PACK

NAFOPHANU

Ambasáid na hÉireann
Embassy of Ireland

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

January 2019

Acknowledgement

Citizen's empowerment is critical in ensuring that high quality social services are delivered by the responsible duty bearers. Assessing health service delivery in health care facilities is one of the ways that citizens can give feedback to government and other implementing partners on effective delivery of quality health services

NAFOPHANU is grateful to the Embassy of Ireland through the Prevention of HIV&AIDS in Communities of Karamoja (PACK) project for financial support that facilitated the community score card assessment in the district of Nakapiripirit. The District local government staff represented by the District Health Officer (DHO) and HIV Focal Person, Nakapiripirit District PLHIV leaders, research assistants and NAFOPHANU staff that actively participated in the exercise are appreciated.

Special appreciation is extended to the staff of the selected health facilities of Tokora HCIV, Lorachat HC III, Brigade 407-Moruita HC III, Nakapiripirit HC III, Nabilatuk HC III, and Namalu HC III local leaders and PLHIV network members for participating in this assessment and giving their feedback on the quality of services both as service providers and beneficiaries.

The struggle to eliminate HIV/AIDS in our communities continues.

Together for a positive difference!

Stella Kentutsi
Executive Director

ABBREVIATIONS AND ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
AIS:	AIDS Indicator Survey
AMICAALL:	Alliance of Mayor and Municipal Leaders' Initiative for Community on Aids at Local level
ANC:	Ante-natal Care
ART	Anti-Retroviral Treatment
CSC	Community Score Card
DHO:	District Health Officer
DHT:	District Health Team
eMTCT:	elimination of Mother-to-Child Transmission of HIV
FDG:	Focus Group Discussion
GBV:	Gender Based Violence
HC:	Health Centre
HIV:	Human Immuno deficiency Virus
HMIS:	Health Management Information System
HSD:	Health Sub-District
HSDP:	Health Sector Development Plan
HTS:	HIV Testing Services
IEC:	Information Education and Communication
IPD:	In- Patient department
LC:	Local Council
MNCH:	Maternal, Neonatal and Child Health
MTCT:	Mother-to-Child Transmission
NAFOPHANU	National Forum for People Living with HIV/AIDS Networks in Uganda
NPAP:	National Priority Action Plan
NSP:	National HIV Strategic Plan
OPD:	Out-Patient Department
PACK:	Prevention of HIV&AIDS in Communities of Karamoja
PHC:	Primary Health Care
PLHIV:	People Living with HIV
PNC:	Post-Natal Care
SDG:	Sustainable Development Goal(s)
SMC:	Safe Male circumcision
SPSS:	Statistical Package for Social Scientist
STF:	straight Talk Foundation
TASO:	The AIDS Support Organization
TB:	Tuberculosis
UAC	Uganda AIDS Commission
UAIS:	Uganda AIDS Indicator Survey
UBOS:	Uganda Bureau of Statistics
UDHS:	Uganda Demographic Health Survey
VHT:	Village Health Team
VL:	Viral Load

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EXECUTIVE SUMMARY

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

In January 2019, on behalf of PACK partners, NAFOPHANU conducted a community score card to assess the level of health service delivery in the district of Nakapiripirit basing on the National HIV Strategic Plan (NSP) thematic areas of HIV prevention, care and treatment, social protection and systems strengthening (staffing norms, infrastructure and equipment). The scorecard is a participatory community based monitoring and evaluation tool that enables citizens to assess the quality of services such as health care and make recommendations to various stakeholders in the district.

The assessment targeted a catchment of six (6) ART accredited ART health care facilities distributed according to different levels of service delivery. They included; 2 heath Centre IVs and four Health Centre IIIs with a total number of 296 participants. The facilities were; Tokora HCIV, Lorachat HC III, Brigade 407-Moruita HC III, Nakapiripirit HC III, Nabilatuk HC IV, and Namalu HC III. Data was obtained through desk reviews, focus group discussions, key informant interview, direct observations and interface meetings. Quantitative data was entered using EPI INFO and analyzed using statistical package SPSS while qualitative data was analyzed using thematic analysis. Data is presented in frequency tables and graphs.

The assessment revealed commendable efforts by health providers 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 government ceiling, the staff were able to multi-task to fill existing gaps. Equipment and infrastructure remain inadequate as few health workers are accommodated and have limited structures to work from.

The gaps that negatively affect HIV service delivery included; lack of comprehensive counseling skills, sporadic stock outs of drugs and supplies, low levels of staffing, lack of transport, stigm, AIDS incompetent staff, lack of youth friendly services and limited linkages between health facilities and surrounding community. In addition, there were no systems to monitor and report on HIV community systems and preventive initiatives, inadequate public education and poor communication facilities.

The key recommendations from the assessment focused on infrastructure development, recruiting more staff to fill the gaps, strengthening monitoring systems, develop HIV/AIDS strategic plan, ensure regular supply of drugs and other supplies as well as community sensitisation on various aspects for better health outcomes.

1.0 Introduction

Health is a right and everybody should have uninterrupted access to quality health care. The Constitution of republic of Uganda (1995) article, XIV states that "The State shall endeavor to fulfill the fundamental rights of all Ugandans to social justice and economic development and shall, in particular, ensure that (b) all Ugandans should enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security and pension and retirement benefits". Fulfillment of the government of Uganda's vision to transform the country from peasant to a modern and prosperous country by 2040 as envisaged in Vision 2040 will be a dream unless the country's health sector is attended to.

The Government of Uganda recognizes this important aspect and has made efforts to address some of the key constraints to health service delivery. The Health Sector Medium Development Plan (Health Sector Development Plan 2015/16- 2019/20), vision for Uganda's health sector is "To have a healthy and productive population that contributes to economic growth and national development". The Health Sector Development Plan (HSDP) goal is to accelerate movement towards universal health coverage with essential health and related services needed for promotion of a healthy and productive life.

The HSDP has targets for the health sector to be achieved by 2019/20 that include; 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% and increasing TB case detection rate from 80% to 95%.

Despite the above efforts, there are still challenges that affect the delivery of health care services. According to HSDP, HIV, malaria, lower respiratory infections such as meningitis and tuberculosis are leading cause of death in Uganda. Inadequate health workforce is still a key bottleneck for access to and utilization of services in Uganda. The above situation needs to be urgently addressed for the country to meet the Sustainable Development Goals (SGDs) targets on health by 2030; 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."

The National HIV Strategic Plan (NSP) 2015/16-2019/20 whose vision is a healthy and productive population free of HIV and AIDS and its effects 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 ensure universal access to quality, efficient and safe services.

1.1 HIV/ AIDS situation in Uganda

The HIV epidemic remains one of the single most human health scourge still challenging the world. While globally the epidemic shows prospects towards a decline, the magnitude of the situation in East and Southern Africa remains worrying (17.7 – 20.5 million People Living with HIV) 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 Indicator Survey and high HIV infections in specific sub-populations and sub-regions (Central I at 10.4%, Central II at 9.0%, East central at 5.6%, Mid-East at 4.1%, North East at 5.3%, Mid North at 8.3%, West Nile at 4.9%, Mid-west 8.2% and South West 8.0%) (UPHIA, 2016).

1.1.1 Situation in North Eastern Uganda

Regarding Karamoja Sub region, prevalence is estimated at 3.7% (UPHIA, 2016-17) having reduced from 5.3% by UAIS, 2014. Viral load suppression among men and women aged 15 - 24 years is below 50%. The same estimates indicate a further decline in AIDS-related deaths of 28,000 from 31,000 in 2016, Karamoja region being among the least affected followed by West Nile at 3.1% despite the barriers that drive the epidemic.

1.2 Nakapiripirit District

1.2.1 Geographical scope and population

Nakapiripirit District is located in the North-Eastern corner of Uganda, bordered by Napak District to the north, Moroto District to the northeast, Amudat District to the east, Kween District to the southeast, Bulambuli District to the southwest, Kumi District to the west and Katakwi District to the northwest. The main activity in the district is animal husbandry and the majority of the population are pastoralists. However, in some areas, especially in the south, some agricultural activity takes place. Nakapiripirit District is made up of one county – Kopoth and Karamajongs; comprising of two (2) constituencies; Pian County and Chekwili (Kadam) county, 7 sub-counties, 1 town council, 68 Parishes, 521 LC 1Villages and 52,814 households. The district has a population of 156,690. Those aged between 10-19 years are 40,791 (21,005 females and 19,786 males). The average density is 44 persons per sq km and over 95% live in rural areas and practice nomadism. (Nakapiripirit District Development Plan, 2015/16-2019/20).

1.2.2 Prevention AIDS Communities of Karamoja (PACK) Project

With the overall goal of reducing new HIV infections amongst young people and adolescents (10-24 years) in 7 districts of Karamoja, the five year project (2016-2020) is funded by Embassy of Ireland to increase demand and access to quality HIV&AIDS services for adolescents and young people. In this consortium arrangement of 4 organisations; NAFOPHANU, AMICAALL, TASO and STF, each organisation is responsible for delivering on a number of outputs. NAFOPHANU takes lead in facilitating the strengthening of community structures of PLHIV in the 7 districts of Karamoja sub region. The activities include mobilization for HIV prevention and treatment services by partners, implementing stigma reduction activities and strengthening the leadership of the networks as advocates for PLHIV rights. To enable citizens understand and give feedback on the quality of HIV&AIDS service, NAFOPHANU undertook a service delivery assessment using a Community Score Card in the district of Nakapiripirit.

1.2.3 Scope of the assessment

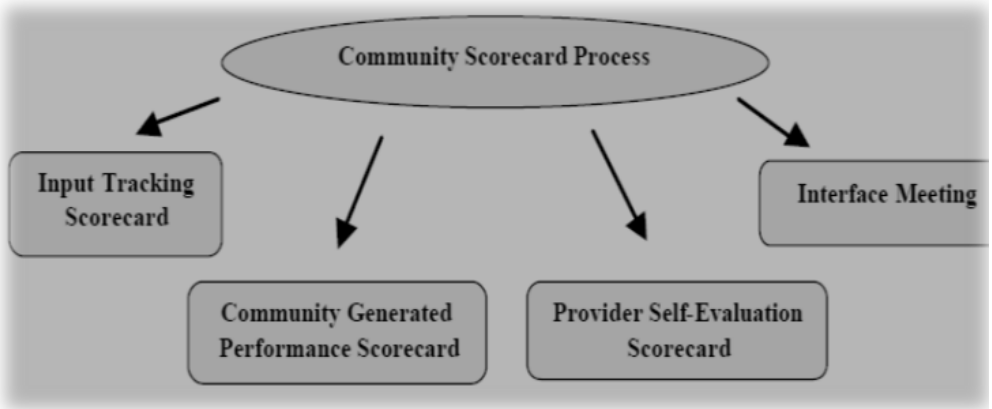
The assessment was conducted in 6 health facilities of Nakapiripirit District. Three Focus Group Discussions (FGDs) comprising of 8 men, 8 women and 8 service providers aged 18+ years in each health facility were conducted in Tokora HCIV, Nabilatuk HC IV, Lalachat HC III, Brigade 407-Moruita HC III, Nakapiripirit HC III, and Namalu HC III.

Three interface meetings were held, where representatives from the three groups that participated in the FGDs together with their community, sub county leadership gathered to rate the availability and quality of the services. One key informant interview was conducted with the in-charge of each health facility visited.

A set of service delivery quality measurement indicators translated into the local languages were developed and agreed upon by the community, service providers and the facilitating team. Scores ranging from 1 to 5 were applied, where 1 represented a very poor service, 2 for poor, 3 average, 4 Good and 5 Very good.

