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THE UGANDA AIDS ACCOUNTABILITY SCORE CARD

The Uganda Network of AIDS Services Organizations (UNASO)

February 2014

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For your contribution, we thank you all.

Bharam Namanya
Executive Director

FOREWORD

In thirty years since HIV and AIDS was first identified, confusion persists over effective mechanisms for controlling the epidemic. The disease has evolved from primarily a public health concern into a major development challenge of crisis proportions. The HIV prevalence has continued to rise from 6.4% to 7.3% according to the Uganda AIDS Indicator Survey 2011.

Over the years, assessments on how the response is managed have been spear-headed by Uganda AIDS Commission (UAC). The reviews have mainly focused on numbers of people who have accessed HIV and AIDS services and less on the voices of the beneficiaries of the services.

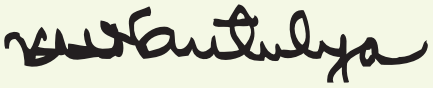
For the first time, Uganda has produced a National HIV and AIDS Accountability Score Card Report. The voices and assessment given by the beneficiaries in the communities provide a better understanding of the efforts done by the different players in addressing the HIV epidemic. One distinct attribute is the exciting way the scorecard increases participation, accountability and transparency among service users, providers and decision-makers.

A scorecard is an opportunity to improve service delivery and offers a platform for communication between health service users and the service providers. It is not meant to be a forum for confrontation. It is therefore not about people or individuals, but systems, structures, policies and processes. It is a participatory tool that generates information through focus group interactions, enables maximum participation of the community, and provides immediate feedback to all stakeholders. It underscores immediate response and joint decision-making, with well generated and shared plans for improvements arrived at through mutual dialogue between stakeholders. This makes it easy to be owned and implemented by everybody.

I welcome the initiative taken by UNASO, in collaboration with UAC, Ministry of Health and Local Governments for coordinating the development of the National HIV & AIDS Accountability Score Card and responses given by the different communities reached. We urge partners in the HIV & AIDS response to use the information in this report to maintain the good work and improve in areas where we are not scoring well.

I would like to acknowledge all those who provided support to the successful development of the National HIV & AIDS Score Card Report; the communities, the district local governments, health center in-chargers, the Technical Working Group and UNDP for their technical and financial support.

UAC commits to adopt this methodology in assessing the HIV and AIDS response every two years.



Professor Vinand Nantulya
Chairman, Uganda AIDS Commission

Abbreviations' & Acronyms

ADPs	AIDS Development Partners
AIDS	Acquired Immune Deficiency Syndrome
AMICAALL	The Alliance of Mayors and Municipal leaders on HIV/AIDS in Africa
ANC	Antenatal CareARV Antiretroviral drugs
CAO	Chief Administrative Officer
CBG	Capacity Building Grant
CBO	Community Based Organization
CSC	Community Score Card
CSOs	Civil Society Organisations
DAC	District AIDS Committee
DDP	District Development Plan
DEC	District Executive Committee
DFP	District HIV/AIDS Focal Person
DHO	District Health Officer
DPU	District Planning Unit
FBO	Faith Based Organization
FGDs	Focus Group Discussions
GBVs	Gender Based Violence Services
GYNA & OBS DEPT	Gynaecology & Obstetrics Department
HBC	Home Based Care
HCT	HIV Counseling and Testing
HIMS	Health Information Management System
HIV	Human Immunodeficiency virus
HMIS	Health Management Information System
I.M.S	Interface meeting
IEC	Information Education Communication Material
IGA	Income Generating Activities
IP	Implementing Partner
IPD	Inti-patient Department
JAR	Joint Annual Review
LC	Local Council
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MACA	Multi Sectoral AIDS Control Approach
MARPS	Most At Risk Populations
MDG	Millennium Development Goals
MOES	Ministry of Education and Sports
MOH	Ministry of Health
MOLG	Ministry of Local Government
MOT	Mode of Transmission
MOU	Memorandum of Understanding
MTCT	Mother to Child Transmission
NAADS	National Agricultural Advisory Services
NAFPOHANU	National Forum of PLHA Networks in Uganda
NGOs	Non Governmental Organizations
NPAP	National Priority Action Plan
NSP	National Strategic Plan
NUSAF	Northern Uganda Social Action Fund
OPD	Out Patient Department
OVC	Orphans and Vulnerable Children
PC	Partnership Committee
PETS	Public Expenditure Tracking Survey
PF	Partnership Fund
PLHIV	People Living With HIV
PHC	Primary Health Care
PLHIV	People Living with HIV

