NAFOPHANU

USING COMMUNITY SCORECARD TO ASSESS THE QUALITY OF SEXUAL REPRODUCTIVE HEALTH AND RIGHTS (SRHR) AND HIV SERVICE DELIVERY IN ISINGIRO DISTRICT

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ACKNOWLEDGEMENT

Empowering recipients of care and service providers to assess quality of health service delivery has over time enabled a more critical understanding of what actually goes on in our health facilities and appropriate recommendations made. It also provides feedback to government and its partners, both state and none state, to replicate best practices and address the identified gaps.

NAFOPHANU is grateful to Swedish International Development Agency (SIDA) that funded the Community Score Card survey in Isingiro District through the Centre for Health Human Rights and Development (CEHURD). Isingiro District Local Government represented by the District Health officer (DHO) and District HIV Focal Person, Isingiro District Forum of People Living with HIV headed by Ms. Resty Mbabazi, research assistants, data analyst and NAFOPHANU staff that actively participated in the exercise.

Special appreciation goes to the staff of the selected health facilities of Rwekubo HCIV, Kabuyanda HCIV, Nyamuyanja HCIV, Kakoma HCIII, Ngarama HCIII and Kikagate HCIII and PLHIV representatives that participated in the score card survey. It is as a result of their participation that this report has come out.

Delivery of Sexual Reproductive health and Rights (SRHR) and HIV services remains core as we serve the community members at various levels.

Together for a Positive Difference!

Stella Kentutsi
Executive Director

ACRONYMS

AIDS	:	Acquired Immune Deficiency Syndrome
ANC	:	Ante-natal Care
ART	:	Anti-Retro Viral Treatment
ASRH	:	Adolescent Sexual Reproductive Health
CBO	:	Community Based Organization
CEHURD	:	Centre for Health Human Rights and Development
CSC	:	Community Scorecard
CSO	:	Civil Society Organization
DHO	:	District Health Officer
DHT	:	District Health Team
DLG	:	District Local Government
eMTCT	:	elimination of Mother-to-Child Transmission of HIV
FGDs	:	Focus Group Discussion
FP	:	Family Planning
GBV	:	Gender Based Violence
HC	:	Health Centre
HIV	:	Human Immune Virus
HTS	:	HIV Counseling Testing Services
IEC/BCC	:	Information Education Communication/Behavioral Change Communication
IPs	:	Implementing Partners
LC	:	Local Council
MNCH	:	Maternal Neonatal and Child Health
MoGLSD	:	Ministry of Gender Labour and Social Development
MoH	:	Ministry of Health
MTI	:	Medical Teams International
NAFOPHANU:		National Forum of People Living with HIV/AIDS Networks in Uganda
NSP	:	National Strategic Plan
OIs	:	Opportunistic Infections
OVC	:	Orphans and Other Vulnerable Children
PEP	:	Post Exposure Prophylaxis
PHC	:	Primary Health Care
PLHIV	:	People Living with HIV
PNC	:	Post-Natal care
PrEP	:	Pre-Exposure Prophylaxis
RHITES SW	:	Regional Health Integration to Enhance Services in South-West Uganda
SGBV	:	Sexual Gender Based Violence
SIDA	:	Swedish International Development Agency
SMC	:	Safe Male Circumcision
SRHR	:	Sexual Reproductive Health Rights
STIs/STDs	:	Sexually Transmitted Infections/Sexually Transmitted Diseases
UAC	:	Uganda AIDS Commission
VHT	:	Village Health Team(s)

KEY DEFINITIONS

Adolescence
Is a period of transition from childhood to adulthood. It is characterized by physical, psychological, social and behavioural changes between ages 10-19 years. Therefore, an adolescent is a person aged 10-19 years.

Adolescent sexual and reproductive health
Refers to the physical and emotional wellbeing of adolescents and includes their ability to remain free from unwanted pregnancy, unsafe abortion, STIs (including HIV&AIDS) and all forms of sexual violence and coercion.

Antiretroviral Therapy (ART)
Is treatment with antiretroviral (ARVs) drugs that inhibit the ability of HIV to multiply in the body, leading to improved health and survival of HIV positive persons

Community Score Card (CSC)
Is a participatory, community based monitoring and evaluation tool that enables citizens to assess the quality of priority public services such as health, school, public transport, water among others.

Gender Based Violence (GBV)
Refers to any act that is perpetrated against persons connected to the normative understanding of their gender. It can be physical, emotional, psychosocial or sexual in nature

Psychosocial Support (PSS)
Refers to all actions and processes that enable People Living with and those affected by HIV to cope with stressors in their won environment and to develop resilience and reach their full potential.

Reproductive Health (RH)
Is a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or medical condition in all matters relating to the reproductive system, its functions and processes.

Sexual Gender Based Violence (SGBV)
Is any sexual act or unwanted sexual comments or advances using coercion, threats of harm of physical force by any person, regardless of their relationship to the victim, in any setting. Thus, it includes forced sex, sexual coercion, rape of adult and adolescent men and women as well as child sexual abuse.

Sexual Reproductive Health and Rights (SRHR)
Refers to concept of human rights applied to sexuality and reproduction

Social accountability
Refers to actions initiated by citizen groups to hold public officials, politicians and service providers accountable for their conduct and performance in terms of delivering services, improving people's welfare and protecting people's rights.

Youth Friendly services (YFS)
Are services that all adolescents and young people are able to obtain. These services should meet adolescents' expectations and needs and improve their health. **A "youth-friendly corner,"** is a private space set apart from the rest of the health facility were young people can freely come and go without worrying about adult interaction

EXECUTIVE SUMMARY

With support from Centre for Health Human Rights and Development (CEHURD) under the Joint Advocacy on Sexual Reproductive Health and Rights (JAS) programme funded by Swedish Agency for International Development (SIDA), the National Forum of People Living with HIV/AIDS Networks in Uganda (NAFOPHANU) a conducted a community scorecard to assess the quality of Sexual Reproductive Health (SRHR) and HIV services in Isingiro district. A community scorecard is a participatory, community based monitoring and evaluation tool that enables citizens/beneficiaries to assess the quality of services they receive such as health, education, transport, water, waste disposal systems among others.

The assessment covered six (6) health facilities (HCs) of Kakoma HC III, Ngarama HC III, Kikagate HC III, Nyamuyanja HC IV, Rwekubo HC IV and Kabuyanda HC IV that were purposively selected to represent the various constituencies, health facility levels and the population served in the district reaching 126 respondents (50 Male, 76 Female). These were reached through focus group discussions and interface meetings with service beneficiaries and service providers for consensus scoring. Both quantitative and qualitative data was also obtained through desk reviews and direct observations. Findings are presented in color coding, frequency tables and graphs as well as the qualitative components capturing community voices.

The indicators assessed were based largely on the thematic areas of prevention, care and treatment social support and systems strengthening such as staffing, equipment and utilities for SRHR, HIV and other integrated services These were; access to Ante Natal Care (ANC) services, Condom supply and distribution, Testing services, Mentorship and coaching Programs, access to Gender based Violence (GBV) services, Family Planning (FP), Adolescent HIV services, Integrated TB services, Nutrition services, Home Based Care, Treatment for Opportunistic Infections (OIs), Legal Support and Protection, Capacity Building for Care Givers, Rights Awareness, Psychosocial Support (PSS), as well as staff attitude towards work.

Rated as good was ANC including eMTCT programme, male condoms, testing services, family planning, STI treatment, integrated TB services, staff attitude towards work and power supply. Fairly rated was safe male circumcision (SMC), IEC materials, Gender based services (GBV), mentorship of peer buddies, youth friendly services, nutrition, psychosocial support, building capacity of care givers, rights awareness and support, clean and safe water, communication gadgets and staff accommodation. Poorly scored was female condoms, cancer screening, home based care, legal support and transport means. There were concerns were sporadic stock outs of drugs and other supplies, understaffing, lack of transport means, lack of youth friendly services, poor referral systems, limited capacity building among others. On staffing norms, Nyamuyanja HCIV had 77%, Rwekubo HCIV had 85%, Kabuyanda HCIV had 79%, Kakoma HCIII had 53%, Ngarama HCIII had 68% and Kikagate had 74%, with most facilities missing critical staff which led to multitasking. Space, equipment and utilities were inadequate.

The key recommendations raised included infrastructural development, recruitment of more staff to fill the existing gaps, SRHR/HIV integrated wok plans, provision of staff accommodation, regular supply of drugs and supplies to reduce on sporadic stock outs, continuous community sensitisation on various health aspects to prevent new infections and enable access to already available services.

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1.0 INTRODUCTION

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

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

Despite the above efforts, there are still challenges that affect the delivery of health care services. According to HSDP, HIV, malaria, lower respiratory infections, meningitis and tuberculosis are the leading cause of death in the country. In additional, inadequate health workforce and infrastructure is still a key bottleneck to access and utilization of services. The above situation needs to be urgently addressed for the country to meet the SDG targets on health by 2030. More especially, target 3 of SDG 3 that states that "by 2030, end the epidemics of AIDS, TB, malaria and Neglected Tropical Diseases, and combat hepatitis, water-borne diseases and other communicable diseases."

1.1 Background

With support from Centre for Health Human Rights and Development (CEHURD) under the Joint Advocacy on Sexual Reproductive Health and Rights (JAS) programme funded by Swedish Agency for International Development (SIDA), the National Forum of People Living with HIV/AIDS Networks in Uganda (NAFOPHANU) a conducted a community scorecard to assess the quality of Sexual Reproductive Health (SRHR) and HIV services in Isingiro district. This was to track and measure critical indicators in each of the key thematic areas of the SRHR and HIV response taking into consideration pregnancy, childbirth, postnatal and childhood and other cross-cutting issues, to enable stakeholders including service users to provide systematic and constructive feedback about the performance and benefits of the SRHR, HIV and other critical interventions. In order to strengthen accountability, a common agreement was derived to fully engage and support the communities to hold the duty bearers accountable on services that they receive.

The assessment covered areas of country policy on SRHR and HIV but also cognizant of MCHNB and GBV and premised on a number of policies/strategies such as Adolescent and Sexual Reproductive Health Guidelines of 2012, National HIV Strategic Plan (NSP) 2020/2021-2024-2025 and Gender Based Violence Policy of 2016. Therefore, the community score card was conducted in the selected health facilities of Isingiro district to inform programming where service delivery best practices are raised for replication and gaps identified for redress.

1.2 Understanding the SRHR Policy, NSP and GBV Policy context in Uganda

This aims at providing deeper understanding of country policy framework on SRHR/HIV and how best to enhance social accountability to strengthen SRHR and HIV Policy implementation thereby enhancing the delivery of services to both young and old, living with and affected by HIV in an integrated manner.

1.2.1 National HIV Strategic Plan (NSP) 2020/21-2024/25

The NSP has adopted a prioritized scale up scenario that envisions scaling up of a comprehensive set of interventions to the maximum feasible coverage. The interventions include HIV testing services, ART, condoms especially male condoms, safe male circumcision, eMTCT, Early Infant Diagnosis (EID) and programme for Key Populations (KPs). The enablers that are expected to influence uptake of key services include social and behavioral change communication (SBCC), stigma and discrimination, violence prevention, as well as interventions targeting adolescent girls and young women. Expected as a result of this scaled up, new HIV infections are expected to decline by 71% between 2019 and 2025, reaching 15,000 in 2025, and would avert 72,000 of new HIV infections during this period, and about 43% of the infections that would have otherwise occurred. The thematic areas of prevention, care and treatment, social support and systems strengthening remain the pillars of the NSP. Ending AIDS as a public health threat by 2030 remains a big driving force of the NSP and as guided by the Presidential Fast Track Initiative.

1.2.2 National Policy on Elimination of Gender Based Violence (2016)

The Government of Uganda recognizes the burden that gender inequality and Gender Based Violence (GBV) place on social and economic development. The Policy defines GBV as acts perpetrated against women, men, girls and boys on the basis of their gender which cause or could cause them physical, sexual, psychological, emotional or economic harm, including the threat to take such acts, or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peacetime and during situations of armed or other forms of conflict. The policy emphasizes increasing access to Gender Based Violence (GBV) and gender-based discrimination prevention programs in various settings, increase access to multi-sectoral response (remedial and protection) services for survivors of GBV, strengthening government capacity to implement GBV prevention and response programs with a focus on work-place and community level interventions. Mainstreaming GBV in all sectors with an aspect of managing cases and creating awareness at all levels is recommended.

1.2.3 Adolescent Health Policy Guidelines and Service Standards (2012)

The policy aims at rationalizing the provision of adolescent-friendly health services to the beneficiaries and provide for a minimum package of services to be considered adolescent- friendly while at the same time ensuring national uniformity in their provision. Whereas adolescents can access services for malaria and other common illnesses, they tend to shy away from SRH/HIV/GBV/Family Planning services. Hence the policy addresses factors affecting uptake of services by adolescents such as long waiting time and queues, and how the adolescents and young people can be managed when they access available services.

