PACK

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USING THE COMMUNITY SCORE CARD TO ASSESS THE QUALITY OF HIV & AIDS SERVICE DELIVERY IN AMUDAT DISTRICT

2017 | MARCH

ALLIANCE OF MAYORS AND MUNICIPAL LEADERS ON HIV/AIDS IN AFRICA

Straight TALK FOUNDATION

THE AIDS SUPPORT ORGANISATION
TASO
LIVING POSITIVELY WITH HIV

THE NATIONAL FORUM OF PLHA NETWORKS IN UGANDA
THE UGANDA HIV/AIDS PARTNERSHIP
NAFOPHANU

ACKNOWLEDGEMENT

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Together for a positive difference!

Stella Kentutsi
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NAFOPHANU

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AIDS:	Acquired Immune Deficiency Syndrome
AIS:	AIDS Indicator Survey
ANC:	Ante-natal Care
ART	Anti-Retroviral Treatment
CPR:	Contraceptive Prevalence Rate
CSC	Community scorecard
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:	House Hold
HIV:	Human Immuno deficiency 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
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

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 March 2017, on behalf of the PACK, NAFOPHANU conducted community scorecard to assess the level of health service delivery in the district of Amudat basing on the National HIV Strategic Plan thematic areas of; HIV prevention, care and treatment, social protection and protection and system strengthening (staffing norms, infrastructure and equipment). The Community Scorecard is a participatory community based monitoring and evaluation tool that enables citizens to assess the quality of services rendered to the citizens such as health care. The purpose of community scorecard was to empower the community and other stakeholders (service beneficiaries, service providers and other key stakeholders) assess the quality of HIV&AIDS services and make recommendations on HIV services to policy makers, Policy Implementers, Development Partners, Civil Society, Private Sector and other stakeholders.

The assessment targeted a catchment of four (4) ART accredited health centers distributed according to different grades of service delivery that included: 1 General Hospital, 2 Health Center IIIs and 1 Health Center II. The methodology to obtain data included using desk reviews, focus group discussions, key informant interviews, consultative meetings, direct observations and interface meetings. Quantitative data was entered using EPI Data and analyzed using statistical package SPSS whereas qualitative data was analyzed using thematic analysis and then 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. Whereas the staffing norms have not reached the maximum of the government ceiling, the staff available were overworked as they multi-task to fill existing gaps which negatively affect the quality of services. Equipment and infrastructure remain inadequate but a few health workers are accommodated and have structures to work from.

The gaps that negatively affect HIV and general health service delivery in the district such as lack of comprehensive counseling skills for health workers, stock outs of drugs and other supplies, low levels of staffing, lack of transport, absence of Viral load testing services, high levels of stigma which limits PLHIV from accessing services, few AIDS competent staff, limited youth friendly services, limited linkages between health facilities and community, low political involvement and absence of HIV& AIDS strategic plans at the district level. There was no system 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, recruiting of more staff to fill the gaps, constant supply of drugs and reagents, strengthening supervision and monitoring systems and district to develop its own HIV&AIDS Strategic Plans. There is also need to continue with community sensitisation sessions on various topical areas such as family planning, stigma, palliative care, TB management among others.

1.0 BACKGROUND

Over the last couple of years, Government of Uganda has made efforts to achieve better health for the people and thereby contributing to the enhancement of the quality of life and productivity. A number of strategies have been undertaken including putting in place a legal and policy frame works.

Uganda's long term plan (Vision 2040) envisions a transformed country from peasant to a modern and prosperous country by 2030. The second national development plan (National Development Plan II) stresses the need to invest in health for the country to reach middle income status by 2020. To realize the vision, the Ministry of Health developed a five year, health sector development plan (HSDP) for the period 2015/16-2019/20), with its vision as "To have a healthy and productive population that contributes to economic growth and national development". 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 Development Plan (HSDP) goal is to accelerate movement towards universal health coverage with essential health and related services needed for promotion of a healthy and productive life. The HSDP indicates targets for the health sector to be achieved by 2019/20 that include: 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% and increasing HC IVs offering Comprehensive Emergency Obstetric Care (CEmOC) services from 37% to 50%.

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 leading cause of death in the country. The health sector is a labor intensive sector and availability of adequate human resource for health is pivotal in the achievement of the objectives. The absence of adequate health workforce is still a key bottleneck for the appropriate provision of health services, with challenges in adequacy of numbers and skills, retention, motivation, and performance. Despite the recruitments undertaken by government and partners in 2014, the status of the health care workforce is at 69% of the approved posts as at the end of 2015.

The above situation needs to be urgently addressed for the country to meet the Sustainable Development Goal (SDG) targets on health by 2030 especially target 3 of SDG 3 that 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 mitigate 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.

1.1 HIV & AIDS Situation in Uganda

The HIV epidemic remains the single most human health scourge 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) 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 National AIDS Survey and high HIV infections in specific sub-populations and sub-regions (Central 1 10.4%, Central 2 9.0%, East central 5.6%, Mid east 4.1%, Mid-North 8.3%, West Nile 4.9%, Mid-West 8.2% and South West 8.0%)
Regarding Karamoja Sub region as part of North Eastern Uganda, the prevalence is estimated at 5.3% (UAIS 2011), having increased from 3.5% in 2004. There is also high prevalence of other life threatening diseases such as Hepatitis B at 21.7%, higher than the national prevalence rate of 10.2%.

1.2 Amudat district

1.2.1 District Profile

Amudat District is located in the North East, 217 km north West of Kampala the capital city of Uganda and is bordered by Moroto District in the north, Nakapiripirit in the west, Kenya in the east and Kapchorwa and Bukwo in the south. Administratively, the district is comprised of one (1) county. This is further sub divided into four (04) sub-counties; Amudat, Karita, Loroo and Amudat Town Council.

Table 1: Population by sex, Sub County, County

SN	SUB-COUNTY	NO. OF HOUSEHOLDS	POPULATION		
			MALES	**FEMALES**	**TOTAL**
1	Amudat	4,305	16,867	14,169	31,036
2	Amudat Town Council	2,292	5,750	5,867	11,617
3	Karita	4,822	19,877	16,021	35,898
4	Loroo	4,431	16,004	17,203	33,207
	TOTAL	**15,850**	**58,498**	**53,260**	**111,758**

Source: Amudat District Planning Office (2015)

3.0 THE PREVENTION OF AIDS IN THE COMMUNITIES OF KARAMOJONG (PACK) PROJECT

In this consortium arrangement, each organisation is responsible for delivering on a number of outputs. NAFOPHANU takes lead in facilitating the strengthening of community structures of People living with HIV in the seven districts of Karamoja sub region. The activities include mobilization for HIV prevention and treatment services by partners, implement stigma reduction activities, and strengthen the leadership of the networks as advocates for PLHIV rights. To enable citizens, understand and give feedback to the quality of HIV&AIDS service, NAFOPHANU undertook a service delivery assessment using a Community Score Card in the district of Amudat. 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.

3.1 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

3.2 Scope of the Assessment

This Assessment covered a total of four (4) accredited ART health care facilities in Amudat district. Different methods were used in undertaking this assessment. The assessment involved examining the quality of health service delivery in health facilities with FGD for community members and health workers to get the feedback on the services offered.

3.3 Source of information

The assessment used a multifaceted design comprising of both qualitative and quantitative. The major source of information included review of secondary data, Focus Group Discussions of the service users (men and women), service providers, Interface meetings, key informant interviews, health facility interviews (input tracking) and observation of the nature of service delivery and physical checking on the available facilities.

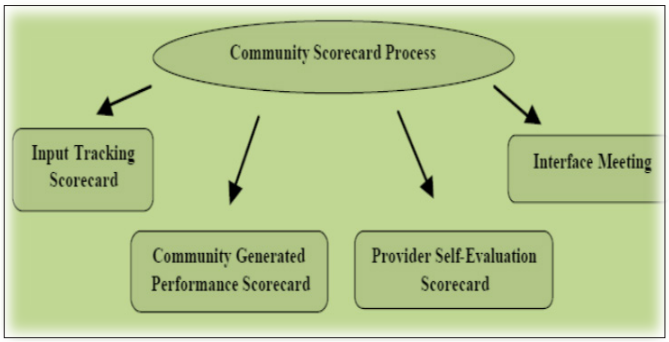
3.4 Study Population

The study was undertaken in a catchment of four health centers in Amudat district. The team conducted 12 Focus Group Discussions, 4 interface meetings and 4 Key Informant Interviews. A total of one hundred and ninety two people (96 males and 96 females) participated in the Focus Group Discussions and 196 (135 females and 105 males) participated in the interface meeting. The key informant interviews were conducted with the in charges of the 4 health centers totaling to four persons.

4.0 METHODOLOGY

The assessment used a Community Score Card (CSC) methodology. The Community Score Card (CSC) sometimes known as a community voice card is a participatory community based monitoring and evaluation tool that enables citizens to assess the quality of priority public services such as health,

education, 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 the 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 for improved service delivery. The CSC provides valuable feedback that helps to improve services and provide important information to guide government policy-making reform initiatives.



Source:Janmejay & Parmesh (2009)

The assessment team undertook 4 inter-related steps in undertaking this assignment that included generating supply side data through input tracking, gathering service user feedback through FGD for women, men and health workers. Key Informant Interviews, generating service provider's feedback through provider self-evaluation and interface meetings that generated a consensus score.

4.1 Objectives of the Community Score Card

- To empower the community to assess the quality of HIV&AIDS in the Amudat district.
- To enable the service providers self-evaluate the quality of HIV&AIDS services they offer to the community.
- To make recommendations on how HIV&AIDS, service delivery to state and non-state actors.

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.

5.1 Demographic Representation

The study was conducted in four (4) health facilities in Amudat district. Three (3) Focus Group Discussions (FGDs) attended by groups of; men, women and service providers were carried out in each of the 4 health facilities making a total of 12 FGDs. Four interface meetings were also held and were attended by representatives from the three groups that participated in the FGDs and selected community leaders who gathered to brainstorm on the availability and quality of the services and made recommendations on what is needed to improve the quality of services. One key informant interview was conducted with the in-charge of each health facility visited where staffing norms, services and equipment availability was discussed.

Table 2: Study demographic characteristics

Name of Facility	*Level III*	*FGDs (N)*	Interface meetings *(N)*	*Key Informant/Input Tracking (N)*
Amudat	G/H	3.00	1	1
Karita	HC III	3.00	1	1
Loroo	HC III	3.00	1	1
Alakas	HC II	3.00	1	1
		12.00	**4**	**4**

4.2 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

This mainly relied on intensive interaction with the key stakeholders at both district and facility level. Interviews were held with Local Government leadership at district and health facility management at facility levels targeting District Health Officer (DHO), HIV Focal Person, District Planner and health Facility in-charges and health unit management committee members.

Input tracking

In Amudat, 4 health facilities were visited to gather information on key inputs that include staffing levels and infrastructure. This involved desk reviews, verification of the set standards such as on staffing and direct observations on what was available at the time of the survey.

Focus Group Discussions

The focus group discussions were used to collect qualitative and part of quantitative data from PLHIV (Men and women separately) and the health workers.