PMTCT	Prevention of Mother To Child Transmission
PPDA	Public Procurement and Disposal of Public Assets Authority
PPPH	Public Private Partnership for Health Policy
PS	Private Sector
PWDs	Persons with Disabilities
QUAM	Quality Assurance Mechanism
RDC	Resident District Commissioner
SCE	Self-Coordinating Entities
SGBV	Sexual Gender Based Violence
SMC	Safe Male Circumcision
STD	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
SWOT	Strengths-Weaknesses-Opportunities-Threats
TB	Tuberculosis
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UAIS	Uganda AIDS Indicator Survey
UDHS	Uganda Demography Health Survey
UHRC	Uganda Human Rights Commission
UHSBS	Uganda HIV&AIDS Sero-Behavioral Survey
UNAIDS	United Nations Joint Programme on HIV&AIDS
UNASO	Uganda Network of AIDS Service Organization
UNDP	United Nations Development Program
UNEPI	Uganda Expanded National Expanded Programme on Immunization
UNESCO	United Nations Educational, Scientific and Cultural Organization
UPE	Universal Primary Education
USE	Universal Secondary School
VHTs	Village Health Teams

Executive Summary

BACKGROUND INCLUDING THE METHODOLOGY AND SCOPE OF ASSESSMENT

This report presents the process of preparation of the National AIDS accountability scorecard and the execution of the scorecard exercise itself. The process was undertaken by UNASO from September to December 2013. The scorecard exercise was a response to the recommendation made earlier in a report that assessed governance and accountability mechanisms for HIV and AIDS in 2012. The report recommended for development of a national AIDS Accountability Scorecard. The process was conducted with financial support from UNDP and technical oversight by a 15 member Technical Working Group (TWG) appointed by the Uganda AIDS Commission (UAC).

The major objective of developing the National AIDS Accountability Scorecard was to positively influence the quality, efficiency and accountability in HIV&AIDS service provision at national and district levels.

The scoring process focused on HIV prevention, care and treatment, social support and protection and systems strengthening as National HIV&AIDS Strategic Plan 2011/12-2014/15 and performance indicators. A detailed document review was conducted to obtain information to prepare the national performance at glance (table 2). To establish community s views and scores, participatory approaches were adopted including conducting community scorecard, and key informant interviews in fourteen districts covering 28 health facilities.

To establish the status of equipment and infrastructure, input tracking based on approved standards for each of the health facility level was used. Furthermore, staffing norms as per the Ministries of Health and Public Service standards were used to obtain information on staffing status for the health facilities reached during the assessment.

Key Results

Regarding key findings the report notes that the respondents were happy with the performance of the prevention interventions like prevention of mother to child transmission (PMTCT), HIV counseling and testing (HCT), and safe male circumcision (SMC). The study findings show that anti-retroviral therapy (ART) for both adults and children was performing well as well as tuberculosis (TB) treatment. The assessment however, noted that adolescent treatment, social support and systems strengthening interventions were not performing well. Concerning input tracking, the findings indicate that most health facilities had infrastructure however, most health facilities had not had any renovation and required facelift for they were generally characterised by worn out paintings, dust stained louvers, dirt stained and damaged screening meshes, stained and damaged ceilings, damaged doors, cracked walls, non-functional water taps. Inadequate supplies of beddings in health facilities were the other major problem that cut across all facilities visited. Cases of broken beds without replacements or even repair were prevalent in all facilities visited. Some lacked running water, there were

not enough toilets, and lacked emergency transport facilities. The results furthermore, indicate that there were some health facilities that had more staff than what is provided for in the guidelines while others lacked some of the critical staff.

