USING THE COMMUNITY SCOREACARD TO ASSESS THE QUAILITY OF HIV SERVICE DELIVERY IN ABIM DISTRICT.

2017 | MARCH

ACKNOWLEDGEMENT

Citizen's empowerment is critical in ensuring meaningful participation through planning and monitoring service delivery. Assessing health service delivery in health care facilities is one of the ways that citizens can give feedback to government and other stakeholders on how they are satisfied or not with the quality of public services.

Government services should be monitored by beneficiaries. In assessing citizen's satisfaction in the quality of HIV & AIDS in Abim district, NAFOPHANU extend the appreciation to all those who participated in the exercise. The findings will be used to improve to inform planning and programming at all levels in the district for improved service delivery.

NAFOPHANU is very grateful to the Embassy of Ireland through the Prevention of HIV & AIDS in Communities of Karamoja (PACK) project for financial support that facilitated the assessment in the district of Abim.

Appreciation is further extended to the Abim District local government through the District Health Officer (DHO) and HIV Focal Person, the PLHIV Coordinator, PACK Consortium members and secretariat team.

Special tribute goes to the staff in selected health facilities of Abim General Hospital, Orwamuge HC III, Alerek HC III, Morulem Mission HC III, Gangming HC III, Amita HC II, Katabok HC II and Nyakwae HC II, Adea HC II, Bolokom HC II, Awach HC II, local leaders (cultural and political), sub-county leaders, PLHIV network members and community members for participating in the assessment and giving their feedback on the quality of services amidst their busy schedules. The assessment participants are appreciated for their contribution, without which the assessment would not have been a success.

The struggle to eliminate HIV&AIDS in our communities is still continuing!

Together for a positive response!

Stella Kentutsi
Executive Director

ABBREVIATIONS AND ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
AIS:	AIDS Indicator Survey
ANC:	Ante-natal Care
ART	Anti-Retro Viral Treatment
CPR:	Contraceptive Prevalence Rate
DHO:	District Health Officer
DHT:	District Health Team
eMTCT:	elimination of Mother-to-Child Transmission of HIV
HC:	Health Centre
HCT:	HIV Counseling and Testing
HH:	Household
HIV:	Human Immune Virus
HMIS:	Health Management Information System
HSD:	Health Sub-district
LC:	Local Council
MNCH:	Maternal Neonatal and Child Health
MTCT:	Mother-to-Child Transmission
NAFOPHANU	National Forum for People Living with HIV Networks in Uganda
NSP	National HIV/AIDS Strategic Plan
PACK:	Prevention of HIV AIDS in communities of Karamoja
PLHIV:	People Living with HIV/AIDS
PNC:	Post-natal care
SDG:	Sustainable Development Goal(s)
TBA:	Traditional Birth Attendant
ToR:	Terms of Reference
U5:	Children under-five years of age
UAC	Uganda AIDS Commission
UBOS:	Uganda Bureau of Statistics
UDHS:	Uganda Demographic Health Survey
VHT:	Village Health Team(s)

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EXECUTIVE SUMMARY

The Prevention of HIV&AIDS in Communities of Karamoja (PACK) project was rolled out in October 2016 with the goal to reduce new infections amongst the young people and adolescents aged 10 - 24 years. The project that runs from 2016 -2020 is implemented by the CSO consortium comprised of National Forum of People Living with HIV/AIDS Networks in Uganda (NAFOPHANU), Straight Talk Foundation (STF), The AIDS Support Organization (TASO) and Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL). In order to achieve the project objectives, collection of evidence is inevitable.

In October 2017, on behalf of PACK partners, NAFOPHANU conducted a community score card to assess the level of health service delivery in the district of Kotido basing on the National HIV Strategic Plan thematic areas of HIV prevention, care and treatment, social protection and systems strengthening (staffing norms, infrastructure and equipment). The scorecard is a participatory community based monitoring and evaluation tool that enables citizens to assess the quality of services such as health care. The purpose of the Community Score Card was to empower the community and other stakeholders (service beneficiaries, service providers and other key stakeholders) assess the quality of HIV&AIDS and make recommendations on HIV&AIDS services to policy makers, policy implementers, Development Partners, Civil Society, the Private sector and other stakeholders

The assessment was targeting a catchment of eleven (11) ART accredited health care facilities, distributed according to different levels of service delivery that included 1 General Hospital, 5 Health Center IIIs and 5 HC II: Abim General Hospital, Orwamuge HC III, Alerek HC III, Morulem Mission HC III, Gangming HC III, Amita HC II, Katabok HC II and Nyakwae HC II, Adea HC II, Bolokom HC II, Awach HC II) with a total number of 605 participants.

Data was obtained through desk reviews, focus group discussions, key informant interview, direct observations and interface meetings. Quantitative data was analyzed using statistical package SPSS and qualitative data was analyzed using thematic analysis. Data is presented in frequency tables and graphs.

The assessment revealed that their efforts to ensure access to health services such as eMTCT, Safe male Circumcision, Testing and Counseling, HIV care and treatment, Adolescent HIV services, integrated TB services, Nutrition services, Home care, treatment for Opportunistic infections, Family planning as well as supplies such as, testing kits, reagents, condoms, IEC materials among others. Whereas the staffing norms have not reached the government ceiling, the staff available is able to multi-task to fill existing gaps. Equipment and infrastructure remain inadequate as few health workers are accommodated and have structures to work from.

The gaps that negatively affect HIV service delivery included comprehensive counseling skills, stock outs of drugs and supplies, low levels of staffing, lack of transport, lack of viral load testing and CD4 count machines, stigma and discrimination, AIDS incompetent staff, lack of youth friendly services and limited linkages between health facilities and community. In addition, and there are no systems to monitor and report on HIV community systems and preventive initiatives, inadequate public education and poor communication facilities.

The key recommendations from the assessment were focused on infrastructure development, recruitment of more staff to fill the gaps, constants supply of drugs and reagents, strengthening monitoring systems. Provide staff accommodation, National Medical Stores (NMS) to ensure regular supply of drugs and reagents including testing kits to reduce on frequent drug stock outs. There is also need to continue with community sensitisation on various services such as on family planning benefits and the need to integrate other community components to ensure an all round health service delivery

1.0 Introduction

The health of the population of any country is central to socio –economic transformation of the people and improved welfare. The Government of Uganda recognizes this important aspect and has made efforts to address some of the key constraints to service delivery. The Health Sector medium development plan (Health Sector Development Plan 2015/16- 2019/20), vision for the Uganda's health sector is "To have a healthy and productive population that contributes to economic growth and national development". The Health Sector Development Plan (HSDP) goal is to accelerate movement towards Universal Primary Health Coverage with essential health and related services needed for promotion of a healthy and productive life.

The HSDP has targets for the health sector to be achieved by 2019/20 that include amongst others: increasing ART coverage from 42% to 80%, increasing deliveries in health facilities from 44% to 64, reducing the Infant Mortality Rate per 1,000 live births from 54 to 44 and the Maternal Mortality Ratio per 100,000 live births, from 438 to 320/100,000; reducing fertility to 5.1 children per woman; reducing child stunting as a percent of under-5s from 33% to 29%; increasing measles vaccination coverage under one year from 87% to 95%; increasing TB case detection rate from 80% to 95%.

Despite the above efforts, there are still challenges that affect the delivery of health care services. According to HSDP, HIV, malaria, lower respiratory infections, meningitis and tuberculosis are the leading cause of death in the country. In addition, inadequate health workforce and infrastructure is still a key bottleneck to access and utilization of services.

The above situation needs to be urgently addressed for the country to meet the Sustainable Development Goals (SDG) targets on health by 2030. More especially, target 3 of SDG 3 states that "by 2030, end the epidemics of AIDS, TB, malaria and Neglected Tropical Diseases, and combat hepatitis, water-borne diseases and other communicable diseases."
This is in line with Uganda National HIV Strategic Plan (NSP) 2015/16 - 2019/20 whose vision is a healthy and productive population free of HIV&AIDS and its effects. The NSP aims at reducing new HIV infections, decreasing HIV related mortality and mobility, reducing vulnerability to HIV/&AIDS and mitigating its impact on PLHIV groups and other vulnerable groups, as well as having an effective sustainable HIV service delivery system strengthened for universal access to quality efficient and safe services.

[1]New Vision, Monday July 25, 2016

1.1 HIV/AIDS Situation in Uganda

The HIV epidemic remains the single most human health scourge still challenging the world. While globally the epidemic shows prospects towards a decline, the magnitude of the situation in East and Southern Africa remains worrying (17.7 – 20.5 million People Living with HIV(PLHIV) contributing over a half of the world's HIV burden (36.7 million). Despite marked progress in reducing the new HIV infections in Uganda, particularly among children and minimizing AIDS related death, the country continues to have a high burden of the disease as indicated by the 7.3% HIV prevalence in the 2011 Uganda AIDS Indicator Survey (UAIS) and high HIV infections in specific sub-populations and sub-regions (Central 1 10.4%, Central region 2 9.0%, East central 5.6%, Mid East 4.1%, North East 5.3%, Mid North 8.3%, west Nile 4.9%, Midwest 8.2%, South West 8.0%)
Karamoja Sub-region, as part of North Eastern region has a prevalence being at 5.3% in (UAIS 2011, having increased from 3.5% in 2004. There is also a high prevalence of other life threatening diseases such as Hepatitis B, at 21.7%, higher than the national prevalence rate of 10% . In addition, the Adolescent Girls Vulnerability index shows that over half (54%) of the adolescent girls 10-19 years are vulnerable at all three levels; individual (92%), household (57%) and community levels (100%), (UNICEF 2013)

The Uganda Population HIV Impact Assessment (UPHIA:2017) states that HIV prevalence among adults in Uganda aged 15 - 49 is at 6%. Total number of adults and children living with HIV in Uganda is estimated to be 1.3 million. HIV prevalence among women is 7.5% compared to 4.3 among men. HIV prevalence among 15 – 19 year olds is (1.8 girls and 0.5 in boys). The prevalence increases to 6.3% among men and women aged 25-29. Women and girls constitute the largest proportion of PLHIV (UPHIA). Viral load suppression among Men and women aged 15 - 24 is below 50 %. The same estimates indicate a further decline in AIDS-related deaths of 28,000 in 2017 from 31,000 in 2016.

2.0 ABIM DISTRICT PROFILE

Geographical scope

Abim District has a total land area of 2,337 km^2 with a projected population of 91,474 people(CIS) report and population density of 40 people per sq kma medium population density. The district boards lira in the south west, Pader in the Western, Kotido in the Eastern and Napak in the Southern. The district has an average altitude of 100 meters-1800 meters above sea level.

The district covers a total area of approximately 2,337 km2 of which 2% is under open swamps and water while 1% is under forest cover, leaving 2,267 km2 (97.0%) for human settlement and agriculture

Historical Background

Abim District was formed in 2006 from the then Kotido District. The district is largely occupied by the Ethur ethnic group, with its sister districts of Kotido, Kaabong, Moroto, Napak, Amudat and Nakapiripirit that are mainly occupied by the Karamojong ethnic group. While these ethnic groups have differences in language and culture, they share similar socio-economic lifestyle as they are agro pastoralist – practicing subsistence crop production and semi nomadic animal rearing.

The origins of the Ethur are somewhat obscure but it is believed to have originated from Abyssinia in Ethiopia. They are considered to be part of the Nilo-Hamites (also known as semi-Hamitic) group which includes the Teso, Kumam and Karamojong tribes. The Ethur, in contrast to their fellows, have adopted the simpler Nilotic tongue called Lebuthur. It is believed that their move from further North into the present habitat took place between the years 1800-1890.

Administrative Structure

Abim district is made up of 1 County of Labwor,5 Sub Counties of Abim, Alerek, Lotuke, Morulem and Nyakwae, 1 Town Council, 35 parishes/wards and 309 villages.

Main economic activities in Abim district

In Abim district, 42.4 % of the total population are mainly engaged in agriculture, 1.2% in trade, 0.8% in manufacturing, 12.7% in service delivery and only 33.6 of the population in other activities.

Health Service Delivery

In terms of health infrastructure, the district hosts a general hospital, and other health care facilities include four (4) private/ NGO facilities, eight (8) government HCs and several private clinics and drug shops. Abim District has one health sub district at Abim General Hospital (Abim District Development Plan (DDP) 2015/16-2019/20

2.2. Prevention of AIDS in Communities of Karamoja Project

Funded by the Embassy of Ireland, PACK is a five-year project implemented by a consortium of five organizations that include; National Forum of People Living with HIV Networks in Uganda (NAFOPHANU), The AIDS Support Organization (TASO), and Alliance of Mayors on HIV and Health at the Local Level in Africa (AMICAALL), and Straight Talk Foundation (STF). The project goal is to reduce new HIV infection amongst young people and adolescents (10-24 years) in Karamoja sub-region over the period 2016-2020

The project objectives are;

a) To increase demand and access to quality HIV&AIDS services for Adolescents (10-19yrs), young people (10-24yrs) and /key population,

b) To empower communities to address social cultural barriers including violation of human rights, and access to justice to HIV&AIDS prevention, care and treatment and social support

c) To develop the capacity of CSOs in good governance, advocacy, resource and community mobilization to deliver their mandate in the HIV /AIDS response at national and local levels.

d) To strengthen evidence based HIV&AIDS and SRHR programming and documentation of lessons learnt and best practices at national and local levels over the period 2016-2020 HIV&AIDSOn behalf the consortium NAFOPHANU conducted the CSC to assess the quality HIV service delivery as part of project implementation in the seven districts of Karamoja.

The purpose of the study was to empower the community and other stakeholders (service beneficiaries, service providers and other key stakeholders) asses the quality HIV&AIDS and make recommendations on HIV&AIDS services to policy makers, policy implementers, Development Partners, Civil Society, the Private sector and other stakeholders

HIV & AIDS 2 Objectives of Community Score Card assessment

- To empower the community (service beneficiaries) assess the quality HIV&AIDS services in Kotido district
- To enable the service providers self-evaluate the quality of HIV&AIDS services that they offer to the community.

