

Rose

DRAFT REPORT
OF THE
PUBLIC ACCOUNTS COMMITTEE
ON
THE LIRA SOCIAL AND PUBLIC
ACCOUNTABILITY
PILOT PROJECT



NOVEMBER 2005

LIST OF ACRONYMS AND ABBREVIATIONS

HIV	-	Human Immune Virus
AIDS	-	Acquired Immune Deficiency Syndrome
MPs	-	Members of Parliament
NGO's	-	Non-Government Organizations
CBO	-	Community Based Organizations
IDPs	-	Internally Displaced People's Camps
VCT	-	Voluntary Counselling and Testing Services
ARV's	-	Anti Retro-Virals
UNICEF-		United Nations International Children Emergency Fund
PAC	-	Public Accounts Committee

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1.0 Introduction

The Public Accounts Committee conducted a pilot study on social and public accountability monitoring of public funds in Lira District between 29th August and 4th September 2005. This pilot project was a follow-up to the poverty reduction-training programme for MPs, parliamentary staff and civil society leaders implemented by the Institute for Policy Alternatives, Tamale, Ghana, with support from the Canada Parliamentary Center.

The study was collaborative in nature involving the following:

1. Parliamentary Public Accounts Committee of Uganda
2. Development Network for Indigenous and voluntary Associations (DENIVA) OF Uganda.
3. Canadian International Development Association (CIDA) through the ambit of Canada fund for Africa (CFA).
4. Parliamentary Centre Canada (CPC)
5. Institute for Policy Alternatives (IPA).

2.0 Purpose of the Pilot

The pilot project was aimed at increasing Parliament's ability to monitor and evaluate government projects. This is in line with the Parliamentary Strategic Investment Development Plan (PSIDP) pillars of increasing accountability. Currently over 813 billion shillings is allocated for poverty alleviation by Government of Uganda.

The Public Accounts Committee conducted a survey on community assessment of poverty reduction initiatives with respect of accessibility to HIV/AIDS funds by the poor. The pilot initiative was geared towards social and public accountability

¹²monitoring of HIV/AIDS programmes in six communities of Lira District namely; Ireda, Erute, Railway quarters, Barr, Aloï and Pentecostal Church Camp.

Lira District is one of the Districts badly hit by rebel activity with many people living in camps making service delivery is difficult to monitor. The District therefore provides fertile ground for the pilot. Some camps like Aloï hosts up to 54,000 people.

3.0 Background to the Pilot

Many scholars and policy makers have globally labeled HIV/AIDS as the most daunting disease mankind has faced in this century. Several attempts have been made to curb the disease and it is one of the Millennium Development Goals (No. 6). In Uganda, the first HIV/AIDS case was identified in 1982 along the shores of Lake Victoria. Consequently the epidemic progressed very fast to a national prevalence rate of 18.3% with some centers registering prevalence above 30% by the end of 1992. It was also recognized that its magnitude and impact cut across all sectors of life. In response, the President of Uganda Y.K Museveni established a Presidential Initiative to curb the disease. The Government also reviewed the PEAP to strengthen HIV/AIDS intervention by adopting a multisectoral approach to control the disease and the prevalence rates have therefore dropped to below 8 percent over the last decade due to national prevention and education strategies.

Uganda Aids Commission (UAC) was also established in 1992 by an Act of parliament to oversee and coordinate the multisectoral efforts to ensure focus on a common goal through a harmonized approach.

Currently all Government ministries and Local Governments, several local and international NGOs, FBOs, CBOs, bilateral agencies and the United Nations

have developed and/or support HIV/AIDS programs targeting different issues of the epidemic in the country. Considerable resources have been channeled to combat the epidemic making it imperative for the committee to evaluate the extent to which the poor accessed the services.

4.0 Objective(s) Of the Pilot

The objectives of the pilot study were to:

- Assess the HIV/AIDS policy in Uganda.
- Assess the level of awareness on HIV/AIDS prevention policies.
- Establish the opinion of community members on the HIV/AIDS health care provision by the Government.
- Inform the community about their entitlement with regard to HIV/AIDS health care provisions.
- Provide an interface between the service providers and the communities in regard to HIV/AIDS activities in the district.
- Disseminate the results to policy makers, Parliament and other stakeholders.

5.0 Methodology

The implementers used two social and public accountability tools namely; the Citizen Report Card (CRC) and the Community Score Card (CSD). The CRC and CSC are participatory surveys that solicit user feedback on the performance of public services. They are a mimic to the private sector practice of collecting consumer feedback and applying it to the context of public goods and services. Most accountability mechanisms for public agencies focus on expenditures rather than outcomes such as literacy and mortality. To be effective, traditional public accountability systems need to be strengthened through innovative approaches

that involve public participation. These methods emphasize immediate feedback and reform and are highly flexible and adaptive.

In light of the above the CRC was used to solicit user feedback on the performance of HIV/AIDS programs in the four communities of Lira which fall in the urban and peri-urban setting. Thirty (30) structured questionnaires were used in each of the six communities totaling to 180.

The CSC was also used to enhance civic engagement in the six communities within the ambit of a rural setting. This tool was used to generate qualitative data and score performance of service providers. Indicators were generated and later ranked by the community members.

6.0 Data Collection

- The implementation process began with the identification of Research Assistants, Interpreters and the six communities in Lira district. Two communities each represented the urban, the peri – urban and the rural settings.
- Pre-training activities for the Research Assistants and Interpreters on processes and tools to be used for community engagement was undertaken.
- Supply side data was collected by the researchers and Members of Parliament from: Ministry of Health District Politicians; Civil Servants; the Resident District Commissioner (who is the Central government Representative in the District); the Medical officer who is also the District Director for Health Services (DDHS), the Medical Superintendent of Lira Regional Referral Hospital; the Pharmacist, the Laboratory Technical Officer, the Senior Nursing Officer (Sister) and other Medical Practitioners..

- This was followed by the validation of the supply side data through discussions with the community. Questionnaires (the CRC) were generated from the data gathered. These questionnaires were pre-tested before they were finally administered.
- The community Score Card commenced after the CRC questionnaires had been administered to respondents. Community voices were also recorded as part of the community score card.
- Information gathered from the above was processed/analyzed and presented during an interface session between the service providers and representatives from the six communities. During the meeting both parties expressed their views about the report and these concerns have been considered in the observations and recommendations at the end of this report.
- The findings have been processed into a report by the Public Accounts Committees and disseminated using various approaches including debate in Parliament, workshops, community meetings, advocacy by civil society groups as well as electronic and print media. Thereafter, efforts will be made to institutionalize the method.

7.0 HIV/AIDS ACTIVITIES IN LIRA

Implementation of HIV/AIDS activities in Lira is based on a sectoral approach, initiated by the Uganda Aids Commission (UAC). The co-ordination mechanism in the District is vested in the District HIV/AIDS Committee (DAC), for technical co-ordination and the District AIDS task force, for political co-ordination.

District implementation is being guided by the National Strategic Framework for HIV/AIDS (2001-06), which aims at:

- Prevention of further spread of HIV/AIDS
- Mitigation of the Health and Social – Economic effects of HIV/AIDS
- Building a firm national capacity to respond to HIV/AIDS

The district is currently implementing three programmes namely:

- The Uganda HIV/AIDS Control Project (UACP)
- The AIDS / HIV integrated Model District Programme
- The Uganda Programme for Human and Holistic Development (UPHOLD)

7.0 Research Findings

7.1 Findings Based on the Citizen Report Card

a) Background information on respondents

(i) Sex of respondents

Female respondents constituted 49% while the male were 51% (**chart 1**).

(ii) Marital Status

57% of total respondents were married, singles constituted 21%, widowers 12%, the widowed 9%, and divorced 2%,

(iii) Education

53% of the respondents attended primary school education, 27% did not attend school, 17% attended ordinary level, 1% attended high school and 2% other tertiary education (**Chart 3**). These statistics imply that most of them understood the questionnaires which were administered in both English and the local language.

