THE REPUBLIC OF UGANDA

VALUE FOR MONEY AUDIT REPORT ON

UGANDA AIDS CONTROL PROJECT

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LIST OF ACRONYMS ABBREVIATIONS

ACP: AIDS Control Programme
AIDS: Acquired Immunodeficiency Syndrome
ANC: Antenatal Clinic
ART: Anti-Retroviral Therapy
ARV: Anti-retroviral
BCC: Behaviour Change Communication
CAO: Chief Administrative Officer
CBO: Community Based Organisation
CFO: Chief Finance Officer
CHAI: Community Led HIV/AIDS Initiatives
CME: Continuing Medical Education
CSO: Civil Society Organisation
DFP: District focal Person
DHAC: District HIV/AIDS Committe
DDHS: District Director of Health Services
FBO: Faith based organizations.
GOU: Government of Uganda
HIV: Human immuno deficiency virus
HBC: Home based care
HC: Health Centre
HCT: HIV/AIDS Counseling and Testing
HCW: Health care worker.
IDA: International Development Association
IEC: Information, education and communication
LC: Local council
MAP: Multi country AIDS programme in Africa (World Bank)
M & E: Monitoring and Evaluation.
MOFPED: Ministry of Finance Planning and Economic Development.
MOES: Ministry of Education and Sports
MOGLSD: Ministry of Gender, Labour and Social Development.
MOH: Ministry of Health
MOLG: Ministry of Local Government
MTCT: Mother to Child Transmission.
NGO: Non-Government Organization.
NSF: National strategic framework
OAG: Office of the Auditor General
OOP: Office of the President.
OVC: Orphans and Vulnerable Children
PLWA: People living with AIDS
PHC: Primary health care
PMTCT: Prevention of Mother to Child Transmission.
PMR: Project Management Reports
PCT: Project Coordination Team
PSC: Project Steering Committee
SDR: Special Drawing Rights

SOE:	Statement of Expenditure
STD:	Sexually Transmitted Disease
STI:	Sexually transmitted infection
TB:	Tuberculosis
UAC:	Uganda Aids Commission.
UACP:	Uganda Aids Control Project.
UBOS:	Uganda Bureau of statistics
US $:	United States Dollar
VCT:	Voluntary Counseling and Testing.

EXECUTIVE SUMMARY

This is a value for money audit report of the HIV/AIDS campaign of the Uganda Aids Control Project. The findings in the report are based on a study carried out on a sample of 10 randomly selected districts.

The HIV/AIDS campaign by the UACP is implemented by ministries (as an interministerial activity), districts, civil society organizations (CSO) and Community Based Organizations. Each of these implementing agencies draws up workplans which are discussed and agreed to with the project. Districts are responsible for the HIV/AIDS campaign in their area.

We examined the impact of the campaign with the overall objective of ascertaining whether value for money was achieved in the implementation of this program.

The exercise was carried out in two phases namely; the preliminary survey/ pre-study and the main study. In both stages we employed a number of data collection methods which included interviews, documents review and inspections.

SUMMARY OF FINDINGS

The audit revealed that the HIV/AIDS campaign has not been as effective as originally envisaged. This was mainly attributed to:

1. **Delays in release of funds to the districts, NGOs and CBOs.**

   The districts visited reported that there were delays in disbursement of funds by the UACP. This greatly affected the execution of their work-plans and implementation of activities such as public education and training of health workers in HIV/AIDS counseling. This negatively affected the effectiveness of the prevention campaign.

2. **Inadequate access to Information, Education and Communication messages**.

   A general survey conducted revealed that the population does not have access to HIV/AIDS messages. The posters and education materials (flip-charts) that are produced are not distributed to the users in many districts. This has contributed to the poor dissemination of information on the prevention and behavioral change.

3. **Limited coverage of HCT and PMTCT services.**

   It was noted that some health centers (HCs) do not have HIV counseling and testing (HCT) and Prevention of Mother to Child Transmission (PMTCT) services. As a result, people willing to be tested are not tested. Infected mothers are therefore not knowledgeable of their status and can not be assisted to protect their unborn babies from infection.

4. **Inadequate training of health officials involved in HIV/AIDS activities especially at district level and among CBOs and CSOs.**

   It was noted that some health officials involved in HIV/AIDS activities have not undergone any training in this field. Besides, some of those who have received some training have taken long without undergoing refresher training. As a result, they cannot handle HIV/AIDS matters with the required expertise in accordance with the national HIV/AIDS guidelines. This negatively affects the number of people willing to go for voluntary testing and consequently the behavioral change campaign.

5. **Non compliance with National Guidelines on facilities for HCT and PMTCT**.

   HCs do not have the required facilities required, such as personnel, proper infrastructure for confidential counseling and laboratory or materials for conducting HIV testing. A number of HCs are not fully staffed. The staff trained in HIV/AIDS activities spend most of the time attending to patients, leaving little time to attend to HIV/AIDS activities. The counseling rooms do not confirm to the standards of confidentiality. This has led to reduced counseling and testing.

SUMMARY OF RECOMMENDATIONS

In light of the above, it is recommended that:-

1. The project speeds up the process of disbursing funds to the implementers. Efforts should be made to ensure that all approved work-plans are financed during the planning period.

2. There is need to ensure that the project work-plans and budgets cover all the vital activities. In addition, monitoring should be carried out at all levels of implementation. Enhanced dissemination of information will help in saving a bigger population from contracting HIV/AIDS especially the 30% who do not have access to radios. The project should train people who will communicate the messages in the IEC materials to the community.

3. HCs III and IV should be provided with HIV/AIDS counseling and Testing facilities. The project should allow the districts to include the provision of these facilities in their planned activities of the districts.

4. Proper planning for training of health workers should be carried out and the cheapest possible training should be undertaken. The project coordination unit should monitor and find out the number of health workers who have not undergone training in HIV/AIDS counseling and PMTCT and make strategies to increase the number of trained health workers and have them distributed in the HCs and hospitals that offer VCT, HCT and PMTCT services.

5. All HCs providing HIV/AIDS counseling and testing should be advised to provide counseling rooms that comply with national guidelines.

6. Project accounts staff should regularly monitor the operations of the district project accounts staff to ensure that accountability for disbursed funds are submitted and reviewed in time.

CHAPTER 1

1. INTRODUCTION

1.1. Background to the Audit

Reducing the prevalence of HIV/AIDS is a high priority for the Government of Uganda as defined in the National Strategic Framework (NSF) 2000/2001-2005/2006. The leading agency in the fight against HIV/AIDS is the Multi country AIDS Project (MAP).

