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ANTI CORRUPTION COALITION UGANDA

Project Evaluation Report

Citizen Action Platform (CAP)

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By

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This report highlights an evaluation of the project expected results its contribution to the expected development outcomes.

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Finally, our appreciation goes to Harriet Namisi for carrying out this evaluation exercise and putting together this report.

Kagaba

Ms. Cissy Kagaba
Executive Director

Table of Contents

LIST OF ACRONYMS

ACCU	Anti-Corruption Coalition Uganda
ADLG	Apac District Local Government
CAO	Chief Administrative Officer
CAP	Citizen Action Platform
CSO	Civil Society Organisation
DHO	District Health Officer
DISO	District Internal Security Officer
DLC	District Local Council
DPC	District Police Commander
HC	Health Centre
HUMC	Health Unit Management Committee
IBM	Independent Budget Monitors
IEC	Information Education and Communication materials
ICT	Information Communication Technology
LC III	Local Council Three Chairperson
LC V	Local Council Five Chairperson
OPD	Out Patients Department
PAF	Public Accountability Forum
PHC	Primary Health Care fund
PTF	Partnership for Transparency Fund
RDC	Resident District Commissioner
TAACC	The Apac Anti-Corruption Coalition
TIU	Transparency International Uganda
VHT	Village Health Team

Executive Summary

This end of project independent evaluation report has been prepared for the Anti-Corruption Coalition Uganda (ACCU) on the Citizens Action Platform Project (CAP Project) in Apac District of Uganda. The two-year pilot project was implemented by ACCU in collaboration with The Apac Anti-Corruption Coalition (TAACC) with financial support from the Partnership for Transparency Fund. The CAP project sought to amplify citizens' voices through technology to demand for improved service delivery in the health sector. At the heart of the project was its Information and Communications Technology (ICT) platform for citizens and civil society organizations (CSOs) to easily gather information provided by citizens at the grassroots level to inform policy makers and the media, ultimately improving health service delivery, thus contributing to the attainment of the Millennium Development Goal (MDG) 6.

The evaluation considered both qualitative interviews with 37 people participating in the Focus Group Discussions at the health centers and 42 quantitative interviews. Six sub counties were visited including: Abongomola, Chawente, Apac, Aduku, Ibuje and Akokoro.

On provision of corruption free services, medicines and clinical care through an appropriate level of quality and accessibility, the project has realized a 19.6% improvement from 42.4% at baseline to 62% in the people who reported an improvement in the quality of service delivery. There are current efforts in the visited hospital and Health Centres to ensure that patients access the required services where possible, except in circumstances where drugs may not be available or any other supplies. This is due to the service provider's knowledge that any poor handling of the patients will be reported via CAP or on radio or maybe discussed in a Public Accountability Forum.

In relation to drug stock outs, the project has realized a 1.2% improvement from 72.8% at baseline to 74% at evaluation in the number of people who were interviewed and indicated that there were no more reported drug stock outs in the Health Centres. 17% said there were reports of drug stock outs while only 9% said they had not experienced any cases of drug stock outs.

On the other hand, the status of soliciting bribes from health service users, there was a reduction of 9.7% of people not asked for money in order to get a service from 69.7% at baseline to 60% at end of project evaluation. There was a reduction of 4.3% of people asked for money for a service from 30.3% at baseline to 26% at end of project evaluation.

However, late coming and absenteeism have slightly increased from 18.2% at baseline to 30 % end of project evaluation and the number of respondents reporting no absenteeism has reduced 75.7% at baseline to 66% at the end of project evaluation.

In regard to improved transparency and communication between service providers and citizens; 48 % had reported improvement in communication with their health workers, as compared to 21.3% at baseline. However, there has been a reduction in the number of citizens able to consult their local

leaders and service providers from 78.7% at baseline to 52 % because of the delayed responsiveness to citizens concerns that are reported to them.

Overall, positive progress was noted in demanding for transparency through the PAF, radio, IBMs and directly talking to the service providers at the service points. In order to enhance the quality of communication, community outreaches by health workers have been carried out to interest the community to access health services. This has also been enhanced by the improved knowledge levels of the communities on their health rights with 90% acknowledging that they are now more aware of their rights as a result of the sensitization through CAP from the baseline value of 81.8%.

During the life of the project when the ICT platform was functional (Jun 15/2014- 31st Oct/ 2015), a total of 1219 complaints were received of which 1031 were consider spam and only 188 substance reports. Of the 188 reports, 85 were received via SMS and 103 via call centre. All reports were analysed and verified, 50 (27%) were resolved and 138 (73%) were still outstanding by the time of the evaluation.

In regard to the design, the use of multiple strategies such as ICT, PAFs, IBMs and Media to promoting citizen participation in reporting complaints in the health sector, were helpful in the realization of the CAP Project. PAFs and IBMs solicited more participation as compared to ICT. There was less effort geared towards response to complaints reported with 73% cases still pending by the time of the evaluation.

Lessons learnt include; the importance of the Health Unit Management Committees (HUMCs) in promoting good governance, the use of media in promoting anti-corruption initiatives in the health care, developing stronger partnerships with the local government over health service provision, and the importance of flexibility to adopt to new ideas during implementation.

Challenges include; limited local government resources to quickly respond to issues; limited facilitation, especially in terms of supplies, which health service providers use to justify the charging of fees to purchase gloves, spirit, among others; and limited technology use in the communities public.

Recommendations may include; strengthening the Health Unit Management Committees (HUMCs) through trainings, sensitizing citizens more on the need to demand public accountability and reporting grievances, and encouraging citizens to speak more to their leaders. To further this, it is worth considering the establishment of a local steering committee to follow the discussion on emerging issues in the district in regard to healthcare, so as to ensure that there is more government responsiveness towards people's healthcare needs. Continue the use of multiple strategies in the implementation of CAP through the media, IBMs and PAFs so as to acquire maximum results as well as encourage the use of the toll-free line to report grievances in the health sector.

In conclusion, the CAP strategy was noted to be cost effective, promoting value for money, efficiency and effectiveness of health care service delivery in Apac District. The use of multiple implementation

strategies too proved successful in amplifying the level of project success. Since the tool has already been developed, tested and proved to be easily useable, the level of explicability is highly commendable as a tool useful enough to stamp out theft of health centre supplies, office abuse, corruption, and lack of responsiveness by the local leaders towards people's needs.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background to the Citizens Action Platform (CAP) Project

This report has been prepared for the Anti-Corruption Coalition of Uganda (ACCU) as an independent end of project evaluation of the Citizens Action Platform Project (CAP Project) implemented in the Apac District - Uganda, in collaboration with The Apac Anti-Corruption Coalition (TAACC). This project implementation was possible with funding from Partnership for Transparency Fund (PTF).

The CAP project sought to amplify citizens' voices through technology to demand for improved service delivery; promote increased participation of citizens in the local governance processes as well as improve the quality of health service delivery.

At the heart of the project was its Information and Communications Technology (ICT) platform that enabled Civil Society Organizations (CSOs) to easily gather information provided by service users at the grassroots level to inform policy makers and the media, ultimately improving health service delivery, thus contributing to the attainment of the Millennium Development Goal (MDG) 6. This project further sought to facilitate CSOs to increase their reach and impact in monitoring government performance using ICT tools such as web-based content management, SMS, toll-free telephone and geo-mapping. The approach aimed at providing a mechanism for citizens to report government service deficiencies, present information to duty bearers, track responses and provide feedback to citizens on outcomes. The project was premised on improving health service delivery to the poorest citizens who are most affected by corruption and poor governance[1].

This report is divided into five chapters. *Chapter One* is the introduction. *Chapter Two* provides an assessment of the CAP project's design, intended to situate the assessment of the project's outcomes and impacts into perspective. This chapter also provides an assessment of the relevance of project objectives, strategies and approaches, as well as the implementation of planned project activities and achievement of outputs, and the project monitoring indicators. The expected project results against objectives are analysed in *Chapter Three*. The Lessons learnt, Challenges, recommendations and concluding remarks are stated in *Chapter Four*. Annexes are highlighted in *Chapter Five*.

1.2 Methods Of Evaluation

In order to undertake this evaluation, a desk review of the baseline report, mid-term evaluation report and project reports were reviewed. Fieldwork in Apac was preceeded by a meeting between the

[1] ACCU Terms of Reference for conducting the end of project evaluation for the Citizen Action Platform (CAP Project).

independent evaluator, the Project Manager in Kampala and the TAACC Director and Field Coordinator.