(IV) Occupation

58% of the respondents were peasant farmers, 12% were farmers, 5% business people, 8% unemployed among others. This gives a picture of the kind of people leaving in both urban and rural camps in Lira, Uganda.

(b) Awareness

100% of the respondents had heard of HIV/ AIDs .66% of the respondents know how to access information on HIV prevention **(Chart 6)**. 42% of the people felt the hospital was the right place to get information.

67% of the respondents understand what Voluntary Testing and counseling Centres are **(chart 7)**.90% of the people know that AIDS/ HIV is not curable **(Chart 4)**. 91% know methods of preventing HIV/AIDs. Faithfulness, Abstinence and use of condoms scoring 27%, 24% and 23% respectively **(Graph 3)**.

(c) Sources of information on HIV/AIDS prevention

Radio, Health workers and places of worship were most popular with 30%, 17% and 15% respectively. Local leaders and workshops scored 7% and 9% respectively **(graph 2)**.

(d) Voluntary Counseling and Testing Services

67% of the respondents have knowledge on voluntary counseling and testing services. 50% of the Voluntary Counseling and testing Centres are less than 4 kilometers away **(graph 4)**. 49% of the respondents know the exact services offered at Voluntary testing Centres.

(e)Efforts in fighting HIV/ AIDs

65% of the respondents are aware of the efforts to provide HIV/AIDS health care services in the locality. NGOs and Government are the leading providers of HIV health care services with 45% and 32% respectively **(Graph 5)**. Churches and mosques provide 12% of health services according to the respondents. Counseling, prevention methods and testing are the main services provided in most health centers.

(f) Government efforts in fighting HIV/AIDs

7% felt Government had done a very good job, 36% were of the opinion that Government has done a good job in fighting Aids while 34% felt Government had done a fair job. Only 6% of the respondents felt Government had done a very poor job (**Graph 6**).

(g) Variety of Services provided at Government Aided Health Centres

22% of the respondents were of the opinion that HIV counseling was provided at the local health care center in the locality. 24% of the respondents felt health care centre was for HIV/aids prevention methods. Only 2% of the respondents were of the opinion that anti- retro viral drugs could be provided at the Centres.

(h) Provision of HIV/ Aids services by government

29% of the respondents were of the view that Government provided mainly testing services at the health facilities. The same proportion was of the opinion that Government provided counseling at the health Centres. 36% and 23% of the respondents respectively were dissatisfied with the provision of anti- retroviral drugs and counseling services. In general 60% of the respondents were dissatisfied with the provision of health services by Government.

(i) Perceptions on HIV/ AIDS

98% of the people agreed that they had been affected by HIV / Aids in one way or another (**Chart 9**). 59% had lost relatives while 8% had lost spouses.

100% are of the respondents were of the opinion that HIV /AIDS patients should be given care like any other patient. 53% of the respondents have actually cared for AIDS victims

7.1.2 Charts and graphs

Chart 1: Sex of respondents

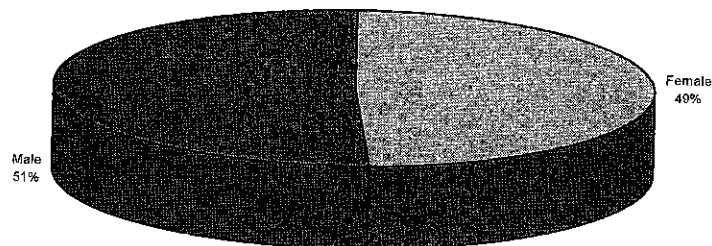


Chart 2: Marital status of respondents

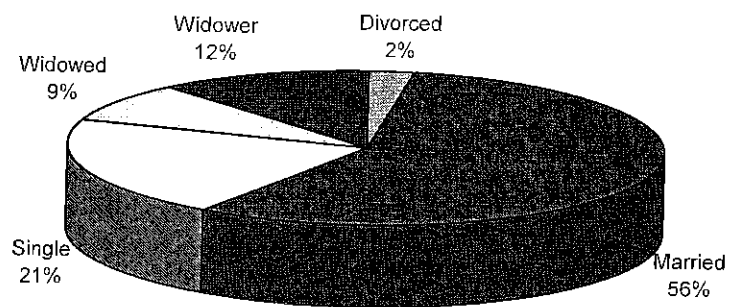
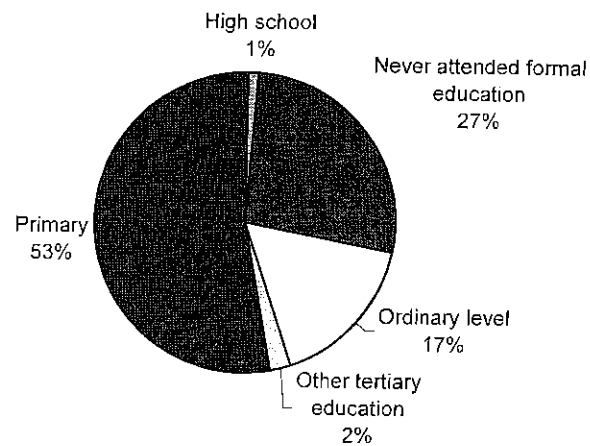
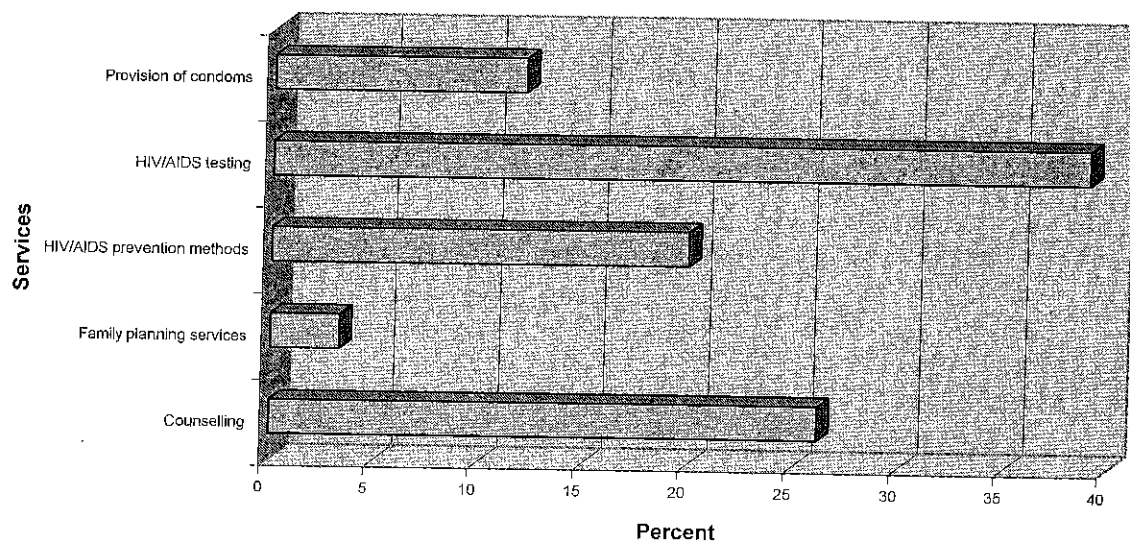