Interface Meeting

Joint meetings targeting decision makers (politicians, technocrats) service users (community men/women including PLHIV and community members), service providers and opinion leaders (community and religious leaders) were held at each of the sites. The interface meetings were to measure the scores against the performance indicators of the community and service providers for a consensus score (overall score). It was also to come up with recommendations on how to address the identified gaps.

4.3 Data Management and Analysis

Quantitative data was entered in EPI data and analyzed using Statistical Package for Social Scientist (SPSS). Qualitative data was collected through key informant interviews and FGDs and analyzed using thematic analysis, where recurrent ideas are categorized and grouped according to the key assessment questions.

4.4 Quality Assurance

The assessment team employed a number of quality assurance mechanisms that included, training of data collectors, review of secondary data, and supervision of data collectors at all the data collection sites. A one-day training of research team on the scorecard process was undertaken to enable the implementers become familiar with the tool.

Research assessment team after the training

4.5. Ethical Considerations

The study was not subjected to ethics body approval as it is not classified as human subject research. The researchers obtained written approval from the district local government to visit health care facilities and requested permission and consent from in charges of health care facilities and respondents in the FGDs to collect the data on HIV&AIDS service delivery.

5.0 FINDINGS

This section presents results for the study conducted in Amudat District. The findings are presented in line with the thematic areas of the National Strategic Plan for HIV&AIDS; Prevention, Care and Treatment, Social Support and Systems Strengthening.

5.1 Staff tracking

Based on MoH Guidelines, tracking was done to ascertain the number of different staff categories at the all the health care facilities visited that included one General Hospital, two Health Center IIIs and one Health Center II.

5.1.1 Adherence to Staffing Norms in Amudat General Hospital

Amudat has only one General Hospital and it was the only facility in this category during the assessment.

Medical Officers staff category

Medical officers are critical in any health care facility for they undertake diagnostic and advice on many health related issues. According to the accepted minimum standards, a general hospital is expected to have 7 medical officers. These comprise of a Principal Medical Officer, Medical Officer Special Grade, Senior Medical Officer and four Medical Officers. Amudat GH had only 3 medical officers leaving a gap of 4 staff. This calls for recruitment of the missing cadres to fill the gaps where referral could be a problem from a diverse, mountainous and hard to reach district. The 3 available should

Table 3: General hospital staffing norms: Medical officers

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

Source: Field data (2017)

Allied Health Professionals

Out of the 27 staff in this category, only 12 staff are available in the category of Allied Health Professionals leaving a gap of 15. These categories consist of Clinical officers, Dermatologist, Anesthetic officer, orthopedic officer, Physiotherapist, Occupational therapist, Radiographer and laboratory staff. Details of these are discussed in the subsections below. The absence of such a big numbers of staff indicates deficiency in service delivery as most of these staff are front line that handle the bulk of the clients at the health care facility.

Clinical Officers

The approved standards for a general hospital are 8 clinical officers that include One (1) Senior Clinical Officer, five (5) Clinical Officers, one (1) Psychiatric Clinical Officer and one (1) Ophthalmic Clinical Officer. Amudat GH had 3 clinical officers out of 5 approved. The facility had no senior clinical officer, Psychiatric clinical officer, 2 Radiographer, Physiotherapist, occupation therapist, 2 Orthopediadic officers, Assistant health educator, Anesthetic officer, Theatre Attendant,

Laboratory staff

Amudat GH did not have the required laboratory personnel (Laboratory technologist and laboratory Attendants). Out of the 5 staff, only 2 were available. This leads to work overload and delays on patients receiving their results.

Other Allied Health Professionals

These include; Medical Entomology Officer, Radiographers, Occupational Therapists, Anesthetic Officers, Health Inspector, Theatre Attendants and Health Education Officer. Amudat General Hospital has only 3; Health Inspector, Orthopedic Officer and Theatre Attendant. There is urgent need to fill the 8 critical positions to ensure efficient service delivery at the facility.

Table 4: Number of Clinical officers and other Allied Health Professionals at Amudat GH

Table 4: Number of Clinical officers and other Allied Health Professionals at Amudat GH

Post	Approved	Filled	Gap
Senior clinical officer	1	0	1
Clinical officer	5	3	2
Psychiatric clinical officer	1	0	1
Ophthalmic clinical officer	1	1	0
Health inspector	1	2	1+
Medical Entomology officer	1	1	0
Radiographer	2	0	2
physiotherapist	1	0	1
Occupational therapist	1	0	1
Orthopedic officer	2	0	2
Health Educator	1	1	0
Assistant Health Educator	1	0	1
Anesthetic officer	2	0	1
Theater Attendant	2	1	1
Senior Lab. Technologist	1	0	1
Lab Technologist	1	1	0
Lab Technician	2	1	1
Lab Assistant	1	1	0
Total	27	12	16

Source: Field Data (2017)

Dental staff

According the standards, staffing norms for a General hospital are 4 approved dental staff; 1 dental surgeon, 2 public health dental officers (PHDO) and 1 dental attendant. Amudat GH had no staff in this department. This implies that patients have to travel long distances to Moroto RRH and other hospitals to access dental services which is costly in terms of money and time.

Table 5: Number of Dental staff

Post	Approved	Filled post	Gap
Dental Surgeon	1	0	1
Public Health Dental Officer	2	0	2
Dental Attendant	1	0	1
Total	4	0	4

Pharmacy

As per minimum standards, a General Hospital should have one pharmacist and 2 dispensers. However, Amudat GH revealed 100% gap in this category. This therefore has led to multi tasking by the available staff and there is an urgent need to recruit and fill this gap.

Table 6: Number of Pharmacists at Amudat GH

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

Administration

Amudat General Hospital had a gap of 9 staff out of the 13 staff recommended. These include; Senior Hospital Administrator, Personnel officer, Medical Social Worker, Supplies officer, Nutritionist, Office Typist, Medical Records Assistant, Senior Accounts Assistant and Stores Assistant. This means critical administrative functions could affected by absence of staff which and overload for staff who have to take on extra responsibilities.

Table 7: Number of Administration staff

Administrative staff	Approved post	Filled post	Gap
Senior Hospital Administrator	1	0	1
Hospital Administrator	1	1	0
Personnel officer	1	0	1
Medical Social Worker	1	0	1
Nutritionist	1	0	1
Supplies officer	1	0	1
Office Typist	1	0	1
Stores Assistant	2	1	1
Medical Records Asst.	2	1	1
Senior Accounts Assist.	1	0	1
Accounts Assist.	1	1	0
Total	13	4	9

Nursing staff

Nurses play a critical role at every service point in a health care facility handling the bulk of hands on services to the patients. Out of the 113 nursing staff supposed to be at the general hospital, only 23 are available leaving a gap of 90 staff. The absence of the majority of the nursing staff implies overload for available staff and delays for patients to receive care.

Table 8: Number of nursing staff

Nursing Staff	Approved post	Filled post	Gap
Principal Nursing officer	1	0	1
Senior Nursing officer	5	1	4
Nursing officer/Nursing	17	0	17
Nursing officer/midwifery	3	3	0
Nursing officer/psychiatrist.	1	0	1
Enrolled Nurse	46	7	39
Enrolled Midwife	25	1	24
Nursing Assistant	15	11	4
	113	23	90

Support Staff

Support staff such as cleaners, security guards, drivers and other attendants ensure that the food, hygiene, security and transport at health care facility are in good order. The assessment revealed a gap of 7 staff while some staff categories are overfilled. Fear and equitable distribution for these cadres is needed.

Table 9: Number of support staff

Support staff	**Approved posts**	**Filled posts**	**Varia**
Darkroom Attendant	1	0	1
Driver	2	1	1
Security Guards	2	3	1+
Cold Chain Attendant	1	0	1
Mortuary Attendant	1	2	1+
Cook	3	2	1
Artisan	3	0	3

In conclusion, Amudat GH is highly understaffed. The few staff available are overwhelmed by a high number of patients received. The Government and other stakeholders need to step up and sort out the staffing gap before it goes out of hand.

5.2.2 Adherence to Staffing Norms in Health Centre Level III

A total of 19 personnel are recommended for a Health Centre III. These included; 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). Two (2) HCIIIs of Karita and Loroo were assessed.

Table 10: Adherence to staffing norms in Health Centre level III

Staffing norms		Karita		Loroo	
	Norm	Filled	Gap	Filled	Gap
Senior Clinical Officer	1	0	1	1	0
Clinical Officer	1	1	0	1	0
Nursing officer	1	0	1	0	1
Laboratory Technician	1	0	1	0	1
Enrolled Mid-Wife	2	2	0	2	0
Enrolled Nurse	3	3	0	1	2
Laboratory Assistant	1	1	0	1	0
Health Assistant	1	1	0	1	0
Nursing Assistant	3	1	2	3	0
Health Information Assistant	1	1	0	0	0
Askari	2	1	1	1	1
Porter	2	1	1	1	1
Total	**19**	**12**	**7**	**13**	**6**
Percent		**63**	**37**	**68**	**32**

The results gathered from Karita HC III indicate a gap of seven (7) staff that include; Senior. Clinical Officer, Nursing Officer, Laboratory technician, 2 Nursing Assistants, Askari and porter. Data in Loroo HC III revealed a gap of 6 staff and these include, enrolled Mid-wife, Nursing Assistant, Laboratory technician, Laboratory Assistant, Health Assistant, Porter and Askari. This implies multi tasking, work overload but also delays for patients to be served.

5.1.3 Adherence to Staffing Norms Alakas Health Centre II

Alakas HC II had 5 staff out of the 9 that is recommended for a HCII. The available staff were; enrolled nurse, enrolled mid-wife, nursing assistant, porter and askari

Table 11: Adherence to staffing norms in Health enter level II

Staff norms	Approved	Filled	Gap
Enrolled nurse	1	1	0
Enrolled mid-wife	1	1	0
Health assistant	1	0	1
Nursing assistant	2	1	1
Askari	2	1	1
Porter	2	1	1
Total	**9**	**5**	**4**

The core cadres at the facility were available and therefore the missing staff were being covered, creating overload for some.

5.2 Input Tracking: Infrastructure

The following sections report on the available infrastructure for Amudat GH, Karita and Loroo HCIIs and Alakas HCII at the time of the visit. The infrastructure included buildings, consultation rooms, theatres, wards and others provide a conducive environment for patients to seek health services. It also enables health service providers to operate in a professional manner including ensuring privacy which is a critical ethical issue in delivery of health services for patients. The outpatient (OPD) and the inpatient departments (IPD) of the General Hospital, HCIII and HCII were assessed

5.2.1 Outpatient Department (OPD)

An Out Patient Department (OPD) is designed for treatment of patients who do not require to be admitted, thus patients are attended to by health workers and return to their places of aboard. Under OPD the assessment examined health education, counseling room, dental clinic, dispensing room, ART clinic, OPD drug store, examination room, laboratory, treatment room, UNEPI records and operating theatre and early infant diagnosis.

Counseling Room

Loroo HCIII, Karita HCIII and Alakas HCII had no counseling rooms except Amudat GH ART clinic. For the lower level facilities, therefore, counseling sessions were therefore being conducted in consultation, treatment and dispensing rooms.

