Systems run by the respective funders. Examples of the funders include USAID, DANIDA, Irish Aid, PEPFAR and CDC; examples of the respective MISs include MEEP and the CSF system.
5 Some of them have multiple funders, each covering a specific project in their service delivery spectrum, and each requiring a different approach to reporting.
6 Because of the project nature of their work, some of their activities vary from year to year, although they often have some core activities
7 Even for vertical programmes that have a monitoring and coordination desk within the ACP or other relevant sectors, some of these agencies use the official forms used in the vertical reporting mechanisms for these programmes; e.g. some of the agencies use the official ART reporting forms while others do not; in addition, compliance to reporting varies from regular in some agencies to no information shared at all; some say they run their own ART programmes, not part of the national response; some report monthly, others quarterly, and others once in 6 months or less frequently.

4.1.3 Recommendations on Integrating National Level CSO into the M&E Loop

1 Formation of a national committee for these agencies; the committee should include the ADPs to which their information flows; the committee can be used to coordinate their activities and to promote negotiations and information sharing; many key informants note that it is within the mandate of the UAC to cause this coordination mechanism. It is through this mechanism that the UAC can leverage a common approach to reporting. The UAC and MOH should convene a meeting with the major national level CSO to agree on the modalities for capturing data from the CSO as part the monitoring of the national response.
2 Much as NGOs are being funded by ADP, they have a duty to be accountable to their line sectors at national level. National level CSOs should therefore be engaged to report to their line sectors and there ought to be a national level policy and deliberate action within the Ministries to develop this information loop
3 For national level CSOs that run district level operations, reports for the district level service delivery points should be channeled to the District Health Offices and the aggregated reports should clearly indicate to the Ministry of Health the part of their outputs that was reported through the district system and the part that was not

4.2 District Level ASOs

4.2.1 Description of the context

At the district level, there are many organizations, of various sizes, and many of them are not officially monitored by the DACs. However, UNASO recommends that all AIDS related CSOs operating service delivery points at the district level (including CBOs) should be appropriately registered by the district authorities. UNASO also recommends that for those agencies that have the capacity 9e.g. those running health units), there should be a reporting mechanism that connects them to the District HIV Focal person, and to the HMIS in the District Health Office. However, this is not occurring because the coordination of HIV/AIDS services in districts is still poor according to UNASO.

Based on their experience operating in districts, UNASO observes that the general status of HIV/AIDS coordination in the districts in poor. UNASO notes that most DACs and DATs only exist in writing and they do not meet at all. In many districts, the DAC is viewed as separate from the District Technical Planning Committee, yet a large part of their membership is similar. However, the biggest challenge facing districts is in operationallising their broad mandate for service delivery – districts are often lax

in creating an organizational vision for their activities and do not appear to 'own their HIV intervention'. Focal persons are often ill-supervised and are not checked for outputs. In many cases, this cannot even be done because their duties and responsibilities have not been stipulated as part of their terms of service. All these gaps are attributed to three gaps: lack of capacity, lack of commitment, and inadequately developed systems. In addition, UNASO observes that because of the previous project models that arose as a result of the MAPs and CHAI Projects, districts developed a mentality that HIV/AIDS is a Uganda AIDS Commission issue and always expected vertical funding for these activities and when these projects closed, the DACs became dormant – these clearly points to low perceived ownership of their response. UNASO even suggests that if resources were available, a full position of HIV Focal Person should be created in the civil service structure of the districts, with a clear scope of work and terms of reference.

4.2.2 Recommendations on integrating district level CSOs into the M&E System

1. District level CSOs should be coordinated at the district, and therefore report their data and information through the district.
2. The UAC should work together with the ACP to develop a simple tool that can be used to capture key outputs from registered CSOs in the districts, on a quarterly basis. Otherwise, facility based CSOs should use similar reporting tools to those used by public facilities
3. In order for the monitoring information at the districts to be complete, there has to be strong and deliberate action to integrate district level CSOs into the Management Information Systems in the districts.

5.0 Summary

The proposed approach to operationallising the PMMP is tiered at three levels: Monitoring the National Response, monitoring the district response and monitoring the civil society response. This report presents findings from the assessment phase of the consultancy for support to the UAC in operationallisation for operationallisation of the PMMP.