To make recommendations on how improving HIV & AIDS service delivery to policy makers, policy implementers and other stakeholders

Inception meeting

The meeting was between the survey team and the District Health Officer for information and authorization to carry out the study. It was also to obtain district data as part of district back ground information. The meeting helped create good understanding and working relationship between the different parties and also benefitted in receiving the required information (input tracking) that was useful in the scorecard implementation in the field.

2.3 The scope of the assessment

This Assessment covered ten (11) health care facilities in Abim district that are accredited to provide ART services. Different methods were used in undertaking this assessment.

2.4 Source of information

Using both qualitative and quantitative methods, the major

source of information included Focus Group Discussions of the service users (men and women), service providers, interface meetings, key informant interviews, health facility interviews (input tracking) and review of secondary data that included district reports, national planning frameworks, Ministry of Health reports, PACK project documents, NAFOPHANU reports

3.2. Scope of the study

This Study covered eleven (11) health care facilities in Abim district that are accredited to provide ART services.

3.3. Study Design

The study used a multifaceted design comprising both qualitative and quantitative. The major source of information included Focus Group Discussions of the service users (men women and service providers), Interface meetings, key informant interviews, health facility exit interviews, and direct observation among others.

Table 1: Sample Size Distribution

Name of Facility	In put tracking and staffing	Focus Group Discussions (N)	Interface (N)	Key Informant (N)
Abim general Hospital	2	3	1	1
Orwamuge HC III	2	3	1	1
Gangming HC III	2	3	1	1
Alerek HC III	2	3	1	1
Morulem HC III	2	3	**1**	**1**
Nyakwae HC III	2	3	1	1
Awach HC II	2	3	1	1
Adea HC II	2	3	1	1
Amita HC II	2	3	1	1
Bolokom HC II	2	3	1	1
Katabok HC II	2	3	1	1
TOTAL	22	**33**	**11**	**11**

Source: Field data (2017)

3.4 Health Facility Selection

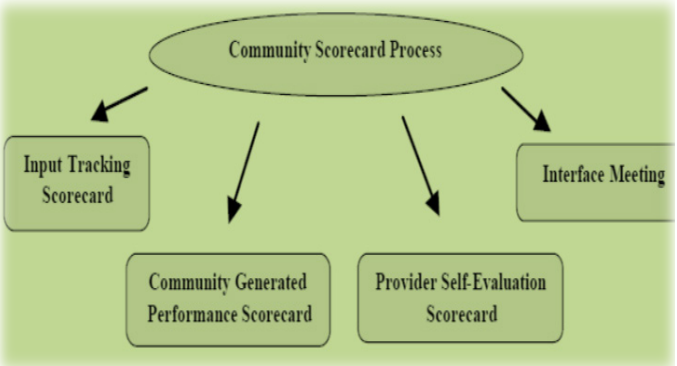
A total of eleven (11) accredited health care facilities providing ART were purposively selected. These included Abim General Hospital, Orwamuge HC III, Alerek HC III, Morulem Mission HC III, Gangming HC III, Amita HC II, Katabok HC II, Nyakwae HC II, Adea HC II, Blokom HC II and Awach HC II. The choice of these HCs created a balance for both urban and rural areas across various grades from H/C II, III, Hospital).

3.5. Study Participants for both qualitative and quantitative approaches

Participants for qualitative and quantitative were purposively selected from various categories that included groups of people with the diseases (PLHIV, TB), local leaders including kraal and clan leaders and sub county heads within the catchment of a health facility. Informants from the local governments (LGs) included technical staff as well as political leaders of the district and sub-counties.

3.0 Methodology

The assessment used a Community Score Card (CSC) methodology developed by Care International in 2001. The Community Score Card (CSC) is a participatory, community based monitoring and evaluation tool that enables citizens to assess the quality of priority public services such as health, school, public transport, water, waste disposal systems among others. It is an instrument used to elicit social and public accountability and increases the responsiveness of service providers by enabling citizens to voice their assessment of a priority public service. It is used to inform community members about available services and their entitlements and to solicit their opinions about the accessibility and quality of these services. By providing an opportunity for direct dialogue between service providers and the community, the CSC process empowers the public to voice their opinion and demand improved service delivery. The CSC provides valuable feedback that helps to improve services and provides important information to guide government policy-making reform initiatives.



Source: Janmejay & Parmesh (2009)

Quantitative Data collection methods

A questionnaire was developed to capture facility data that included staffing, equipment and other infrastructure and was administered to the in charges of health care facilities visited

Key informant interviews

The research team held meetings with the district leadership represented by the District Health Officers (DHOs) to inform them about the study, request for authorization to visit Health Centers and access to district data such as from the District Development Plan, and district budgets). This meeting helped create good understanding and working relationship between the different parties and also benefitted in receiving the required information (input tracking) that was useful in the scorecard implementation in the field.

Input tracking

In Abim District, eleven (11) health facilities were visited to gather information on key inputs that include staff and infrastructure in facilities that was to be used to inform participants of their entitlements during the focus group discussions. Findings informed the meetings on the current state of the health facility.

Focus Group Discussions

The focus group discussions were used to collect qualitative and partly quantitative data from the community (Men and women separately) and the health workers and the FGDs were guided by performance indicators (scores) and the thematic areas of the HIV strategic plan as per HIV services; prevention, care and treatment, social support and protection and system strengthening.

Interface Meeting

This was a joint meeting of both the service users (community men/women), service providers and opinion leaders (Community and Religious Leaders). The interface meeting was to measure against the performance indicators of the community and service providers to come up with a consensus score and also develop a joint action plan with commitment in terms of time and responsible party for follow up.

3.6. Data Management and Analysis

Quantitative data was collected, coded and entered in EPI data and analyzed using statistical package for social scientist (SPSS), statistics includes; frequencies and graphs used to describe findings while cross tabulations were calculated to drive some associations. Qualitative data collected through key informant interviews and FGDs was analyzed using thematic analysis, where recurrent ideas are categorized and grouped according to the key assessment questions in order to identify perspectives and reporting done in an integrative manner.

3.7. Quality Assurance

The assessment team employed a number of quality assurance mechanisms that included training of data collectors, review of secondary data, accompanying data collectors to all the data collection sites and recording voices of the participants in the FDG meetings.

A half day training for moderators and scribes was conducted to ensure better understanding of the process of conducting the scorecard. This enabled the implementers become familiar with the tool to ensure standardization of the data collected. An interview guide was then issued to the data collectors.

3.8. Ethical Considerations

The researchers obtained written approval from the district local government to visit health care facilities and conduct the survey. Consent was obtained from all respondents.

4.0 FINDINGS

In this section findings are categorised as per thematic areas of the National Strategic Plan 2015/16-2019/20 (NSP) i.e. HIV prevention, care and treatment, social support and systems strengthening. However, the score card methodology and subsequent findings are presented in 4 sections as; systems strengthening (staffing norms and infrastructure) since all the other areas of HIV prevention, care and treatment and social support rotate around availability of human resource, structures and equipment to carry on their work.

4.1 Staffing

The MoH has established the staffing needs in different categories of health care facilities and advises the Ministries of Public Service and Local Government on implementation and deployment. Based on staff requirements outlined in the MoH Guidelines, a General Hospital is supposed to have 179 staff, 48 for HCIV, 19 for HCIII and 9 for HCII. The following sections highlight the results from the staff tracking at the 11 health centres the assessment was undertaken.

4.1.1 Adherence to staffing norms in Abim General Hospital

One key element that determines the quality of service delivery is the availability of human resource. According to the government staff sealing, the general hospital is supposed to have a minimum of 179 health practitioners. Abim has a general hospital and its staffing norms were grouped as medical officers, allied health professionals, dental, pharmacy, administrative, staff, nursing and support staff. According to the DDP 2015/16-2019/20, the facility serves as HC III for Abim subcounty, Referral facility for Abim and the neighbouring districts of Agago, Otuke, Kotido and Amuria thus staffing has a huge impact on service delivery. Out of the 179 staff for the general health facility, Abim General Hospital had 146 (81.5%) filled posts with a gap of 33(18.5) staff. The facility had improved structures having undergone renovations which had improved service delivery.

Medical Officers

This category comprised of a Principal Medical Officer, Medical Officer special grade, Senior Medical Officer and four Medical Officers totaling to seven (7) officers. Results gathered from the Abim General Hospital indicated a gap of 2 staff in this category as depicted in table 3.

Table 2: Medical Officers staffing Norms of the General Hospital

	Approved post	Filled post	Gap
Medical Officers			
Principal Medical officer	1	1	0
Medical officer special grade	1	0	1
Senior medical officer	1	1	0
Medical officers	4	3	1
Total	7	5	2

Source: Field data (2017)

Out of the 7 medical officers approved for General hospital, only 5 are available and the facility receives all the referrals from health centres in the district. Some of the health workers are supported by implementing partners which has helped to reduce their workloads. The district health office and planning department should construct more staff quarters and pay staff hardship allowances and other benefits to attract and retain specialized staff in the facility.

Allied Health Professionals

The category of Allied Health Professionals consisted of Clinical officers, Dermatologist, Anesthetic officer, orthopedic officer, Physiotherapist, Occupational therapy, Radiographer and laboratory staff. Details of these are in the subsections below. In this category, out of the 27 staff required at the hospital, only 17 (63%) were available leaving a gap of 10 (37%). This situation hinders effective service delivery leading to the long waiting periods and some patients not attended to on time.

Clinical Officers

The approved standard for a hospital is One (1) Senior Clinical Officer, five (5) Clinical Officers, one (1) Psychiatric Clinical Officer and one (1) Ophthalmic Clinical Officer. Results indicate that Abim General Hospital had 3 clinical officers out of 5 approved. The ophthalmic clinical officer and psychiatric clinical officer were missing

Laboratory staff

According to the standard staffing norms at general hospitals, the needed staff were all employed in this position. There was

1 senior laboratory technologist, 1 laboratory technologist, 2 laboratory technicians and 2 laboratory assistants.

Other Allied Health Professionals.

Out of the 27 staff supposed to be at the hospital, only 17 are available leaving a gap of 10. This has led to multi tasking as shown in table 3.

Table 3: Number of clinical officers

Post	Approved	Filled	Gap
Senior clinical officer	1	1	0
Clinical officer	5	3	2
Psychiatric clinical officer	1	0	1
Ophthalmic clinical officer	1	0	1
Health inspector	1	1	0
Medical Entomology officer	1	0	1
Radiographer	2	1	1
Physiotherapist	1	0	1
Occupational therapist	1	1	0
Orthopedic officer	2	2	0
Health Educator	1	1	0
Assistant Health Educator	1	0	1
Anesthetic officer	2	1	1
Theater Attendants	2	2	0
Senior Lab. Technologist	1	0	1
Lab Technologist	1	0	1
Lab Technician	2	2	0
Lab Assistant	1	1	0
Total	**27**	**17**	**10**

Source: Field Data (2017)

Dental staff

Abim General Hospital has 2 out of the 4 dental staff meant for a hospital. The available staff were Public Health Dental Officer and Dental Attendant. Long lines were witnessed in the department as some clients waited for quite a long time before being attended to.

Table 4: Dental staff

Post	Approved	Filled post	Gap
Dental Surgeon	1	0	1
Public Health Dental Officer	2	1	1
Dental Attendant	1	1	0
Total	4	2	2
Percent (%)		50	50

Source: Field Data (2017)

Pharmacy

According to Ministry of Health (MoH) Guidelines 2002, general hospitals are required to have 1 pharmacist and 2 dispensers recruited. Abim General Hospital did not have a Pharmacist and pharmacy is managed by 2 dispensers. This situation needs to be addressed urgently for such a high volume and referral hospital.

Table 5: Number of Pharmacists

Post	Approved posts	Filled post	Gap
Pharmacist	1	0	1
Dispenser	2	2	0
Total	3	2	1

Source: Field data (2017

Administration

According to MoH Guidelines 2002, a general hospital is required to have 14 administration staff to for the day to day management of the hospital. Out of 14 required, Abim General had had 11 (79%) staff with a gap of 3 (21%).

Table 6: Administration staff

Administrative staff	Approved post	Filled post	Variance
Senior Hospital Administrator	1	0	1
Hospital Administrator	1	1	0
Personnel officer	1	1	0
Medical Social Worker	1	1	0
Nutritionist	1	0	1
Supplies officer	1	1	0
Office Typist	1	1	0
Stores Assistant	2	1	1
Medical Records Asst.	2	3	1+
Senior Accounts Assist.	1	1	0
Accounts Assist.	1	1	1
Total	14	11	3
Percentage (%)		**79**	**21**

Source: Field data (2017)

Nursing

The Nursing staff provide the bulk of the health care service providers in any hospital for they are frontline staff. Out of the 113 staff approved to be at the general hospital, 81 (72%) were currently deployed at the facility leaving a gap of 32 (28%). The absence of some nursing staff could be leading to the current ones being overwhelmed with clients

Table 7: Nursing staff

Nursing Staff	Approved post	Filled post	Gap
Principal Nursing officer	1	0	1
Senior Nursing officer	5	4	1
Nursing officer/Nursing	17	15	2
Nursing officer/midwifery	3	2	1
Nursing officer/psychiatrist.	1	1	0
Enrolled Nurse	46	29	19
Enrolled Midwife	25	16	15
Nursing Assistant	15	14	1
Total	113	81	32
Percent(%)		72	28

Source: Field data (2017)

Support staff

Out of the 13 staff required at the health facility, 9 (69%) were available leaving a gap of 4 (31%). The missing included darkroom attendant and mortuary attendant. Therefore a strong need to recruit the two critical staff to man the mortuary and cold chain.