Qualitative and quantitative interviews were also undertaken with specific CAP implementing staff namely; the National Project Coordinator, the ACCU IT/ Systems Administrator, Field Coordinator and Executive Director TAACC. Sample selection was done purposively and based on reports of improvements and challenges in healthcare services and level of accessibility. Thus, the Sub Counties of Abongomola, Chawente, Akokoro, Ibuje, Aduku and Apac Town Council were included in the evaluation sample.

No.	Sub County	Category of Health Centre reached
1	Apac Town Council	Apac General Hospital
2	Akokoro Sub County	Akokoro Health Centre III
3	Ibuje Sub County	Ibuje Health Centre III, Alado II
4	Aduku Sub County	Aduku Health Centre IV
5	Abongomola Sub County	Abongomola Health Centre III
6	Chawente Sub County	Chawente Health Centre III

Table 1: List of Health Centers reached and the Sub County it is located

In determining the CAP project's results, special attention was paid to the changes and benefits perceived to have taken place as a result of the project interventions. The Consultant also looked for indications of impact in the form of long term changes associated with the CAP project's overall objectives.

A select number of sub-county health units[2] were visited, not only to see some of their interventions, but also to hold Focus Group Discussions (FGDs) with their service users to determine how the programme may have contributed to changes in their health care.

A total of 79 people were interviewed (38 participated in the qualitative and 42 participated in the quantitative interviews. Amongst these, 30 were female participants. 6 duty bearers were interviewed (one town clerk – Aduku Town Council; the Sub County Chief Ibuje Sub County; the health Centre (H/C) in Charges of Alado and Abei H/Cs; and two nursing Officers in Abongomola H/C). Unfortunately, it was not possible to meet with political leaders because the exercise took place during a period when NRM primary elections were taking place and they were all out in the field; the RDC

[2] Abei, Abongomola, Akokoro, Apac General Hospital, Aduku, Alado

was monitoring the exercise; while the technical staff (CAO and DHO) had travelled on official duties outside the district.

The independent evaluator documented testimonies about participants experiences that were later spelt out as success stories, while recollecting on the situation before CAP project's interventions. From these varied lived experiences, many useful and positive lessons were learnt from CAP project stakeholders (duty bearers, implementers) and targeted beneficiaries. There were two types of success stories, ranging from personal stories to an overall picture about the changes engendered by the project at Sub County and district levels.

1.3 Citizen Action Platform (CAP) Project Design

In assessing the logical coherence of the CAP project, the evaluation was aimed at assessing the project performance as per the expected results and development impact indicators.

a. Expected Results

1) Medicines and clinical care provided corruption-free and at appropriate level of quality and accessibility.
2) Fewer bribes solicited/paid.
3) Reduced absenteeism among doctors and nurses.
4) Clinics open during mandated hours of operation.
5) Improved transparency and communication between service providers and citizens.

b. Expected Development Impact

i. An empowered citizenry with a multi-channel platform from which to actively participate in improving their health services;
ii. Improved rural health service delivery and health outcomes;
iii. Catalyzed growth and intensity of citizens engagement to demand public accountability;
iv. Improved government responsiveness to citizen concerns and CSO capacity to constructively resolve issues with authorities

The CAP project was also informed by the following five immediate objectives:

- *Immediate objective 1:* To deliver an open-source, integrated ICT platform designed specifically for CSOs to monitor report and redress issues with fulfillment of public duties.
- *Immediate objective 2: To* demonstrate improved health service delivery, transparency, reliability and public responsiveness in the Apac district.
- *Immediate objective 3:* To improve citizens' health through greater access to required government services.

- *Immediate objective 4:* To achieve clearer understanding of where breakdowns exist in health service delivery.
- *Immediate objective 5:* To strengthen existing reporting tools by providing visual information, data and feedback mechanisms to the public, media and government.

Some of the indicators that were preferred for measuring development impact of the planned interventions were neither adequate nor Specific, Measurable, Accurate, Realistic and Time-bound (SMART). For example, there were many indicators that did not provide a target that could be measured quantitatively, nor any indication of the anticipated impact on the basis of which progress made towards achievement of the ultimate target could be measured. Most of the indicators did not specify which implementation quarter they were intended for within the period of implementation.

1.4. The Use of ICT in Awareness Raising, Monitoring and Communication

The CAP project's strategic approach selected the use of ICTs as the most viable means by which positive change would be derived. The process was intended to facilitate self-awareness among the powerless and marginalised groups through community dialogue, collective action and eventual social change. The use of ICT was a capacity building process because it enhanced the ability of individual citizen action and built capacity of community members to question and demand political responsiveness over existing circumstances on health. The use of ICT is unique and relevant for the Apac context because it focuses on both the individual and the aggregate community, both of which are essential for sustainable social change towards promoting integrity, transparency and responsiveness in health service delivery.

1.5. The Programme Delivery Mechanism

i. The CAP project made use of the following forms of intervention strategies:*The use of ICT Modules*: The project set out to develop and pretest three ICT Modules that included; (a). Collection of grievances on the health care delivery system from citizens through the use of mobile phones, Short Message System (SMS) and the website; (b). Creating a response system to the citizens' complaints through the mobile phones, SMS or emails; and (c). Map all complaints received and the responses made on a public website.

ii. *Baseline survey*: A baseline survey was conducted to ascertain the state of the healthcare system in Apac district with bias towards the availability of heath supplies and medicines, doctor/nurse absenteeism, and the quality and accessibility of medical services, including the frequency of bribes paid by citizens to access them.

iii. Awareness Raising Campaign: By holding Public Accountability Forums (PAFs), media reports, radio talk shows and airing of radio jingles; ACCU and TAACC made use of these platforms to raise public awareness of the project on health rights and obligations of

citizens in the health sector within Apac district. Meetings were supposed to be held with key groups such as the Health Sector Anti-Corruption Working Group (District Health Officer, Health Facility Personnel, Malaria Focal Person); local leaders (Chief Administrative Officer, Resident District Commissioner, LC V Chairperson, LC III Chairpersons, Sub County Chiefs, etc.); while PAFs were used for creating dialogue and interaction between the citizens and duty bearers.

Below are the CAP Planned Activities:

1. *Collection of Grievances:* This activity was aimed at soliciting citizen complaints on their health care system in regards to missing drugs, absenteeism of medical personnel, any forms of bribery solicitations or corruption; and quality/accessibility of medical services. Through the use of the ICT system, information was due to be solicited through voice messages, SMS, and the website forms.

2. *Aggregation, Verification and Analysis of Grievances*: ACCU/TAACC aggregated, verified and analyzed all received complaints received through system categorizations, (i.e. justified complaints and their relationship to healthcare in Apac District).

3. *Resolution of Grievances*: All complaints/grievances were filtered and allocated to different stakeholders for redress. While some were destined for the national level, the rest would be directed to the local government leaders – the Chief Administrative Officer (CAO); District Health Officer (DHO) and the Resident District Commissioner (RDC). The rest were used by ACCU for inputting into the national level advocacy groups such as the Health Sector Anti-Corruption Working Group (HSACWG) and documentary research on sale of government drugs in open markets.

4. *Response to Citizens*: Following the allocation of complaints above and resolution respectively, all resolved cases were manually entered into the ICT platform. The platform was then used to direct all resolved cases to the respective citizens who reported them. In addition to providing feedback to the citizens who raised the complaints, Public Accountability Forums (PAFs) would be held at health centres and these issues discussed further with the community members, health service providers and local leaders both at the district and sub county level. The forums were further used to solicit additional complaints and jointly derive solutions.

5. *Visualize and Map Outcomes:* Following the data entry into the CAP platform, a map would be automatically mapped by the system and categorized into; individual, verified grievances and responded to grievances. This was the only way it was possible to communicate the available information to the relevant community and local leaders as a way of enlisting responsive governance, health care management and service delivery.

CHAPTER TWO

2.0. CAP PROJECT FEASIBILITY

2.1. Project Thematic Approach

The thematic areas chosen by the CAP project, namely the use of ICT in monitoring quality service delivery, is extremely relevant to both ACCU and TAACC's quest to create an enabling environment for addressing high levels of corruption existent in health service delivery; as well as improving on the governance environment in health service delivery in Apac district.

