NAFOPHANU

USING COMMUNITY SCORECARD TO ASSESS THE QUALITY OF SEXUAL REPRODUCTIVE HEALTH AND RIGHTS (SRHR) AND HIV SERVICE DELIVERY IN KAMULI 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 Kamuli District through the Centre for Health Human Rights and Development (CEHURD). Kamuli District Local Government represented by the District Health officer (DHO) and District HIV Focal Person, Kamuli District Forum of People Living with HIV coordinated by Mr. John Stephen Salamuka, 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 Kamuli General Hospital, Namwendwa HCIV, Mbulamuti HCIII, Namasagali HCIII, Kitayunjwa HCIII and Balawoli 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
MCH	:	Maternal Neonatal and Child Health
MoGLSD	:	Ministry of Gender Labour and Social Development
MoH	:	Ministry of Health
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
PHCV	:	Primary Health Care
PLHIV	:	People Living with HIV
PNC	:	Post-Natal care
PrEP	:	Pre-Exposure Prophylaxis
SGBV	:	Sexual Gender Based Violence
SIDA	:	Swedish International Development Agency
SMC	:	Safe Male Circumcision
SRHR	:	Sexual Reproductive Health Rights
SRMNCAH	:	Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health
STIs	:	Sexually Transmitted Infections
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) conducted a community scorecard to assess the quality of Sexual Reproductive Health (SRHR) and HIV services in Kamuli 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 Kamuli General Hospital, Namwendwa HC IV, Namasagali HC III, Balawoli HC III, Kitayunjwa HC III and Mbulamuti HC III that were purposively selected to represent the various health facility levels and the population served in the district reaching 152 respondents (58Male 94Female). These were reached through focus group discussions with service beneficiaries and service providers and interface meetings involving key stakeholders such as leaders at community, facility and local government levels 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 ANC services, Condom supply and distribution, Testing services, Mentorship and coaching Programs, access to GBV services, Family planning, Adolescent HIV services, Integrated TB services, Nutrition services, Home Based Care, Treatment for Opportunistic Infections, Legal Support and Protection, Capacity Building for Care Givers, Rights Awareness, Psychosocial Support, as well as staff attitude towards work and attending to patients such as observance of working hours, listening to patients problems, politeness and respect for patient's rights.

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, gnder based violence 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. Key community concerns were sporadic stock outs of drugs and other supplies, understaffing, lack of ambulance and coordination vehicles, stigma and discrimination, lack of youth friendly services, poor referral systems, limited capacity building and coaching among others. On staffing norms, Kamuli General Hospital had 89.9%, Namwendwa HCIV had 66.7%, Balawoli HCIII had 84.2%, Kitayunjwa HCIII had 89.5%, Namasagali HCIII had 84.2% and Mbulamuti had 78.9%, with most facilities missing critical staff which led to multitasking. Space, equipment and utilities were inadequate.

The key recommendations raised from the assessment included infrastructural development, recruitment of more staff to fill the existing gaps, strengthening monitoring systems and the district to development of the HIV/AIDS strategic plan and SRHR/HIV integrated wok-plans. Others included; provision of staff accommodation, regular supply of drugs and supplies by National Medical Stores (NMS) to reduce on sporadic drug 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 Kamuli 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 Kamuli 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)

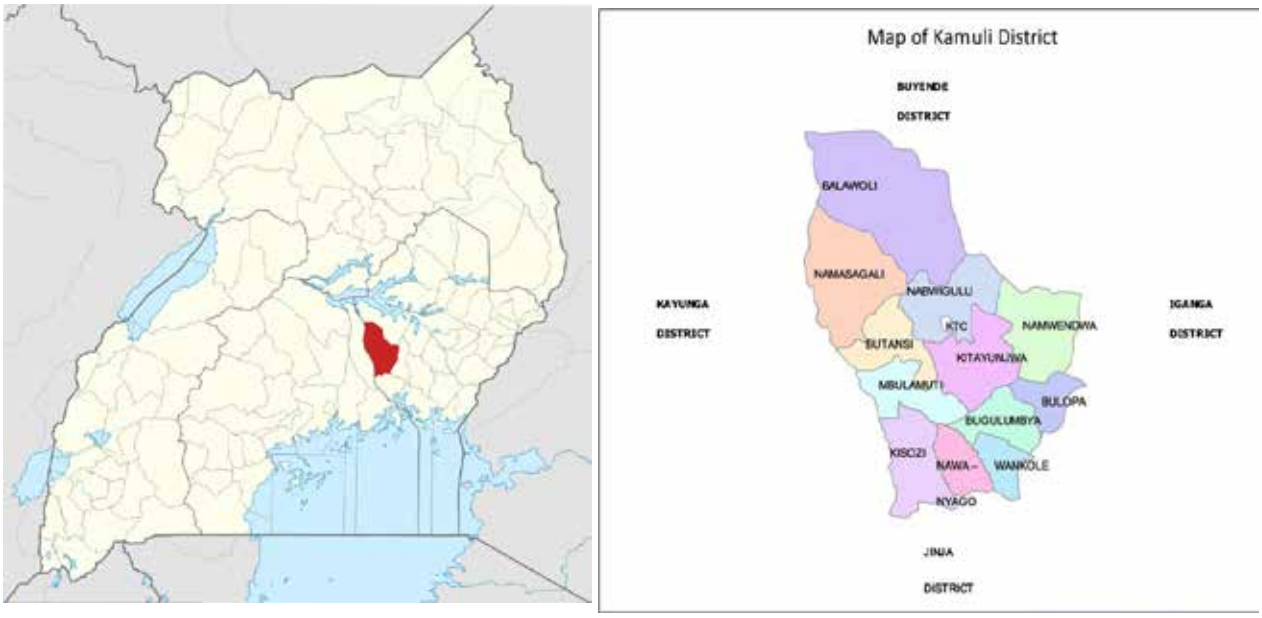
Adolescents are a heterogeneous group with different needs for health information, education and services. Reproductive health services are a basic human right for all people including adolescents. The participation and involvement of adolescents in planning, implementation, monitoring and evaluation 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 Kamuli District

Kamuli District is located in East Central Uganda bordered by Buyende District to the North, Luuka District to the East, Jinja District to the South and Kayunga District to the West. The district headquarters at Kamuli are approximately 74 kilometres (46 miles), by road, North of Jinja, the largest city in the Busoga sub-region. With counties of Bugabula and Buzaaya, there are 14 Sub counties, 71 parishes and 693 villages. When combined with Kamuli Municipal Council the district now comprises of 30 LCIIIs, 91 LCIIs and 773 LCIs. Those aged between 0-17 years are 126,093, aged 18-30 years are 41,137 and aged 31-59+ years are 35,794. The average population density is 68 persons per sq km and over 95% people live in rural areas as per Kamuli District Development Plan, 2015/16-2019/20.

The main activity in Kamuli district is agriculture and the majority of the population are farmers growing food crops such as maize, vegetables, cereals, bananas, potatoes, cassava, fruits and cash crops especially sugarcane and coffee. Fishing, cattle keeping, stone quarrying, bee keeping and retail trading are some of the extra economic activities undertaken by the populace in the district. Besides, the district is a multi-ethnic and multi-cultural society, with the predominant ethnic group being the Basoga who comprise 76 percent of the population. The Iteso people make up 3.9 percent and the Banyoro and Bagungu together make up 1.8 percent. Other Ugandan ethnicities make up the remainder (18.3 percent). The predominantly language spoken in Kamuli District is Lusoga, with some Luganda and English



Map of Uganda showing location of Kamuli district and its sub counties

1.4 Scope of the assessment

This Assessment covered one (1) General Hospital, one (1) Health centre IV and three (3) health centre III facilities in Kamuli 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.