General Challenges for Prevention

- Stigma still limiting identified HIV positive clients from accessing treatment
- Shortage of midwives in supported lower level facilities especially among health centres III
- Lack of comprehensive counseling skills at ANC, women fear to test
- Scarcity of both female and male condoms- female condoms are not available and there is limited public education on them
- Inadequate public education, and where it is available, it carries confusing messages from multiple implementers
- The programmes for Key populations are limited.
- Biting poverty in the community has been a hindrance to honoring of referrals. Clients are willing to access service in health facilities but they claim not to have transport.
- Some women and religious leaders do not support SMC
- Frequent stock out supplies such as HIV testing kits SMC supplies and consumables
- Uptake of FP services is still low and is exacerbated by low male involvement
- Frequent gender based violence with limited interventions that focus on linkages between HIV and SGBV

General Challenges for Treatment and support

- Facility-community linkage is still weak and where VHTs exit, some have not been trained. There is limited PLHIV networks involment as well as expert clients.
- Inadequate home based interventions.
- High staff attrition and transfer rates
- When HIV+ mothers disclose their sero-status to spouses, they experience more Stigma and discrimination and domestic violence.
- Adolescent treatment is faced with limited linkages between health centres with education institutions and limited adolescent-focused interventions that integrate both HIV and Sexual and reproductive health.
- Poor counseling for the adolescents; and generally there are no youth friendly services

Systems

- No national systems to monitor and report on HIV community systems and prevention initiatives
- Lack of national estimates of key populations
- Weak data management (quality, completeness and timeliness) characterized by limited data use;
- Coordination structures for both public sector and CSOs are weak.
- Insufficient staff to provide comprehensive and integrated HIV services,
- Retention of staff is a major issue across all cadres at various health facility levels.

Recommendations

Prevention

- Support interventions and standardize prevention package for key populations.
- Promote partnership building between the public health sector and non-public sector to address the barriers to SMC uptake.
- Integrate gender services into the PMTCT program including male partner testing & linkage into SMC.
- Standardize prevention messages at all levels.
- Scale up support to therapeutic and supplementary feeding to mothers living with HIV and their babies.
- Strengthen community systems to ensure community mobilization and strengthen facility linkage

including supporting PLHIV adherence and retention in care. Strengthen integration of nutrition assessment in ANC services.

Treatment care and support

- Mainstream HIV intervention in existing financial savings and credit opportunities for the moderately vulnerable households
- Strengthen linkages between formal health facilities and informal community based services
- Enhance Community-Facility Linkages through increasing use of peer mothers and community support (PLHIV Networks) to increase adherence and retention
- Build capacity of paralegals to provide legal aid to PLHIV and orphan and other vulnerable children (OVC)
- Promote community health insurance and co-save as sustainable structural interventions
- Support most vulnerable PLHIV households and their beneficiaries to meet immediate needs for proper nutrition and income-generating activity (IGA)

Systems

- Advocating for a National Health Trust Fund Levy that is ring-fenced for investment in HIV and AIDS response
- Support and invest in the civil society-driven advocacy, monitoring and accountability of treatment and prevention programs
- Promote community ownership of programme through citizen engagement in the HIV response to enhance ownership and sustainability
- Identify alternative sources of financing for HIV and AIDS response such as community health insurance
- Support district based capacity-building interventions in stock management to improve availability of drugs and reduce leakages.
- Invest in renovation of structures
- Recruitment of more health workers
- Mainstream all development partners support in existing health facilities to ensure uniform service delivery and management.
- Institutionalize the Community scorecard approach and conduct it every 2 years
- Conduct an assessment on functionality of the governance mechanisms/systems for health facilities.