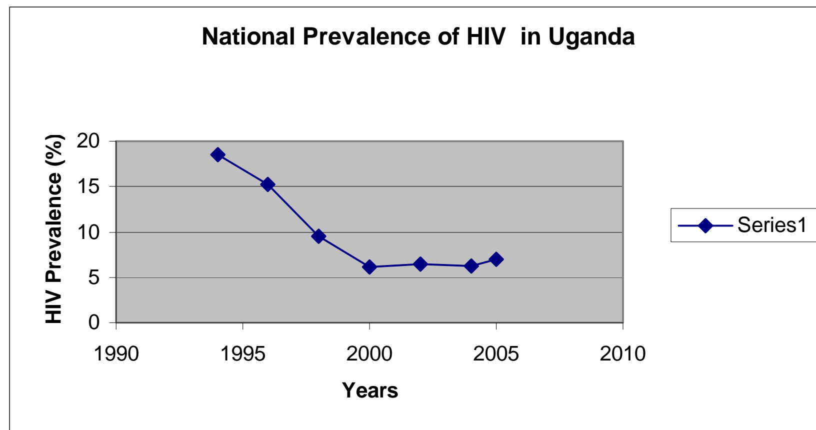
MAP was designed to support the operationalization of the NSF specifically meant to increase the national response. It implements a set of interventions with funding from the World Bank.

The Uganda AIDS Control Project is a Government project, which aims at meeting the goals of the National Strategic Framework for HIV/AIDS. This study was undertaken to assess the effectiveness of the Uganda AIDS Control Project (UACP) in achieving its goals of combating the economic and social erosion by HIV/AIDS.

1.2. Motivation

HIV/AIDS is a major public health problem in Uganda. The most affected population is the reproductive age group of 15 – 49 years. Since the 1990s, HIV/AIDS has slowly but progressively attained alarming levels and the pandemic at one point registered an average prevalence rate of 30%. Due to focused interventions the AIDS prevalence rate had reduced to 6% by 2000. This was through a multi-sectoral and multi-disciplinary approach supported by both civic and political commitment. However, since 2000 the AIDS prevalence stagnated at 6% until 2004 when it rose to 7% as shown in the graph below:

Graph 1



Source: MOH

Over the years, HIV/AIDS has eroded and continues to erode not only the human and social economic development but also national productivity. Uganda experiences a 0.8% loss to GDP annually due to death from AIDS. About one million (1,000,000) people are estimated to be living with HIV/AIDS while eight hundred forty thousand (840,000) have died. The cumulative number of orphans due to AIDS in Uganda is about two million (2,000,000).

The UACP has been at the centre of mitigating the effects of the pandemic. From July 2001 to September 2005, a total of US$ 48.6 million was spent on HIV/AIDS activities by the Uganda HIV/AIDS Control Project. However, complaints have arisen from the public regarding poor dissemination of information about HIV/AIDS, lack of condoms in most areas, poor facilities for VCT and untrained health workers in VCT in many HCs.

It is alleged that the UACP campaign on prevention and behavioral change has not been effective; many people have not accessed the IEC messages and the facilities for VCT and PMTCT. This value for money audit was conducted to establish the reasons why and to recommend appropriate measures on how improvements can be made.

1.3. Design of the audit

1.3.1. Scope

This audit was conducted on the activities of UAC with focus on UACP. The study focused on the economy and efficiency with which the agencies utilized the funds that they received and their impact on the timely achievement of reducing prevalence by 25%.

1.3.2. Time scope

The study covers the period from July 2001 when project activities commenced to June 2006.

1.3.3. Geographical scope

The study was carried out in (11) districts randomly selected from each of the four regions of Uganda.

Districts selected in each region are as follows;

Table I

Central Region	East Region	West Region	North Region
Mukono	Mbale	Kabarole	Lira
Masaka	Soroti	Hoima	Arua
Kampala		Mbarara	Nakapiripirit

1.3.4. Audit Objective

The aim of the audit was to assess the economy, efficiency and the effectiveness of the UACP's preventive and behavioral change campaign as well the impact it has had on the reduction of AIDS prevalence. As a result of the audit, recommendations have been made which may be considered to improve on the efficient and effective delivery of service in this area.

1.3.5. Audit methods

This audit was carried in accordance with the INTOSAI auditing standards and guidelines. We are required by the standards to plan the audit and report on the economy and efficiency

with which resources are acquired and used, and the effectiveness with which objectives are met.

The audit methods employed included interviewing various stakeholders, reviewing documents at the project office and at the implementing agencies as shown in *Appendix A* and physical inspection of facilities at the districts to assess compliance with national guidelines.

1.4. Description of the audit objective

UACP supports the goals of NSF for HIV/AIDS and is the biggest government project in this area. It is a multi-Disciplinary and Multi-Sectoral project.

UACP was a five year project which was commissioned in May 2001 and commenced operations in July 2001.Guided by the multi sectoral and decentralization policies, UACP sought to increase the response to the HIV/AIDS epidemic by supporting line ministries, Faith based organizations (FBOs), Civil society Organizations (CSOs), District local Governments and communities and implementing interventions relevant to their mandates and in line with the objectives.

1.4.1. Statutory Mandate.

UAC was established by statute No. 2 of 1992, UACP on the other hand is a project under the UAC.

An agreement was signed on 15th February 2001 between the Republic of Uganda and the International Development Association (IDA) for SDR 37.3million equivalent to US $ 47.5million to support HIV/AIDS related activities. UACP is the implementing agency of UAC under this program. The project is part of the Multi country HIV/AIDS program for Africa region.

1.4.2. Vision of UAC

The vision of UAC is ‘The eventual elimination of HIV/AIDS in Uganda’

1.4.3. Mission Statement of UAC

Its mission is “To provide leadership in coordination of HIV/AIDS programs and activities by all stakeholders in Uganda through advocacy, joint planning, monitoring and evaluation to eventual elimination of the AIDS scourge in Uganda”.

1.4.4. Goals and objectives

The UACP supports the goals of NSF for HIV/AIDS.

The goals of the project are;

i. To reduce HIV/AIDS prevalence by 25%

ii. To mitigate the effects of HIV/AIDS

(a) To mitigate the health effects of HIV/AIDS and improve the quality of life of PLWAs

(b) To mitigate the psychosocial and economic effects of HIV/AIDS.