2.1.2. Awareness Raising, Monitoring and Communication

a) Use of the Media

Once the platform was created and a short -code generated, ACCU and TAACC embarked on carrying out massive sensitizations of all citizens through the media. The 6363 sms short code was advertised to citizens in the various communities and leaders as a mechanism to report any issues of dissatisfaction from their local health centres. The initial mode of communication was widely disseminated through the sms short code 6363. Thus radio jingles, radio spots and call in talk shows were aired in English and Luo on Radio Apac 92.9 FM, which also has the largest listenership in the district.

The second medium of communication was through the toll-free line (0800200188); established in partnership with Transparency International Uganda (TIU). The toll free line attracted more participation because issues were received and clearly discussed and further clarification sought from the person on phone.

As a result, a total of 1219 complaints were received during the life of the project (Jun 15/2014- 31st Oct/ 2015) of which 85 were received via SMS and 103 via call centre hence a total of 188 were verified and found to be relevant, 50 of these were resolved and 138 were still outstanding by the time of the evaluation. The toll-free line attracted more participation since the SMS platform had more challenges both to implementers and the beneficiaries. And just like any other codes ever issued by the Uganda Communications Commission (UCC), majority were closed by UCC across the country because of complaints received from the citizens about receiving unsolicited messages from the various short codes including the 6363 SMS short code.

b) Working with Independent Budget Monitors (IBMs)

In addition to the above platforms were the IBMs. These were identified from the communities and equipped with knowledge concerning the CAP. The IBMs were trained and educated on the use of both the voice and SMS. Through this initiative, ACCU in partnership with TAACC, and TIU worked with 77 independent Budget Monitors/Community Monitors. IBMs were responsible for collecting data from health centres; preparing reports for the constructive dialogues; and making

follow-up to ensure implementation of the commitments by duty bearers. They were later instrumental in further disseminating the acquired knowledge and sensitizing their local communities and monitoring services in their nearest health centres. IBMs were also relevant in monitoring project implementation and directly reporting to TAACC. This team was significant in ensuring the scientific advocacy based initiative sustained by ACCU and TAACC. The reports generated through the platform, toll-free line and IBMs, were instrumental in causing a constructive dialogue with the health centre management and local leaders in seeking solutions to the identified issues.

c) Public Accountability Forums (PAFs)

Awareness raising was further done through the PAFs held at health centres. A total of 6 PAFs were held during the life of the project. These were used to educate the communities of their rights and obligations in health care. The Forums led to interaction between the service providers and citizens, as well as local leaders (CAO, RDC, LCV and LC III Chairpersons; Sub County Chiefs and Councillors) who are the overall service monitors. PAFs were all held at health centres so that both health care beneficiaries and the service providers could meet to talk about their concerns and find possible solutions. PAFs were promoted because other than the demand for public accountability; it was a platform where citizen education on rights and obligations was also done.

As a result of the above forms of sensitization, the SMS code, toll-free lines, IBMS and PAF point out chain break down points in the health sector in terms of; availability of health supplies and medicines, doctor/nurse absenteeism, the quality and accessibility of medical services including the frequency of bribes paid by the citizens to access these services among others.

Challenges

However, the ICT was not without challenges. The platform in particular attracted a lot of spam messages 1031 resulting into 93 % of the total number of messages received. This has been attributed to the fact that the code was formally used for sports before it was directly handed down to the CAP project. Some were too short to comprehend, or map out; while others reported on issues that were not related to health, thus ending up in the spam lot.

Relevancy

Despite that, CAP has demonstrated that the use of ICT is relevant to the context of Apac, in terms of documentary evidence and on spot access by all the key stakeholders (ACCU and TAACC) for use in advocacy both at national and local level. This helped to offset challenges of delayed transmission of data from the field to the ACCU head office and improved the level of efficiency and effective in ascertaining facts has also improved, thus making it easy to capture only health concerns of the project. ICT is also sustainable because gaps are easily identifiable and addressed immediately through a system analysis, people's identities are protected and there is feedback provided which acts as a motivation to the complainants.

Given the level of success so far, this technology can be replicated because of the high value for money aspect; less deployment of human resources; and time. The platform also protects the identity of the persons reporting, so as not to jeopardize the relationships with the service providers. According to Radio Apac FM, over 400,000 people (In Apac and the neighbouring districts of Kole, Masindi, Oyam and Lira) have so far been reached with the sensitization messages as opposed to other mechanisms, such as workshops that require substantial funding for physical requirements (e.g. venue, food, transport facilitation, etc).

2.1.3 Complaints Raising, Analysis/Processing

The design of the CAP project promoted submission of anonymous messages to the platform, independence of the reporters and on spot submission of the complaints. A range of issues were reported from all the sub counties of Apac and they included the lack of water and electricity in the health centres; un-coded health centres in the district thus affecting their ability to access their own drugs for community use. Others involved security of the health centres; inadequate staff accommodation at health centres; filled pit-latrines, placenta pits; among others. During the project's life time, a total of 1219 messages were received, 85 via SMS, 103 via call centre, 188 were verified and found to be relevant, 50 of these were resolved and 138 are still outstanding. A total of 1031 messages were found to be spam.

2.1.4 Aggregation, Verification and Analysis of Grievances

ACCU and TAACC periodically generated reports as a result of an analysis and a verification exercise. This step was important in ensuring that all complaints are given individual attention in terms of understanding the point of origin, relationship with the health sector and if relevant, schedule a relevant department for redress.

2.1.5. Response to Citizens

The CAP project worked out a modality of working directly with relevant departments in addressing the citizen's grievances. These included the District Health Officer, Department, CAO, RDC, LCV, Sub County Chief, LC111 Chairpersons, Health Unit in-charges, Hospital Superintendents and Health Management Committees; among others. These offices provided technical and policy feedback to the grievances raised respectively. Meetings with these respective service providers were held prior to Public Accountability Forums (PAFs) where citizens would receive feedback on all complaints raised in a particular health unit.

The organizations are now highly regarded in the district and service providers, especially at the health units, health workers are keen when serving patients because community monitors often sit with patients to observe the conduct of service providers. As a result of the constructive engagement; several achievements have been reported: staff engaged in office abuse, corruption and fraud; were disciplined and transferred to other centres (the in-charge of Abei, and Alado were transferred; and one Aduku health staff); the staffing gaps have largely been filled out in all the Health Centres that had complaints for instance in Abongomola health centre that previously had 7 workers only, now has 15. 8 more were recruited; renovation of Abei Health Centre 111 was done; restoration of

electricity in Aduku health centre 3,000,000 was required; 2,000,000 paid by the Town Clerk's office and 1,000,000 was still pending; among others. Also, as a result of ACCU's work in the district through the CAP project.

As a result of ACCU's advocacy and partnership strength, strategic meetings were held with the Health Sector Anti-Corruption Working Group[3], a national advocacy group well respected for influencing health issues at national level. As a result, some of the policy issues were recorded for consideration by the CAP project were taken up by the Ministry of Health such as the coding of pending health centres in the district. Thus, the already established structure by ACCU/TAACC from the village – district and national level is strength that points towards the project sustainability. The improved level of citizen awareness, ability to demand for quality service delivery and corruption tendencies once held in the district's health sector is plausible and strategies recommended for replication in other districts care sector.

2.2. Overall Impact of Technology

The use of technology and steps taken in monitoring service provision; promoting anti-corruption campaigns and abuse of office. During the pilot phase of implementation, a number of issues emerged;

2.2.1. Citizen reporting (what worked/didn't work)

In regard to the use of ICT, the toll-free line solicited more participation as opposed to the SMS and web form based system as 85 complaints were received via SMS and 103 received via call centre,This can be attributed to the level of illiteracy – not many are comfortable with typing out the messages and besides, the character space provided was not enough to articulate all the issues. The toll free line can easily be used by both the community members and the implementers. Reports are more elaborate and complete, besides, the reporters are also satisfied with calling because they are able to get immediate feedback on the next steps.

The short code was suspended by the Uganda Communications Commission and so, it has since February 2015 not been possible to make use of it. However, the biggest problem was that majority of the messages on the platform were spam totaling to 1031; which is 93 %. There was also time lost in sending back complaints submitted in Luo to TAACC for interpretation and feedback given to ACCU.

Through the different ICT reporting channels used by the citizens, the call center worked better citizens felt comfortable speaking with someone and that was an assurance that their complaint was going to be handled immediately.

