FLEP
BUSOGA DIOCESE

USING THE COMMUNITY SCORE CARD TO ASSESS THE QUALITY OF SRH/HIV/AIDS SERVICE DELIVERY IN JINJA DISTRICT

September 2018

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In undertaking the assessment of HIV/AIDS and Adolescent Sexual Reproductive Health and Rights service delivery in Jinja district, FLEP is thankful to the district leadership for the good relations and partnership with FLEP.

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Executive Director

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List of Abbreviations and Acronyms

AGYW	Adolescent Girl Youth and Women
AIDS:	Acquired Immune Deficiency Syndrome
AIS:	AIDS Indicator Survey
ANC:	Ante-natal Care
ART	Anti-Retroviral Treatment
ASRH	Adolescent Sexual Reproductive Health
CPR:	Contraceptive Prevalence Rate
CSC	Community scorecard
DHO:	District Health Officer
DHT:	District Health Team
eMTCT:	elimination of Mother-to-Child Transmission of HIV
FLEP	Family Life Education Program
FP	Family Planning
GUSO	Get Up Speak Out
HC:	Health Centre
HH:	House Hold
HIV:	Human Immuno deficiency Virus
HMIS:	Health Management Information System
HSD:	Health Sub-District
HTS:	HIV Counseling Testing services
IEC	Information Education and Communication Materials
IPD	In Patient Department
LC:	Local Council
MNCH:	Maternal, Neonatal and Child Health
MoGLSD	Ministry of Gender Labour and Social Development
MoH	Ministry of Health
MTCT:	Mother-to-Child Transmission
NAFOPHANU	National Forum of People Living with HIV/AIDS Networks in Uganda

OPD	Out Patient Department
OVC	Orphans and Other Vulnerable Children
PHC	Primary Health Care
PLHIV:	People Living with HIV/AIDS
PNC:	Post-natal care
RH	Reproductive Health
SBCC	Social Behavior Change Communication
SDG:	Sustainable Development Goal(s)
SRHR	Sexual Reproductive Health Rights
STI	Sexual Transmitted Infection
TBA:	Traditional Birth Attendant
ToR:	Terms of Reference
U5:	Children under-five years of age
UAC	Uganda AIDS Commission
UBOS:	Uganda Bureau of Statistics
UDHS:	Uganda Demographic Health Survey
UNEPI	Uganda National Expanded program on Immunization
UNYPA	Uganda Network of People Living with HIV
VHT:	Village Health Team(s)
YPE	Youth Peer Educator

EXECUTIVE SUMMARY

Get Up Speak out (GUSO) project was rolled out in October 2016 with the goal to reduce new infections amongst the young people and adolescents aged 10 - 24 years. The project that runs from 2016 -2021 is implemented by alliance members comprised of, Family Life Education Program (FLEP), UNYPA, National Forum of People Living with HIV/AIDS Networks in Uganda (NAFOPHANU), Straight Talk Foundation (STF), Restless Development, Reach hand Uganda, and Reproductive health Uganda. In order to achieve the project objectives, collection of evidence is inevitable.

In October 2018, on behalf of the GUSO alliance, FLEP conducted community scorecard to assess the level of health service delivery in the district of Jinja. Basing on the Adolescent sexual reproductive health policy and National HIV strategic plan. The assessment looked at 4 thematic areas of; prevention, care and treatment, social protection and protection and system strengthening (staffing norms, infrastructure and equipment). The Community Scorecard is participatory community based monitoring and evaluation tool that enables citizens to assess the quality of services rendered to the citizens such as health care.

The purpose of community scorecard was to empower the community and other stakeholders (service beneficiaries, service providers and other key stakeholders) assess the quality of SRHR & HIV services for the young people and make recommendations on SRHR & HIV services to policy makers, Policy Implementers, Development Partners, Civil Society, Private Sector and other stakeholders.

The assessment targeted a catchment of four (4) integrated health centers distributed according to different levels of service delivery that included: Budondo HC IV, Bugembe HC IV, Butagaya HC III and Magamaga HC III. The methodology to obtain data included using desk reviews, focus group discussions, key informant interviews, consultative meetings, direct observations and interface meetings. Quantitative data was entered using EPI Data and analyzed using statistical package SPSS whereas qualitative data was analyzed using thematic analysis and then presented in frequency tables and graphs.

The assessment revealed that their efforts to ensure access to health services such as Youth friendly HIV prevention messages available, Availability of HIV and STI prevention commodities, Provision of IEC Materials

on comprehensive YFS related to SRSHR and HIV, Integrated out reaches that target young people, Mentorship programmes for the peer educators/buddies, YP care and treatment IEC materials tailored to STI and HIV related issues, Health worker's competence on AY people SRHR and HIV prevention and management, Consolidated AY people ART, Youth friendly counsellors, /peer counsellor's /expert clients or champion, gazetted days for YP to get HIV, STI treatment and Family Planning Service, Referral mechanism, Respect to Patients' Rights, Attitude of staff, Knowledge on laws, policies on SRHR and HIV and Health workers' knowledge on rights Whereas the staffing norms have not reached the maximum of the government ceiling, the staff available were overworked as they multi-task to fill existing gaps which negatively affect the quality of services. Equipment and infrastructure remain inadequate but a few health workers are accommodated and have structures to work from.

The gaps that negatively affect HIV and Sexual Reproductive Health service delivery in the district such as lack of comprehensive counseling skills, stock outs of drugs and other supplies, low levels of staffing, lack of transport, absence of Viral load testing services, high levels of stigma which limits PLHIV from accessing services, limited HIV competent staff, poor counselling for the adolescents, and lack of youth friendly services, limited linkages between health facilities and community, limited political involvement and absence of HIV& AIDS strategic plans at the district level. There were no systems to monitor and report on HIV community systems and preventive initiatives, inadequate public education and poor communication facilities.

The key recommendations from the assessment were focused on infrastructure development, recruiting of more staff to fill the gaps, constant supply of drugs and reagents, strengthening supervision and monitoring systems and district to develop their own HIV/AIDS Strategic Plans. There is also need to continue with community sensitisation sessions by the district local government, health facilities and VHT on family planning benefits and maternal health services.

1.0 BACKGROUND

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

Uganda's long term plan (Vision 2040) envisions a transformed country from peasant to a modern and prosperous country by 2030. The second national development plan (National Development Plan II) stresses the need to invest in health for the country to reach middle income status by 2020. To realize the vision, the Ministry of Health developed a five year, health sector development plan (HSDP) for the period 2015/16-2019/20), with its vision as "To have a healthy and productive population that contributes to economic growth and national development". The health of the population of any country is central to socio –economic transformation of the people and improved welfare. The Government of Uganda recognizes this important aspect and has made efforts to address some of the key constraints to service delivery.

The Health Sector Development Plan (HSDP) goal is to accelerate movement towards universal health coverage with essential health and related services needed for promotion of a healthy and productive life. The HSDP indicates targets for the health sector to be achieved by 2019/20 that include: increasing ART coverage from 42% to 80%, increasing deliveries in health facilities from 44% to 64%, reducing the Infant Mortality Rate per 1,000 live births from 54 to 44 and the Maternal Mortality Ratio per 100,000 live births from 438 to 320/100,000; reducing fertility to 5.1 children per woman; reducing child stunting as a percent of under-5s from 33% to 29%; increasing measles vaccination coverage under one year from 87% to 95%; increasing TB case detection rate from 80% to 95% and increasing HC IVs offering Comprehensive Emergency Obstetric Care (CEmOC) services from 37% to 50%.

Despite the above efforts, there are still challenges that affect the delivery of health care services. According to HSDP 2016, HIV, malaria, lower respiratory infections, meningitis and tuberculosis are leading cause of death in the country. The health sector is a labor intensive sector and availability of adequate human resource for health is pivotal in the achievement of the objectives. The absence of adequate health workforce is still a key bottleneck for the appropriate provision of health services, with challenges in adequacy of numbers and skills,

retention, motivation, and performance. Despite the recruitments undertaken by government and partners in 2014, the status of the health care workforce is at 69% of the approved posts as at the end of 2015.
The above situation needs to be urgently addressed for the country to meet the Sustainable Development Goal (SDG) targets on health by 2030 especially target 3 of SDG 3 that states that "by 2030, end the epidemics of AIDS, TB, malaria and Neglected Tropical Diseases, and combat hepatitis, water-borne diseases and other communicable diseases."

This is in line with Uganda National HIV Strategic Plan (NSP) 2015/16 - 2019/20 whose vision is a healthy and productive population free of HIV and AIDS and its effects. The NSP aims at reducing new HIV infections, decreasing HIV related mortality and mobility, reducing vulnerability to HIV/AIDS and mitigate its impact on PLHIV groups and other vulnerable groups, as well as having an effective sustainable HIV service delivery system strengthened for universal access to quality efficient and safe services.

The Adolescent sexual and reproductive health policy 2015 mainstreams adolescent health concerns in the national development process in order to improve their quality of life and standards of living by providing and increasing availability and accessibility of appropriate, acceptable, affordable quality information and health services to adolescents, influence positive behavioral change amongst adolescents, provide policy makers and other key actors in the social and development fields, reference guidelines for addressing adolescent health concern, creating an enabling legal and social-cultural environment that promotes provision of better health and information services for young people.

Adolescent health policy guidelines and service standards, 2011 aim to rationalize 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.

1.1 HIV/AIDS Situation in Uganda.

The HIV epidemic remains the single most human health scourge challenging the world. While globally the epidemic shows prospects towards a decline, the magnitude of the situation in East and Southern Africa remains worrying (17.7 – 20.5 million People Living with HIV) contributing over a half of the world's HIV burden (36.7 million). Despite marked progress in reducing the new HIV infections in Uganda, particularly among children, and minimizing AIDS related death, the country continues to have a high burden of the disease as indicated by the 6.2% HIV prevalence national wise, 7.6% among females and 4.7% among males. This corresponds to approximately 1.2 million people aged 15 to 64 living with HIV in Uganda. HIV prevalence is higher among women living in urban areas (9.8%) than those in rural areas (6.7%). (UPHIA report, 2017) and high HIV infections in specific sub-populations and sub-regions (Central 1 8.0%, Central 2 7.6%, East central 4.7%, Mid east 5.1 %, Mid-North 7.3 %, West Nile 4.9%, Mid-West 5.7% and South West 7.9%)

1.1.2 SRH and HIV situation in Jinja

Regarding east central region prevalence is estimated at 4.7% (UPHIA). In Jinja District, HIV prevalence rate is at 5.4% compared to the National prevalence rate of 7.3%, thus the target population of PLHIV is estimated to be 26997 adults and children (District HIV Strategic Plan, 2018). The key drivers of HIV &AIDS epidemic are: early, multiple and extra marital unsafe sexual relationships and Behavioral practices like widow inheritance, commercial sex work among others.

1.1.3 Health Care Service Delivery in Jinja

Jinja has 72 health care points distributed across the 5 health sub districts in both urban and rural setting. Despite having an even distributed health facility across, the district acknowledges a number challenges that affect service delivery in accordance with swot SWOT analysis carried out in 2018. These include; Very old structures of health facilities, Lack of fire safety equipment and insurance, Lack of adequate staff accommodation, None insurance of the IT equipment, Delays during procurements based on the PPDA act, Inadequate staffing levels, Weak appraisal system, Limited knowledge of health managers in financial management for none financial managers, -Late submission of reports and order forms, Limited in-service training for health workers especially at health Centre IIs, and Limited analysis and utilization of information generated at lower levels (District Health Sector Work-Plan, 2018).