(c) To mitigate the impact of HIV/AIDS on the development of Uganda.

iii**.** To strengthen the national capacity to coordinate and manage the multi sectoral response to HIV/AIDS

The audit focused on goal 1 whose objectives are as below:-

i: To promote safe sexual behavior among particular population categories, especially young people aged 15-24 years.

ii: To reduce the current 2-4% (Yr 2000) risk of blood borne transmission by at least 50%

iii: To reduce prevalence of sexually transmitted infections other than HIV by 25%

iv: To reduce the current 15-25% risk of mother to child HIV transmission (MTCT) by 30%

1.4.5. Activities

To achieve the above goals the UACP carries out the following activities

- Institutional capacity building
- Community mobilization
- Appraisal and Approval of community proposals

- Training
- Program management, monitoring and evaluation

1.4.6. Organizational Structure

UACP operates under UAC, which falls under the Office of the President. The Director General of UAC is the overall manager of all projects under UAC. Each project is headed by a project coordinator. The Project Coordinator of UACP is assisted by the project steering committees. UACP has three sections headed by specialists who directly report to the Project coordinator. The National and district initiative specialist has regional coordinators who oversee the work in the districts under their jurisdiction. At the districts the CAO is responsible for ensuring the smooth running of the project. He appoints a District Focal person to oversee all the project activities. The other specialists are the community led HIV/AIDS initiatives (CHAI) specialist and Monitoring and Evaluation specialist. The Organization structure of the project is as shown in *Appendix B*.

The project is divided into three components namely national, district and community components and focuses on 6 program areas;

Component A: Nationally Coordinated Initiatives

These are support activities designed to strengthen the capacity of the Uganda AIDS Control Program. They co-ordinate the multi sector HIV/AIDS activities and support the implementing agencies including line ministries, national and regional civil society led prevention and care activities.

Component B: District Level Initiatives

These are multi sectoral HIV/AIDS interventions which are planned and implemented by district departments, civil society organizations, and other implementing partners operating at the district level that are supported by the project.

The activities supported mainly include HIV/AIDS planning, education and communication for behavior change, counseling and testing, PMTCT training care, and STI and other associated diseases and home care.

Component C: Community led HIV/AIDS Initiatives

These are community based organizations and Civil Society Organization led HIV/AIDS control activities. They include;

(a) The provision of prevention related activities to stop the spread of HIV and

(b) The provision of care and support for poor orphans and people living with HIV/AIDS and their families.

They focus on the following program areas:-

i) Behavior change Communication (BCC)

ii) Capacity building

iii) Supervision, monitoring and evaluation

iv) Quality services delivery including sexually transmitted infections (STI) management.

v) VCT and condom use

vi) Treatment, care and support of persons living with HIV/AIDS (PHAs) and support for orphans.

1.4.7. Staffing

The establishment for the entire project has seventeen technical and administrative staff. All the positions were occupied by the time of audit.

1.4.8. Financing

Total funding for the project for a five year term (July 2001 to June 2006) was US $50 million of which IDA financing was US $ 47.5 Million while GOU counterpart funding was US $ 2.5 Million.

As at 30th Sept 2005, arising from an appreciation of SDR against US dollar a cumulative exchange gain of US $ 4.5 Million was realized. The total expenditure on project activities as at 30th September 2005 was $US 48.6M.

CHAPTER 2

2. FUNCTIONAL AND PROCESS DESCRIPTIONS

This chapter provides a detailed description of the systems of the project as set out in the design of the project. They include the roles and responsibilities of the various stakeholders and the processes involved in execution of these responsibilities. These are derived from the project operational guidelines and financial management arrangements.

2.1. Functional Description

UACP is multi sectoral and operates at national, civil and community levels. The following are the various key stakeholders and the roles they play in the HIV/AIDS prevention campaigns.

2.1.1. Uganda AIDS Commission

UAC has the overall responsibility of coordinating and planning for HIV/AIDS prevention and control. It ensures that sector, district, community, CSO/CBOs proposals and work plans conform to the overall national strategic plan. It approves overall annual work-plans and budgets for funding by the project basing on the recommendations of the Project Coordination Team (PCT)

2.1.2. Project Coordination Team (PCT)

PCT is responsible for project planning and budgeting and provides assistance in the development of annual planning guidelines. They carry out review of the project budget and analyse and consolidate monthly, quarterly and annual financial reports from the districts. PCT enforces timely delivery of budget proposals and ensures timely disbursement and accountability of project funds through the project finance and accounts unit. This unit is headed by a Financial Controller and has three accountants and three Accounts assistants.

2.1.3. Project Steering Committee (PSC)

PSC plays an oversight role in the supervision of the project, by guiding and monitoring project implementation. The committee ensures that project implementation is harmonized with other Government programs.

2.1.4 Technical Resource Network (TRN)

TRN operates at the National and district level to provide technical support to the project at both levels. At the central level it comprises sector/ministry focal persons and other key technical staff, PCT technical staff, representatives of UAC and a representative of CSOs and PLWA. At the district level the District HIV/AIDS committee (DHAC) plays the role of the TRN. Each district has a DHAC comprising of heads of department, municipal and town councils and relevant CSOs. At the district level it operates as a sub committee of the district technical planning committee (DTPC) which is chaired by the district focal person.

2.1.5 The District Technical Planning Committee (TPC)

The District Technical Planning Committee has the overall responsibility of planning, including the development of HIV/AIDS prevention and control work-plan. The TPC has a sub-committee, the District HIV/AIDS Committee (DHAC) which is responsible for directing development of integrated district HIV/AIDS work-plans. The DHAC reviews and approves both the district level initiatives and community HIV/AIDS sub-projects.

2.1.6 District level line sectors, Municipal and Town councils, CSOs and CBOs

The district level line sectors, Municipal Councils and Town councils develop their annual work-plans and submit them to the DHAC for approval.

2.1.7 Internal Audit Unit

The unit was established to enhance monitoring of operations internally as well as providing external reviews in accordance with UAC and external funding and donor agencies requirements. The unit is headed by the Chief Internal Auditor and their work plans are agreed with an audit committee. The unit conducts technical, impact and other evaluations and investigations and monitor performance of the different implementers.