Table 8: support staff

Support staff	Approved posts	Filled posts	Gap
Darkroom Attendant	1	1	0
Driver	2	2	0
Askari	2	2	0
Cold Chain Attendant	1	0	1
Mortuary Attendant	1	0	1
Cook	3	2	1
Artisan	3	2	1
Total	13	9	4
Percent (%)		69	31

Source: Field data (2017)

Out of the 197 staff that are required at the facility only 146 staff were filled up in Abim General Hospital which is about 74% of the required staff leaving the gap of 51.Among the missing staff were; 2 Medical officer special grade, 1 Psychiatric clinical officer, 10 other allied professionals, 8 Laboratory staff, 2 Dental staff, 1 Pharmacy staff, 32 nursing staff, 3 Theatre staff, 4 support staff, and 3 Administrative and finance staff respectively as shown in the subsequent.

4.1.2 Adherence to Staffing Norms in Health Centre IIIs

According to MoH standards, Health Centre III is supposed to have 19 staff who include Allied health staff (Senior clinical officer, Clinical officer, laboratory technician, laboratory assistant and health assistant), Administrative staff (Health information assistants), Nursing (nursing officer, Enrolled Nurse, Enrolled midwife and Nursing assistants), Support staff (Askari and Porter).

In Abim the assessment carried out in 4 health center IIIs of Alerek, Orwamuge, Morulem and Nyakwae revealed a staffing gap consisting of; senior clinical officer (Orwamuge , Morulem and Nyakae), 1 Lab. Technician in Nyakwae, 1 enrolled mid-wife in Alerek, enrolled Nurse (2 Alerek , Orwamuge and Nyakwae), nursing assistant (2 Orwamuge, 1 Alerek and Nyakwae), Lab Assistant (Nyakwae) and in Morulem the facility had staffing

beyond the minimum standard comprising of; (Psychotherapist, Accountant, Records assistant, Cashier, Driver, 2 Nursing aid, 4 ground workers).

Alerek HC III handles 150- 300 patients daily yet according to the findings 5 out of 19 (26%) staff were missing which include; Senior clinical officer, Enrolled Mid wife, enrolled Nurse and Nursing assistant.

Orwamuge HC III which receives 240-250 patients daily had 15/19 (79%) of the staff available at the facility and 4/19 (21%) staff missing, including Senior Clinical Officer, Enrolled nurse and Nursing Assistant.

Morulem Mission HC III revealed that only 18/19 (95%) staff were posted and available at the facility with only 2/19 (5%) missing. Only a Senior Clinical Officer was missing however the facility had more support staff comprising; Psychotherapist, Accountant, Records assistant, Cashier, Driver, 2 Nursing aid, 4 Ground workers.

Nyakwae HCIII 53% of the positions were filled and 47% missing The missing staff were; Senior clinical Officer, Lab. Assistant, Enrolled Nurse, Nursing assistant, Lab. Technician and Health Assistant

Table 9: Adherence to staffing norms in health center IIIs

Staffing norms	Alerek HC III			Orwamuge HC III		Morulem HC III		Nyakwae HC III	
	Norm	Actual	Gap	Actual	Gap	Actual	Gap	Actual	Gap
Senior. clinical Officer	1	1	0	0	1	0	1	0	1
Clinical Officer	1	1	0	1	0	1	0	2	0
Nursing officer	1	1	0	1	0	1	0	1	0
Lab. Technician	1	0	1	1	0	1	0	0	1
Enrolled Mid-Wife	2	1	1	2	0	2	0	2	0
Enrolled Nurse	3	1	2	2	1	2	1	3	0
Lab. Assistant	1	1	0	1	0	1	0	1	0
Health Assistant	1	1	0	1	0	1	0	1	0
Nursing Assistant	3	2	1	1	2	3	0	1	2
Health Information Assistant	1	1	0	1	0	1	0	1	0
Askari	2	2	0	2	0	3	2+	1	1
Porter	2	2	0	2	0	2	0	1	1
TOTAL	**19**	**14**	**5**	**15**	**4**	**18**	**2**	**14**	**5**
Percent (%)		**74**	**26**	**79**	**21**	**95**	**5**	**74**	**26**

Source: Field data (2017)

Delivery bed Alerek HC III

4.1.3. Staffing in Heath Centre II

The district is mainly covered by Health Centre II facilities. Because sub-counties with challenges of long distance to access services were accredited to offer even ART services especially eMTCT. The health facilities visited were: Amita HC II, Adea HC II, Awach HC II, Bolokom HC II, Gangming HC II and Katabok HC II

Table 10: Staffing at health centre II in Abim district

Staffing norms	Amita HC II			Adea HC II		Awach HC II		Bolokom HC II		Gangming HC II		Katabok HC II	
	Norm	Actual	Gap	Actual	Gap	Actual	Gap	Actual	Gap	Actual	Gap	Actual	Gap
Enrolled nurse	1	1	0	1	0	2	+1	1	0	1	0	1	0
Enrolled mid-wife	1	0	1	1	0	1	0	1	0	1	0	0	1
Health assistant	1	0	1	0	1	0	1	0	1	1	0	1	0
Nursing assistant	2	1	1	2	0	3	+1	1	1	2	0	1	1
Askari	2	0	2	1	1	2	0	1	1	1	1	1	1
Porter	2	2	0	1	1	1	1	1	1	2	0	2	0
Total	**9**	**4**	**5**	**6**	**3**	**9**	**1**	**5**	**4**	**8**	**1**	**6**	**3**
Percentage (%)		**44**	**56**	**67**	**33**	**89**	**11**	**56**	**44**	**89**	**11**	**67**	**33**

Most HCIIs are well staffed such as Awach and Gangming at 89% Amita and Bolokom are below 60%. This disparity needs to be addressed to ensure the hard to reach and to stay receive the people receive all the needed services.

4.2 Input Tracking Equipment

Every health care facility is supposed to have certain equipment to support staff to deliver services efficiently. These include buildings, office space, laboratories, and theatre. The team obtained data on the Out-Patient Department (OPD) and In-Patient Department (IPD) structures following the government set guidelines and for the minimum requirements of the facilities. In put tracking was undertaken in Abim General Hospital, Morulem HC III, and Alerek HC III, Orwamuge HC III, Nyakwae HC III, Amita HC II, Adea HC II, Awach HC II, Bolokom HC II, Gangming HC II and Katabok HC II.

Table 11: Input ranking at Abim General Hospital

Section	Indicator	Existence	Status
OPD	Out patients clinic	Yes	The out patients clinic was operation at the OPD, physiotherapy and occupational theater
	Special out patients clinic	Yes	The facility had a HIV clinic within the OPD, cancer management clinic, well furnished with equipment and facilities to be able to offer the services
	Examination room for clinical officer	Yes	The room was available spacious in the newly constructed OPD and well equipped
	Examination room for medical officer	Yes	The room is well-furnished and stocked with necessary medical equipment's for diagnosis and examination
	Injection room	Yes	The room was available on OPD and other departments at the facility and well-furnished and ventilated and waiting area.
	Treatment room	Yes	The treatment room at OPD was equipped with tray, treatment bed and screens
	Waiting room	Yes	The OPD had a waiting room spacious enough with seats for clients for clients and patients to wait from for the appointments and treatment
	Multifunctional room	Yes	The room was clean and well furnished
	MCH(ANT/FP)	Yes	It is in good state there are partitions , privacy is available, with enough space
	Laboratory store	Yes	The lab store is fully stocked with enough lab equipment
	Blood bank	No	Blood is kept in the central laboratory and no specific room for blood
DENTAL DEPARTMENT	Treatment room	Yes	Two rooms were available with 2 stretcher and operation beds and screens and tray.
	X ray	Yes	The room is clean with X ray machines, operation bed and chair but squeezed.
	Radiology	Yes	The machines were in place with only one machine functional the other had no supportive batteries, reported regular stock out of reagents and equipment to be used.

Section	Indicator	Existence	Status
	Radiology film processing	Yes	All the radiology films are functional and working and had a dark room for development of the graphics
	Radiology waiting area	Yes	The room is small with fewer waiting seats
GYNA & OBS DEPT	Treatment room	No	The treatment room improvised in the OPD treatment room, it has some sometimes inconveniences other service delivery
PYSIOTHERAPY	Treatment room	Yes	The room is small, squeezed and looks not been operational for awhile
OPERATING THEATRE	Changing room	Yes	The theatre had a changing room with equipment and reagents necessary for the operationalizing a theatre
	Locker area	Yes	The locker area was available and with shelves and rockers
	Operating theatre	Yes	The theatre was operational however some of the equipment were not in use. However with the facility had only one oxygen supporting cylinder which is shared among the facility
	IN PATIENTS DEPARTMENT (IPD)		
MATERNITY (DELIVERY UNIT)	Medical ward	Yes	The male and female ward exists at the facility. But in poor condition and state
	Surgical ward	No	There is no surgical ward for male, they are referred to the general ward
	Obstetrics/ gynecology wards	Yes	Antenatal, maternity first labor, the post-natal and delivery wings and gynecology room exists at the facility however the state of the structure in which there are old and not well ventilated
	Pediatric ward	Yes	The pediatric ward was available and sectioned for nutrition and neonatal. But no enough beds and linen and mosquito nets
	Psychiatry ward	No	The ward does not exist at the facility
	Tuberculosis ward	Yes	The wing and ward are there but the state of the ward is poor no beddings, poor hygiene and not well exenterated
	First stage labor	Yes	There room is small and yet the facility admits a lot of patients and mothers
	Mid wife office	Yes	It is small and squeezed and some functions such as sterilization is done in

Section	Indicator	Existence	Status
			the same rooms
	Premature room	Yes	The room exist large but no incubator
	Store	Yes	The ward store exists but squeezed, small and not well ventilated
PHARMACY	Pharmacy dispensary	Yes	the room is well spacious and well-furnished and well shelved
	Preparation room	Yes	The room is available with selves and functioning equipment for keeping drugs
	Store	Yes	The room is large, well condition and well organized
	Mortuary	Yes	The mortuary is available however not in good condition , the fridge is not functioning and no office
	Office	Yes	The offices are clean well-furnished and conditioned.
	Store	Yes	The store is large, well organized and stocked
ADMINSTRATION	Conference room	Yes	The room is large well vanished with board and furniture
	Library	No	The facility had no library
	Office secretary	Yes	The office is large equipped varnished and with computer, printer and stationary
	Administrators office	Yes	The office is large equipped varnished and with computer, printer and stationary
	Personnel's office	Yes	The office is large equipped furnished and with computer, printer and stationary
	Hospital directors office	Yes	The office is large, furnished and equipped with computer.
	Staff tea room	No	No designated room for tea
	Store	Yes	Staff keep the equipment in their offices
KITCHEN	Preparation Area	Yes	There is no kitchen for patients
	Store	Yes	There are 2 large stores equipped with food supplements and food for the mothers and malnourished.
	Wet area	No	There is no specific wet area they use the laundry.
	Laundry	Yes	The laundry is small with no poor drainage system
	Laundry store area	No	There is no store for laundry.
	Laundry store area	No	There is no laundry store for dirty linen.
	Generator room	Yes	The facility has 2 generators but one is not functioning

Drug store in Abim General Hospital

Male ward in Abim general hospital

Radiography machine in Abim General Hospital

Oxygen machine at theatre in Abim General Hospital

4.2.2 In and Out-patients' Department Structure at Health Centre IIIs

All the facilities visited had OPD departments. However, their functionality was lower than the required minimal standards. In Alerek HC III, the OPD was in fair state with solar system but not fenced, Morulem HC III OPD was in good state with solar system lighting and functioning and equipment and Nyakwae HC III had equipment and solar but not stable to support some equipment. All the facilities visited had a lab, although functionality was below the required minimum standards in the facilities. The facilities had ART clinics and drug stores.

Presence of an IPD (delivery room) was confirmed in all facilities visited. However, lack of a nearby water source, absence of solar/ electricity, inadequate space/ rooms, lack of mama kits and other supplies proved a challenge. Seventy five percent (75%) – Morulem, Alerek and Nyakwae had a maternity ward but not all had maternity first labor and maternity waiting room

respectively. Inadequate space, water, beds and bedding and medical supplies were also mentioned as some of the challenges of the maternity division.

Although all the HC IIIs facilities offer maternity services and are functional, access to reproductive health services is limited due to few maternity units' staff to offer the services. Morulem HC III lacked a solar system in the maternity ward, in Alerek HC III there were poor structures. Other challenges included lack of reliable transport mechanism (ambulance) and lack of incinerators for medical waste disposal in Alerek HC III and Orwamuge HC III.

Incinerator at Alerek HC III

Table 12: Out and in-patient department health centre

Indicators	Alerek	Morulem	Nyakwae	Orwamuge	Status
OPD	**AVAILABILITY**				
Counseling room	No	Yes	No	No	Morulem- had a counseling room and the others improvised counselling services in the Clinician's office
Dispensing room	Yes	Yes	Yes	Yes	All the facilities had a dispensing room, well furnished with dispensing table and cupboards for keeping drugs
Treatment room	Yes	Yes	No	Yes	Nyakwae had no treatment room and services were being carried out in the examination room In Morulem and Alerek the rooms were full and functional with treatment bed, screens, waiting area, equipment, weighting scale and tray and trolley
Laboratory	Yes	Yes	Yes	Yes	All the labs were equipped with necessary equipment. Morulem; Gene expert machine, CD4 count machine, water extension, wet area, store and microscope and testing kits and reagents
OPD drug store	Yes	Yes	Yes	Yes	It exists and well organized
ART clinic	Yes	Yes	Yes	Yes	All the facilities visited had ART clinics though there was lack of space. The integration of services principle was involved in Morulem to reduce stigma and discrimination among the clients
Examination room	Yes	Yes	No	No	Not all health care facilities had, others improvised
IPD	**AVAILABILITY**				

Indicators	Alerek	Morulem	Nyakwae	Orwamuge	Status
Male ward	No	Yes	No	No	All facilities visited had no wards for male patients. Morulem had 6 beds, drill stands and beddings
Children/Female ward	Yes	Yes	Yes	Yes	Yes but limited beds
Linen store	No	Yes	No	No	In all the facilities visited, bed linen was found in only Morulem HC III.
Delivery Room	Yes	Yes	Yes	Yes	There is a delivery bed, drip stand and trolley in the delivery room, It has a sterilization area for equipment and kits
Maternity ward	No	Yes	Yes	Yes	The ward was well furnished and spacious in Morulem HC III, Nyakwae HC III and Orwamuge HC III, There were only two beds, lack of screens and poor hygiene in the ward at Alerek HC III
Maternity first labor	No	Yes	Yes	No	In all facilities', only Morulem and Nyakwae HC IIIs had first labour rooms. In Alerek HC III and Orwamuge HC III mothers wait from the maternity ward.
Maternity waiting room	Yes	Yes	Yes	No	All the health facilities visited had designated maternity waiting rooms except in Orwamuge HC III
Ward nurse station	No	Yes	Yes	Yes	Morulem HC III, the small Ward Nurse station is used for other purposes such as sterilization.
Sterile store	No	Yes	No	No	In all the facilities there were no sterilization stores except in Morulem The facility had a sterile stove and cooker for equipment used in the surgery

OPD in Nyawae HC III Abim District

Delivery bed in Morulem HC III

Children ward in Alerek HC III

Consultation meeting in Morulem HC III

Children ward in Morulem HC III

4.2.4 Out and in patient in HC IIs

All the health centre IIs visited Amita HCII, Adea HC II, Awach HC II, Bolokom, HC II, Gangming HC II and Katabok HC II assessed had an OPD and were offering antenatal services.