Table 12: Existence of a counseling room

	No	Yes
	N (%)	N (%)
Level III	2(100)	0(0)
Level II	1(100)	0(00)
General Hospital	0(0)	1(100)

Health Education Centre (shelter)

Health care facilities are required to offer health education as part of good health practices and ensure prevention of diseases. All the facilities visited had health education rooms and shelters that were used on antenatal and ART clinic days. There were IEC materials on malaria prevention, Family Planning, HIV prevention, T.B prevention/ management and nutrition. However, they lacked furniture and hygiene was poor.

Dispensing Room

All 4 health facilities visited had dispensing rooms with dispensing windows, cabins and tables. Furthermore, the drugs are well stored and, the rooms were clean and well ventilated. During the key informant meetings, the facility management expressed concern about limited space, congestion, absence of shelves and furniture, lack of curtains leading to direct sunlight on the drugs and inadequate staff.

Dispensing desk at Karita HCIII

OPD: Drug Store

In order to ensure quality of medicines,a drugstore should be well ventilated with temperature of 15-25% free from dust, pests and direct sunlight (WHO guidelines for Drugstore, 2015). The input tracking in Amudat General Hospital, Karita HC III, Loroo HCIII and Alakas HC II confirmed existence of OPD drug store. Poor ventilation, lack of temperature monitoring devices and poor structure, congestion all have an impact on shelf life of the drugs.

Table 13: Drug store availability

	No	Yes
	N (%)	N (%)
Level III	0(0)	2(100)
Level II	0(00)	1(100)
General Hospital	0(0)	1(100)

Drug store at Amudat general Hospital

Drug store at Loroo HC III

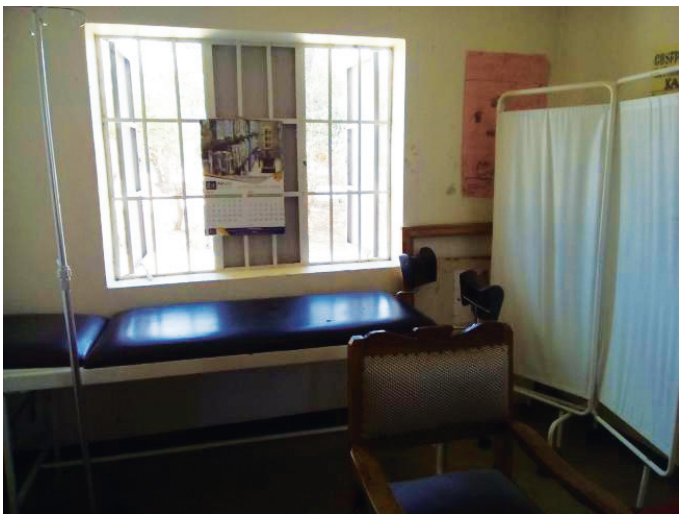
OPD: Examination Room

In a hospital or any health care set up, an examination room is very key for the ill or injured patients. It plays a big role in deciding the right treatment. Examination rooms are meant to consist of an examination bed, store cabin, examination stool, screens, seat, medical examination light, counter space, sink, computer stand or table and integrated diagnostic setup

In Amudat district, all the 4 health facilities had examination rooms, operated by both clinical and medical officers. However, not all the required equipment existed as; limited space, lack of furniture, no screens, no computer stand or table and computer in all the 4 health facilities while there was no integrated diagnostic setup in Alakas HC II and Loroo HC III.

Table 14: Examination room availability

	No	Yes
Facility level	N (%)	N (%)
Level III	0(0)	2(100)
Level II	0(0)	1(100)
General hospital	0(0)	1(100)



Examination bed at Amudat General Hospital

Examination room at Loroo HC III

OPD: Laboratory

A Laboratory is required to have a sink, eye wash station, functional biosafety area, fire extinguisher, chemical fume hood, chair and table, computer, electricity connection, refrigerator, microscope, water connection, waste segregation bins, reagents, bin liners, cabins and screens and adequate lighting. All the 4 health facilities (Amudat General Hospital, Loroo HCIII and Karita health center IIIs and Alakas HC II) had a laboratory. However, none of the laboratories met the standards. In any case, most did not have the required staff .The laboratories lacked reagents and test kits, waste segregation bins, bin liners, inadequate water supply and essential equipment.

Table 15: OPD Laboratory

	No	Yes
Facility level	N (%)	N (%)
Level III	0(0)	2(100)
Level II	0(0)	1(100)
General Hospital	0(0)	1(100)

OPD: Treatment Room

The OPD treatment room requires to have crash trolley, defibrillator, sterilization equipment, gloves, face masks, water connection, sink, screens, treatment bed, light, locker area and the rooms are attended to by the nurses. All 4 facilities confirmed availability of treatment rooms, Loroo HC III and Alakas HC II lacked treatment beds, but generally the rooms were small and not furnished with basic requirements for all the facilities.

Table 16: Availability of treatment room

Facility name	*Availability*	*Status*
Amudat GH	Yes	Treatment in OPD were available but no screens and curtains
Karita HC III	Yes	Room is small with no screens and stretcher bed
Loroo HC III	Yes	They use a bed from the ward not a stretcher bed, no pits, no screens and poor hygiene
Alakas HC II	Yes	There are no screens, no water, tiny

OPD: Operating Theatre

General hospitals, regional referral and health centre IVs in Uganda are required to have an operating theatre where minor and/or major surgeries are done.

As Amudat had only 1 hospital and no HCIV, it was the only the GH that was assessed. Amudat GH had operating theatres. However, the was no running water, no operating lights, lacking waste bin and liners, lack of trolleys for rolling patients, protective gear and other supplies. Constant equipment breakdown and inadequate space were also cited as main issues.

Other OPD infrastructures at General hospital

Other components of the outpatient department at the hospital level that were considered in the CSC process are summarized in table below.

Table 17: Other OPD structures in Amudat General Hospital

	GH		*Status/observation*
	No	Yes	
Injection room			Had injection bed, screens, trolley, lighter, curtain, locker area and face mask
Waiting room			Had shelter, seats, IEC materials and suggestion box.
MCH(ANT/FP)			Spacious well furnished with IEC materials, seats and examination bed.
Multi-Functional room			Not available
MCH store			Semi functional, the room is small
Laboratory store			Had spacious well-furnished and ventilated with Cabins and selves, electricity connection, refrigerator and temperature monitoring machine
Blood bank			Blood storage rooms spacious with refrigerators and temperature monitoring machines.
X-ray Radiology			Had x-ray machine and screens
Radiology film processing			Very small room, well equipped, air conditioned, examination stool and seat
Radiology waiting area			Small with no seats and screens
Gynecology and Obstetrics department(treatment room)			Examination table, seat, screens and linen
Physiotherapy			Small with no equipment to support service delivery
Changing room, Locker Area Operating theatre			No specific locker area for the theatre

Waiting area at OPD in Karita HC III

5.3 Inpatient Department (IPD)

Patients that need 24 hour attention and observation are residents at a health centre until the health workers discharge them. Health care facilities from HCIII on wards are supposed to admit patients as per their mandate. An assessment of the 3 health care facilities visited had some of the IPD facilities as described in the subsequent sections.

5.3.1 Inpatient department: General Hospital

According to standard guidelines and procedures for a general hospital, the in-patient department must have a maternity unit, pharmacy department, administrative department and kitchen to support and manage diagnosis of diseases. The input tracking assessed the availability of equipment, facilities, space and condition at the facility through observation and key informant interviews with health facility administrative personnel.

Table 18: Input ranking at Amudat General Hospital

	IN PATIENTS DEPARTMENT		
Section	**Indicator**	**Existence**	**Status**
MATERNITY (DELIVERY UNIT)	Medical ward	No	Had no specific ward, patients were admitted in the general ward
	Surgical ward	No	Had no specific ward, patients were admitted in the general ward
	Obstetrics/ gynecology wards	Yes	Antenatal, maternity first labor, the post-natal and delivery wings and gynecology room existed at the facility, spacious, with screens, well-furnished and conditioned
	Pediatric ward	Yes	Fewer beds, no mosquito nets, no provision space for care takers and linen
	Psychiatry ward	No	Improvised in the general ward.
	Tuberculosis ward	No	No specific ward for TB patients, admission was made in general ward.
	First stage labor	Yes	With examination bed, screens, intensive lights, rocker area, trolley and cabins.
	Mid wife office	Yes	Spacious with office table and chair, cabin, IEC materials, sterilization machines and equipment's, HP machine and cardiology equipment
	Premature room	Yes	Incubation machine, temperature, curtains, and weighing scale existed
	Store	Yes	Small, with equipment (mama kits, linen, gloves, detergents and reagents).
PHARMACY	Pharmacy dispensary	Yes	Well spacious and furnished and shelved
	Preparation room	Yes	Attached to the dispenser room, well shelved, spacious with locker area (cabins).
	Store	Yes	Large, well condition and well organized
	Mortuary	Yes	Not equipped to the standards (no refrigeration system)
	Office	Yes	Clean well-furnished and conditioned.
	Main Store	Yes	large, well organized, stocked and conditioned
ADMINSTRATIO	Conference room	Yes	Small with no furniture
	Library	No	The facility had no library
	Office secretary	Yes	Well-furnished and with computer, printer

	IN PATIENTS DEPARTMENT		
Section	**Indicator**	**Existence**	**Status**
			and stationary
	Administrators office	Yes	Spacious equipped with waiting area
	Personnel's office	No	Improvised in the secretary's room
	Hospital directors office	No	Share with administrative officer
	Staff tea room	No	No designated room for tea
	Store	No	No store space
KITCHEN, LAUNDRY	Preparation Area	Yes	no kitchen for patients
	Store	No	No specific Kitchen materials were kept in the general store
	Wet area	No	No specific wet area.
	Laundry	Yes	The laundry is small with no poor drainage system
	Laundry store area	No	No store for laundry.
	Laundry store area	No	No laundry store for dirty linen.
	Generator room	No	No generator

Drug store at Amudat general hospital

5.3.2 IPD at Health Centre III

According to Government of Uganda standards for Health, HCIIIs, it should have children/ female ward, delivery room, linen store, male ward, maternity ward, maternity first labour, maternity waiting room, ward nurse stations and sterile store. However, the facilities visited confirmed some gaps. Loroo and Karita HCIII had IPDs albeit with challenges such as inadequate space, few beds and beddings, no water especially in the dry season, generator fuel, frequent power shortages, lack of mama kits and other maternity supplies.

Table 19: IPD at Health Centre III Level

IDP	NO	YES	Status general comments
	N (%)	N (%)	
Children/ Female ward	1(50)	1(50)	Loroo HC III- had children and female ward at the facility. poor hygiene, no mosquito nets, no drip stands, IEC materials and incinerator Karita HC III- No specific wards for both female and children
Delivery room	0(0)	1(100)	Karita HCIII- had delivery bed, screens, crash trolley and sterilizer. However, with no water facility in the delivery room Loroo HC III- no screens in delivery room
Linen store	1(50)	1(50)	Karita HC III- had linen store with no linen Looro HC III-No linen store and linen
Male ward	2(100)	0(0)	In Looro- improvise in the female or general ward Karita HCIII -Improvise in the maternity ward
Maternity ward	0(0)	2(100)	Loroo HCIII-no screens, 4 beds, no IEC materials and small room with poor hygiene Karita HC III- screens, 7 beds and no IEC materials
Maternity first labor	0(0)	2(100)	Both improvised in maternity ward.
Maternity waiting room	0(0)	2(100)	In both facilities, patients wait in the maternity ward.
Ward nurse stations	2(100)	0(0)	Nurse on night duty commute from staff quarters to attend to patients
Sterile Store	2(100)	0(0)	Both lacked the store
Incinerator	0(0)	2(100)	Distant from the maternity ward and labor room

Delivery bed at Karita HC III

Sterile machine at Karita HC III

Record keeping at Karita HC III

Consultation room at Karita HC III

5.3.3 IPD in Health Centre II

Health Centre IIs support service delivery through eMTCT and outreach programs. During the input tracking, the score card examined facilities for ANC services through the availability of the equipment, maternity rooms, and accessibility. Alakas HC II had ANC services with functional delivery room, waiting room, wet area and placenta pit to support personnel at the facility but had no screens, trolley, linen and cabins).