2.2 Process Description

2.2.1 Planning, monitoring and supervision

As stated in 1.4.6 above, UACP comprises three components around which planned activities are considered for funding. Planning, monitoring and supervision are done at the different levels namely, Nationally coordinated initiatives, District initiatives and Community-led HIV/AIDS initiatives (CHAIs)

Nationally Coordinated Initiatives

The project supports HIV/AIDS control activities directly carried out or contracted out by UAC or by different line ministries. Line ministries prepare work plans that are consistent with their mandate, project objectives, the national strategy for prevention and control of HIV/AIDS and the decentralization policy. Implementation and utilization of funds for the intended purposes and in accordance with donors and government regulations are carried out under the supervision of the respective accounting officers. Line ministries are expected to account for funds and make progress reports to UAC/PCT.

District initiatives

Districts and CSOs operating in the districts play a central role in project implementation. The DTPC ensures that all sectors at the district submit their work-plans and the DHAC draws up integrated district HIV/AIDS work-plans. The DHAC reviews and approves both the district level initiatives and community HIV/AIDS sub-projects.

The DHAC monitors progress of the district implementation and ensures that the DFP supervises progress of CHAIs implementation.

2.2.2 Funds Requisition and Disbursement

i)Transfer of funds from IDA to PCT

After the initial deposit into the special account (made at the inception of the project), subsequent disbursements to the project account are made either as replenishments to the special account or Special commitments and Direct payments. Replenishments are made

either on the basis of withdrawal applications and Statement of Expenditure (SOE) or are based on Project management reports.

ii) Transfer of funds from PCT to implementing agents

Disbursements to line ministries and national level CSOs and CBOs are based on quarterly schedules of planned activities extracted from their work-plans and budgets.

At the district level, initial disbursement is made upon receipt of funds request from a district, the PCT disburses the initial imprest equivalent to estimated expenditure for the first quarter to the district project account.

iii) Disbursement to CHAIs

At the CHAI level, the CAO requests for funds from PCT to fund the approved subprojects. Based on the list submitted by the CAO, the PCT transfers the funds required to meet all the costs of each subproject to the districts for onward transfer to the beneficiaries. The districts however, release funds to subprojects in installments and usually subsequent installments are made only after the DFP receives a statement of expenditure for previous disbursements and a report on planned and actual progress and work-plan for the next phase.

2.2.3 Providing VCT services

The districts are responsible for ensuring that HCs III and IV and hospitals have facilities and personnel for carrying out the VCT services. Provisions are made in the districts initiative annual budgets and once approved, the procurement process is handled by the district. The project at the district level works closely with the HCs to train staff at the HCs in counseling and testing skills. Once funds are released for training, districts select staff for training from the HCs and procure training provider from the available CSOs to carry out the required training.

2.2.4 Developing and distributing preventional campaigns materials

The PCT has a department in charge of developing materials for educating the population on prevention and VCT. They work in collaboration with the districts to translate the materials in the local languages and the districts are responsible for distributing the materials to the users.

2.2.5 Delivering BCC messages

The BCC messages are disseminated in different forms including posters, flip charts, radio shows, drama shows and seminars. The implementers such as districts and CSOs make provisions in their work-plans and implement them when funds are released.

i) Posters

At the districts the district health education department is responsible for ensuring that posters which are in a language which is understood by the local community are displayed at strategic places where people can see. They are usually placed at HCs, hospitals, Trading centers and places of worship.

ii) Flip Charts

The flip charts are used by health personnel and other CSOs and CHAIs that provide HIV/AIDS sensitization, training and counseling. The district health education department is responsible for distributing them to users and training them in delivering the message to the community.

iii) Drama shows

At the districts HCs that carry out out-reach VCT services organize drama shows which are expected to attract many people. Usually CHAIs carry out Music, Dance and Drama activities in their districts.

iv) Radio Shows and Seminars

The districts may include sensitization through seminars at a physical location or via Radio shows on FM stations in the area to cater for different sectors of the population, such as youth, farmers e.t.c. in their planned activities.

CHAPTER 3

3.0 FINDINGS

This chapter presents the audit findings. The findings relate to;

Disbursement of funds, Access to IEC messages, Availability and adequacy of HCT and PMTCT facilities, Compliance with HIV/AIDS national guidelines on facilities, and Sufficiency of trained health workers in HIV/AIDS counseling.

3.1 Disbursement of funds

Replenishments to the special account (PMR basis) are expected to be made quarterly based on project management reports that integrate project accounting, procurement, contract management, disbursement and audit with physical progress of project implementation. Replenishments are made under two different arrangements. Those made on the basis of SOE method, are made for specific defined expenditure items and ceilings and are supported by SOE forms as the only supporting documentation. On the other hand, replenishments under the direct payments method are made against withdrawal applications which are accompanied by relevant supporting documents such as copies of the contract, contractor's invoices and appropriate certifications.

Funds are disbursed by the project to the district for both the district initiative and the sub projects which include the CSOs and CHAIs. The districts then disburse to the CSOs and CHAIs as specified in each release.

3.1.1 Disbursements to the Special Account

It was noted that total disbursements to the special account during the period were expected to be US $ 53,062,227.09 comprising of; Initial deposit, Replenishments, Special Commitments and Direct payments. Out of this sum however, withdrawal applications totaling to US$ 5,292,392.96 had not been credited to the special account by 30th June 2006. Besides, there was an unspent balance on the account of US$ 3,276,062.78, implying that a total sum of US$ 8,568,455.74 was not disbursed to the implementers during the project period.

This was attributed to delay in disbursing funds to the project which eventually resulted into extending the project term by six months.

3.1.2 Disbursement to districts

Release of funds by the project to recipient districts is normally done every quarter in the first month of the quarter. However, it was noted that many times most disbursements to the Districts for the District initiative delay by more than 9 months as shown in Table II below.

Table II

District	**No. of disbursements**	**Delay in disbursing of funds (No. of disbursements delayed**				
		1-3 Mths	3-6 Mths	6-9 Mths	9-12 Mths	More than 12 m
Lira	20	2	5	2	1	1
Hoima	12	3	1	2	2	2
Arua	18	4	3	2	1	2
Mbale	21	5	3	1	2	2
Soroti	15	2	1	1	1	1
Masaka	21	4	3	4	1	2
Mukono	19	2	1	1	3	2
Mbarara	13	2	1	2	1	0
Kabarole	12	3	1	2	1	1
Nakapiripirit		1	1	3	1	1

The delay is attributed to, among other reasons inadequate monitoring and supervision by the project monitoring unit. The staffing of the project monitoring unit is thin comprising only one internal auditor, who cannot regularly visit the districts and other implementing agencies to ensure that they implement their activities and submit their accounts timely.