1.2.4 Adolescent Sexual Reproductive Health (ASRH) Guidelines (2012)

Adolescents are a heterogeneous group with different needs for health information, education and services. Reproductive health services are a basic human right for all people including adolescents. The participation and involvement of adolescents in planning, implementation, monitoring and evaluation of programmes is of critical importance to ensure that their needs are fully addressed. Community involvement and parental support are crucial for sustainable adolescent reproductive health programmes. ASRH guidelines encompass promotive, preventive, curative and rehabilitative care and promote gender equality and equity. Effective and sustainable adolescent reproductive health services require human resource development, strategic leadership, knowledge management, dissemination of lessons and institutional capacity building. Adolescent reproductive health needs are immense and to address them holistically, special mechanisms for networking and partnerships between various stakeholders are essential. Hence, the policy focuses on provision and increasing availability and accessibility of appropriate, acceptable, affordable quality information and health services to adolescents; creating an enabling legal and social-cultural environment that promotes provision of better health and information services for young people; protect and promote the rights of adolescents to health, education, information and care and train providers and reorient them on health system at all levels to better focus and meet special needs of adolescents.

1.3 Profile of Isingiro District

Isingiro District is located in Western Uganda. It is bordered by Mbarara to the North West, Ntungamo to the West, Kiruhura to the North, Rakai to the East and Tanzania to the South. The District currently has Town Councils of Kabuyanda, Kaberebere, Isingiro, Kamubeizi, Kikagate, Bugango, Ruhiira and Endiinzi. Isingiro also has Sub Counties of Birere, Endiinzi, Kabingo, Kabuyanda, Kakamba, Kashumba, Kikagate, Masha, Mbaare, Ngarama, Nyakitunda, Nyamuyanja, Ruborogota, Rugaaga and Rushasha. There are two refugee settlements namely Nakivale and Oruchinga which are managed by the Office of the Prime Minister, United Nations High Commission for Refugees among other relief and implementing partners.

As per the population census 2014, Isingiro District had a population of 540,650 people with 108,112 Refugees. For Fiancial year (FY) 2019/2020, the projected population 636,941, with nationals 496,788 and 140153 Refugees, (7913 in Oruchinga and 132240 in Nakivale settlement). The district had a refugee influx during the third quarter of FY 2019-2020. There are 3 HSDs - Isingiro North, Isingiro South and Bukanga with 73 reporting Health Units, 4 HC IV, 20 HC III, and 49 HC II. With 56 Government owned Health units (inclusive of Isingiro Police HC II and Isingiro Prisons HC II, 10 PNFP owned Health Units (PNFPs) and 7 PFPs. There are 36 Health facilities offering MCH services, HIV and SRHR services been rendered to the community. Isingiro has 27 ART sites.

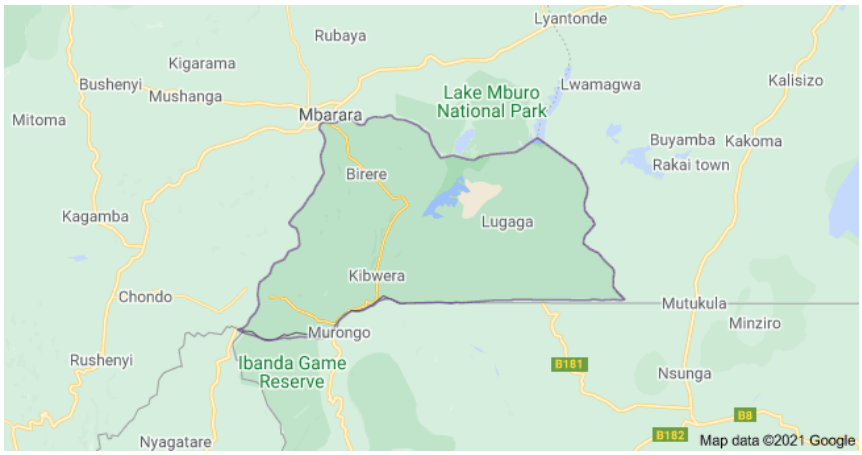


Fig. 1: Maps of Isingiro showing boundaries

Key partners that are currently supporting HIV/SRHR work in Isingiro district include UNICEF, Baylor Uganda, Regional Health Integration to Enhance Services in South-West Uganda Project (RHITES SW)/ Elizabeth Glazer Paediatric Foundation (EGPAF), The AIDS Support Organisation (TASO), UNHCR/medical Teams International (MTI), AIDS Information Centre, Marie Stopes International Uganda, UNAIDS- HISP, Alliance of Women Advocating for Change (AWAC), World Food Programme (WFP) among others.

1.4 Scope of the assessment

This Assessment covered three (3) health centre III facilities and three (3) health centre IV facilities in Isingiro district. A mixture of approaches and methods were used in undertaking this assessment. The assessment involved examining the quality of health service delivery in health facilities with Focus Group Discussions (FGD) for community members and health workers to get the feedback on the services offered and later joined interface meetings to agree on final score. The participants, both male and female, ranged from adolescents, young people and adult PLHIV from the community as service beneficiaries but also health workers who represented service providers.

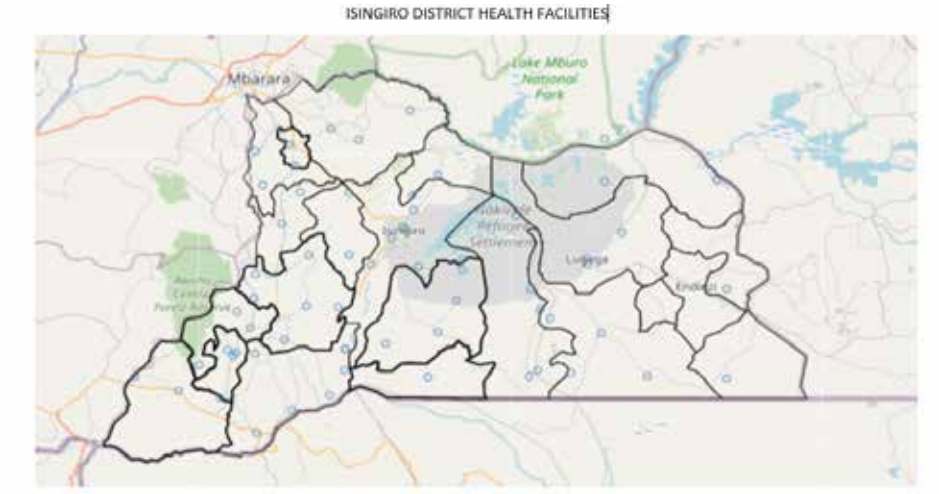


Figure 2: Map showing all health facilities in Isingiro District, shown by blue dots

1.5 Assessment design

Based on the SRHR related policies, GBV policy and NSP, the scorecard assessment used a cross-sectional design comprising of both qualitative and quantitative methods. The major source of information included review of secondary data, FGDs of the service users (men and women), service providers, interface meetings for consensus score, input tracking including physical check-up for facility equipment, infrastructure and utilities as well as observations of the nature of service delivery.

1.6 Study population

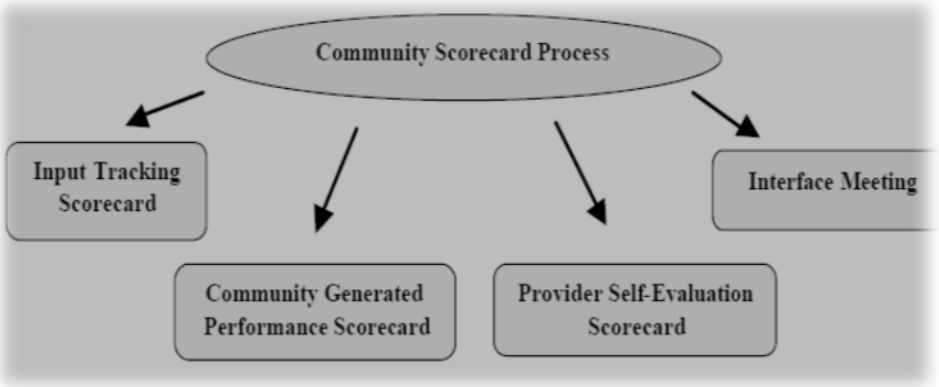
The study was undertaken in a catchment of six health centers; three (3) Health Centres IIIs and three HC IVs in Isingiro District, reaching 126 participants with 50 men and 76 women.

1.7 Study Participants for both qualitative and quantitative approaches

Participants for qualitative and quantitative were purposively selected being cognizant of various categories that included; all age and gender categories for recipients of care within the catchment of each health facility on one hand and then health workers working at each particular health facility.

2.0 METHODOLOGY

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



Source: Janmejay & Parmesh (2009)

2.1 Objectives of the Community Score Card

1. To empower the service beneficiaries (adolescents and young people, men and women) to assess the quality of SRHR and HIV services in Isingiro district.
2. To enable the service providers self-evaluate the quality of SRHR and HIV services offered to the community.
3. To make recommendations on how SRHR and HIV service delivery can be improved by both state and non-state actors.

2.2 Inception meeting

The pre-entry meeting was held between the survey team and the District Health Officer for information and authorization to carry out the study. The meeting helped create good understanding and working relationship between the different parties and also predetermined which facilities to participate in the score card assessment.

2.3 Demographic Representation

The study was conducted in a catchment of 6 health facilities in Isingiro district. Eighteen (18) Focus Group Discussions (FGDs) attended by groups of; adolescent and young men (15-24 years), adolescent girls and young women (15-24 years), men and women 25 years and above and service providers were carried out in each of the 6 health facilities. Six (6) interface meetings were held and attended by representatives from the eighteen (18) groups that participated in the FGDs and brainstormed final score that rated availability and quality of the services being rendered and made recommendations to improve the quality of services.

Table 1: Study demographic characteristics at health facility level

Name of Facility	Level III	FGDs (N)	Interface meetings (N)	Male	Female	Total
Nyamuyanja	HC IV	3	1	12	13	25
Rwekubo	HC IV	3	1	6	17	23
Kabuyanda	HC IV	3	1	13	14	27
Kakoma	HC III	3	1	8	9	17
Ngarama	HC III	3	1	7	15	22
Kikagate	HC III	3	1	4	8	12
TOTAL	6	**18**	**6**	**50**	**76**	**126**

2.3.1 Quantitative Data collection methods

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

2.3.2 Input tracking

In Isingiro District, six (6) health facilities were visited to gather information on key inputs that included staff as well as infrastructural facilities that were being used to deliver health services at each of the health facilities.

2.3.3 Focus Group Discussions

The focus group discussions were used to collect both qualitative and quantitative data from both service users and service providers, each group scoring separately.

2.3.5 Interface Meeting

Joint meetings targeting service users (community PLHIV members) and service providers 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 key recommendations on how to address the identified gaps.

Interface meeting at Kakoma HCIII

FGD at Ngarama HC II

Interface meeting at Rwekubo HCIV

Interface meeting at Kabuyanda HCIV

Interface meeting at Kikagate HCIII

Interface meeting at Nyamuyanja HCIV

2.4 Data Management and Analysis

Quantitative data was entered in Excel data form. Qualitative data was collected through FGDs and interface meetings and analyzed using thematic analysis and community voices captured as well.

2.5 Quality Assurance

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

2.6 Ethical Considerations

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

3.0 FINDINGS

This section presents results from the findings generated during the community scorecard conducted in Isingiro District under systems strengthening, prevention, care and treatment, social support and protection.

3.1 System strengthening (Staff Tracking)

In order to provide information and services for SRHR/HIV staffing is crucial. The assessment, however, examined the entire staffing status bearing in mind that a number of staff tend to multi task and issues for human resources for health are part of an advocacy agenda. Based on staff requirements outlined in MoH Guidelines (1995), tracking was done on staffing norms to ascertain different staff categories available at the health care facilities visited that included 3 Health Centre IVs and 3 Health Centre IIIs. The assessment looked at staffing as a whole not necessary focusing on staff competencies and skills in SRHR and HIV as a result of multitasking of health worker(s).

3.1.1 Staffing at Nyamuyanja, Rwekubo and Kabuyanda HC IVs

A total of 48 staff are required in every Health Centre IV categorized as Medical Health Workers, Allied Health professionals, Dental, Pharmacy Nursing) and Support staff. Nyamuyanja, Rwekubo and Kabuyanda HCIVs had staffing issues as per expected HCIV level though some cadres were missing, thus had extra staff in certain positions as reflected in Table below

Table 2: Staffing levels at HC IVs

Staff cadres	Norm	Nyamuyanja HC IV		Rwekubo HC IV		Kabuyanda HC IV	
		Actual	Gap	Actual	Gap	Actual	Gap
Sen. Medical Officer	1	0	1	1	0	0	1
Medical Officer	1	1	0	4	+3	3	+2
Senior Nursing Officer	1	0	1	0	0	2	+1
Public Health Nurse	1	0	1	0	1	1	0
Clinical Officers	2	1	1	4	+2	3	+1
Ophthalmic Clinical Officer	1	0	1	0	1	0	1
Health Inspectors	2	0	2	0	2	1	1
Dispenser	1	0	1	1	0	0	1
Public Health Dental Officer	1	1	0	1	0	1	0
Lab. Technician	1	0	1	5	+4	1	0
Ass. Entomological Officer	1	0	1	0	1	0	1
Nursing Officer(Nursing)	1	1	0	1	0	1	0
Nursing Officer(Midwifery)	1	0	1	0	1	0	1
Nursing Officer (Psychiatry)	1	1	0	1	0	0	1
Ass. Health Educator	1	0	1	0	1	0	1
Anesthetic Officer	1	0	1	0	1	1	0
Theatre Assistants	2	1	1	4	+2	0	2

Staff cadres	Norm	Nyamuyanja HC IV		Rwekubo HC IV		Kabuyanda HC IV	
		Actual	Gap	Actual	Gap	Actual	Gap
Anesthetic Assistants	2	0	2	0	2	0	2
Enrolled Psychiatric Nurse	1	0	1	1	0	1	0
Enrolled Nurses	3	4	+1	9	+6	5	+2
Enrolled Mid-Wives	3	5	+2	4	+1	6	+3
Cold Chain Assistant	1	0	1	0	1	0	1
Office Typist/Secretary	1	0	1	0	1	0	1
Lab. Assistant	1	2	+1	0	2	2	+1
Stores Assistant	1	0	1	0	1	0	1
Accounts Assistant	1	1	0	0	1	1	0
Health Assistant	1	1	0	0	1	0	1
Health Information Assistant	1	1	0	1	0	1	0
Nursing Assistants	5	3	2	1	4	2	3
Driver	1	1	0	1	0	1	0
Askari/guards	3	1	2	0	3	2	1
Porters	3	12	-	2	1	3	0
Total	**48**	**37**	**24 (+4)**	**41**	**25 (+13)**	**38**	**20 (+10)**

From the table above, Nyamuyanja had 77% staffing levels but critical staff were missing, for instance, the theatre was nonfunctional because the facility lacked an anesthetist and a theatre assistant. At Rwekubo, staffing was at 85% with some seconded staff at theatre and pharmacy by MTI. At Kabuyanda HCIV, staffing was at 79%. To note is that these HCIVs are high volume sites, serving over 200 patients daily and hence require more than 100% to serve the populace in and around the facilities, including referrals from lower level facilities.