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) and 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

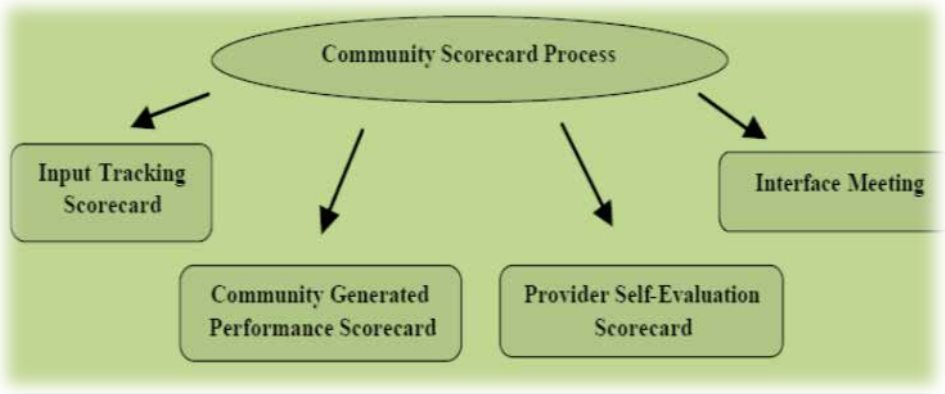
The study was undertaken in a catchment of six health centers; one general hospital, 1 health centre IV and three (3) health centres IIIs. In total, there were 9 Focus Group Discussions and 3 interface meetings reaching 152 participants with 58 men and 94 women.

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 feedback 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 Kamuli 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, GBV, HIV & MHCNB 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 Kamuli district. Eighteen (18) Focus Group Discussions (FGDs) attended by groups of; adolescent and young people (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	FGDs (N)	Interface meetings (N)	Male	Females	Totals
Kamuli	General Hospital	3.00	1	10	16	26
Namwendwa	HC IV	3.00	1	10	14	24
Namasagali	HC III	3.00	1	10	21	31
Balawoli	HC III	3.00	1	10	14	24
Kitayunjwa	HC III	3.00	1	7	15	22
Mbulamuti	HC III	3.00	1	11	14	25
TOTAL		**18.00**	**6**	**58**	**94**	**152**

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 Kamuli 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 Namasagali HCIII

Focus group discussion at Namwendwa HCIV

Interface meeting at Kitayunjwa HCIII

Interface meeting at Kamuli GH

Interface at Mbulamuti HCIII

Interface meeting at Balawoli HCIII

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& AIDS/GBV service delivery.

3.0 FINDINGS

This section presents results from the findings generated during the community scorecard conducted in Kamuli 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 1 general hospital, 1 health centre IV 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).

3.1.1Staffing at Kamuli General Hospital

A total of 179 staff are required in every general hospital, 161 were available and 18 missing, although had extra staff in certain sections as per table below;

Table 2: Staffing levels at Kamuli General Hospital

	Norm	Actual	Gap
MEDICAL OFFICERS			
Principal Medical officer	1	0	1
Medical officer special grade	1	0	0
Senior medical officer	1	2	1+
Medical officers	4	3	1
Sub Total	**7**	**5**	**3 [1+]**
ALLIED HEALTH PROFESSIONALS			
Senior clinical officer	1	6	5+
Clinical officers	5	3	2
Psychiatric clinical officer	1	1	0
Ophthalmic clinical officer	1	1	0
Health inspector	1	1	0
Medical Entomology officer	1	0	1
Radiographer	2	1	1
Physiotherapist	1	1	0
Occupational therapist	1	1	0
Orthopaedic officer	2	1	1
Health Educator	1	0	1
Assistant Health Educator	1	2	1+
Anaethetic officers	2	1	1
Theater Attendants	2	2	0
Senior Lab. Technologist	1	1	0
Lab Technologist	1	0	1
Lab Technicians	2	4	2+
Lab Assistant	1	5	4+
Sub Total	**27**	**33**	**6 [12+]**
DENTAL			
Dental Surgeon	1	0	1
Public Dental Health Officer	2	2	0
Dental Attendant	1	1	0
Sub Total	**4**	**3**	**1**

	Norm	Actual	Gap
PHARMACY			
Pharmacist	1	1	0
Dispenser	2	1	1
Sub Total	**3**	**2**	**1**
ADMINSTRATIVE STAFF			
Senior Hospital Administrator	1	1	0
Hospital Administrator	1	1	0
Personnel officer	1	1	0
Medical Social Worker	1	1	0
Nutritionist	1	1	0
Supplies officer	1	1	0
Office Typist	1	1	0
Stores Assistant	2	1	1
Medical Records Asst.	2	2	0
Senior Accounts Assist.	1	1	0
Accounts Assist.	1	0	1
Sub Total	**13**	**11**	**2**
NURSING			
Principal Nursing officer	1	1	0
Senior Nursing officer	5	5	0
Nursing officer/Nursing	17	9	8
Nursing officer/Midwifery	3	11	8+
Nursing officer/psychiatry	1	0	1
Enrolled Nurse	46	23	23
Enrolled Midwife	25	25	0
Nursing Assistant	15	9	6
Sub Total	**113**	**57**	**58 [8+]**
SUPPORT STAFF			
Darkroom Attendant	1	1	0
Driver	2	3	1+
Askari	2	9	7+
Cold Chain Att.	1	1	0
Mortuary Att.	1	1	0
Cook	3	2	1
Artisan	3	2	1
Sub Total	**13**	**9**	**4 [8+]**
TOTAL	**179**	**161**	**18 [19+]**

Kamuli General Hospital had 89.9% staffing as per expected of a General Hospital with some critical cadres missing, though had extra staff in certain positions.

Table 3: Staffing levels at Namwendwa HCIV

Staff cadres	Namwendwa HC IV		
	Norm	Actual	Gap
Senior Medical Officer	1	0	1
Medical Officer	1	1	0
Senior Nursing Officer	1	1	0
Public Health Nurse	1	0	1
Clinical Officer	2	2	0
Ophthalmic Clinical Officer	1	1	0
Health Inspector	2	1	1
Dispenser	1	1	0
Public Health Dental Officer	1	0	1

Staff cadres	Namwendwa HC IV		
	Norm	Actual	Gap
Lab. Technician	1	1	0
Ass. Entomological Officer	1	1	0
Nursing Officer(Nursing)	1	1	0
Nursing Officer(Mid-Wifely)	1	1	0
Nursing Officer (Psychiatry)	1	1	0
Ass. Health Educator	1	1	0
Anesthetic Officer	1	1	0
Theatre Assistant	2	1	1
Anesthetic Assistant	2	1	1
Enrolled Psychiatric Nurse	1	1	0
Enrolled Nurse	3	3	0
Enrolled Mid-Wife	3	3	0
Cold Chain Assistant	1	0	1
Office Typist	1	0	1
Lab. Assistant	1	1	0
Stores Assistant	1	1	0
Accounts Assistant	1	0	1
Health Assistant	1	1	0
Health Information Assistant	1	0	1
Nursing Assistant	5	0	5
Driver	1	0	1
Askari/guard	3	3	0
Porter	3	3	0
Total	**48**	32	16

Of the 48 staff expected at the facility, 32 were available representing 66.6%.