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Chapter One

BACKGROUND TO THE STUDY

1.0 INTRODUCTION

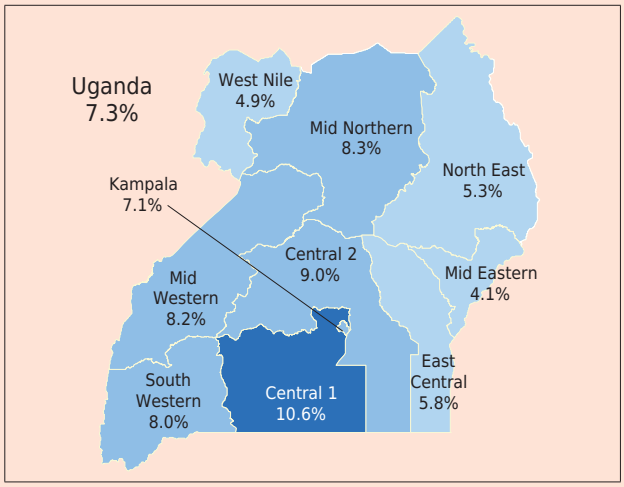
This Chapter presents the background to the preparation of the AIDS Accountability Score Card of the HIV and AIDS situation in Uganda. It also presents a snapshot of the national performance against the National Strategic Plan (NSP) targets for the period 2011/12-2012/13. In 2000 when the global leaders gathered to discuss the agenda for the Millennium Development Goals 18.8 million people had died of AIDS, a further 34.3 million people were living with HIV and a few had access to antiretroviral therapy. Through the MDGs and the 2001 Declaration of commitment on HIV &AIDS, all the United Nations member states committed themselves to a series of actions and concrete time bound targets to reverse the spread of HIV and mitigate the impact of the AIDS epidemic. In adopting the United Nations Declaration Commitment, all member states also committed themselves to report regularly on the progress made in responding to the epidemic in line with universal access to comprehensive HIV prevention programmes, treatment and support.

The AIDS Accountability Country Score Card aims to help evaluate and rate the country response towards various commitments in the response. Thus, this effort feeds into international and national long-term strategy that is necessary to achieve long-term agenda of getting to zero new infections, zero stigma and discrimination, and zero AIDS related deaths .

1.1 HIV & AIDS SITUATION IN THE COUNTRY

The Uganda AIDS Indicator Survey [(UAIS) (UAC 2011)] reported that the prevalence of HIV among the adult population in the country increased from 6.4% in 2004/5 to 7.3% in 2011. Against this, more women than men are infected, as the prevalence among women in age group 15-49 is 7.7% while that of men is 5.6%. HIV prevalence among the youth in the age-group 15-19 was only 2%. The peak in prevalence of the epidemic is among those in the age group 35-39 at 10.3%. There is also regional variation with the highest prevalence at 10.7% found in Central Region 1 while the lowest is at 3.7% for Mid Eastern Region.

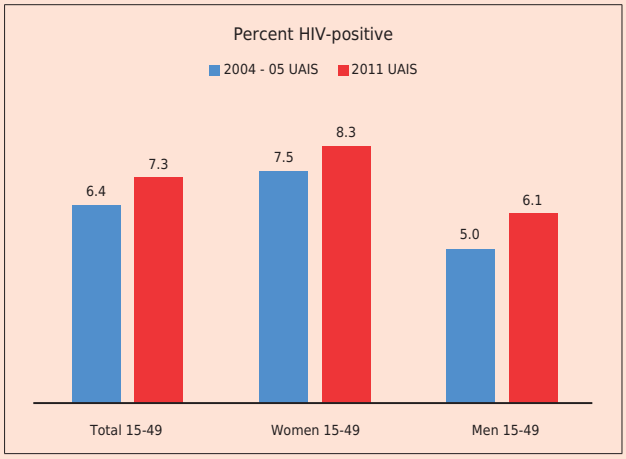
Figure 1: HIV prevalence by region



Source: Uganda AIDS Indicator Survey (UAC 2011)