[3] National Medical Stores, Medicines and Health Services Delivery Monitoring Unit, Public Procurement and Disposal of Assets, Directorate of Ethics and Integrity, Ministry of Health, Directorate of Public Prosecutions among others and civil society organisations like Uganda Debt Network, HEPS-Uganda, Transparency International among others.

2.2.2. Overall Management by ACCU/TAACC (What worked well/didn't)

The partnership between ACCU/TAACC has so far been positive since both institutions primarily focus on good governance and the fight against corruption in service delivery. The staff in both institutions received training on the use of the platform and an orientation on how the toll free line operates. There was efficiency in project implementation and considered challenges as learning opportunities. For instance, when the SMS system failed to attract adequate participation, there was a quick decision to partner with Transparency International Uganda which has a call centre in Lira. The level of collaboration has continued to grow with the pulling of locally identified issues for engagement with the national level actors engaging on health issues.

On the other hand, the implementation was affected by delayed feedback and disbursement of funds by the Partnership for Transparency Fund. This affected the smooth implementation of planned activities and disrupted scheduled activities. This affected the extent to which impact could be realised.

2.2.3. Promoting Government Responsiveness

In regard to the level of responsiveness, a total of 188 cases were verified as relevant; however, only 50 have been resolved to date giving it only 27% government responsiveness. Nevertheless, in promoting government responsiveness, a number of factors were useful including;

Media: the use of the media has been very significant in promoting government responsiveness for instance on the issue of Abei health Centre and the invasion of the bats. Action was quickly taken by relocating resources from PHC for the renovation of the affected buildings. This was because of the media reports that appeared in the local and national media houses – both print (NTV) and electronic (the Monitor Newspaper). A lot of pressure was instead put on the local leaders from the national level to address the issues raised with immediate effect.

IBMs: the presence of the IBMs in the local communities and their availability to always follow up accountability issues in the service points was helpful in ensuring responsiveness especially by health workers because they go, sit in and observe them work, as part of monitoring. This alone in effect, makes the health workers do the right things, otherwise, the issues will be raised and reported to the relevant authorities for action.

The PAF: The use of the PAFs provided both an accountability platform and at the same time, an opportunity for dialogue between the citizens and relevant service providers at the health centre, sub county and district level. The PAFs were also used for soliciting complaints and awareness creation on health rights. Respondents included the RDC, Local Councillors, Sub County Chiefs; health centre in-charge, HUMCs and the DHO; among others. In addition was the media and civil society actors.

While the above strategies were all effective, the media turned out to be most effective and efficient in promoting responsiveness of service providers because it attracted the attention of both local leaders and those at the national level such as the Members of Parliament and the Ministry of Health. This strategy was enhanced by the reports from the IBMs and the PAFs.

Although the strategies worked out, there were other areas that have still remained untouched despite the demands. For instance, the platform reports a total of 138 cases (73%) are still pending resolution by the local leaders.

2.2.4 Improved Service Delivery

As a result of the CAP project, service delivery has slightly improved in some areas such as Abei, Abongomola and Aduku. However, Akokoro and Alado still have an outcry for an ambulance and maternity wards respectively. Responsive governance was noted in some of the health centres and the district leadership. Issue based transfers were initiated to remove non-performing officers (in-charge Alado, Abei and health officer – Aduku) as a way of protecting them against the community members and punishing them for misconduct and fraudulent acts committed by some of the reigning in-charge officers at the time. Maintenance of the health centre compounds are still pending in Abei, while the other H/Cs have improved.

On the positive note, improved (e.g. in Alado waste compound was cleared to make the facility clean and a new waste pit was dung). Fraud involving the sale of mosquito nets by the Health Centre in-charge in Alado was cleared by making him refund the profits. Health centre budgets are now displayed for citizens to see how much was allocated and for what purpose in Alado, Abei and Abongomola. In addition, drugs are announced to the HUMC when received and stock taken and reported for all to see and ensure proper use. This has made the citizens satisfied with the services and are actually in agreement when it is reported that drugs have run out, which is also rare these days with the implementation of the CAP project.

2.3. CAP Project Exit Strategy (Sustainability)

The choice of the CAP intervention strategies, implementation mechanisms and activities laid a foundation for sustainability and hence a safe exit strategy for ACCU/TAACC in Apac.

i). Through sensitisation, over 400,000 citizens have received awareness messages and therefore understood their rights in regard to health services. This information is empowering in itself to all the individuals involved. It is hoped that those that did not receive awareness messages will indirectly receive knowledge from those that have been reached by the radio programmes and public accountability forums. Thus, these people can never be the same again in terms of knowledge regarding their health rights. For instance, the case of the sale of government drugs in a private clinic in Aduku Town Council was reported by an ordinary citizen.

ii). The presence of the IBMs in each community neighbouring health centres provides an opportunity for further follow up of any complaints. The IBMs are respected by the communities and feared by the health service providers because of their role in reporting any identified complaints and their capacity strengthened. In turn, these community monitors were already mentoring other individuals in the community. The service providers are keen to provide quality services because they

know that someone is keeping an eye on them and sometimes, they do not know who it is but a report is produced and they are asked to respond to issues raised.

iii). The presence of an already developed structure through the IBMs in the communities promote responsive governance and the good relations at the district with local leaders is a good sign that cannot be easily wished away.

iv). On the other hand, the partnership with TI that introduced people to the toll free line has helped revamp the level of sustainability because TI has a longer interest in the Lango sub region, and besides, they too are monitoring social service delivery and in particular health and education.

Although the above may appear to give a strong view point on sustainability, it is also important to note that this capacity is still nascent and any disengagement from actors may cause a return to negligence, office abuse, and resource abuse in the health service delivery chain in Apac district. Areas of emphasis is to get the communities engage their health workers and local leaders to be more responsive.

CHAPTER THREE

3.0 CAP PROJECT OUTCOMES AND RESULTS

This section outlines a number of outcomes and impacts realized during the CAP project's implementation period. During the design phase, the following outcomes were earmarked:

1) Medicines and clinical care provided corruption-free and at appropriate level of quality and accessibility.
2) Fewer bribes solicited/paid.
3) Reduced absenteeism among doctors and nurses.
4) Clinics open during mandated hours of operation.
5) Improved transparency and communication between service providers and citizens.

The Expected Development Impacts

(i) An empowered citizenry with a multi-channel platform from which to actively participate in improving their health services;
(ii) Improved rural health service delivery and health outcomes;
(iii) Catalyzed growth and intensity of citizens engagement to demand public accountability;
(iv) Improved government responsiveness to citizen concerns and CSO capacity to constructively resolve issues with authorities.

However, some of the outcomes are ambiguous especially since there was no mechanism instituted from the start on how health outcomes would be measured. Therefore, this section will provide an elaborate presentation of the CAP project's results more broadly.

3.1. Medicines and Clinical Care Provided Corruption – Free and at an Appropriate Level of Quality and Accessibility

62 % reported an improvement in the quality of service delivery, 10 % were not sure and 28 % reported no improvement. This is an improvement of 19.6% from 42.4% at baseline who were faced with a problem of quality and cost of health care services.

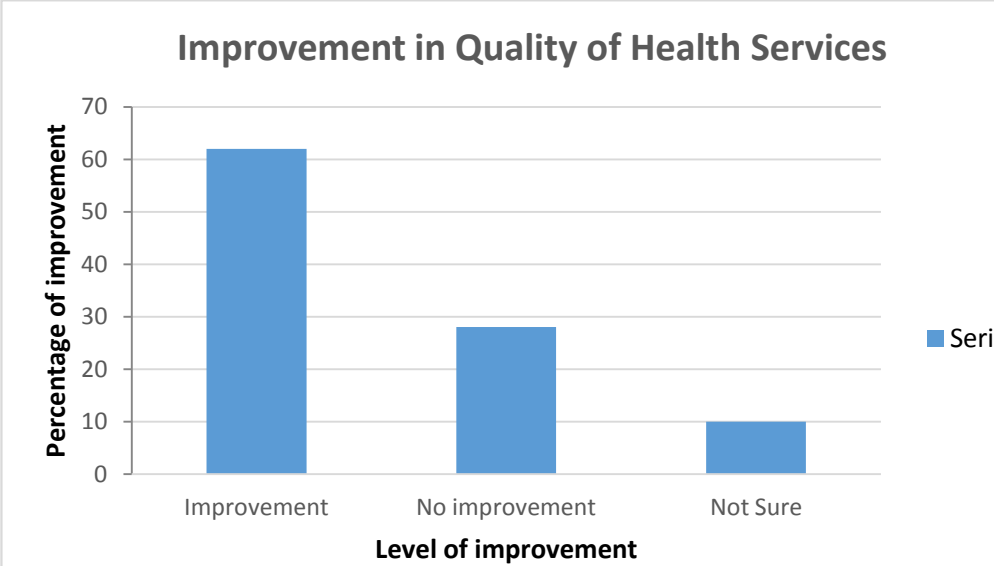

Chart 1: Showing improvement in the quality of health services

There are testimonies showing an improvement in terms of access and quality of health care. Below is a caption of Alado health centre 11 which was previous littered with poor sanitation, and unattended to with no safe disposal mechanism. The place has since been cleaned as a result of interventions under CAP.