Namwendwa HCIV is a high volume facility that needs all the required staff to satisfy service delivery. We overwork to serve the many people that come in or stay here on a daily basis.' In Charge, Namwendwa HC IV

3.1.2 Staffing at Namasagali, Balawoli, Kitayunjwa and Mbulamuti HCIIIs

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

Table 4: Adherence to staffing norms in health centre IIIs

Staffing norms		Namasagali HC III		Balawoli HC III		Mbulamuti HC III		Kitayunjwa HC III	
	Norm	Actual	Gap	Actual	Gap	Actual	Gap	Actual	Gap
Senior Clinical Officer	1	0	1	1	0	0	1	1	0
Clinical Officer	1	1	0	0	1	1	0	1	0
Nursing Officer	1	1	0	1	0	1	0	2	1+
Registered Midwife	0	1	1+	0	0	0	0	0	0
Laboratory Technician	1	1	0	1	0	1	0	1	0
Enrolled Midwife	2	2	0	4	2+	3	1+	3	1+
Enrolled Nurse	3	2	1	4	2+	2	1	3	0

Lab. Assistant	1	1	0	2	1+	1	0	1	0
Health Assistant	1	1	0	1	0	1	0	1	0
Nursing Assistant	3	1	2	1	2-	2	1	0	3
Health Information Assistant	1	1	0	0	1	1	0	1	0
Entomology Assistant	0	1	1+		0	0	0	0	0
Askari/guard	2	2	0	2	0	1	0	2	0
Porter	2	1	1	1	0	1	1	1	0
TOTAL	**19**	**13**	**6**	**16**	**3**	**15**	**5**	**17**	

Table 5 : Kamuli District Score card-Summary staffing

Facility	Norm	Actual	coverage	add +	added %	Final coverage
Kamuli Gen Hospital	179	161	89.9	7	3.9	93.9
Namwendwa HC IV	48	32	66.7	0	0.0	66.7
Namasagali HC III	19	16	84.2	0	0.0	84.2
Balawoli HC III	19	16	84.2	0	0.0	84.2
Kitayunjwa HC III	19	17	89.5	2	10.5	100.0
Mbulamuti HC III	19	15	78.9	1	5.3	84.2

3.2 System Strengthening (Input Tracking: Infrastructure)

Health facilities infrastructure such as buildings, consultation rooms, theatres and others provide a conducive environment for patients to seek health services. It also enables health service providers to operate in a professional manner including ensuring privacy which is a critical ethical issue in health services such as Maternal Child Health (MCH), HIV and SRHR. Structural elements of the outpatient and the inpatient departments of the General Hospital, aHealth Centre IV and health centre IIIs were assessed for existence, functionality and performance. To note is that equipment and infrastructure remain inadequate in all the facilities visited.

Out Patient Department (OPD)

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, treatment, dispensing and counseling rooms, dental clinic, special clinics such as ART clinic, drug and general stores, laboratory, Uganda National Expanded Programme for Immunization (UNEPI) records, operating theatre among others as per Ministry of Health Guidelines (2000).

In Patient Department (IPD)

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.

3.0.1 Out Patient Department (OPD) and In Patient Department (IPD) at Kamuli General Hospital

Table 6: Input ranking at Kamuli General Hospital

Section	Indicator	Status	Comments
OUT PATIENT DEPARTMENT	OUT PATIENT DEPARTMENT		
	Out patients clinic	Yes	Adequate, has waiting area and seats
	Special out patients clinic	Yes	Psychiatry, ART, ANC and Family Planning, all adequate ART clinic with a youth corner, well organized Records Department Inadequate counselling rooms but adequate supply of ART drugs
	Examination room for clinical officer	Yes	Had examination coach table and integrated diagnostic setup
	Examination room for medical officer	Yes	Adequate and well furnished
	Injection room	Yes	Well-furnished, ventilated with waiting area, screens, lighter, trolley and injection stretcher bed.
	Treatment room	Yes	Adequate with coded waste bins
	Waiting room	Yes	Spacious area with seats for clients and patients seeking appointments and treatment; seats, IEC materials, condom dispenser and suggestion box.
	Multifunctional room	Yes	Immunization and UNEPI programme and storage of vaccines
	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, there is a phlebotomy area in addition to waiting area space
	Laboratory store	Yes	The laboratory store is fully stocked with laboratory equipment and reagents other stocks are got from the general store and has running water
	Blood bank	No	Blood is kept in the central laboratory and no specific room for blood from Nakasero blood bank.
DENTAL DEPARTMENT	Treatment room	Yes	Adequate with relevant equipment
RADIOLOGY DEPARTMENT	X-ray	Yes	Machine donated for chest and orthopedic but has never worked for more than twenty years. A small donated chest x-ray machine with gene expert machine in use. Orthopedic cases are referred. Need a consultant radiologist to check and find out why machine not in use
	Radiology film processing	Yes	Adequate
	Waiting area	yes	Adequate
GYNA & OBS DEPT	Treatment room	No	No special clinic

Section	Indicator	Status	Comments
PYSIOTHERAPY	Treatment room	Yes	Working daily, combined with Orthopedic clinic, the room was not adequate for the two departments
OPERATING THEATRE	Changing room	Yes	Adequate with changing shoes and boots
	Sterilization Room	Yes	Small , with shelves and lockers
	Sluice room/ Laundry	Yes	No laundry machine and this cause delays in case it rains
	Operating theatre(s)	Yes	One theatre with two operating tables but one overhead light for Caesarian section and general operations, sometimes they improvise with the screen to perform two operations. Oxygen supply is a challenge
GENERAL WARDS	IN PATIENTS DEPARTMENT		
	Medical ward	Yes	Existing in Male and Female wards in their segregated cubicles
	Surgical ward	Yes	Existing in Male and Female wards in their segregated cubicles
	Children's ward	Yes	Available with well segregated cubicles. Had ward reserved. IEC materials were well displayed
	Tuberculosis ward	No	No specific ward for TB patients at the facility.
	Obstetrics/ gynecology wards	Yes	Antenatal, maternity first labor, and delivery room with four beds and 25 bed capacity of the post-natal ward. The Gynecology room does exist at the facility but patients are treated as general patients and are handled at OPD and admitted at the Female Ward. Need more delivery beds and delivery sets.
	First stage labor	Yes	Had an examination bed, screens, intense lights, locker area, trolley and cabins.
	Midwife office	Yes	Adequate
	Nurses station	Yes	Not adequate in relation to the available staff
	Premature room	Yes	Intensive care unit neonates and premature babies is available but inadequate in relation to the demands. The Good news was that there are IPs who are constructing a 1000 bed capacity for neonates to serve the Busoga Region and beyond.
	Store	Yes	Adequate and computerized
PHARMACY	Pharmacy dispensary	Yes	Adequate
	Preparation room	yes	Had shelves and functioning equipment for keeping drugs
	Store	Yes	Adequate, well organized shelves
	Mortuary	Yes	Active, need rehabilitation, It is a referral Mortuary from lower level facilities
	Office	No	None
	Store	Yes	But not in use (the hospital does not receive a vote on food supplies for patients)

Section	Indicator	Status	Comments
KITCHEN AND LAUNDRY	Preparation Area	Yes	Had kitchen for patients
	Store	No	There is a steady supply of Ready to eat ready-to-use therapeutic food (RUTF) supplements for HIV clients and exposed infants and positive children who are malnourished.
	Wet area	No	None
	Laundry	No	No laundry, there is a designated area for caretakers washing
	Laundry store area (dirty)	No	Not available
	Laundry store area (clean)	No	Does not provide linen to patients apart from theatre.
	Generator room(s)	Yes	Near Maternity and Theatre

Kamuli GH - Xray machine and dental room

Kamuli GH showing general area

3.2.2 Out Patient Department (OPD) and In Patient Department (IPD) at Namwendwa HCIV

Table 7: Input tracking at Namwendwa HC IV

Indicator	Status	Comments
OUT PATIENT DEPARTMENT		
Health Education	Yes	Done on a daily basis
Counselling Room	Yes	Adequate, need a bigger waiting area
Dental Clinic	Yes	Not functional
Dispensing Room	Yes	Available, small
HSD office	Yes	Inadequate
Laboratory	Yes	Small
Treatment room	none	Improvised
UNEPI room and Records	Yes	Well kept
Operating Theatre	Yes	Operational
OPD drug store	yes	Adequate
Records Room(s)	Yes	ART Files for both general and Maternity (EID)
OPD Pharmacy	yes	Adequate
OPD Examination Room	No	Improvised by use of screens
In Patient Departments		
Children Wards	Yes	Combined with female adults
Female wards	Yes	Combined with Children and Males
Male Wards	Yes	Combined with Children and females and children, have a general ward for all patients
Maternity Waiting Room	No	Use Postnatal ward
Maternity First stage Labour Room	No	Use Postnatal ward

Indicator	Status	Comments
Maternity sluice Room	Yes	Available
Delivery Room	Yes	Adequate
Linen Store	No	Not Available
Neonatal Intensive Care Unit	Yes	Not available
Maternity and Postnatal Ward	Yes	Adequate
Placenta Pit	Yes	Available
Rubbish Pit	yes	Not adequate, littering in the compound
Incinerator	Yes	Adequate
Washing Area	Yes	A spot in the compound for care takers
Youth Friendly Corner	Yes	Inadequate, need more facilities
Mortuary	Yes	Misused/Abandoned
Transport	Yes	Motorcycle, no ambulance, old one grounded
Generator	Yes	Only at maternity and theatre side

General ward at Namwendwa H/C III

Delivery room at Namwendwa H/C III

Laboratory at Namwendwa H/C III

UNEPI at Namwendwa H/C III



Namwendwa HCIV unused mortuary, *OPD waiting area and Theatre*


Namwendwa HCIV OPD Namwendwa HCIV IPD

3.2.3 In Patient Department (IPD) and Out-patients' Department (OPD) Structure at, Namasagali, Balawoli, Kitayunjwa and Mbulamuti Health Centre IIIs.