The district focal persons in charge of the project operations in the district are usually transferred without the knowledge of the project coordination unit and transfers among the accountants handling project funds in the districts are frequent. Some accountants are transferred soon after training in handling project funds before the project benefits from the training. These factors also contribute to delayed implementation of project activities in the districts.

3.1.3 Disbursements to implementing CHAIs

Districts are expected to disburse funds to CHAIs in two equal annual installments. The first installment is made in the first quarter of the year and the second installment is expected to be made in the third quarter but after submission of accountability for at least 30% of the first installment.

We noted that on average more than 50% of the approved CHAI work plans in the districts were partly funded as a result of delays in disbursement of funds.

We established that the delays in disbursement of funds were caused by the delay in submission of accountabilities by the implementing agencies. CHAIs lack qualified personnel to compile and submit their accounts on time.

According to the DFPs, some CHAIs that were partly funded were unable to utilize the first installments within the first period of the year and as a result the second release could not be made within that year. This could probably have been caused by inadequate supervision and monitoring of CHAIs by the districts as well as by the project. In districts like Masaka and Mukono, the number of CHAIs was very big which made supervision and monitoring all of them very difficult.

Delayed disbursements have resulted in planned activities not being implemented on time. Activities, especially those involving sensitization and behavioral change communication targeting students were greatly affected by delayed disbursements. Example in Mukono district, delayed disbursements affected schools sensitization programs. Funds were disbursed after the school terms had closed and when the targeted students had left for holidays. This meant that fresh programs had to be drawn up at an extra cost.

Delay in implementing project activities results into more administrative costs to the project. The UACP was supposed to wind up its activities on 30th June, 2006, however the closure was postponed to December 2006. As a result extra administrative costs were incurred for the extra 6 months by the project.

The extra administrative expenses reduce funds available for budgeted activities which in the end are not implemented.

The delay in implementing some activities affects the objectives of the project.

3.2 IEC materials

The national guidelines on HIV/AIDS prevention require all people between the ages of 15 to 59 to have access to information on prevention. To achieve this, the project is expected to support key activities necessary to lead to an expected behavioral change, and these are:-

- i) Development and dissemination of a multi-sectoral Behavior Change communication strategy.
- ii) Production, translation and distribution of HIV/AIDS information flip chart to districts/line ministries/national, CSO/Secondary schools.
- iii) Community AIDS education through CHAIs.

3.2.1 Posters

It was noted that in 80% of the districts, many HCs did not have posters with HIV/AIDS prevention messages in strategic places. Out of the 12 districts visited, only the HCs in Mukono and Mbarara districts had posters strategically placed for clients to see both in English and the local languages. Of the HC IIIs and IVs inspected in the remaining districts, only Oli HC III in Arua district had a poster in English which had been financed by the project whereas the local language is Lugbara. 80% of the HCs did not have any posters.

Picture I

Examples of posters in English and Luganda at one HC

Effective monitoring by the project implementation would have identified lack of posters in strategic places and directed effort thereto. The project did not make sufficient provision to ensure that posters are availed to all strategic places where people could read them and access the messages.

3.2.2 <u>Flip Charts</u>

It was observed that although the districts have translated and produced materials such as flip charts for communicating the IEC messages, 40% of the districts had not distributed these materials to the users. In the districts visited, it was noted that over 60% of them did not have trained community educators to pass the messages across to the people.

This is attributed to poor planning. For instance in Mukono district the reason for not distributing flip charts was that distribution costs were not budgeted for, hence funds were not available to finance distribution. As a result, the IEC messages do not reach the intended audience and this has greatly affected the campaigns in the prevention of HIV/AIDS.

3.2.3 <u>Drama shows</u>

It was noted that drama shows are used mostly during VCT outreaches. These are organized by the HCs especially at the health sub-district level. The CHAIs that carry out sensitization through plays facilitate during such out reaches. It is therefore expected that districts would provide these groups with IEC materials to assist them to focus the plays on BCC.

Statistics, however, show that in all the districts, the highest numbers for VCT were recorded during the out reaches. People's responses after the shows towards VCT were very positive.

3.3 HCT and PMTCT infrastructure

The national guidelines on HIV/AIDS require that all health facilities from HC III to National Referral Hospitals have VCT/HCT and PMTCT facilities.

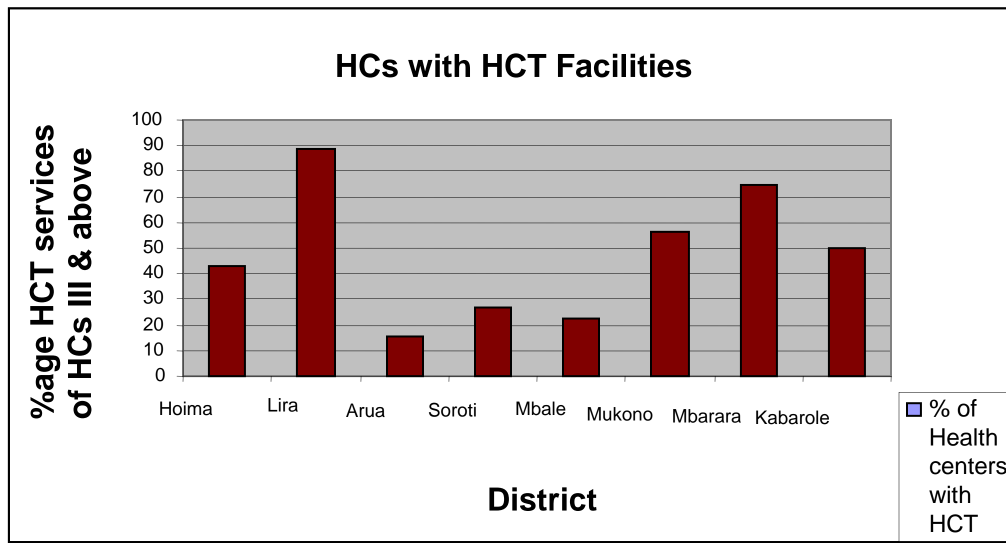
It was noted that out of the 104 HCs inspected, only 47% have HCT facilities. This is quite low, meaning that the people who are sensitized and want to access the facilities to establish their sero status cannot access them. The project has funded a few HCs with facilities such as buildings for counseling and laboratories while the remaining HCs still provide these services in the existing structures.