Under OPD, the assessment further examined the availability of treatment room, counseling room, dispenser, drug store, minor lab for testing and ART clinic and maternity ward for ANC program. However, in Adea HC II, Awach HC II and BolokomHC II, the facilities had neither treatment rooms nor ART clinic but offered ART services through eMTCT to the community with support from Abim General Hospital.

Dispensing window Awach HC II

Examination room in Gangming HC II

Drugs store in Gangming HCII

5.0 FINDINGS FROM FOCUS GROUP DISCUSSIONS AND INTERFACE MEETINGS

This section contains discussions from the Focus group discussions for men, women, service providers and interface meetings including actions required and recommendations. These are arranged according to the HIV/AIDS national strategic plan themes. During the mobilization, participants agreed on the scoring criteria where 5 meant a very good service, 4, Good, 3, Fair, 2 poor and 1 very poor.

SCORE	VARIABLE	COLOR
5	Very good	
4	Good	
3	Average	
2	Poor	
1	Very poor	

Though the graphs in proceeding sections have scores for men, women and service providers respectively, what is discussed is the consensus score when all the groups interfaced.

5.1 HIV PREVENTION

Assessment of HIV prevention services considered the quality of elimination of Mother to Child Transmission (eMTCT), safe male circumcision, provision of IEC materials, condom supply (female and male), HIV testing counseling services and sexual and gender based violence services among the indicators of HIV prevention. Each facility is supposed to be functional providing curative, preventive and integrated HIV services. In Abim, HIV services are rendered at all levels (general hospital, HC IIIs and selected accredited HC IIs) thereby shortening distances to nearby facility (DDP 2015/16-2019/20).

5.1.1 Quality of eMTCT Services

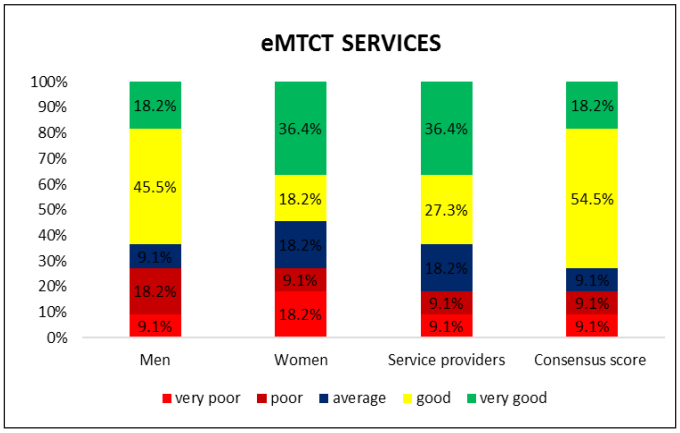
eMTCT is one of the priorities adopted to have an AIDS free generation. The scorecard assessed; level of male involvement, competency of health workers in comprehensive HIV care, stock status of commodities, follow up mechanism and community knowledge and awareness. During the interface meeting 54.5% rated it as good, 18.2% as very good and only 9.1% reported as average, poor and very poor service respectively.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The good ranking was a result of; staff trained in comprehensive HIV care, community awareness on the services, peer to peer support, strong follow up mechanism, strong collaboration and support from implementing partners. The gaps were on limited follow up mechanism for lost mothers, mothers still attending to traditional birth attendant, poor structures and equipment, limited staff in the lower Health facilities and low male involvement. The community urged the Implementing Partners to strengthen follow up mechanisms in Abim General Hospital by supporting the health workers and VHTs, whereas in lower health Centre IIs (Adea HC II, Awach HCII Bolokom HC II and Katabok HC II) the respondents emphasized the upgrading of the facility to HC III level to be able to avail staff and offer more HIV&AIDS services.

In Alerek HC III, Morulem and Orwamuge and Nyakwae HC III recommended DHO's office to recruit and train health workers to be AIDS competent, support extension workers (expert clients and VHTs) to conduct follow up, use local and traditional leaders to sensitize the community, encourage male involvement and promote privacy of patients in HIV service uptake.

Figure 1: Participants rating of EMTCT services



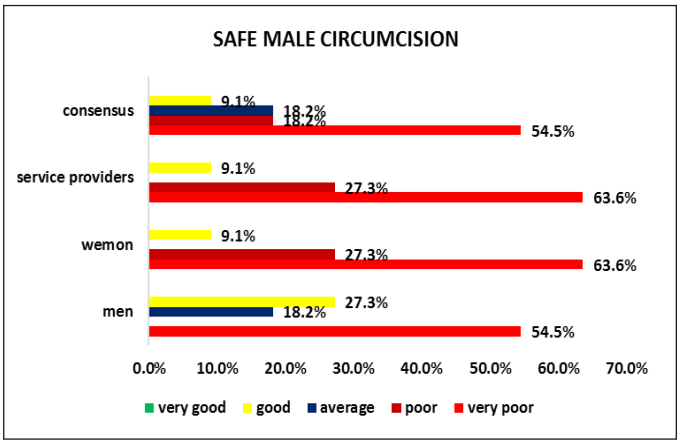
5.1.2 Availability of SMC Services

In September 2010, the Government of Uganda launched an initiative to provide Safe Male Circumcision (SMC) as part of an essential health service for HIV prevention. The initiative sought to increase the number of circumcised men through educating the population about safe male circumcision, increasing the number of health facilities that provide circumcision services and equipping health providers with the necessary skills to conduct the procedure. The scorecard assessed; availability of service (static or on outreach arrangement), competent personnel in SMC, community awareness and involvement, follow up, availability of kits and local and traditional leader's involvement. During the interface meetings, 54.5% of the participants ranked it at very poor, 18.2% poor and average respectively and 9.1% good service.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The poor rankings were based on SMC services not being static in the health facilities and only at Abim General Hospital was offering the service, done on appointment, limited trained staff in offering the service, limited uptake due to fear and cultural beliefs, lack of equipment and and the long process to undergo SMC. Based on these reasons, the community recommended increased sensitization of the community members, adequate training of staff in safe male circumcision, provision of appropriate equipment and conduct outreaches in the health facilities that do not offer the service.

Figure 2: Safe male circumcision performance percentage scores



5.2 Blood Transfusion (only Abim GH)

Availability and safety of blood safety is important in the health care set up. The community scorecard assessed availability, accessibility and storage of blood as well as and community awareness. Blood transfusion services were only available at Abim General Hospital. Men ranked blood transfusion as a good service, female counterparts ranked it as average service, whereas the service providers ranked it a very good service. During the interface meeting, participants ranked it as a very good service. The good rating was based on constant availability of blood and proper storage facilities. However, the gap was community ignorance about the availability of service at the facility.

Blood bank in Abim general hospital

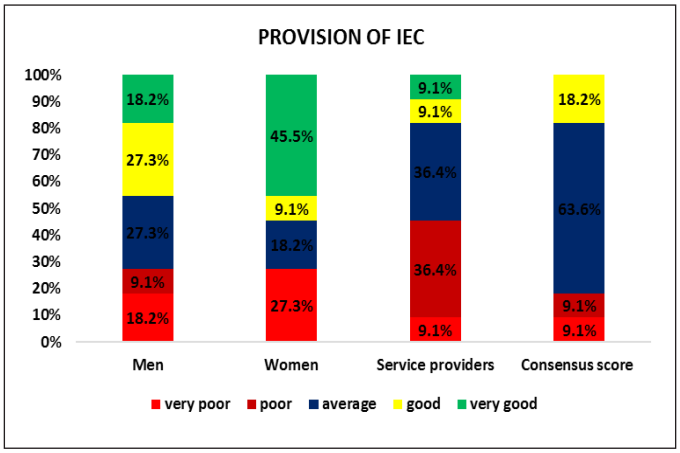
5.3 Provision of IEC materials

Print materials such as posters, brochures, flyers, and billboards are intended to draw attention to information about disease or risks to health. Public service announcements, radio, television, and video programs that disseminate information are part of IEC materials. The scorecard assessed availability of materials in both English and local languages, materials being updated as per intended interventions, dissemination plat forms, community awareness and knowledge. During the interface meetings (consensus score), 63% of the participants ranked it average, 18.2% as good and 9.1% as very poor and poor respectively.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The reason for good ranking were; materials available in both English and local language, located in strategic places, media platforms such as radio, media campaigns "Obulamu" and Televisions programs. The gap was that IEC materials were not regularly updated to suit national focus, adequate and few materials translated into the local languages. With high illiteracy rates among the community members, IEC materials are ineffective and this requires oral interpretation during health education talks. The community recommended provision of translated materials and to interpret the messages during health education talks for those who are illiterate.

Figure 3: Provision of IEC



IEC material in Alerek HC III

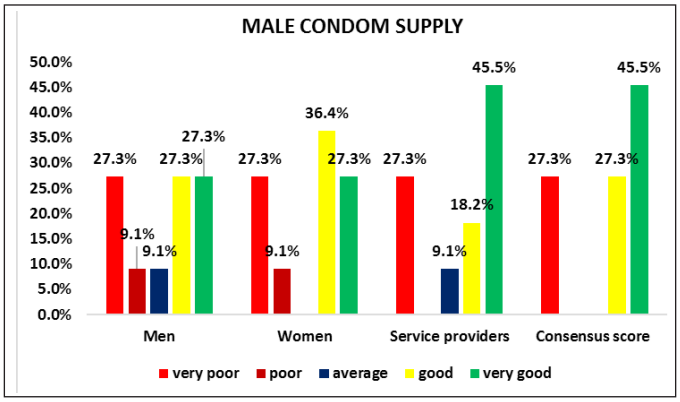
5.4 Condom Supply for Men

Correct and consistent condom use is a recommended HIV/ AIDS preventive measure. The community score card assessed availability of condoms, distribution channels, uptake and community perception. During the interface meeting for Consensus score, 45.5% ranked supply and uptake of male condoms as very good, 27.3% as good and 27.3% as poor respectively.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The positive ranking was based on availability of condoms, the community awareness on male condom usage and uptake, quality and condom accessible points. The gaps were on lack of awareness, availability, and perception of men who use condoms to be adulterous. Recommendations included; sensitization of the community on the availability and importance of the both the male and female condoms, involvement of religious and community leaders as well as increase on the number of condom distributors and supplies at both health facilities and in the communities to avoid stock outs.

Figure 4: Condom supply for Men



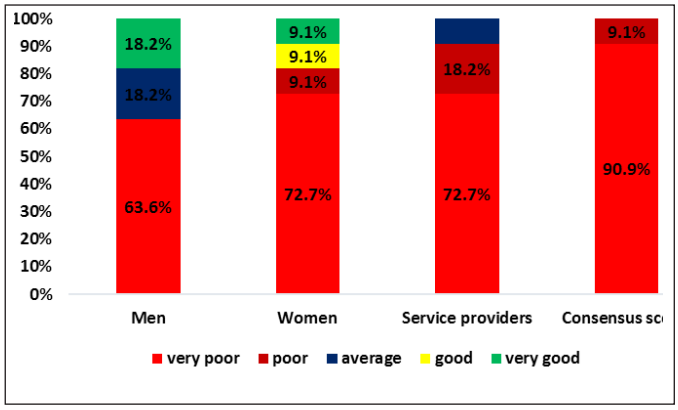
Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

Availability of female condoms in all the 11 health facility visited was poor and very poor, the reasons were: some communities and even the health workers have never received any stock of female condoms, it was recorded that carrying a condom is a male responsibility. Recommendations included: availing female condoms, sensitisation of women on condom use, and awareness creation to the community that women can also carry their own condoms.

5.5 Condom Supply for Females

Female condoms give women power and control over their protection from HIV and other sexually transmitted infections. The scorecard assessed the availability, accessibility, uptake and community awareness. During the interface meetings, (consensus core), 90.9% ranked it very poor and 9.1% as poor.