1.3 METHODOLOGY

This section contains the methodology used and the steps undertaken to collect the information. The assessment used a Community Score Card (CSC) methodology developed by Care International in 2001. The CSC also 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, school, public transport, water, waste disposal systems and so on. It is an instrument used to solicit for social and public accountability and increases the responsiveness of service providers by enabling citizens to voice their assessment of a priority public service. The CSC is used to inform community members about available services and their entitlements and to solicit their opinions about the accessibility and quality of these services. By providing an opportunity for direct dialogue between service providers and the community/ beneficiaries, 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 provides important information to guide government policy-making reform initiatives



Source: Janmejay & Parmesh (2009)

The assessment team undertook 4 inter-related steps in carrying out this assignment that included; generating supply side data through input tracking, gathering service user feedback through FGDs for women and men, key informant interviews, generating service provider's feedback through provider self-evaluation and interface meeting that generated a consensus score and developing action plans.

1.3.1 Objectives of the assessment

i. To empower the community (service beneficiaries) assess the quality of HIV&AIDS services in Nakapiripirit district
ii. To enable the service providers self-evaluate on the quality of HIV&AIDS services that they offer to the community.
iii. To make recommendations on how to improve HIV&AIDS service delivery to policy makers, policy implementers and other stakeholders in Nakapiripirit district.

1.3.2 Assessment Design

The assessment used a multifaceted design that was both qualitative and quantitative. The major source of information included Focus Group Discussions of the service users (men and women in separate groups), service providers, interface meetings, key informant interviews, health facility exit interviews (input tracking) and review of secondary data that included district reports, National Planning Frameworks, Ministry of Health reports, PACK project documents, NAFOPHANU reports and Policy documents.

1.3.3 Inception meeting

The meeting was between the survey team and the District Health Officer (DHO), HIV Focal Person and District Planner 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.

1.4.1. Demographic representation

The assessment was conducted in 6 health facilities in Nakapiripirit District. Three (3) Focus Group Discussions (FGDs) were carried out in each of the 6 health facilities making a total of 18 FGDs, groups of; men, women and service providers attended. Six (6) workshops/ interface meetings were also held and representatives from the three groups that participated in the FGDs and selected community leaders gathered to brainstorm of the availability and quality of the services and made recommendation on what is needed to address the gaps. One key informant interview was conducted with the in-charge of each health facility visited where staffing norms and equipment availability was discussed. It should also be noted that 4(66.7%) of the assessment was conducted in Health Centre three (III), 2(33.3%) in Health Centre IV as shown in table 1.

Table 1: Assessment demographic characteristics

Name of Facility	In put tracking and staffing (N)	Focus Group Discussions (N)	Interface (N)	Key Informant (N)
Nabilatuk HC IV	2	3	1	1
Tokora HC IV	2	3	1	1
Nakapiripirit HC III	2	3	1	1
Namaru HC III	2	3	1	1
Lalachat HC III	2	3	1	1
Brigade 407-Moruita HC III	2	3	1	1
TOTAL	**12**	**18**	**6**	**6**

Source: Field data (2018)

1.4.2 Quantitative Data collection methods

A questionnaire was developed to capture facility data that included staffing, equipment and other infrastructure and was administered to the service providers and service beneficiaries (community) of health care facilities visited.

1.4.3 Key informant interviews

The interviews were conducted with Health Centre in charges to verify some of the data collected through input tracking.

1.4.4 Input tracking

In Nakapiripirit district, 6 health facilities were visited to gather information on key inputs that included staff and infrastructure facilities. This involved desk reviews, verification of the set standards such as on staffing and direct observations on the available infrastructure and equipment.

1.4.5 Focus Group Discussions

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

1.4.6 Interface Meeting

Joint meetings targeting decision makers (politicians, technocrats) service users (community men/women including PLHIV, key population), 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 develop a joint action plan on how to address the identified gaps.

1.4.6 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.

1.4.7 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. One-day training of research team on the scorecard process was undertaken to enable the implementers become familiar with the tool.

1.4.8 Ethical Considerations

The study was not subjected to ethics body approval as it is not classified as human subject research. The researchers obtained 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 as per CSC requirements.

FINDINGS

This section presents results for the CSC study conducted in Nakapiripirit District. The findings are presented under major themes of the study that include input tracking and service delivery assessment in line with the thematic areas of the National Strategic Plan for HIV&AIDS; prevention, care and treatment, social support and systems strengthening.

2.0. SYSTEM STRENGTHENING STAFF TRACKING

2.2 Adherence to staffing norms in Tokora and Nabilatuk health centre level IVs

The district had 2 HC IVs that serve patients across the two counties. Each is expected to have 48 staff and are categorized as Medical Health Workers, Allied Health Professionals Dental (Public health dental officer (PHDO), Pharmacy, Nursing and Support staff.

Tokora Health Centre IV receives on average 175 patients daily from within and outside the district. Tokoro HC IV had 36 (75%) staff leaving a gap of 25%. The missing were; Senior medical officer, Ophthalmic Clinical Officer, 2 Health Inspectors, Dispenser, Public Health Dental Officer, Nursing Officer (Psychiatry), Anesthetic Officer, Theater Assistant, Anesthetic Assistant, Office Typist, 3 Nursing Assistants and Askari. They however, had more 2 Lab. Technicians, 1 Nursing Officer (Nursing) and 1 Porter

Nabilatuk HC IV receives on average 160 patients daily. Out of 48 staff, 29 (61%) available leaving a gap of 19 (39%) were missing at the facility. These include; Medical Officer, Clinical Officer, Ophthalmic Clinical Officer, Health Inspector, Ass. Entomological Officer, Nursing Officer (Psychiatry), Anesthetic Officer, Theatre Assistant, Enrolled Psychiatric Nurse, 2 Enrolled Nurse, Enrolled Mid-Wife, Cold Chain Assistant, Stores Assistant, 2 Nursing Assistant Porter and Askari.

Limited staffing may impact the quality of service rendered to the community since the facilities are high volume ones. Staff are credited for multitasking and covering positions originally not meant for them.

Table 2: Staffing in Tokora and Nabilatuk HC IVs

	Expected	Tokora HC IV		Nabilatuk HCIV	
	Norm	Actual	Gap	Actual	Gap
Sen. Medical Officer	1	0	1	1	0
Medical Officer	1	1	0	0	1
Senior Nursing Officer	1	1	0	1	0
Public Health Nurse	1	1	0	1	0
Clinical Officer	2	1	1	1	1
Ophthalmic Clinical Officer	1	0	1	0	1
Health Inspector	2	0	2	1	1
Dispenser	1	0	1	1	0
Public Health Dental Officer	1	0	1	1	0
Lab. Technician	1	3	+2	1	0
Ass. Entomological Officer	1	1	0	0	1
Nursing Officer(Nursing)	1	2	+1	1	0
Nursing Officer(Mid-Wifely)	1	1	0	1	0
Nursing Officer (Psychiatry)	1	0	1	0	1
Ass. Health Educator	1	1	0	1	0
Anesthetic Officer	1	0	1	0	1
Theatre Assistant	2	1	1	1	1
Anesthetic Assistant	2	1	1	1	0
Enrolled Psychiatric Nurse	1	1	0	0	1
Enrolled Nurse	3	4	+1	1	2
Enrolled Mid-Wife	3	2	1	2	1
Cold Chain Assistant	1	1	0	0	1
Office Typist	1	0	1	1	0
Lab. Assistant	1	2	+1	1	0
Stores Assistant	1	1	0	0	1
Accounts Assistant	1	1	0	0	1
Health Assistant	1	1	0	1	0
Health Information Assistant	1	1	0	1	0
Nursing Assistant	5	2	3	3	2
Driver	1	1	0	1	0
Askari	3	1	2	2	1
Porter	3	4	+1	3	1
Total	**48**	**36**	**12**	**29**	**19**

Source: Field data (2018)

2.2. Adherence to staffing norms in Health Centre IIIs

According to MoH staffing guidelines, 19 staff are supposed to be at a Health Centre III. These are categorised as Allied Health staff (Senior Clinical Officer, Clinical Officer, Laboratory technician, Laboratory Assistant and Health Assistant), Administrative staff (Health Information Assistants), Nursing Officer (Enrolled Nurse, Enrolled midwife and Nursing assistants), Support staff (Askari and Porter).

Brigade 407- Moruita HC III- receives between 70-100 patients on a daily basis, had 12(63%) posts were filled with a gap of 7 staff (37%). The missing was; Clinical Officer, Nursing Officer, Lab. Technician, Health Assistant, 2 Enrolled Nurse and Health Information Assistant.

Nakapiripirit HC III which receives between 50-80 clients daily had 11 (58%) of the required medical personnel available at the facility and 8 (42%) missing. The missing staff included; Sen. clinical Officer, 2 Enrolled Nurse, Lab. Assistant, 2 Nursing Assistant, Health Information Assistant, and Askari.

Namalu HC III had 14(74%) medical personnel available at the facility and 9(26%) missing. The missing staff included; Clinical Officer, Health Assistant, 2 Nursing Assistant, and Health Information Assistant.

Lorachat HC III had 10(52%) were available and 9(48%) missing who included; Senior clinical Officer, Enrolled Nurse, Health Information Assistant, Askari and Porter.

The understaffing of the HCIIIs could be impacting on the health care package offered which calls for immediate deployment to cover the identified existing gaps.

Table 3: Staffing in 7 Health Centre IIIs

Staffing norms	Expected	Brigade 407 Moruita HC III		Namalu HC III		Lorachat HCIII		Nakapiripirit HC III	
	Norm	Actual	Gap	Actual	Gap	Actual	Gap	Actual	Gap
Sen. clinical Officer	1	1	0	1	0	0	1	0	1
Clinical Officer	1	0	1	0	1	1	0	1	0
Nursing officer	1	0	1	1	0	1	0	1	0
Lab. Technician	1	1	1	1	0	1	0	2	+1
Enrolled Mid-Wife	2	1	1	2	+1	2	0	2	0
Enrolled Nurse	3	1	2	2	0	1	2	1	2
Lab. Assistant	1	1	1	1	0	1	0	0	1
Health Assistant	1	0	1	0	1	1	0	1	0
Nursing Assistant	3	1	2	1	2	1	0	1	2
Health Information Assistant	1	0	1	0	1	0	1	1	1
Askari	2	2	0	2	0	1	1	1	1
Porter	2	2	0	3	+1	1	1	3	+1
Total	**19**	**12**	**8**	**14**	**5**	**10**	**9**	**11**	**8**

Source: Field data (2019)

3.0. System strengthening-Input tracking on infrastructure and utilities

Health Centre infrastructure such as buildings, consultation rooms, theatres 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 health services such as for HIV&AIDS and sexual reproductive health. Structural elements of the outpatient and the inpatient departments of level IV and level III facilities were assessed for existence and performance.

3.1. Out Patient Department (OPD)

This examined health education room, counseling room, dental clinic, dispensary,ART clinic, OPD drug store, examination room, HSD office, laboratory, treatment room, UNEPI records, operating theatre and Early Infant Diagnosis.

3.1.1. OPD Counselling room

In regard to existence of OPD counseling room; services were witnessed at all the facilities despite facilities having specific rooms for counselling. Services were improvised in consultation and examination rooms HC III had dedicated counseling rooms

The quality of service for counseling was affected by lack of dedicated counseling rooms, limited privacy, and lack of adequate furniture, inadequate space and poor ventilations.

"Absence of critical space like the counseling rooms prohibits clients from freely discussing their problems with the health care provider and compromises aspects of confidentiality. This is likely to affect the quality of diagnosis and further prohibit clients from seeking health services", in charge Namalu.