The functionality of IPD and OPD has a direct bearing on service delivery for SRHR, HIV and other integrated services.
The table below highlights status of IPD and OPD at Namasagali HC III, Balawoli HC III, Kitayunjwa HC III and Mbulamuti HCIII.

Table 8: Out and In-patient Department Health Centre IIIs

Indicators	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III	Status
Counseling room	Yes	No	yes	Yes	Had a counseling room, improvised counselling services in the Clinician's office Not adequate in Mbulamuti HC III
Dispensing room	Yes	Yes	Yes	Yes	The four facilities had dispensing rooms, well furnished with a dispensing window, table and cupboards for keeping drugs
Treatment room	No	No	Yes	Yes	The facilities had no treatment rooms and treatment was being carried out in the examination rooms

Indicators	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III	Status
OPD Laboratory	Yes	Yes	Yes	Yes	The laboratories were functional at all facilities, with microscope and testing kits and reagents. Gaps were on missing critical equipment such as Genexpert, water extension and sporadic stock out of testing supplies.
OPD drug store	Yes	Yes	Yes	Yes	Existed at all facilities and well organized. Challenge was limited space
ART clinic	Yes	Yes	Yes	Yes	Available in all the facilities although space was limited.
OPD Examination room	No	Yes	Yes	Yes	Kitayunjwa HC III improvised in examination room Adequate, with screens and supportive equipment Mbulamuti HC III- was in poor condition, awaiting launch of new building block Namasagali HCIII used treatment room
Male ward	No	No	No	Yes	Had no wards for male patients, mixed up with women
Children/ Female ward	Yes	Yes	Yes	Yes	Available but with few beds, all patients combined
Linen store	No	No	No	No	The facilities had no linen store and some health workers kept in their homes
Delivery Room	Yes	Yes	Yes	Yes	The facilities had delivery beds, screens, crash trolley and sterilizer. However, there was no water facility in the delivery room
Maternity ward	Yes	Yes	Yes	Yes	Available but limited space. The ward had no screens and beds were inadequate. Poor hygiene remains a critical gap
Maternity first labor	No	No	No	No	Facilities improvised in maternity ward
Maternity waiting room	No	No	No	No	All had no designated maternity waiting rooms
Ward nurse station	No	No	No	No	Improvised on ward
Sterile store	No	No	No	No	No store but had sterile stove and autoclave (boiler) for the equipment are used in some facilities e.g Balawoli HC III

'Although our facility offers maternity services and are functional, access to reproductive health information and services is limited' Expert Client, Mbulamuti HCIII

Triage area, Mbulamuti HCIII

Examination room at Kitayunjwa HC III

Examination room at Mbulamuti HC III

Delivery bed at Mbulamuti H/C III

UNEPI fridge Balawoli HCIII

Health education space at Balawoli HCIII

New block at Mbulamuti constructed by a Power Company

Dental bed at Namasagali HCIII OPD

Ward beds, with mosquito nets at Balawoli HCIII

UNEPI fridge at Mbulamuti HCIII

Ward at Namasagali 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, 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 educator/buddies, access to Post Exposure Prophylaxis (PEP), Pre Exposure Prophylaxis (PrEP) for adults and availability of family planning services as the indictors of prevention.

Indicators	Kamuli GH	Namwendwa HCIV	Namasagali HCIII	Kitayunjwa HCIII	Mbulamuti HCIII	Balawoli 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 Quality of ANC Services (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	Kamuli GH	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti 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. The staff were competent with some having benefitted from comprehensive maternal child health training. The elimination of Mother to Child Transmission (eMTCT) programme to ensure delivery of HIV free babies was being undertaken in all the facilities. Post natal care was being provided and immunization of babies done. Despite the good ranking, there were gaps that require attention such as low male involvement and limited follow up on mothers in the community. Recommended was to support expert clients and VHTs to conduct follow up, use local and traditional leaders to sensitize the community on importance of strict attendance of ANC as well as encouraging male involvement in service uptake.

'If the VHTs could be supported by IPs plus linkage facilitators to conduct follow ups, this would make 100% ANC service uptake.' Female participant Kitayunjwa HCIII.

Delivery bed at Namasagali HCIII

Early Infant Diagnosis (EID) Office at Kamuli GH

Neonatal unit, Namwendwa HCIV

Weighing scales at Balawoli HCIII's delivery room

Nursery beds at Namwendwa HCIII

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. Epidemiological evidence suggests that safe male circumcision reduces the risk of sexually transmitted diseases (STD) and HIV infection by 60%. 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. 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, availability of kits and local and traditional leader's involvement. During the interface meeting for consensus score, the participants ranked SMC as good at Kamuli General Hospital and Namwendwa HCIV and the rest of the facilities were not carrying out the SMC hence the poor rating.

Category	Kamuli GH	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti 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 at Kamuli GH and Namwendwa HCIV. But the HCIIIs were not conducting SMC on a regular basis and would rely on outreaches from Implementing Partners (IPs) despite the fact that some of their staff had been trained as SMC surgeons. Recommended was that SMC should be static at HCIII level.

'The health workers were trained and can conduct SMC but there are no kits.' In Charge Balawoli HC III.

SMC tent at Kamuli GH

4.1.3 Provision of IEC/BCC materials

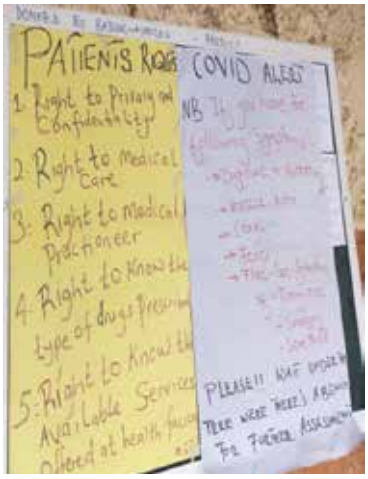
IEC materials such as posters, brochures, flyers and billboards among others are intended to draw attention to information about basic facts on diseases such as on mode of transmission, prevention or risks to health. IEC materials for SRHR, HIV and other integrated services can be in various forms to 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, Kamuli General Hospital participants ranked IEC/BCC as good while the rest of the facilities ranked fair respectively.

Category	Kamuli G H	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus Score						
Service providers score						
Women score						
Men score						

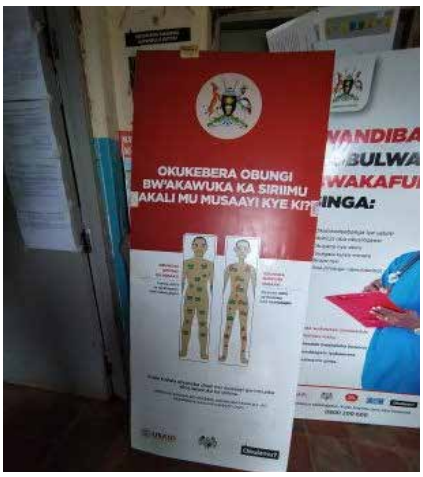
The good rating was due to the fact that IEC materials especially posters were available, most with up to date information, placed in strategic points including trees in the compound and some in translated in local languages. For instance, Namwendwa HCIV had a 'talking compound' with a good number of messages placed on trees and outer side of the walls while Kamuli GH had a television on top of very many posters placed in strategic sections of the hospital. Though IEC materials existed, some had old information and had few translated into Lusoga, the locally spoken language and many others needed replacement as papers were tearing. Also to note is that some materials were in small font or photocopies of black and white making it difficult to read from afar. Recommendations included provision of translated materials and updating materials to align with the community and national programs.