Delivery bed at Alakas HC II

Bins and bin liner at Alakas HC II

5.4 Service Delivery Assessments

This section provides results from the assessment by the community, service providers, and interface meetings on the performance of the health facilities. The participants included the community members (clients of health services) and service providers. The assessment benchmarked the NSP for HIV&AIDS thematic areas that include prevention, care and treatment, social support and systems strengthening. Prior to the meetings, participants developed and agreed on the parameters for the scoring of the services and the agreed consensus of scores included 1 to represent very poor , 2 to represent poor, 3 to represent average service, 4 to represent good and 5 to represent very good service. The scoring was based on the participant's opinion guided by the standards of service as per the Government of Uganda service delivery guidelines. What is represented in the following sections is what all participants agreed to as the final/consensus score.

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

Table 20: Health Centers sampled in Amudat District

Health Centre	Community FGDs	Interface
Amudat	3	1
Loroo	3	1
Karita	3	1
Alakas	3	1
Total	**12**	**4**

5.4.1 HIV Prevention

Assessment of HIV prevention services examined the quality of eMTCT, Safe Male Circumcision, provision of IEC materials, condom supply (female and male), testing and counseling services, sexual and gender based violence services as the indictors of HIV prevention

5.4.1.1 Quality of eMTCT.

The National HIV/AIDS Strategic Plan (2015/16 to 2019/20) has eMTCT as one of the priorities to have an AIDS free generation. The assessment focused of evidence of roll out of option B+ and availability of staff to support the program. The quality of service received by HIV+ pregnant women was rated at 50% very good in Loroo HC III and Alakas HCII, 25% good in Amudat General Hospital and 25% average in Karita HC III.

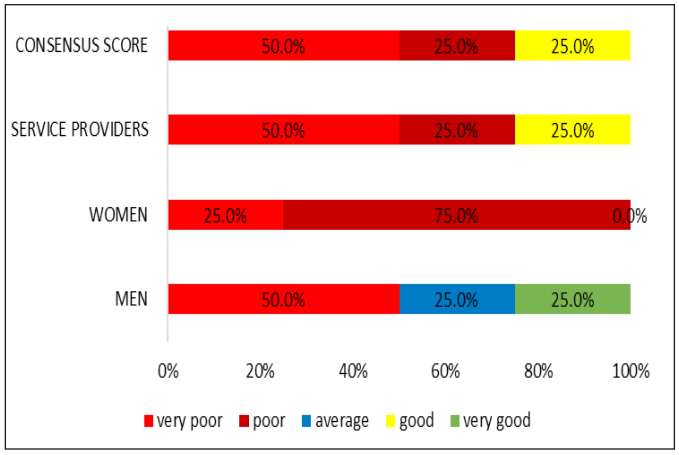
Figure 1: Quality of eMTCT

The reasons for good scores were; the availability of the service in all the facilities, mothers being linked to care and treatment when they test positive, counselling and male involvement. However, gaps to address included increasing male involvement, lack of follow ups and at times drug stock outs for both mothers and infants.

5.4.1.2 Safe Male Circumcision (SMC)

In September 2010, the Government of Uganda launched an initiative to provide Safe Male Circumcision (SMC) as an essential health service for HIV prevention. The initiative seeks to increase the number of circumcised men by 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. During the interface meeting for consensus score, safe male circumcision was ranked as very poor service in Karita HC III and Alakas HC III, poor in Loroo HC III and good in Amudat General Hospital.

Figure 2: Safe male circumcision

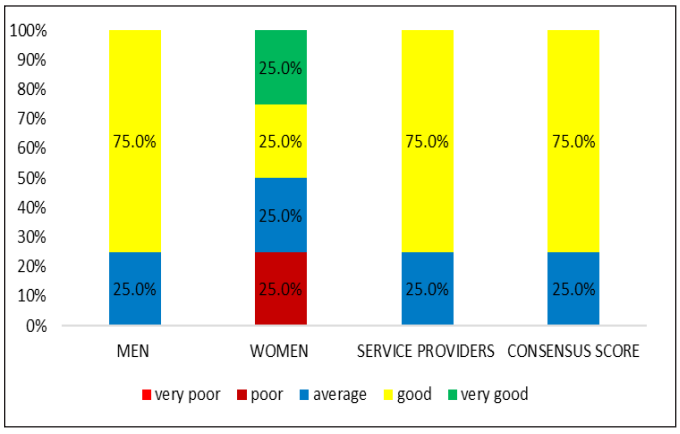


The Good score was due to; staff being trained in SMC, community awareness on SMC and availability of IEC materials for SMC. The poor scores were due to; absence of static program in all the other facilities, limited mobilization, absence of surgeons and rigidity of the community members on the adoption of the new programs. The recommendations were; sensitization of the community members, adequate training of staff in SMC, provision of the appropriate equipment and having static sites as well as outreach programmes.

5.4.1.3 Provision of IEC Materials

IEC materials such as posters, brochures, flyers, billboards are intended to draw attention on information about diseases or risks to health. During the consensus scoring, 75% Amudat General Hospital, Loroo HCIII, and Alakas HC II rated it as good service and 25% for Karita HC III as average.

Figure 3: Provision of IEC materials



Results indicated that most facilities visited had some IEC materials but these were not adequate to cover all strategic corners. Others were written in English language and were not

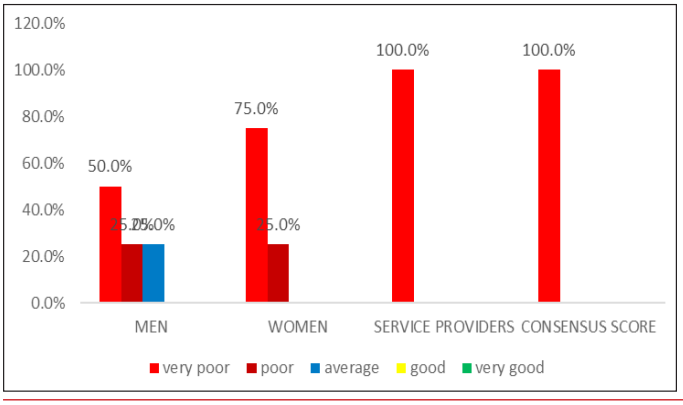
translated into the local languages. There were also reports of high illiteracy levels among the community members rendering some IEC materials ineffective. The community recommended provision of translated IEC materials and interpreted messages during health education talks for those who are illiterate.

Simplified IEC materials at Amudat general hospital

5.4.1.4 Condom Supply (Female)

Condoms are identified as one of the measures for HIV prevention. The community score card assesses availability, community uptake and usage of services and community perception on condom use. In the interface meeting (consensus score), all the 4(100%) visited health facilities ranked condom supply for females as very poor.

Figure 4: Female condom supply

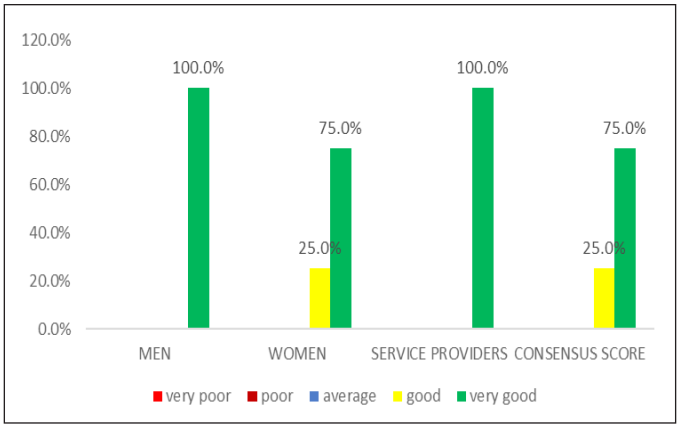


The very poor score was due to; lack of awareness, availability and use of the female condoms, perception of women that carrying condoms is a men's responsibility. Some community members said that they had never seen a female condom but others had a negative attitude towards female condoms as against cultural and religious norms.

5.4.1.5 Condom Supply (male)

Male condoms were available in all the health facilities visited. The community scorecard examined availability, accessibility and uptake o condoms. During the interface meeting (consensus score) 75% Amudat general Hospital, Karita HC III and Alakas HC II ranked male condom supply and uptake as very good and 25% Loroo HC III as average respectively.

Figure 5: Male condom supply

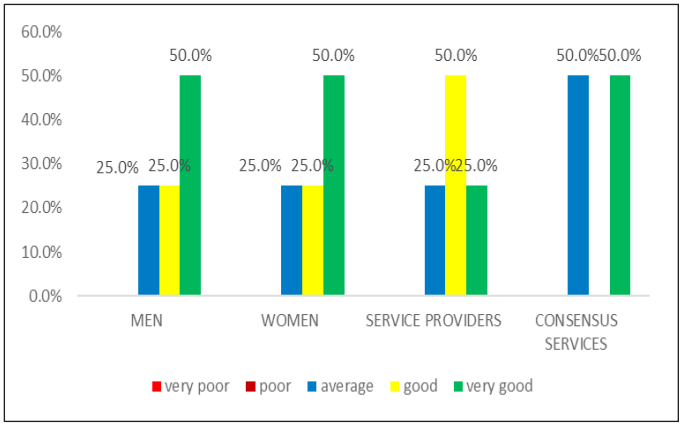


Male condoms were reported as available in all the health facilities visited. Condom corners in all the facilities to ease accessibility to condoms were made. It was however noted that married men feared picking condoms especially in Amudat General Hospital, that they would be seen and questioned. The recommendations included sensitization and awareness on condom use and increase supply of female condoms as women would be in control where men would fear to get male condoms.

5.4.1.6. HIV Testing Services (HTS)

Scaling up HIV prevention through extending coverage and uptake of HTS will enable attainment of the global target of first 90. The scorecard assessed the availability of testing kits, pre and post counselling services, community awareness on the services and community programs on testing services. During the interface meeting (consensus score), Amudat General Hospital and Karita HC III ranked the service very good (50%) and 50% Alakas HC II &Loroo HC III as good.