Overall, HIV prevalence among women and men aged 15-49 increased from 6.4% between 2004-5 to 7.3% by 2011. The AIDS epidemic is still predominantly heterosexually transmitted accounting for 80% of infections. Mother-to-child transmission accounts for 20% while blood-borne and other infections account for less than 1%. The Mode of Transmission Study (MOT) indicated that the risk factors responsible for the spread of HIV transmission are of two types:, modifiable and non-modifiable. The modifiable risk factors comprise multiple partnerships, HIV sero-discordance, inconsistent condom use, infection with sexually transmitted infections (STIs), and lack of male circumcision while the non-modifiable factors include urban residence, old age, being married, being female, and residence in Northern Uganda.

Figure 2: Trends in HIV prevalence



Source: Uganda AIDS Indicator Survey (UAIS) 2011

1.2 INTRODUCTION TO AIDS ACCOUNTABILITY SCORE CARD

Between September-October 2012, UNASO, with support from UNDP commissioned a study aimed at Assessing Governance and Accountability Mechanisms in HIV and AIDS Programme in Uganda . The exercise was carried out at national level and in the 9 Uganda Demographic Health Survey (UDHS) regions, covering 18 selected districts. The objectives of the study were (i) to assess how the concept of HIV&AIDS governance and accountability is perceived by the different stakeholders;(ii) to examine the existing governance and accountability mechanisms amongst the different actors with the view to identifying the good, average, and bad practices within them;(iii) to explore the main challenges affecting governance and accountability in the national HIV&AIDS response and (iv) to recommend appropriate governance and accountability model(s) or mechanisms) for the various actors in the national HIV response.

While the study revealed availability of a number of mechanisms for governance and accountability such as; UAC, Partnership Forum (PF), Annual Joint AIDS Review (JAR), partnership committee, Joint review mission by Ministry of Health and several others, it also highlighted a number of issues that affect enforcement of governance and accountability in the HIV&AIDS response. These included; (i) limited consultations with Local Governments (LGs) and other stakeholders before JAR, PF and Joint Health Reviews are held (ii) limited participation of citizens in review of the response performance (iii) measurement of performance not clear to stakeholders (iv) limited community ownership of the response and (v) transparency on resource utilization remains an issue.

To address the above challenges the study team recommended conducting and establishment of a National AIDS Accountability scorecard. To implement the above recommendation, UNASO Secretariat conducted fieldwork to facilitate the development of the National AIDS Accountability scorecard. This activity was conducted with financial support from UNDP and technical oversight by a 15 member TWG appointed by UAC.

1.2.1 Description of the National AIDS Accountability Score Card

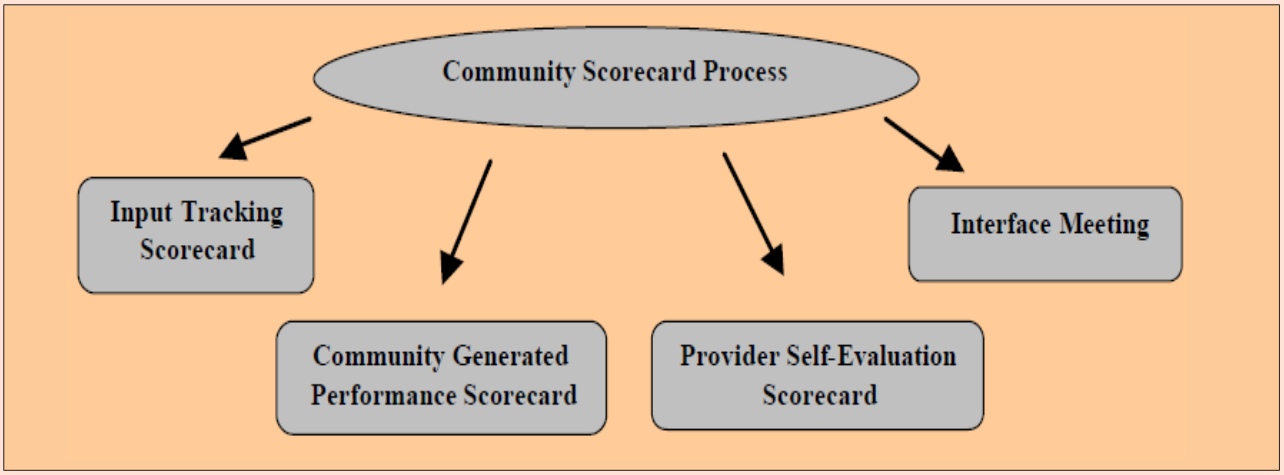
The AIDS Accountability Scorecard (like balanced scorecard) was initiated by AIDS Accountability International Collective Foundation (Sweden) in 2007/2008 as a response to the critical gap of moving beyond the Monitoring and Evaluation (M&E) statistics of reporting progress in the HIV and AIDS response. The National AIDS Accountability Scorecard is a rating of the degree to which governments are fulfilling their commitments to respond to the epidemic. It provides for transparency, participation, consultation, analysis and consensus among stakeholders, on the indicators of the success in the national response to HIV and AIDS.[1]