'We need posters more posters especially on the rights of patients, causes of diseases and how to mitigate or manage. This would ease our work spending a lot of time explaining to patients. Sometimes we have to go our own way in order to keep our clients up to date.' Nurse, Namasagali HCIII

'We have a good poster for PLHIV and ho we can be managed but is it in black and white making it difficult to read from distance. The posters are indeed a big source of information and so having good clear ones in full colour will be very helpful.' Female participant, Kitayunjwa HCIII



IEC materials at Namwendwa HCIV



Pull up banner at Mbulamuti HCIII

IEC materials at Kitayunjwa HCIII

IEC material at Namasagali HCIII

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. The community scorecard assessed availability, accessibility and uptake of condoms. During the interface meeting for Consensus score all participants ranked male condom supply as good at Kamuli General Hospital, Namasagali HC III, Balawoli HC III and Mbulamuti HC III. Kitayunjwa scored fair due to low stock supplies which do not satisfy the target receivers; while Namwendwa HV IV ranked poor due to stock outs for three months

Category	Kamuli GH	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

The strong points were; availability of condoms and condom dispensers in an open strategic spaces for access. A number of messages on condom use and demonstration aides were available at most facilities. However, sporadic stock out of condoms and limited condom education were cited as challenges that require urgent redress.

'When condoms are delivered here, they get finished in the very week of delivery. Then we have to wait till next delivery schedule. We need a much bigger supply. Some of our facilities should not receive as per level but as per consumption.' Health worker, Kitayunjwa HCIII

Male condom Dispenser at Balawoli HC III

Male condom dispenser at Namwendwa HCIV

4.1.5 Condom Supply for women

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 it as poor service except Kamuli General Hospital who ranked as fair.

Category	Kamuli GH	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

The reasons for poor rating included; there were no female condoms but also poor attitude engraved in cultural values for male domination and that a woman should never be seen carrying condoms. In addition females need to be educated/sensitised, put dispensers for female condoms and encourage women for usage. Recommendations included: availing female condoms, sensitisation of women on condom use, and awareness creation to the community that women can also carry their own condoms. 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 if this prevention method is to effectively take root.

'I have never seen female condoms, so there is need to create demand through awareness. The hospital should put dispensers for female condoms as well, preferably with different colors on top of condom education.; Personally, I am ready to try them' Female Participant, Kamuli General Hospital

'Women are still shy and do not like female condoms knowing that men can use theirs. We would bring them and they would expire, we will try again and sensitise them to enable uptake.' Health Worker, Mbulamuti HCIII

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 and pregnancy testing as good while all rated cancer screening as poor. For STI/STD esting/screening, it was ranked good at Kamuli GH, Balawoli and Mbulamuti HCIIIs and fair at Namwendwa HCIV, Kitayunjwa HCIII and Namasgali HCIII.

Testing services for HIV

Category	Kamuli GH	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

Testing services for pregnancy

Category	Kamuli GH	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

Cervical and breast cancer screening

Category	Kamuli GH	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

Testing and treatment services for STIs/STDs

Category	Kamuli GH	Namwendwa HCIV	Namasagali H III	Balawoli HCIII	Kitayunjwa HCIII	Mbulamuti H 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. 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 STDs such as 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, other suspected cases were referred. In instances were screening is done, the facilities may not give treatment but just prescriptions and so patients buy from outside the health facilities. Key recommendations included stocking adequate treatment supplies for STIs and putting cancer education and screening on the agenda of each health facility.

'Cancer is a very big threat and yet its screening is not given as much as HIV or even TB testing. Community sensitisation on cancer is almost non-existent. Our health workers need to talk about timely cancer screening and management since early detection can save live.' Female participant, Namwendwa HCIV

4.1.7 Access and availability of 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 Ministry 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. SGBV has often been attributed to traditional/cultural beliefs, alcoholism, illiteracy and poverty among others and many victims are afraid to report rape and other forms of violence due to intimidation, lack of support from authorities especially police, non-existent of post trauma support, hostility and ridicule from the community and state's inaction in ensuring redress. 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, Namwendwa HCIV and Mbulamuti HCIII participants ranked SGBV as good while Kamuli General Hospital, Namasagali HC III, Kitayunywa HC III and Balawoli HC III scored fair respectively.

Category	Kamuli GH	Namwendwa HCIV	Namasagali HCIII	Balawoli HCIII	Kitayunjwa HCIII	Mbulamuti H III
Consensus score						
Service providers score						
Women score						
Men score						

The good ranking was a result of availability of PEP and emergency contraceptive pills to victims of rape and defilement, community awareness and support, awareness programs and support by health workers in conducting physical examinations and filling of police form 3. This was also attributed to the fact that the police case forms were free but had to be signed at a fee of UGX 20,000 as facilitation to court. They recommended that the health workers should examine all clients and sign for free but let the budget cater for court facilitation from the in charge. Further to notice were gaps on counseling victims and encouraging victims to take PEP. Therefore, community sensitization, training of staff and community resource persons to be SGBV 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.

'Women do not know procedures to follow when SGBV occurs. Health workers are cooperative, referrals are done and police form signed but upon payment of a fee. Even then, HWs fear to be summoned or getting facilitated and thus need formal training on GBV. Also, sometimes, PEP/emergency pills are out of stock and this limits the kind of support victims get as part of emergency care.' Female participant, Balawoli HCIII.

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 and HIV programs. During the interface meeting for consensus score, Kamuli GH, Namwendwa HCIV, Namasagali HCIII, Balawoli HC III and Kitayunjwa HC III participants' ranked mentorship program as good while Mbulamuti HCIII ranked as fair respectively

Category	Kamuli GH	Namwendwa HCIV	Namasagali HCIII	Balawoli HCIII	Kitayunjwa HCIII	Mbulamuti HCIII
Consensus score						
Service providers score						
Women score						
Men score						

The good score stemmed from the fact that all peer educators/buddies are supported in a timely and were doing well in the health facilities attached to. A number of peers had participated in continuous medical education and refresher trainings alongside the health workers. Several IPs had supported capacity building of the community resource persons including peer buddies. The fair rating at Mbulamuti HC III was due to lack of adequate buddies' training. However, the number of peers remains low to serve at the health facilities and follow up colleagues in the community and this therefore calls for recruitment, regular training and mentoring of more peer buddies. Facilitation of peers should equally be considered although it is a voluntary role as they have responsibilities to take care of.

'We are 'dangerous' substitutes when it comes to serving our peers and hence must be well armed with sufficient and up to date information for our ART clients. We however need regular updates on new regimens and related information'. Expert Client, Mbulamuti HC III.

4.1.9. Family Planning

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 scorecard examined accessibility of services, stock status of commodities, community perception and changes encountered on uptake of service. During the interface meeting for consensus score, participants ranked family planning as good save for Namasagali that scored fair due to stock outs of some short term methods as well as no female condoms uptake.