Figure 6: HIV Testing services

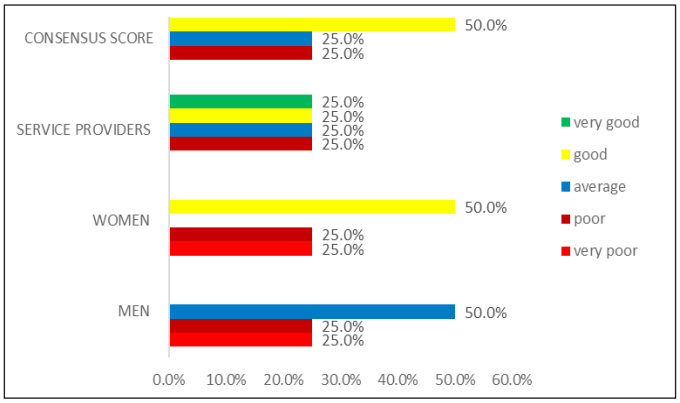


The quality of HIV testing services was ranked as very good. However, in some facilities such as Loroo HCIII and Alakas HCII it was ranked as average. Some of the reasons given for the scoring included; limited number of staff, lack of counseling rooms hence denying privacy, lack of skilled counselors and inadequate testing kits. there is therefore need for separate counseling rooms, regular supply of test kits, awareness campaign on couple testing, recruitment and training of existing staff in counseling and carrying out community outreaches to promote testing outside health centre set up.

5.4.1.7 Sexual and Gender Based Violence Services (SGBV)

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. The increase of SGBV has often been attributed to traditional/cultural beliefs, alcoholism, illiteracy and poverty. Many victims 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 the state's inaction in ensuring redress. The community scorecard assessed access to HIV preventive measures (PeP and morning after pills) that SGBV services at facilities were rated good in both Amudat GH and Loroo HC III, average in Karita HC III and poor in Alakas HC II respectively.

Figure 7: Sexual and gender violence services



The recommendations were; intensified sensitization of both the community and health workers on the dangers of SGBV, involvement of cultural and religious leaders in the fight, police enforcement of the law against offenders and development partners' support through funding of campaigns against SGBV that will lead to reduction of the vice. Health workers were requested to be cooperative in filling police forms, examining the victims and to dispense the required drugs on time.

5.1.4.8 Blood Transfusion

Blood transfusion was only measured at Amudat General Hospital and the score card assessed availability of blood and storage capacity. During interface meeting it was ranked as good. The good rating was based on constant availability of blood, community awareness, proper storage facilities though the gap was on some community members being ignorant about the availability of the service.

5.4.2 Care and Treatment

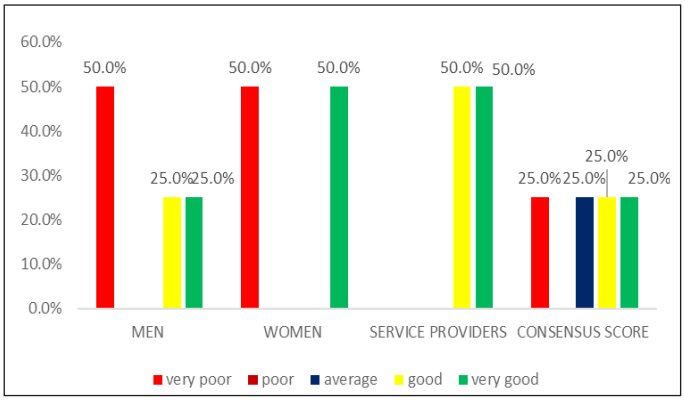
This sub section illustrates care and treatment in regard to access to ART for adults, pediatric HIV care, adolescent HIV treatment, integrated TB services, family planning services, nutrition services and home based care.

5.4.2.1 Access to ART for Adults

In regards to access to ART for Adult, community score card assessed availability of drugs, male involvement, integrated service delivery to eliminate stigma, competent staff in provision of comprehensive HIV services, privacy and outreach programs.

CSC results during the interface meeting (consensus score), ART services were ranked as very good in Amudat General Hospital, good in Loroo HC III, average in Karita HC III and very Poor in Alakas HC II. Sporadic ARV stock outs, stigma, inadequate staffing, and lack of privacy were reported as issues that need to be resolved to improve the availability to and access to ART services.

Figure 8: Access to ART



The good score for services were, drug availability, testing for viral load and CD4 where available and male involvement. The gaps were; limited space for large number of clients, drug stock outs, limited male involvement as a good number of men take their women's drugs, overwhelming numbers especially at Amudat General Hospital, stigma leading to fear by the PLHIV to access drugs, reliance on expert Clients to pick drugs for patients, no CD4 count machines. Recommendations were to train staff in comprehensive HIV services to make them AIDS competent, community sensitization, target men, uninterrupted supply of drugs and availing of results for viral load in time.

5.4.2.2 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.

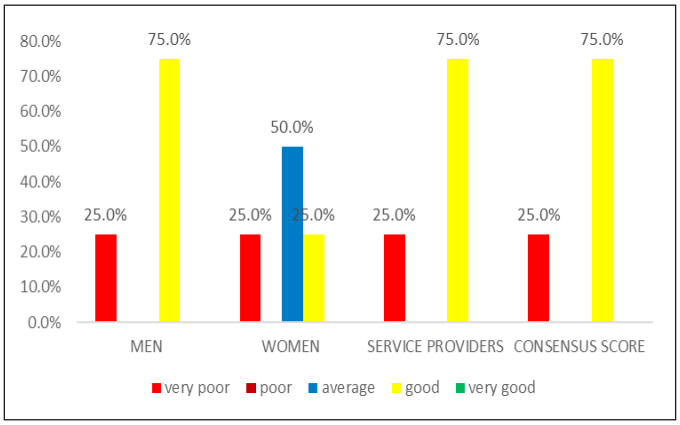
During the interface meeting (consensus score), respondents in Amudat General Hospital ranked as good service, Loroo HC III as very good, Karita HC III as average and Alakas HC II very poor services. The very good, good and average was noted to be as the result of availability of drugs, public education, and counseling provided specifically for mothers/caregivers. The gaps were on irregular supply of drugs especially pediatric drug regimens, and some care givers being reluctant to follow up and administer drugs to children. There were also cases of delayed enrollment of children after getting positive, not able to conduct EID, understaffing, stigma and inadequate space. The recommendations were; need to strengthen children enrollment and maintain them in pediatric care through adherence to treatment, and training staff in Integrated HIV care. There is also need to strengthen community linkages and referrals.

Figure 9: Pediatric HIV care

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 meeting (consensus score), Amudat General Hospital ranked services to adolescents as good, Loroo HC III as good, Karita HC III as good and Alakas HC II respectively.

Figure 10: Adolescent HIV treatment



The good ranking based on youth ART refill specific days, youth friendly corners, follow up through peer buddies and integrated program. The challenges were; absence of appropriate adolescent friendly services in most of the health care facilities, limited follow up, mobile nature of young people, stock out of drugs, stigma and discrimination. Participants recommended provision of services and support tailored to adolescents' needs, community sensitization on adolescent friendly services at the facilities and community and schools to ensure that adolescents who require services are followed up in their schools and community through peer buddies.

5.4.2.4 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 interface meeting (consensus), integrated TB services, Amudat General Hospital ranked it as good (25%), Loroo HCIII as average (25%), both Karita HC III and Alakas HC II ranked as a very poor service (50%).

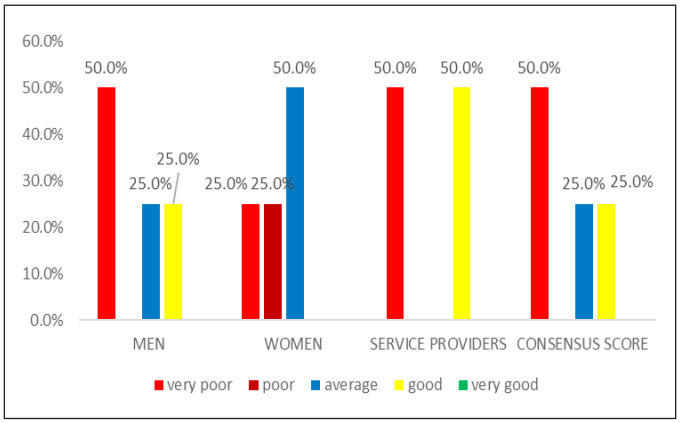
The good ratings was based on trained health workers and availability of drugs and TB services (screening and testing), community awareness, TB management

mechanism (Genexpert machine, microscope), and access to TB information at Amudat GH. The poor ranking was as a result of lack of TB specific spaces/wards, drug stock outs, limited follow ups, poor records management and unhygienic environment.

Recommendation for improvement included sensitization on TB drug adherence, building of separate TB screening rooms/ wards, promoting awareness of the availability of TB treatment among the community members, training of health staff on TB/HIV co-management, and avoiding stock out of TB drugs and testing reagents.

"Integrated TB service is a problem in the whole of Amudat district. The rate at which the infection is spreading is high, yet community awareness is low." A health worker in Amudat GH

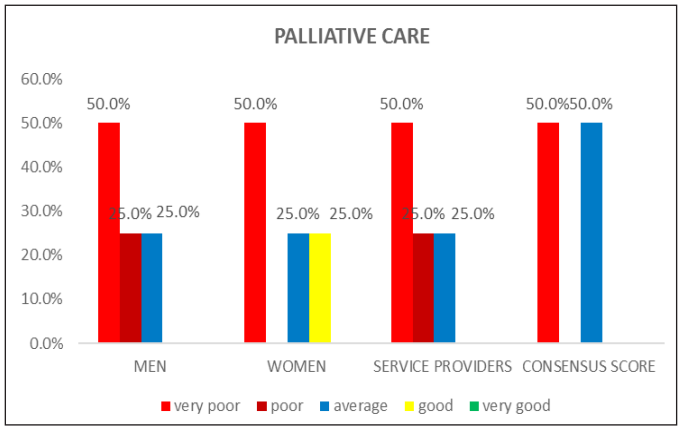
Figure 11: Integrated TB Services



5.4.2.5 Palliative Care Services

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. Palliative care was only considered in Amudat General Hospital and the participants agreed that the quality of the palliative care services was average respectively, due to availability of palliative care drugs, and trained staff in palliative care services. 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: need to train health workers in 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 Services



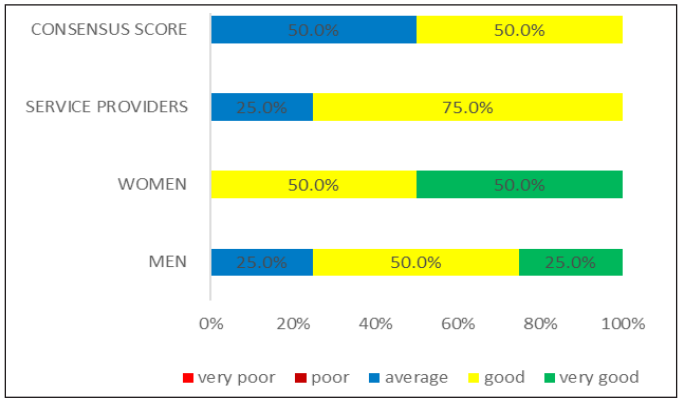
Note: Assessed only at Amudat GH

5.4.2.6 Family Planning Service

Family planning services were available in all facilities. However, some forms of family planning methods especially the permanent and long term methods were not available at Health Centre II and III levels. The scorecard assessed accessibility of services, stock status of commodities, community perception on services uptake and challenges encountered. Constant shortages especially for the "long term" commodities were recorded at Amudat General Hospital.