Picture II

A building for HCT that was constructed through funding by UACP in Mukono District

As seen in the Graph below the district with the highest percentage of HCT facilities is Lira with almost 90% and the lowest is Arua with 15%.

Graph II



This was due to little coordination between the project management and the district to ensure that the HCs III and IV are equipped with these facilities.

Inadequate HCT services greatly affected the preventional campaigns as these were expected to be the immediate action points following sensitization. People are motivated to protect themselves from infection once they are sure of their sero status.

3.3.2 PMTCT Facilities

The project's aim is to provide PMTCT facilities at HCs III and IV that offer maternity services to target mothers who come for ante natal so that they can be counseled, tested and if found positive, PMTCT administered to them to ensure that the un-born child is protected from infection.

We noted that about 70% of the HCs did not have PMTCT facilities arising from little coordination between the project management and the districts in ensuring that the HCs III and IV are equipped with the required facilities.

At HC, where PMTCT services are not available, infected mothers are not informed of how to avoid transmitting HIV/AIDS to their unborn children. The aim for the requirement for all HC offering maternity services to have PMTCT services is therefore not achieved.

3.3.3 Testing Kits

It was noted that some of the HCs that offer these services are plagued by frequent run-out of testing kits. All the HCs visited had experienced an average of one month testing kits stock out.

The anomaly is attributed to little coordination between the project management and the district in ensuring that the HCs III and IV are equipped with the required facilities.

3.4 Training of health workers in HIV/AIDS

The National guidelines on HCT require all health workers to be trained in VCT and PMTCT. HCT providers are expected to have training of at least 2 weeks of classroom instruction and 1 week of practical experience and must regularly update their knowledge. Non medical HCT providers are expected to receive 24 hours of refresher training per year. All HCT providers are required to complete 3 months of supervised practice with endorsement by a counselor supervisor.

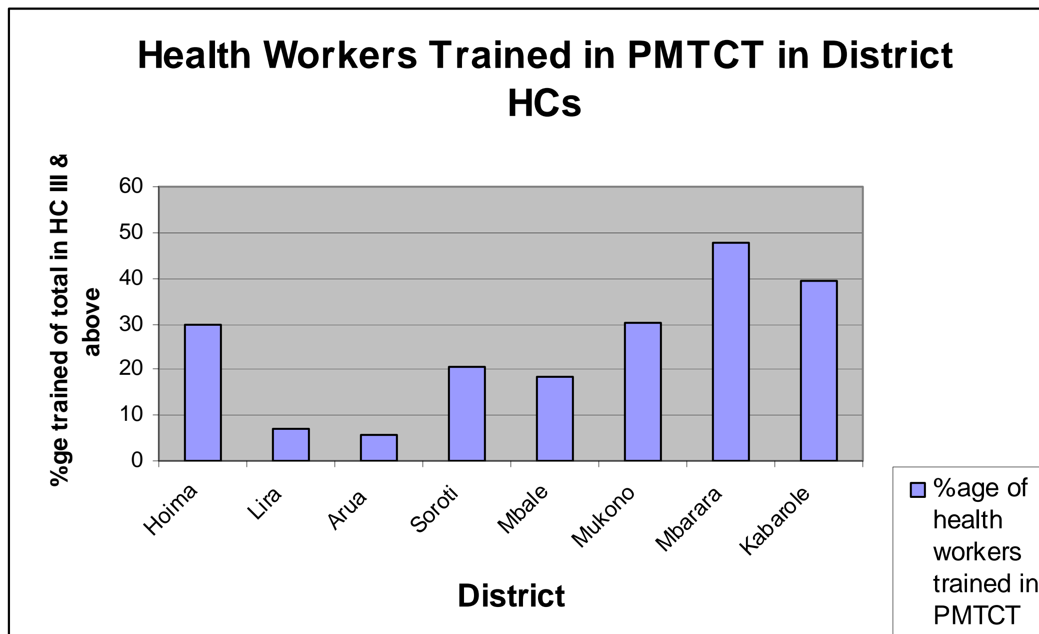
HCs that offer maternity services should be able to provide PMTCT services as well, hence should have trained health workers in PMTCT.

3.4.1 Health Workers Trained in PMTCT

It was noted that on average only 21% of health workers in HCs III and above in the districts are trained in PMTCT. This implies that 79% of the health workers cannot effectively carry out counseling of mothers that attend PMTCT and assist to prevent the un-born child from being infected by the mother.

As seen in graph III below, the percentage of health workers trained in PMTCT is highest in Mbarara District which is still below 50% and lowest in Arua district which is slightly above 5%.

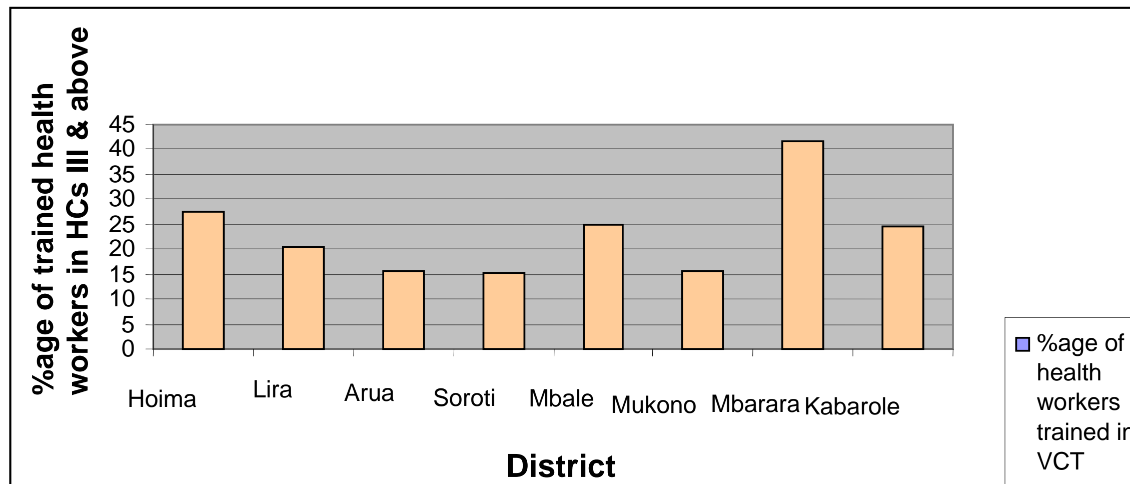
Graph III



3.4.2 <u>Health workers trained in VCT</u>

Evidence from the HCs visited revealed that about 20.2% of health workers in the districts are trained in VCT. As seen from graph IV, Mbarara district had the highest percentage of health workers trained in VCT which is slightly above 40% and Mukono has the lowest which is slightly above 15%. This is contrary to the HIV/AIDS national guidelines that require all health workers to be trained in HIV/AIDS counseling

Graph IV **Health workers trained in VCT**



Poor planning and lack of monitoring has resulted in fewer health workers being trained in HIV/AIDS counseling. For example, Shs13.2 Million was used to train 10 health workers from Arua district in counseling and testing. The training was carried out in Gulu although TASO which was providing the trainers had given the district the option of training 20 people at the same cost in Arua which was a much cheaper option but the focal person opted for training only 10 which was an expensive option.