Chart 3: Highest education level attained by respondents



Graph 1: Services offered at VCT centres



graph 2: Sources of information on HIV /AIDS

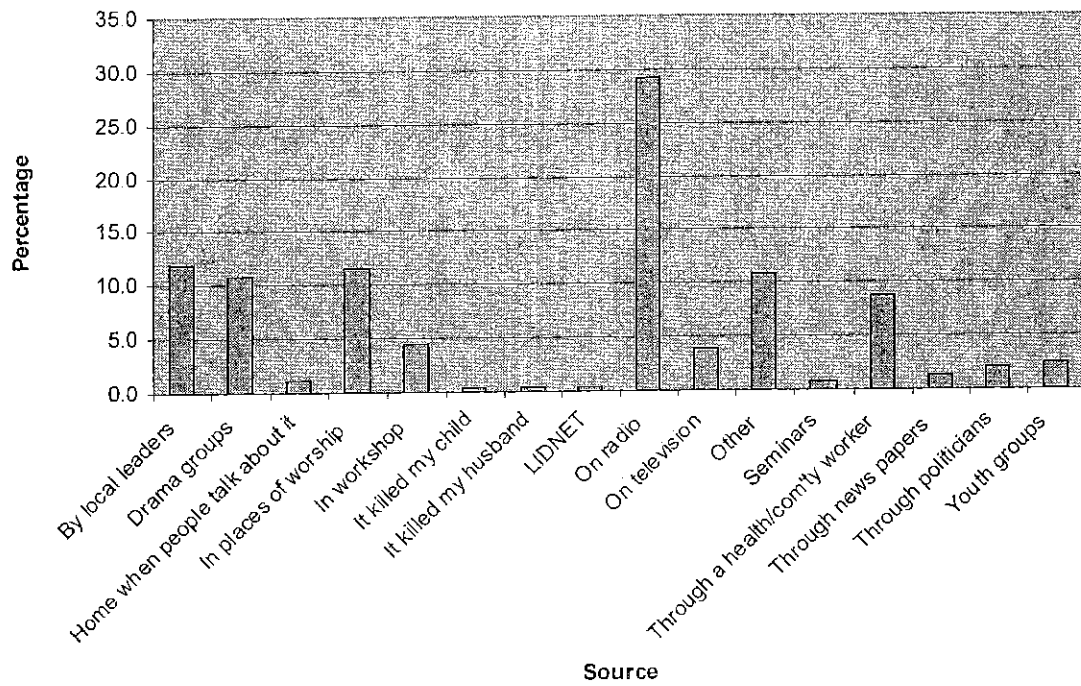


chart 4: knowledge on whether HIV/AIDS is curable

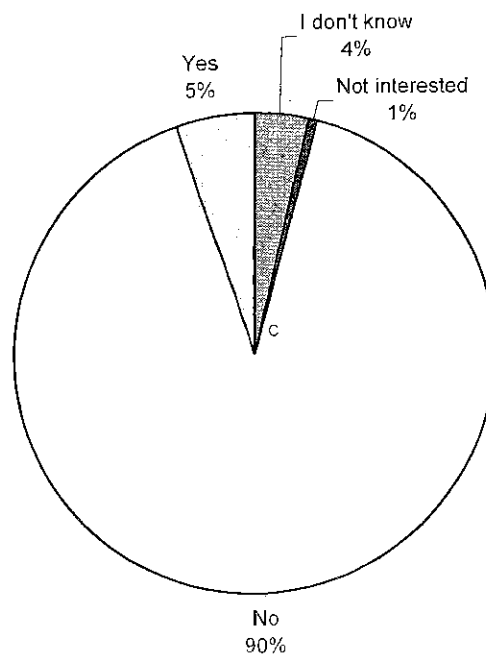


chart 5: Awareness on availability of HIV/AIDS health care services in the locality

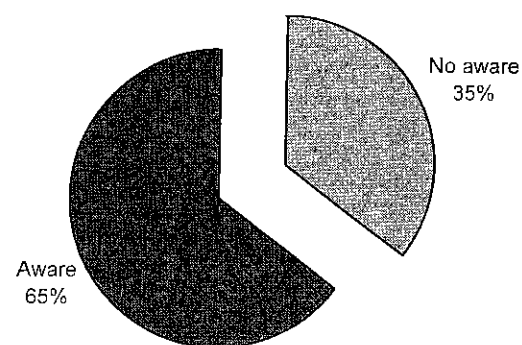


Chart 6: Knowledge of HIV/AIDS information

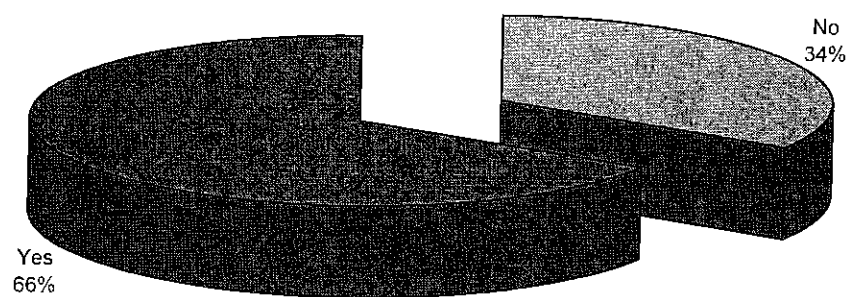
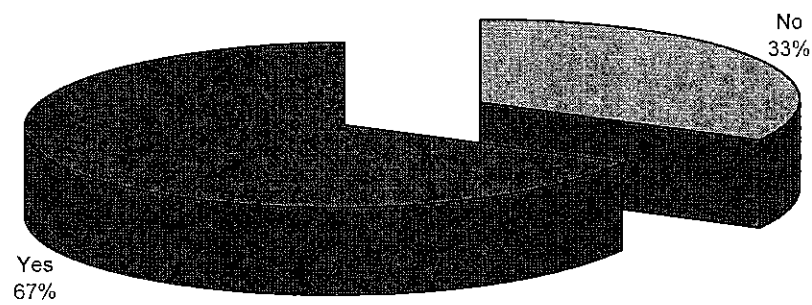
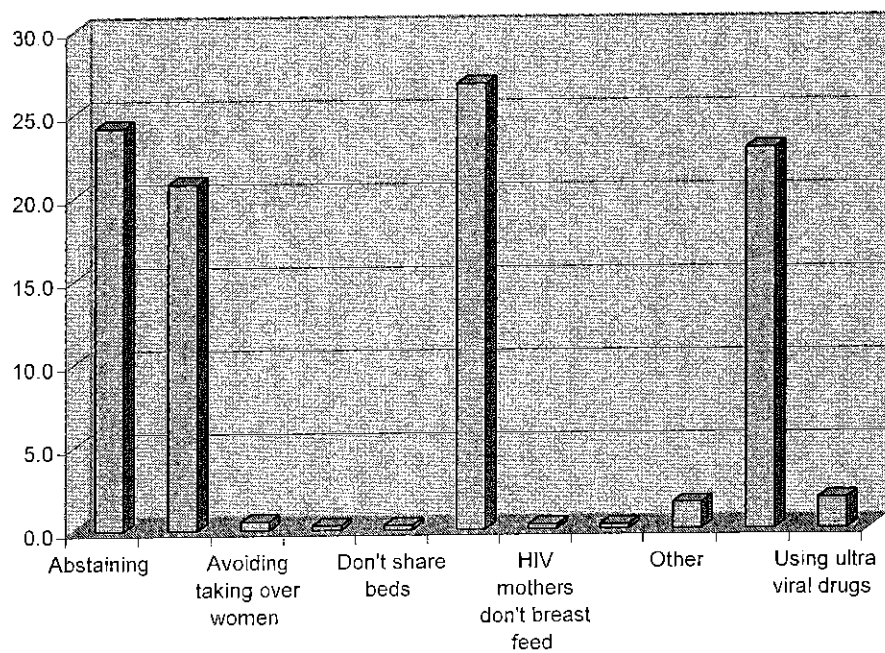