'Our facility is a high volume site that even though we have most of the required staff, there is still a lot of extra support needed. We serve many people every day.' In Charge, Rwekubo HCIV

3.1.2 Staffing at Kakoma, Ngarama and Kikagate Health Centre IIIs

A total of 19 personnel are expected at HCIII including allied health staff (Senior Clinical Officer, Clinical officer, laboratory technician, laboratory assistant and health assistant), Administrative staff (Health information assistants), Nursing (nursing officer, Enrolled Nurse, Enrolled midwife and Nursing assistants), Support staff (Askari and Porter)

Table 3: Adherence to staffing norms in health centre IIIs

Staffing norms		Kakoma HC III		Ngarama HC III		Kikagate HC III	
	Norm	Actual	Gap	Actual	Gap	Actual	Gap
Senior Clinical Officer	1	0	1	1	0	0	1
Clinical Officer	1	1	0	0	1	1	0
Nursing Officer	1	1	0	1	0	1	0
Lab. Technician	1	0	1	1	0	0	1
Enrolled Mid-Wife	2	1	1	2	0	2	0
Enrolled Nurse	3	1	2	4	+1	5	+2
Lab. Assistant	1	2	+1	0	1	1	0

Health Assistant	1	1	0	1	0	1	0
Nursing Assistant	3	0	3	1	2	0	3
Health Information Assistant	1	0	1	0	1	1	0
Askari/guards	2	1	1	1	1	0	2
Porter/cleaner	2	1	1	1	1	2	0
Cashier		1		NA		NA	

Staffing at Kakoma HCIII that handles between 20 - 30 patients daily was at 53% and being a church founded facility, had a cashier. Ngarama HCIII, serving between 40-80 patients daily had 68% staffing norm with a good number of critical staff missing. Kikagate HCIII handling between 40-80 patients daily had 74% staffing and also had critical staff missing. On a good note, 2 Enrolled Nurses were added to make 5 out of existing three (3). There is a gap of 3 Nursing Assistants who may not be replaced by government since they are being phased out.

'Although we are at HCIII level, work is overwhelming to have only 19 staff as per government guideline, who again unfortunately are not all on the ground. We need to have this revised as a HCIII serves an entire sub county and beyond.' Health Worker, Ngarama HCIII

'As a community, we are worried over our pregnant women. Imagine we have only two midwives, so when one is off, the burden falls on the remaining midwife. We know nurses come in to help but they are also busy doing their chores. This norm must be revised.' Female participant, Kikagate HCIII

3.2 System Strengthening (Input Tracking: Infrastructure)

Health facilities infrastructure such as buildings, consultation/treatment rooms, theatres, wards, and others provide a conducive environment for patients to seek health services. It also enables health service providers to operate in a professional manner including ensuring privacy which is a critical ethical issue in health services such as HIV, SRHR and other integrated services. Structural elements of the outpatient and the inpatient departments of the Health Centre IV and III were assessed for existence, functionality and performance. Equipment and infrastructure remain inadequate in all the facilities visited in Isingiro District as per presentations in subsequent sections. The facilities improvise a lot to serve the community members.

3.2.1 Out Patient Department (OPD) and In Patient Department (IPD) at health Centre IV level

In a Health Care Centre, Out Patient Department (OPD) is part of facility designed for diagnosis and treatment of patients by health workers and return to their places of aboard. This so common for SRHR/ HIV cases that report to a facility and return home, unless it is giving birth or a person has a serious condition requiring admission. Under OPD, the assessment examined health education, consulting, examination and counseling rooms, dental clinic, dispensing room, ART clinic, drug store, examination room, laboratory, treatment room, Uganda National Expanded Programme for Immunization (UNEPI) records, operating theatre, and early infant diagnosis among others as per Ministry of Health Guidelines (2000).

For IPD, patients that need routine 24 hour monitoring/observation and attention are residents at a health centre until the health workers discharge them. Health care facilities from health centre IIIs on wards are supposed to admit patients according to their mandate. This requires spaces for wards for men, women, children, maternity and other specialised spaces such as for surgery and TB.

OPD and IPD at Nyamuyanja HCIV

Nyamuyanja HC IV services being offered.

Table 4: Input tracking: In Patient Department (IPD) and Out-patients' Department (OPD) at Nyamuyanja HC IV

Section	Indicator	Status	Comments
	OUT PATIENT DEAPARTMENT		
	Out patients clinic	Yes	Operational with dispensing area, waiting area and seats, weighing scales, small though for high number of patients
	Special out patients clinic	Yes	ART, ANC and Family Planning
	Examination room for clinical officer	No	Using clinical room as an examination room
	Examination room for medical officer	Yes	Available
	Injection room	Yes	But needs a bed
	Treatment room	No	Using injection room
	Waiting room	No	Use the OPD waiting area
	Multifunctional room	No	Not available
	MCH (ANT/FP)	Yes	Available
	MCH store	No	Improvising
	Laboratory	Yes	But with limited space
	Laboratory store	No	Improvising
	Blood bank	No	Not available
DENTAL DEPT	Treatment room	Yes	Have a dental room with necessary equipment
RADIOLOGY	Xray	No	Not done
	Radiology film processing	No	Not done
	Radiology waiting area	No	Not available

Section	Indicator	Status	Comments
GYNA & OBS DEPT	Treatment room	No	Improvising
PYSIOTHERAPY	Treatment room	No	Not done, referrals are given for patients requiring physiotherapy
OPERATING THEATRE	Changing room	Yes	Not in use as theatre is closed
	Locker area	No	Not available
	Operating theatre	Yes	But nonfunctional due to lack of anesthetist
GENERAL WARDS	**IN PATIENT DEPARTMENT**		
	Medical ward	Yes	The male and female wards existed at the facility, in clean environment
	Surgical ward	No	No operations are happening as theatre is closed
	Tuberculosis ward	No	No specific ward for TB patients at the facility, improvised with available spaces
MATERNITY (DELIVERY UNIT)	Maternity ward	Yes	Available, with bathroom and laundry area. Limit is space as facility has many deliveries
	Obstetrics/ gynecology wards	Yes	Serves those with abortions, ectopic pregnancy, septic infections, those with pregnancies below 28 weeks among others
	Pediatric ward	Yes	Few beds
	First stage labor	No	Admitted at maternity ward
	Mid wife office	No	Improvised in empty space
	Premature room	No	Referred or recommend warm clothes for the mothers that can afford referrals to Mbarara RRH
	Store	Yes	Available
	Nurse duty station	No	Improvised
	Central sterilization department	No	Not available
PHARMACY	Pharmacy dispensary	Yes	Have a pharmacy and dispensing room
	Preparation room	No	Not available, improvise
	Store	Yes	Have bulky store and main store
	Mortuary	No	Attendants are advised to take their bodies immediately
	Office	Yes	With only 2 seats for visitors
	Store	Yes	Available

Section	Indicator	Status	Comments
ADMINISTRATION	Conference room	No	All not available, staff improvise
	Library	No	
	Office matron	No	
	Reception	No	
	Staff tea room	No	
	Stores	No	
	Medical director's office	No	
KITCHEN AND LAUNDRY	Preparation Area	Yes	Available
	Store	No	Not available, improvise
	Wet area	No	
	Laundry	No	
	Laundry store for clean items	No	
	Laundry store area for dirty items	No	
	Generator room	No	What is available is hosting a nonfunctional generator

IPD ward and drug store at Nyamuyanja HCIV

OPD and IPD ward at Nyamuyanja HCIV

Female&Children's ward and improvised staff accommodation room at Nyamuyanja HCIV

3.2.2 In put tracking: In Patient Department (IPD) and Out-patients' Department (OPD) at Rwekubo HCIV

The functionality of IPD and OPD has a direct bearing on service delivery for SRHR/HIV and other integrated services. Table below gives status of Rwekubo HCIV at the time the score card was conducted in September 2020.

Table 5: Input ranking at Rwekubo HC IV

Section	Indicator		Status	Comments
OPD	**OUT PATIENT DEPARTMENT**			
	Out patients clinic		Yes	Operational with waiting area, seats and weighing scales. Space is limited as it is inside a building, no chance to expand unless a new one is constructed
	Special out patients clinic		Yes	ART, Family Planning, Ante Natal Care and immunisation
	Health Education		Yes	At ART clinic, space limited. Counselling and education rooms are available
	Examination room for clinical officer		Yes	Available
	Examination room for medical officer		Yes	Available with adequate space, bed, chair, table, screens, dustbins, sink
	Injection room		Yes	Available
	Treatment room		Yes	Limited space
	Waiting room		Yes	Inadequate space as facility is high volume
	Multifunctional room		Yes	Inadequate
	MCH (ANT/FP)		Yes	Available
	Laboratory		Yes	Available, with necessary equipment meeting desirable standards
	Laboratory store		Yes	Available
	Blood bank		Yes	Blood picked from Mbarara Blood Bank and stored in a designated fridge in the laboratory

Section	Indicator		Status	Comments
DENTAL DEPARTMENT	Treatment room		Yes	Available
GYNA & OBS DEPT	Treatment room		No	Cases handled in maternity ward
PYSIOTHERAPY	Treatment room		No	Improvise
OPERATING THEATRE	Changing room		Yes	Inadequate
	Locker area		Yes	Inadequate
	Operating theatre		Yes	Operational, but had only one oxygen cylinder supporting even other among departments/sections
GENERAL WARDS	**IN PATIENTS DEPARTMENT**			
	Medical ward		Yes	The male and female wards existed at the facility. But limited by space. No mosquito nets. Some patients sleep on the floor due to limited beds
	Surgical ward		No	There was no surgical ward, patients are referred to the general ward
	Tuberculosis ward		No	No specific ward for TB patients at the facility, improvised within available spaces
	Obstetrics/ gynecology wards	Yes	Serves those with abortions, ectopic pregnancy, septic infections, those with pregnancies below 28 weeks among others	
	Pediatric ward	Yes	Had ward and inadequate beds, linen and mosquito nets	
	Delivery room	Yes	Had two delivery beds	
	First stage labor	No	Mothers waited in maternity ward or labour room	
	Mid wife office	Yes	Small and squeezed, some functions such as sterilization was done in the same room.	
	Premature room	Yes	Available	
	Store	Yes	Squeezed, small and not well ventilated	

Section	Indicator		Status	Comments
PHARMACY	Pharmacy dispensary	Yes	Well spacious, well-furnished and well shelved. Medical Teams International (MTI) had just constructed a big pharmacy and store that was serving as a central hub for other facilities.	
	Preparation room	Yes	Had shelves and functioning equipment for keeping drugs	
	Store	Yes	Large, well-conditioned and organized	
	Mortuary	Yes	Had 2 mortuary centres, not in good condition, the refrigeration system was not well functioning and no office for the attendant	
	Office	No	Improvised in the preparation room	
	Store	Yes	Newly constructed with support from MTI, was large, well sectioned, organized and stocked	
KITCHEN AND LAUNDRY	Preparation Area	Yes	Had kitchen for patients but inadequate to support the many attendants	
	Store	No	No food supplements and food for the mothers and malnourished.	
	Wet area	No	Had no specific wet area, use the laundry.	
	Laundry	Yes	Had laundry area for maternity ward and theatre. Others used open spaces	
	Laundry store area	No	The facility had no linen and store areas for laundry.	
	Laundry store area	No	Had no specific laundry store for dirty linen.	
	Generator room	Yes	Had stand by generators, had the challenge of fueling	

Store at Rwekubo HCIV, supported by MTI

Theatre machine at Rwekubo HCIV

Theatre bed and OPD at Rwekubo HCIV

3.0.3 Input Tracking: In Patient Department (IPD) and Out-patient Department (OPD) Structure at Kabuyanda HC IV

Being a border health facility, Kabuyanda HCIV serves a multitude of Ugandans and Tanzanians. It is therefore imperative that all sections are functional to enable effective service delivery.