Figure 5: Condom supply for female



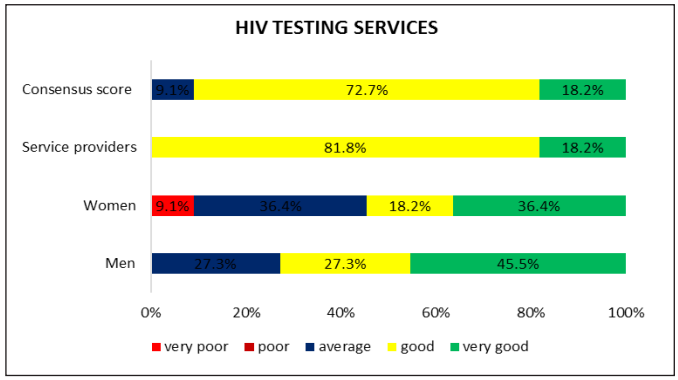
5.6 HIV Testing Services (HTS)

HTS testing is the gateway to knowing one's HIV status. The scorecard assessed availability of testing kits, pre and post counselling services, community awareness of the services and community programs on testing services. During the evaluation for consensus scoring, HTS ranked 72.7% as good, 18.2% very good and 9.1% average.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The good ranking was a result of pre and post counselling services, health workers encouraging testing, counselling was being done, strong follow up mechanism through extension workers and expert clients. Gaps raised included; lack of comprehensive HIV trained counsellors, inadequate test kits, no funds for outreaches, limited support to the extension workers and expert clients to conduct follow ups. Recommendations were; train health workers and community extension workers in comprehensive HIV counselling, regular supply of test kits, community sensitisation, community outreaches and link up with other implementing partners to support HTS.

Figure 6: Testing and counseling



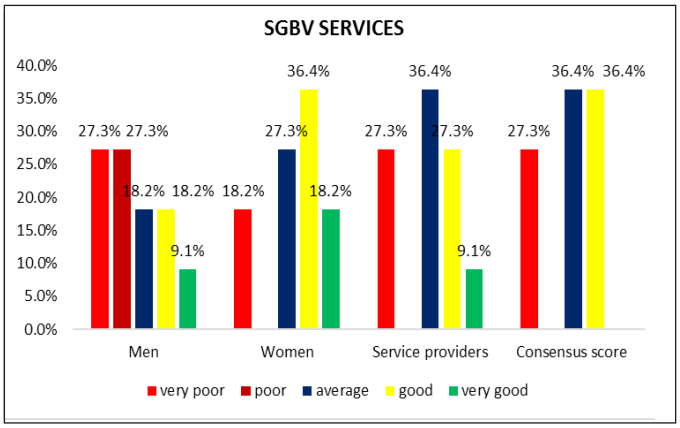
5.7 Availability of SGBV Services

According to MGLSD (2011), gender based violence (GBV) is defined as any harmful act that is perpetrated against a person will and is based on ascribed gender differences between male and female. Sexual Gender-based violence is a reality existing in all societies regardless of income, class and culture. The rampant increase of SGBV has often been attributed to traditional/ cultural beliefs, alcoholism, illiteracy and poverty. The community scorecard assessed access to HIV preventive measures (PEP and morning after pills) and reference for legal support. Despite this fact, many are afraid to report rape and other forms of violence, not only because of intimidation, hostility and ridicule from the community but also due to state delays in ensuring redress. During the interface meetings (consensus score), 36.4% considered the services as good, 36.4% as average and 27.3 as very poor.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The good ranking was a result of; access to PEP and contraceptive pills, community awareness and support from the health facility, awareness programs with support from implementing partners and local and cultural leaders' involvement. The gaps were; limited access to preventive commodities in a number of facilities, lack of counselling for SGBV victims, acceptable vices such as rape, stigma that hinders community uptake of services and low involvement of cultural and opinion leaders. Recommendations were; community sensitization, train staff and community extension workers to be SGBV/HIV competent, sensitization and involvement of religious, local and cultural leaders and support and to involve local police.

Figure 7: Availability of SGBV services



Laboratory equipment in Abim General Hospital

5.2 HIV TREATMENT AND CARE

The assessment conducted in 11 health facilities in Abim district aimed at assessing the access to ART for Adults, pediatric HIV care, Adolescent HIV care, integrated TB services, palliative care services, nutrition services and Home Based care programs.

5.2.1 Access to ART for Adults

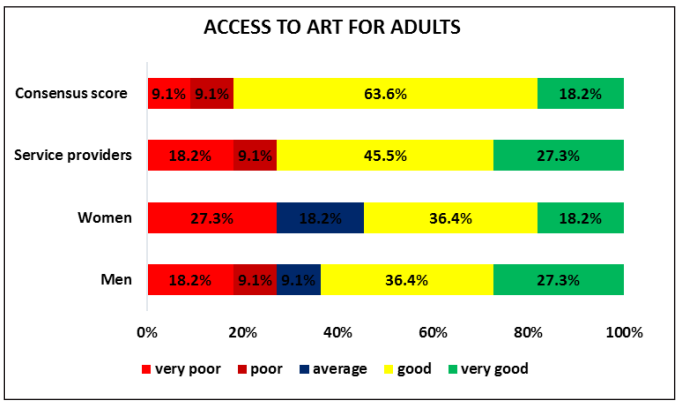
In regards to access to ART for Adult, community scorecard assessed availability of drugs, male involvement, integrated service delivery to eliminate stigma, competent staff in HIV comprehensive management, privacy and outreach programs. During the interface meetings, 63.6% ranked access to ART as good, 18.2% as very good and 9.1% as very poor and poor service respectively.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The good score was result of having specific days for ART refill, roll out of Test and Treat, HIV competent staff, integrating HIV to reduce stigma, availability expert clients to support peers, availability of viral load and CD4 services. The poor ranking was a result of; limited or no specific space for ART clinic, poor clients' data management, high alcoholism, delay of both CD4 and viral load results to monitor treatment adherence, low male involvement, high levels of stigma and discrimination (within

community and families), long distance moved by clients to access treatment, poor follow up mechanism and sporadic stock out of drugs leading to drug switching. Recommendations; encouraging male participation including picking own drugs, train more staff to be HIV competent, roll out integration approach to eliminate stigma, conduct outreach programs, eliminate stock out of drugs, capacity building of expert clients and community extension workers (VHTs) to conduct follow ups and support clients to adhere to treatment and create awareness among the community members to support positive living.

Figure 8: Access to ART for adults



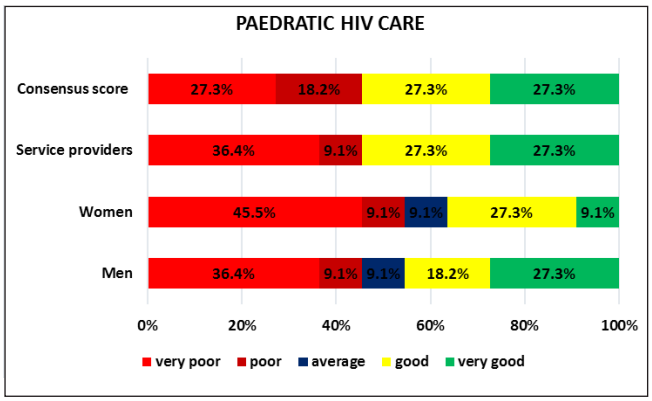
Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

5.2.2 Paediatric HIV Care

Access to Antiretroviral therapy is vital for a sustainable provision of chronic care for patients initiated on ART. It is therefore crucial to expand and consolidate pediatric HIV care in all accredited ART sites. The score card assessed pediatric drug stock status, counselling and follow up mechanism. During the interface meetings for consensus score, on average 27.3% of the participants ranked it as very good, good and very poor respectively and 18.2% as poor services respectively.

The good ranking was based on availability of paediatric treatment, community awareness, strong referral systems and capacity building for guardians and caretakers. Whereas the low ranking was as a result of no ART specific clinic for children thus receive drugs alongside the adults, stock outs for paediatric regimens such as Nevirapine syrup, parents and guardians do not bring children back for follow up and stigmatization registered in the communities and schools. Recommendations made included; community sensitization, strengthen stocks monitoring for ART drugs, capacity building for staff and extension health workers to be HIV competent to conduct follow up and treatment, capacity building of care givers to ensure adherence by the children.

Figure 9: Peadiatric HIV Care



Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

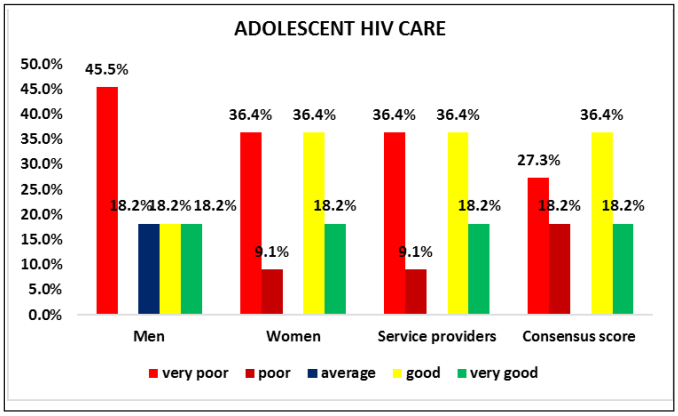
5.2.3 Adolescent HIV Treatment

According to WHO Guidelines 2015, adolescent's treatment is defined as services that are specifically integrated in Health care service for the youth health related care. The assessment focused on youth friendly corners, youth access to ART on designated day, integrated system for ART access and sensitization. During the interface meetings for consensus score, 36.4% ranked as good, 27.3% as very poor, 18.2% as very good and poor services respectively.

The assessment was conducted in all the accredited ART sites. However, most of the health centre IIs support HIV service delivery through eMTCT and outreach programs by health facilities (IIIs and general hospital) which impacted the scoring. The other challenges affecting services were; stigma and discrimination among the youth, absence of adolescent

friendly services in most of the health care facilities visited, lack of linkages between the health facilities and communities where the young people live and stock out of drugs. Recommendations included; provision of services that are tailored to adolescents' needs, community sensitization on adolescent friendly services at the facilities, engage community and schools to ensure that adolescents who require services are followed up in their settings and support to buddies to reach peers.

Figure 10: Adolescent HIV treatment



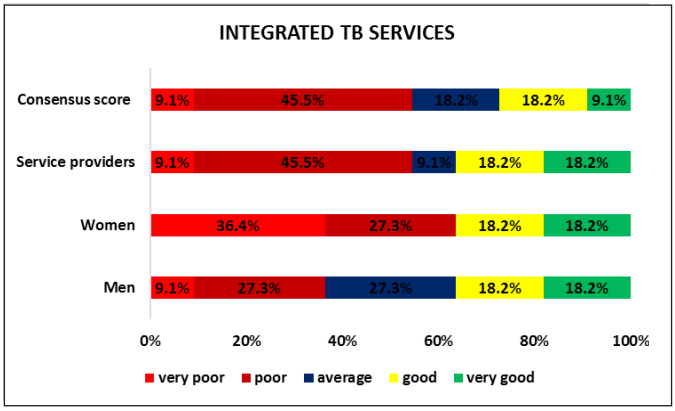
5.2.4 Integrated TB services

TB is one of the number one killers of PLHIV, causing more AIDS related deaths. In line with Uganda's National Policy on TB/AIDS 2006, collaborative services emphasize integrating care and treatment for patients with TB, through enhancing screening patients, testing and diagnosis of TB. The score card assessed availability of TB services such as TB machines, screening service, follow up and community sensitization. During the consensus meetings, integrated TB services showed that 45.5% ranked it as a poor service and 18.2% average and good service.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The good ratings training was based on availability of TB drugs, TB services, (screening and testing), community awareness, the TB equipment (Genexpert machine, microscope), TB isolation rooms/ward and access to TB information among others. The poor ranking was as a result of no TB specific spaces/wards, drug stock outs, limited follow up made to patients, poor records management, and unhygienic environment among others. Recommendation for further improvement included sensitization on TB drug adherence, building of separate TB screening rooms/ wards, promoting awareness of the availability of TB treatment and that it is curable among the community members, training of health staff on TB/HIV co-management and elimination of stock out of TB drugs and testing reagents.

Figure 11: Integrated TB services



5.2.5 Palliative Care

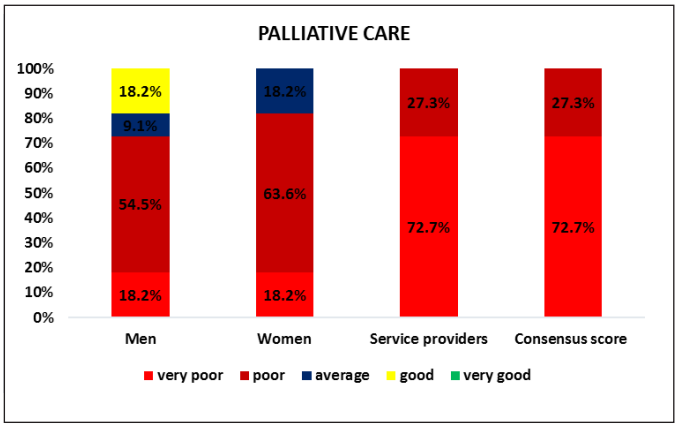
In 1993, the Government of Uganda introduced palliative care as a mechanism to support patients with life threatening illness to control extra pain. The score card assessed availability of palliative drugs, capacity of the human personnel to offer the service, the community knowledge on service availability and the referral mechanism. The service was only found in Abim General Hospital. However, the assessment was carried out in all the health facilities visited to access the level of knowledge on palliative care services. During the interface meetings, majority of the participants ranked the service at 72.7% very poor and 27.3% as poor.

Health Facility	**Score**	**Health Facility**	**Score**	**Health Facility**	**Score**
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The very poor ranking was based on; limited skilled personnel in palliative care services, low supply of palliative care drugs, poor referral mechanism for patients, poor health facility-community linkage through home visits by health workers and drug stock outs such as for oral morphine. The recommendations were: introduce palliative care services in the facilities, train health

workers on palliative care, avail medicines and scaling up the services to the all the ART accredited health facilities since AIDS and its co-morbidities are chronic diseases.