Chart 7: Knowledge on voluntary counseling and testing services



Graph 3: Methods of HIV/AIDS prevention



Graph 4: Distance to nearest VCT centre

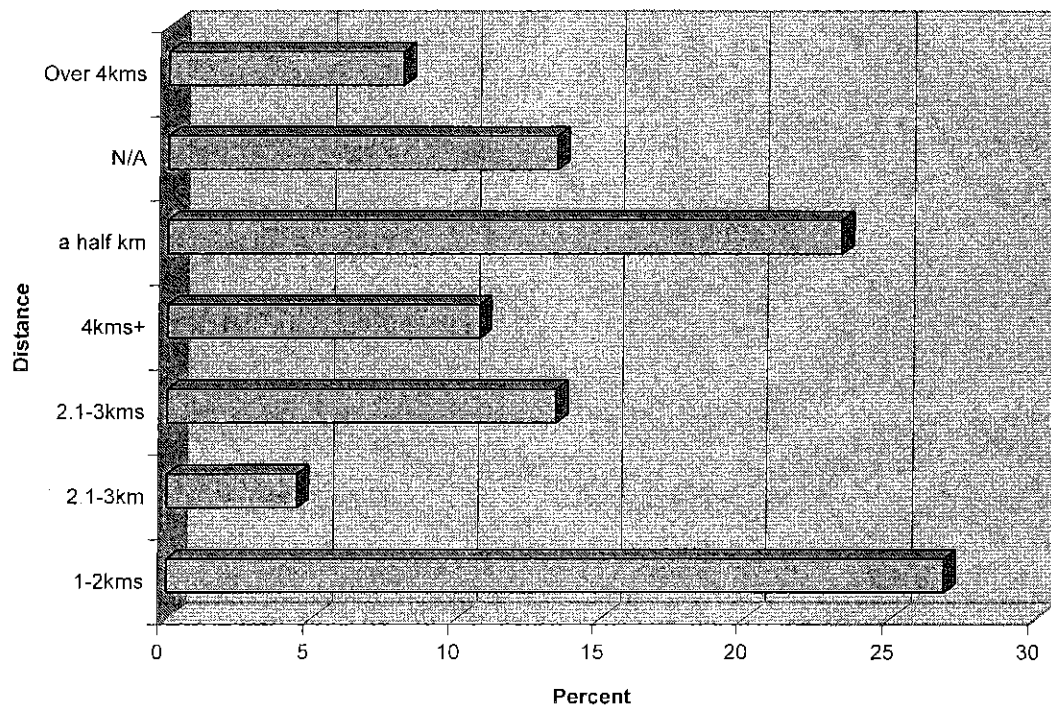
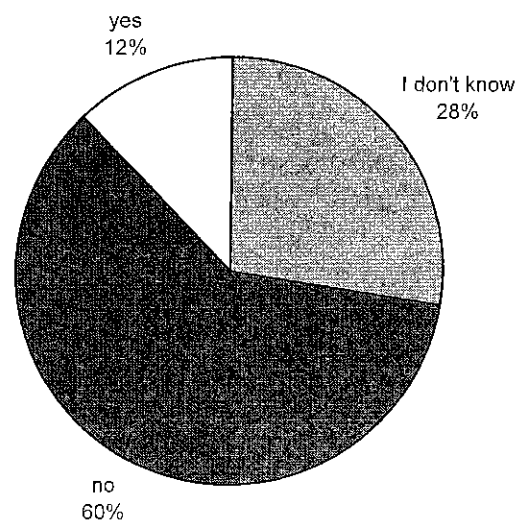
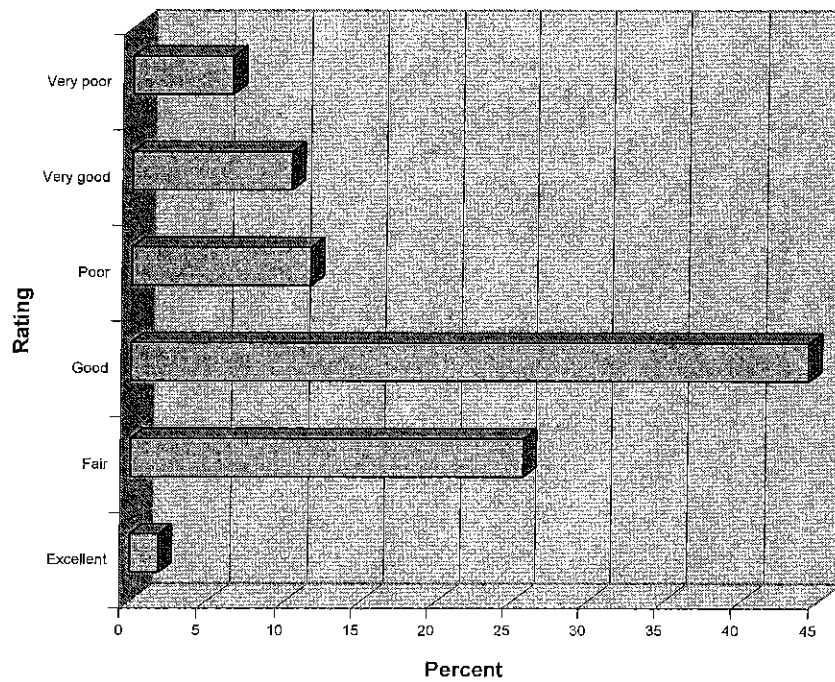


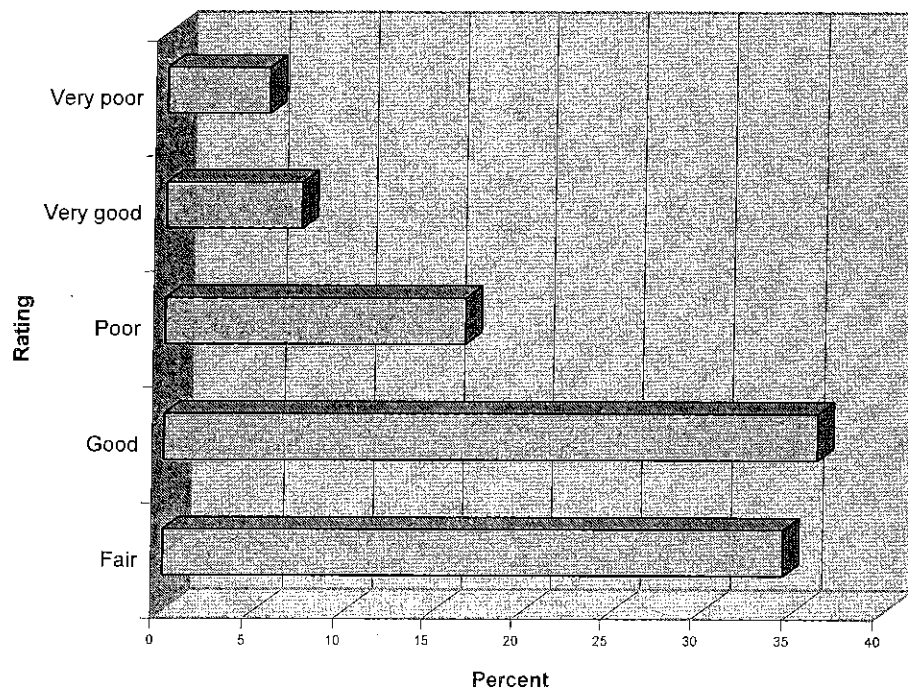
Chart 8: Sufficiency of HIV/AIDS services provided at Government health centres