Table 6: Input tracking at Kabuyanda HCIV

Section	Indicator	Status	Comments
	OUT PATIENT DEPARTMENT		
	Out patients clinic	Yes	Available with waiting room and rooms for consultations/examination
	Special out patients clinic	Yes	Catering for ART, ANC, FP
	Examination room for clinical officer	Yes	Available
	Examination room for medical officer	Yes	Available
	Injection room	Yes	Well-furnished, ventilated with waiting area, screens, lighter, trolley and injection stretcher bed.
	Treatment room	Yes	Had bed from the ward, no stretcher bed, no bin and bin liners, no screens and room had poor hygiene. Used syringes and bottles were put in a paper box
	Waiting room	Yes	Spacious area with seats for clients and patients seeking appointments and treatment; shelter, seats, IEC materials and suggestion box.
	Multifunctional room	yes	Clean and well-furnished room. Services such as immunization and UNEPI programme, community engagements but also storage of vaccines, reagents and other supplies are kept
	MCH (ANT/FP)	Yes	Spacious well furnished with IEC materials, table, seats and examination bed.
	Laboratory	Yes	Spacious, well-furnished and ventilated with cabins and shelves, electricity connection, refrigerator and temperature monitoring machine
	Laboratory store	Yes	The laboratory store is fully stocked with laboratory equipment and reagents
	Blood bank	Yes	Blood is kept in the central laboratory and no specific room for blood

Section	Indicator	Status	Comments
DENTAL DEPT	Treatment room	No	Not available
GYNA & OBS DEPT	Treatment room	No	Improvised in the OPD treatment room
PYSIOTHERAPY	Treatment room	Yes	The room was small, squeezed and dusty
OPERATING THEATRE	Changing room	Yes	Available with adequate equipment and reagents
	Locker area	Yes	Available, with shelves and lockers
	Operating theatre	Yes	Operational, but had only one oxygen cylinder supporting even other among departments/ sections
GENERAL WARDS	**IN PATIENTS DEPARTMENT**		
	Medical ward	Yes	The male and female wards existed at the facility. But in poor condition and state
	Surgical ward	No	There is no surgical ward for the males,, they are referred to the general ward
	Tuberculosis ward	No	No specific ward for TB patients at the facility, improvised with available spaces
MATERNITY (DELIVERY UNIT)			Antenatal, maternity first labor, the post-natal and delivery wings and gynecology room existed at the facility, all done in the maternity ward
	Obstetrics/ gynecology wards	Yes	Available
	Pediatric ward	Yes	
	Delivery room	Yes	
	First stage labor	Yes	
	Mid wife office	Yes	
	Premature room	Yes	
	Store	Yes	
PHARMACY	Pharmacy dispensary	Yes	Available
	Preparation room	yes	
	Store	Yes	
	Mortuary	Yes	
	Office	No	Used dispensary area
	Store	Yes	Available

Section	Indicator	Status	Comments
KITCHEN AND LAUNDRY	Preparation Area	Yes	
	Store	No	
	Wet area	No	
	Laundry	Yes	
	Laundry store area	No	
	Laundry store area	No	
	Generator room	Yes	


Delivery bed and baby incubator at Kabuyanda HC IV

Theatre and female ward at Kabuyanda HCIV

3.3.0. IPD for Health Centre IIIs

IPD is concerned with patients who require admission. 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 stage labour, maternity waiting room, ward nurse stations and sterile store. The table below summarises status of IPD and OPD at Kakoma, Ngarama and Kikagate HCIIIs.

Table 5: Out and In-patient Department health centre III

Indicators	Kakoma HC III	Ngarama HC III	Kikagate HC III	Status
Counseling room	No	Yes	Yes	Kakoma had improvised counselling room services in the Clinician's office Kikagate HC III space not adequate
OPD Dispensing room	Yes	Yes	Yes	All had dispensing rooms and windows
Treatment room	Yes	Yes	Yes	All had but space limited
Laboratory	Yes	Yes	Yes	Kakoma HCIII functional, limited space, had a microscope Ngarama HC III functional, microscope missing a bulb Kikagate HC III had a functional lab missing running water.
OPD drug store	Yes	Yes	Yes	Existed at the three facilities and well organized
ART clinic	Yes	Yes		Available though space was limited.
Examination room	No	Yes	Yes	Kakoma HCIII improvised
Male ward	No	No	No	Had no wards for male patients, mixed up with women
Children/Female ward	No	No	No	All patients mixed up, space limiting
Linen store	No	No	No	The facilities had no linen store
Delivery Room	Yes	No	yes	Kikagate HC III-adequate with good delivery beds, screens, trolleys and running water Kakoma has 1 delivery bed with 1 midwife Ngarama HCIII had repairs and room adjustments going on
Maternity ward	Yes	No	Yes	Kikagate HC III-good but need more space due to high demand Ngarama HCIII was undergoing renovation
Maternity first labor	No	No	Yes	Kikagate HC III, good
Maternity waiting room	No	No	Yes	Kikagate HC III, good but inadequate
Ward nurse station	No	No	No	Kikagate HC III, has no nurses' station, turned to counselling room.
Sterile store	No	No	No	All not available

'Although Kakoma HC III offers maternity services and are functional, access to reproductive health information and services is limited due to having one staff to offer the services'. Expert Client, Kakoma HCIII

'Integrate HIV services to reduce stigma but also create space other than having specific ART clinic days. 'Peer Educator,Kikagate HC III

Construction of a new block at Kakoma HCIII

Ngarama HCIII main block

Delivery bed at Kikagate HCIII

Dispensing window at Kakoma H/C III

Dispensing area at Ngarama H/C III

Pharmacy at Kakoma H/C III

UNEPI at Kakoma HCIII

Drug store at Kakoma HCIII

The only ward at Kakoma HCIII

Repairs at Ngarama HCIII

UNEPI and some of the stored drugs at Kikagate HCIII

4.0 SERVICE DELIVERY ASSESSMENTS

This section provides results from the scoring by the community members and service providers on the performance of the health service delivery. Information gathered from interface meetings and focus group discussions was scored using the community score card technique. The participants included the community members as recipients of care that comprised of adolescents and young people (15-24 years), adult men and women as well as service providers. The assessment benchmarked service delivery in line with HIV/SRHR and other integrated hinged on prevention, care and treatment, social support and systems strengthening. Prior to the meetings, participants took on the parameters for the scoring of the services and the agreed consensus of scores included one (1) and colour red representing a poor service, two and colour yellow (2) representing a fair service and (3) with colour green representing a good service. The scoring was based on the participants' opinion guided by the standards of service as per the Government of Uganda (GoU) service delivery guidelines.

SCORE	VARIABLE	COLOR
3	Good	
2	Fair	
1	Poor	

4.1 SRHR/HIV: PREVENTION

The score card assessed levels of prevention efforts but also services provided such as quality of ANC services (eMTCT, Post ant natal care), Safe Male Circumcision, Provision of IEC/BCC materials, male and female condom supply, both male and female, testing services for HIV, pregnancy, cervical cancer and breast cancer screening, STIs and STDs screening, services, availability of mentorship programmes for the peer buddies, access to Sexual and Gender Based Violence Services (SGBV) services such as Post Exposure Prophylaxis (PEP) and availability of family planning services as the indicators for prevention.

Table 6: SRHR/HIV PREVENTION

Indicators	Nyamuyanja HCIV	Rwekubo HCIV	Kabuyanda HCIV	Kakoma HCIII	Ngarama HCIII	Kikagate HCIII
ANC (eMTCT, Post natal care) services						
Safe Male Circumcision						
IEC materials						
Male condom						
Female condom						
Testing (HIV)						
Testing (Pregnancy)						
Testing (STIs/STDs)						
Testing (cancer)						
Family Planning						
SGBV						
Mentorship of peer buddies						

KEY	Poor	Fair	Good

4.1.1 Ante Natal care (ANC), EMTCT and Post natal care Services

According to WHO 2016, ANC reduces maternal and prenatal morbidity and mortality both directly, through detection and treatment of pregnancy-related complications, and indirectly, through the identification of women and girls at increased risk of developing complications during labour, delivery and post-delivery, thus ensuring referral to an appropriate level of care. ANC should be provided by skilled health-care professionals to pregnant women to ensure the best health conditions for both mother and baby during pregnancy. The components of ANC include: risk identification; prevention and management of pregnancy-related or concurrent diseases; and health education and promotion. If mother is HIV positive, eMTCT is applied. The score card examined availability of ANC services, screenings, STIs treatment, integration at maternity, access to post-natal and abortion care, leaders' engagement and community perception. During the interface meeting for consensus score, all facilities rated quality of ANC services as good.

Category	Nyamuyanja HC IV	Rwekubo HCIV	Kabuyanda HC IV	Kakoma HC III	Ngarama HCIII	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The good score in all the facilities was as a result of provision of ANC services that ranged from regular physical examination for pregnant women, provision of medication such as folic acid and multi vitamins, mama kits for delivery, actual deliveries and support to mothers and babies after delivery. Referrals were done as appropriate. The elimination of Mother to Child Transmission (eMTCT) programme to ensure delivery of HIV free babies was being undertaken in all the facilities. For instance, Rwekubo had good eMTCT progamme and health workers do their best to handle eMTCT programmes that they had not had cases of HIV+ babies. Despite the good ranking, there were gaps that require redress to make ANC care effective and efficient. For instance at Ngarama HCIII, men do not escort their wives, no electricity and solar and so, use paraffin based lamp 'katadoba', had one midwife causing heavy work overload, no gloves, maternity ward was dirty and being renovated while post natal was usually one day and then discharged. There were also few beds in maternity ward. Recommendations: recruit more staff and create a platform to engage men to interest them more in supporting their spouses during and post natal period.

Delivery bed at Ngarama HCIII

Newly constructed Maternity ward at Kikagate HCIII

ANC room at Nyamuyanja HCIV

Maternity ward at Rwekubo HCIV

4.1.2 Availability of Safe Male Circumcision (SMC) Services

In September 2010, the Government of Uganda launched an initiative to provide SMC as an essential health service for prevention of mostly HIV and other STIs. The initiative seeks to increase the number of circumcised men by educating the population about SMC, increasing the number of health facilities that provide circumcision services and equipping health providers with the necessary skills to conduct the procedure. Epidemiological evidence suggests that safe male circumcision reduces the risk of sexually transmitted diseases (STD) and HIV infection by 60%. Therefore, the scorecard assessed availability of SMC service whether static or on outreach arrangement, personnel in handling SMC, community awareness, involvement and perceptions, follow up mechanism and availability of kits. During the interface meeting for consensus score, Nyamuyanja HCIV, Rwekubo HCIV and Kakoma HCIII rated SMC as good, was fair at Kabuyanda HCIV while it was poor at Ngarama and Kikagate HCIIIs.

Category	Nyamuyanja HC IV	Rwekubo HCIV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The good score based on having SMC as a static service with trained surgeons and kits. A number of partners such as RHITES SW were supporting facilities with outreach programmes, for instance, at Kakoma HCIII, the day the survey was being conducted, RHITES SW was on the ground conducting SMC. Kabuyanda HCIV scored SMC as fair because SMC kits were stocked out and Implementing Partners (IPs) had phased out their support. Ngarama and Kikagate HCIIIs did not have SMC as a static function and so referred to higher level. Community sensitization was highly recommended but also to plan for SMC across all HCIIIs.

'SMC is conducted when an outreach is done here. SMC surgeons come from implementing partners such as Marie Stopes. But we have to remove community fears that there is a lot of pain and that wounds become septic. Community sensitization and making SMC a static service here is paramount.This will go hand in hand with training of existing staff and provision of kits.' Health worker, Ngarama HCIII

'SMC is a static service for all ages but more embraced by children, adolescents and young people than adult men whose turn up is low despite community sensitization. It has also been observed that women discourage their men as SMC is associated with promiscuity. This calls for specific interventions targeting adult men and women'. Health Worker, Rwekubo HCIV

'However much SMC may be a good thing, few men would be willing to incur transport costs to go for it outside our community parameters. So plans to have it as a static service should be put in place.' Male community member, Kikagate HCIII

SMC mobile tent at Kakoma HCIII

SMC service signpost at Rwekubo HC IV

Poster on SMC at Rwekubo HCIV

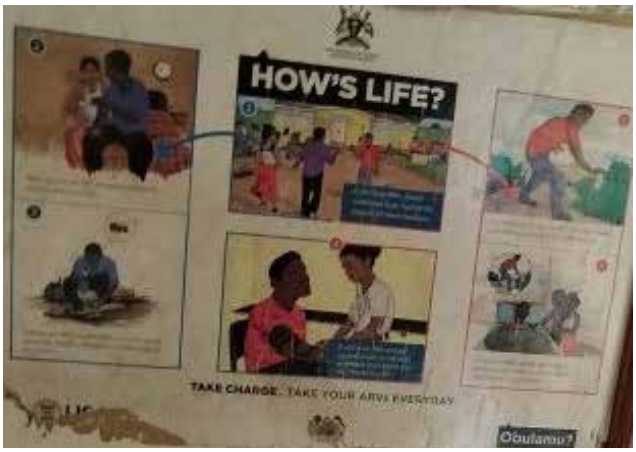
4.1.3 Provision of IEC/BCC materials

IEC materials such as posters, brochures, flyers and billboards among others are intended to draw attention to information about basic facts on diseases such as on mode of transmission, prevention or risks to health. IEC materials for SRHR, HIV and other integrated services can be in various forms to enable community members' access information and make informed decisions when they uptake and utilize the available services. It is important to note that while patients wait to be examined or treated, they need materials with information on various diseases right from causes, prevention to treatment options. During interface meeting for consensus score, both Rwekubo HCIV and Kikagate HCIII participants ranked IEC/BCC materials as good while the rest of the facilities rated it as fair.