Category	Kamuli GH	Namwendwa HCIV	Namasagali HCIII	Balawoli HCIII	Kitayunjwa HCIII	Mbulamuti HCIII
Consensus score						
Service providers score						
Women score						
Men score						

The positive ranking of the service was based on availability of both short and long terms FP methods at the facility and community awareness of the 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, cultural 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 nightmare for most male partners, most times they are not bothered and often outcomes of not paying attention are usually long lived and negative.' Male participant, Balawoli HC III

Family planning post at Balawoli HCIII

IEC material on free FP at Mbulamuti HCIII

4.2 SRHR/HIV: CARE AND TREATMENT FOR SRH/HIV/GBV

This sub section illustrates care and treatment in regard to; Access to Family planning, ANC & ART commodities, 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

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
Kamuli GH							
Namwendwa HC IV							
Balawoli HCIII							
Mbulamuti HCIII							
Kitayunjwa HCIII							
Namasagali HC III							

Key			
	Poor	Fair	Good

4.2.1 Access to ART commodities

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, other than Namwendwa HCIV that score fair, the rest of the facilities scored good.

Category	Kamuli GH	Namwendwa HCIV	Namasagali HCIII	Balawoli HCIII	Kitayunjwa HCIII	Mbulamuti HCIII
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. The newly initiated PLHIV under the Test and Treat programme were covered alongside health education talks that were being conducted especially by expert clients to promote adherence and general positive living. At Namwendwa HCIV, they were experiencing sporadic stock outs especially of DTG, Lopinavir pellets and AZT. Recommended was uninterrupted access of ART as HIV management is chronic and to avoid drug resistance that can be fatal.

'Although ARVs are readily accessible, we still have long turnaround time to receive our viral load results, which by the way health workers no longer explain. As long as they see a happy face emoticon, they say all is well and nothing more. And then, what happened to CD4 count? We were always told it is the baseline but now viral load testing has taken over all other tests. As PLHIV, we need to be educated on which is which.' Male Participant, Namasagali HCIII

PLHIV ART files at Balawoli HCIII. All the visited health facilities have files arranged well that way

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 other 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, participants ranked treatment for opportunistic infections as good at Kamuli General Hospital, Kitayunjwa HCIII and Mbulamuti HCIII, fair at Namwendwa HCIV and Balawoli HC IIIs while it was poor at Namasagali HCIII respectively.

Category	Kamuli GH	Namwendwa HCIV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

Treatment for OIs and STIs was available but health workers indicated that 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 this 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. Special to note was the issue of abrupt Septrin disconnections where most clients were noting a feeling of insecurity psychologically as it was not well explained and well understood. Recommended that the counsellors and expert clients continuously educate and support them in order to cope.

'At first I had to buy some septrin supplies because I was feeling funny and feeling sick whenever I would stop, note that I have been on this for more than thirty years so it was part of me. However, because of continuous support from the staff I came to terms with the situation and eventually stopped taking Septrin. So, we need more information on the eligibility criteria as we talk to our peers.' Expert Client, Kamuli General Hospital.

4.2.3 Adolescent SRH/HIV Treatment and Youth Friendly Services (YFS)

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, young people involvement in facility management, trained personnel to support young people,

integrated system for service access including safe corners and sensitization to increase service uptake. During the interface meeting for consensus score, all facilities ranked the YFS as good apart from Mbulamuti HC III who rated the services as fair and Kitayunjwa HC III who had no services.

Category	Kamuli GH	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

The reason for the good services was the presence of Implementing Partners (IPs) that support youth friendly services at the various facilities, with games and sports items and trained health workers to manage youth friendly corners/spaces. Special to note on Namasagali HC III Corner needs renovations or they find another space within the facility to offer the services from. The participants recommended that the YFS should continue and the staff need to fight stigma among the adolescents who still feel shy to come and assess the services. For Kitayunjwa HCIII, the district need to support the centre to create the youth corner and train the health workers as well.

'We try our best to help the youth but we still feel we need to reach out to their parents to understand how parenting is, through outreaches and parenting seminars for those in school and those out of school.' Youth Corner Supporter Nurse, Namasagali HCIII

'Our Youth Corner is still wanting, the issue of free STIs treatment leaves a lot to be desired and often our stocks cannot suffice the whole quarter.' Nurse, Mbulamuti HCIII

The youth friendly corner at Namasagali HCIII that requires urgent renovations and furnishing

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 all participants rated TB diagnosis treatment while for Hepatitis B, it was scored good at Kitayunjwa and Mbulamuti HCIII,

fair at Kamuli GH and Namwendwa HCIV and poor at Namasagali and Balawoli HCIIIs.

Integrated TB Management

Category	Kamuli G H	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus Score						
Service providers score						
Women score						
Men score						

Hepatitis B Screening and vaccination services

Category	Kamuli GH	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HCIII
Consensus score						
Service providers score						
Women score						
Men score						

The scoring for TB was good due to availability of Anti TB drugs and community linkage with the VHTs for follow up and sessions targeting TB management ongoing. 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 Kamuli Hospital and IPs such as TASO, AIDS Information Centre, among others. RHITES EC was supporting a number of facilities in B management including laboratory repairs and equipment. Coughers spaces were being created though the community observed that a number of times TB results delay and no isolation wards. 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. Even then, TB was given a lot of attention compared to Hepatitis B. 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. Recommended also the building of an adequate TB ward at Namwendwa HC IV and Kamuli General Hospital for referrals and more support by the district health office to Namasagali HCIII and Balawoli HCIII over Hepatitis B testing and vaccination.

'Many people do not know much about Hepatitis B and many health workers in Kamuli District are not immunized against the disease thereby putting them at risk. We need to be sensitised on a regular basis.' Female participant Kitayunjwa HC III

TB signpost at Kitayunjwa HCIII

Kamuli GH laboratory was upgraded courtesy of RHIRES EC

4.2.5. Nutrition services

In a bid to complement service and support 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 as well as nutritional counseling services. During the interface meeting for consensus Kamuli General Hospital rated it as fair while the rest of the participants ranked nutrition support and services as poor while

Category	Kamuli GH	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus Score						
Service providers score						
Women score						
Men score						

Facilities were not offering nutrition or food supplements for the severely malnourished people, and awareness creation with demonstrations and during health talks at OPD, ART clinic day, ANC and Maternity ward for new mothers was quite limited. Where food supplements were provided, which was quite irregular, did not cover all the people who needed the food supplements, whether children, elderly and general PLHIV community. The poor ranking was attributed to lack of food supplements and demonstration facilities. The recommendations were provision of food supplements to the vulnerable PLHIV especially children, pregnant and lactating mothers, elderly and other highly needy people affected by HIV, community sensitization on nutrition and support demonstrations at facilities.

4.2.6. Home based care programs

Home Based Care works within the health systems and structures in each health care service delivery points, involving cross referrals from all levels of care whether public or private, formal or informal to the households. This involves health workers, health extension workers and expert clients visiting the clients for psychosocial and adherence support, testing services, screenings, referrals and linkages, immunization and vaccination, health education among others. During interface meeting for consensus score, Kamuli General Hospital participants ranked the Home Based Care programs as fair while the rest of the health facilities rated HBC as poor respectively.

Category	Kamuli GH	Namwendwa HCIV	Namasagali HCIII	Balawoli HCIII	Kitayunjwa HCIII	Mbulamuti HCIII
Consensus score						
Service providers score						
Women score						
Men score						

The good score stemmed from having a lot of support from implementing partners, for inastance, RHITES

EC was providing a lot of support for home based care. The reasons for poor ranking were attributed to lack of funds for transport yet with wide geographical area, poorly motivated and facilitated village health teams (VHTs) and expert clients, and work overload where staffing levels are low requiring multi-tasking. The recommendations were to 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.

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 as well as legal support services.

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
Kamuli GH				
Namwendwa HC IV				
Kitayunjwa HCIII				
Mbulamuti HCIII				
Namasagali HCIII				
Balawoli HCIII				

KEY			
	Poor	Fair	Good

4.3.1 Quality of Psychosocial support services

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 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 SGBV victims, rape and defilement cases, referral system and supporting tools. During the interface meeting for consensus score, psychosocial support services were scored good at Namwendwa HCIV, Namasagali HCIII, Kitayunjwa HCIII and Mbulamuti HCIII whereas it was fair at Kamuli GH and Balawoli HCIII

Category	Kamuli G H	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

The strong points included availability of both pre and posttest counseling especially for HIV, presence of expert clients to support peers, ensuring patient's privacy and confidentiality by having designated counselling rooms/spaces, follow ups and referrals when individual cases require more external support or lost to follow. The gaps were; inadequate counseling rooms/spaces few skilled personnel trained in counselling and management of trauma cases especially for rape and defilement and lack of facilitation for expert clients to follow up their peers. Recommendations were; establishment of post-test clubs,

community +`sensitization available psychosocial support services to increase uptake, training of health workers in psychosocial counseling, strengthening community referral and support systems to ensure victims get justice.