1.2 Jinja district

1.2.1 District Profile

Jinja district is located in the south eastern part of Uganda. It is a small district found east of the Nile River and along the Northern shores of Lake Victoria. The district is sub divided into 3 counties namely, Butembe, Kagoma, and Jinja Municipality. There are 11 sub counties; 52 parishes and 427 villages.

Table 1: The district projected demographics for 2015/16

Demographic Variable	Proportion	Estimated Population
Total Population	100%	499,941
Children below 18 years	56%	279,967
Adolescent youth (10 -24 yrs)	34.70%	173,480
Orphans (for children below 18yrs)	10.90%	54,494
Infants below 1 year	4.30%	21, 497
Children below 5 years	20.20%	100,988
Women of reproductive age	20.20%	100,988
Expected number of pregnancies	5%	24,997
Number of suspected Tuberculosis cases	0.30%	1,500
Number of expected births	4.90%	24,497
People under 15 years of age	46%	229,973
Estimated PLHIV	3.50%	17,498

Source: Jinja Health sector budget work plan (2018)

2.3 ABOUT FLEP

Family Life Education Program (FLEP) is a non-political, non-profit making organization founded in May 1986 under the auspices and patronage of the Church of Uganda-Busoga Diocese. FLEP aims to increase access to, coverage of, and utilization of quality and comprehensive reproductive health, HIV&AIDS and TB prevention, care and treatment services to communities in eEast Central Uganda (Busoga region). This is achieved by promoting and providing integrated high quality clinical, community based and mobile reproductive health HIV&AIDS and TB services. FLEP is implementing five projects targeting young people 10-24years; by providing Sexual Reproductive Health and Rights services through the Get up Speak out (GUSO).

3.0 THE GET UP SPEAK OUT (GUSO) PROJECT

Get up speak out is a 5year (2016-2020) project implemented through the alliance of 8 organisations; Reproductive Health Uganda, Reach A Hand Uganda, Restless Development, Family Life Education Program, Straight Talk Foundation, CEHURD, Co-option of Health Entrepreneurs for GUSO-Flex Project and UNYPA/ NAFOPHANU. The project aims at strengthening and sustaining alliance, empowering youth to voice out their rights, ensuring access to SRHR information through channels, increasing use of friendly SRHR services and improving social, cultural and political environment for gender sensitive youth friendly SRHR. Each of the organisations is responsible for delivering on a number of outputs. FLEP takes lead increasing access to and provision of youth friendly services and increases district advocacy for sexual reproductive health rights and HIV& AIDS response. The project targets adolescents and young people aged 10-24 years, including in-school and out-of-school youth, teenage mothers, pregnant girls and young women and young people living with or affected by HIV together with their Gate keepers such as parents, teachers in the Jinja, Iganga, Mayuge and Bugiri districts.

The activities include; strengthening peer provider on HIV/SRHR out reaches, operational research, strengthening referral, innovation in mix method, and joint community health work raining in PEs and PPs. To enable citizens, understand and give feedback to the quality of SRH and HIV/AIDS service, FLEP undertook a service delivery assessment using a Community Score Card in the district of Jinja.

GUSO-Flex is a 2 year program that aims at addressing the key bottlenecks hindering young peoples' access to integrated SRHR/HIV information and services. Flexibility Fund project focuses on thematic areas of the National HIV Strategic Plan of HIV Prevention, Care, Treatment and Support, Social Support and Systems Strengthening. The project centers around three goals namely i) An integrated range of SRHR services and HIV testing, prevention and treatment methods ii) Improved access for people living with HIV to SRHR services and iii) Provision of sexuality education, which includes attention to gender relations and stigma surrounding HIV/AIDS.

To enable citizens understand and give feedback on accessibility and quality of SRH and HIV/AIDS services, the SRHR Alliance-Uganda undertook a service delivery assessment using the Community Score Card methodology where Restless Development took lead in conducting the community scorecard in Jinja District.

3.1 Scope of the Assessment

This Assessment covered a total of four (4) accredited ART health care facilities namely; Budondo HC IV, Bugembe HC IV, Magamaga HC III and Butagaya HC III Jinja 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 FGD for community members and health workers to get the feedback on the services offered.

3.2 Assessment Design

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

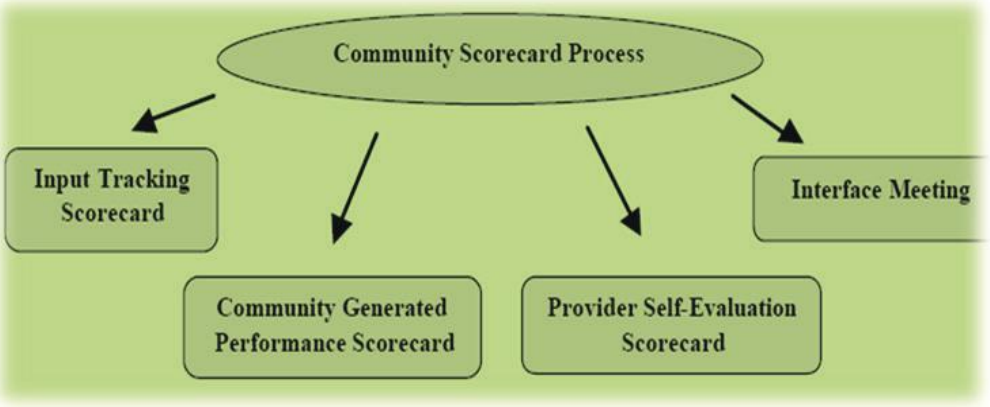
3.3 Study Population

The study was undertaken in a catchment of four health centers in Jinja district. In total, there were 12 Focus Group Discussions, 4 interface meetings and 4 Key Informant Interviews. A total of one hundred and ninety-two people (96 males and 96 females) participated in the Focus Group Discussions and 196 (135 females and

105 males) participated in the interface meeting. The key informant interviews were conducted with the in charges of the 4 health centers totaling to four persons.

4.0 METHODOLOGY

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



Source: Janmejay & Parmesh (2009)

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

4.1 Objectives of the Community Score Card.

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

Inception meeting.

The meeting between the survey team and District Health Officer for information and authorization to carry out the study. The meeting was used to obtain district data as part of district back ground information, disease management and planning and other resource document to inform the assessment. The meeting was informative on which health facilities to access and key indicators to access as per the guidelines and polices that guide implementation of programs.

Training in social accountability.

Five days training of research team on the score card process was undertaken to enable the implementers become familiar with the tool and social accountability was conducted to the One DHO's Representative, selected 8 district youth leaders from Bugembe Division, Butagaya, Budondo and Buwenge , 5 FLEP staff and 2 peer educators to support the process, the training covered a number of policy documents and guidelines in service delivery. Prior to field assessment tools were reviewed and key indicators identified guided by the consultant.

4.2 Demographic Representation

The study was conducted in a catchment of four (4) health facilities in Jinja district. Three (3) Focused Group Discussions (FGDs) attended by groups of; boys/men 10- 24 years, girls and young women and service providers were carried out in each of the 4 health facilities making a total of 12 FGDs. Four interface meetings were also held and were attended by representatives from the three groups that participated in the FGDs and selected community leaders who gathered to brainstorm on the availability and quality of the services and made recommendations on what is needed to improve the quality of services. One key informant interview was conducted with the in-charge of each health facility visited where staffing norms, services and equipment availability was discussed.

Table 2: Study demographic characteristics

Name of Facility	Level III	FGDs (N)	Interface meetings (N)	Key Informant/Input Tracking (N)
Bugembe	HC IV	3.00	1	1
Budondo H	C IV 3	.00	1	1
Magamaga	HC III	3.00	1	1
Butagaya	HC II	3.00 1	1	
		12.00	**4**	**4**

4.3 Quantitative Data collection methods

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

Key informant interviews

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

Focus Group Discussions
The focused group discussions were used to collect qualitative and partly quantitative data from adolescent's youth and peer educators (Men and Women separately) and the health workers.

Interface Meeting
Joint meetings targeting decision makers (politicians, technocrats) service users (community Youth (men and women) including youth leaders, peer educators and community members), service providers and opinion leaders (community and religious leaders) were held at each of the sites. The interface meetings were to measure the scores against the performance indicators of the youth and service providers for a consensus score (overall score). It was also to develop a joint action plan on how to address the identified gaps.

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

4.5 Quality Assurance
The assessment team employed a number of quality assurance mechanisms that included, training of data collectors, data review, and supervision of data collectors at all the data collection sites.

4.6. 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 to collect the data on SRH & HIV / AIDS service delivery.

5.0 FINDINGS

This section presents results for the study conducted in Jinja District. The findings are presented in line with the thematic areas of; Prevention, Care and Treatment, social support and systems strengthening and per the reviewed tool by GUSO member alliance widely guided by the indicators of the adolescent sexual reproductive health and national HIV strategic plan 2016-2020

5.1 In-put tracking

Based on MoH staffing and infrastructure guidelines, tracking was done to ascertain on the number of different facilities and systems such as; support infrastructure, human resources, leadership and governance, equipment data management to have a comprehensive health package in the health care facilities visited that included 2 Health Centre IV and 2 Health Center IIIs

5.1.1 Infrastructure

During the input tracking, the assessment focused on the number of health facilities offering AY SRHR and HIV services, storage facilities, commodities and medicines for HTS/STI/Cancer/CD4/Viral load testing equipment; OLs, STI treatment; contraceptives, emergency pill, as well as ART, PEP, PrEP, and condoms, head gears, lubricants, gloves, sanitizers condom dispenser, operational AY people days/corners, gender sensitive toilets with water and drainage, health education facilities and out reaches. Screening for cancer, STI and hypertension was being conducted in all the 4 facilities visited In Budondo HC IV, CD4 count machine were present, with Functional laboratories and testing kits for STI and HIV. Amidst the service rendered at the facility viral load services were being supported by the hub transport system.

In Budondo HC IV the facility has a store all other commodities to support uptake of services are available except no cancer screening machine, and PreP. However, access to the available services is based up screening and testing. Facility had youth friendly corner that operates on every Tuesday. On access to facilities like gender sensitive latrine, the facility has for both female and male by not PWD complaint.

Basing on the minimal requirement for a health facility according to the adolescent sexual reproductive health services in Bugembe HC IV the facility had no specific storage facilities for both commodities and equipment for all the department, no cancer screening conducted, no lubricants supplies, however all the preventive measures and supporting equipment were available such access to PrEP, PEP, contraceptive pills, and condom supplies with dispenser at strategic locations in the facility such as at the designated youth friendly corner which supplement uptake of youth friendly services.

Magamaga HCIII with minimal health package offers only screening for hepatitis, diabetes and pressure services. Facility has a drug store and minor store, commodities like contraceptive pills, STIs and cancer screening. Machines assessed were BP machine, Pima machine for CD4, testing kits, condoms and condom dispensers.

Butagaya HC III had 3minor stores and 1 main store for drug store, cancer screen, treatment for opportunistic infections, and access to ART, PrEP and PEP. The facility had Youth friendly corner, with genders sensitive toilets and specific days for health education

Adequate Toilets, Kitchen and Shelter; in a bid to support access to services at the facility, Toilets, Kitchen and shelter necessitates to complement adherence to services. Scorecard assessed shelter kitchen and toilet availability, the community awareness on using the facilities, the sanitation and hygiene at the facilities, availability of facilities that are disabled compliant.