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The good rating was due to the fact that IEC materials especially posters were available, most with up to date information, placed in strategic points including trees in the compound and some in translated in local languages. For instance, at Rwekubo HCIV, they had many posters in strategic places, with phone contacts in case someone needed extra information. The fair score was largely due to inadequacy of materials, some had old and outdated information and few translations which left out illiterate clients who cannot read and yet limited health education talks. Each of the facility sections/department had IEC materials. Recommendations included provision of translated materials and updating materials to align to the community and national programs, including emerging issues that affect community uptake of available services such as Covid19.

'We need posters in our local community set up.We have strategic locations such as town centres where information can be given especially on disease prevention as not all people visit health facilities.' Female participant, Nyamuyanja HCIV



IEC poster at Nyamuyanja HCIV and teaching aide Kakoma HCIII

Posters at Rwekubo and Kabuyanda HCIVs

4.1.4 Condom Supply for Men

As per national condom programming, condom use is a critical prevention element for effective and sustainable approach to STIs and STDs as well prevention of unwanted pregnancies. This is because condoms provide an impermeable barrier to particles the size of sperm and STI pathogens as well as viruses including HIV. Condoms, when used consistently and correctly, are highly effective in preventing STDs and unwanted pregnancies. The community scorecard assessed availability, accessibility and uptake of male condoms. During the interface meeting for consensus score, five health facilities ranked male condom supply as good while it was rated as poor by Kakoma HCIII, being Catholic founded and founding body policy indicates no condom supply from the facility though condom education is provided.

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The strong points were; availability of condoms and condom dispensers in open strategic spaces for access, availability and awareness drives conducted to sensitize the community on condom usage and demystifying myths and misconceptions. However, sporadic stock out of condoms and limited condom

education were cited as challenges and equally related was shyness of some men, especially the married ones who prefer to buy from shops, even when the condoms can be accessed from the health centres. Recommendations included; sensitize the community on the availability and importance of correct and consistent condom use, involvement of religious and community leaders to increase uptake, increasing the number of condom distribution points at both health facilities and in the communities and steady condom supply to avoid stock outs.

'Men shy away from getting to the facility even though condoms could be available at the facility. So we buy from shops and bars although even there, they are limited. A pack of 3 condoms is at UGX 500.' Male participant, Ngarama HCIII

Empty condom dispenser at Ngarama HCIII

Condom dispenser at Nyamuyanja HCIV

4.1.5 Female Condom Supply

Like the male condoms, female condoms are a prevention measure against STIs, HIV and unwanted pregnancy. The community scorecard examined availability, usage and community perception on female condom use. During the interface meeting for consensus core, all participants ranked female condom supply as poor service.

Category	Nyamuyanja HC IV	Rwekubo HCIV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The very poor score at all facilities visited was due to; no supplies of female condoms, very limited sensitization and various myths and misconceptions associated with female condoms use such as making noise during sex and fear could move up to the uterus since it is inserted in the vagina. Recommendations included: availing female condoms and sensitisation of women on female condom use. Men should be brought on board as champions to encourage their women take female condoms and to limit any likely

gender based violence. The health facilities need also to order for female condoms and pilot with a few women, having educated them on how to correctly insert the condom. Therefore, awareness creation to the community that women can also carry and use their own condoms is critical.

'We have never seen female condoms. My request is that the facility orders for them and we are taught on how to use them. Distribution points should be in areas where women can freely access the condoms.'Women participant, Ngarama HCIII

'We have some few female condoms available provided by AIDS Information Centre (AIC) but women have not embraced female condom use. Some shy away at mere mention of condoms.We need to critically strategise on how we can have these condoms used as much as we have done for male condoms.' Health worker, Rwekubo HCIV

'Most women have never seen female condoms and yet the little stock that would be brought here would expire. So we need to balance awareness and demand creation.' Health worker, Kabuyanda HC IV.

4.1.6 Testing services for HIV, pregnancy, cervical and breast cancer screening, STIs and STDs screening

Testing and counseling processes are a powerful tool for helping people including adolescents and young people to deal with peer pressure and begin to adopt and sustain healthy behaviors that benefit them the rest of their lives. This therefore determines demand for service uptake and to make informed decision concerning own health. Testing services impact health seeking behaviors, enhance prevention of sexually transmitted infections (STIs) and unintended pregnancy among other benefits. The scorecard assessed availability of testing kits, pre and post-test counseling services, community awareness on testing services available, trained personnel to handle issues of all age categories. During the interface meeting for consensus score, all health facilities rated HIV, pregnancy and STIs/STDs testing as good while all rated cancer screening as poor as seen below;

Testing services for HIV

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC III	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

Testing for pregnancy services

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC III	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

Cervical and breast cancer Screening

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

STIs and STDs screening

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC III	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The good ranking was a result of availability of kits to carry out most of the tests that include pregnancy test, HIV, STI and STDs, the laboratories are able to do the screening, all the time, including even duo kits for HIV and STIs. Pre and post HIV counselling and testing services and pregnancy related tests were done. The testing was timely and health workers were available and competent. The gaps included; sporadic stock out of testing kits that a number of times health workers prescribe drugs without testing, cases of poor management of syphilis and no or few outreaches to find community members where they reside. Cancer screening including cancer education were largely missing, even for simple exercises like for breast cancer examinations. Community members only benefitted from outreaches conducted by partners where cancer screening was added. For instance, Medical Teams International (MTI) was supporting Rwekubo HCIV with laboratory and outreaches and RHITES SW was supporting several facilities in the district. Referrals were made when cancer was suspected by all the facilities. Recommendations were to train health workers and community extension workers to be competent in counselling, regular supply of test kits and commodities, community mobilisation and sensitisation especially on timely cancer screening, carrying out community outreaches and use of peers to reach their buddies. More attention should also be given to cancer screening and early detection, including simple methods that do not require sophisticated gadgets such as breast examination and including sessions on cancer during health education talks. Engagement of implementing partners was also highly recommended.

'HIV testing is done anytime one comes in. The 'Test and Treat' is on, even with support from various partners, HIV testing outreaches are conducted.' We need to continue integrating testing to cover all disease areas.' Health worker, Ngarama HCIII

Laboratory at Kakoma HC III

Laboratory building at Rwekubo HCIII

4.1.7 Access to and availability of Sexual Gender Based Violence (SGBV) services (PEP, Follow up and Referral)

The NSP emphasises strengthening capacity of health workers, legal and social service providers to manage SGBV cases. Gender based violence is any harmful act that is perpetrated against a person's will and is based on ascribed gender differences between male and female. According to Minstry of Gender, Labour and Social Development (2011), GBV is national problem and a gross violation of fundamental human rights, with severe, long-term negative impacts on the physical, sexual and mental wellbeing of the survivors, family and community. The World Health Organization Global Sector Strategy on SGBV, which guides the health sectors response to prevention and treatment, clearly highlights the linkage between HIV&AIDS, STI and post care services for SGBV victims. There are many socially constructed norms around SGBV that many cases go unreported. The score card thus examined access and availability of GBV services such as emergency contraceptive pill, post exposure prophylaxis (PEP), facility support and follow up and referrals. During the interface meeting for consensus score, SGBV services were rated good at Nyamuyanja HCIV, Rwekubo HCIV, Kakoma HCIII and Kikagate HCIII while it was fair at Kabuyanda HCIV and poor at Ngarama HCIII.

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The gaps were on limited skills to counsel GBV victims and amount to be paid for Form 3 that ranged from UGX 20,000 to 30,000 and more money is paid when lodging the case at police station. For a health worker to appear in court, the transport is born by the aggrieved person. This burdens the already traumatized victims and challenge is that even cases that do not require payment such as rape and defilement, the money is paid. Therefore, community sensitization, training of staff and community resource persons to be GBV competent, awareness creation for community members to understand the legal processes and involvement of local leaders and police in ensuring justice were recommended. IEC materials on processes undertaken by victims of SGBV were urgently needed to be placed at strategic points of the health facilities and community centres and be part of health education talks.

'Payment for Police form 3 is cumbersome for victims who are poor and needy. Let health workers examine and sign for free.' Female participant, Kikagate HCIII

'Majority of the people do not know procedures once injustice has been experienced. In addition, Form 3 has challenges as health workers want to fill it at a fee, others fear to be summoned and want to be facilitated to appear in court. Therefore, training of community resource persons and health workers on GBV and all processes involved to support victims will be very helpful.' Male participant, Kabuyanda HCIV

'It takes a lot of courage and hard work to convince a victim of rape/defilement to take PEP. We need skilling in counseling.' Health Worker, Rwekubo HCIV

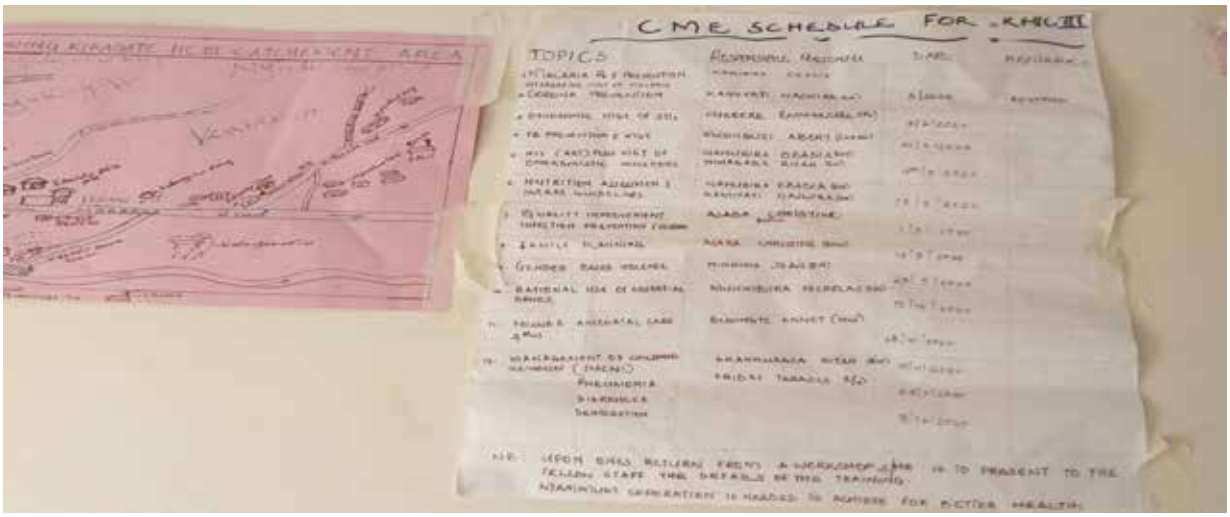
4.1.8 Availability of mentorship programmes for the peer educators/buddies

A number of community resource persons support the health workers to beef up the staffing gap. Known by different names such as expert clients, peer buddies or Village health teams, these are usually untrained community volunteers that require mentorship to enable them deliver services with or without health worker supervision. Mentorship is a relationship in which a more experienced/knowledgeable person helps to guide a less experienced or knowledgeable one. To provide intensive health care package to the adolescent and young people and community generally, mentorship of peer buddies on the existing programmes and procedures is therefore key. The community scorecard assessed the availability of mentorship programs to equip the peers with knowledge on SRHR/HIV programs. During the interface meeting for consensus score, Nyamuyanja HCIV and Kikagate HCIII scored good, Kabuyanda and Rwekubo HCIIIs rated as fair and was poor at Kakoma and Ngarama HCIIIs.

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The strong points centered on a number of Implementing Partners (IPs) that have supported skilling of peers/expert clients/linkage facilitators to support their buddies and some health workers continuously mentor them on one to one basis. However, the number of peers remains low to serve at the health facility and follow up colleagues in the community and this therefore calls for recruitment, training and mentoring of more peer buddies. The dependency on IPs to train, mentor, coach and empower the community resources must be supported by the District Local Government (DLG) and health facilities for sustainability.

'Dispensing of drugs including ARVS is the duty of the health worker but due to limited personnel and high numbers on ART clinic days, we have mentored the expert clients to dispense ARVs and treatment for Opportunistic infections and they are doing it very well.' In Charge, Kikagate HCIII



Continuous Medical Education (CME) schedule at Kikagate HCIII

4.1.9. Family Planning (FP) services

With very high fertility, maternal mortality and teenage pregnancy rates in Uganda, Uganda is committed to scaling up the use of modern family planning methods to ensure that every Ugandan woman can choose when and how many children they can have. Family planning access as a birth control measure still indicates higher growth rates, and yet contraceptive use has persistently remained low, and the unmet need for family planning is high (Population Census, 2014). The score card examined accessibility of FP services, stock status of both short and long term FP commodities and community perception. During the interface meeting for consensus score, Nyamuyanja HC IV, Rwekubo HC IV, Kabuyanda HC IV and Kikagate participants ranked family planning as good. Ngarama HC III rated FP services as fair and it was poor at Kakoma HCIII, because of being catholic based and modern family planning methods are not meant to be provided.

Category	Nyamuyanja HC IV	Rwekubo HCIV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The positive ranking of the service was based on availability of both short and long term FP methods at the facility and community awareness of the available services. However, the challenges affecting quality and utilization of FP services included; stock outs of family planning supplies, perceived side effects, inadequate skills in management of complications, few family planning competent staff leading to workload and low involvement of men, local and religious leaders to support uptake. Sensitization of the community on family planning is crucial, training of health staff to be competent, deliberate involvement of men and uninterrupted supply to avoid stock outs were key recommendations.