3.1.2. OPD Health education

Health care facilities are required to undertake health education as part of promoting good health practices and ensure prevention of diseases. All the facilities visited had health education rooms and the health education centres (shelter) was used on antenatal day, with Information of Education and Communication (IEC) materials such as on; malaria prevention, Family Planning, HIV prevention, T.B prevention/ management and nutrition. It was observed that the furniture is not adequate for all the clients and this affects attendance as some patients move away or do not stay for long and miss critical information aimed at promoting their wellbeing.

3.1.3. OPD Dispensary

The functional dispensing rooms serve as the central points for drug dispensation. This was examined at all health facilities and results show that all facilities had dispensing rooms. Most dispensing rooms examined were well arranged and in good condition and with shelter for clients. However, inadequate space and lack of furniture were noted as the major challenges.

Dispensing window in Namalu HC III

Dispensing in Nakapiripirit HC IV

3.1.4. OPD Drug store

A functional drugstore should be well ventilated with temperature of 15-25% free from extraneous odours (intense light, and free from vectors and vices) as per WHO guidelines for drugstore, 2015. Tokora HCIV, Lorachat HC III, Brigade 407-Brigade 407-Moruita HC III, Nakapiripirit HC III, Nabilatuk HC III, and Namalu HC III had well-stocked OPD drug stores. However, some were congested with poor storage conditions such as poor ventilation, lacked temperature monitoring devices and lacked curtains leading to direct sunlight and this could affect the drugs.

3.1.4. Examination room

In a health care setup, an examination room is an entry point for disease diagnosis. An examination room consists of examination bed upon which patients' seat or lay down, store cabin, exam stool, doctors' seat, medical examination light, counter space and bin, computer stand or table and integrated diagnostic setup. The six facilities visited of Tokora HCIV, Lorachat HC III, Brigade 407-Brigade 407-Moruita HC III, Nakapiripirit HC III, Nabilatuk HC III, and Namalu HC III had examination rooms. Irrespective of their existence, they were limited with space, inadequate furniture, no screens in the rooms. In a bid to provide better services, some have improvised for examinations to be done in the treatment rooms.

Trolley and surgical equipment in Tokora HC IV Examination desk in Moruita 407 Brigade HC III

3.1.6. OPD: Laboratory

A Laboratory is required to have a sink, eye wash station, function bio safety Laboratory, 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. Availability of laboratory facilities was affirmative in all health facilities at both level IV and III. Despite that, there were concerns of inadequate space, shortage of reagents, test kits, power and waste segregation bin liners mainly in Brigade 407-Maruita Health Centre III

Laboratory in Nabilatuk HC IV

3.1.7. OPD: Treatment room

At OPD, a treatment room is required to have a crash trolley, defibrillator, sterilization equipment, gloves, face masks, water connection, sink, screens, treatment bed, light, locker area and the rooms attended to by the nurses. Tokora HCIV, Lorachat HC III, Brigade 407-Brigade 407-Moruita HC III, Nakapiripirit HC III, Nabilatuk HC III had treatment rooms though lacked stretcher beds, water connections, screens and bins.

Table 6: Availability of treatment room

Facility name	Availability	Status
Tokora HC IV	YES	A well-furnished room with Screens, treatment bed, extension light, locker area, groves, water connection and face masks existed
Nabilatuk HCIV	YES	Well furnished with treatment bed, bins, water sink, locker area, face masks and screen existed
Brigade 407- Brigade 407-Moruita HC III	YES	Existed put attached to IPD with no screens, water connection, intense lighter and locker area.
Nakapiripirit HCIII	YES	No standard treatment bed, mattress, no water connection and power extension
Namalu HCIII	YES	Had 2 drip stands, screens, bins, intense lighter and stretcher bed
Lorachat HCIII	YES	Well-furnished spacious clean room with curtains in the widows, treatment bed and cabins. However, had no power connection, trolley and desk for clinician.

Patients waiting area in Lorachat HC III

3.1.8. OPD: Dental clinic

A dental clinic is supposed to have a retractor, dental instruments, hand pieces, local anesthesia, burs, restorative instruments, mouth mirror, burnishers, periodontal scalers and extraction instruments according to the standard guidelines for a dental clinic (MoH, 2000). Nakapiripirit had only one facility with dental services. Referrals for dental services were largely to Matany and Moroto Regional Referral Hopsitals.

Table 7: Availability and status of dental clinic in Karenga.

Availability of dental clinics		
Facility name	**Availability**	***Status***
Nabilatuk HC IV	YES	Well furnished, with necessary equipment and instruments for dental services.
Tokora HC IV	NO	Improvised in minor theatre however, dental instruments, such as hand pieces, mouth mirrors, burnishers, and restorative instruments

3.1.9. OPD: HSD office

The health sub district aims at strengthening the records, ordering and disease burden management of health services and improving equity of access to essential health services by the population. (MoH Standard Procedures, 1999). Tokora Health Centre IV confirmed existence of a Health Sub District office. However, this office had limited space, facility had no staff while Nabilatuk conformed existence of data management

Table 8: Existence and status of HSD offices in Level IV health Centres

Availability of an HSD office		
Facility name	*Availability*	
Nabilatuk HC IV	YES	Limited space and furniture with no designated records personnel and limited
Tokora HC IV	YES	Had cabins, computer and printer

3.1.10. OPD: UNEPI records

According to the UNEPI Guidelines, (2016), immunization program is a key component in disease management (infectious and non-infectious diseases), the guidelines provide procedures on how to handle disease outbreak records at all levels in health service delivery points. These include; record keeping on the disease and people at risk, vaccines provision and distribution. The scorecard (input tracking) assessed availability of records room, cold chain system for reagents and vaccines, personnel and support system for UNEPI. All facilities visited had UNEPI support systems however; it was further examined at Nabilatuk & Tokora heath Centre IVs being the Health sub district (HSD) Centres. Tokora HCIV had UNEPI record room, with fridges and cold chain system.

3.1.11. 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. According to the standard procedures, certain equipment and facilities are needed to meet the minimal requirements for an operating theatre such as; clog washer, hybrid room, patients' support system, patients' protection packs, surgical lights and tables, pendants, anesthesia machine, sterilizer machine, cardiology equipment, cabins, locker area, screens, disposal bins, glovers, screens, bath room, theatre ward, linen and surgical diathermy. (WHO, 2015).

Both Tokora and Nabilatuk HC IVs had major and minor operational theatre. The theatres hwoever, lacked equipment such as screens, oxygen machine trolleys, screens, Anesthesia machine, cardiology equipment, scanners and stand (functional generator).

Operation bed in Theater Tokora HC IV

3.1.12 Other OPD structures at Nabilatuk and Tokora HC IVs

AREA	STATUS	STATUS (Nabilatuk and Tokora HC IVs)
Injection room	YES	Had injection table, screens, IEC materials, trolley, curtains and locker area
Treatment room	YES	Had Treatment bed, trolley, screens, cardboard
Waiting room	NO	Clients wait in the corridors
MCH(ANT/FP)	YES	Spacious, fridges and containers for keeping reagents and vaccines safe
Multifunctional room	NO	Improvise in the MCH room
MCH store	YES	Poor hygiene, squeezed with no equipment and furniture
Labratory store	YES	Well-conditioned, spacious room with shelves and temperature measure
Blood bank	YES	Small with few blood packs
DENTAL DEPARTMENT		
Treatment room	YES	With chair, table, treatment bed, light, locker area, face masks, gloves and IEC materials.
X ray	YES	Had X-ray machine, films and screens
Radiology	NO	Improvised in the x-ray room
Radiology film processing	NO	No machines
Radiology waiting area	YES	Clean spacious with seating area and IEC materials
GYNA & OBS DEPT		
Treatment room	NO	No specific room for gynecology and obstetrics services
PHYSIOTHERAPY		
Treatment room	NO	No equipment and services rendered

3.2. IN-PATIENT 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 health centre III on wards are supposed to admit patients according to their mandate. An assessment of the 6 health care facilities visited had some of the IPD facilities as described in the subsequent sections.

3.2.1 IPD: Health Centre IV

According to Government of Uganda Standards for Health centre IV, there should be Maternity room, labour room and waiting rooms, sterile and linen store, ward nurse duty station and general ward and other facilities that include children, female and male wards, placenta pits with ambulance for transporting patients. (National Medical equipment policy, 2009).

Some of the observations during in-put tracking were; fewer beds and beddings, inadequate space leading to congestion and sharing of ward by different patients, dirty toilets leading to poor hygiene of patient's, inadequate staff, and high client volumes, shortage of drugs, power and inadequate water supply especially in dry seasons.

Figure 1: In-patient department Tokora and Nabilatuk Health Centre IVs

IDP	Nabilatuk	Tokora	General Comment
Maternity ward	Yes	Yes	Nabilatuk- 12 beds, curtains, drip stands, mosquito nets and good hygiene. Tokora- 16 beds, 6 drip stands and linen
Delivery room	Yes	Yes	Nabilatuk- Spacious, with screens, sterilization machine, have 2 delivery beds, deposit bins, cabins and pressure machine, and trolley Tokora- spacious with 2 delivery beds, bin and bin liners
1st_stage labor	No	Yes	Nabilatuk- Examination bed, screens, intense lighter, trolley and rocker area. Tokora- Examination bed, screens and trolley
Waiting room	No	No	Nabilatuk- Mothers wait in the maternity ward. Tokora- with seats and IEC materials
Sterile store	Yes	Yes	Nabilatuk- Sterile machine, power extension and trolleys Tokora- sterile machine with power extension and charcoal stove
Linen store	No	No	Tokora- Linen were kept in the ward station
Ward nurse duty station	No	No	Tokora- No nurse duty station, nurses on a night shift commute from the quarters. Nabilatuk- improvised in the officer
General ward	Yes	Yes	Tokora- 15 beds in the ward, patients/ mothers sleep on the floor. However, Poor hygiene and the ceiling boards had cob webs. Nabilatuk- 17 beds with linen and drip stands
Children's ward	Yes	Yes	Nabilatuk- 6 beds to accommodate and no glasses, mosquito nets, linen and no mattress.
Female ward	Yes	Yes	Nabilatuk- 9 beds no linen, curtains and wash room Tokora- 12 beds with linen, drip stands and mosquito nets
Male ward	Yes	Yes	Nabitatuk- 5beds with no beddings (mattress, and mosquito nets) Tokora- 4 beds with drip stands, curtains and mosquito nets
CD4 count machine	Yes	Yes	Tokora- Pima machines (stocked out of reagents and cartilage) Nabilatuk- Pima machine with reagents.
Placenta pit	Yes	Yes	Nabilatuk- Serves both theatre and maternity ward Tokora- both at theatre and maternity ward
Incinerator	No	Yes	Nabilatuk- Littered in the pits
IDP	Nabilatuk	Tokora	General Comment
			Tokora- well-built and fenced
Water facilities	Yes	Yes	Nabilatuk- Water taps/rain water tanks. Tokora- water tank and tapped running water

Maternity ward in Tokora HC IV

Delivery bed in Nakapiripirit HC III

3.2.2. IPD: Health Centre III

According to government of Uganda Standards for Health Centre III, 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 had gaps faced by the in-patient department included inadequate space, beds and beddings, water especially in the dry season, fuel for generator, frequent power shortages, lack of mama kits and other maternity supplies.