At the national level, the Uganda AIDS Commission should identify contact persons in the seven agencies that are required to provide the up-date information on the 58 indicators and disseminate to them their scope of indicators. It should then hold negotiation meetings to come up with a common agreement on how these indicators will be up-dated. For indicators that require updating on an annual basis (e.g. those from programme reports), the UAC needs to work with the contact persons in these agencies to articulate a clear reporting mechanism and specify the reporting date as the 1st of July; for indicators that require national surveys that are predictable (e.g. the UDHS and AIS), the UAC should be part of the planning processes for these surveys to negotiate for inclusion of the indicators of interest and should establish a mechanism for up-dating these indicators once the surveys have been conducted. For indicators that require special surveys (e.g. MARPS or PHA Surveys), the UAC should negotiate with the responsible agencies on how resources can be mobilized for these special surveys to be conducted. In addition to these processes, the UAC should negotiate with the Ministry of Education and the Ministry of Gender, so that some PMMP output indicators can be incorporated into their sectoral MISs under development. There are also some indicators that need to be added to the HMIS and the UAC can take the opportunity of the planned review of the HMIS this year to negotiate for these. The UAC should appoint a liaison officer responsible for actively searching for up-date information from where it is expected. This officer should maintain a simple spread sheet that shows the current status of each of the indicators.

The UAC should also work with sectors to develop a 5 year schedule for indicator updates clearly indicating the date, month and year on which each indicator needs to be up-dated and disseminate it to the stakeholders. The UAC should also develop an automated spreadsheet that shows the status of each of the indicators, when it was last updated and when it is due for up-dating. The system should be able to raise a red flag when the indicator is out-dated. It should be maintained by the M&E coordinator. If data on an indicator is not available at the time it is scheduled to be updated, then the update should reflect the most recent estimate available and indicate that this information is not up-to-date. The recipient data-base should be able to indicate the due dates for each indicator, the date when they were last updated and if they are out of date indicate by how many months

At the district level, the UAC should press for uniformity in coordination of HIV services, so that a department or unit in the district is accountable for coordinating the multi-sectoral response, rather than an individual. To foster a multi-sectoral response, there seems to be agreement that the District Planning Unit should play an active role in providing the resources for coordination of HIV/AIDS activities, regardless of which department hosts the HIV Focal Person. The HIV Focal Persons should receive clear terms of reference and a scope of work, so that they are accountable; they should report to the District Planner, who then reports to the CAO.

The UAC should also build multi-sectoral M&E team in the districts, composed of a critical number of sector representatives that can collect the required monitoring information. Our assessment indicates that there are about 15 officers critical to completing the loop required to collate information for the 50 district level output indicators and the 30 district level outcome indicators. The UAC should therefore train at least 10 of these officers per district, and mentor them to develop an M&E strategy for HIV/AIDS in the districts. The strategy should describe mechanisms by which the

different stakeholder departments in the district will work together to complete the quarterly monitoring report and use this information for planning.

The UAC should also develop and disseminate an electronic interface that can help districts to translate the written reports into an electronic storage system and it should articulate a mechanism for information use as well as the stakeholders in the information sharing loop. If the district data-bases become credible, then Sectors shall be more included to tap into them. The UAC should conduct a series of trainings to cascade the capacity building process to all 80 districts – the training should be for 'district teams' rather than individuals, so that a multi-sectoral M&E alliance is created among sectors. The critical number of members on the district M&E teams should be about 6, representing the critical sectors involved in sourcing the required information. The UAC should then describe a mechanism of initial follow-up to the districts to support them.

Monitoring the CSO response is a larger challenge. There is consensus that District level CSOs should be monitored at district level and national level CSOs at national level. Mechanisms for tapping into their outputs should be developed – probably through a reporting tool. There is a realization that National level CSOs contribute significant promotion of the HIV/AIDS outputs and ignoring them may undercount key outputs. Yet coordinating them is an up-hill task because each agency seems to have its own processes and reporting lines. Since most of these agencies report to their funders, one mechanism for tapping into this information source would be to negotiate with the ADP-MISs for greater sharing of their aggregated outputs. However, mechanisms should be developed for national level CSOs to report to the line sectors, regardless of their reporting obligations to funding partners. Likewise, district level CSOs should be required to report to districts or a regular basis, so that their outputs are captured in their line departmental MISs in the districts.