One of the patients – Amoo Denis, had this to say about the Alado Health in Ibuje sub-county "… *you need to spend some time in the community to understand how much health care has improved in this place…".*

Beatrice Okello said, "*I live near Ayago Health Centre but prefer to walk a distance of 5 kilo meters to come to Alado because the health services here are better, you cannot leave without medicine".*

On drug stock outs, 74 % of the people interviewed indicated that there were no more reports of drug stock outs in the Health Centres. 17 % said there were reports of drug stock outs while only 9 % said they had not experienced any cases of drug stock outs. This is an improvement of 1.2% from 72.8% at baseline who were receiving drugs in the right amount.

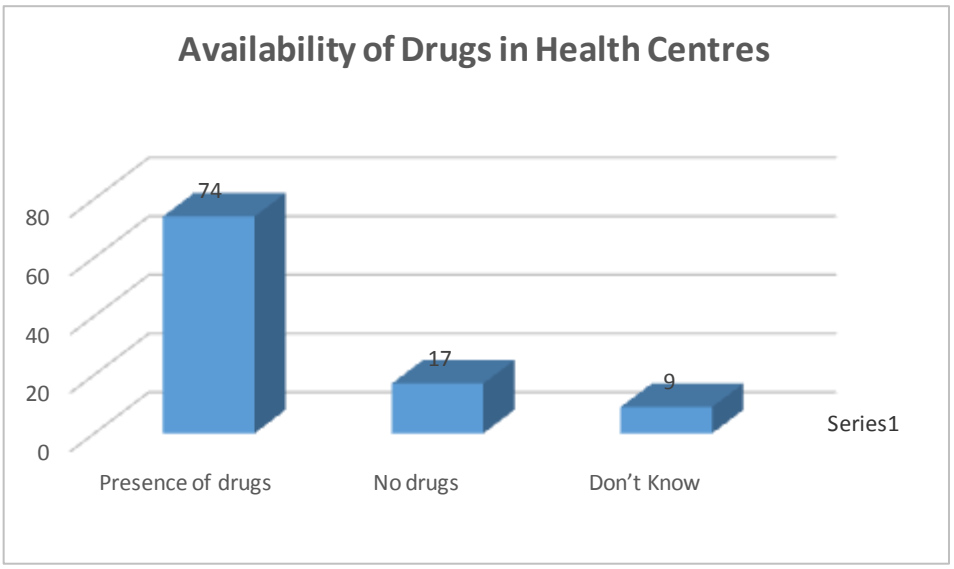

Chart 2: Showing availability of drugs

The theft of medicines for sale in the open market was also reported especially in Health Centres within the town councils of Aduku and Apac. This is because the health inspectors have not been vigilant enough to monitor and ensure that those found are penalized for theft of government supplies for sale on the open market. Efforts to curb this habit have only been done under the CAP intervention.

3.2. Fewer Bribes Solicited/paid

60 % compared to 69.7% at baseline said they had not been asked for money in order to get a service, 26% compared to 30.3% at baseline said they had been asked for money for a service; while 14 % said they had been asked to buy drugs from the drug shop.

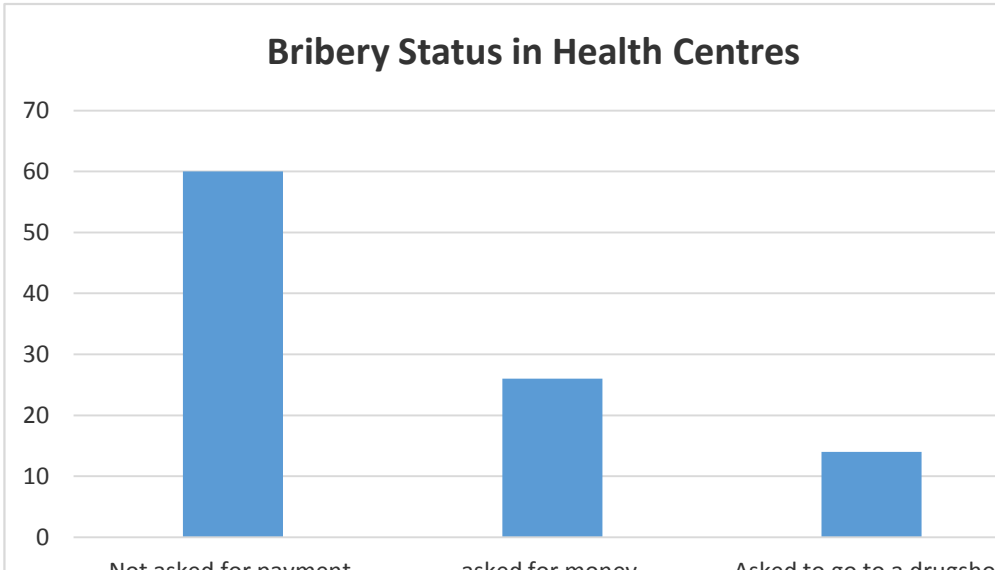

Chart 3: Percentage of people being asked to pay for free medical services

However, in Apac it was reported by one of the IBMs that, *"accessibility to health services is not orderly, many times, those who come in vehicles are handled first before the rest…".* However, due to limited resources, and the lack of availability of supplies such as plaster, surgical spirit and gloves, especially in Apac General Hospital where the Dental Clinic was reported to charge 3,000 shillings per a patient seeking dental health assistance to be able to operate. The same happens in Akokoro Health Centre where mothers that go to deliver are not released unless they have paid between 5,000 – 10,000 Ug. Shillings. Thus the demands for money were linked to inadequate supplies to facilitate the operations at the hospital and Health Centres.

3.3. Reduced Absenteeism among Doctors and Nurses and Mandated Hours of Operation

66 % of the interviewees indicated that there was no absenteeism of Doctors and Nurses. These complaints were mostly reported in Aduku Health Centre 1V and Apac Hospital. In addition, Health Centre IIIs reported absenteeism mostly during night hours where the staff scheduled for work rarely turned up for duty.

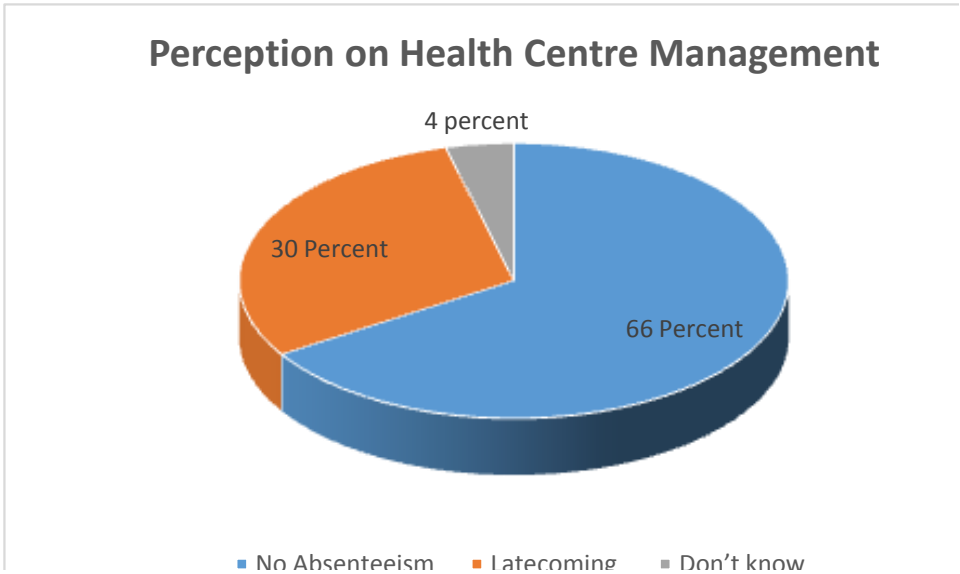

Chart 4: Percentage on absenteeism and late coming

According to Koli Hellen (IBM Apac) indicated that "*the challenge with Apac is that there are many workshop invitations for doctors and staff. You can find that all staff leave for workhops and the hospital remains in the hands of junior staff…*".