Table 9: IPD at Health Centre III Level

IDP	No	Yes	Status general comments
	N (%)	N (%)	
Children/ Female ward	0(0)	4(100)	Nakapiripirit HC III-had only female wards with 12 beds, poor hygiene and no mosquito nets Namalu HC III-well-furnished with 12 beds curtains, mosquito nets, linen and drip stands Moruita Brigadier 407 HC III-spacious, with IEC materials, 15 beds with beddings, curtains and drip stands. Lorachat HC III-well-furnished spacious rooms with curtains, 15 beds and beddings
Delivery room	0(00)	4(100)	Nakapiripirit HC III-2 delivery beds, screens, cabin, lighter and linen. Moruita Brigadier 407 HC III-one delivery bed, weighing machine, linen, water tank, and lighter extension. Lorachat HC III-2 delivery beds, screens, power extension, trolley, deposit bins and weighing machine Namalu HC III-sink, delivery bed, screens, trolley and pressure machine.
Linen store	4(100)	0(00)	All facilities had linen but with no linen store area.
Male ward	1(25)	4(75)	Lorachat HC III-7 beds, no mosquito nets and curtains. Moruita brigadier 407 HC III-12 beds, power extension, drip stands, and curtains Namalu HC III-6 bed, drip stands, and mosquito nets. Nakapiripirit HC III-9 beds with solar power
Maternity ward	0(00)	4(100)	Nakapiripirit HC III- well-furnished room with IEC materials, curtains and mosquito nets Lorachat HC III-poor hygiene with no mosquito nets and curtains. Namalu HCIII- 4 beds with no water and power extension. Moruita Brigadier 407 HC III-small in size with no linen, and power extension
Maternity first labour	2(50)	2(50)	Nakapiripirit HCIII- examination table (bed), pressure machine, cabins, lighter and rocker area. Lorachat HCIII-Examination table, screens, pressure machine, doctors seat and intense lighter
Maternity waiting room	3(75)	1(25)	Witnessed in Lorachat HC III with no waiting seats and shelter
Ward nurse stations	2(50)	2(50)	Lorachat HC III and Nakapiripitit HC III had small rooms with no linen. In the rest of the facilities health workers
Linen Store	4(100)	0(00)	None of the facilities visited had a linen store.

Drug store in Namalu. HC III

Maternity ward in Nakapiripirit HC III

Delivery bed in Nabilatuk HC IV

Maternity Ward in Namalu HC III

Wash room in Namalu HC III

Male ward in Tokora HC IV

4.0. HIV/AIDS SERVICE DELIVERY ASSESSMENT

This section highlights reports from scoring by the community members, service providers, and interface meetings on how they feel the health care facilities are performing. The information gathered from workshops, focus group discussion and interface meetings was scored using the community score card technique. The participants included the community members (clients/beneficiaries of health services), service providers, local leaders, policy makers, opinion leaders, religious leaders and representatives of CSOs among others. The assessment benchmarked the National Strategic Plan (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 a very poor service, 2 to represent a poor service, 3 to represent an average service, 4 to represent a good service and 5 to represent a very good service. The scoring was based on the participant's opinion (men, women, service providers and all jointly) guided by the standards of service as per the Government of Uganda service delivery guidelines.

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

Table 8: Sample Distribution In Heal Facilities

DISTRICT	HEALTH CENTRE	Focus Group Discussions	INTERFACE
Nakapiripirit	Tokora HC IV	3	1
	Nabilatuk HC IV	3	1
	Lorachat HC III	3	1
	Nakapiripirit HC III	3	1
	Moruita Brigadier 407 HC III	3	1
	Namalu HC III	3	1
	Total	**18**	**6**

4.1 HIV PREVENTION

Assessment of HIV prevention services examined the quality of eMTCT, Safe Male Circumcision, availability of IEC materials, condom supply (female and male), HIV testing services, Sexual and Gender Based Violence services as the indicators of HIV prevention

4.1.1 Quality of eMTCT.

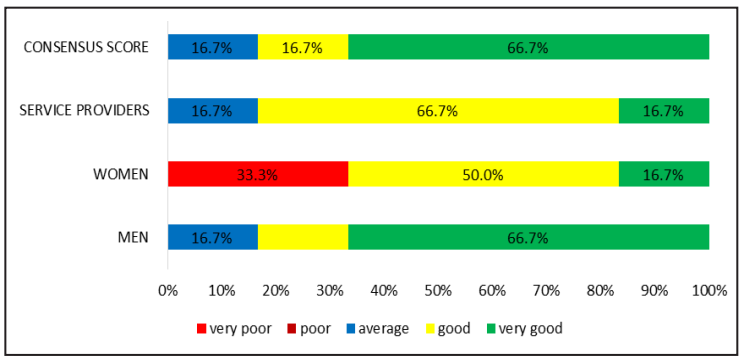
National HIV/AIDS strategic plan identifies eMTCT as one of the priorities supposed to be adopted by 2015 with a more cost-effective treatment regimen, beefing up health infrastructure to increasing women's access to family planning and eliminating mother to child infections. Scorecard assessed. Scorecard assessed; level of male involvement, competency of health workers in comprehensive HIV care, stock status of commodities, follow up mechanism and community knowledge and understanding.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

During the interface meeting for consensus score, the quality of eMTCT was 66.7% ranked as very good service, 16.7% good and 16.7% as average respectively. The good rankings was as a result of; staff trained in comprehensive HIV care including eMTCT, community awareness of the services and strong follow up mechanism in the health facilities in addition to strong collaboration and support from Implementing Partners. The reasons for the low ranking were; low male involvement, the long distance to reach health facilities that lead mothers to attend t Traditional Birth Attendants (TBAs), poor community health facility linkage and follow up mechanism and inconsistent medical supply (pediatric drugs).

Recommended were; comprehensive HIV training of health workers to make them AIDS competent, support extension workers (expert clients and VHTs) to conduct follow up, use local and traditional leaders to sensitize the community, promoting privacy of patients and encourage male involvement in service uptake.

Figure 2: Quality of eMTCT



4.1.2. Safe Male Circumcision (SMC).

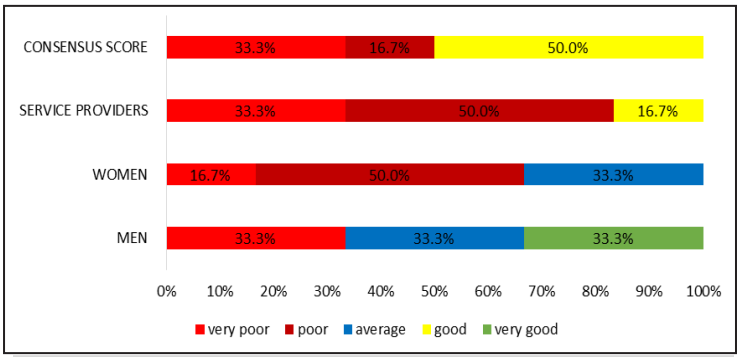
In September 2010, the Government of Uganda launched an initiative to provide Safe Male Circumcision (SMC) as an essential health service as part of HIV prevention. The initiative seeks to increase the number of circumcised men by educating the population about safe male circumcision, increasing the number of health facilities that provide circumcision services and equipping health providers with the necessary skills to conduct the procedure. The scorecard assessed availability of service (static or on outreach arrangement), competent personnel in SMC, community awareness, involvement and perception, follow up mechanism, availability of kits and local and traditional leader's involvement. During the interface meeting (consensus score) 50% both participants ranked it good service, 33.3% as very poor and 16.7% as average respectively.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The good raking was a result trained personnel to, availability theatre and equipment, community awareness and leaders involvements. The poor ranking was a result of; service was not static at all health Centre IIIs, lack of kits, lack of trained staff to handle surgery, negative community perception, limited IEC materials on SMC and low involvement of local and traditional leaders.

The remedies were; community sensitization, involvement of religious and cultural leaders in designing intervention programs that are culturally sensitive, equip the facilities with kits, train staff and provision of IEC materials and use other platforms such as community dialogues, radio and TV programs for awareness.

Figure 3: Safe Male Circumcision



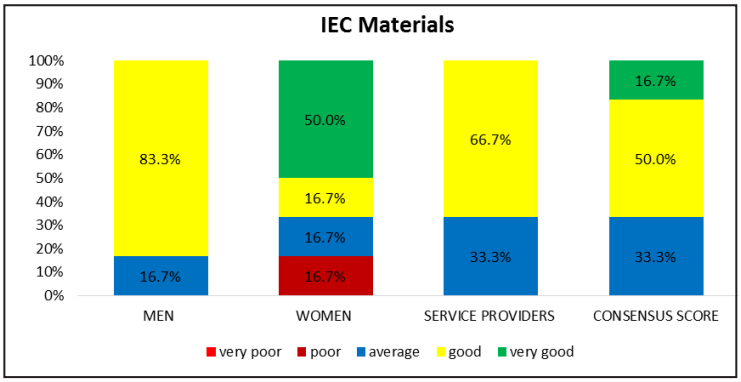
4.1.3. Provision of IEC materials

Print materials such as posters, brochures, flyers, billboards, are intended to draw attention to information about disease or risks to health are often called "Information, Education, And Communication" (IEC) materials. Some electronic media can be IEC-focused as well as; announcements and radio, television, and video programs that disseminate information whether as a straight forward explanation or in the form of stories are also IEC materials. In regard to availability of IEC, during the interface meeting 50% of the participants ranked it as good, 33.3% average and 16.7% as very good.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The good rankings were as a result of; materials available being in both English and local languages, materials being disseminated up to the community and information being disseminated with different materials. The average ranking was due to; IEC materials but were not adequate and others were written in English language, some of the materials available were not translated in the local languages. There were also reports of high illiteracy rates among the community members rendering some IEC materials ineffective. The community recommended provision of translated materials and to interpret the messages during health education talks for those who are illiterate.

Figure 4: Provision of IEC materials



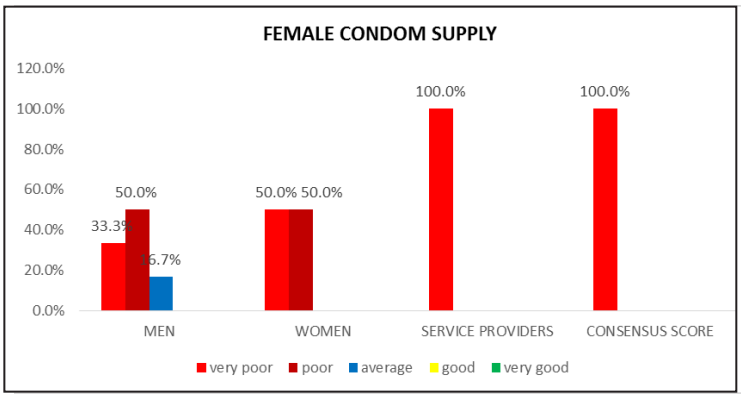
4.1.4. Condom supply (female)

Condoms were identified as some of the best means of HIV& AIDS prevention as part of ABC strategy. The community scorecard looked at availability, community uptake and usage of services and community perception on condom use.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

All the participants in 6 health facilities ranked availability of female condoms very poor services. The poor ranking was attributed to stock outs of condoms, myth on female condoms and community and local leaders' perception and cultural beliefs and practices that condoms are for promiscuous women.

Figure 5: Female condom supply



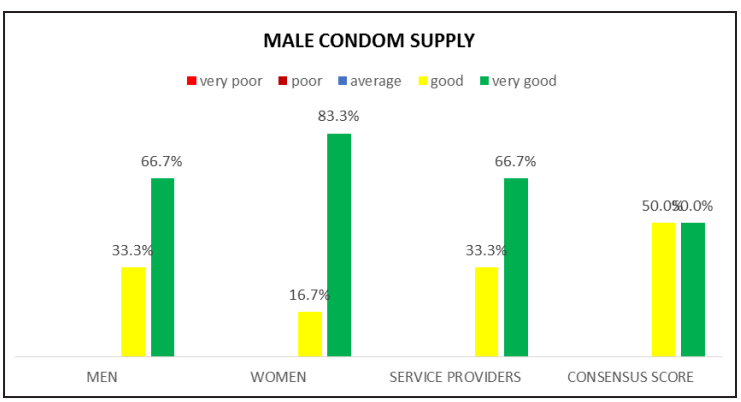
4.1.5. Condom supply (male)

Community scorecard looked at availability, accessibility and uptake o condoms. Male condoms were available in all the health facilities visited. Availability of male condoms was ranked as very good in, Tokora HC IV, Nabilatuk HC IV and Nakapiripirit HC III and good in Lorachat HC III, Moruita Brigadier 407 HC III and Namalu HC III.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

Male condoms were reported as a very good service in all the health facilities visited. The reasons for a good service were: availability of condom corners in all the facilities to ease accessibility of condom. Recommendations included; sensitization of the community on the availability and importance of the both the male and female condoms, involvement of religious and community leaders as well as increase on the number of condom distributors and supplies at both health facilities and in the communities to avoid stock outs.