'Family planning is a woman's thing. As men, we are not supposed to be concerned ourselves with something we have no control over.' Male participant, Nyamuyanja HCIV

FP signpost post Ngarama HCIII

4.2 SRHR/HIV: CARE AND TREATMENT SERVICES

This sub section illustrates care and treatment in regard to; Access to Family planning, ANC, Treatment for STI/opportunistic infections HIV care, Adolescent SRH/GBV/HIV treatment (youth friendly services), Support equipment at health facility service points, Nutrition support and educational services and Home based care programs.

Table …: Summary of Care and Treatment services

Health Facility		SRHR/HIV/GBV CARE AND TREATMENT					
	ART services	Treatment for STI/OIS in HIV care	Adolescent SRHR/HIV Management	Integrated TB Services	Hepatitis B screening& treatment services	Nutrition support services	Home based care
Nyamuyanja HC IV							
Rwekubo HC IV							
Kabuyanda HC IV							
Kakoma HC III							
Ngarama HC III			-				
Kikagate HC III							

Key			
	Poor	Fair	Good

4.2.1 ART services

People need medicines required to achieve good health and such access is part of the right to health. AIDS mortality rates can reduce if the HIV commodities are readily available as timeliness is crucial. Important to note that HIV management is chronic and requires uninterrupted uptake if positive living is to be achieved. To this end, the scorecard assessed accessibility and availability of ART and during the interface meeting for consensus score, all facilities visited ranked ART services as good.

Category	Nyamuyanja HC IV	Rwekubo HC III	Kabuyanda HC IV	Kakoma HC II	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The good score was a result of constant availability of ARVs, and where stock outs were witnessed, buffer was provided from neighbouring health facilities or IPs. Even the newly initiated PLHIV under the Test and Treat programme were covered. Health education talks were available on adherence and a number of expert clients/linkage facilitators were available to support peers for counselling, ART treatment support for adherence, follow up and general psychosocial well being. The community applauded the health workers and requested them to keep it up.

'We need more attention to Viral Load information. We come here and if suppressed, they show you a happy face and that is it. The health workers need to go beyond that.' PLHIV leader, Rwekubo HCIV

'On CD4 count, this is no longer being given as much attention as it was before viral load testing. Yet, we have colleagues failing on drugs yet viral load low. How shall we manage Advanced HIV Disease when this crucial test is not considered.' PLHIV Chairperson, Isingiro District.

Tent at Ngarama HCIII, donated by RHITES SW for PLHIV to receive ART, strategically facing off the road to minimize stigma

4.2.2 Treatment for STI/Opportunistic Infections (OIs) in HIV care

Opportunistic infections occur more often in people with a compromised immune system. This is common with PLHIV and others with chronic ailments. The assessment examined availability of commodities, screening and treatment, community awareness on OIs, counseling and follow up for support. During the interface meeting for consensus score, Nyamuyanja HCIV, Rwekubo HCIV and Kakoma HCIII participants ranked treatment for Opportunistic infection as good and it was fair at Kabuyanda HCIV, Ngarama HCIII and Kikagate HCIII respectively.

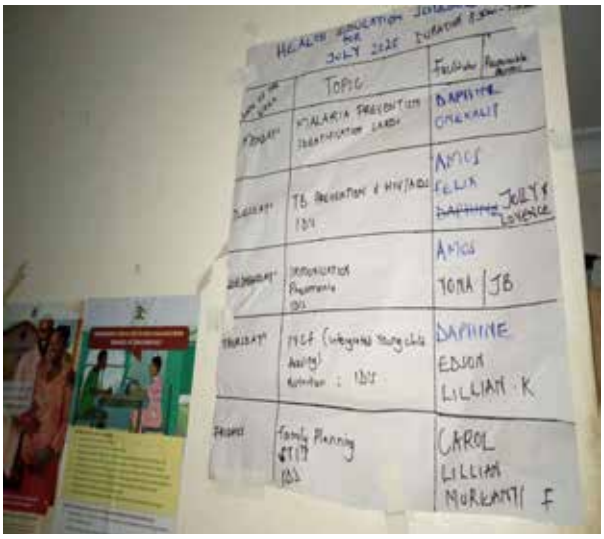
Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

Treatment for OIs and STIs was available but health workers indicated the community was not keen on accessing. A good number of PLHIV who experience OIs need extra support as that is an indicator of onset

of AIDS which could be culminating from poor adherence. With phase out of cotrimaxozole (septrin), some PLHIV had not been told on why which was causing anxiety that some buy from drug shops. Others were experiencing stigma and which affected their ability to disclose and access the available services. Recommended therefore was having a steady supply, community sensitization and working with PLHIV network leaders to support stigma reduction to increase access to OI treatment. Continuous sensitization on eligibility criteria of who requires Septrin should be undertaken.

'OIs treatment is available everyday but mostly from Monday to Wednesday if drugs are not stocked out.' Health worker, Ngarama HCIII

'For OI Treatment, PLHIV are given first priority.' Health worker, Kakoma HCIII



Health education schedule

4.2.3 Adolescent SRHR/HIV Treatment and youth friendly services

In all health care settings, adolescents' treatment is expected to be treated as different from other age categories to enable a better health seeking behavior. This is because any slight discomfort, they will shun the treatment, however critical it is to their life. The score card therefore examined availability of youth corners and other safe spaces, young people involvement in facility management, trained personnel to support young people, integrated system for other services and sensitization to increase service uptake. During the interface meeting for consensus score, it was good at Rwekubo HCIV, fair at Nyamuyanja while Kabuyanda HC IV, Kakoma HCIII, Ngarama HC III and Kikagate HC III rated the youth friendly services as poor.

Category	Nyamuyanja HC IV	Rwekubo HC III	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus score						
Service providers score						
Women score						
Men score						

The good ranking at Rwekubo HCIV was based on availability of a youth friendly corner and having a specific day for youth access to treatment especially ART. Kabuyanda HCIV youth corner required renovation while the three HC IIIs had no youth corners. But all facilities were setting aside days for youth to access their ARVs and where not possible, young people were given special consideration of being treated first. Stigma

was also a barrier that many young people were not comfortable to pick their treatment. This therefore called for provision of services and support tailored to adolescents' needs, community sensitization on adolescent friendly services at the facilities and integration of services to enable and ease access to what they needed beyond HIV care. Recommended was that all health facilities at the various levels set up well equipped youth friendly corners that are integrated and are a one stop centre for all adolescent and youth needs.

'The youth friendly corners need to have integrated services so that they are not labeled for HIV treatment alone. This will diffuse stigma that continues to bar most young people from accessing ART services from the nearest health facility.' Female participant, Rwekubo HCIV

'As window of opportunity, we need to support this silent group to access and utilize the needed services for them to be healthy and productive. Use of peers and role models is also critical here.' Male Participant, Nyamuyanja HCIV

Ngarama HCIII signpost but no youth friendly services are offered and a Youth friendly container, under renovation at Kabuyanda HCIV

4.2.4 Integrated TB, Hepatitis B services and other related services

Collaborative health services emphasis integrating care and treatment for patients with TB, Hepatitis B, cancer services with other HIV and SRHR related through enhancing screening for patients, routine testing, diagnosis and management. The MOH 2010 Guidelines on TB, for instance, emphasise testing and treatment for TB as essential if other diseases management is to be effective. The Scorecard assessed availability of screening equipment, supplies, presence of screening services at the health facilities, follow up and community sensitization among others. During the interface meeting for consensus score, other than Kabuyanda HCIV that rated TB services as fai, the rest rated TB services as good. For Hepatitis B, Rwekubo HCIV, Kakoma HCIII and Ngarama HCIII rated as good while it was fair at Nyamuyanja HCIV, Kabuyanda HCIV and Kikagate HCIII.

Integrated TB services

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

Hepatitis B

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

To note was that TB was given a lot of attention compared to Hepatitis B. TB services ranging from screening, initiating treatment and follow up were being done by all facilities with appropriate referrals such as for Multi Drug Resistant (MDR) TB were being sent to Mbarara Regional Referral Hospital and IPs such as TASO, AIDS Information Centre, MJAP among others. Coughers spaces were being created though the community observed that a number of times TB results delay. The 6 month TB Preventive Therapy (TPT) was being administered. Some of the facilities were testing and vaccinating against Hepatitis B but community awareness was very low. Recommendations included equipping the facilities with the necessary equipment as per level, training of health workers to provide health education talks on identification of symptoms, regular community sessions on causes, symptoms, treatment and adherence. Community members must be told that TB is curable and that Hepatitis B has a vaccine.

'We have no idea that Hepatitis B+ testing is being done here. We are learning today that treatment for Hepatitis B is ARVs but that unlike HIV, can be vaccinated against. We need to scale up community sensitization to increase uptake.' Expert client, Nyamuyanja HCIV

4.2.5. Nutrition services

In a bid to complement service and support to vulnerable population to adhere to medication, the NSP recommends provision of nutrition feeds to boost their immunity. The Health Sector Investment Plan (2015) emphasizes integrating nutrition, counselling and support in care and treatment services including use of ready-to-use therapeutic food (RUTF) for severely malnourished. The community score card assessed the availability of feeds, provision of food to the index population (PLHIV and malnourished) and provision of nutritional information to vulnerable and nutritional counseling services. During the interface meeting for consensus score, nutrition support services were rated as good at Kakoma HCIII and fair at the other 5 health facilities respectively.

category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

Nutritional support was quite limited and this was partly explained by the nature of the district that has a lot of agricultural potential with bananas, cereals, fruit and vegetable growing that few partners consider nutritional support for Isingiro. All facilities were however providing nutritional education and supplements in case they received them. The recommendations were to systematically map and provide food supplements to the very vulnerable children, mothers and elderly if positive living is to be attained. Demonstrations at facilities should also be undertaken.


Staff banana and vegetable gardens at Ngarama HCIII that can serve as demonstration site

4.2.6. Home based care programmes

Home Based Care works within the health systems and structures in each health care service delivery point, involving cross referrals from all levels of care whether public or private, formal or informal to the households. This involves health workers, health extension workers and expert clients visiting the clients for psychosocial and adherence support, testing services, screenings, referrals and linkages, immunization and vaccination, health education among others. Diseases that require chronic management such as HIV do not necessarily require patients to report to health facilities every time and this gap would be covered by well streamlined home based care programme. During interface meeting for consensus score, all facilities scored home based care programmes as poor.

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The reasons for poor ranking were attributed to lack of funds for transport yet with wide geographical area, no coordination cars and motor cycles, poorly motivated and facilitated village health teams (VHTs) and expert clients and work overload where staffing levels to cover the highly demanding health facility work cannot allow health workers conduct home based visits. The recommendations were to systematically plan for HBC as part of duty rota, train health workers in integrated outreach, motivating and facilitating available health care structures (expert clients and, peer buddies, VHTs) and the district to allocate additional funds alongside the primary health care (PHC) money for health workers to reach out to the community members.

'It is important that we visit our patients who are under chronic care management. It is particularly more critical when all facilities in Isingiro are not offering palliative care services.' Health worker, Kabuyanda HCIV

4.3 SRHR/HIV: SOCIAL SUPPORT AND PROTECTION

The quality of social support and protection service was assessed basing on the quality of psychosocial services, capacity building for care givers, rights awareness and support and legal support services. These are discussed further in the subsections below.

Table : Social Support and Protection

Health facility	HIV/SRHR Social Support and Protection			
	Quality of Psychosocial Services	Capacity Building for Caregivers	Rights Awareness and Support	Legal Support Services
Nyamuyanja HC IV				
Rwekubo HC IV				
Kabuyanda HC IV				
Kakoma HC III				
Ngarama HC III				
Kikagate HC III				

KEY			
	Poor	Fair	Good

4.3.1 Quality of Psychosocial Services

The NSP 2020/2021-2024/2025 highlights interventions that need to be done to contribute to psychosocial support and social protection needs for PLHIV, OVCs and other vulnerable groups. Psychosocial support helps individuals and communities to heal the psychological wounds and rebuild social structures. To eliminate stigma and discrimination and attract people to develop a good health seeking behavior, the community scorecard assessed; quality of counseling (pre and post counseling) services rendered, the capacity of the health workers to handle vulnerable groups, support to Orphans and Vulnerable Children (OVC), SGBV victims, rape and defilement cases, as well as referral system. During the interface meeting for consensus score, Nyamuyanja HCIV and Kakoma HCIII rated quality of counseling as good, fair at Kabuyanda HCIV and Kikagate HCIII and poor at Rwekubo HCIV and Ngarama HCIII.

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The strong points included availability of both pre and posttest counseling sessions, where counseling room space is small or nonexistent, space is improvised, presence of expert clients to support peers, ensuring patient's privacy and confidentiality, follow ups and referrals when individual cases require more external support. However, the health facilities were having challenges of high numbers which affects the time given to each patient, limited space for effective counseling, few trained counselors and beyond HIV, few health workers were trained to handle sexual gender based violence cases for counseling traumatised cases such as of rape and defilement. Recommendations were; establishment and/or strengthening of post-test clubs/ PLHIV networks, training of health workers in psychosocial counseling, strengthening community referral and the law courts to expedite the judicial processes to cut on time when witnesses appear and victims get justice.