Graph 5: Rating Government efforts in creating awareness on HIV/AIDS



Graph 6: Rating Government efforts in the fight against HIV/AIDS



Graph 7: Comparison of efforts in the fight against HIV/AIDS

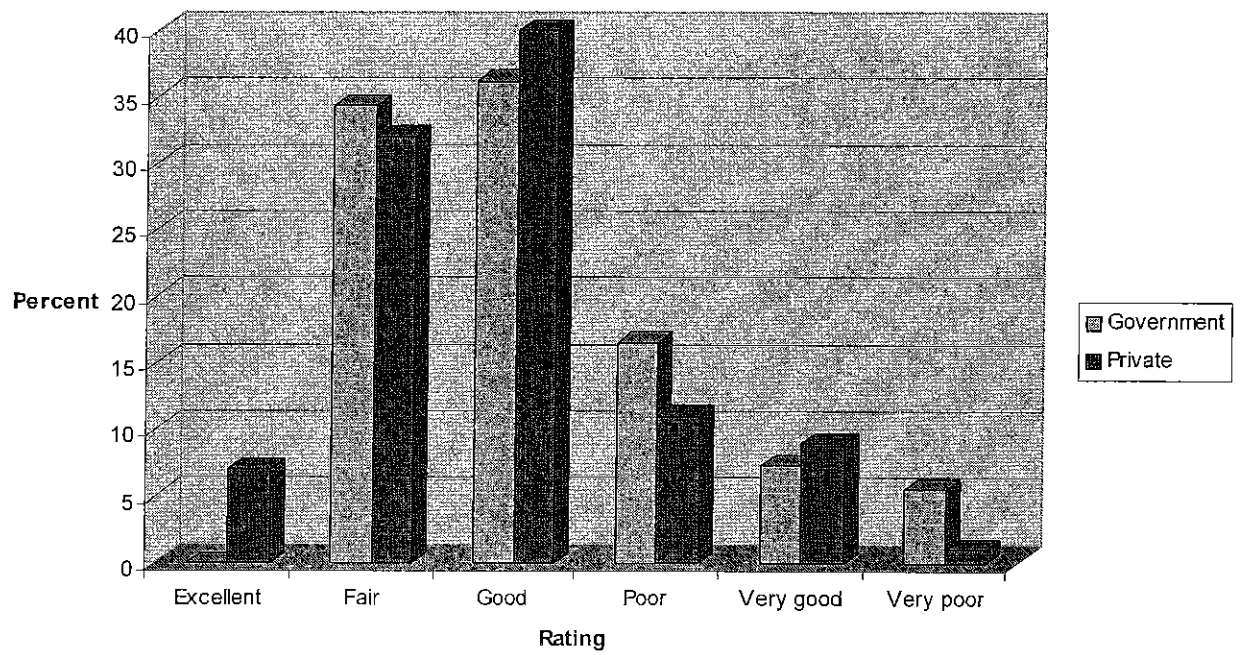


Chart 9: Respondent has Been affected by HIV/AIDS

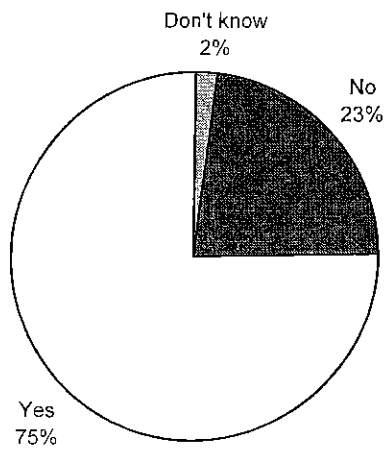
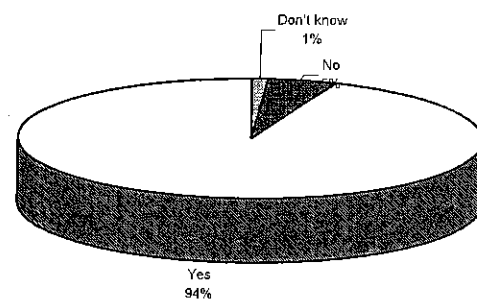
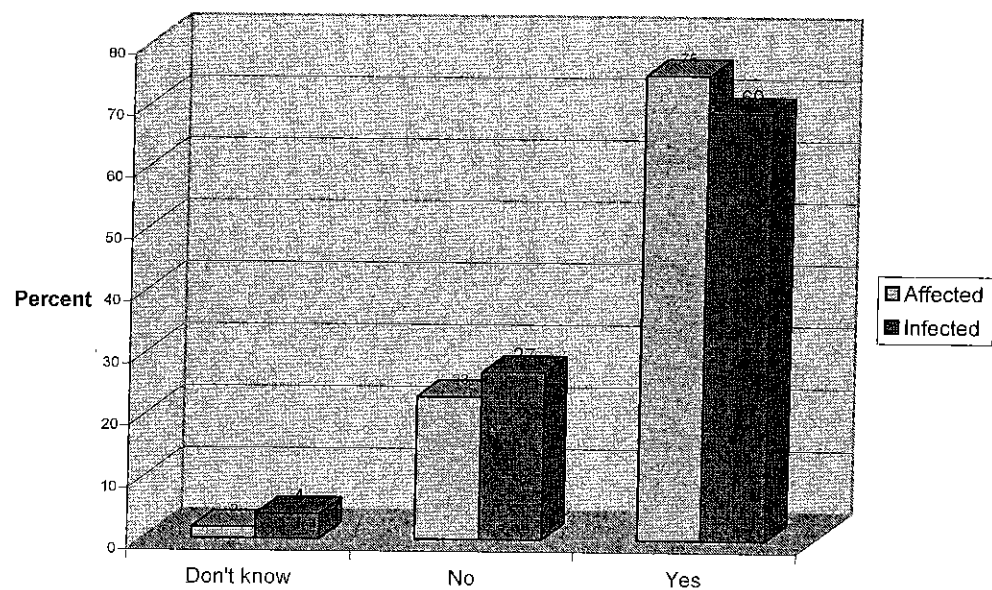


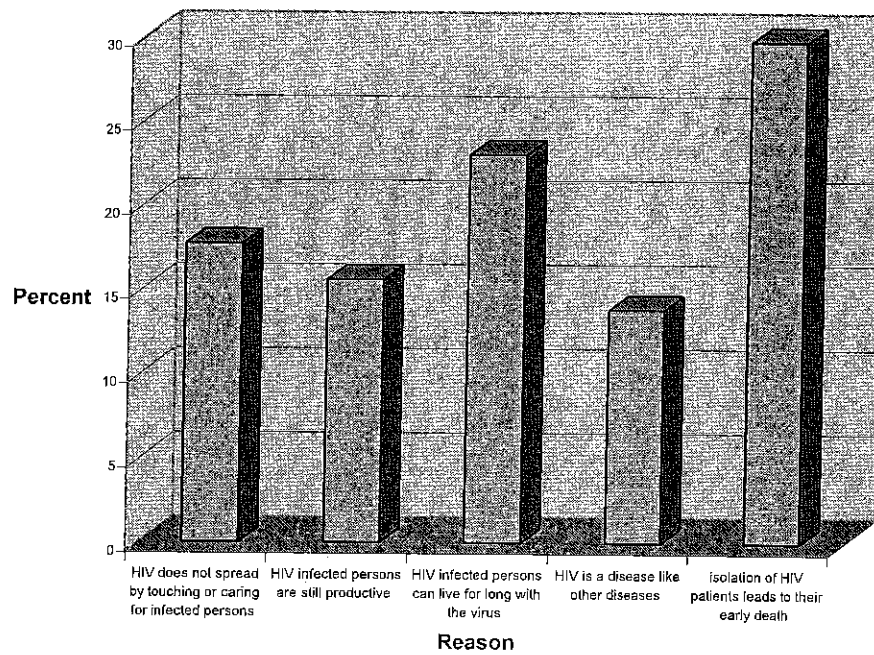
Chart 10: Respondent thinks that HIV/AIDS patients should be given sufficient care



Graph 8: Respondents have been affected and are/ have had infected relatives



Graph 9: Reasons for caring for HIV/AIDS infected persons



7.2 Findings Based on the Community Score Card

The focus group discussions were held with all the six communities selected for the study. The purpose of the focus group discussions was to get an in depth understanding on the performance of Government in providing HIV/AIDS services to the communities. The tool was also used to triangulate the information obtained using the structured questionnaires. The indicators used for the study were derived by the individual communities through the community engagement process. Interestingly they were great similarities in indicators identified and subsequent ratings as indicated in the table and graphs that follow. The community itself set the parameters like availability of services, presence of health workers, attitude of health workers and cost of services.

The indicators were scored by delegates selected by the focus groups. Below is the summary of the score card findings;

(a) Awareness of services and knowledge on HIV/AIDS

This indicator scored an average of two (**Table 1**) ranked as fair. This sign indicates that some effort is being put to improve knowledge of people living in IDP'S on HIV/AIDS.