The system was infiltrated by long turn over time for CD4 and Viral load results in lower health facilities, poor hub system in the district, limited staff trained in comprehensive HIV service delivery and knowledge, stock out of reagents, long distance moved by clients to access the services and CD4 machine break downs, no cancer screens, poor youth friendly services at all health facility entry points.

Water Sink at maternity ward in Budondo HC IV


Stand by generator in Bugembe HC IV

5.1.2 Human Resources

Based on the sexual reproductive health policy and facility standard guidelines for equipment, community scorecard assessed the number of staff competent enough to serve AY, VHTs services and peer support focused to AY. It further looked at trained and refresher training of health workers on AY SRHR/HIV services provision, attitude of health workers and support staff to AY people at HC and availability of clean and safe water.

5.1.3 Leadership and Governance

Leadership structures at the unit with representation of ay- local council, HIV AIDS Committes. committee, health management, Human Unit Management Committees. District SRHR/HIV policies, plan and progammes, feedback and redress system for AY SRHR/HIV violations in service delivery and budget allocation to AY SRHR/HIV services- budget allocation for Adolescent and Young People's programmes.

5.2 Input Tracking: OPD and IDP

Health center 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 SRHR/ HIV and sexual reproductive health Structural elements of the outpatient and the inpatient departments of the Health Centre IV and Health Center level III facilities were assessed for structural existence and performance.

5.2.1 Outpatient Department (OPD)

An Out Patient Department (OPD) is designed for treatment of patients who do not require to be admitted. (Patients are attended to by health workers and return to their places of aboard). Under OPD the assessment looked at health education, counseling room, dental clinic, dispensing room, ART clinic, OPD drug store, examination room, laboratory, treatment room, UNEPI records and operating theatre and early infant diagnosis.. (Ministry of Health guidelines 2000). At the 4 four health centers visited, the team observed the following;

Counseling Room

The health centers II and III visited had no counseling rooms except in Budondo HCIV. The facilities with no counseling room were, Bugembe HCIV, Butagaya and Magamaga HCIII. However, they carry out counseling sessions in the consultation room, treatment room and dispensing room.

Table 3: Existence of a counseling room

	No	Yes
	N (%)	N (%)
Butagaya and Magamaga HCIII	2(100) 0	(0)
Bugembe HCIV	1(100)	0(00)
Budondo HCIV	0(0) 1	(100)

Health Education Centre (shelter)

Health care facilities are required to offer health education as part of good health practices and ensure prevention of diseases. All the facilities visited had health education rooms (Centre) and the health education Centre (shelter) was used on antenatal clinic days. The Centre had (IEC) materials on malaria prevention, Family Planning, HIV prevention, T.B prevention/ management and nutrition. However, the Centres lacked furniture, and the available structures were in poor condition with Poor hygiene.

Dispensing Room

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

OPD: Drug Store

In order to ensure quality of medicines, drugstore should be well ventilated with temperature of 15-25% free from (WHO guidelines for drugstore, 2015) The input tracking in Budondo HCIV, Bugembe, Butagaya and Magamaga HCIII confirmed existence of OPD drug store. Poor ventilation, lack of temperature monitoring devices and poor structure, congestion which an impact on shelf life of the drugs.

Table 4: Drug store availability

Health facility	No	Yes
	N (%)	N (%)
Butagaya and Magamaga HCIII	0(0) 2	(100)
Bugembe HCIV	0(00)	1(100)
Budondo HCIV	0(0) 1	(100)

OPD: Examination Room

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

In Jinja all health facilities had examination rooms, the rooms were operated by both clinical and medical officers. However, not all the required equipment existed. These included limited space, lack of furniture, no screens, no integrated diagnostic setup in Butagaya and Magamaga HCIII, no computer stand/ table and computer in all the 4 health facilities which affect disease diagnosis and management at the facility level.

	No	Yes
Facilities visited	N (%)	N (%)
Butagaya and Magamaga HCIII	0(0) 2	(100)
Bugembe HCIV	0(0)	1(100)
Budondo HCIV	0(0) 1	(100)

Table 5: Examination room availability

OPD: Laboratory

A Laboratory must have a sink, eye wash station, functional biosafety area, fire extinguisher, chemical fume hood, chair and table, computer, electricity connection, refrigerator, microscope, water connection, waste segregation bins, reagents, bin liners, cabins and screens and enough light. All 4 health facilities Budondo HCIV, Bugembe, Butagaya and Magamaga HCIV had laboratories. However, none of the laboratories met the standards which implies improper testing procedures .

The laboratory lacked some reagents and test kits, small size, waste segregation bins, bin liners, inadequate water supply and lack of essential equipment.

Table 6: OPD Laboratory

	No	Yes
Facility level	N (%)	N (%)
Butagaya and Magamaga HCIII	0(0) 2	(100)
Bugembe HCIV	0(0)	1(100)
Budondo HCIV	0(0) 1	(100)

OPD: Treatment Room

The OPD treatment room require to have crash trolley, defibrillator, sterilization equipment, gloves, face masks, water connection, sink, screens, treatment bed, light, locker area and the rooms are attended to by the nurses. All 4 facilities confirmed availability of treatment rooms, Budondo HCIV, Bugembe HC IV, Butagaya and Magamaga HC II lack treatment beds, rooms were small and not furnished with basic requirements.

Table 7: Availability of treatment room

Availability of treatment room

Facility name	*Availability*	*Status*
Budondo HCIV	Yes	Treatment in OPD were available but no screens and curtains
Bugembe HC IIV	Yes	Room is small with no screens and stretcher bed
Butagaya HC III	Yes	They use a bed from the ward not a stretcher bed, no pits, no screens and poor hygiene of the room
Magamaga HC II	Yes	There are no screens, no water, very small


Treatment bed in Butagaya HC III

OPD: Operating Theatre

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

CSC results indicate that only Butagaya HC IV had an operating theatre. However, they were substandard with no running water, no operating lights, no waste bin and liners, lack of trolleys for rolling patients, and protective gear and other supplies. Constant equipment breakdown and inadequate space were also cited as main issues.

5.2.2 Other OPD infrastructures at Budondo HC IV

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

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

Laboratory space in Bugembe HC IV

5.3 Inpatient Department (IPD)

Patients that need 24hour attention and observation are residents at a health centre until the health workers discharge them. Health care facilities from health centre III on wards are supposed to admit patients according to their mandate. An assessment of the 4 health care facilities visited had some of the IPD facilities as described in the subsequent sections.

5.2.3 Inpatient department: Bugembe and Budondo HC IV

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

Table 9: Input ranking at Bugembe and Budondo HC IV

	IN PATIENTS DEPARTMENT			
Section	**Indicator**	**Existence**		**Status**
		Bugembe	Budondo	
MATERNITY (DELIVERY UNIT)	Medical ward	No	No	No specific ward for medical personnel at the facility.
	Surgical ward	No	No	Had no specific ward patients are admitted in the general ward
	Obstetrics/ gynecology wards	Yes	Yes	Antenatal, maternity first labor, the post-natal and delivery wings and gynecology room exists at the facility, spacious, with screens, well-furnished and conditioned
	Pediatric ward	Yes	Yes	Fewer beds, no mosquito nets, no provision space for care takers and linen
	Psychiatry ward	No	No	Been improvised in the general ward.
	Tuberculosis ward	No	No	No specific ward for TB patients, admission was made in general ward.
	First stage labor	Yes	Yes	With examination bed, screens, intensive lights, rocker area, trolley and cabins.
	Mid wife office	Yes	Yes	Spacious with office table and chair, cabin, IEC materials, sterilization machines and equipment's (pressure machine and cardiology equipment)
	Premature room	Yes	Yes	Incubation machine, temperature machine, curtains, and weighing scale existed
	Store	Yes	Yes	Small, with equipment(mama kits, linen, gloves, detergents and reagents).

PHARMACY	Pharmacy dispensary	Yes	Yes	Well spacious and furnished and shelved
	Preparation room	Yes	Yes	Attached to the dispenser room, well shelved, spacious with rocker area (cabins).
	Store	Yes	Yes	Large, well condition and well organized
	Mortuary	Yes	Yes	Not equipped to the standards (no refrigeration system)
	Office	Yes	Yes	Clean well-furnished and conditioned.
	Main Store	Yes	Yes	large, well organized, stocked and conditioned
ADMINSTRATION	Conference room	Yes	Yes	Small with no furniture
	Library	No	No	The facility had no library
	Office secretary	Yes	Yes	Well-furnished and with (computer, printer and stationary)
	Administrators office	Yes	Yes	Spacious equipped with waiting area

Premature machine in Budondo HC IV

Maternity ward in Budondo HC IV

5.2.4 IPD at Health Centre III

According to Government of Uganda standards for Health centre III, it should have children/ female ward, delivery room, linen store, male ward, maternity ward, maternity first labour, maternity waiting room, ward nurse stations and sterile store. However, the facilities visited confirmed some gaps.

Some of the challenges faced by the in-patient department included inadequate space, beds and beddings, water especially in the dry season, generator fuel, frequent power shortages, lack of mama kits and other maternity supplies as in table 19.

Table 10: IPD at Health Centre III Level

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

5.3 Staff Tracking

Based on MoH guidelines, tracking was done to ascertain on the number of different staff categories at the all the health care facilities visited that included 2 Health Centre IV and 2 Health Center IIIs. The further assessment investigated whether the tracked staff were HIV and SRHR competent to handle the young people at different entry points in health care for packages.

5.3.1 Adherence to Staffing Norms in Budondo health centre IV and Bugembe HC IV.

The Jinja district has 2 HC IV that serves patients including; the key population, track drivers, female sex workers, unformed personnel, factory workers and large youth population among other because of its location. On average, Bugembe Health center IV receives a total of 350 patients daily from within and outside the district. A total of 48 staff are required in every Health center IV and these are categorized; Medical Health Workers, Allied Health professionals, Dental, Pharmacy Nursing) and Support staff.

Budondo HC IV receives on average 430 patients among whom referral from the lower level health facilities most especially the youth. forty-nine (49) of the 48 required. However, among the cadres that were required assistant Entomological offer, 2 theatre attendants, Anesthetic Assistant, enrolled psychiatric nurse, cold chain assistant, 1 store assistant and 1 health information assistant. The extra includes: 1 Ophthalmic clinical officer, 3 nursing officer (nursing), 4 nursing officer Mid-wifely, 1 nursing officer (psychiatry), 1 enrolled nurse, 3 enrolled mid-wife and 1 lab assistant.

Bugembe HC IV had 47(98%) staff with a gap of 1(2%) of the intended 48 for level IV facilities. However, according to the staffing standard procedures not all the categories were filled some had extra staff and others had gaps. The missing staff included; 1 health inspector and theatre attendant the extra were 2 clinical officer, 1 ophthalmic clinical officer, 3 nursing officer (nursing), 4 nursing officer mid-wifely, Anesthetic officer, enrolled nurse, 5 enrolled mid-wife, 1 lab assistant, 2 health information assistant and 1 porter

Among the 49 staff in Budondo HC IV 4 and Begembe HCIV 13 health workers were trained in adolescent comprehensive care and working directly with the youth.