Figure 6: Condom supply male



Condom Dispenser in Nabilatuk HC IV

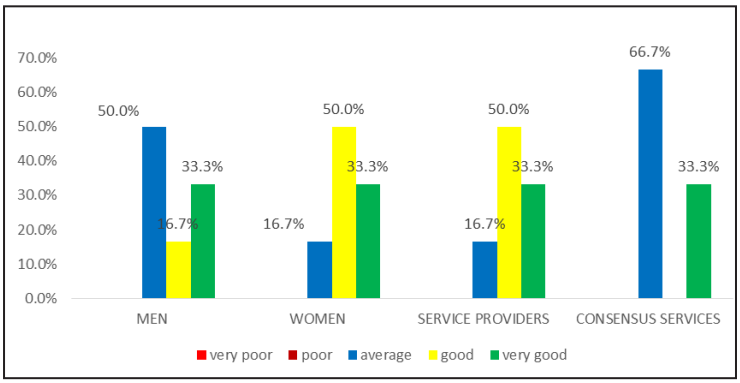
4.1.6. Testing and counselling services

The NSP and NPAP objective 2 stipulate the biomedical way of scaling up HIV prevention and through extending coverage and uptake of HTC and enhancing quality assurance to achieve 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), 50% of the participants rated as very good, 33.3% as good and 16.7% as average services.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The good ranking was a result of available pre and post counselling services, health workers encourage couple testing and counselling, strong follow up mechanism through extension workers and expert clients. However, gaps raised included lack of skilled counsellors and inadequate test kits and no outreaches done by the health workers. Accordingly, need for separate counselling rooms, regular supply of test kits, recruitment and training of existing staff in counselling and carrying out community outreaches to promote testing for HIV&AIDS.

Figure 7: Testing and counseling services



4.1.6. Sexual and Gender Based Violence services (SGBV)

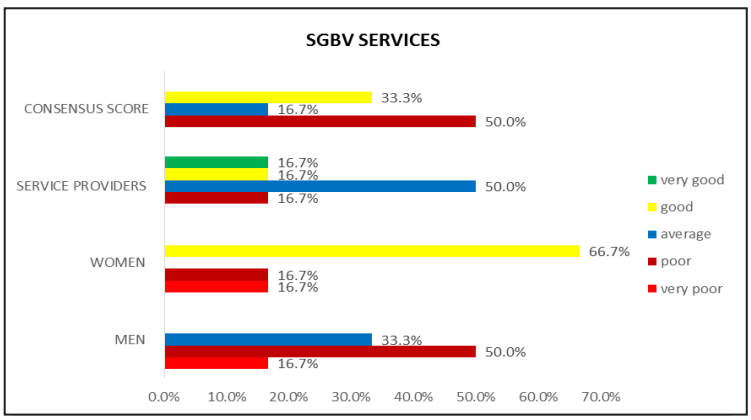
SGBV has often been attributed to traditional/ cultural beliefs, alcoholism, illiteracy and poverty. According to GBV policy 2009, many victims are afraid to report rape and other forms of violence not only because of intimidation, hostility and ridicule from the community but also due to the state's inaction in ensuring redress. The community

scorecard assessed access to HIV preventive measures (availability of PeP and morning after pills) and community perception. Results of the assessment conducted during interface indicate that 66.7% ranked service as good, 16.7% as average and poor respectively.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The good ranking was a result of community awareness, availability and accessibility of PeP and contraceptive pills and community and law enforcement involvement.
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 to support funding of campaigns against SGBV to reduce of the vice.

Figure 8: Sexual and gender violence services



4.2. CARE AND TREATMENT

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

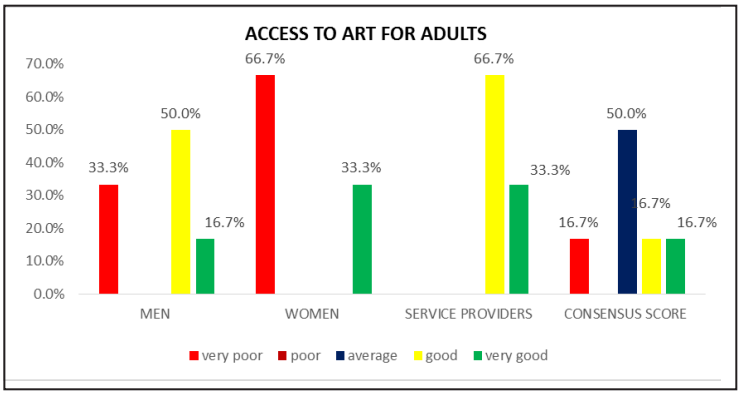
4.2.1. Access to ART for Adults

In regards to access to ART for Adult, the community scorecard assessed availability of drugs, male involvement, integrated service delivery to eliminate stigma, competent staff in HIV comprehensive services, privacy and outreach programs. During the interface meeting for consensus score, 50% rated as average, 16.7% as very good, good and very poor respectively.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The good score for services were, availability of ART drugs, testing for viral load and CD4 in Tokora and Nabilatuk HC IV. Challenges; limited space for large number of clients, sporadic drug stock outs, low male involvement, overwhelming numbers, stigma leading to fear by the PLHIV to access drugs, reliance on expert Clients to pick drugs for patients, no CD4 count machines at lower HC IIIs, and few HIV competent staff. Recommendations were; train staff in comprehensive HIV services, community sensitization to encourage male involvement, steady supply of drugs and availing of result for viral load in time.

Figure 9: access to ART for Adults



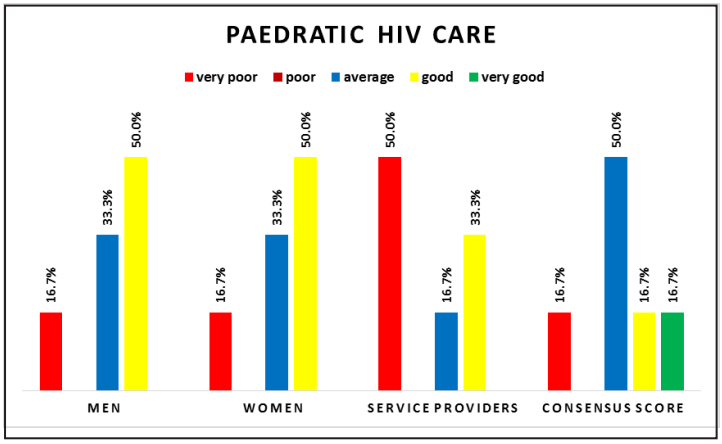
4.2.2. Paediatric HIV care

According to NSP access to Antretroviral therapy is a sustainable provision of chronic care for patients including paediatrics; that implies expanding and consolidating pediatric in all accredited ART sites. The score card examined health workers having comprehensive knowledge to handle children, early infant diagnosis, community-health facility linkages as well as provision of HIV related services. The pediatric HIV care was generally ranked as good by 50% of facilities, 16.7% as very good, average and very poor respectively.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The good ranking was as the result of availability of drugs, public education and counseling provided specifically for mothers. The poor rating was due to; regular stock out of Nevaripine syrup, poor follow up mechanism, few health workers competent in HIV/AIDS care for children and high stigma and discrimination among the caregivers. Remedies were; active engagement of parents/caregivers of the children on service uptake, having specific appointment days for pediatric care, strengthening follow up mechanism using community resource personnel/expert clients and elimination of stock outs.

Figure 10: Pediatric HIV care



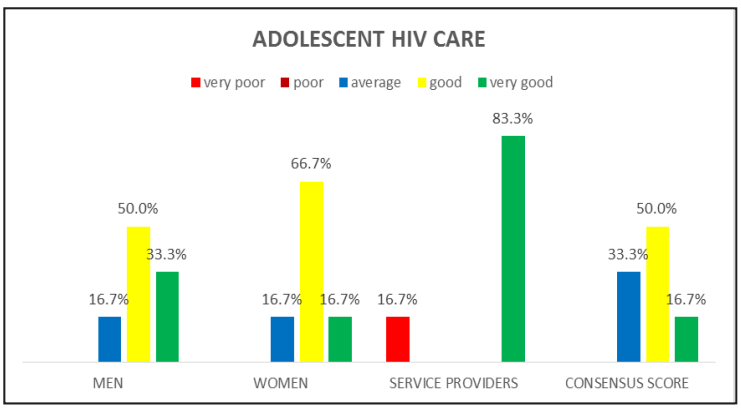
4.2.3. Adolescent HIV treatment.

The WHO Guidelines on Care and Treatment, (2015), adolescent's treatment are services specifically integrated in Health care system for the youth health related events. The assessment examined youth friendly corners, youth ART refill designated days, integrated system for ART access, and sensitization. During the interface meeting (consensus score), 50% ranked as good, 33.3% as average and 16.7% as very good service.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The good ranking based on youth ART refill specific days, youth friendly corners, follow up through peer buddies and integrated program. Challenges noted were; inadequate adolescent friendly services in most of the health care facilities visited, lack of linkages between the health facilities and community where the adolescents stay, sporadic stock out of drugs and stigma and discrimination. Recommendations included; 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.

Figure 11: Adolescent HIV treatment



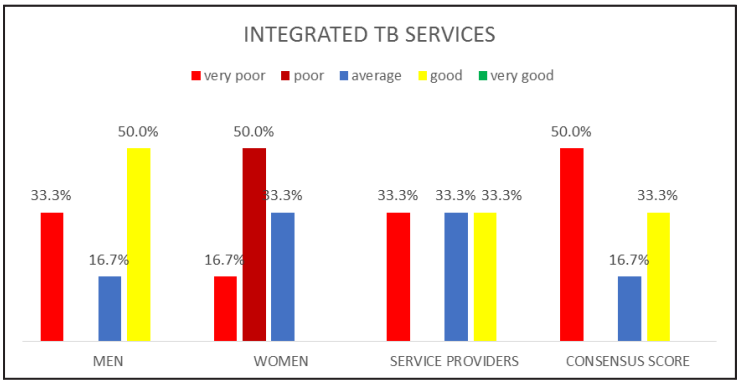
4.2.4. Integrated T.B services.