Appendix 12: Operationallisation of the PMMP: Proposed Next Steps

<table>
<tr><th colspan="2">Activity</th><th>Guidance Notes</th></tr>
<tr><td>1</td><td>Break down the 58 outcome indicators by responsible agency at the national level</td><td>• Break down is available in the matrices of the final report</td></tr>
<tr><td>2</td><td>Develop a real-time timetable with dates for each national indicator</td><td>• Indicate real dates for a 5-year period</td></tr>
<tr><td>3</td><td>Identify focal point persons to provide information for each indicator in the relevant sectors</td><td>• In addition to sector focal persons, different indicators need to be provided by different desk officers; all of these should be identified</td></tr>
<tr><td>4</td><td>Package all this into a memo for each sector</td><td>• Develop a specific memo for each sector</td></tr>
<tr><td>5</td><td>Write officially to the Permanent Secretaries and Sector Focal Persons (Ministry of Health; Labour, Gender, and Social Development; Education and Sports; Local Government) and append the monitoring requirements</td><td>• The reporting and monitoring requirements need to be made formal</td></tr>
<tr><td>6</td><td>Hold meeting with Permanent Secretaries (Ministry of Health; Labour, Gender, and Social Development; Education and Sports; Local Government) to communicate UAC's position on monitoring</td><td></td></tr>
<tr><td>7</td><td>Hold meeting with sector focal persons to disseminate monitoring priorities</td><td></td></tr>
<tr><td>8</td><td>Hold meeting with sector HIV/AIDS monitoring team, Ministry of Health</td><td rowspan="4">• Develop sector action plans, showing how each indicator will be sourced (for the annual indicators expected from programmes, for the annual indicators expected from special surveys, for the indicators expected from national surveys)</td></tr>
<tr><td>9</td><td>Hold meeting with sector HIV/AIDS monitoring team, Ministry of Labour, Gender, and Social Development</td></tr>
<tr><td>10</td><td>Hold meeting with sector HIV/AIDS monitoring team, Ministry of Education and Sports</td></tr>
<tr><td>11</td><td>Hold meeting with sector HIV/AIDS monitoring team, Ministry of Local Government</td></tr>
<tr><td>12</td><td>Harmonization micro-planning retreat, Ministry of Health</td><td rowspan="4">• Ensure that all sectors describe how they will integrate all required indicators (or provide them if already integrated)
• Ensure that all sectors agree on the internal adjustments needed to incorporate all required indicators, from the primary data sources (should be guided by the indicator evaluation matrices in the final report)</td></tr>
<tr><td>13</td><td>Harmonization micro-planning retreat, Ministry of Labour, Gender, and Social Development</td></tr>
<tr><td>14</td><td>Harmonization micro-planning retreat, Ministry of Education and Sports</td></tr>
<tr><td>15</td><td>Harmonization micro-planning retreat, Ministry of Local Government</td></tr>
</table>

Activity		Guidance Notes
16	Develop a strategy by which UAC will update its own indicators that the PMMP assigned to it as the lead source	
17	Finalize central database at UAC	• Database developed by Infotronics should then be up and running
18	Set up sector databases	• The same database should be set up in the 4 sectors (MoH, MoGLSD, MOES, MOLG), with the Sector Focal Persons as the custodians • Database should cover both the national-level indicators and the district-level indicators
19	Set up district databases in the District Planning Units of 90 districts	• Similar databases should be set up at the district level but covering only the district level output and outcome indicators
20	Circulate reporting forms for sectors	
21	Circulate reporting forms for districts	
22	Communicate to district to plan for the training	
23	Conduct district-level trainings	• 12 people per district to form the district HIV monitoring team • Details of whom, how, when to train are provided in the final report
24	Follow-up districts to provide quarterly monitoring reports	• Generate the first district quarterly reports and validate them • Provide supportive supervision to District HIV Focal Persons and District Planning Units • Conduct annual meeting of District HIV Focal Persons • Monitor the quarterly reporting from districts for output indicators
25	Conduct annual meeting of Sector Focal Persons	
26	Monitor the sectoral reporting for national-level indicators, guided by the indicator update schedule	
27	Support sectors to support districts in line sector monitoring activities	

Activity		Guidance Notes
28	Meeting with MoH and UBOS to develop strategy for National Surveys (UDHS, Census, AIS)	• Ensure that all national-level indicators that should be sourced from these are included in protocols, with the needed level of disaggregation • Ensure that all UNGASS indicators needed from surveys are incorporated, with the required level of disaggregation
29	Meeting with MoH and UBOS to develop strategy for special surveys (PHA, Health Facility, Condom Availability, and MARPs)	• Agree on priority special surveys to be conducted (PHA, Health Facility, Condom Availability, and MARPS), how regularly, which ones can be merged
30	Support to sectors to mobilise resources, specifically for AIS	
31	Support to sectors to mobilise resources, specifically for special surveys	
32	Hold meeting of national-level CSO representatives	• Develop harmonization and reporting strategy
33	Develop standard LQAS protocol	• These activities are aimed at institutionalizing LQAS at district level
34	Disseminate protocol to District Planners and microplan with them for regularization of LQAS	
35	Mobilise resources for the first round of LQAS in districts	
36	Support districts in conducting their first LQAS and update the district-level outcome indicators	
37	Follow-up district planners to regularize LQAS using recourses available	
38	Develop guidelines and a form for district-level CSO reporting	
39	Hold meeting of Community-Based Services Officers and District Planners to disseminate guidelines for district-level CSO reporting	
40	Other activities as identified by UAC	