5.3.2 Adherence to Staffing Norms in Health Centre Level III

A total of 19 personnel were assessed for availability at each of the Health Centre III visited. These included; allied health staff (Senior Clinical Officer, Clinical officer, laboratory technician, laboratory assistant and health assistant), Administrative staff (Health information assistants), Nursing (nursing officer, Enrolled Nurse, Enrolled midwife and Nursing assistants), Support staff (Askari and Porter).

Table 11: Adherence to staffing norms in Health Centre level III

Staffing norms	Butagaya			Magamaga	
	Norm	Actual	Gap	Actual	Gap
Sen. clinical Officer	1	1	0	1	0
Clinical Officer	1	1	0	0	1
Nursing officer	1	1	0	0	1
Lab. Technician	1	1	0	1	0
Enrolled Mid-Wife	2	3	+1	2	0
Enrolled Nurse	3	3	0	6	+3
Lab. Assistant	1	1	0	1	0
Health Assistant	1	1	0	1	0
Nursing Assistant	3	2	1	2	1
Health Information Assistant	1	1	0	1	0
Askari	2	2	0	2	0
Porter	2	2	0	2	0
Total	**19**	**19**	**1**	**19**	**2**

The results gathered from Butagaya HC III and Magamaga HC III indicate the facility had no gap.

5.4 SERVICE DELIVERY ASSESSMENTS

This section provides results from the assessment by the community, service providers, and interface meetings on the performance of the health facilities. Information gathered from workshops and focus group discussion was scored using the "community score card technique.

The participants included the community members (clients of health services) and service providers. The assessment benchmarked the Adolescent sexual reproductive health rights policy and National S strategic Plan for HIV/ AIDS 2015/16-2019/20 that was structured following the thematic areas of prevention, care and treatment, Social support and systems strengthening.

Prior to the meetings, participants developed and agreed on the parameters for the scoring of the services and the agreed consensus of scores included 1 to represent a very poor service, 2 to represent a poor service, 3 to represent an average service, 4 to represent a good service and 5 to represent a very good service. The scoring was based on the participant's opinion guided by the standards of service as per the Government of Uganda service delivery guidelines.

SCORE	VARIABLE C	OLOR
5	Excellent	
4	Good	
3	Average	
2	**Below average**	
1	Poor	

5.4 SERVICE DELIVERY ASSESSMENTS

Health Centre C	ommunity FGDs	Interface
Budondo	3	1
Bugembe	3	1
Magamaga	3	1
Butagaya	3	1
Total	**12**	**4**

5.4.1 Prevention

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

5.4.1.1 Youth friendly HIV prevention messages available.

The adolescent Sexual reproductive health policy identifies youth friendly services with targeted messages key in attracting youth to end the barriers affecting the adolescent to access services. Community scorecard assessed the availability of IEC materials tailored to the AY, the message development dissemination to the youth people, the counselling procedures and techniques that attract young people to access services and facility plan and programs tailored to the young people. During the interface meeting participants in Magamaga HC IV ranked the service excellent, Budondo HC IV as good, Bugembe HC IV as average and Butagaya HC III as excellent respectively.

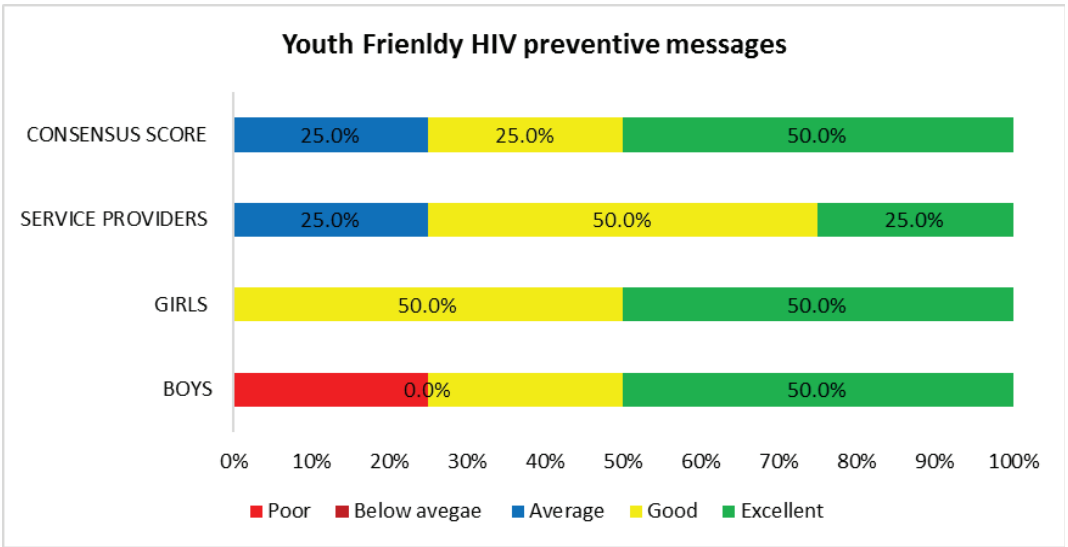


Figure 1: Youth friendly HIV prevention messages available.

The reasons for the excellent and good scores were; the youth corners were available, in Budondo HC IV the youth corner was equipped with materials, attached youth leader at the corner, trained health worker to support the youth to access services. Some participants who mentioned that it was average sighted issues like limited space, limited staff to handle youth and poor counselling, lack of consultation room, in Bugembe services improvised at OPD no specific corner area for adolescents.

5.4.1.2 Availability of HIV and STI prevention commodities.

The scorecard assessed the accessibility and availability of commodities by the young people; such as STI, testing kits, condom and lubricants, education sessions and condom dispensers at the facility.

Condoms are identified as a safe measure of HIV& AIDS prevention and STIs alongside Family Planning method.The community scorecard looked at availability, community uptake and usage of services and community perception on condom use. The youth behavior on access to the commodities such as condoms is more affected by the allocation of the condom dispenser. During the assessment the team critically observed the allocation and accessibility especially for the young people. During the interface meeting Budondo ranked it Excellent, Butagaya HC III as good, Magamaga as good and Bugembe as average respectively.

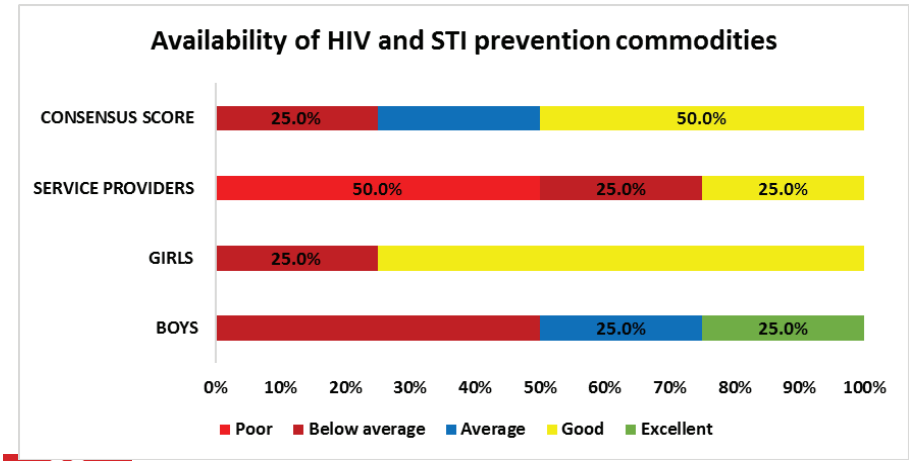
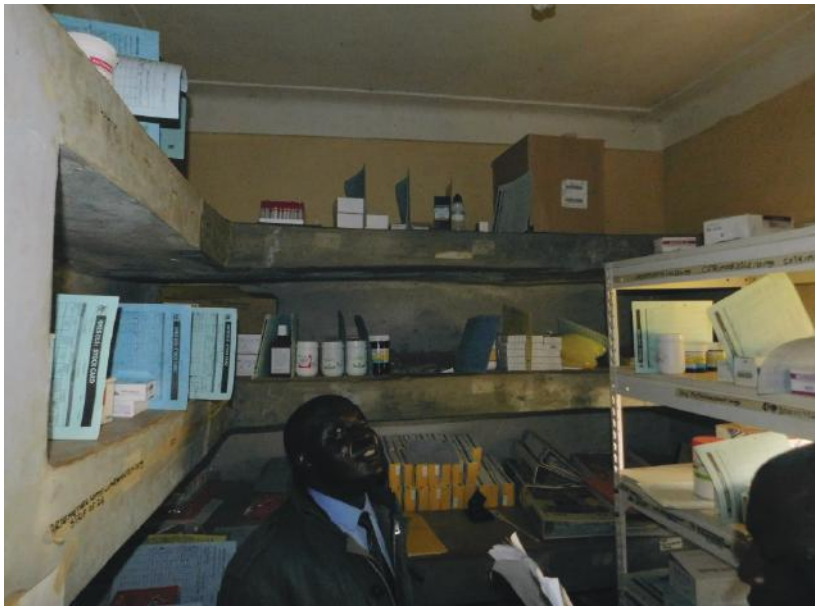


Figure 2: Availability of HIV and STI Prevention Commodities

The specific facility ranking were based on; Buyagaya HC III condom dispensers were in an open space for access, female condoms were stocked out, no specific health education targeted to adolescent and young people, and sporadic stock out of testing kits and other commodities for SRH). Bugembe HC IV the facility had no designated condom corners and no treatment for opportunistic infections (STIs and other infections). Bundondo HC IV had condom dispenser, condom stock for both male and female, testing kits, and lubricants and also educational program and demonstration for the adolescents on prevention and use of the commodities.

Magamaga HC III, had no condom dispenser, stock out testing kits and reagents, no sterilization areas, stock out of commodities for opportunistic infections and no specific youth friendly corner which implies access is limited only those who can demand for them.



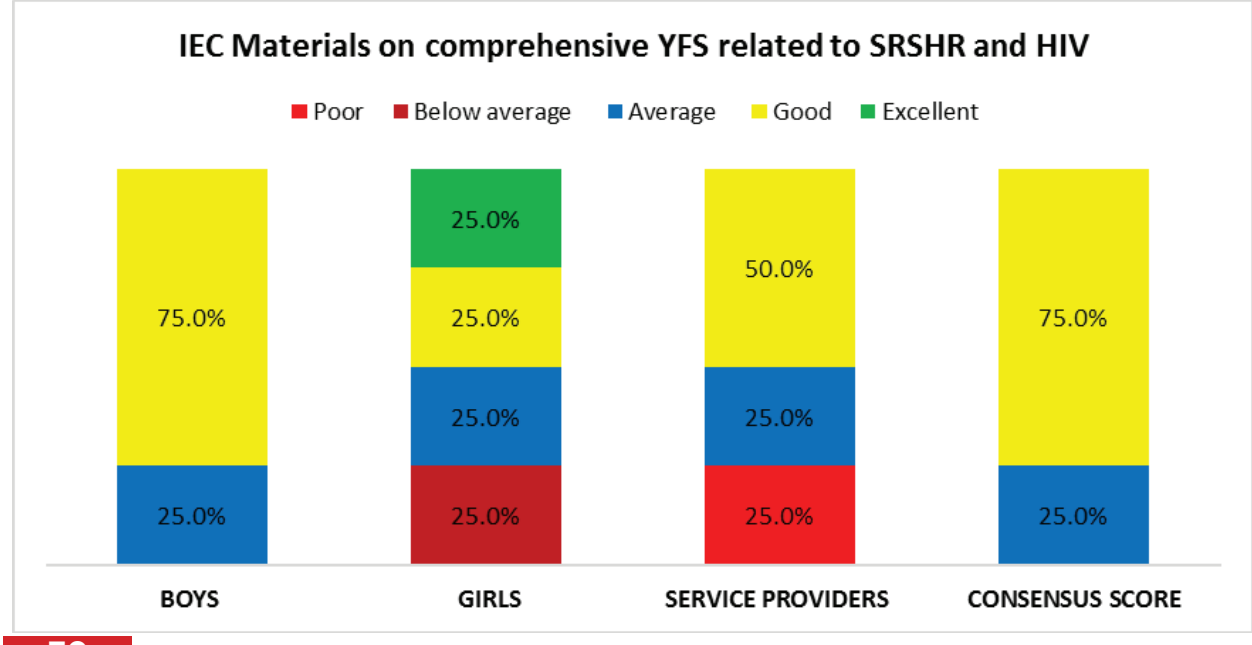
Drug store in Butagaya HC III

5.4.1.3 Provision of IEC Materials on comprehensive YFS related to SRSHR and HIV.

IEC materials such as posters, brochures, flyers, billboards, that are intended to draw attention on information about diseases or risks to health are often called "Information, Education, And Communication" (IEC) materials. Some electronic media messages can be IEC-focused such as; message spots on radio and, television, and video programs that disseminate information whether as a straight forward explanation or in the form of stories are also IEC materials.