In line with Uganda's national policy guidelines for TB/AIDS collaborative activities in Uganda, 2006, collaborative services emphasis integrating care and treatment for patients with TB/HIV, through enhancing screening for patients, routine testing and diagnosis of TB. TB is one of the number one killers of PLHIV, causing more AIDS related deaths. To improve the outcomes for clients in high TB/HIV and treatment activities throughout Uganda, integrating TB screening in HIV testing and treatment is essential. Scorecard assessed availability of TB expert machine, screening service, follow up and community sensitization among others.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

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

Figure 12: Integrated T.B services



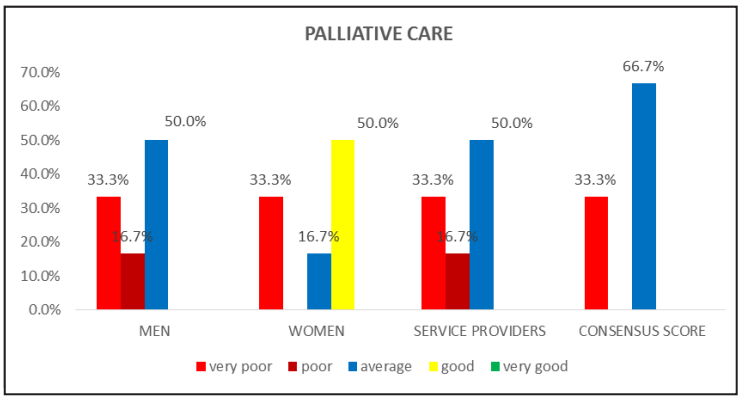
4.2.5. Palliative care services

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 based assessed availability of palliative drugs, capacity of the human personnel to offer the service, the community knowledge on service availability and the referral mechanism.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

During the assessment, 66.7% of the participants agreed that the palliative care services was average and 33.7% as very poor. The reasons were; lack of palliative care units/rooms/wards, lack of drugs and incompetent health workers in palliative care. There is therefore 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 13: Palliative care services



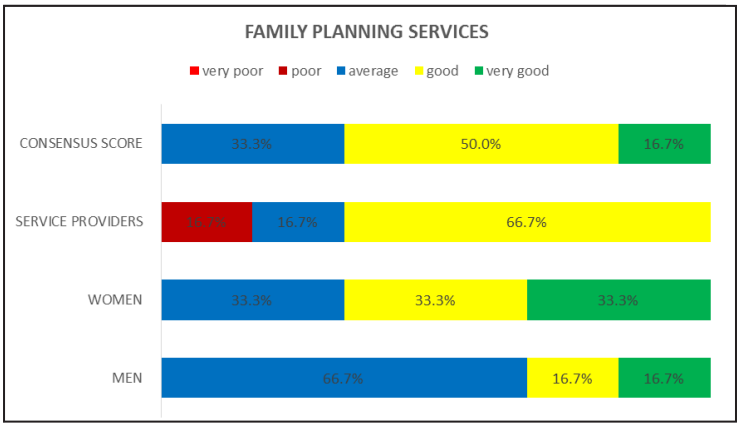
4.2.6. Family planning service

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 on service uptake. Constant shortages especially for the long term commodities were recorded at Nabilatuk HC IV and Tokora HCIV.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The consumers of family planning (FP) services ranked the quality of service as good service while the service providers ranked it as average. The positive ranking was based on availability of methods at the facility and community awareness of the services. However, there are factors affecting quality and utilization of FP services such as stock outs of family planning supplies and test kits, perceived side effects, inadequate skills in management of complications, inadequate staffing leading to workload, low involvement of men, cultural and religious beliefs such as no need to stop bearing children and negative attitudes in the community like use of contraceptive pills makes one infertile.

Figure 14: Family planning services



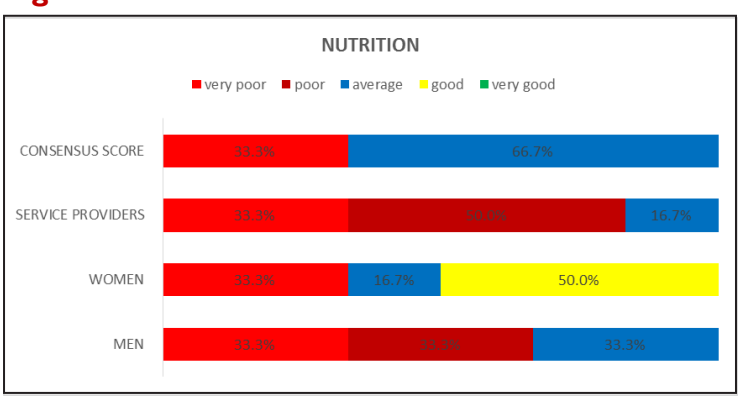
4.2.7. Nutrition Support services

In a bid to complement service and support vulnerable clients on medication, nutrition feeds to boost their immunity is recommended. The community scorecard assessed the availability of feeds, provision of food to the index population (PLHIV and malnourished children), provision of nutrition information to all PLHIV clients and counselling services. During the interface meetings (consensus score), 66.7% participants ranked as average, 33.3% as very poor.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The results revealed that nutritional supplements are often out of stocks, and educational programs at all the facilities visited were limited to provision of IEC materials and training without provision of adequate or any food supplements, only given to the malnourished yet there was a general outbreak of hunger in Karamoja region requiring PLHIV to access the supplements to adhere to ART and exclusion of the elderly since food provision was only offered to the expectant mothers and children under the age of 6 years. 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.

Figure 15: Nutritional services



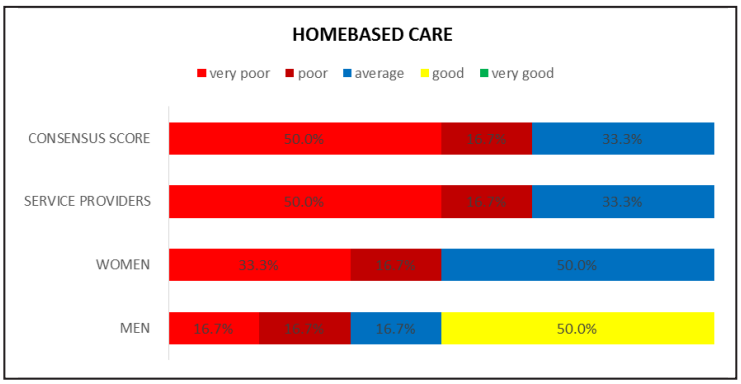
4.2.8. Home Based Care Services

Home Based Care contributes to the second goal of the National Health Strategic Plan (NHSP) through strengthening the community based systems such as Village Health Teams (VHTs) to improve the quality of life especially of PLHIV by mitigating the health effects of HIV&AIDS. Home Based Care works within the health system and structures in each health service delivery point, involving cross referrals from all levels of care (whether public or private, formal or informal) to the households, follow up of people in the community by trained health workers to reach services for the vulnerable and bed redden.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

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 were need for intensive training in Home Based Care services, IPs to use the available health care structures (expert clients and VHTs), facilitation and motivation of community resource persons such as expert clients to reach their peers and the district to allocate additional funds alongside the primary health care (PHC) money from the local revenue to facilitate health workers to reach out to the community.

Figure 16: Home Based Care Programme



4.3. SOCIAL SUPPORT AND PROTECTION

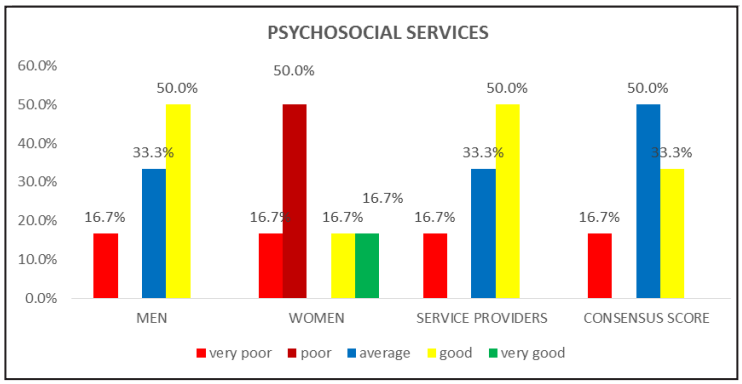
The Community Score card assessment examined the quality of psycho social services, capacity building of care givers, provision of food and education services as well as legal support and social services. Results from the discussions are presented in the subsequent sub sections. According to the NSP Social, support and protection further aim at reducing the vulnerability to HIV&AIDS and mitigate its impact on PLHIV and other vulnerable groups. This is through scaling up elimination of stigma and discrimination, mainstreaming development programs in all relevant sectors and life cycle and comprehensive package of social support and protection intervention for PLHIV. In a bid to eliminate stigma and discrimination and adherence to treatment among the PLHIV, the survey assessed 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 and supporting tools and IEC materials. During the interface meeting for consensus score, 50% of the participants ranked it average, 33.3% as good and 16.7 % as very poor respectively.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The good ranking was due to; skilled personnel in psychosocial counseling, existence of expert clients to conduct follow up, facilitation to support clients to adhere to treatment, referral system, privacy and confidentiality at health facilities. However, there were gaps such as; low male involvement, fewer staff trained in psychosocial supportive services, limited

privacy and associated stigma, poor document for follow up and referral. Remedies were; train staff in counselling, facilitate VHTs and expert clients to conduct referral and strengthen follow up mechanism of clients.

Figure 17: Quality of psychosocial services.



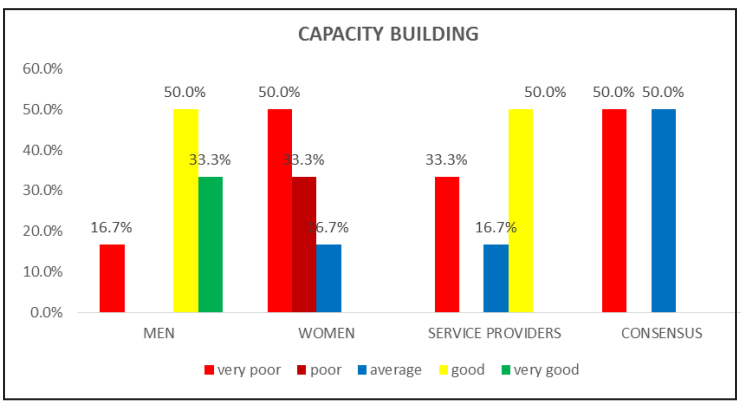
4.3.2. Capacity building for care givers

Health workers mentor caretakers on how to manage patients especially those living with HIV. Sometimes health workers follow up community members at the grassroots. However, at times this becomes impossible due to limited number of health workers. The assessment revealed that the capacity building of care givers was poor due to limited staff and the unwillingness of some care givers to undertake capacity building programs. In regard to capacity building, it was ranked at 50% average and 50% very poor service.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The reasons given included limited human resource persons, patients not coming along with care givers, stigma among the community members, low male involvement and high illiteracy levels among the community members. Recommendations were; recruitment of more staff, community sensitization and logistical support in terms of drugs, protective gear and other supplies will help improve and build the capacity of care givers to avoid cross infection among other things.

Figure 18: Capacity building for care givers



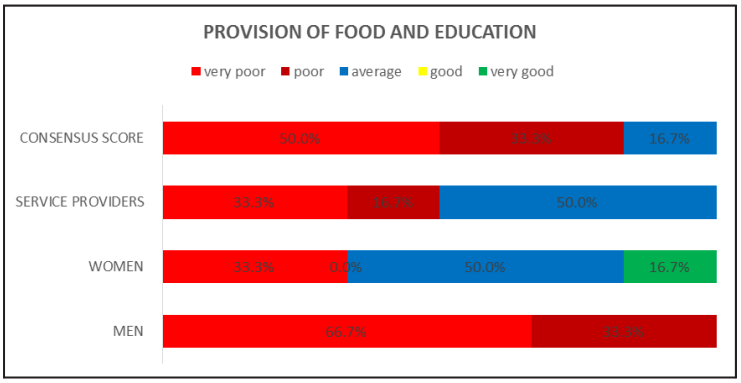
4.3.3. Provision of food and educational services

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. During interface meeting 77.8% of the participants ranked the service as very poor and 22.2% as average respectively.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The reason for very poor score were; no meals provision, poor hygiene and sanitation, hunger and high level of malnutrition, no significant food provision for vulnerable people including PLHIV clients. Recommendations included; 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 to support the vulnerable PLHIV with food supplements to be able to live a productive life.