(b) Supplementary Feeding

Supplementary feeding scored an average of 1 (**Table 1**) ranked as bad. This indicates that this intervention was not meeting its objectives. Most people in the camps have no employment and therefore need supplementary feeding especially if they are HIV positive.

(c) Presence and attitude of Health Workers

The presence of health workers and attitude of health workers both scored 2(**Table 1**) ranked as fair. Noting the shortage of health workers country wide this is a fair score. With more assistance from government much more can be done.

(d)Availability of drugs

Availability of drugs scored 1 (**Table 1**) ranked as bad. This is a persistent problem nation wide due to low funding in the sector. The problem in the camps is however compounded by insecurity and un employment.

(e)Time spent at the health facilities.

This indicator scored 1 (**Table 1**) ranked as bad. This is largely due to the shortage of health personnel in government owned facilities. During discussions some participants also indicated that some health personnel own personal clinics, drugs stores etc and preferred to work there due to low pay in government facilities.

(f) Cost of Services

Cost of services scored 1 (**Table 1**) ranked as bad. This is a persistent problem nation wide due to low funding in the sector. Patients are required to pay for medical forms, tests and finally drugs. As earlier mentioned people in the camps cannot afford to pay for these facilities.

(g)Testing Equipment

Testing equipment scored 1 (**Table 1**) ranked as bad. This is mainly due to lack of personnel to provide services to those who have been tested. Many participants complained that they had been tested but had failed to get there results after several trips to the hospital.

(h) Fairness/ Equity

Fairness/ Equity scored 1 (**Table 1**) ranked as bad. Many participants complained that people in IDPs were regarded as inferior to other citizens. There are referred to as "mere IDPs"

(i) Availability of Condoms

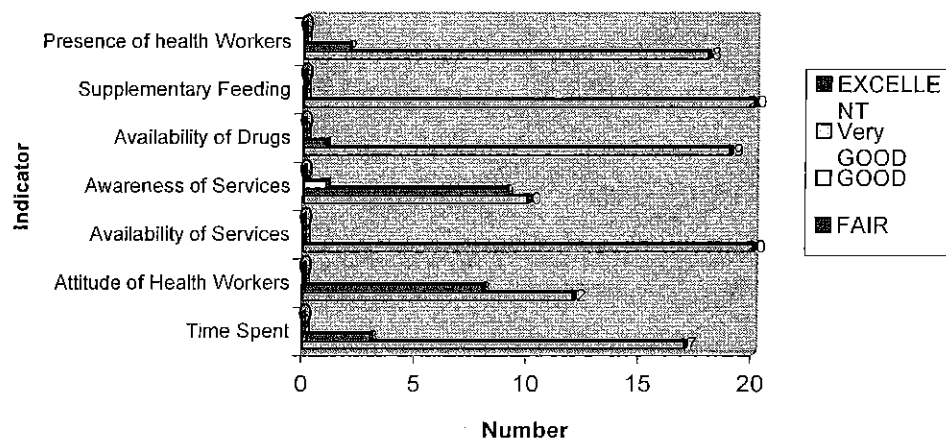
This indicator scored an average of two (**table 1**) ranked as fair. This sign indicates that some effort is being in providing condoms to the society at a fair price.

Availability and access to service

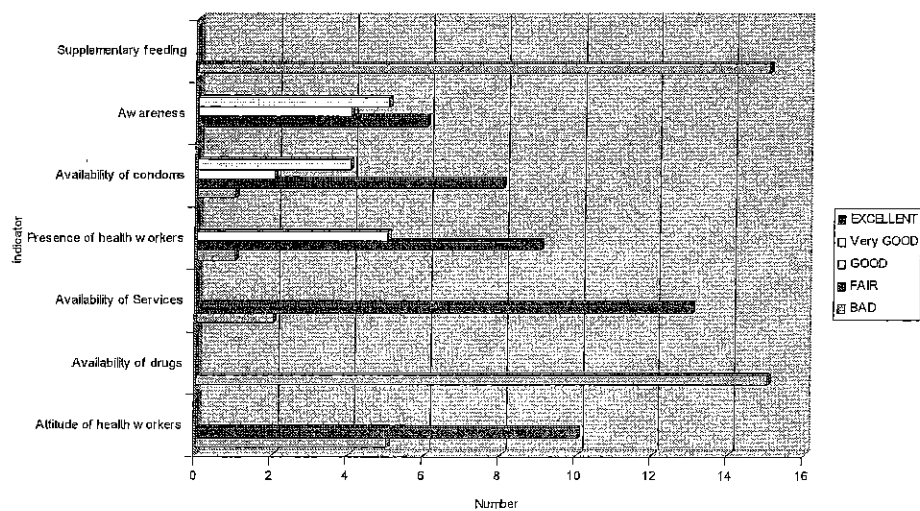
This indicator scored an average of two (**table 1**) ranked as fair. This sign indicates that some effort is being made to provide HIV/ AIDS services to the camps. Results of the survey indicated that most VCT Centres were less than 4 kilometers away.

7.2.1 Graphs and Charts

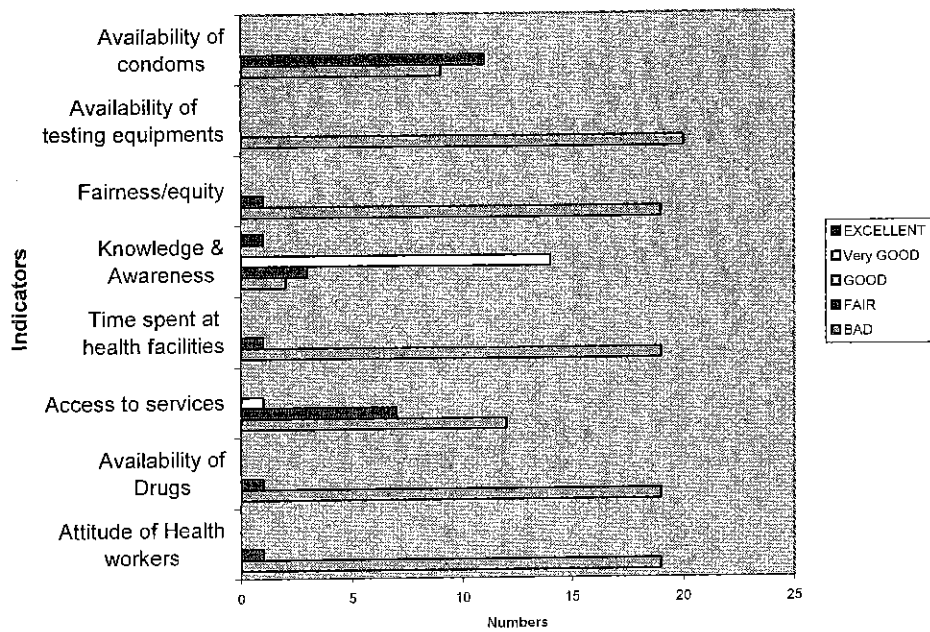
Graph 10: Community Score for Ireda Camp



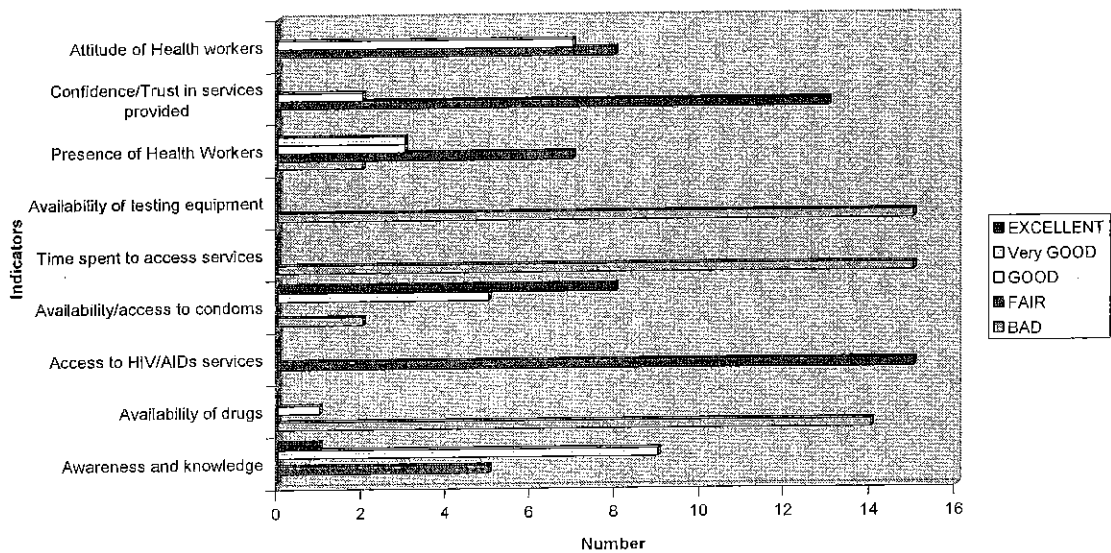
Graph 11: Community Score card for Erule