During the consensus score 75% Budondo HC IV, Butagaya HCIII, and Magamaga HC III ranked it as good services and 25% Bugembe HC IV as average respectively.

Figure 3: Provision of IEC Materials on comprehensive YFS related to SRSHR and HIV.



Results indicated that most facilities visited had some IEC materials but these were not adequate and others were written in English language and were not translated in the local languages. There were also reports of high illiteracy levels among the community members rendering some IEC materials ineffective.
The community recommended provision of translated IEC materials and interpreted messages during health education talks for those who are illiterate.

IEC materials in Butagaya HC III

5.4.2.4 Integrated out reaches that target young people.

Integrated Outreaches works within the health system and structures in each Health care service delivery points, involving cross referrals from all levels of care (whether public or private, formal or informal) to the households and community. This involves health workers, health extension workers and expert clients visiting the clients for psycho social support, adherence support, HIV testing, TB screening, referrals and linkages, health education among others.

CSC results revealed that integrated outreaches are considered to be poor in all the facilities visited (Budondo HC IV, Bugembe HC IV, Magamaga HC III and Butagaya HC II).

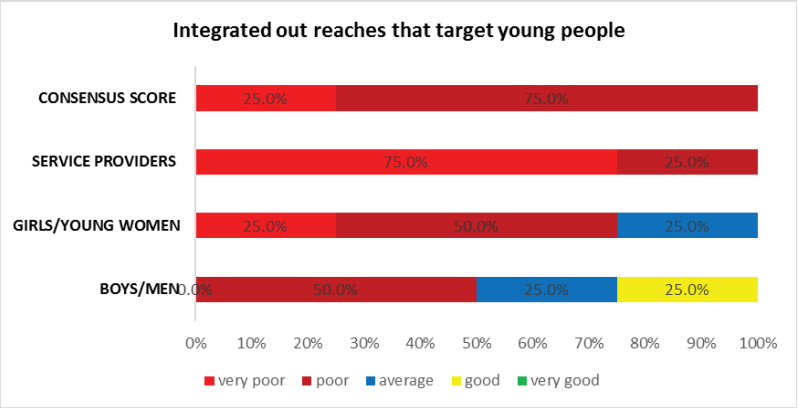


Figure 4: Integrated out reaches that target young people.

The reasons for poor ranking were; lack of funds for transport yet with wide geographical area, poorly motivated village health teams (VHTs) and expert clients, health workers and peer buddies, implementing partners (IPs) work separately from the health care setting and systems.

The recommendations were need for intensive training in integrated outreach for young people, IPs to use the available health care structures (expert clients and, peer buddies, VHTs), facilitation and motivation of community resource persons such as expert clients to reach their peers and the district to allocate additional funds alongside the primary health care (PHC) money from the local revenue to facilitate health workers to reach out to the community.

5.4.1.5. Availability of mentorship programmes for the peer educators/buddies

In a bid to provide intensive health care package to the adolescent and young people, mentorship of peer buddies to the programmes and procedure is key. Community scorecard assessed the availability of programs, knowledge on SRHR and programs, the number youth supported and the facilities with programs to engage the services. During the interface meeting (consensus score) 50% Budondo HCIV and Bugembe HC IV ranked the service below average and 25% Butagaya HC III as poor & 25% Magamaga HC III as good service respectively.

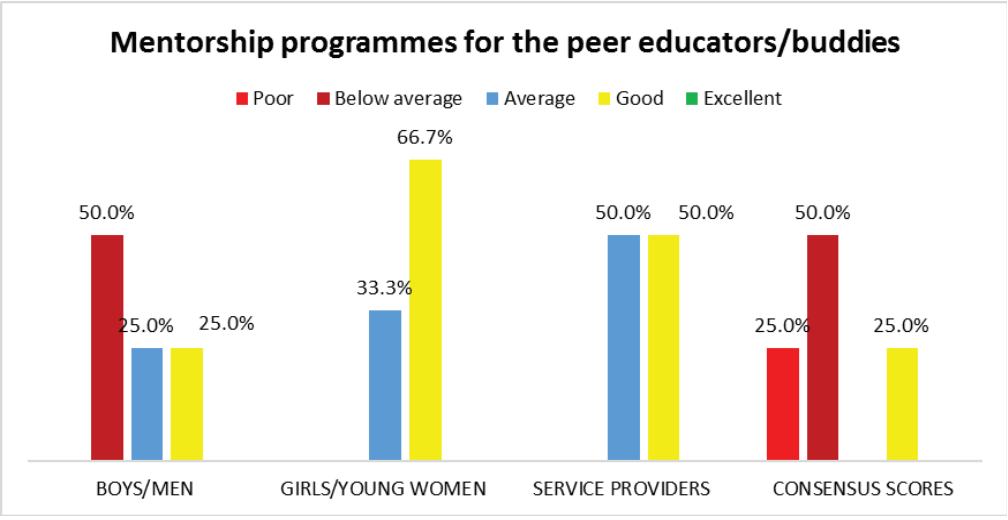


Figure 5: Mentorship programmes for the peer educators/buddies

The availability of mentorship program was ranked as average. However, in some facilities such as Butagaya HCIII and Magamaga HCIII it was ranked as average. Some of the reasons given for the scoring included; limited number of staff, lack of counseling rooms hence denying privacy, lack of skilled counselors and lack of facilitation.

There is therefore need for separate counseling rooms, regular supply of test kits, awareness campaign on couple testing recruitment and training of existing staff in counseling and carrying out community outreaches, allocate resources out of the PHC funds to mentor peer buddies/ educators.

5.4.2 CARE AND TREATMENT

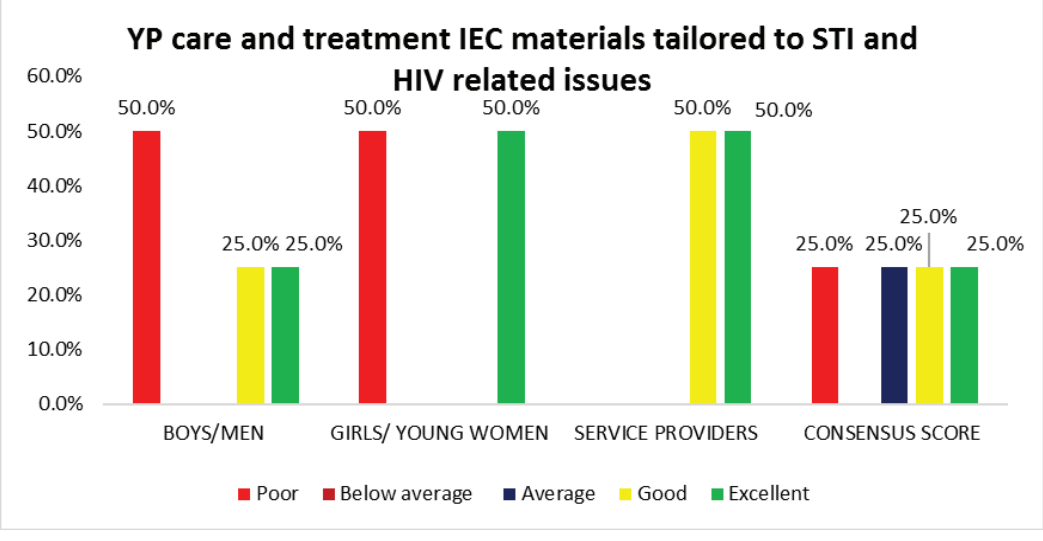
This sub section illustrates care and treatment in regard to availability of YF care and treatment IEC materials tailored to STI and HIV related issues, Health worker's competence on AY people SRHR and HIV prevention and management, Consolidated AY people ART, Availability of youth friendly counsellors, /peer counsellor's /expert clients or champion and Availability of gazetted days for YP to get HIV, STI treatment and Family Planning Service.

5.4.2.1 Availability of YP care and treatment IEC materials tailored to STI and HIV related issues

In regards to availability of YF care and treatment IEC materials tailored to STI and HIV related issues, community scorecard assessed availability of IEC materials, materials in local and age group categorised to deliver messages to the young people, integrated service delivery to eliminate stigma, competent staff in HIV/ SRHR comprehensive services, privacy, and outreach programs.

CSC results during the interface meeting (consensus score) indicate that availability of Young people care and treatment materials tailored to STI &HIV services were ranked Excellent in Budondo HCIV, good in Bugembe HC IV, average in Magamaga HC III and Poor in Butagaya HC III respectively. Sporadic ARV stock outs, stigma, inadequate staffing, and lack of privacy were reported as issues that need to be resolved to improve the availability to and access of ART services.

Figure 6: YP care and treatment IEC materials tailored to STI and HIV related issues.



The good score for services were, drug availability, testing for viral load and CD4 and Male involvement. Challenges; limited space for large number of clients, materials in language people do not understand, illiteracy level, stigma leading to fear by the PLHIV to access drugs, reliance on peer buddies and VHTs for information and access to services.

Recommendations were; train staff in comprehensive HIV services, avail materials in local language, community sensitization, update of the IEC materials.5.4.2.2 Health worker's competence on AY people SRHR and HIV prevention and management.

The ministry of health guidelines and standard procedures provide an opportunity for the health workers to be trained to meeting the required treatment procedures recommended by the world health organization and others across the global. Scorecard assessed health workers' competences in SRHR and HIV integrated for the young people, the supporting equipment and infrastructure, drug stock status, counselling and follow up mechanism to support.

During the interface meeting respondents from Budondo HC IV ranked it an average service, Bugembe HC IV as Poor, Magamaga HC III as average and Butagaya HC III as average respectively.