On the other hand, while the health Centre 11s are mandated to open between 8:00 – 5:00p.m; the health Centre 111s, 1Vs and hospitals are expected to have adequate staffing that can keep the facilities open at least 24 hours a day. However, late coming has slightly increased from 18.2% at baseline to 30 % at the end of project evaluation. and the number of respondents reporting no absenteeism has reduced 75.7% at baseline to 66% at the end of project evaluation and 4 % did not know the status of management in the Health Centres and hospitals.

Late coming has been associated by the health workers to the inadequate accommodation in the health institutions. Staff are forced to travel several distances to get to their places of work as explained by Harriet Aol (Nursing Officer) in Abogomola said "*late coming is the biggest problem here, if only all the workers had accommodation around here, may be it would be helpful*".

The interviewees noted that although the clinics and hospitals may be open by 9:00a.m, it is sometimes possible to find only the security personnel or only one health worker. Thus in order to be served, patients have to wait until all the key staff arrive. It was further reported that it was difficult to find especially doctors in some health centers in the afternoon hours. Those who require their services needed to report during morning hours.

Late coming has been blamed on the fact that there is inadequate supervision of the health workers by local leaders such as the Sub County Chiefs and local politicians. However, the Town Clerk Aduku mentioned that "…*there are attempts to supervise the medical workers, however, it is also important to be considerate given that the facilities do not provide them with all the required services such as accommodation nor transport*".

3.4. Improved transparency and Communication between Service Providers and Citizens

Although those willing to approach service providers are at 48%, as compared to the 21.3% at baseline and 52% compared to the 78.7% at baseline who felt they could not consult their local leaders and service providers, there is positive progress qualitatively on the level of demand for public services. The 26.7% increase in people willing to approach service providers is attributed to various channels of communication established by the project. Through the PAFs and radio talk shows citizens can now demand for public accountability from service providers and local leaders.

However, the reduction in the number of citizens able to consult their local leaders and service providers is attributed to delayed responsiveness to citizen's grievances that have been reported about service delivery gaps.

The Health Unit Management Committees (HUMCs) are increasingly beginning to be functional in monitoring service delivery at the health centres and providing reports to the District Health Office. HUMC are responsible for monitoring staff absenteeism, late coming, drug stock outs, inspection of delivery of drugs and corruption.

However, the HUMCs have limited resources and skills to oversee the work of professionals. In the Abei sub-county for instance, the HUMC is handling the issue of an absentee public health officer from station. He has been reportedly spending most of his time in Apac town council where he resides, and as a result, the compound of the health centre is bushy with nobody to attend to it. A report has since been forwarded to the District Personnel Officer and the Chief Administrative Officer for disciplinary action.

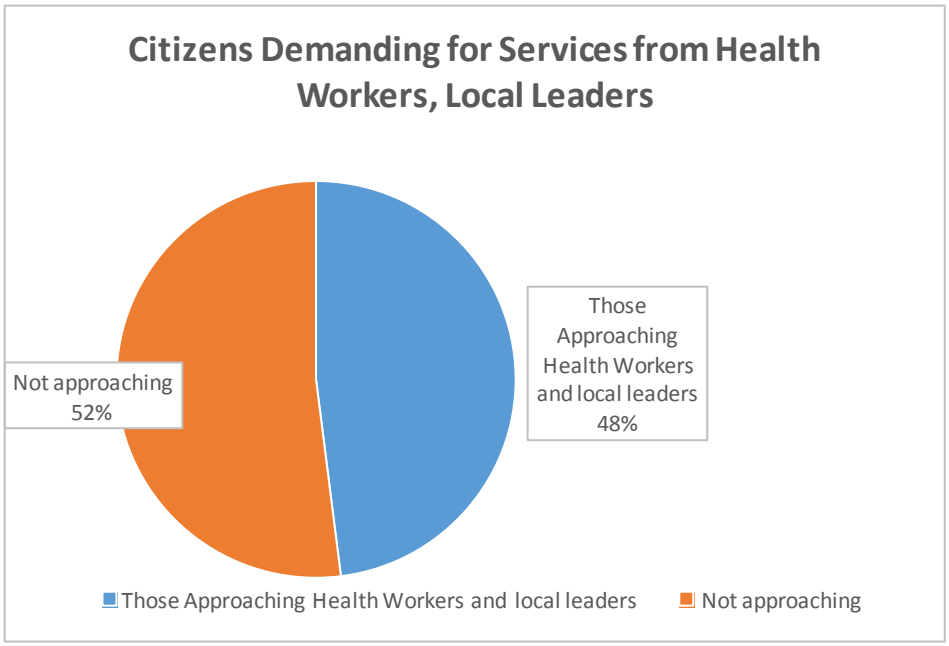

Chart 5: Citizens connected to duty bearers

According to the in-charge of Abei Health Centre, "…*before the introduction of the CAP project, citizens were reportedly not seeking healthcare services at the Abei Health Centre, mainly because of the poor attitude of health workers towards patients, run down infrastructure, and absenteeism or late coming of service providers. Service providers were seen to be abusive, traumatizing the patients, especially mothers seeking maternal health care services. After the CAP project began implementation, the Health Centre management in Abei for instance mobilized people to come for health care through various social gatherings such as churches, burial places, and during market days. At the moment, attendance to health care has greatly improved*".

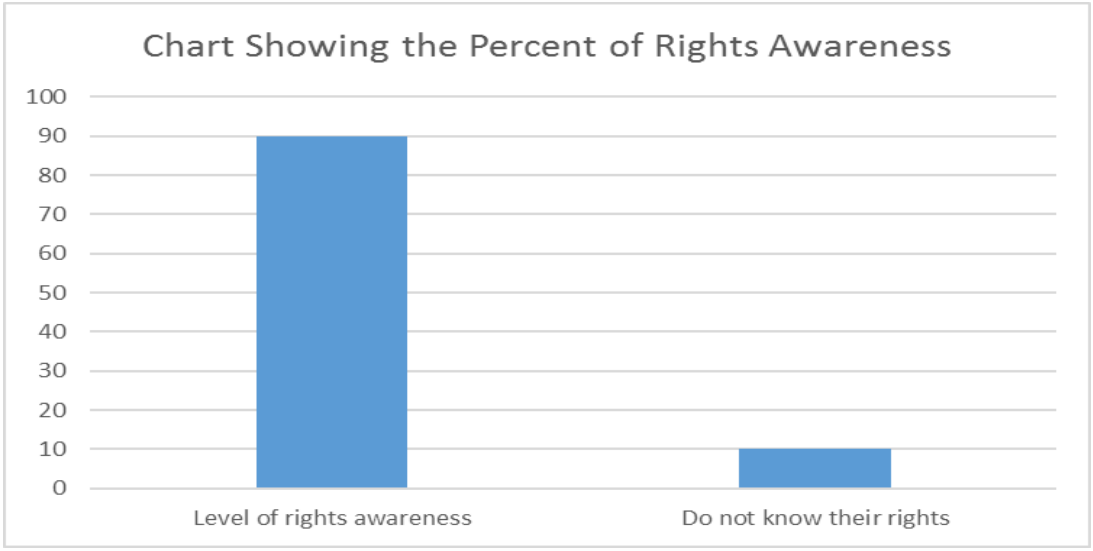

Chart 6: Percentage on citizens level of awareness of their rights

The level of improved communication is also attributed to the improved knowledge of rights by the citizens at 90 %. This number has increased by 9.2% from the baseline value of 81.8 %. The rights that they mentioned included: the right to medical services without payment, the right to have their blood tested before provision of medicines, and the right to demand an explanation if they were not happy with the manner in which services were being handled.

As a result of the above level of awareness; 18 % of the people interviewed had ever sent messages to the SMS platform, while 22 % said they had made calls to the toll-free line. On the other hand, 38 % had reported presenting their complaints during the PAF session and 14 % had presented to the IBMs, while 8 % had not participated at all in reporting complaints on their health system.