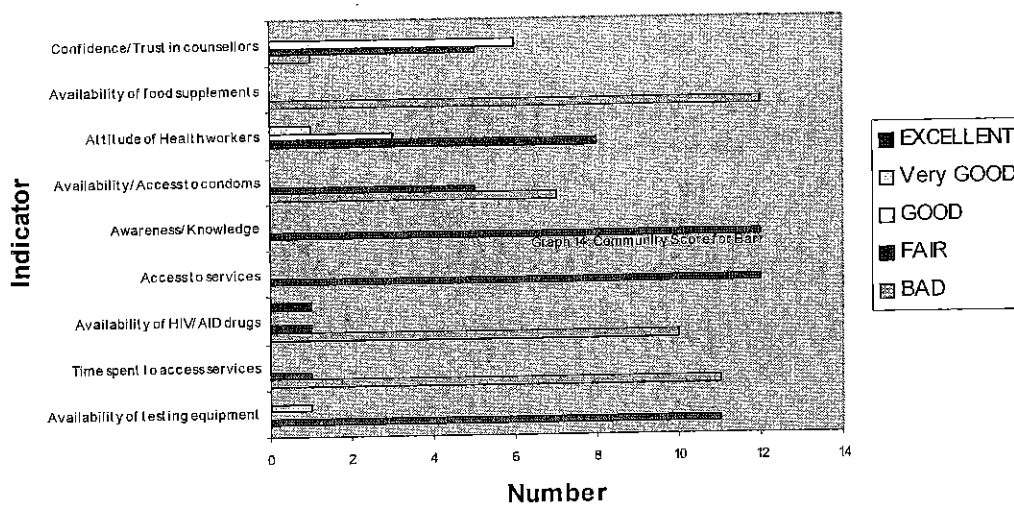
Graph 12: Community Score for Railway Camp



graph 13: Community score card for Pentecostal Church Zone



Graph 14: Community Score Card for Barr Camp



Graph 15: Community Score Card for Aloi Camp

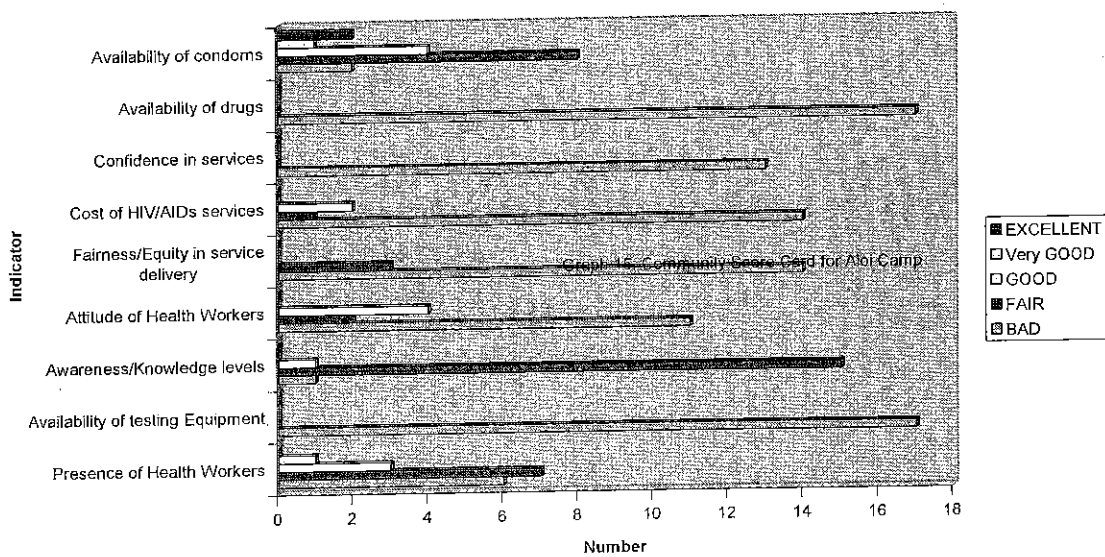


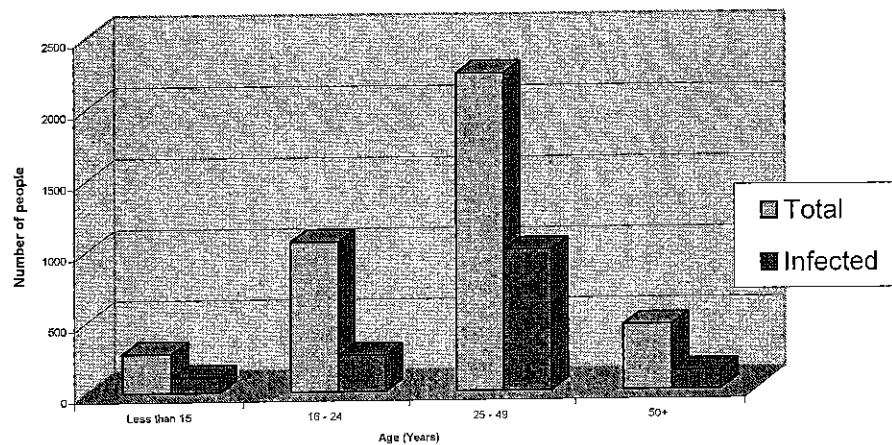
Table 1: Rating of indicators for accessibility to HIV/AIDS health services in the six selected camps in Lira district

INDICATOR	Camps							Av. score
	IREDA	ERUTE	RAIL WAYS	PCU	BARR	ALOI	TOTAL	
Presence of Health Workers	1	3		2		2	8	2
Supplementary feeding	1	1			1		3	1
Availability of drugs	1	1	1	1	1	1	7	1
Awareness of services/Knowledge	2	3	3	3	2	2	14	2
Availability and access to service	1	2	1	2	2		8	2
Attitude of Health workers	1	1	1	2	2	2	10	2
Time spent	1		1	1	1		4	1
confidence/Trust				2	2	1	6	2
Condoms		2	2	4	1	2	11	2
Testing Equipment			1	1	2	1	5	1
Fairness/Equity			2			1	2	1
Cost of Services						1	1	1