'There is need for extra training and refresher courses for specialized skilling in psycho social support for all health providers in our sub district. HIV counselling has been largely handled especially with support from expert client but for rape and defilement cases, we do not know what to do.' Health Worker, Namwendwa 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, Namasagali, Balawoli and Mbulamuti HCIIIs scored good while Kamuli GH, Namwendwa HCIV and Kitayunjwa HCIII ranked it as a fair service.

Category	Kamuli GH	Namwendwa HCIV	Namasagali HCIII	Balawoli HCIII	Kitayunjwa HCIII	Mbulamuti HCIII
Consensus Score						
Service providers score						
Women score						
Men score						

Although health workers are always available at dispensing drugs prescribed, 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 and SRHR care and limited space at health facilities to cater for patients' privacy. RHITES EC has also made a positive change reflecting the reasons for the good scores. Recommendations included; training of care givers and provision of facilitation for these trainings, have a position of a counselor as part of government staffing norms, recruitment and/or allocate more staff especially in high volume sites, community sensitization on role of treatment supporters and PLHIV buddies to be given central stage as number one caregivers.

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 and health worker support to patients to access treatment and justice and respect for patients' dignity. During the interface meeting, participants from Kitayunjwa and Mbulamuti HC IIIs ranked rights awareness as good and the rest of the facilities scored fair.

Category	Kamuli GH	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

The good ranking at Kitayunjwa and Mbulamuti HC IIIs was attributed to availability of patients' charter both in English and local language (Lusoga), education by health providers to create awareness among community members on rights and responsibilities and available services. The fair ranking from the rest of facilities was reflecting the gaps that 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

Patients' charter at Balawoli HCIII

Lusoga version of the Patients' Charter at Mbulamuti HCIII

4.3.4 Legal Support and Protection

The NSP indicates strategic interventions 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 affected by HIV. 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, all participants from all facilities ranked legal awareness and support as fair.

Table 4: Legal Support and Protection

Category	Kamuli G H	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

The fair ranking was 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 were 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. The community paralegals that are crucial for community judicial information especially steps to accessing justice by the aggrieved parties were not exisiting. 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, even for cases such as rape and defilement that do not require such a payment. 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. Immediate attention was for NAFOPHANU and CEHURD to produce IEC materials on outlined steps for victims to access justice and train community advocates as paralegals to combine roles.

'Like the rest of Busoga, Kamuli as a district experiences many cases of rape and defilement. But people do not know how to handle when they experience such cases. As a matter of urgency, we need IEC materials such as posters and training of community paralegals to teach people the various steps taken incase have an SGBV case to report.' Male Participant, Namwendwa HCIV

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 Safe Water	Transport	Staff Houses	Toilets	Kitchen	Shelter	Communication facilities	Power and type
Kamuli GH								
Namwendwa HC IV								
Kitayunjwa HCIII								
Mbulamuti HCIII								
Namasagali HCIII								
Balawoli HCIII								

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, theater (where it exits), delivery room, laundry area, bathrooms and other key sections requiring direct water connections. Results gathered from interface meeting for consensus score, participants from Kamuli General Hospital, Namasagali HCIII, Balawoli HC III and Mbulamuti HCIII ranked clean and safe water as good while Namwendwa HC IV and Kitayunjwa HC III rated as fair.

Category	Kamuli GH	Namwendwa HCIV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

The good ranking at Kamuli General Hospital was attributed to water sources being within the facility, water connected to all key sections such as the theatre, laboratory, maternity ward and staff quarters. Other health facilities had adequate water supplies with several wzater harvesting tanks. The fair rating was attributed to unreliable water supply, water not being connected to key sections such as maternity and laboratory, poor water management and access systems and water shortages especially in dry seasons. 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 to be harvested and/or stored.

Water tank at Namasagali HC III

Water tanks at Kitayunjwa HCIII

Water source at Kitayunjwa H/C III

Rainwater harvesting at Balawoli HCIII

Bore hole at Namwendwa HCIII

Kamuli GH water tank

Patient drinking water, Balawoli HCIII and Namasagali HCIII, donated by KOICA

4.4.2 Transport Means

According to the MoH standards, facilities are supposed to have an ambulance/ means of transport to strengthen referral and follow up mechanism of patients within their geographical coverage and outside to other facilities. The transport means for the health is fundamental to support operations of the health facilities, strengthening linkages, referrals and outreach programs. The community scorecard assessed availability of an ambulance, motor ambulance care, motorcycles and facility specific vehicles. During the interface meeting for consensus score, participants' ranked transport means as fair at Kamuli General Hospital and Kitayunjwa HCIII while the rest of the health facilities rated as poor.

Category	Kamuli GH	Namwendwa HCIV	Namasagali HCIII	Balawoli HCIII	Kitayunjwa HCIII	Mbulamuti HCIII

Consensus score						
Service providers score						
Women score						
Men score						

Kamuli General Hospital means of transport was rated fair because of one working ambulance that was donated by the Japanese Agency for International Development while the second ambulance was at the time of the study in the garage. Another one was grounded requiring costly repairs. Kitayunjwa HV III's had a tricycle as a means of transport, Namwendwa HC IV, Namasagali HC III and Balawoli HC III were rated poor because they completely had no means of transport at the time of survey. Namwendwa HCIV had a grounded irreparable ambulance while Namasagali HC III's ambulance needed equally costly repairs. This greatly affects mostly maternal referrals and hence all respondents recommended acquisition of ambulances by government but also targeting aspiring members of parliament to procure and donate.

'Our ambulance has been grounded for a long time so when we refer mothers, they have to use private cars or we call ambulance from Kamuli General hospital at a fee and sometimes mothers cannot afford; if it can be r

'We get challenged when we need to refer mothers to Kamuli Genral Hospital, sometimes we end up losing babies because of transport delays.' Midwife, Mbulamuti HC III)

Grounded ambulance at Namasagali HCIII

Tricycle at Kitayunjwa HCIII

Transport at Namwendwa HCIV

Grounded ambulance at Kamuli GH

New Kamuli GH Ambulance donated by KOICA

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 each of the facilities. During the interface meeting for consensus score, staff accommodation was scored fair at Kamuli General Hospital, Balawoli HCIII and Namasagali HCIII and while it was scored poor at Namwendwa HCIV, Kitayunjwa HCIII and Mbulamuti HCIII respectively.

Category	Kamuli GH	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

Generally staff accomodation was not good. Kamuli Geneal Hospital, Namasagali HC III and Balawoli HC III was rated as fair because they had staff housed but were not sufficient for all the staff and lacked security thereby required fencing. In other facilities, most staff were either commuting from outside the facility or were sharing. At Namasagali HCIII, the houses were old and shared for most of the staff. At Namwendwa HCIV, staff houses were few and needed fresh painting and somerepairs. For some, houses lacked water and electricity connections. Even then, most of the houses were old requiring urgent renovations. Recommendation were to construct more staff houses, renovation of existing structures and provision of housing allowances to staff not accommodated at the facility.