Table 11: Provision of food and education services



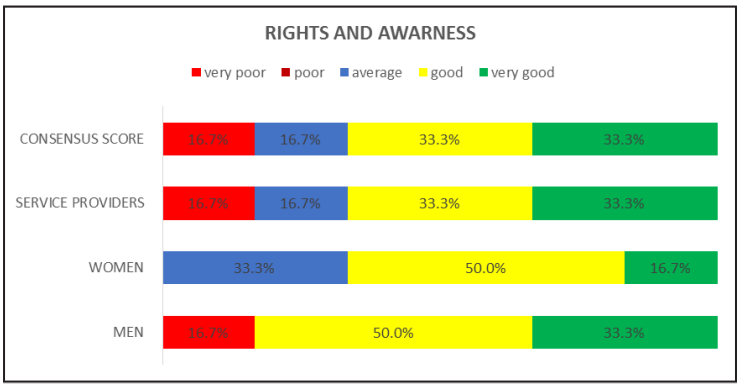
4.3.4. Rights awareness and support.

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 ard assessed 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. During the interface meeting (consensus score) 33.3% of the participants ranked rights awareness and support to patients to know and understand their rights as very good and good whereas 16.7% rated as both average and very poor service respectively.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The poor ranking was based on lack of awareness on rights for services by both health workers and community members, inadequate IEC materials on patients' rights in the local languages, limited health facilitty and partner's engagement, low involvement of local and cultural leaders to create awareness among the community (service users). The recommendations raised were; sensitization about rights and responsibilities be done through seminars, involve local and cultural leaders, hold community meetings and translate materials in language languages.

Figure 19: Rights awareness and support.



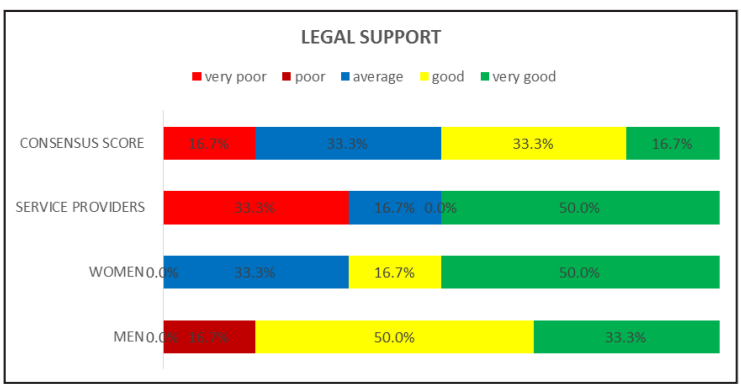
4.3.5. Legal support and social services

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. During the interface meeting (consensus score), 33.3% rated as good, 33.3% as average, 16.7% as both very good and poor service respectively.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The good and average 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 case of assault and filling of police forms to support the victims. The poor rating was as a result of community not seeking legal support from facility, still high levels of stigma and discrimination, 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. More paralegals were recommended to support community members to access justice.

Figure 20: Legal support and social services



5.0 SYSTEMS STRENGTHENING

5.0. Infrastructure, utilities and equipment.

Availability of adequate utilities such as water, sanitation and hygiene encourages patients to visit health care facilities. It also reduces re- infections and co-infections. An assessment of the infrastructure, utilities and equipment focused on the availability of good and safe water, availability of transport, adequate number of staff houses, adequate toilets, kitchen, and shelter, availability of CD4 testing machine, communication facilities and availability of power & type of power available was done.

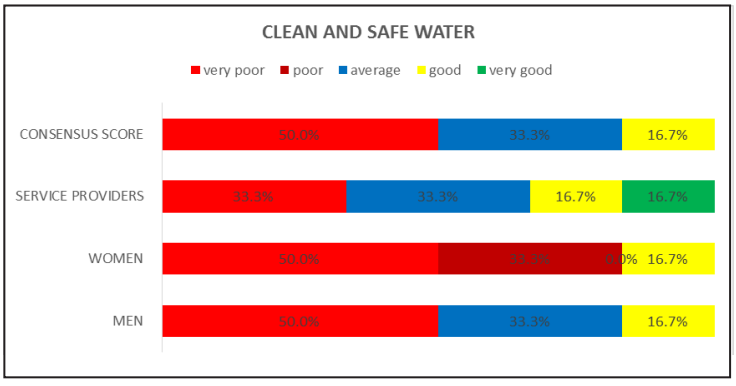
5.1. Availability of clean and safe water

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. As per guidelines, there should be a water source to supply the facility, water connected especially to the laboratory, theater (where it exits), delivery room, laundry area, bathrooms and other key sections requiring direct water connections. During the interface meeting (consensus score), 50% of the participants ranked it a very poor service, 33.3% as average, 16.7% as very good.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC IV	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The average ranking was as a result of ……. and health service providers, water shortages regularly occur, water sources are far from the facilities and water storage tanks are inadequate. Recommendations included the installation of running water at all the health facilities and additional water storage units such as tanks are installed such that more water can be harvested and/or stored.

Figure 21: Availability of good and safe water



Water storage tank in Nabilatuk HC IV

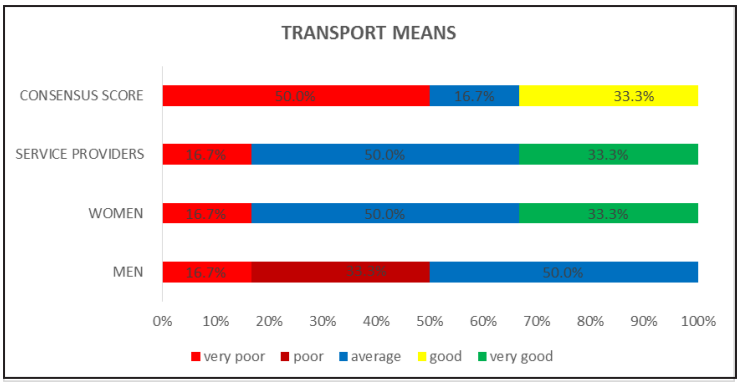
5.2. Availability of transport

Transport means are fundamental for strengthening hospital running, ambulance system, linkages through referral support and outreach program. The community scorecard assessed availability of an ambulance, motor ambulance care, motorcycles and facility specific vehicles. During the interface meeting for consensus score, 50% of the respondents ranked it as very poor, 33.3% as good, and 16.7% as average.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The poor scoring was a result of; lack of ambulances, motorcycles or bicycles attached to the facilities, poor maintenance mechanism of the Ambulance in Tokora and patients incur cost of fueling the ambulance which was expensive, poor road networks especially to the communities. Recommendations included; the need by the Ministry of Health/Local Government to provide the Health Centres with ambulances, motor cycles and bicycles for outreaches, wheel chairs and stretchers for patients and repair the existing ambulances as well as allocate fund for maintenance.

Figure 22: Transport means



Breakdown facility Vehicles in Nabilatuk HC IV

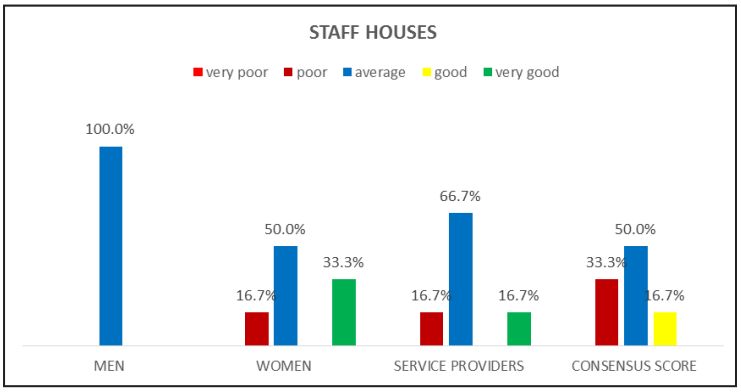
5.3. Adequate number of staff houses

The 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. In regard to staff houses, 44.4% of the participants during the interface meeting ranked as both average and poor service and only 11.1% was very poor service.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The reasons for poor service was based on low staff and quarter ratio, the condition in which the structures were, and the poor attitudes towards residing at the facility by the health workers. The average ranking was as a result of availability of staff houses and general good conditions of the staff houses. Recommendations were; more staff houses be constructed and the existing ones be renovated.

Figure 23: Adequate number of staff houses



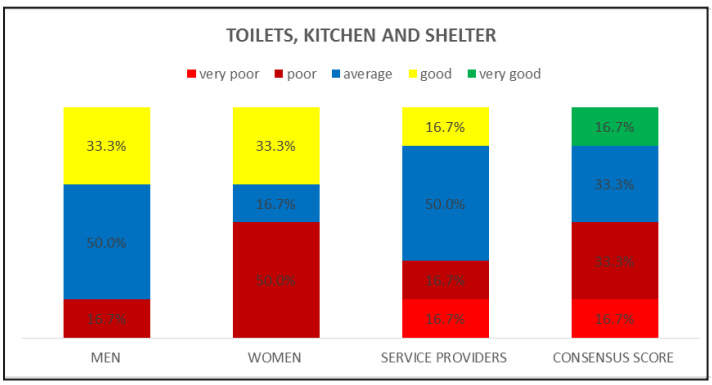
5.4. Adequate toilets, kitchen, and shelter

In a bid to support access to services at the facility, toilets, kitchen and shelter are necessary to complement adherence to services. The scorecard assessed availability of shelter, kitchen and toilet, the community awareness on using the facilities, the sanitation and hygiene situation at the facilities, and availability of facilities that are people with disability compliant. Results indicate that 55.6% of the participants during the interface meeting (consensus score) rated it as poor, 33.3% as average and 16.7% as very good.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The poor ranking was a result of inadequate not disabled sensitive, lack of sufficient latrines and dirty. The shelters on the other hand were lacking especially for patients at ART clinic and kitchens for patients were largely nonexistent. Recommended that more toilets be erected, kitchen facilities and shelter be availed especially in in Nabilatuk HC IV and Nakapiripirit HCIII.

Figure 24: Adequate toilets, kitchen, and shelter



Cooking area in Tokora HC IV

Latrine in Tokora HC IV

Latrine in Namalu HC III

Washroom in Nabilatuk HC IV

Waiting area at OPD in Nabilatuk HC III

Latrine in Tokora HC IV

Latrine in Nabilatuk HC IV

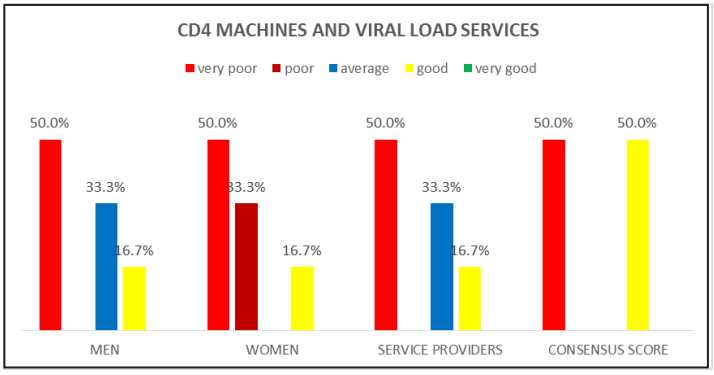
5.5. Availability of CD4 and Viral load services

HIV treatment and disease burden monitoring and management required CD4 count and viral load testing to monitor the clients' adherence to HIV treatment and viral load 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 Tokora HC IV and Nabilatuk HC IV therefore all ART sites are served from one Centre. 66.7% of the participants rated it as very poor, 22.2% as good and 11.1% as poor service.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

However, the poor ranking was; long turn over 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,CD4 machine break downs and lack of maintenance service contracts at Tokora health Centre IV. It was recommended that more CD4 machines be distributed/procured, increase stock supplies of CD4 machine both low and high volume depending on facility clientele numbers and provision of maintenance service contracts. PLHIV recommended timely delivery of viral load results.