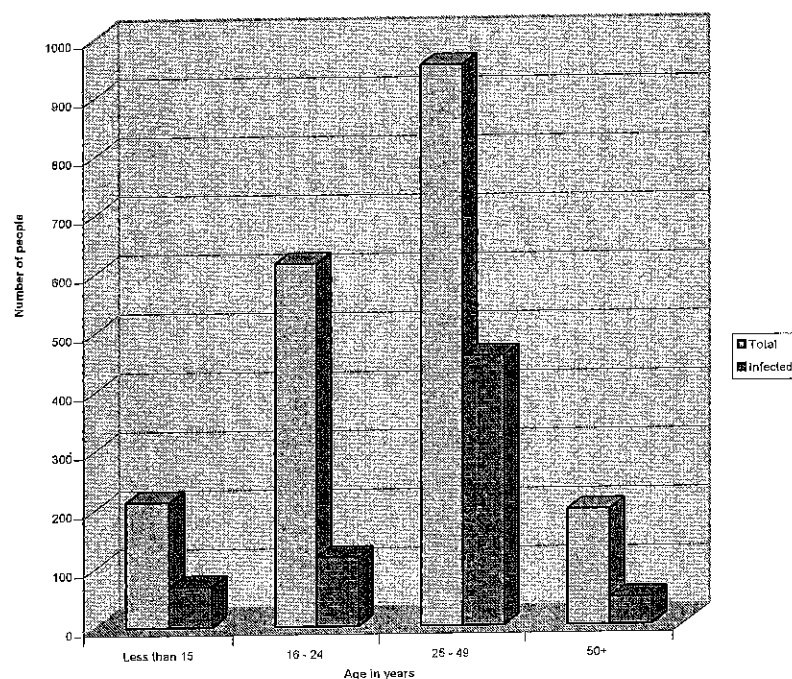
Key
1 - Bad
2 - Fair
3 - Good
4 - Very Good
5 - Excellent

Supply side Data

Graph 16: VCT visits in Lira Referral Hospital, 2004



Graph 17: Persons who visited VCT centres and those infected by HIV/AIDS



Source: Lira Referral Hospital

7.2.2 Community voices

Some community voices were recorded verbatim and have been presented below

"When I go to the hospital, we are treated as if we are not people" Woman, Ireda IDP Camp

"I went to the hospital when my child was sick, I asked for assistance and a health worker threw my forms. I cried and went back home, developed pressure, got unconscious and ended up in a health centre" Woman Ireda camp

"We do not get any assistance at the hospital, people are dying everyday, we are actually having difficulty in burying people" A man at Barr camp

"Testing services are offered on sectarian grounds at the hospital. I went there and they asked me for 10,000. I will not go there anymore". A man from Barr camp

"When you go for testing and they discover you are a displaced person, they tell you to move away" A man at Erute Camp

"Our greatest problem is that when you go and ask for condoms you are not given". A man at Erute Camp

"When we go to the hospital, we are referred to Clinics in town yet we have no money". Echoed in almost all camps

"Am surprised that ARVs are being given for free. No body in this camp is getting free drugs or testing". A man at PCU camp

"When you go for testing you are never given your results, I went to the hospital 3 times and failed to get my results". A man at PCU Camp

"The health workers do not keep time, when you go there at 8.00am you may wait for a Doctor until 2.00pm." A man at Ireda Camp

"When we go to the hospital, we get no help, you buy a book and line up for 4 days, blood test takes too many days ". A woman from Railways Camp

"We in the camps are not looked after I have lost 6 children and I have been bathing them with bare hands. I may also be infected". A woman at Ireda Camp

"Counselors release our results carelessly after testing leading to stigmatization in Society". A man at Barr Camp

"When we go to the hospital for testing Doctors and testing facilities are not available, they should be brought out here". A man at Alooi Camp

"Hurry and test everybody, children, soldiers, school children. All people should be tested". A woman at Barr Camp

8.0 OBSERVATIONS

The major observations drawn from the results of the survey and supply side collected are as follows:

1. There was a clear pattern that the Communities are knowledgeable about HIV/AIDS. Government and NGO'S have done a commendable job in sensitizing people about HIV/AIDS. Public awareness is being addressed through, Radio, print media, primary health care outreach programmes through community leaders, drama groups etc.
2. Communities have a positive perception towards HIV/Aids patients. They openly declared that they had been affected by HIV/AIDS in one way or the other and supported the issue of caring for AIDS victims when sick. This can be attributed to the public awareness mentioned above.
3. While the regional HIV prevalence rate was established at 9% the VCT results in Lira District show 26%. This shows that HIV is on the increase in the camps. The increase is as a result of the war, the condition of displacement coupled with a degeneration of morals. Behavioral change seems to be limited. Conditions in the camps have led to destruction of the social fibre, decay in morals, breakage of families, and prostitution.
4. Large scale interventions for HIV services in Lira District only began in May 2004 which is considered late since the District encountered the problem much earlier. Free medical care is being provided to a range of beneficiaries which include: children less than 18 years, widows, the poor, the orphans and pregnant women-mothers. There is current shortage for free drugs however.
5. Facilitation of health facilities in Lira is very poor. Health facilities are perceived as facilities for testing and counseling not provision of treatment. Lira Referral hospital has only 6 doctors servicing 7 districts. These include Apac, Kotido, Pader, Abim, Kabong, Amolator etc. This

stretches the manpower needs of the hospital. The physician Doctor Services the HIV/Aids clinic in additions to his other professional schedules in the children's wing and Hospital management. The presence of only one focal personnel causes delay in service delivery.

6. Facilities for AIDs care and HIV patients are limited this also applies to for general hospital services. It was revealed that the equipments are limited in supply especially with regard to test tubes, syringes, and CD4 count machines. There is only 1 machine to service the region. The capacity of the machine is to serve 10 people on a daily basis. Previously, there was an attempt to increase capacity to 15 people per day, but the 1st attempt led to equipment failure and yet the servicing is not readily available (it is done by experts from Kenya). It was noted that while over 100 people come to the hospital every morning, the available machine can only serve 10 people. This situation had prompted people to come to the Hospital as early as 5.00 a.m to line up.
7. There was limited supply of HIV Drugs. The available free drugs are insufficient to meet the needs of the community. Funds are released the hospital personnel some time borrow drugs from other projects to assist those in critical conditions.
8. Though the district is supposed to provide Food supplements to a given category of people living with HIV/AIDS there are insufficient funds to carry out the programme. The programme is almost non operational and yet people living with HIV/Aids in camps do not have sufficient food to counter the effect of taking strong drugs.
9. A lot of funds are lost due to bureaucratic transmission and poor co-ordination in the utilization of HIV funds. Government of Uganda, the Aids Information Centre, the Aids support Organization (TASO), Aids Integrated Model (AIM) project, Community House holds aids intervention (CHAI) Project, UNICEF, Medicines San frontiers are all engaged in provision of HIV related services but there is no proper co-

ordination of activities . The Chief Administrative Officer informed the Committee that Global Fund HIV/AIDS activities had eluded the District HIV/AIDS Coordination mechanism. This has led to duplication of services and corruption.

10. Funding to the District is generally poor and definitely affects HIV programmes. The district requires an annual budget of 2bn/= but can only access 300m/= from the various sources leaving a shortfall of 1.7 billion.
11. There were reports of dishonesty and corruption among NGO's, Government officials and Community project Committee members this partly explains the gaps in service delivery in the district. Some corruption cases were being handled by police.

9.0 Recommendations

1. Government should increase funding of HIV/ AIDS activities and ensure that they are well utilized. This can be done by effective monitoring at different stages of disbursement.
2. Special attention should be directed to HIV / Aids programmes in war ravaged areas. Crowding and idleness have led to escalation of infection in those areas.
3. Government should consider increasing the number of health personnel in government facilities. Lira referral hospital should be particularly taken care of.
4. Health facilities should be stocked with drugs and equipment to cater for the needs of the population. The number of people living in Lira town and its suburbs has greatly increased over the years due to insurgency in the region.
5. Mobile services (testing, counseling, provision of condoms e.t.c) should be provided to the camps to halt the escalating rate of HIV/ AIDS infection. People in the camps do not have funds to pay for these facilities.

6. There should be more effort in co-ordination of HIV /AIDS activities in the District. Merging of activities between Government and NGO's should be considered. According to the District authorities some NGO'S have been found to be un- co-operative.
7. More funds should be directed towards radio programmes, they seem to be the most effective way of increasing public awareness on HIV/Aids.
8. Food supplements should be provided to those on Anti –retroviral drugs in the camps.

10.0 Conclusion

There is a growing concern about the performance and accountability of public institutions in the delivery of services to the masses. Public and social Accountability tools help pull together myriad individual problems facing various programs into common Sectoral issues that can be easily addressed by Parliament.

This Pilot has been an eye opener to the committee and can be turned into a distinct programme.