Overall, the number of people participating in the Public Accountability Forums (PAF) and Independent Budget Monitors (IBMs) was found to be highest as compared to those who participated through ICT (SMS platform and the toll-free line). Thus calling for the need to carry out additional awareness creation towards the use of the existing communication mode (the toll-free line) so as to enhance the level of citizen participation in the submission of their grievances and be able to promote more transparency and communication with the service providers.

CHAPTER FOUR

4.1 LESSONS LEARNT

- There is strength in the use of the media. Issues reported by ACCU and TAACC caused a media outcry in the country. For example, the national television network, NTV, presented and exposed the bats in Abei Health Centre in the viewership of the entire country. This caused an urgent redress of the problem and brought together local leaders including the RDC, CAO, LCs and Heads of Department. The NTV news broadcast caused wide discussed at national and local level issues concerning the state of health care in Apac district

- The absence of monitoring and supervision by the local government of its social service structures and the inadequate participation of the community in local governance to promote transparency and integrity in service delivery lead to rampant abuse of office, corruption, theft and negligence of duty among staff. The monitoring by both government and the citizens has led to great improvement in health care in the district.

- Civil society's thirst for transparency and accountability made the DHO to improve on the working environment of staff at the health centres. For the first time, the DHO organised for a meeting with all the in-charge staff of health centres to reorganize themselves and prepare to respond to the pressure coming in from ACCU and TAACC as well as celebrate some of the successes in the department. This helped improve on attitudes by service providers at the local government level while emphasizing the importance of accountably service delivery.

- Strengthening the functionality of HUMCs is very significant in promoting good governance – and avoiding abuse of office, fraud and negligence. The moment these groups started to operate as per requirement, there was significant change in the state of service delivery. Time management improved tremendous and the health centres have stayed open through the stipulated timelines.

- Collaboration with other partners is important in offsetting governance challenges such as corruption in the health sector. The experiences and character of corruption and abuse of office seem to be similar across the board. Thus the meeting between ACCU and the Health Sector Anti-Corruption Working Group was commendable because it provided an effective platform where issues emerging from the grassroots level filtered through to the national level and various state actors committed to resolving the issues brought to the forum. As a result the MHSDMU asked CSOs to report to police whenever they discover government labelled medicines and medical supplies in private clinics or markets and if no action is taken by police, cases should be forwarded to MHSDMU for swift action. It's because of this

commitment that four people selling medicines in Ayago market in Akororo sub-county in Apac District were arrested.

4.2. CHALLENGES

- The communities are still limited in terms of participation through ICT. Some of the people however reported that they find it easier to notify the IBMs and to attend the PAFs to share their grievances. The limited participation is also riddled by high levels of illiteracy – making it difficult for them to read and write especially for the SMS platform.

- The inadequate skills and training for the HUMCs have limited their participation in the governance of their health services. It was only after pressure was mounted through the citizen demand for public accountability that these groups started to hold meetings and occasionally monitor the performance of the health centres.

- There was a delay in the understanding that the platform code 6363 was for the CAP project. Apparently, the code 6363 was initially assigned for football activities by a media group and nearly all initial messages that came in were in regard to football. On the other hand, the SMS platform was not very attractive to the citizens until a toll free line was identified in collaboration with Transparency International.

- In addition to the above, technology is still alien to the local communities. While the SMS system had its challenges, people are still reluctant to make calls through the toll-free line. A continuous awareness rising is necessary to have everyone on board.

- The SMS platform was overwhelmed by spam messages (1031) which was very unrealistic. This filled up the platform and some could not be related to any health issues mainly because of the UCC recycles the use of short codes in Uganda.

- Although there is need for improved health services, the health sector also experiences some inherent challenges mainly related to resource limitations. In Apac General Hospital for instance, the important supplies such as cotton, gloves, spirit, etc. were inadequate and so the service providers were forced to collect money from the patients. Other places such as Teboke and Alado that require maternity wards cannot have them because of lack of resources, while Akokoro cannot have their ambulance repaired for the same reasons.

4.3. RECOMMENDATIONS

- Prioritize the use of the PAFs, IBMs and Media in the next phase of implementation as a mechanisms for enhancing results. The evaluation reported higher participation during PAFs and thus these should be expanded, while the media performed well in sensitizing the community members on CAP project

- HUMCs are important in promoting responsive governance. These groups should be assessed to establish their legality, and capacity in managing the stipulated roles of this function followed by training to enhance their skills in monitoring service delivery and ensuring transparency and integrity of the sector.

- An in-built steering committee should be established at the district and sub county level to enhance the level of monitoring by the local leaders. Issues emerging from the sub county/Health Centre can then be forwarded to the district level where ACCU/TAACC and the district officials can meet on quarterly basis to jointly review performance, issues raised, and commitments made in the previous quarter as well as plan for the next quarter. This structured mechanism will be helpful in keeping dialogue open to all stakeholders and avoid counter accusations of TAACC rushing to the media without first consulting with the local authorities. Policy issues for the national level can be picked up used by ACCU for developing policy papers/briefs for engaging with the national level stakeholders in the Ministry of Health and the Social Services Committee in Parliament, among others.

- More sensitization to encourage people to participate more in the issues concerning their health and demystify the service providers so that more public accountability can be sought for more responsive service delivery.

- There is success noted at the local level – sub counties and district of Apac, however, ACCU in collaboration with other actors such as TAACC and TIU need to step up their presence and advocacy efforts at the national level using existing coalitions to be able to spread out the risks of losing out on issues. Issues identified from the health centres and district should be followed up at the line ministry level and the social services committee in Parliament. This is because some of the issues identified are bigger than what the local governments can do especially when it comes to resource allocation and policy change issues.

- ACCU and TAACC need to strengthen their relationship with TI and promote more of the toll free number whose popularity is currently in the rise. The introduction of the toll-free number also led to increased ICT citizen participation in reporting grievances.

5.0 CONCLUSION

In conclusion, the CAP intervention under this initial pilot phase has recorded achievements as indicated above especially relating to levels of awareness, reducing absenteeism of health workers at the health units; denial of healthcare for lack of money; mistreatment especially of expectant mothers; and demands for bribes. Others included the sale of supplies such as mosquito nets and mama kits. All these factors undermine all efforts towards the objectives of local governance and good governance as a whole. The local leaders are in support and therefore, the next phase of implementation should consider developing stronger partnerships with the local leaders, and strengthening national level advocacy. The independent budget monitors are increasingly growing stronger in the communities on accountability issues and are highly regarded by the service providers, this team should be further supported to since they are the vigilant eyes and ears of CAP on the ground.

It is still relevant to strengthen monitoring structures at the sub county and district level through quarterly meetings that will ensure consolidation of issues, commitments and sieving of policy issues for follow up at the national level.

Although there is success reached already in regard to some of the citizen complaints and demands, the capacities are still nascent and require additional interventions to make them more vibrant, cause more engagement and therefore responsive governance.

CHAPTER FIVE

Appendix 1: Terms of Reference

CONDUCTING AN END OF PROJECT EVALUATION FOR THE CITIZEN ACTION PLATFORM PROJECT

1. Background

The Anti-Corruption Coalition Uganda (ACCU) was formed in January 1999 and formally registered as an NGO under the NGO Statute in 2003. The organization brings together like-minded entities and individual actors whose preoccupation is publicizing, exposing and advocating for curbing corruption in Uganda. ACCU provides a forum through which these actors can enhance their capacities in the fight against corruption as one strong voice and force that can effectively engage government on issues of corruption. The organizations' mission is to: "*empower people to actively and sustainably demand for transparency and accountability from public and private sector"* and her vision of attaining a *"transparent and corruption free society".*

ACCU in collaboration with The Apac Anti-Corruption Coalition (TAACC), with funding from Partnership for Transparency Fund (PTF) has been implementing a pilot project entitled the Citizen Action Platform (CAP) project in Apac district.

The Citizen Action Platform (CAP) project is an open source platform that seeks to amplify citizens' voices through technology to demand for improved service delivery in the health sector. The heart of the project is its ICT platform that enables CSOs to easily gather information provided by users at the grassroots level to inform policy makers and the media, ultimately improving health service delivery, thus contributing to the attainment of the Millennium Development Goal (MDG) 6. This project allows for CSOs to increase their reach and impact in monitoring government performance using ICT tools such as web, SMS and geo-mapping. The approach provides a mechanism for citizens to report government service deficiencies, present this information to duty bearers, track responses and provide feedback to citizens on outcomes. The project is premised on improving health service delivery to the poorest citizens who are most affected by corruption and poor governance.