It was observed that in instances where training was centralized at the districts, very few people were able to train contrary to training programmes which are organized by the health sub districts. For example, in Mbarara district, the training of health workers in counseling and testing is organized at the sub district level. This to enable easy identification of training needs and supervision at the HCs.

People avoid untrained health workers from testing them because they believe that they lack the necessary skills to carry out proper counseling. Consequently, this weakness affects the project's objective of promoting safe sexual living.

3.4.3 Supervision of HCT Providers

It was noted that there was very minimal supervision of HCT providers contrary to what is required by the National Guide-lines. Health workers who had been trained in VCT and PMTCT but found themselves posted to HCs that did not have VCT and PMTCT services

felt under utilized and they expressed fear that the skills they had acquired could easily be lost for lack of practice.

In addition there was no refresher training for the health workers providing HCT services. According to the district health department, this is attributed to small number of workers that have been trained. As a result, instead of re-training those trained before, they train the ones not yet trained at all. This, they explain is attributed to little funding for training.

3.5 Provision of HCT and PMTCT services

According to the national guidelines on HIV/AIDS Programs, all HCs, including the private sector offering HIV counseling and Testing must conform to national standards for delivery of services. At a minimum HCT service providers must have personnel, space for confidential counseling and laboratory or materials for conducting HIV testing.

3.5.1 Personnel

It was noted that all the HCs providing HCT and PMTCT services had specific personnel particularly in charge of offering these services.

3.5.2 Counseling rooms

i) It was established that out of the 104 HCs inspected, only 18 (17%) had counseling rooms that complied with national guidelines. (As shown in Table III below)

Table III

District	No of HCs Inspected	HCs with HCT	% of HCs with HCT	No of ideal counseling rooms
Hoima	7	3	42.8	0
Lira	9	8	88.8	1
Arua	26	4	15.3	1
Soroti	15	4	26.6	1
Mbale	9	2	22.2	1
Masaka	8	3		0
Mukono	16	9	56.2	7
Mbarara	8	6	75	6
Kabarole	6	3	50	1
TOTAL	**104**	**42**		**18**

In many HCs, the consultation rooms also serve as counseling rooms while in others, the rooms lack privacy and therefore discourage potential clients.

This has been caused by failure by the implementers in the HIV/AIDS campaign to enforce the standards of counseling rooms.

Picture III

An example of HC with an appropriate waiting room in the HCT unit

ii) The HCs have also not been assisted in setting up counseling rooms that comply with the national guidelines. Many HCs have never expanded their facilities to accommodate the rising demand for handling HIV/AIDS related activities. Whereas many HCs were set up to provide the traditional health services, they have

not been expanded hence the need to improvise space using the available facilities to accommodate both consultation and counseling services.

The inappropriate rooms hinder service delivery and are bound to discourage people who would be willing to take the HIV/AIDS tests.

Picture IV

A counseling session in an improvised space

3.5.3 Laboratories

It was noted that all HCs that provide HCT and PMTCT have laboratories for testing. However, in a few cases the laboratory technicians were not always available at the HCS which forces counselors to request clients who accept to return for testing afterwards, after accepting testing following counseling sessions. In some of such cases, the clients never return.

Absence of laboratory technicians also results from frequent testing kits stock outs and a small number of people who come for testing.

It was noted, however, that HCs that provide laboratory services for ART patients were attracting more people even for the HCT services. This was particularly noted in St. Francis

Clinic in Mukono district, Mayanja Memorial Hospital in Mbarara district and Virika hospital in Kabarole district.

3.6 Submission of Accounts Statements

The Project implementation manual requires that accounts Statement be submitted quarterly within one month after the end of the quarter. The CHAIs are required to submit their accounts for at least 50% of the first release before the last release can be processed.

3.6.1 It was established that the delay in submitting accountabilities by most of the CHAIS ranges from a few days to many months in many districts surveyed.

3.6.2 There is high turnover of accountants in charge of the project in the districts. Besides, sometimes the accounts staff are required to assist with other district accounts duties. Some of the accountants do not know on how to compile the accountabilities.
There is little support supervision provided to the CHAI implementers at the district resulting into them failing to submit their accountabilities in time.

3.6.3 Delay in submitting accountabilities results in delays in the disbursement of funds to implementing agencies. Consequently planned activities are not implemented in time or not implemented at all.

CHAPTER 4

4.0 CONCLUSIONS

4.1 Funds Disbursement

The UACP has not provided sufficient guidance and monitoring during project implementation. This is very crucial as the project involves stakeholders from different sectors of the economy. Implementers especially at district and community levels have not been able to meet the requirements of the project. This has mainly been caused by late disbursement of funds to them.

4.2 IEC Materials

The project has been able to design a strategy for behavioural change and produced materials to assist implementing the strategy. It has, however not been effectively utilized by the different players in the communities because of poor distribution of the materials produced.

4.3 Training of Health workers

It is evident that very few health workers have so far been trained in VCT and PMTCT. The project withdrew from PMTCT during the project period. The project has not liaised well with the districts to ensure that the National guide lines on HIV/AIDS prevention are supported.

4.4 HCT and PMTCT Facilities

The project has been able to equip very few HCs with HCT facilities. Many HCs are struggling to offer these services within the limited available space. Consequently the standards are not met especially in the provision of space for confidential counselling and testing. The personnel available are again responsible for the usual clinical duties sometimes leaving little time for handling HCT services effectively.

CHAPTER 5

RECOMMENDATIONS

1. The project should speed up the process of disbursing funds to the implementers to avoid delay.

2. The project should increase distribution of IEC materials to strategic places. This could save a number of people from contracting HIV/AIDS especially the 30% who do not have access to radios. The project should also train people who will communicate the messages in the IEC materials (which were developed by the project) to the community.