During the interface meeting (consensus score), participants in Alakas HC II rated it as good service, average service in Amudat General hospital and Loroo HC III and very poor in Karita HC III respectively. The consumers of family planning services ranked the quality as fair/average and the providers ranked it as good. This was based on availability of the FP methods to choose from, trained staff and space. Challenges were; stock outs of family planning supplies and test kits, perceived side effects, inadequate skills in management of side effects, inadequate staffing leading to heavy workload, low involvement of men, negative cultural and religious beliefs, myths and misconceptions. Participants recommended sensitization of the community on family planning, training of health staff on and availing long term methods, management of side effects and increase on the supply to avoid stock outs.

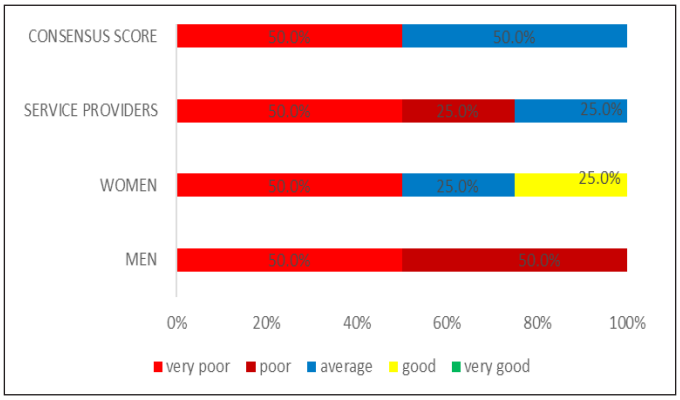
Figure 13: Family Planning



5.4.2.7 Nutritional Services

The CSC examined availability of nutritional services particularly to vulnerable children, lactating mothers and PLHIV. During the interface meetings (consensus score), participants ranked the service average in Both Amudat General Hospital and Loroo HC III and very poor in Karita HC III and Alakas HC II.

Figure 14: Nutritional services

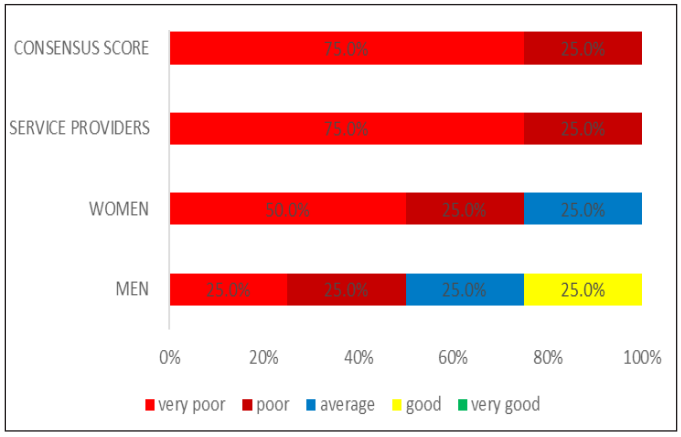


The results revealed that nutritional supplements are often out of stocks and educational programs at all the facilities visited were limited to provision of IEC materials and training without provision of adequate food supplements. The little that was available was given to the malnourished children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

5.4.2.8 Home Based Care Services

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. Home visits were ranked as very poor in all the facilities visited (Amudat General Hospital, Loroo HC III, Karita HC III and Alakas HC II).

Figure 15: Home Based Care Services



The reasons for 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 included; intensive training in Home Based Care services, IPs to use the available health care structures (expert clients and VHTs) as part of sustainability, 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 members.

5.5 Social Support and Protection

The quality of social support and protection service was assessed based on the quality of psychosocial services, capacity building for care givers, provision of food and education services, right awareness and support, legal support and social services.

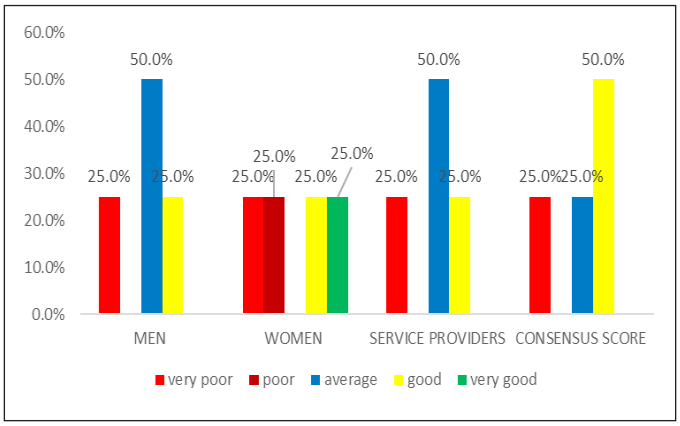
5.5.1 Quality of Psychosocial Services

In a bid to eliminate stigma and discrimination and 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, Amudat General hospital and Loroo HC III ranked psycho social services as good, Karita HC III as average and Alakas HCII as very poor respectively.

The good ranking was because of availability of counseling spaces, patient's privacy and confidentiality among the health workers and strong referral system for clients to specialized/ trained personnel. 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 as well as stigma and discrimination. There were also high client numbers compared to staff numbers leading to work overload and stress, low spirit of voluntarism yet the facilities are marred with financial constraints which affects effective client follow up. Participants recommended establishment of post-test clubs, community sensitization, training of health workers in psychosocial counseling, strengthening community referral and the law courts to expedite the judicial processes to cut on time when witnesses appear and victims get justice.

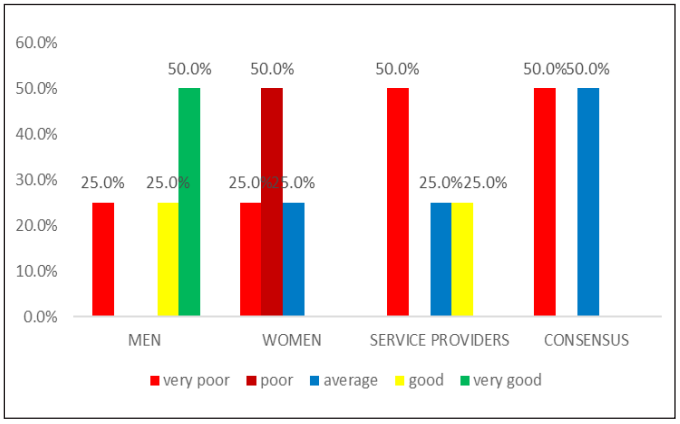
Figure 16: Quality of psychosocial services



5.5.2 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. The assessment revealed that the capacity building to care givers was poor due to limited staff who are already overloaded due to understaffing but also unwillingness of care givers to undertake capacity building programs.

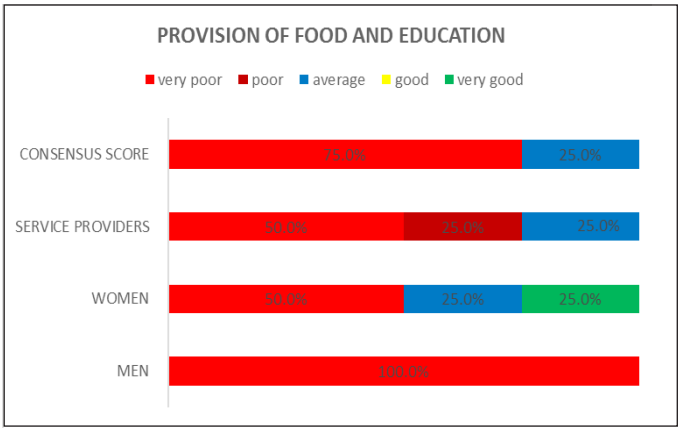
Figure 17: Capacity building for caregivers



5.5.3 Provision of food and educational 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. All the 4 facilities were equally affected that during interface meeting s, 75% of the participants ranked as very poor and 25% as average respectively. The poor rating was as a result of no food supplements to the vulnerable groups (PLHIV, and elderly) and no nutritional talks. Recommendations were; need to standardize the protocol for feeding, service providers to continue sensitizing the community on balancing diets, having gardens as part of food security and support the vulnerable PLHIV with food supplements to be able to live a productive life.

Figure 18: Provision of food and educational services



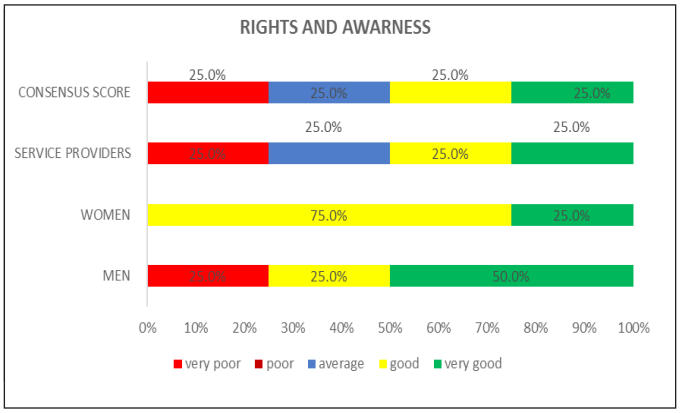
5.5.4 Rights Awareness and Support

The Uganda Patients Charter of 2009 describes a set of rights, responsibilties and duties under which a person can seek and recieve health care services, empowers patients to responsibly demand for quality health care and actively participate in their care at health facilities. The community score card assesed 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 and cultural and religious leader's involvement and awareness to address cultural norms. In the interface meeting (consensus score), Alakas HC II ranked as good, Amudat General Hospital and Loroo HC III as average and Karita HC III as poor respectively.

The short comings of the services were; lack of awareness on rights for services by both health workers and community members, inadequate IEC materials on patients' rights in the local languages, low involvement of local and cultural leaders to create awareness among the community (service users).

The recommendation were; sensitization about rights and responsibilities be done through seminars, involve local and cultural leaders, hold community meetings and translate materials into local languages.

Figure 19: Rights awareness and support

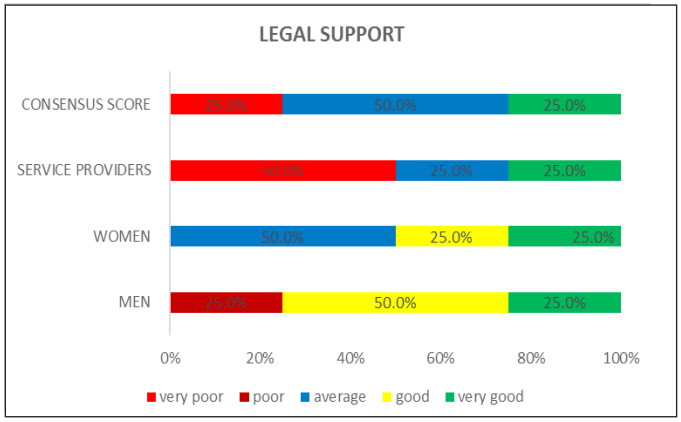


5.5.5 Legal Support and Social Services

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. In Amudat district, Loroo HC III ranked it as good service, both Amudat General Hospital and Alakas HC II as average service and Karita HC III as poor respectively.

The good ranking was as a result of health workers offering service and follow ups on the victims, provision of testing services and legal support in representations in courts of law for cross examination and witnessing, community sensitisation on seeking legal services in care and filling of police forms to support the victims. The poor rating was as a result of community not seeking legal support from facilities, still high levels of stigma and discrimination, limited by 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 especially on rape cases as it is a culturally accepted norm.