2. Rationale

The CAP project was implemented with the **objectives** to:-

i. Deliver an open-source, integrated ICT platform designed to monitor, report and redress issues with fulfilment of public duties
ii. Demonstrate improved health service delivery, transparency, reliability and public responsiveness
iii. Improve citizens' health through greater access to required government services
iv. Achieve clearer understanding of where breakdowns exist in health service delivery

v. Strengthen existing reporting tools by providing visual information, data and feedback mechanisms to the public, media and government

The **expected project results** were;-

i. Medicines and clinical care provided corruption free and at appropriate level of quality and accessibility
ii. Fewer bribes solicited/ paid
iii. Reduced absenteeism among doctors and nurses
iv. Clinics open during mandated hours of operation
v. Improved transparency and communication between service providers and citizens

The **Expected Development Impacts** were;-

i. Empowered citizens with a multi-channel platform from which to actively participate in improving their societies.
ii. Improved rural health service delivery and health outcomes.
iii. Catalyzed growth and intensity of citizen's engagement to demand public accountability.
iv. Improved government responsiveness to citizen concerns and CSO capacity to constructively resolve issues with authorities.

So it is upon this back ground that ACCU seeks a consultant to conduct an end of project evaluation with respect to the expected results.

3. Objectives of the Evaluation

- To assess the project performance as per the expected results, and development impact indicators
- To draw key lessons learnt for replication and learning (assess the project achievements)
- To assess the feasibility using the feasibility Indicators (cost effectiveness and effective implementation) of the project

4. Nature of the Assignment

- Under take a desk review of the project documents to get further information about project implementation and partners
- Write an inception report with clear methodology of executing the exercise
- Design data collection tools that can pick information on all project indicators and general observations of intended and unintended outcomes
- Undertake data collection, cleaning, entry and analysis using relevant soft ware
- Write a report with relevant illustrations to ease comprehension
- The consultant shall present a draft report to ACCU team for validation.

5. Key Deliverables/Expected Out put

The consultant is expected to produce the following:

a) An inception report (with his/her understanding of the ToRs and statement of methodology, financial breakdown as well as reflection guide)
b) A first draft of the evaluation report by November 13th, 2015
c) Final report by November 20th, 2015

6. Proposed Time Schedule

The timing and duration for the assignment will be 1 month effective from the date of signing of the contract.

Relevant Skills and Experience

The suitable person/consultant is expected to have the following:

- Excellent knowledge and skills in conducting qualitative and quantitative research.
- Experience in evaluating governance projects.
- Knowledge of geographical area of project implementation
- Excellent report writing and documentation.

Supervision of Consultancy

The consultant in all undertakings and processes related to this assignment shall work closely with the M&E officer and the CAP project officer.

7. Tax Obligations

- A withholding tax of (6%) from the total contractual sum to be remitted to URA shall be deducted by ACCU.
- 10% deduction off professional fees as a contribution towards ACCU's sustainability

8. Submission of proposals

Interested consultants should submit their **Technical** and **Financial Proposals** to the Executive Director, ACCU, info@accu.or.ug or kagabac@accu.or.ug not later than **14th/10/2015**.

Appendix II: Quantitative Questionnaire

1. Have you heard of the citizen's action platform?

Yes
No

2. Do you know of your rights under the citizen's participation platform?

Yes
No

3. If you answered yes above, what are these rights?

Yes
No

4. When did you know about these rights?

Before CAP intervention
After CAP was introduced

5. Do you know of the SMS number or toll free number used for reporting grievances under CAP?

Yes
No

6. Have you ever submitted a complaint to the SMS Platform or called the toll free line?

Yes
No

7. Have you talked to your local leader or health centre personnel about any issues you are not satisfied with?

Yes
No

8. Have you been asked to pay money in order to get a service in the health centre?

Yes
No

9. If yes, what are some of those things they have asked you to pay for?

Medicines
Blood tests
Others

10. Has there been any change in the nature of service delivery since the CAP intervention started?

Yes
No

11. Do your health personnel always report to work, or do they miss work sometimes?

Yes

No

12. Do the health workers keep time and open the health centre early?

Yes
No

13. Have you experienced any cases of drug stock outs in the last 2 years?

Yes
No

14. Do you think the rural health services are improving or not?

Yes
No

15. Are the local leaders now more responsive to your needs as local citizen beneficiaries at the health centre?

Yes
No

16. What are the issues that local leaders have acted upon since you last had a local meeting with them?

Infrastructure
Monitoring
Drugs
Staff supervision

Appendix III: Qualitative Questionnaire

1. Have you heard of the CAP project?
2. If yes, what does this project do?
3. Are you happy with the nature of service delivery in the health centres?
4. If not, have you participated at all in reporting any complaints?
5. What are some of the complaints you have on the health care system in the district?
6. If not, why have you not yet reported any complaint?
7. Are there any changes you think were brought about by CAP on the health service delivery in the district?
8. What have you learnt as a result of CAP implementation?
9. What recommendations do you have towards improving healthcare in the district?
10. If you found any problem with accessing a service in the health unit, would you tell the health workers or local leaders about it?

Appendix V: List of Persons interviewed using Quantitative Questionnaire

No	Name	Contact
	Chawente	
1	Pule James	0774562862
2	Amos Jasper	0782248075
3	Bonny Owinyo	0785992311
4	Ogwang Denis	0780963983
5	Alum Middy	0771054329
6	Acuk Andrew	0781708032
7	Ketty Adongo	0784404728
8	Apio Brenda	0775059462
9	Akao Susan	0771014142
10	Sarah Pule	0787325207
	Ibuje	
11	Odongo Franco	0781866024
12	Elizabeth Odyero	
13	Anna Alele	0757775003
14	Ganyseke Janet	
15	Susan Anyanga	0784114544
16	Opio Augustine	0759934975
17	Apili Auma	
18	Awino Harriet	0758417105
19	Ogwang Eugenious	
	Apac	
20	Adero Eunice	0752910166
21	Auma Laura	0789153812
22	Okullu Bonny	0779333171
23	Okeng Jasper	0785663047
24	Ogwal Linus	0775482694
25	Alum Robina	0751664529
26	Betty Akaca	0780719984
27	Adupa Tonny	0755781338
28	Acio Priscilla	0705831583
29	Adong Susan	0775064460

	Name	Telephone
	Aduku	
30	Etin Lawrence	0782686957
31	Ogwal Geoffrey	0774290695
32	Martin Okullu	0777155070
33	Emer David	0782063301
34	Amongu Harriet	0784485940
35	Jesca Opio	0772654353
	Abogomola	
36	Omara Severino	0785493635
37	Owinyi Alex	0784804941
38	Mary Otyama	
	Akokoro	
39	Okello Job	0773732267
40	Acheng Leonorah	0773725164
41	Ochen Charles	0783335465

Appendix VI: List of Participants who took part in the Qualitative Interview

	Name	Contact
No	**Akokoro**	
1	Angom Mary	
2	Ocen Charles	
3	Acio Matta	
4	Adiko Patrick	782296387
5	Ejang Albina	
6	Oguta Alfred	775367515
7	Akello Santina	
8	Alobo Betty	
9	Mary Otyama	
10	Pule Rashid	
11	Grace Aloti	
	Abongomola	
12	Egwel Patrick	
13	Owiny Alfred	0772639670/0751353775
14	Odora Martin	
15	Alex Edyel	786436005
16	Okello Joel	783253401
17	Ogwal Geoffrey	
18	Omara Severino	
19	Omara Paul	782686894
20	Grace Ogwal	
21	Owinyi Alfred	
22	Harriet Aol	0782862138
23	Akullo Susan	0777110389
	Chawente	
24	Robert Ongom	
25	Otim William	
26	Ongom Moses	
27	Omara David	
28	Betty Atoo	
	Aduku	
29	Ocen Andrew	

	Ibuje	
30	Alwoch Rose	0779470909
31	Amoo Denis	
32	Auma Caroline	
33	Aceng Lare	
34	Akino Loice	
35	Janet Adong	
	Apac	
36	Koli Hellen	0782491184
37	Evaline Ayugi	0753529431
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