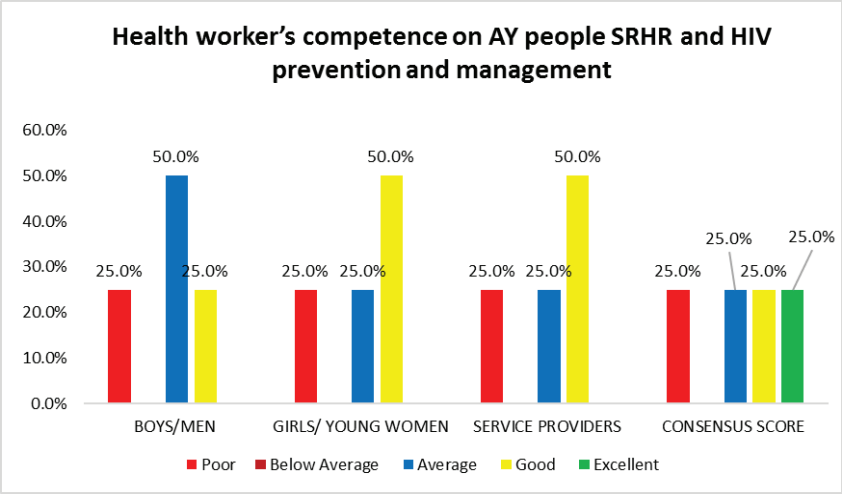


Figure 7: Health worker's competence on AY people SRHR and HIV prevention and management.

The average and poor ranking was attributed to incompetence of some health personnel in handling the peers, high levels of stigma and discrimination, limited funding for SRHR and HIV programs for the youth, limited programs which only target school going students neglecting the ones in the community, low involvement of peer leaders trained in outreach programs and follow ups.

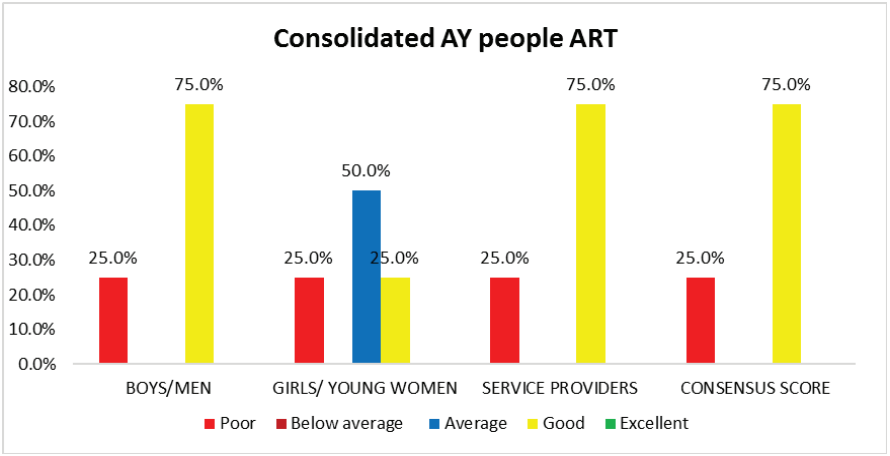
The recommendations were; training of health workers to be HIV and SRH competent, increase and allocate resource to support outreach programs, train youth peers to support follow and linkage of the fellow peers for service uptake in designated facility targeted for youth friendly services.

5.4.2.3 Consolidated AY people ART

The WHO Guidelines 2015 that adolescent's treatment defines HIV treatment as services that specifically integrated in Health care service for the youth health related events. The assessment looked at youth friendly corners, youth ART refill designated day, integrated system for ART access and SRHR services and sensitization and access to health education, one on one counseling and mentorship programs for the peer youth and involvement of youth to handle youth related issues and follow up mechanism for the youth.

During the interface meeting (consensus score) Budondo HC IV ranked as good, Butagaya HC III as good, Magamaga HC III poor respectively.

Figure 8: Consolidated AY people ART



The good ranking based on youth ART refill specific days, youth friendly corners, follow up through peer buddies and integrated program.

Challenges; absence of adequate of adolescent friendly services in most of the health care facilities visited, lack of linkages between the health facilities, stock out of drugs and stigma and discrimination.

Recommendations included; provision of services and support tailored to adolescents' needs, community sensitization on adolescent friendly services at the facilities and community and schools to ensure that adolescents who require services are followed up in their schools and community through peer bubbies.

5.4.2.4 Availability of youth friendly counsellors, /peer counsellor's /expert clients or champion.
Young people in Uganda often face difficulties in access to sexual reproductive health and HIV services that respond to their needs. Only 5 % of the health facilities officer sexual reproductive health services in the country which a youth friendly. The score card assessed availability of consultation rooms, counseling rooms, trained personnel to handle issue of adolescents and young people, integration of services to reduce stigma among the young people, having designated date for adolescents at the facility and involvement of peer educators/ buddies on follow up and mentorship. During the interface meeting (consensus score) Budondo ranked as average, Bugembe HC IV as Below average, Magamaga HC III as good and Butagaya HC III as below average respectively.

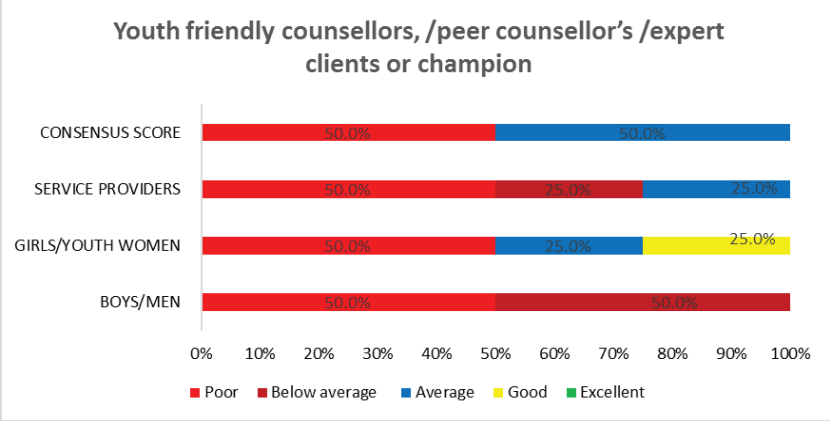


Figure 9: Youth friendly counselors, /peer counselor's /expert clients or champion

The poor ranking was a result of no designated youth corner at the facility, limited trained personnel to handle adolescent young people, low involvement of peer buddies, no facilitation of peers buddies to support the health facility care system and high level of stigma among the youth.

Average and Good score was due to; trained personnel, competent health workers attached to the youth corners, facilitation form the implementing partners.

Recommendations were train health workers to be SRHR and HIV competent, facilitate expert clients and peer buddies, facilities to engage implementing partners during the planning process, train and facilitate youth peer buddies and allocate & provide safer youth spaces to officer counselling and consultation.

Youth friendly corner in Magamaga HC III

5.4.2.5 Availability of gazetted days for YP to get HIV, STI treatment and Family Planning Service.
Youth gazetted day for service uptake for STI, HIV and Family planning services were available in all facilities. However, in regards to family planning methods especially the permanent and long term methods were not available at Health Centre III levels. The scorecard assessed accessibility of services on the designated date, stock status of commodities, community perception on services uptake and challenges encountered on service uptake in regards to designated.

During the interface meeting (consensus score) participants in Magamaga HC III rated it as good service, average service in Bugembe HC IV and Butagaya HC III and excellent in Budondo HC IV respectively.

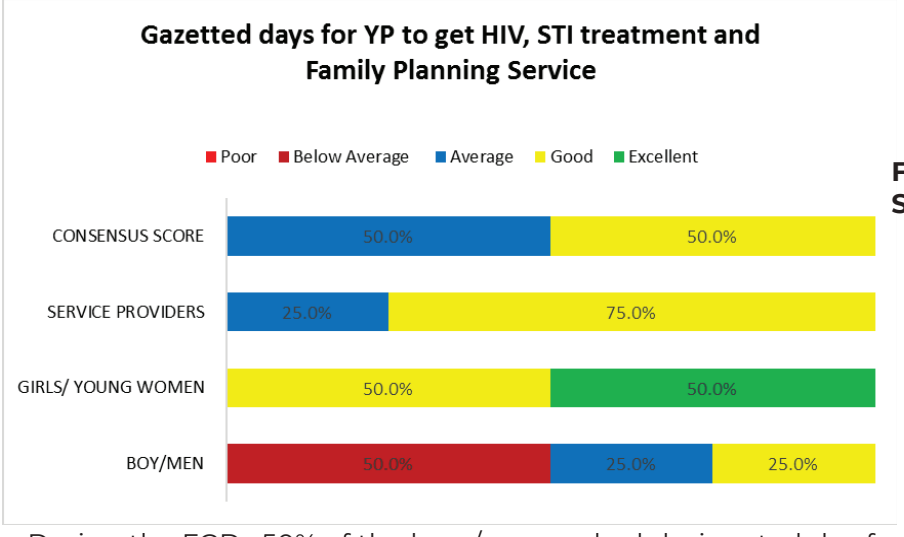


Figure 10: Gazetted days for YP to get HIV, STI treatment and Family Planning Service

During the FGDs 50% of the boys/men ranked designated day for adolescent/young people as below average, Girls/ young women as excellent and good, 75% service providers as good. The good and excellent score were as a result of availability of the methods, trained staff in offering and availability of long term methods in the facilities.

Challenges were; services are mostly rendered to girls and young women stock outs of family planning supplies and test kits, perceived side effects, inadequate skills in management of side effects, inadequate staffing leading to heavy workload, and low involvement of boys and men, cultural and religious beliefs.

Participants recommended sensitization of the community on family planning, training of health staff on long term methods and management of side effects on family planning and increase on the supply to avoid stock outs.

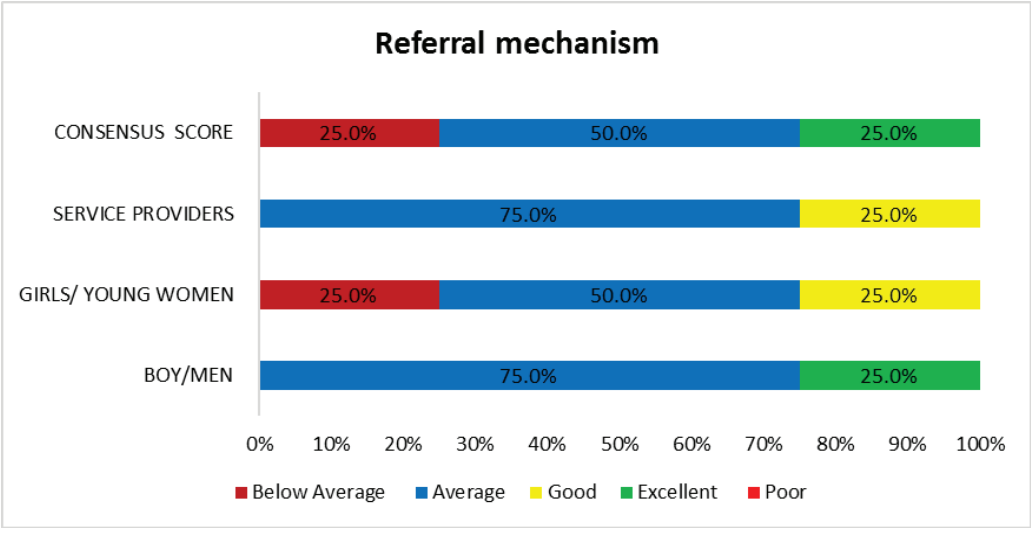
5.5 SOCIAL SUPPORT AND PROTECTION

The quality of social support and protection service was assessed based on the quality of Referral Mechanism, Community Knowledge on laws, policies on SRHR and HIV, Respect of Patients' rights, Health workers' knowledge on rights, capacity building for care givers, provision of food and education services, right awareness and support and legal support and social services. These are discussed further in the subsections below.