'There is no serious counselling done here and no health education talks. We need designated counselors and have expert clients that include a man and young person'. Female participant, Ngarama HCIII

'There is always high patient turn up compared to staff leading to work overload and stress. We need extra counsellors.' Health worker, Kabuyanda HC IV

Counseling Room at Kabuyanda HCIV

4.3.2. Capacity building for caregivers

Whether short time or chronic illness, patients require support of caregivers. These caregivers need information on how to handle and support patients for adherence and general positive living. Health workers are therefore supposed to mentor caretakers on how to manage patients especially the children, adolescents, young people and the elderly. Sometimes, health workers follow up community members at the grassroots but at times, it becomes impossible due to limited number of health workers and no transport means. The score card examined if the caregivers capacity was being built. During the interface meeting for consensus score, caregivers' capacity building was ranked as good at Nyamuyanja HCIV and Kakoma HCIII while Rwekubo HCIV, Kabuyanda HCIV, Ngarama HCIII and Kikagate HCIII ranked it as a fair service respectively.

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus score						
Service providers score						
Women score						
Men score						

The strong points stemmed from the fact that a number of dedicated health workers take caregivers through what it means to care for patients ranging from adherence, nutrition and family support. For some facilities however, other than health workers coming in at prescription time on how drugs can be given, a deliberate programme to build capacity of caregivers was lacking. This was attributed to very high health worker to patient ratio as it limited time and low capacity of health workers to provide comprehensive HIV/SRHR care and services. Recommendations included; training of care givers and provision of facilitation for these trainings, recruitment and/or allocate more staff especially in high volume sites, community sensitization on role of treatment supporters and PLHIV buddies to be given central stage as number one caregivers/treatment supporters. In addition, the district should get partners to support capacity building programs in all health centers and train health workers in capacity building of caregivers in various areas of chronic care management.

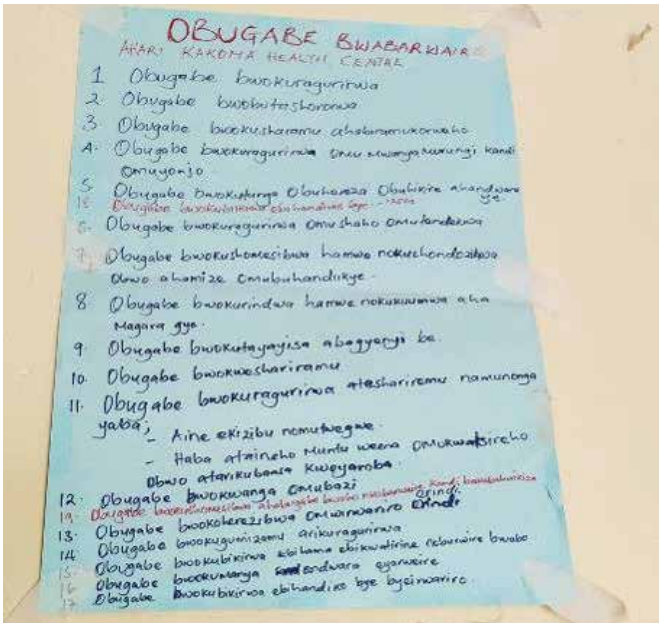
'I sometimes wonder how parents/guardians of children living with HIV manage when little information is given. It is not surprising that viral suppression for children has remained low. Such cases require building capacity of caregivers for effective management of such patients.' Male participant, Rwekubo HCIV

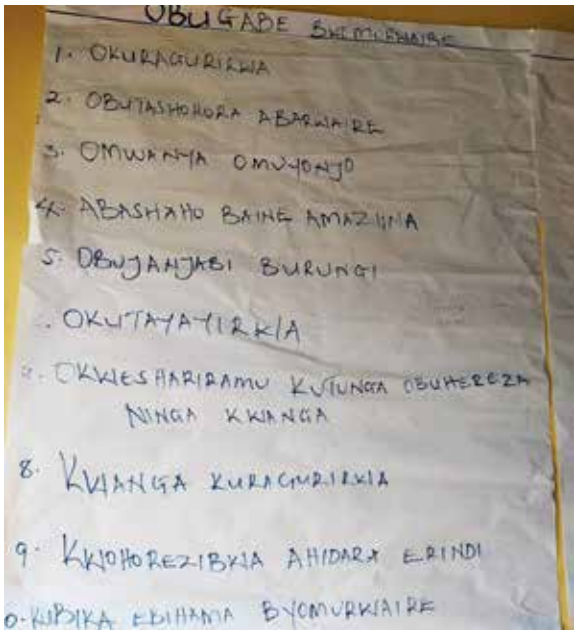
4.3.3 Rights awareness and support

The constitution of the Republic of Uganda (Article 9) stipulates that it is a fundamental right to all the citizens to access health services irrespective of sex, gender, color and origin. This led to the development of the Patients' Charter and health workers' Code of Conduct to support access, treatment and care in health facility set up. The score card considered the community awareness of these rights through availability of patients' charter, health worker support to patients to access treatment and justice and respect for patients' dignity. During the interface meeting for consensus score, Nyamuyanja HCIV and Kakoma HCIII ranked rights awareness as good and it was fair at Rwekubo HCIV, Kabuyanda HCIV, Ngarama HCIII and Kikagate HCIII.

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

Respondents from the 6 health centres indicated had patients' rights displayed in English and Runyankore Rukiga but those who do not know how to read miss out on the information. There is a need to appreciate that some health centres like Kabuyanda HC IV and Kikagate HC III serve patients from neighboring countries like Tanzania and Rwanda who speak Kiswahili requiring posters written in Kiswahili language. The gaps also centred on limited awareness on rights to both health workers and community members as beneficiaries of care, inadequate IEC materials on patients' rights in the local languages, low involvement of local leaders to create awareness among the community members which called for more sensitization through community meetings, health education talks and translate more materials into local languages. Responsibilities must also be emphasized alongside the rights. They therefore recommended that regular awareness be made by the health providers during health education talks and community based engagements.





Translated Patients' rights at Kakoma HCIII and Ngarama HCIII

4.3.4 Legal Support and Protection

The NSP indicates strategic intervention on supporting HIV prevention with strengthening capacity of health, legal and social services providers to manage GBV cases, reduce stigma and discrimination, integrating and expanding social assistance to most vulnerable PLHIV, OVC and other vulnerable persons. 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. 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. 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. During the interface meeting for consensus score, Nyamuyanja HC IV scored good, Rwekubo HC IV participants ranked legal awareness and support as fair and the rest of the health facilities rated as poor respectively.

Legal Support and Protection

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The good ranking was as a result of health workers offering service to victims especially those that report within the stipulated time and not having tampered with evidence, filing police report, referral was needed, follow ups on the victims, and legal support in regards to appearing in courts of law. The gaps were on community members that do not seek support from health facilities, high levels of stigma and discrimination, community members tend to silence the victims on cases and lack of facilitation during court sessions. There were also no paralegals and yet crucial for community judicial information especially steps to accessing justice by the aggrieved parties. But of serious concern was payment for Police Form 3 as majority of victims were too poor to raise the required amount ranging from UGX 20,000 to UGX 30,000. Recommendations were to create awareness and train health workers to be competent, selected community members as paralegals but also facilitate health workers to follow up on reported cases. IPs offering proborno/free services need to be targeted to cater for poor victims.

4.4 SRHR/HIV: INFRASTRUCTURE AND UTILITIES

The National Development Plan (NDP) II emphasizes strengthening of infrastructure for scaling up the delivery of quality health services. It also considers the expansion of the functional laboratory services and increasing access of the community to the minimum health services. The score card therefore examined the infrastructure, utilities and equipment but more specifically availability of clean and safe water, transport, staff housing, toilets, kitchen, shelter, communication facilities as well as availability of power and its type. Utilities, equipment and infrastructure are a support function for provisional of services for HIV, SRHR and other medical services.

Table .: HIV/SRHR infrastructure, utilizes and equipment

Health Facility	HIV/SRHR supportive Infrastructure, Utilities and Equipment							
	Clean and Safe Water	Transport	Staff Houses	Toilets	Kitchen	Shelter	Communication facilities	Power and type
Nyamuyanja HC IV								
Rwekubo HC IV								
Kabuyanda HC IV								
Kakoma HC III								
Ngarama HC III								
Kikagate HC III								

KEY			
	Poor	Fair	Good

4.4.1 Availability of clean and safe water

Availability of clean and safe water, proper sanitation and hygiene is critical in ensuring that patients do not contract water bone diseases and encourage repeat visits. At each health facility, there should be a water source to supply the facility, water connected especially to the laboratory, theatre (where it exits), delivery room, laundry area, bathrooms and other key sections requiring direct water connections. Results gathered from interface meeting for consensus score, Nyamuyanja HCIV and Kikagate HCIII had good water supply, was fair at Rwekubo HCIV, Kabuyanda HCIV and Kakoma HCIII and poor at Ngarama HCIII respectively.

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The good ranking was attributed to having adequate water sources within the facility, water connected to key sections such as theatre, laboratory, maternity ward and staff quarters. The fair rating was attributed to unreliable water supply, water not being connected to maternity and laboratory, water shortages especially in dry seasons and some water sources being a bit far from the facility. Recommendations included the installation of running water at all the health facilities and additional water storage units such as tanks be installed for more water can be harvested and/or stored.

'We have water storage facilities but not enough. Being a high volume site, water runs out fast and dry seasons are usually hard.' Health worker, Ngarama HCIII

Water harvesting at Ngarama HC III

Laundry are at Nyamuyanja HC IV

Water harvest at Nyamuyanja HC IV

Water harvesting at Kikagate HC III

Water harvesting at Rwekubo HCIV

4.4.2 Transport Means

According to the MoH standards, facilities are supposed to have an ambulance and other means of transport to strengthen referrals including emergencies and follow up mechanism of patients within their geographical coverage and outside to other facilities. The community scorecard assessed availability of an ambulance, and motor ambulance care, motorcycles and other facility specific coordination vehicles.

During the interface meeting for consensus score, transport was scored good at Kabuyanda HCIV, fair at Rwekubo HCIV and Kikagate HCIII and poor at Nyamuyanja HCIV, Kakoma HCIII and Ngarama HCIII.

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The good score at Kabuyanda HCIV was due to having an ambulance that even served neighbouring Kikagate HCIII. Rwekubo HCIV was serving a huge population and so required many ambulances and motor cycles for referrrals and coordination. The reasons for poor ranking at Nyamuyanja HCIV, Kakoma HCIII and Ngarama HCIII was due to lack of ambulances and motorcycles attached to the facility. Recommendations were Ministry of Health/government to provide the health centres with ambulances, coordination motor cycles and bicycles for outreaches, where possible repair the existing ambulances and provide a budget for maintenance and fuel.

'We have two ambulances, one donated by the UN and recently by the Member of Parliament preparing for election primaries plus 1motocycle for immunization. The challenge is fuel and maintenance costs and that is why we ask patients to contribute fuel ranging from UGX 70,000 to 120,000 depending on where the referral is.' Health worker, Kabuyanda HC IV

'The newly donated ambulance by the aspiring Member of Parliament during the NRM primaries is a worry to us as there is a likelihood that the politician will come for his ambulance since he did not succeed in NRM primaries. The government needs to plan for us. Majority of us are poor so contributing to fuel costs for the ambulance at Kabuyanda is hard.' Kikagate HCIII

Ambulance at Rwekubo HCIV

Ambulances at Kabuyanda HCIV

4.4.2 Staff houses

Ministry of Health Standard Guidelines (1995) for staff accommodation require that every health worker should be housed at the health facility. The community scorecard assessed availability of staff houses and status of the structures at the facilities. During the interface meeting for consensus score, staff accommodation was scored as fair at Nyamuyanja HCIV, Rwekubo HCIV, Kabuyanda HCIV and Kikagate HCIII while Kakoma HCIII and Ngarama HCIII rated it as poor respectively.

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus score						
Service providers score						
Women score						
Men score						

Good and fair ranking stemmed from availability of staff houses, habitable structures though some needed renovation, water harvesting tanks, kitchen and latrine for staff. In all the health facilities, the houses available could not cover all available staff, which has led to sharing and some facility structures turned into dormitories such as at Nyamuyanja and Rwekubo HCIVs. Nyamuyanja had good houses but inadequate to cover all staff. Some spaces had been improvised to cater for staff accomodation. At Kikagate HCIII, the houses are very old and are shared for most of the staff, however, of recent, an implementing partner Kikagate Power Company built midwives quarters to support maternal services. The house also hosts one nurse for emergencies. At Kabuyanda HCIV, staff houses are shared and they are old requiring urgent repairs and reconstruction. Some houses have no water and electricity supplies. Rwekubo had dormitory style for some staff members. Therefore, staff had to look for accommodation outside facility premises thereby affecting time for arrival and departure, but also management of emergencies if staff are to be recalled from far. For instance, the laboratory technician for Kakoma HCIII was staying away from the facility. Generally about 30% of staff are housed at the aforementioned facilities. Recommendations were to construct more staff houses, renovate existing quarters and provision of housing allowances to staff not accommodated at the facility.