Figure 20: Legal support and social services



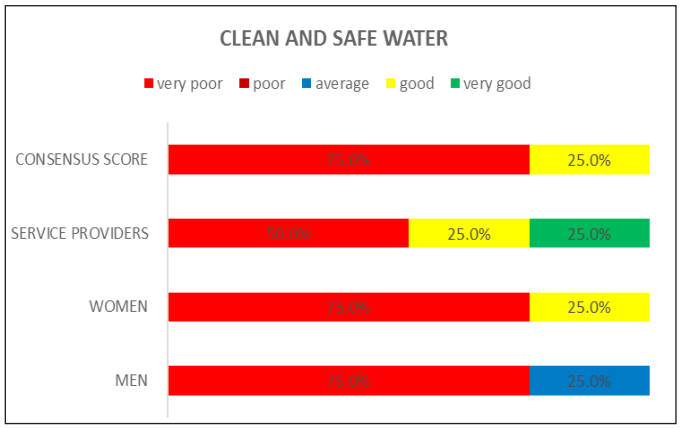
5.6 Infrastructure, Utilities and Equipment

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 plus power types.

5.6.1 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. Results gathered from the interface meeting (consensus score), 75% ranked it poor and 25% as good respectively. The Good ranking was as a result of having water at the facility though water shortages regularly occur, water sources far from the facilities and water storage tanks inadequate. Recommendations included the installation of running water at all the health facilities and additional water storage units such as tanks be installed for more water can be harvested and/or stored.

Figure 21: Availability of good and safe water



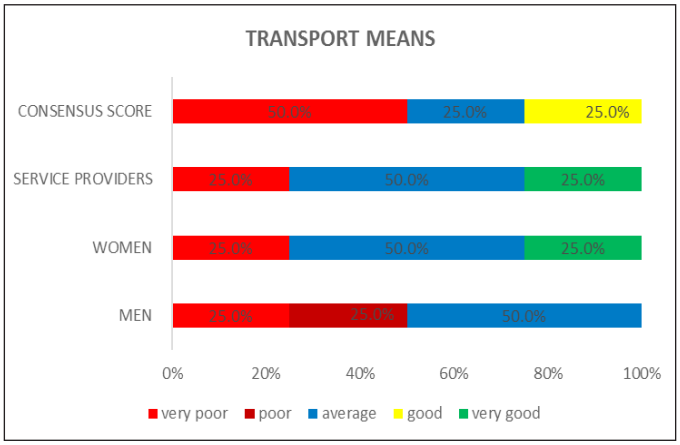
Water harvest tank in Alakas HC II

5.6.2 Availability of transport means

The transport means for the health is fundamental to support operations of the health facilities, strengthening linkages, referrals and outreach programs. The community score card assessed availability of an ambulance, motorcycles and facility specific vehicles. Transport infrastructure was ranked 25% as good, 25% as average and 50% as poor during the interface meeting (consensus score). Two motorcycles were at Alakas HCII for ambulance and immunization and community outreach services, however, at times patients are required to contribute fuel for the motor cycles. This affects the referral system to Amudat General Hospital.

The reasons for poor ranking were; lack of ambulances, 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 Centres with ambulances, motor cycles and bicycles for outreaches, wheel chairs and stretchers for patients, repair the existing ambulances and provide a budget for maintenance and fuel.

Figure 22: Transport means

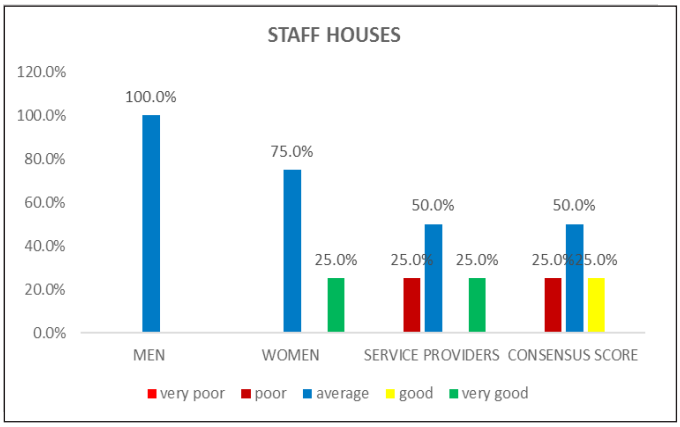


Motor cycles and ambulance carrier at Alakas HCII

5.6.3 Staff Houses

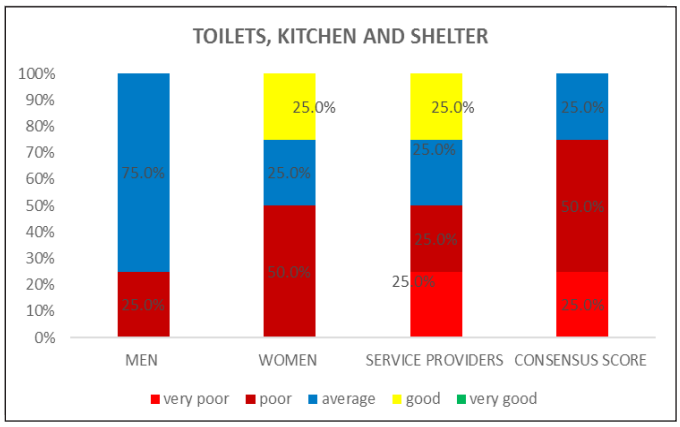
Ministry of Health guidelines for staff accommodation require that every health worker should be housed at the health facility. The community scorecard assessed the availability of staff houses and status of the structures at the facilities. As illustrated by the consensus scores, during the interface meeting (consensus score), 25% ranked it as good, 50% as average and 25% as poor services. The good and average ranking was based on availability of staff houses, and good conditions in which they were whereas the poor ranking was based on high staff and quarter ratio, the poor condition of the structures are, and the staff unwillingness to reside at the facility. Recommendations were; more staff houses be constructed and the existing ones be renovated.

Figure 23: Staff houses



Staff house at Karita HC III

Figure 24: Toilets, kitchen, and shelter



Latrine at Karita HC III

5.6.4 Toilets, Kitchen and Shelter

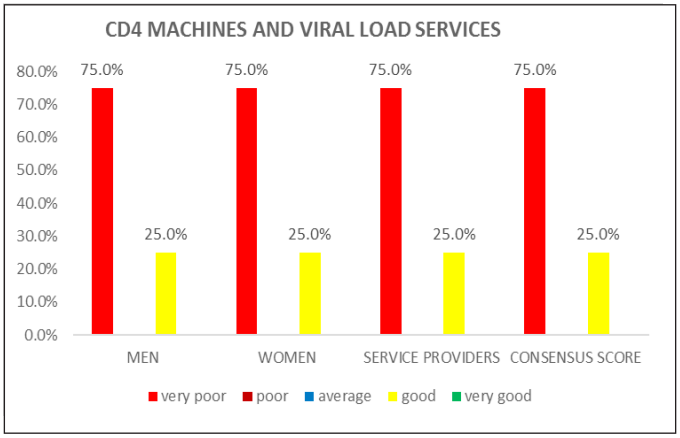
The scorecard assessed availability of shelter kitchen, toilet and community awareness on using these facilities. The study further assessed levels of sanitation and hygiene as well as facilities for persons with disabilities. During the interface meeting (consensus score), 25% ranked as average, 50% as poor and 25% very poor respectively. The reason for the poor ranking was due to; toilets/latrines, were not adequate with no provisions for people with disabilities, most were filled up and very dirty. The shelters on the other hand were lacking especially for patients at ART clinic and kitchens for patients were largely nonexistent. The participants recommended construction of more toilets, kitchens and shelters at OPD and ART clinics.

5.6.5 Availability of CD4 Count Machines and viral load services

HIV treatment and disease burden monitoring and management required 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. The facilities rated CD4 count services as poor because there is only one CD4 machine at Amudat General Hospital, therefore all ART sites are served from one centre, so the facilities use a hub system to transport samples for testing in Amudat General Hospital for CD4 count and for onward delivery to Central Public Health Laboratory (CPHL) in Kampala for viral load testing. During the interface meeting (consensus score), 75% participants ranked the service as poor and 25% good service. The reasons for good service were access based on accessibility to the services (viral load testing and CD4), trained personnel in comprehensive HIV service delivery, less turnover time for results and stock of the CD4 reagents. The poor ranking was; long turnaround time for CD4 and Viral load results in lower health facilities, poor hub system in the district, limited staff trained in comprehensive

HIV service delivery and knowledge, stock out of reagents, long distance moved by clients to access the services and CD4 machine break downs. The recommendations included more CD4 machines be distributed/procured, increase stock supplies of CD4 machine and provision of maintenance service contracts.

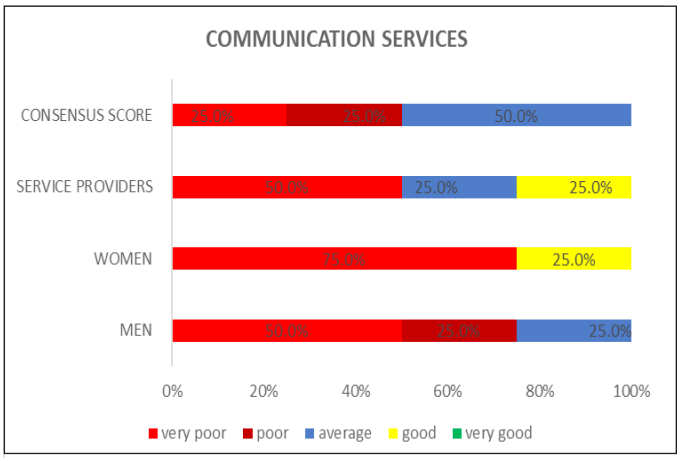
Figure 25: CD4 count machine & Viral Load services



5.6.6 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. Participants (50%) ranked it average, and both 25% as poor and very poor respectively during the interface meeting (consensus score). The poor rating was because most the communication items for patients' use were almost nonexistent. Recommendation were; improvement in areas such as use of suggestion boxes, telephone booth or public pay phones, facility landlines, desk computers and internet.

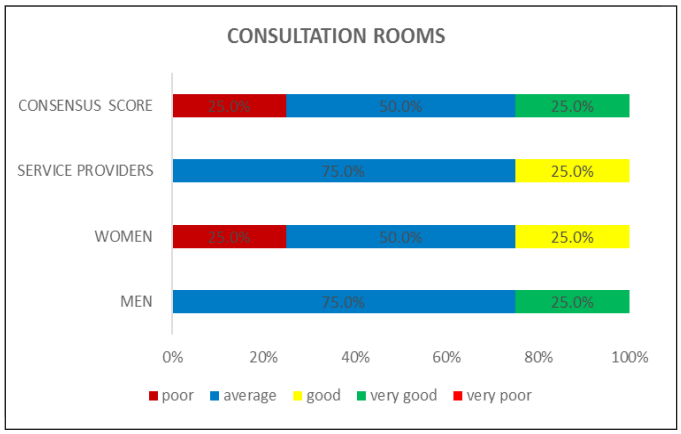
Figure 26: Communications facilities



5.6.7 Availability of Consultation Rooms

In Amudat District the scorecard focussed on whether the facility had a spacious and well equipped consultation room. Also study assessed whether patients' privacy was respected by health workers. During the interface meetings (consensus Score), 50% ranked it average and 25% as good and poor respectively. The low ranking was based in the limited space and rooms to allocate a consultation room and limited privacy during consultations in facilities where they existed. There is therefore need to create more space to enable smooth consultation processes between patients and service providers.