Staff quarters at Kitayunjwa HC III

Balawoli HCIII staff quarters

Mbulamuti HCIII staff quarters

Namwendwa HCIV staff quarters (at OPD and IPD)

Namwendwa HCIV staff quarters (at maternity and theatre area)

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 both people with disabilities and marginalized population 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. During the interface meeting for consensus scores about Toilet, Kitchen and Shelter are reflected in the tables

Regarding toilets, Balawoli and Kitayunjwa HCIIIs score good, was fair at Kamuli GH, Mbulamuti HCIII and Namasagali HCIII while at Namwendwa HCIV, it was a poor score. For instance, at Balawoli HCIII toilets were new, good and enough. Mbulamuti HCIII had new toilest constructed awaiting official launch of all new buildings. The largely fair score stemmed from having toilets on site but largely inadequate compared to numbers served, some old, requiring repairs and mostly unclean. For facility kitchens, though built, they were had small, inadequate and dirty places for cooking.

Toilets

Category	Kamuli G H	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

Toilets at Namasagali HCIII

Toilets at Balawoli HCIII

Toilet at Kitayunjwa H/C

Toilet at Mbulamuti H/C III

New toilet at Mbulamuti HCIII

Toilet at Namwendwa H/C III

Kitchen

Category	Kamuli GH	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

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 both people with disabilities and marginalized population 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. During the interface meeting for consensus score, participants ranked Toilet, Kitchen and Shelter as fair and as good.

Namasagali HCIII kitchen

Kitchen at Kitayunjwa HCIII

Kitchen at Mbulamuti HCIII

Kitchen at Namwendwa

Shelter

Category	Kamuli GH	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

Shelter at Namwendwa HCIV

Shelter at Kamuli GH

'At our health centre, toilets are more than staff houses, so we are fully covered.' Health worker, Balawoli HCIII

Disposal was a big problem, some in open air and others that had disposal bins, sorting was a big problem. Open air burning was happening though facilities like Kamuli GH and Namasagali HCIII had incinerators.

Kamuli GH disposal bins, refuse not sorted and refuse in compound of Namwendwa HCIV

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. During the interface meeting for consensus score, apart from Namwendwa HC IV who rated fair the rest of the health facilities scored communication facilities as good.

Table: Showing availability of Communication Facilities (telephone, suggestion box and call box)

Category	Kamuli G H	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service Providers score						
Women score						
Men score						

Communication materials and facilities such as hospital telephones, suggestion boxes, computer and notice boards were available especially at all health facilities. Apart from Namwendwa HC IV who did not have a phone reflecting a fair rating; an Implementing Partner RHITES EC bought telephones and there is always air time. This has enabled health workers and expert clients to call for follow up and psycho social support. However, the suggestion boxes were not being used and notice boards largely had facility information. At Balawoli HC III, their IP provided internet and a large screen for training and zoom meeting with their partners.

Phone at Kamuli GH

Noticeboard, Balawoli HCIII

Satellite dish at Namasagali HCIII

Suggestion box at Mbulamuti HCIII

TV set at Kamuli GH

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, Kamuli GH, Namasagali and Balawoli HCIIIs rated availability of power as good while it was fair at Kitayunjwa and Mbulamuti HCIIIs and poor at Namwendwa HCIV respectively.

Category	Kamuli GH	Namwendwa HCIV	Namasagali HCIII	Balawoli HCIII	Kitayunjwa HCIII	Mbulamuti HCIII
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. However, Namwendwa HCIV needed strong solar panels and all facilities connected to hydro electric complained on prepaid Yaka method because power can run out when money for that particular quarter has not been released.

Solar panel, Namasagali HCIII

Kamuli GH panels

Kamuli GH switch board

4.5 SRHR/HIV: ATTITUDE OF STAFF

When community members visit the hospital for any given service, health workers are supposed to receive them, listen to their issues and direct/guide on next steps. The score card examined health workers' observance of working hours, politeness to service users, listening to patients' problems and respect for patients' privacy and keeping secrets.

Health Facility	**SRHR/HIV: Attitude of staff**			
	Observing Working Hours	Polite Behaviour	Listening to Patients Problems	Respect of Patients Privacy
Kamuli GH				
Namwendwa HC IV				
Namasagali HC III				
Balawoli HC III				
Kitayunjwa HC III				
Mbulamuti HC III				
Key				
	Poor	Fair	Good	

4.5.1 Observing Working Hours

In order to provide effective and efficient SRHR/HIV and other health related services, health workers must be available. Whether it is a 12 hour or 24 hour based facility, health workers are meant to observe working hours, as per duty rota and attached departments. The community scorecard therefore assessed health workers reporting to duty on a daily basis as per schedule and shifts and if they keep time. During the interface meeting for consensus score all facilities save for Mbulamuti HCIII that scored fair ranked observance of working hours as good.

Category	Kamuli GH	Namwendwa HCIV	Namasagali HCIII	Balawoli HCIII	Kitayunjwa HCIII	Mbulamuti HCIII
Consensus score						
Service providers score						
Women score						
Men score						

In all the six facilities visited facilities for score card, most health workers kept time including those that were not accommodated at the health facility except Mbulamuti HC III who scored fairly. Attending to patients in time, and some health workers reporting early and leaving late amidst the tight schedules without any complaints was noted. The community recommended that the health workers who scored good should keep it up and those who scored fairly improve. There is also need to discipline isolated cases of staff who report late and leave early. Provision of accommodation to staff and a canteen at the facility would reduce on the time spent going home to have meals.

'I do appreciate that even the isolated cases who reach late, once they start no lunch until all the lines are cleared. They need to improve though not to keep patients waiting' Male Participant, Balawoli HC III

'The top managers are always here early, so most staff are always at their stations in time.' Expert Client, Kamuli, General Hospital.

'Our staff are always at station and accessible.' Female Participant, Namasagali HC III

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 outcomes. Ministry of Health provided the 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 work relationship in health care setup following the appropriate procedures provided in the patients' charter 2009. This includes conduct when handling clients, 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	Kamuli GH	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HCIII
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 is still room for improvement for a few health workers who become impolite especially when they are tired. There is therefore need to recruit to cover staffing gaps and create a duty rota that could have shifts for high volume sections.

'The health workers care for us so much that it became easy for me to disclose to them my HIV status. They are polite, caring and will go a long way to ensure you access your treatment and follow you up until you have suppressed viral load.' PLHIV participant, Kitayunjwa HCIII

Support to PWD at Kamuli GH

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. During the interface meeting for consensus score, all facilities participants' ranked listening to patients problems as good.

Category	Kamuli G H	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

Listening as a skill was being practised by health workers which made it easy for patients to open up and even stay in a queue for long hours. Key recommendations given were to recruit more health workers and counsellors to reduce on heavy work load and to continuously organize refresher trainings on various topics including application of listening skills.

'Our counsellors and health providers have 'elephant ears', they do listen and listen sensitively.' Female Participant, Kitayunjwa HCIII.

'Our counsellors are very caring and good listeners; we have no complaints.'Male Participant, Namasagali HCIII.

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. The scorecard assessed respect for patients' and during the interface meeting for consensus score, all health facilities conceded staff are able and keep secrets.

Table 4: Respect of Patients Privacy

Category	Kamuli GH	Namwendwa HC IV	Namasagali HC III	Balawoli HC III	Kitayunjwa HC III	Mbulamuti HC III
Consensus score						
Service providers score						
Women score						
Men score						

The good ranking was based on availability of consultation and examination for confidentiality, rooms with curtains and screens. Even where they are no rooms, the workers improvised to ensure patients are comfortable. The patients' files were well kept. 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.

;Even if it means taking the client outside the tent or in a separate room, they will do it.' Female Participant, Kitayunjwa HC III

'Because rooms are not enough, sometimes they use screens to keep things private in respect of patients and clients.' Male participant, Mbulamuti HC III

Server room and ART records that are securely locked to keep confidentailaity

5.0 LIMITATIONS

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

6.0 CONCLUSIONS

Based on the findings, the assessment concludes that Kamuli District has made efforts to provide quality MCHNB/HIV/SHR/GBV and other integrated services. The rating was good on most components except for female condoms and home based care programmes. Staffing levels were quite high with Kamuli HCIV at 100%. However, there were gaps on staffing, regular stock out of drugs and other supplies, limited follow up of clients in their communities, long and limited information on SRHR/HIV/AIDS/MCHNB/GBV 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. Kamuli 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

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