3. All HCs from HC III and HC IV should be provided with HIV/AIDS counseling and Testing facilities such as counseling rooms and laboratory. The project coordination unit should ensure that these health facilities have sufficient testing kits to ensure continuity of providing HCT services.

4. Proper planning for training of health workers should be carried out and the cheapest possible training should be undertaken.
The project coordination unit should monitor and find out the number of health workers who have not undergone training in HIV/AIDS counseling and PMTCT in the participating districts and ensure that district plans incorporate filling the training gaps in the participating HCs and hospitals.

5. All HCs providing HIV/AIDS counseling and testing should be advised to provide counseling rooms that allow confidentiality to raise people's confidence while seeking VCT services.

6. Project accounts staff should regularly monitor the operations of the district project accounts staff and should write reports thereon.

Project accountants in the districts should be equipped with skills necessary to handle project work more efficiently.

The project should discourage the districts from transferring the district accounts staff in charge of the projects.

APPENDIX A

INTERVIEWS

Interviews were held with the following officers at the UACP office:-
i) Project Coordinator
ii) Financial controller
iii)Internal Auditor
iv) IEC manager
v) Specialist CHAI
vi) Eastern region project officer

At the districts offices visited we held interviews with the following:-
i) CAOs,
ii) DDHS
iii) DFP
iv) Project accountant
v) District Health Educator

During visits to the HCs we held interviews with the following:-
In charge officer
Maternity wards personnel
HCT providers
Laboratory personnel
Medical staff
People found at the health units

Documents reviewed

We reviewed the following to ascertain dates on which funds were disbursed to recipients and were credited to their accounts:

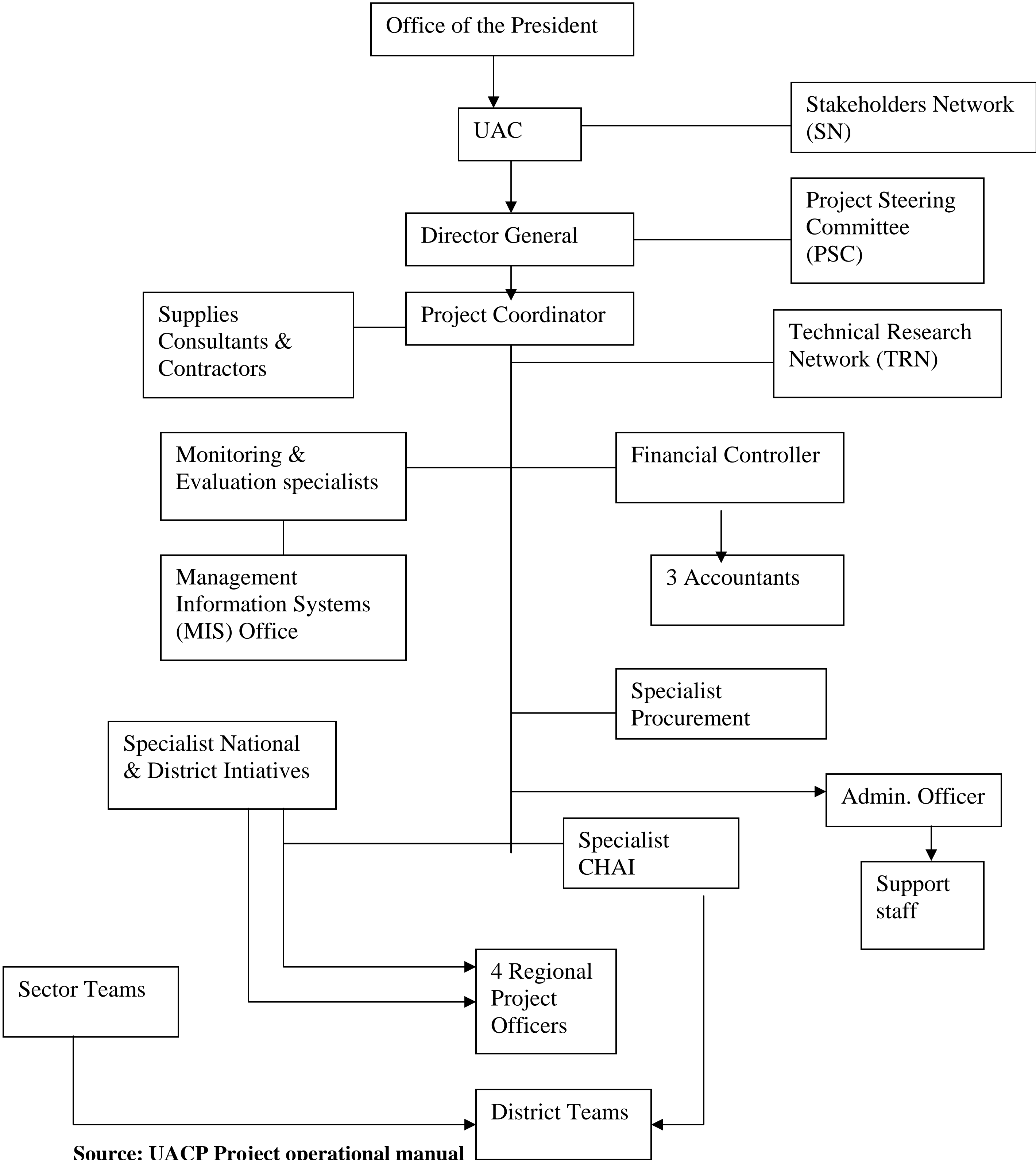
- Project Implementation Manual
- Projects transfer instructions
- Projects bank statements.
- Recipients' bank statements.
- Accountability statements.
- Review personal files of recipients' Accounts staff to ascertain their financial knowledge and experience.

We also reviewed National guidelines on HIV Counseling and Testing
The personnel files of persons involved in HCT activities were reviewed to establish their academic qualification, Continuous Professional Training.
Review documents of the project to establish the HCT providers trained
We also reviewed project documents to establish facilities availed to health centers to facilitate HCT.

We reviewed project documents to establish how IEC messages are disseminated and the costs involved
Reviewed all accountabilities submitted and check if funds are properly accounted for and check dates when the accountability was submitted.

APPENDIX B

ORGANISATION STRUCTURE



Source: UACP Project operational manual