Figure 27: Consultation rooms



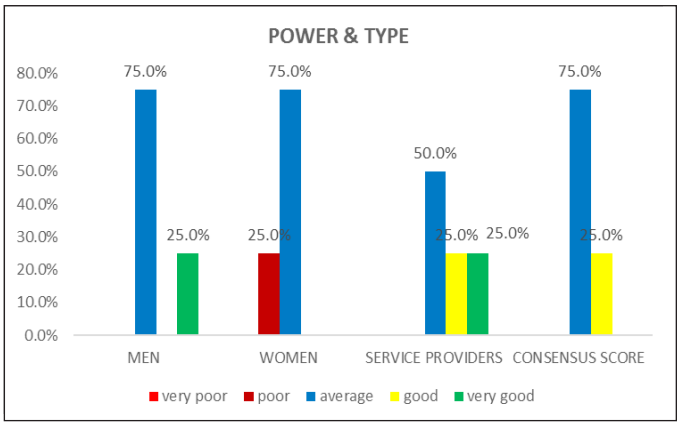
Consultation room in Karita HC III

5.6.8 Availability of Power and Type

The scorecard assessed power extension to the key areas requiring power such as laboratory and maternity delivery rooms, regularity of power supplied, and the different power type supplied. The quality and availability of power was scored as average in all the facilities assessed. The absence of standby generator for the operating theatre was cited as a problem in Amudat General Hospital while there was a general lack of stable power supply in Alakas HC II, Loroo HC III and Karita HC III. Generally, all the facilities visited had solar power for

fridges to store vaccines and other medicines that require refrigeration except in Amudat General Hospital were they had hydroelectricity. Participants recommended installation of hydroelectric power to facilities that did not have power

Figure 28: Power &



Refridgilation system in Alakas HCII

Solar pannels at Alakas HC II

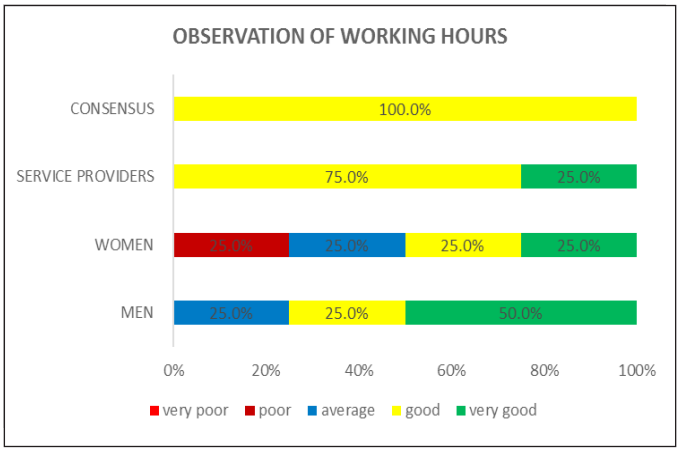
5.7 Attitude of Staff

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.

5.7.1 Observing Working Hours

Health workers are supposed to observe reporting and depating times as per duty rota. All the 4 facilities visited ranked abserving working hours good services. Despite the staffing gap that cause overload, staff keep time and sometimes go beyond the stipulate roat time. The good ranking was based on staff health workers attending patients in time, health work reporting early and leaving late amidst the tight schedules and not complaining. The reasons for the low score were that some some health workers report to work late usually after 8.30am and leaving early at times at midday, inconsistent or poor time management, few staff who work for long hours, time wasting, having frequent breaks, delays in attending to patients, sending patients away to private clinics after midday and not having a proper time table or duty schedule. The Health Unit Management Committeeswere not doing adequate monitoring. Suggestions made were; to stregthen monitoring and follow ups by both DHOs office and health unit management committee, health facility administration to ensure compliance with schedule/, recruiting more staff to reduce workloads, introducing duty rosters to record arrival and departure time, introduce timesheets, appraisials, duty schedules detailing shifts, provide accomodation to staff and have a canteen at the facility to reduce on the time spent going home to have meals.

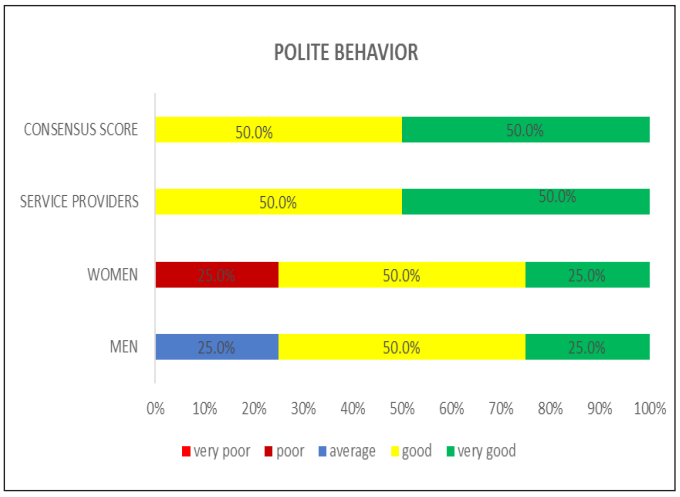
Figure 29: Observing Working hours



5.7.2 Polite Behaviour

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. In all the 4 facilities, politeness by health workers was scored 50% very good and good respectively. This was because health workers offer ample time to listen to clients to support fully diagnosis of the disease and most of the patients ask to be guided. The gaps were on inadequate staffing leading to work over load, stress and frustration and some health workers do not explain prescriptions to patients. Recommendations included; need for comprehesisve senstisation on patients rights and code of conduct, recruit more staff to reduce the work load and train them on customer care.

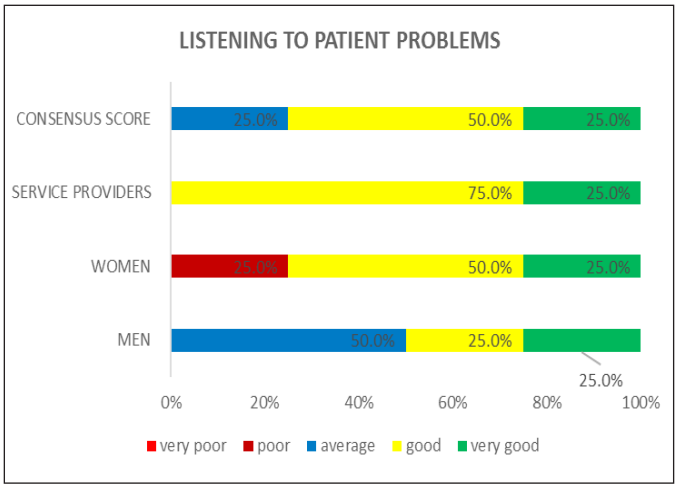
Figure 30: Polite Behavior



5.7.3 Listening to Patients Problems

In abid to manage disease diagnosis in health care system, listening to patients problems/ complaints and complements is crucial. In Amudat,the scorecard assessed wheter patients are listened to, their issues addressed and feedback provided. During the interface meeting (consensus score), all the 4 facilities had 50% ranked as good, 25% very good and 25% average. The beneficiaries agreed that staff were giving ample time to patients and listening attentively to their problems. The health workers also indicated that they litsen to their patients as is part of the 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: Listening to Patients Problems

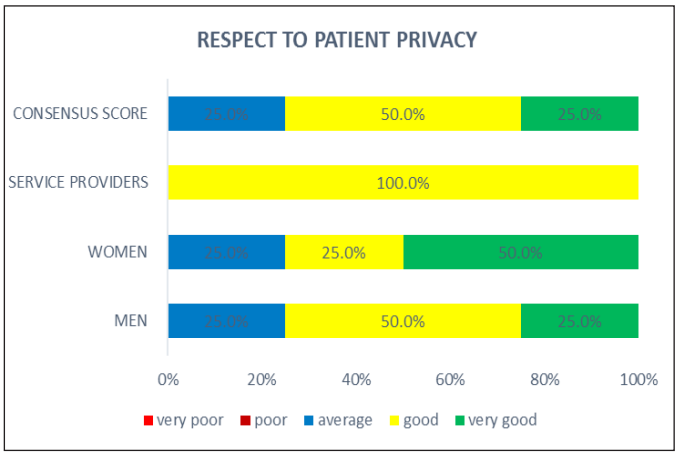


5.7.4 Respect of Patients Privacy and confidentiality

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 meeting. During the interface meetings, 50 % of the participants ranked it as good and 25% as both average and very good service respectively. Patients' privacy was most responded to by all service providers as a good service, community 50% women as very good and 50% men good service. The good ranking was based on availability of consultations and examination, infrastructure and utilities for confidentiality (private rooms with curtains and screens). Even where they are not, the workers improvise to ensure patients are comfortable. Inadequate infrastructure in form of consultation rooms, utilities and equipment (e.g. curtains and screens) were not provided at the facilities to ensure that

the privacy of the clients during examination and counseling is observed. The recommendations were; community and health workers' sensitization on patients' rights, increase on consultation rooms, expansion and renovation of the existing ones structures and procurement of more screens and curtains.

Figure 32: Respect to Patients Privacy



6.0. 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.

7.0 Conclusions

Based on the findings, the assessment concludes that the district has made efforts in providing HIV&AIDS and Sexual Reproductive Health and Rights services in partnership with partners. There were however some constraints that affected the service delivery ranging from limited staffing, stock out of drugs more especially for children, no follow up of lost clients, stock outs of reagents, negative attitude to condom use and family planning services, long distance to health care facilities, and limited information on HIV&AIDS in the local language

8.0 RECOMMENDATIONS

The assessment generated a number of recommendations that include amongst others

- 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 with 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.
- There is need to continue with community sensitisation sessions by the district local government, health facilities and VHTs on condom use, family planning benefits and maternal health services
- 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 and through media
- 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 should be undertaken.
- 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 procure ambulances for health Centre IVs and provide a budget for running it 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 government should construct more structures and equip them with facilities to support quicker diagnostic of the ailments

- Staff houses should be constructed to enable health workers reside at their work stations and report on time. This will also attract staff and retain staff from hard to reach and hard to stay 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 and 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 can include moonlight services, outreach and mobile HIV/ AIDS services

REFERENCES

- National Forum of PLHA Networks (NAFOPHANU) Strategic Plan 2013-2018
- Uganda AIDS Commission: The National HIV and AIDS Strategic Plan 2016/16/- 2019/20
- MOH: Heath Strategic Development Plan (HSDP) 2015/16- 2019/20
- GOU: National Development Plan II (NDP II 2015/16-2019/20)
- Amudat District Development Plan 2015/16- 2019/20
- AMICAALL: Comprehensive Baseline Survey on HIV/AIDS among young people (10-24 years) in Karamoja sub-region (2016)
- MoH: Uganda AIDS Indicator Survey (AIS 2011)

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