Figure 12: Palliative care



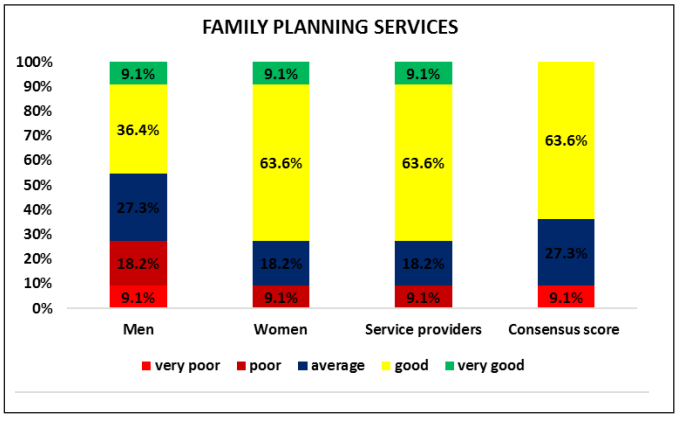
5.2.6. Family Planning

Family planning services were available at all facilities. However, some forms of family planning methods especially the permanent and long term methods were not available at health Centre III and II levels. Hence availability of long term methods were assesses at only Abim General Hospital. Family planning services were scored 63.6% as good service, 27.3% as average and 9.1% as very poor.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The positive ranking of the service was based on availability and uptake of methods at the facilities and community awareness of the services. The gaps affecting quality and utilization of FP services included; stock outs of family planning supplies and test kits, perceived side effects, inadequate skills in management of complications, inadequate health education and counseling on family planning, few staff in the section leading to workload, low involvement of men, cultural and religious beliefs, and negative attitudes in the community that some methods cause infertility. Sensitization of the community on family planning, training of health staff to be family planning competent and increase on the supply to avoid stock outs were key recommendations.

Figure 13: Family planning



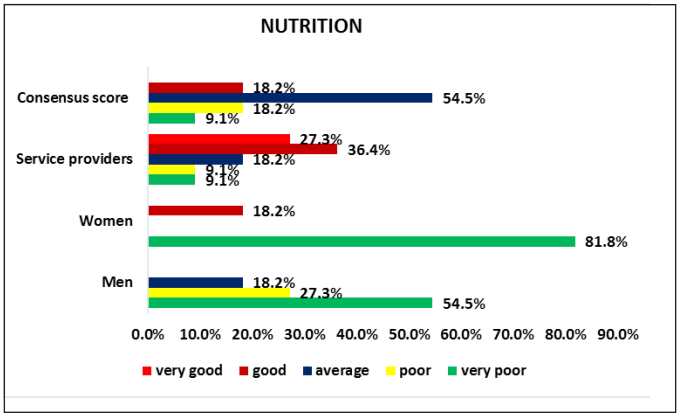
5.2.7. Nutrition Services

The NSP 2015/16-2019/20 emphasizes integrating nutrition, counselling and support in HIV care and treatment service including use of ready-to-use therapeutic food (RUTF) for severely malnourished and linked to increase food security. During the interface meetings (consensus score), 54.5% ranked the services as average, 18.2% as good and very poor respectively and 9.1% as very poor.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The results revealed that nutritional supplements are often out of stocks and educational programs at all the facilities visited were limited to provision of IEC materials and training without provision of adequate or any food supplements. They were given to the malnourished children under 6 years yet there was a general outbreak of hunger in Karamoja region requiring PLHIV to access the supplements to adhere to ART but also excluded of the elderly. The recommendations included need to supply food supplements at the facilities to cover children, pregnant women and even the elderly and other vulnerable groups especially PLHIV who cannot access food to ensure positive living.

Figure 14: Nutrition services



Nutritional feeds in Alerek HC III

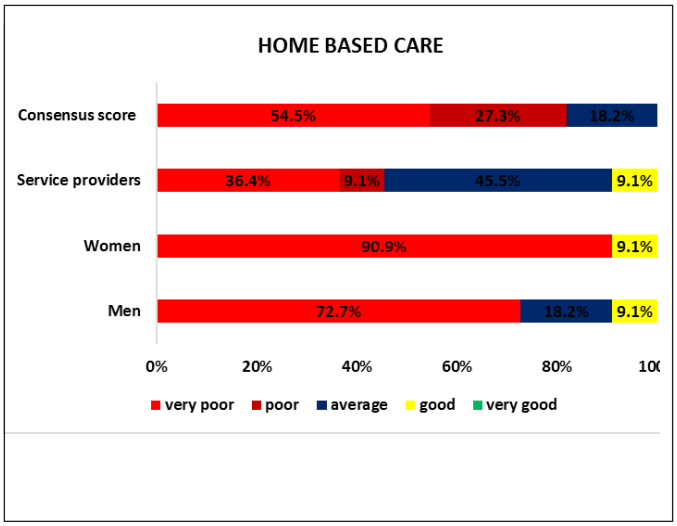
5.2.8. Home Based Care (HBC) programs

Home Based Care contributes to the second goal of the National Health Strategic Plan (NHSP) which is to improve the quality of life especially of PLHIV. Home Based Care works within the health system and structures in each Health care service delivery points, involving cross referrals from all levels of care (whether public or private, formal or informal) to the households. This involves health workers, health extension workers and expert clients visiting the clients for psycho social support, adherence support, HIV testing, TB screening, referrals and linkages, health education among others. During the interface meetings, HBC was ranked at 54.5% very poor, 27.3% as poor and 18.2% as average.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The reasons for the very poor ranking were; lack of funds for transport yet with wide geographical area, poorly motivated village health teams (VHTs) and expert clients, implementing partners (IPs) work separately from the health care setting and systems. The recommendations were need for intensive training in Home Based Care services, IPs to use the available health care structures (expert clients and VHTs), facilitation and motivation of community resource persons such as expert clients to reach their peers and the district to allocate additional funds alongside the primary health care (PHC) money from the local revenue to facilitate health workers to reach out to the community.

Figure 15: Home based Care programs



5.3 SOCIAL SUPPORT AND PROTECTION

Social support and protection services were assessed basing on the quality of psychosocial services, capacity building for care givers, provision of food and education services, rights awareness and support, legal support and social services.

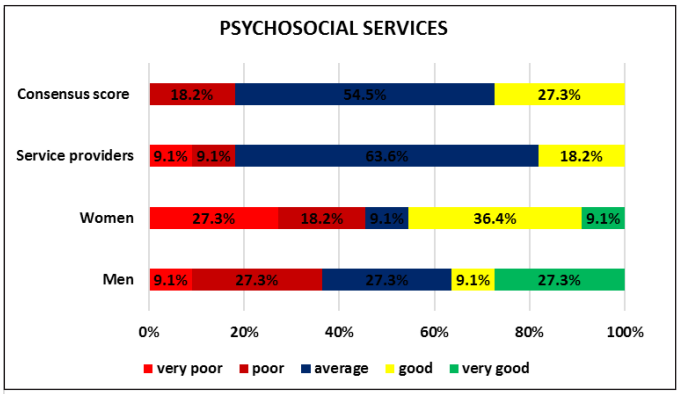
5.3.1 Quality of Psychosocial Services

To eliminate stigma and discrimination and ensure adherence to treatment among the PLHIV, the survey examined the counseling services rendered, the capacity of the health workers to handle vulnerable groups, support to Orphan Vulnerable Children (OVC), SGBV victims, rape and defilement cases, referral system, supporting tools and IEC materials. Availability of counseling services both pre and post test counseling, privacy and documentation to strengthen referral and follow up of clients were considered. During the interface meetings for consensus score, 54.5% ranked the services as average, 27.3% as good and 18.2% as very poor.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The good and average scores were as a result of availability of counselling rooms, patient's privacy and confidentiality among the health workers and strong referral system for clients to specialized/trained personnel. However, the quality of psychosocial support services was constrained by limited skilled personnel in psychosocial support, no facilitation to support clients to adhere to treatment, low staffing, limited budgets to follow up patients and stigma and discrimination and no specific attention to OVC. There were also high client numbers compared to staff numbers leading to work overload and stress and client follow up was very limited. Recommendations; establishment of post-test clubs, community sensitization, training of health workers in psychosocial counseling, strengthening community referral networks and the law courts to expedite the judicial processes to cut on time when witnesses appear and victims get justice. Special attention to OVC issues was needed in Abim.

Figure 16: Quality of psychosocial services



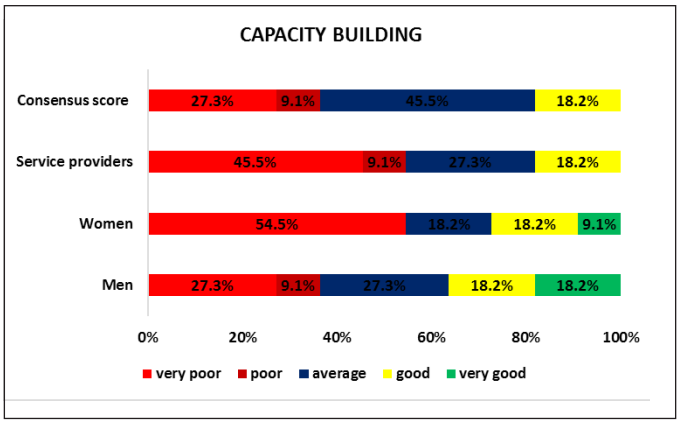
5.3.2. Capacity Building for Caregivers

Health workers mentor caretakers on how to manage patients especially those living with HIV. This would cover treatment literacy, adherence and general positive living. During the interface meetings (consensus score), 45% ranked it as average, 27.3% as very poor, 18.2% as good and 9.1% as poor.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

Challenges noted were; very high health worker to patient ratio which could not enable health workers give patients and their escorts ample time, low capacity of health workers to provide comprehensive HIV care and limited space at health facilities to cater for patients' privacy. Recommendations included; creating time for care givers to explain how to manage the patients especially those with complications, have a position of a counselor as part of staffing norms, recruitment and/or allocate more staff especially in high volume sites, community sensitization on role of treatment supporters and PLHIV buddies to be given central stage as number one caregivers.

Figure 17: Capacity building for caregivers



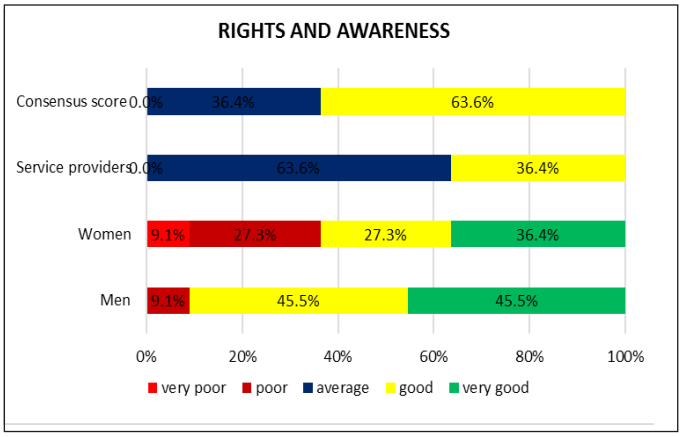
5.3.3 Rights Awareness and Support

The constitution of the Republic of Uganda (Article 9) stipulates that it is a fundamental right to all the citizens to access health services irrespective of sex, gender, color and origin. This led to the development of the Patients' Charter and health workers' Code of Conduct to support access, treatment and care in health facility set up. The score card considered the community awareness of these rights through availability of patients' charter, health worker support to patients to access treatment and justice, respect for patients' dignity and health, cultural and religious leaders' involvement to address cultural norms. The rating by facilities was 42.9% as average, 28.6% as poor and 14.3% for good and very poor respectively.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The low ranking was due to the limited capacity of health workers to take patients through their rights and responsibilities coupled with the community's lack of awareness of their rights. Participants suggested that more sensitization about rights and responsibilities through seminars, workshops, community meeting, displaying the charter, the health centres to disseminate the patient's charter in the local language for awareness creation.

Figure 18: Rights awareness & support



5.3.4 Legal Support and Protection

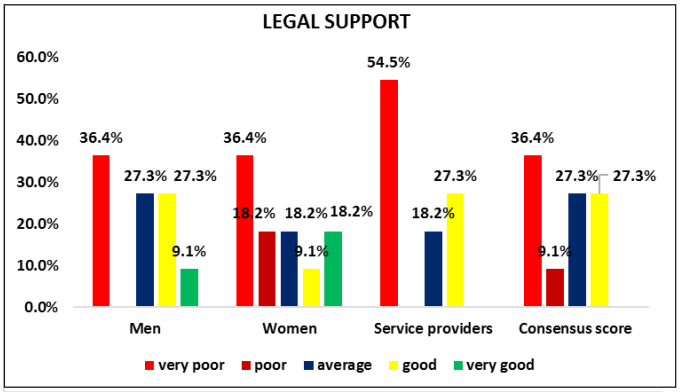
In case of any victimisation, grievance handling, understanding and accessing legal services, people need to know what, where, how, why and to what extent they can go to access legal support and protection. This therefore requires the providers, both health workers and community resource persons, to be skilled in legal procedures and redress mechanisms. The score card assessed how far the providers have been involved in supporting patients/ victims who have been aggrieved. Paralegals and health workers are meant to sensitise community members on human rights, legal and ethical needs as well as support them in accessing justice and services. During the interface meeting (consensus score), 36.4% ranked the service as very poor, 27% as average and good respectively and 9.1% as poor.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The good and average ranking was as a result of health workers offering services and follow ups on the victims, provision of testing services in case of emergency, legal support in form representation in courts of law as witnesses for cross examination, community sensitisation on seeking legal services in care assault and filling of police forms to support the victims.

The poor rating was as a result of community not seeking legal support from facility, still high levels of stigma and discrimination, lack of transport and/or facilitation to follow up on cases, long court processes, inadequate medical staff, shortage of drugs and community members not seeking legal redress and rape cases are rarely reported as is an acceptaed community practice..