5.5.1 Referral mechanism

Referral mechanism supports and strengthen disease management and prevention. The scorecard accessed referral too, access to referral tools, mentorship of the peer buddies, guidelines dissemination for referral, confidentiality among the health works, and other necessity equipment needed to support patients to seek services and consult on the disease.

During the interface meetings (consensus Score), 50% ranked it average and 25% neither good nor below average respectively.



The low ranking was based in the lack of ambulance to strengthen referral, lack of referral forms, limited trained personnel and low involvement of peer buddies. There is therefore need to create involve peer educators, procure ambulance, provide referral form and train VHTS expert clients to strengthen follow up.

5.5.2 Respect of Patients' rights

Patients' charter 2009 indicated that patient shave the rights in course of consultation for treatment and information concerning one's health, except only when it's required by law or court order. It further emphasis that facility management should make the arrangement to ensure that that health workers should not disclose the patients' information brought to their know in course of their duties. Scorecard assessed respect for patients' privacy through both FGD and interface meeting.

During the interface meeting 50 % of the participants ranked it as good and 25% as both average and very good service respectively. Patients' rights was most responded to by all service providers as a good service, community 50% women as very good and 50% men good service.

The good ranking was based on availability of consultations and examination, adequate infrastructure and utilities for confidentiality (private rooms with curtains and screens).

However, the Low ranking of rights during the focus group discussions at all the levels were as a result on; inadequate infrastructure consultation room, utilities and equipment (e.g. curtains and screens) were not provided at the facilities to ensure that the privacy of the clients during examination and counseling is observed.

The recommendations were; community and health workers' sensitization on patients' rights, increase on consultation rooms, expansion and renovation of the existing ones structures and procure screens and curtains.

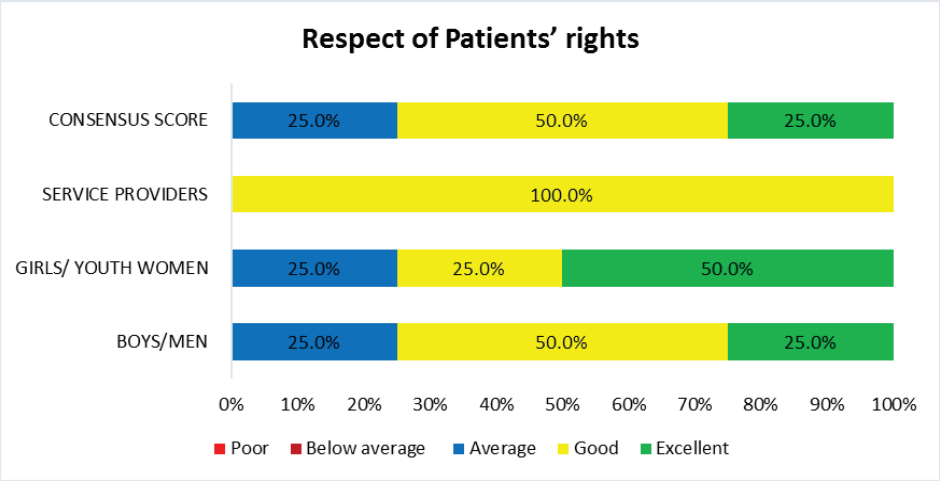


Figure 11: Respect to Patients' Rights

5.5.3 Knowledge on laws, policies on SRHR and 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. This therefore requires the providers, both health workers and community resource persons, to be skilled in legal procedures and redress mechanisms. The score card assessed how far the providers have been involved in supporting patients/victims who have been aggrieved. Paralegals and health workers are meant to sensitise community members on human rights, legal and ethical needs as well as support them in accessing justice and services. In Jinja district, Magamaga HC III ranked it as good service, both Budondo HC IV and Butagaya HC III as average service and Bugembe HC III as poor respectively.

The good and average ranking was as a result of health workers offering service and follow ups on the victims, provision of testing services and legal support in representations in courts of law for cross examination and witnessing, community sensitisation on seeking legal services in care assault and filling of police forms to support the victims. The poor rating was as a result of community not seeking support legal support from facility, still high levels of stigma and discrimination, limited by lack of transport and/or facilitation to follow up on cases, long court processes, inadequate medical staff, shortage of drugs and community members not seeking legal redress

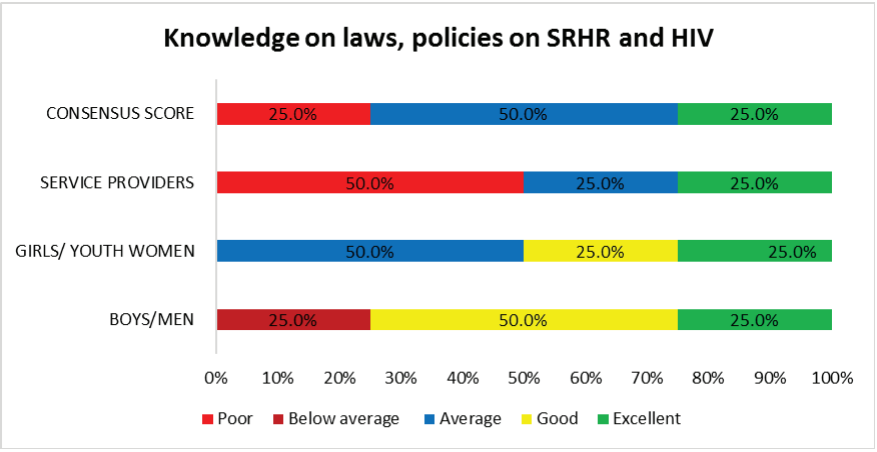


Figure 12: Knowledge on laws, policies on SRHR and HIV

5.5.4 Health workers' knowledge on rights

The Uganda Patients Charter of 2009 describes a set of rights, responsibilties and duties under which a person can seek and recieve health care services, empowers patients to responsibly demand for quality health care and actively participate in their care at health facilities. According to slomkaa apatients rights centerd care approcah is part of the standard health care package and promotes rational and ethical practice and improves health outcomes. Community score card assesed the community awareness of these rights through availability of patients' charter, health worker support to patients to access treatment and justice, respect for patients' dignity and health and cultural and religious leader's involvement and awareness to address cultural norms. In the interface meeting (consensus score) Bugembe HC IV ranked as good, Budondo HC IV and Butagaya HC III as average and Magamaga HC III as poor respectively.

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

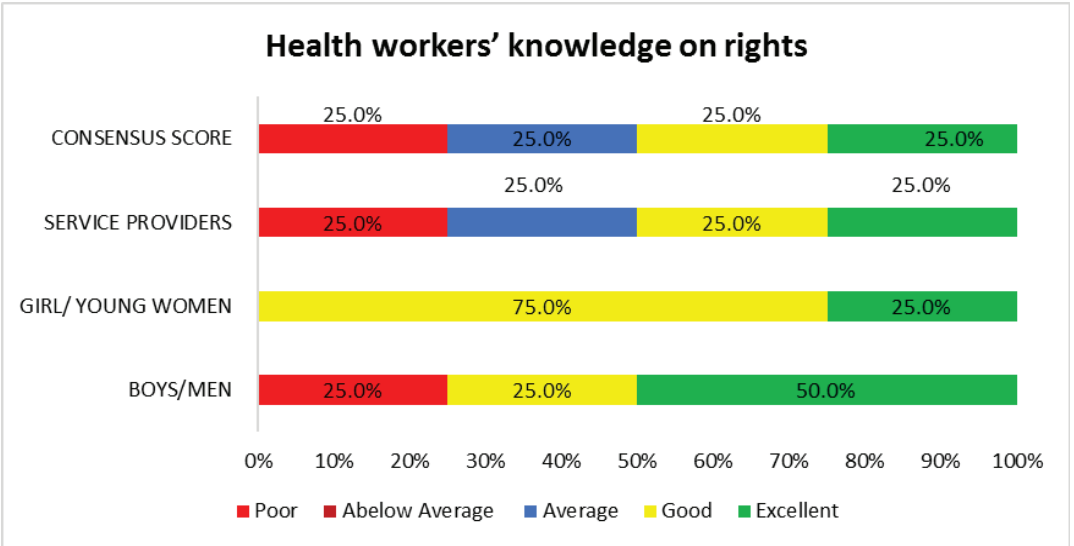


Figure 13: Health workers' knowledge on rights

5.5 Attitude of Staff

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

Observing Working Hours. Stregthening the system was hinged on addressing the issue of human resources from the perspectives, namely, provision of adequate number of resource persons, management capacity of key health workers to stregthen service delivery. the community scorecard assessed the capacity of the management units.

The reasons for the low scorein the FDGs (Men, women and service providers) were; some health workers reporting to work late usually after 8.30am and leaving early at times at midday, inconsistent or poor time management, few staff who work for long hours, time wasting, having frequent breaks, delays in attending to patients, sending patients away to private clinics after midday and not having a proper time table or duty schedule in place and low vigilancy and monitoring by Health unit Management committee.

Suggestions made were; to stregthen monitoring and follow ups by both DHOs office and health unit management committee to ensure complaince with schedule, recruiting more staff to reduce workloads, introducing duty rosters to record arrival and departure time, introduce timesheet and appraisial in human resource mangement and duty schedules detailing shifts, provide accomodation to staff and have a canteen at the facility to reduce on the time spent going home to have meals.

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

Listening to Patients Problems. In abid to manage disease diagonasis in health care system, listening to patients problem/ complaints complements adhernce to care and treatment. The patients redress, (patinets being asssistanted on their rights, health workers receive, invenstagations & process patints complaints and health workers capacity to listen to patinets complaints).

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

During the interface meeting (consensus score) 50% ranked as good, 25% very good and 25% average respectivey.

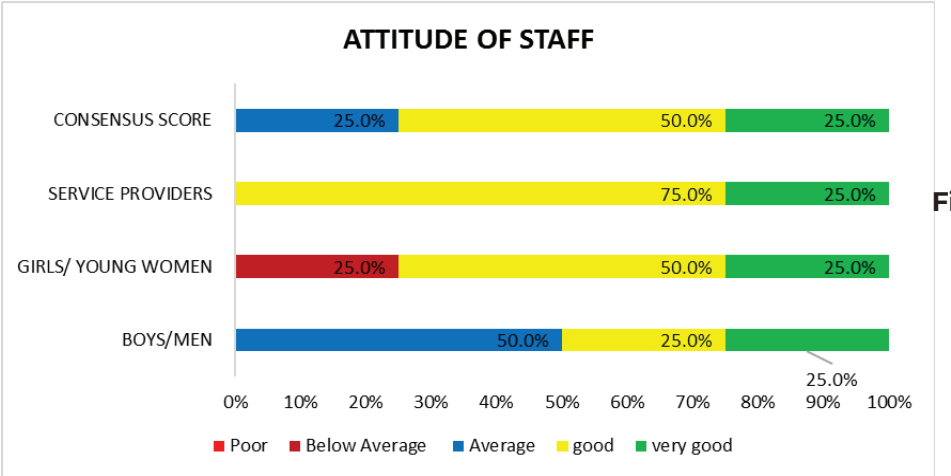


Figure 14: Attitude of staff

6.0. Limitations

- Though the Community Score card centred on the NSP and Adolescent sexual reproductive health policy areas of prevention, care and treatment, social support and systems strengthening, not all areas under each theme were covered.
- The finds 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 accessed.
- The assessment did not necessary consider comprehensive health facility equipment however, focus was given on only SRH & HIV support equipment.