Staff quarters - Nyamuyanja HCIV

Only Staff quarter' block at Kakoma HCIII

Staff quarters at Rwekubo HCIV

Staff quarters at Kabuyanda HCIV

Staff quarter at Kikagate HC III

Staff houses at Ngarama HCIII

4.4.3 Toilets, kitchen and shelter

In a bid to support the medical personnel to do their work, patients are expected to eat, be in clean environment and have facilities that support during the whole diagnosis and treatment phases. This therefore requires that all facilities have clean toilets, a spacious kitchen and a shelter for waiting patients or where attendants stay while health workers are on ward. The ranking for each variable in tables below;

Toilets

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

In all the health facilities, the toilets were available in various degrees. Kakoma HCIII had clean and well demarcated toilets for men and women. Staff toilets were available in staff quarters. Nyamuyanja HCIV had adequate toilets and laundry areas with some abandoned ecosan toilets. For other facilities, toilets were availabe but few compared to numbers served, some structures were dilapidated. But cleanliness was wanting in all, requiring a designated cleaner(s) to ensure cleaniliness at all times. At Kikagate HCIII, patients' toilets were available and staff use maternity staff toilet but at their residence, the toilets are in a sorry state. At Kabuyanda HCIV, patients' toilets are better in Maternity side where mothers are benefiting from a newly constructed toilet. The staff toilet is dilapidated with poor cleaning and maintenance.

Toilet at Ngarama H/C III

Toilet at Kakoma H/C III

Toilets at kikagate HCIII

Toilet at Kabuyanda HCIV

Kitchen

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HCIII
Consensus Score						
Service providers score						
Women score						
Men score						

Kitchen was also a problem for almost all facilities. In facilities such as Nyamuyanja and Rwekubo HCIVs, the kitchen was available but quite small to serve the many attendants for IPD patients. Although HCIIIs have few admissions, kitchen areas were a problem.

Kitchen and store at Kakoma HCIII

Kitchen at Nyamuyanja HCIV

Kitchen at Nyamuyanja HCIV

Kitchen at Rwekubo HCIV

Shelter

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

Shelters were limited. The IP RHITES SW had provided tents to alleviate this problem especially for ART clinic day and other facility meetings/engagements. For instance, at Ngarama HCIII, patients sit in the compound and the tent provided by RHITES SW is for ART clinic day and other engagements. At Kikagate HCIII, there is no shelter for waiting area for patients and the space is insufficient. Many times patients bask in the sun in the compound as well as the veranda, even the seats are inadequate there without space for attendants stay. For Kabuyanda HCIV, the waiting area is inadequate;

Shelter at Kabuyanda HCIV

OPD waiting area at Nyamuyanja HCIV

Disposal and cleanliness remain a big problem for most facilities.

Open air disposal at Kabuyanda HCIV

Dirty toilets at Ngarama HCIII

RHITES SW support to health facilities in Isingiro (Kikagate HCIII) and abandoned ecosan toilets (Nyamuyanja HCIV)

Disposal at Rwekubo HCIII

Placenta bit and incinerator at Kikagate HCIII

4.4.4 Communication Facilities

Another measure of infrastructure, utility and equipment in health facilities is availability of communication facilities. These include; a suggestion box, a telephone booth or public pay phones, facility landlines, emergency numbers for patients, telephone handsets, radio calls and notice boards among others. These enable communication flow between and among staff and patients plus their attendants. During the interface meeting for consensus score, communication was rated as good by Nyamuyanja HCIV, fair by Rwekubo HCIV, Kabuyanda HCIV, Ngarama HCIII and Kikagate HCIII and was poor at Kakoma HCIII respectively.

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service Providers score						
Women score						
Men score						

Most health facilities had noticeboards and suggestion boxes with a lot of information provided. For instance, Nyamuyanja HCIV had a telephone whose airtime was being given by an implementing partner (RHITES SW), Kikagate HCIII and Kabuyanda HCIV had telephones and suggestion boxes, airtime was

either provided by IPs of part of primary health care budget. The gap was on use of suggestion box as community members felt that their concerns were not always addressed but also provision of airtime was affected by lack of budget that health workers were using personal phones to call patients as and when due for appointment. Recommended to have toll free lines to enable community memb8ers call without struggling with airtime. IPs can support this cause to supplement government efforts of serving the vulnerable population. The health centres also required computers and internet to ease communication with outside world but also timely ordering of drugs and supplies.

Notice board at Nyamuyanja HCIV Suggestion box at Kikagate HCIII

Telephone and suggestion box (not within easy reach of most people) at Kabuyanda HCIV

4.4.5 Availability of power and type

In health facility set up, power complements and supports delivery of services, whether it is HIV/SRHR or any other integrated service. The scorecard assessed availability of power, its extension to the key areas requiring power such as the laboratory, theatre and maternity delivery rooms, regularity of power and the different power types supplied. During the interface meeting for consensus score, availability of power was rated as good at Nyamuyanja HCIV, Rwekubo HCIV, Kabuyanda HCIV and Kikagate HCIII whereas for Kakoma and Ngarama HCIIIs, it was fair.

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus score						
Service providers score						
Women score						
Men score						

To note is that the facilities were connected to hydro electric power and had solar panels as backup. Generators were available for a few. Kikagate, Kakoma and Kikagate HCIIIs have hydro electric power and solar, while Kabuyanda HCIV and Rwekubo HCIV had hydro electric power, solar and a standby generator although sometimes challenged by fuel. Ngarama HCIII had just connected to electric power and sections such as maternity had been connected and more connections were happening as not all sections were covered at the time of the survey. There is need to expand solar panels to cut on electric costs and avail funds to procure fuel for the generator.

Non functional generator at Nyamuyanja HCIV

Kikagate HCIII solar power switch

Solar panels at Nyamuyanja HCIV and Kakoma HCIII

'Every time I come here to support my fellow clients, I reach here at 7.30am and I always find OPD health workers already here.' Expert client, Kikagate HCIII

4.5.2 Polite Behavior

Health personnel are supposed to handle the patients well in a bid to strengthen the client-health worker relationship for optimal treatment and care. Ministry of Health provides patients' charter 2009 and code of conduct guidelines to stream line how health workers should operate while handling patients. The scorecard assessed the patients-health worker relationship in health care setup following the appropriate procedures such as conduct when handling patients, the time given to clients when seeking medical information and the supporting systems to complement structures. During the interface meeting for consensus score, all facility participants' ranked politeness by health workers as good.

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Ngarama HC III	Kakoma HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The positive ranking was attributed to staff handling patients well, giving them time through the processes of diagnosis, treatment up to discharge. There room for improvement was on understanding the Patients' Charter to align politeness to what the charter and other guidelines stipulate but also to handle isolated cases of rudeness especially when health workers are tired.

'We have a team that serves us politely, we have not had any incidence where a patient has been mishandled.' Male participant, Kakoma HCIII

4.5.3. Listening to patients problems

In a bid to manage disease diagnosis in health care system, listening to patients' problems/ complaints and complements is crucial. The scorecard assessed whether patients are listened to, their issues are addressed and whether feedback provided is taken in good faith. During the interface meeting for consensus score, all facilities ranked listening to patients problems as good.

Category	Nyamuyanja HC IV	Rwekubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The reasons for good score were; health worker offer ample time to listen to patients to support diagonosis of the disease, most of the patients know their rights and where necessary, informed consent was obtained. However, due to inadequate staffing, there was work over load and some health workers were not adequately explaining prescriptions to patients. Recommendations included; need for comprehesisve sensitisation on patients rights and code of conduct for health workers and and recruit more staff to reduce the work load.

'Our counsellor has 'big listening ears as those of the elephant', she is alone but tries to the best of her ability despite space limitation.' Female participant, Kabuyanda HCIV

4.5.4 Respect of Patients Privacy

The Patients' Charter (2009) stipulates that patients have the right to privacy in course of consultation for treatment and information concerning one's health, except only when it is required by law or court order. It further emphasizes that facility management should make the arrangement to ensure that that health workers do not disclose the patients' information brought to their knowledge in course of their duties. Patients' records are meant to be kept with highest level of privacy and confidentiality. The scorecard assessed respect for patients' and during the interface meeting for consensus score, all facilities ranked respect to patients' privacy as good.

Category	Nyamuyanja HC IV	Rwenkubo HC IV	Kabuyanda HC IV	Kakoma HC III	Ngarama HC III	Kikagate HC III
Consensus Score						
Service providers score						
Women score						
Men score						

The recipients of care agreed that despite limited space and consultation rooms in most faclities, the health workers try to provide all the needed services, with all the confidentiality and privacy it deserves. Rooms were put aside and where not possible, there were screens and curtains to separate spaces. Improvisation of space was also done to ensure patients are comfortable. Tents were provided in some facilities to cater for space but also privacy, for instance at Ngarama HCIII, the tent was facing off the road and facility entrance to keep off prying eyes of who enters the tent especially on ART clinic day.The records were being well kept as well in secure places. The gaps were on inadequate infrastructure in form of consultation rooms, utilities and equipment such as curtains and screens at the facilities to ensure that the privacy of the clients during examination and counseling is observed .Recommended was creation of more spaces to enable more private consultations and counseling.

File management at Kikagate HC III

5.0 LIMITATIONS

i. Though the community score card centred on the HIV/SRHR under prevention, care and treatment, social support and systems strengthening, not all areas under each theme were covered.
ii. The findings presented are limited by observations, input tracking and key informant interviews at that specific time which may lead to some of the equipment not being captured.
iii. The assessment did not necessary consider comprehensive health facility equipment as focus was largely on core support equipment.

6.0 CONCLUSIONS

Based on the findings, the assessment concludes that Isingiro district has made efforts to provide quality HIV/SHR and other integrated services. The rating was good on most components except for female condoms and home-based care programmes. Staffing levels were moderate. However, there were gaps on staffing, regular stock out of drugs and other supplies, limited follow up of clients in their communities, limited information on SRHR/HIV including its translation in the local language. Community mobilization and sensitization by various stakeholders need to remain on top of the agenda if service uptake is to remain high.

7.0 Recommendations

The assessment generated a number of recommendations that include amongst others. Isingiro Local government, Religious leaders, health facilities, Implementing partners, Line ministries, departments and agencies especially MOH, Ministry of Public Service, Ministry of Finance, Planning and Economic Development and Ministry of Gender, Labour and Social Development) and networks of PLHIV.

Indicator(s)	**Key recommendations**	**Responsible body**
SRHR/HIV: PREVENTION	Make Safe male Circumcision service static at HCIII, train more SMC surgeons	MOH, DHO and IPs
	Provide more IEC materials and translate them into local languages, place some in community strategic community points such as trading centres	IPs, DHT
	Provide adequate male condoms to avoid stock outs	IPs, DHT
	Provide female condoms, could start as a pilot. Include men as female condom champions to increase uptake and limit gender based violence	UNFPA, MOH, DHT, IPs, CSOs
	Make testing/screening for cancer and Hepatitis B routine. Provide information for community awareness and appropriate referrals should be made	MOH, DHT, In Charges, IPs
	SGBV services: produce IEC materials on how the community can access justice and more community sensitization on payment of fees for Police Form 3 incase of GBV case reporting	CEHURD, NAFOPHANU, IPs, CSOs
	Involve religious and cultural leaders on issues of sexual gender-based violence	IPs, DHOs, CDOs CSOs
	Make routine mentorship of community resource persons that support health care system	Health facility in-charges, IPs

SRHR/HIV: CARE AND TREATMNET	Ensure constant supplies of ARVs and other essential drugs, supplies and reagents including testing kits to reduce on drug stock outs	National Medical Stores
	Set up and equip youth friendly corners/spaces	DHT, In Charges, IPs, CSOs
	Integrate TB, hepatitis B and HIV services and community sensitization should remain core	MOH, DHO, In Charges
	Nutritional education to promote positive living among PLHIV should take centre stage, including demonstration sites	In Charges, IPs
	All health facilities should embark on home based care programmes	DHO, In Charges and IPs
SRHR/HIV: SOCIAL SUPPORT AND PROTECTION	Provide spaces for counseling to ensure privacy and limit stigma	DHOs, In Charges, local leaders
	Train health workers on legal and human rights to enable them support the community more efficiently.	IPs and DLG
	Sensitization on patients' rights and responsibilities basing on patients' charter. The patients charter should be translated into the local language and disseminated both at the health facility and community	In Charges, DHT, IPs
	Legal support and protection through training of community paralegals and advocates, posters should be produced showing legal processes	IPs, CDOs
SRHR/HIV: INFRASTRUCTURE & UTILITIES	Procure ambulances for Health centers and provide a budget for their fuel and maintenance	Ministry of Health
	Construct staff houses to enable health workers reside at their work stations and report on time. This will also attract and retain staff from hard to reach and hard to stay areas.	DLG, IPs and MoH
	Construction of toilets and ensure cleanliness	DLG, In Charges
	Construct more structures and equip them with facilities to support expeditious diagnosis of client/ patient ailments and stay	MoH and DLG
SRHR/HIV: STAFF ATTITUDES	Intensify monitoring and supervision of the health facilities to reduce on absenteeism and late coming. Capacity building for in charges on modern management including results-based management be undertaken.	District Health Office, HUMC members
	Recruit more health workers to fill up the staffing gaps and reduce on the waiting time that clients take to see health workers.	Ministry of Health (MoH) and District Service Commission

REFERENCES

1. Adolescent Sexual Reproductive health polices, 2015
2. GOU: National Development Plan II (NDP II 2015/16- 2019/20)
3. MoH, National Medical Equipment Policy 2009 http//library. Health.go.ug>policy-documents
4. MOH: Heath Strategic Development Plan (HSDP) 2015/16- 2019/20
5. MoH: Uganda AIDS Indicator Survey (AIS 2011)
6. MoH: National Health Policy, 1999.
7. MoGLSD: National workplace policy 2003.
8. MoH; Uganda patient charter 2009
9. Uganda Aids Commission, National Strategic Plan 2020/2021-2024/2025

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