Figure 19: Legal support and protection



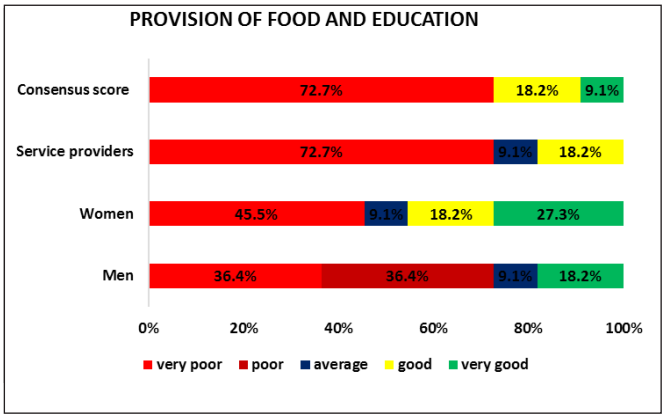
5.3.5 Provision of Food and Education Services

The National Nutritional Planning Guidelines (2014) and the Health Sector Investment Plan (2015/16-2019/2020) provide for integration of nutrition into the treatment and management of HIV&AIDS, TB and malaria. Karamoja sub region still faces the challenge of under nutrition with malnourished (stunt and underweight) persons. Malnutrition is highly caused by inadequate dietary intake and repeated infections, lack of safe water, poor hygiene and sanitation, food insecurity, gender inequality, inadequate education and awareness among the community on importance of proper nutrition. Therefore, the assessment examined availability of food and food supplements, nutrition health talks and demonstrations, follow up and linking clients/patients with implementing partners to support food security and nutrition in community. During the interface meeting (consensus score) 72.7% as very poor, 18.2% as good and 9.1% as very good

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The reason for the low ranking were; that no food is provided to clients and vulnerable people at the facilities save for children and pregnant mothers though at times irregular. The community recommended the need to standardize the protocol for feeding, service providers to continue sensitizing the community and support the vulnerable PLHIV with food supplements, for them to be able to live a productive life. IPs can support setting up of demonstration gardens/farms

Figure 20 Provision of food & education services



5.4 Infrastructure, Utilities and Equipment

As part of the systems strengthening component of the NSP, these supplement the smooth delivery of the services. Therefore, the CSC assessed the health facilities' infrastructure, utilities and equipment such as availability of safe water, transport means, staff houses, toilets, kitchen, and shelter, CD4 count machines, communication means, and power and its type.

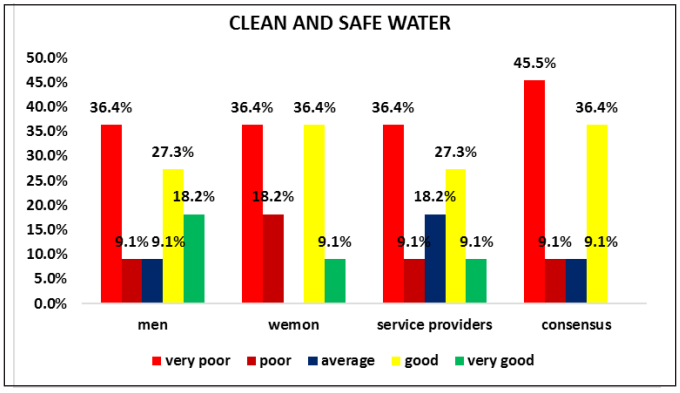
5.4.1 Availability of clean and Safe Water

Availability of clean and safe water, proper sanitation and hygiene is critical in ensuring that patients do not contract water bone diseases and encourage repeat visits. At each health facility, there should be a water source to supply the facility, water connected especially to the laboratory, theater (where it exits), delivery room, laundry area, bathrooms and other key sections requiring direct water connections. During the interface meetings (consensus score), 45% ranked it as very poor, ,36.4% as good, 9.1% as average and poor respectively.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		**Morulem HC III**		**Awach HC II**	
Orwamuge HCIII		**Nyakwae HC III**		**Adea HC II**	
Gangming HC III		**Bolokom HC II**		**Amita HC II**	
Alerek HC III		**Katabok HC II**			

The low rating of the services was that water was not connected to the facilities. For instance in Alerek HC III, water source (bore hole) was within 100 metres from the facility, Orwamuge HC III borehole was 200 metres and sharing with community members, Morulem HC III had solar pumped water running and Nyakwae HC III borehole was 300m from the facility. There was also water shortage especially in dry seasons, inadequate water sources, lacked taps, few tanks to store water and dirty water being. The good ranking was that though inadequate and not connected to the most key areas as is a standard, there was water to use at the facilities. They recommended that piped water be installed at the health facilities, more water tanks be installed for more water to be harvested and/or stored, construction of boreholes and water should be treated.

Figure 21: Availability of clean and safe water



> ***"The DHOs office and MoH should consider access to water prioritized to improve the quality of health services", participant during FDG in Abim general hospital***

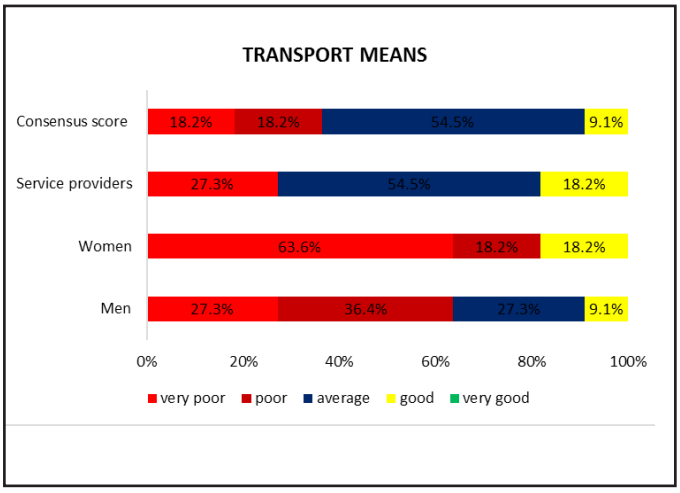
Water harvest tanks at Alerek HC III

Borehole at Abim general hospital

5.4.2 Transport Means

The transport means for the health facility is fundamental to support its operations, strengthening linkages, referrals and outreach programs. The community score card assessed availability of an ambulance, motorcycles and facility specific vehicles. Fifty four (54.5%) average, 18.2% as good and very good respectively. Ambulances were witnessed in Abim General Hospital and Morulem HC III and motor bicycle ambulance carriers were witnessed in all the health Centre IIIs visited. The gaps were; lack of ambulances to traverse the district, motorcycles or bicycles attached to the facility, no funds for maintaining the ambulance and limited community access to the ambulance. Recommendations included; the need by the Ministry of health/government to provide the health Centre with an ambulance, motor cycles and bicycles for outreaches, wheel chairs and stretchers for patients, maintain/repair the existing ambulances and budget for fuel not to burden patients.

Figure 22: Transport means



Tri cycle Ambulance at Alerek HC III Hospital

Broken down ambulances at Abim General

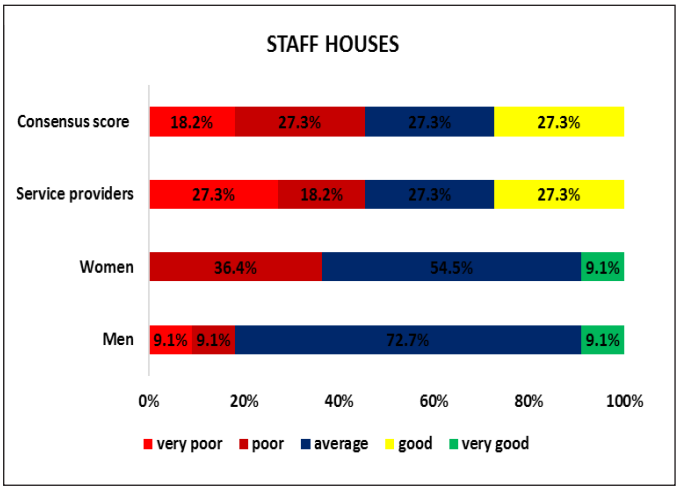
Motor cycles at Alerek HC III

Motor cycle carrier at Nyakwae HC III

5.4.3 Staff Houses

Ministry of Health guidelines for staff accommodation require that every health worker should be housed at the health facility. The community scorecard assessed availability of staff houses and status of the structures at the facilities. The score card found that few staff are accommodated though some facilities have endeavoured to ccomodate over three quarters. For instance, in Alerek HC III only 5/19 health workers, Morulem all the 19/19 staff, Nyakwae HC III 7/19 staff, Orwamuge HC 6/ 3, Abim General Hospital 95/197 staff, Gangming HCII 5/9, Katabok HC II 5/9 and Adea HC II 4/5 staff accommodated at the facility. Given the scores and also from the general observations, Abim district requires support to have staff reside within health facility premises. Hence the score was 27.3% as good, average and poor respectively and 18.2 as very poor service. The gap also remained with the fact that the some of the available structures were in bad shape and health workers therefore prefer to rent in the nearby trading centres. Recommended for construction of staff quarters at the facilities

Figure 23: Staff houses



Staff Quarters in Nyakwae HC III

Staff house in Alerek HC III

Newly constructed staff house in Alerek HC III

Staff houses in Awach HC II

7.4 Toilets, Kitchen, and Shelter

The scorecard assessed availability of shelter kitchen, toilet and community awareness on using these facilities. The study further assessed levels of sanitation and hygiene as well as facilities for persons with disabilities. This therefore requires that all facilities have clean toilets, a spacious kitchen and a shelter for waiting patients or where attendants stay while health workers are on ward. The scorecard assessed availability of shelter, kitchen and toilet, the sanitation and hygiene at the facilities, availability of facilities that are for people with disability. What was discovered was that toilets/latrines were not adequate, not disabled sensitive, most were filled up and dirty. The shelters on the other hand were lacking especially for patients at ART clinic and kitchens for patients were largely nonexistent. The environment was largely unhygienic. The participants recommended construction of more toilets, kitchens and shelters at OPD and ART clinics.

Kitchen in Abim General Hospital

Latrine in Obolokome HC II

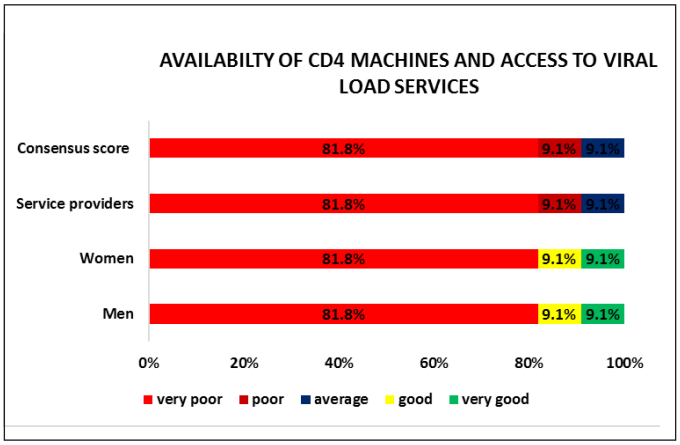
5.4.5. Availability of CD4 count machines and viral load services

HIV treatment and disease burden monitoring and management require CD4 count and viral load to monitor the clients' adherence to HIV treatment and viral suppression. The assessment focused on the availability and accessibility of CD4 count testing services in ART accredited health facilities and turnaround time for viral load results to support optimal treatment outcomes. During the interface meetings (consensus score), 81.8% of the participants ranked as very poor and 9.1% as poor and average service respectively.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

Two CD4 count machines were found at Abim General hospital and Morulem HC III. The hub system was being utilized to reach to the lower health facilities to pick sample and deliver results which sometimes delayed and thus delaying clients to be enrolled on ART. Eighty one (81%) rated it as very poor and 91.2 rated as poor and average respectively. The recommendations included more CD4 machines be distributed/procured, increase stock supplies of CD4 machine both to low and high volume sites depending on facility clientele numbers and provision of maintenance service contracts.

Figure 24: Availability of CD4 count machine



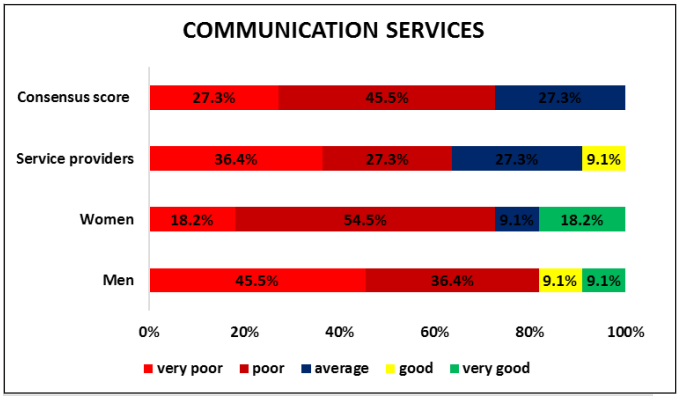
5.4.6 Communication Facilities

Another measure of infrastructure, utilities and equipment in health facilities was availability of communication facilities. These include; a suggestion box, a telephone booth or public pay phones, facility landlines, emergency numbers for patients, telephone handsets, radio calls and notice boards among others. These enable communication flow between and among staff and patients. The results gathered from the assessment shows 45.5% rated communication as poor with 27.3% as average and very poor and average service respectively.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The poor rating was because most the communication items for patients' use were almost nonexistent. Recommendation were to; improvement in areas such as use of suggestion boxes, telephone booth or public pay phones, facility landlines, desk computers and internet to ease communication.