7.0 Conclusions

Based on the findings, the assessment concludes that the district has made efforts in providing HIV /AIDS and Sexual Reproductive Health and Rights services in partnership with partners. There were however some constraints that affected the service delivery ranging from limited staffing, stock out of drugs more especially for STIs and opportunistic infections , no follow up of lost clients, stock outs of reagents, negative attitude to condom use and family planning services, long distance to health care facilities, absence of viral testing machines, existing of emerging key populations and migratory communities such as those in mining areas

and limited information on SRHR&HIV/ AIDS in the local language(Representation of young people of the HUMCs is still lacking).

8.0 Recommendations

The assessment generated a number of recommendations that include amongst others
Jinja Local government, Religious leaders, health facilities, FLEP and other alliance members and Implementing partners, Line ministries, departments and agencies (MOH, Ministry of Public Service, Ministry of Finance, Planning and Economic Development, Uganda AIDS Commission).

- The MOH and the district service commission should recruit more health workers to fill up the staffing gaps and reduce on the waiting time that patients take to see health workers. Additionally, the staff should be well motivated payment for hardship allowance.
- National Medical Stores should ensure constant supplies of drugs and reagents including testing kits to reduce on frequent drug stock outs.
- There is need to continue with community sensitisation sessions by the district local government, health facilities and VHTs on family planning benefits and maternal health services.
- District, IPs and Ministry of health to procure and avail SRHR Commodities (condoms, Testing kits and STI stocks.
- District and HUMIC to strengthen monitoring and supervision of the health facility staffing
- District and IPs to support training and Mentorship YFS.
- Strengthen Supervision and Monitoring quality of service through; SRHR Committee, DAC and SAC, Social Accountability Committee and HUMIC.
- Local government to Allocate and involve Youth Councilors to participate in the budget process
- YP to be represented on the HUMIC.
- Procure and avail IEC Materials tailored messages in local Language, reproduce materials,
- Implementing partners to work with the district health officer to provide tailored messages and distribution (Location of IECs).
- Implementing partners to Increase awareness on SRHR and HIV among the young people.
- Sensitisation on patient's rights and responsibilities and roll out the national patient's charter to all health centres. The patients charter should be translated into the local language and disseminated both at the health care and through media.

- The District Health Office should intensify monitoring and supervision of the health facilities to reduce on absenteeism and late coming. Additionally, capacity building for in charges on modern management including results based management.
- The health in charge should undertake community sensitisation about importance of Integrated SRHR and HIV and train more peer buddies at health centre III to undertake carry out reach and follow ups.
- Provide more IEC materials and translate them in local languages and distribute them in the remotest health centres across the district.
- Ministry of health should procure ambulances for health Centre IVs and provide a budget for running it and maintenance
- There is need to train health workers on legal and human rights to enable them support the community more efficiently.
- There is need to involve religious leaders, Clan leaders and cultural leaders on issues of sexual gender based violence.
- The MOH and district local government should construct more structures and equip them with facilities to support quicker diagnostic of the ailments for the Adolescent young people.
- Staff houses should be constructed to enable health workers reside at their work stations and report on time. This will also attract staff and retain staff from hard to reach and hard to stay areas.
- Parliament and ministry of Finance Planning and economic development should allocate more resources to the health sector to enable the sector implement what has been promised in the Health Sector Development Plan and National HIV and AIDS strategic Plan).
- Special programs for key populations and migrant communities including those in the mining should be promoted. This includes bringing services close to these people. some of the interventions can include moonlight services, outreach and mobile HIV/ AIDS services.

ANNEX

Annex 1. Staffing levels at HC IV

Staff cadres	Budondo HC IV			Bugembe HC IV	
	Norm	Actual	Gap	Actual	Gap
Sen. Medical Officer	1	1	0	1	0
Medical Officer	1	1	0	1	0
Senior Nursing Officer	1	1	0	1	0
Public Health Nurse	1	0	1	0	1
Clinical Officer	2	3	+1	4	+2
Ophthalmic Clinical Officer	1	0	1	2	+1
Health Inspector	2	1	1	1	1
Dispenser	1	1	0	1	0
Public Health Dental Officer	1	1	0	1	0
Lab. Technician	1	1	0	1	0
Ass. Entomological Officer	1	1	0	1	0
Nursing Officer(Nursing)	1	4	+3	4	+3
Nursing Officer(Mid-Wifely)	1	5	+4	5	+4
Nursing Officer (Psychiatry)	1	2	+1	1	0
Ass. Health Educator	1	1	0	1	0
Anesthetic Officer	1	1	0	2	+1
Theatre Assistant	2	0	2	1	1
Anesthetic Assistant	2	0	2	0	2
Enrolled Psychiatric Nurse	1	0	1	1	0
Enrolled Nurse	3	4	+1	5	+2
Enrolled Mid-Wife	3	6	+3	9	+6
Cold Chain Assistant	1	1	0	1	0
Office Typist	1	0	1	0	1
Lab. Assistant	1	2	+1	2	+1
Stores Assistant	1	0	1	0	1
Accounts Assistant	1	0	1	1	0
Health Assistant	1	1	0	1	0
Health Information Assistant	1	0	1	3	+2
Nursing Assistant	5	4	1	5	0
Driver	1	1	0	0	1
Askari	3	3	0	3	0
Porter	3	2	1	4	+1
Total	48	47			

Annex 2. Staffing levels

Staffing norms	Butagaya			Magamaga	
	Norm	Actual	Gap	Actual	Gap
Sen. clinical Officer	1	1	0	1	0
Clinical Officer	1	1	0	0	1
Nursing officer	1	1	0	0	1
Lab. Technician	1	1	0	1	0
Enrolled Mid-Wife	2	3	+1	2	0
Enrolled Nurse	3	3	0	6	+3
Lab. Assistant	1	1	0	1	0
Health Assistant	1	1	0	1	0
Nursing Assistant	3	2	1	2	1
Health Information Assistant	1	1	0	1	0
Askari	2	2	0	2	0
Porter	2	2	0	2	0
Total	**19**	**19**	**1**	**19**	**2**

REFERENCES

- Adolescent sexual reproductive health polices 2015
- FLEP Strategic Plan 2017-2021
- GOU: National Development Plan II (NDP II 2015/16- 2019/20)
- GUSO project concept and project documents 2017-2019
- Jinja District Development Plan 2015/16- 2019/20
- Jinja district HIV strategic plan 2015-2020
- MOH: Heath Strategic Development Plan (HSDP) 2015/16- 2019/20
- MoH: Uganda AIDS Indicator Survey (AIS 2011)
- Uganda AIDS Commission: The National HIV and AIDS Strategic Plan 2016/16/- 2019/20
- Uganda patient charter 2009.

Annex 3. Integrated Adolescents and Young People SRHR and HIV performance score card.

INTEGRATED ADOLESCENTS AND YOUNG PEOPLE SRHR AND HIV PERFORMANCE SCORE CARD

INDICATORS -ONE		SCORES											REASON FOR SCORE	SUGGESTION FOR IMPROVEMENT	
		Needs Urgent Remediation	Needs improvement						Meets expectations	Surpasses expectations					
		0	1		2			3	4	5					
SCORE DEFINITION		Not available	Poor		Below Average		Average	Above Average	Good	Excellent					
SET: 1.0: PREVENTION SERVICES INDICATORS															
1.1	Youth friendly HIV prevention messages available														
1.2	Availability of HIV and STI prevention commodities, HIV and STI testing kits, condom and lubricant education sessions and condom dispensers at the facility														
1.3	Integrated outreaches that target young people														
1.4	Availability IEC materials on comprehensive YFS related to SRHR and HIV services including PMTCT services														
SET: 2.0: CARE & TREATMENT INDICATORS															HIV/SRH competencies
2.1	Availability of YF care and treatment														

1.4A	vailability IEC materials on comprehensive YFS related to SRHR a nd HIV services including PMTCT services													
SET: 2.0: CARE & TREATMENT INDICATORS														
2.1A	vailability of YF care and treatment IEC/BCC sessions a nd materials tailored t o STI and HIV related services													
2.2C	onsolidated AY p eople ART													
2.3A	vailability of Youth friendly counsellors/pe ers counsellor/exp ert youth clients or champions													
2.4A	vailability ARVs, STI Treatment and													

	AYF management services													
	Presence a nd number o f AY F service delivery competent staff													
	Availability of Gazetted days for YP t o get HIV, S TI treatment a nd for FP services													
	Availability and dissemination of Clear follow up m echanism for AY p eople initiated o n ART													
	AY t argeted Home b ased care programme facilitated													
	Affordable SRH and HIV services													
SET: 3.0: SOCIAL SUPPORT AND PROTECTION														
3.1I	s there an													

	established referral mechanism for AY people													
3.2P	resence o f Adolescents and Young Positive Psychosocial support group													
3.3P	resence of AY p eople targeted A nti-Stigma messages o r programmes													
	Partnership with t he c hild protection u nit and probation office													
	Health personnel knowledge o f AY p eople's rights (Health workers Code of C onduct and Patients Charter)													
	Knowledge on laws, policies on S RHR a nd HIV and presence o f support													

	structures a nd legal assistance for AY p eople experiencing violence													
	Fairness o f Representation of Y Ps o n the Health Management Committees													

PROGRESS MADE ON THE SCORE CARD ASSESSMENT COMMITMENTS

FLEP implemented the community score card in four sub counties of Bugembe, Butagaya, Budondo and Buwenge in Jinja district. The survey was conducted in the health centres of Bugembe H/C IV, Budondo H/C IV, Magamaga H/C III, and Butagaya H/C III.The survey was intended tohelp assess the availability, affordability, reliability, utilization and quality of SRHR and HIV & AIDS Services but also a quantifying tool for monitoring, performance and evaluation of services. The community score card model provided a dialogue platform between frontline service providers and the users by providing feedback on the services provided. In reference to the recommendations and commitments made by the respective stakeholders, the following is the progress so far;

- The Executive Council of Jinja district local government passed a budget to build and equip a room which will be designated specifically for the youth corner at Bugembe HC IV. The Council resolved that this will act as the model youth corner in Jinja, however, the members agreed that each financial year , one youth corner will be built until all the sub counties in Jinja district are covered.
- The male youth councilor of Bugembe Town Council committed to buying iron sheets for the youth corner on top of the budget which was passed.
- FLEP s trained 36 health workers and VHTs in provision of youth friendly services in addition to those who were already trained; so as to increase on the number of service providers who can ably offer youth friendly services to the young people.
- FLEP trained peer educators and Community Health Entrepreneurs in making complete referrals and linkages in a bid to strengthen referrals and quality of YFS in the respective health centres.

- As a result of FLEP's continuous engagements with the Health Unit Management Committees of the respective health centres and the DHO's offices, the health centres have revamped their quarterly meetings and now they are sitting regularly
- In the health centres where GUSO/Flex and GUSO main projects are being implemented, HUMC members of the respective health centres resolved to co-opt young people (a male & female) as Ex-officios on the HUMCs; effective July-September 2019 quarterly meetings.
- Furthermore, HUMCs accepted to incorporate youth friendly services in the health centres' annual workplans

Conclusively, the responses to the commitments made by the respective stakelders are encouraging and there are high hopes fulfilling the remaining ones.

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