Figure 25: Availability of CD4 and Viral Load services



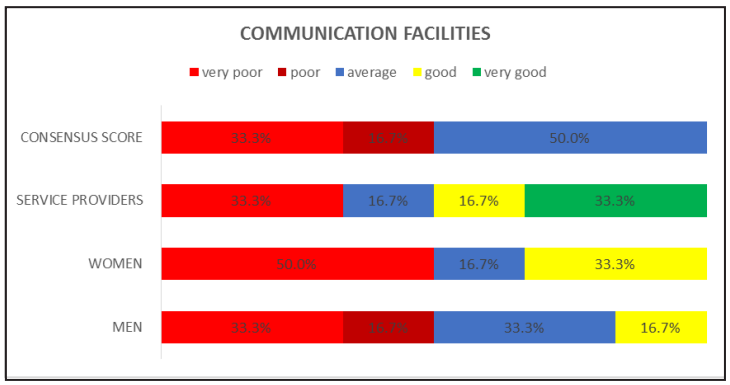
5.6. Communication facilities

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. During the interface meeting (consensus score) 66.7% 0f the participants ranked it as average, 33.3% as very poor and 16.7% as poor respectively.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The poor rating was because most the communication items for patients' use were almost nonexistent such as suggestion boxes, facility landlines and desk computers. Recommendation were to; provide equipment (use of suggestion boxes, telephone booth or public pay phones, facility landlines, desk computers and internet) to ease communication b both health facility staff and patients.

Figure 26: Communication facilities



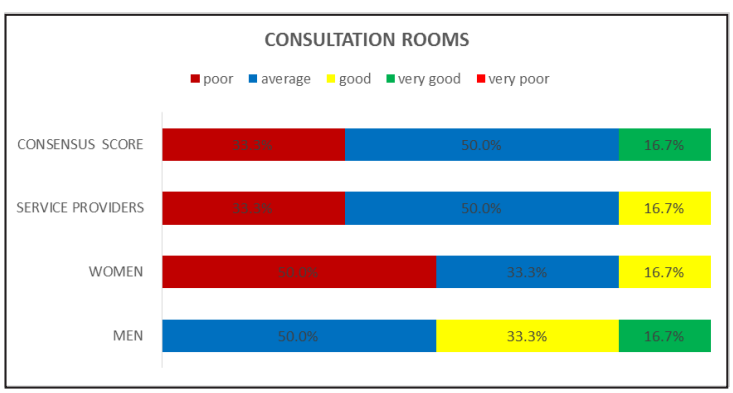
5.7 Availability of consultation rooms

Consultation rooms support counselling through improving privacy and confidentiality among the clients to develop good health seeking behavior. The scorecard assessed patients' privacy, confidentiality among the health workers and other necessity equipment needed to support patients to seek services and consult on the disease. During the interface meetings (consensus scoring), this was ranked as average by 66.7%, poor by 33.3% and very good by 16.7%.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

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

Figure 27: Availability of consultation rooms



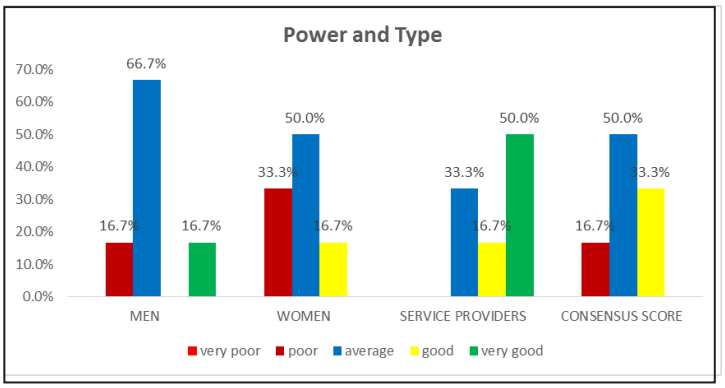
5.8. Availability of power & type

Power in health facility set up complement and support delivery of services. Scorecard assessed power extension to the laboratory and maternity ward and delivery rooms, regularity of power supplied, and the different power supplied. During the interface meeting 50% of the participants ranked the availability of power & type as average, 33.3% good and 16.7% as poor respectively.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The poor ranking was due to lack of electricity (hydro power) and solar panels, weak solar batteries, some wards not having power and frequent power blackouts. The key recommendation was that the government should connect facilities to the national grid (UMEME), generators (with fuel) and solar panels should be installed and have budgets for fuel to run generators.

Figure 28: Availability of power & type



Solar Power in Nabilatuk HC IV

6.0. 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.

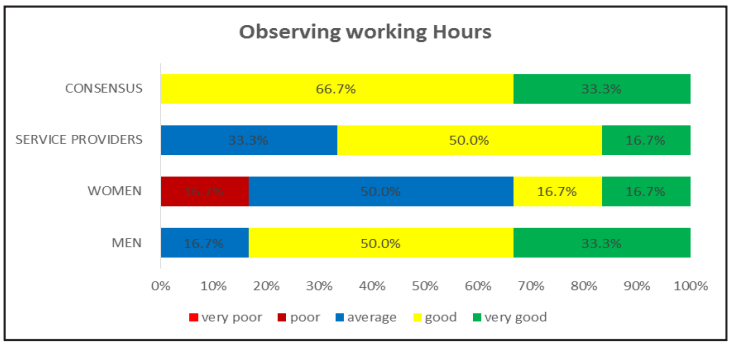
6.1. Observing working hours

According to NSP (2015/16-2019/20), strengthening the system was hinged on addressing the issue of human resources from the perspectives, namely, provision of adequate number of resource persons, management capacity of key health workers to strengthen service delivery. During interface meeting 66.7% ranked it as good, 33.3% as both very good service.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

They attributed these scores to health workers reporting early to work irrespetctive of the shedules, health workers attending to patients in time, reporting early and leaving late amidst the schedules and HUMIC strong mornitoring of health workers. However, the challengess were; some had poor time management habits, inactive Health unit management committees to strenthen monitoring, 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 in place. Recommndations included; monitoring and follow ups to ensure compliance, recruiting more staff, introducing duty roaster, provide accomodation, empower and stregthen monitoing at the facility and introduce timesheet as part of human resource mangement and duty schedules detailing shifts.

Figure 29: observation of working hours



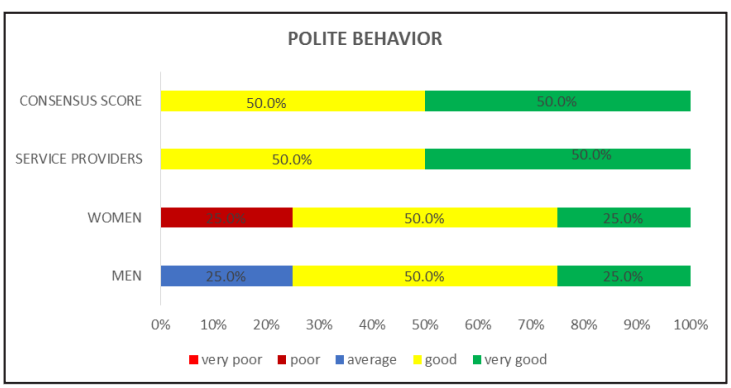
6.2. Polite behaviour

The Patients Charter 2009 guides on how health personnel are supposed to handle the patients 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 apprehended procedures provided in the patients' charter 2009. This included; health worker conduct when handling clients, the time given to clients when seeking medical information and/or care and the supporting systems to compliment structures. During the interface meeting 50% of the participant rated it as good and 50% as very good respectively.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC III	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The reasons for good score were; health workers offer ample time to listen to clients to support fully diagonosis of the disease, most of the patients know their rights and some clients narrated how diagnosis was being conducted on informed consent. The reasons for the low ranking by the particpants during the focus group discusions for both men and women were; inadequate staffing leading to work over load, stress and frustration, some health workers do not explain prescriptions to patients, patients' rudeness towards staff leads to some of the staff being rude to them (clients). They recommended sensitizing of staff on patient handling, change of behaviour and encouraging application of medical ethics, increasing on the number of medical staff to reduce on the work load and sentizing of the community on their rights, responsibilities and how to work in harmony with the health personnel.

Figure 30: Polite behavior



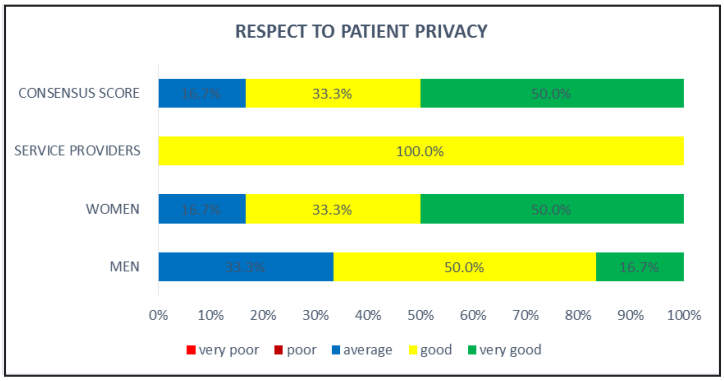
6.3 Listening to client/patients problems

In order to manage disease diagonasis in health care system, listening to patients' problems/ complaints complements adherence to care and treatment. In Nakapiripirit scorecard assessd the patients redress, (patients being assisted on their rights, health workers receive, investigations & process patients complaints and health workers' capacity to listen to patients complaints). During the interface meeting (consesus score) 33.3% ranked it as very good, good and average respectively.

Tokora HC IV	Nabilatuk HC IV	Lorachat HC IV	Nakapiripirit HC III	Moruita Brigadier 407 HC III	Namalu HC III

The good ranking was based on availability of consultations and examination, adequate infrastructure and utilities for confidentiality (private rooms with curtains and screens). Where the rooms were not adequate health workers improvised. However, there were gaps; inadequate infrastructure such as consultation room, 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 screens and curtains.

Figure 32: Respect for patients Privacy



7.0 CONCLUSIONS

Based on the findings, the assessment concludes that the district has made efforts to provide HIV&AIDS services. There are however some constraints that are affecting the service delivery ranging from limited staffing, stock out of drugs more especially for children, limited follow up of patients, stock outs of reagents, negative attitude to condom use and family planning services, long distance to health care facilities, long turnaround time to receive viral load test results, existing of emerging key populations and migratory communities such as those in mining areas and limited information on HIV in the local language

8.0 RECOMMENDATIONS

Line ministries, departments and agencies (MOH, Ministry of Public Service, Ministry of Finance, Planning and Economic Development, Uganda AIDS Commission), Local government, Religious leaders, health facilities, NAFOPHANU and Implementing partners.

- The Ministry of Health (MoH) and the district service commission should recruit more health workers to fill up the staffing gaps and reduce on the waiting time that clients take to see health workers. Additionally, the staff should be well motivated by payment of hardship allowance
- National Medical Stores should ensure constant supplies of drugs and reagents including testing kits to reduce on drug stock outs.
- There is need to continue with community sensitisation sessions by the district local government, health facilities and VHTs on family planning benefits and maternal health services.
- Sensitisation on patients' 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.
- The health in charges should undertake community sensitisation on the 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 Centres which are located very far and provide a budget for their maintenance
- There is need to train health workers on legal and human rights to enable them support the community more efficiently.
- There is need to involve religious leaders, clan leaders, kraal leaders and cultural leaders on issues of sexual gender based violence
- The MoH and district local governments should construct more structures and equip them with facilities to support expeditious diagnosis of client/patient 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

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