Figure 25: Communication facilities



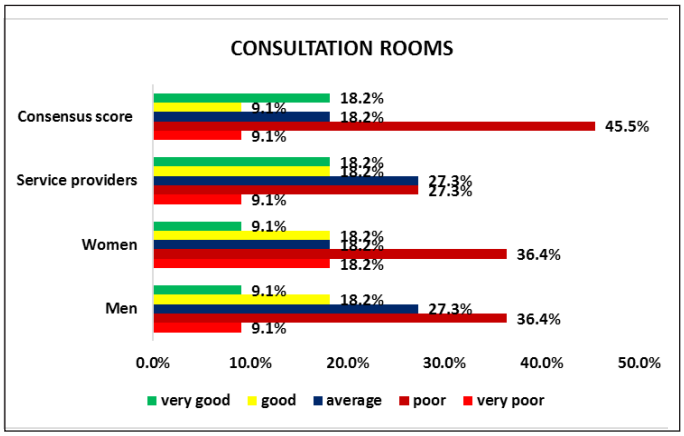
5.4.7 Availability of Consultation Rooms

In Abim District, the scorecard focussed on whether the facility had a spacious and well equipped consultation room and whether patients' privacy was respected by health workers. During the interface meetings (consensus score), 45% of the participants ranked as poor service, 18.2% as very good and average respectively while 9.1% rated as good and very poor respectively.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The good ranking was based on availability of the rooms, high health seeking behaviors and existence of screens and curtains in the rooms. The low ranking was based on the limited space and rooms to allocate a consultation room, limited privacy during consultations in facilities were they existed. Recommendations were; need to create more space to enable smooth consultation processes between patients and care givers

Figure 26: Availability of consultation rooms



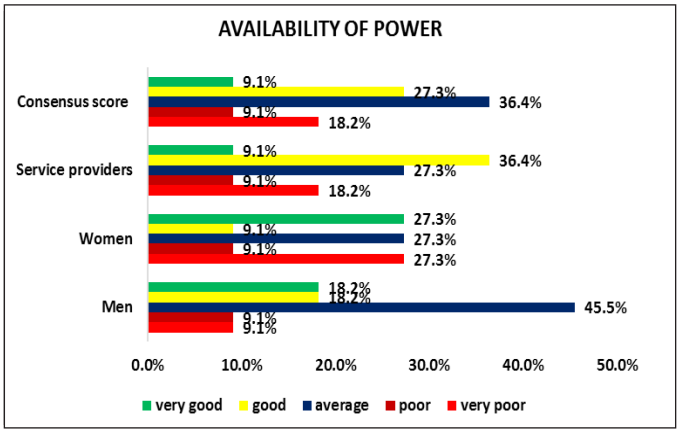
5.4.8 Availability of Power and Type

Power in any health facility set up complements and supports delivery of services. The scorecard assessed power extension especially to key areas requiring power such as to the laboratory and maternity ward and delivery rooms, regularity of power supplied, and the different power types. The quality and availability of power was scored as average in all the facilities assessed. During the interface meetings (consensus score), 36.4%ranked it as average, 27.3% as good, 18.2% as very poor and 9.1% as very good

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The good ranking was based on; availability of hydroelectricity, solar power and generators and gas. Whereas poor ranking was a result of; unreliability of electricity especially in Abim hospital (theatre), lack of fuel for generators and nonexistence of power of any type in lower health facilities and lack of solar batteries. They recommended that the government should connect facilities to the national grid (UMEME), have generators (with fuel) and solar panels should be installed and avail facilitation to procure fuel.

Figure 27: Availability of power & type



Solar System in Abim General Hospital

5.5 Attitude of Staff

The study assessed attitude of staff in terms of meeting reporting and departure schedules and behavior towards clients. This therefore examined health workers' observance of working hours, polite behavior, listening to patients' problems and respect for patients' privacy.

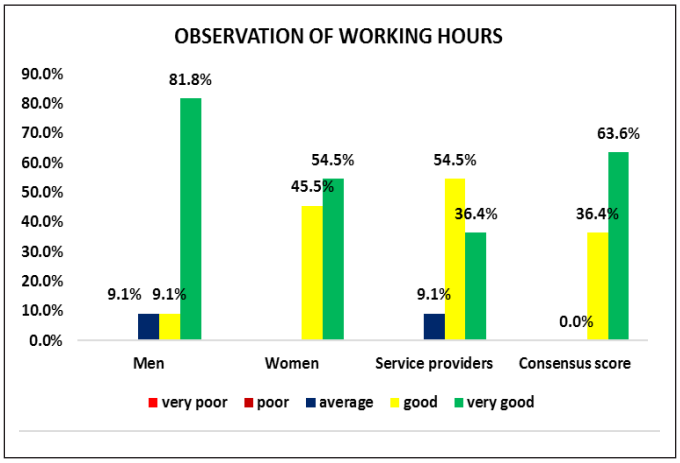
5.5.1 Observing Working Hours

Health workers are supposed to observe reporting and depating times as per duty rota. Health workers report to duty on a daily basis depending on schedule and shifts. Irrespective of schedule, they are suppoesd to be on time. In the interface meetings that involved both beneficiaries and health workers, 63.6% rated as very good and 36.4% as good.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

It was observed by the beneficiaries that some staff were at times reporting to work late usually between 9 and 11am and leaving early. The health workersrevealed that the reasons for late reporting was due to lack of accomodation at the facility, staying and having to walk for long distances to work, other duties such as domestic work also forced them to get to work late, while others alluded to long working hours causing fatigue and thus the much needed to rest. It was also observed that there was a lot of time wasting, having long and frequent breaks for meals, delays in attending to patients and patients themselves reporting late to the health centres respectively. The need to provide accomodation to staff, monitoring attendance, follow ups and sentization to ensure compliance was emphasised. Duty schedules detailing shifts (day and night), introducing of an attendance book on arrival and departure time, motivation of staff and staff endevouring to observe working hours as part of their code of conduct were also recommended.

Figure 28: Observing Working Hours



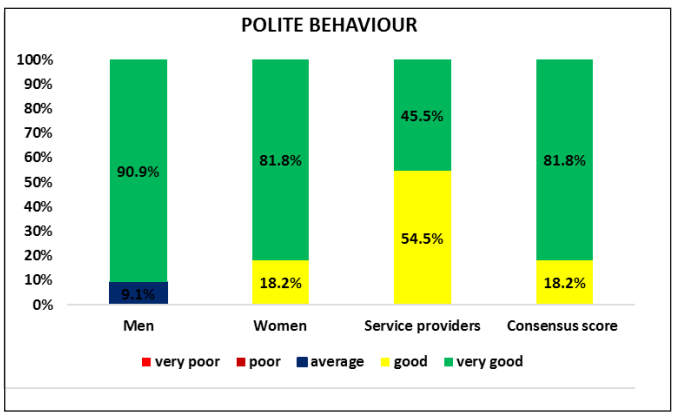
5.5.2 Polite Behavior

The patients' charter 2009, guides on how health personnel are supposed to handle the patients who are seeking for medical attention in a bid to strengthen the client health work relationship in treatment and care. The scorecard assessed the patients-health work relationship in health care setup following the procedures provided. This included; health workers' conduct when handling clients, the time given to clients when seeking medical information and the supporting systems to compliment structures.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

In regard to polite behavior of staff, 81.8% ranked it as very good service 18.2% good and average respectively during the interface meeting. 81.8% of women and 90.9% of men ranked the politiness of health workers very good service community (men and women) and 54.5% of the service providers themselves ranked polite behavior good and 45.4% as very good service. In the general meeting for consensus scoring, very good was at 81.8% and good at 18.2%. The positive ranking was attributed to staff handling patients well and having good customer care, giving ample time to clients and service users when accessing the services. The gap was on patients' impatience and rudeness towards staff, coupled with the some few staff who do not handle patients well. Recommendations were; sensitisation of staff on patient handling and customer care, continous monitoring to ensure that the staff keep up the good behaviour and community health education to strenghten health service provider-patient relationship

Figure 29: Polite behavior



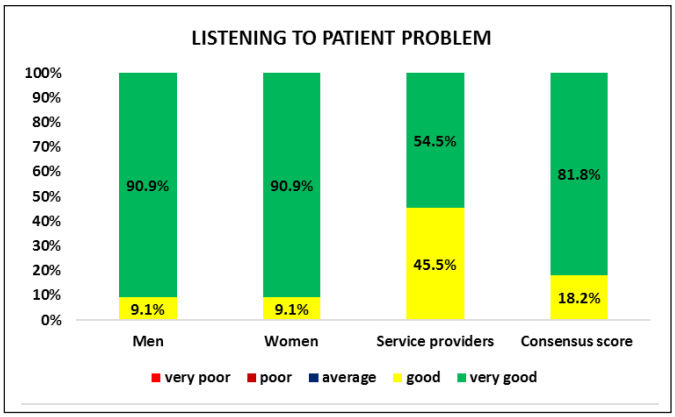
5.5.3. Listening to patients problems

The patients charter 2009, guides on how health personnel are supposed to handle the patients who a seeking medical attention in a bid to strengthen the client health work relationship in treatment and care. The scorecard assessed the patients-health work relationship in health care setup following the given procedures provided in the patients' charter 2009. This included; conduct when handling clients, ability to listen, the time given to clients when seeking medical information and the supporting systems to compliment structures. During the interface meetings (consensus score), 81.8% as very good and 18.2% as good.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The reasons for good score were; health workers offer ample time to listen to clients to support fully diagonosis of the disease, most of the patinets what they want. The gaps were on inadequate staffing leading to work over load, stress and frustration, some health workers do not explain prescriptions to patients and patients' rudeness towards staff. Recommendations included; need for comprehesisve senstisation on patients' rights and code of conduct, have more staff to reduce work load and community dialogues.

Figure 30: Listening to patients problems



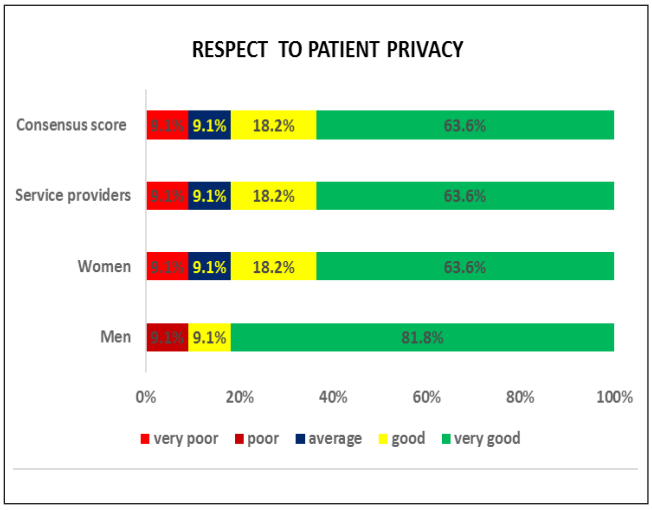
5.5.4 Respect of Patients Privacy

Patients' charter 2009 indicated that patients have the right to privacy during consultations and treatment except only when it's required by law or court order. It further emphasizes that facility management should make arrangements to ensure that that health workers do not disclose the patients' information. Scorecard assessed respect for patients' privacy through both FGD and interface meetings. During the interface meetings (consensus score), 63.6% ranked as very good, 18.2% good and 9.1% as average and very poor respectivey.

Health Facility	Score	Health Facility	Score	Health Facility	Score
Abim GH		Morulem HC III		Awach HC II	
Orwamuge HCIII		Nyakwae HC III		Adea HC II	
Gangming HC III		Bolokom HC II		Amita HC II	
Alerek HC III		Katabok HC II			

The beneficiaries agreed that staff were giving ample time to patients and listening attentively to their problems. The health workers also indicated that they listen to their patients as part of their proffessional training. The gap was on limited staff numbers compared to the patients workload and some few individuals who easily lose temper, being their nature. Key recommendations given were to recruit more health workers to reduce on heavy work and to continuously organise refresher trainings on various topics including application of listening skills.

Figure 31: Respect for patient privacy



6.0 CONCLUSIONS

Based on the findings, the assessment concludes that Abim district has made efforts to provide HIV&AIDS services and has all it takes to provide quality services. There is need to cover staffing gaps, work on infrastructure, sort out stock outs, community mobilization on various topics, engagement with PLHIV, religious and cultural leaders to address the gaps herein identified.

7.0 LIMITATIONS

- Though the Community Score card centred on the NSP thematic areas of HIV prevention, care and treatment, social support and systems strengthening, not all areas under each theme were covered.

- The findings presented are limited to observations, in tracking and key informant interviews at that specific time which may lead to some of the equipment not being accessed.

- The assessment did not necessary consider comprehensive health facility equipment however, focus was given on only HIV related support equipment.

8.0 RECOMMENDATIONS

The assessment generated a number of recommendations that include;

- Continuous with sensitisation sessions by various sectors targeting different categories of people by line ministries, departments and agencies (MOH, Ministry of Public Service, Ministry of Finance, Planning and Economic Development, Uganda AIDS Commission), Local government, Religious leaders, health facilities, NAFOPHANU and Implementing partners)

- Sensitisation on patient's rights and responsibilities and roll out the national patient's charter to all health centres. The patients charter should be translated into the local language and disseminated both at the health care facilities and through media

- The MoH and the district service commission should recruit more health workers to fill up the staffing gaps and reduce on the waiting time that patients take to see health workers. Additionally, the staff should be well motivated through payment for hardship allowance

- National Medical Stores should ensure constant supplies of drugs and reagents including testing kits to reduce on frequent drug stock outs.

- Implementing partners to provide clients with food and food supplements or rations

- The District Health Office should intensify monitoring and supervision of the health facilities to reduce on absenteeism and late coming. Additionally, capacity building for in charges on modern management including results based management.

- The health in charge should undertake community sensitisation about importance of safe male circumcision and train more surgeons at health centre III to undertake SMC

- Provide more IEC materials and translate them in local languages and distribute them in the remotest health centres across the district

- Ministry of Health should integrate HIV services in other departments to reduce stigma and discrimination of PLHIV.

- Ministry of Health should procure ambulances for Health Centre IIIs and provide a budget for its running and maintenance.

- There is need to train health workers on legal and human rights to enable them support the community more efficiently.

- There is need to involve religious leaders, Clan leaders, Kraal leaders and cultural leaders on issues of sexual gender based violence

- The MOH and district local governments should construct more structures and equip them with facilities to support quicker diagnostic of the ailments. Also should consider upgrading some of the facilities to levels III and IV.

- Staff houses should be constructed to enable health workers reside at their work stations and report on time. This will also attract and increase staff retention from hard to reach areas.

- Parliament and Ministry of Finance Planning and Economic Development should allocate more resources to the health sector to enable the sector implement what has been promised in the Health Sector Development Plan and National HIV&AIDS strategic Plan).

- Special programs for key populations and migrant communities including those in the mining should be promoted. This includes bringing services close to these people. Some of the interventions include moonlight services, outreach and mobile HIV/ AIDS services

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