1 World Bank Social Development Department

1.2.2 The Community Score Card:

The Community Score Card (CSC) is a participatory process that empowers communities or service beneficiaries to influence quality, efficiency, effectiveness and accountability in service provision at the local level. The information in the scorecard is used to improve service delivery in communities, support advocacy and develop better monitoring and evaluation of the HIV response. The CSC method was chosen because it is the one among other social accountability monitoring methods/tools (such as citizen report card, social audit, and national dash- boards) that provides a holistic and hybrid tool that brings together duty bearers, various service users (citizens) and service providers. It is a tool that exerts social and public accountability and responsiveness from service providers by linking service providers and leaders to the community; thus citizens are empowered to provide immediate feedback to the service providers and leaders.

Figure 3: Conceptual frame work of CSC



Source: Janmejay & Parmesh[1]

1.2.3 Importance of the Community Score Card

Greater Accountability

- Promotes sustained engagement of beneficiaries in improving service performance
- Increases provider responsiveness to beneficiary preferences
- Increases opportunities for providers and leaders/duty bearers to engage beneficiaries as partners in service process

Empowerment

- Gives voice to the marginalized groups to influence the quality of service delivery
- Provides the comfort zone for all categories of beneficiaries to contribute to the effectiveness of the public services through focus group discussions
- Brings citizens energy to service improvement
- Increases community ownership and responsibility for programs and services

1.3 OBJECTIVES OF THE NATIONAL AIDS ACCOUNTABILITY SCORE CARD

The overall objective of establishing a National AIDS Accountability Scorecard was to positively influence the quality, efficiency and accountability in the provision of HIV&AIDS services at national and district levels.

[1]World Bank Social Development Department

1.3.1. Specific objectives of the study

- To provide information on the extent to which Uganda is achieving targets of the National HIV & AIDS Strategic Plan (NSP) 2011/12 – 2014/15 and the millennium development goals.
- To generate information that will help stakeholders to compare progress against national targets, highlight key issues affecting the response and action needed.
- To provide constructive feedback from communities to stakeholders and service providers about the performance and benefits of theirHIV&AIDS interventions.
- To generate recommendations aimed at enhancing social accountability in the AIDS response in Uganda.

1.4 RATIONALE OF THE NATIONAL HIV&AIDS SCORECARD

- The Scorecard provides information on the extent to which Uganda is achieving targets of the NSP 2011/12 – 2014/15. It tracks and measures critical indicators in each of the key thematic areas of the response i.e. Prevention, Care and Treatment, Social Support and Protection and Systems Strengthening.
- The scorecard will help stakeholders to compare progress against national targets, highlight key issues affecting the response and actions needed.
- The national score enables stakeholders including service users to provide systematic and constructive feedback about the performance and benefits of the HIV&AIDS interventions. The government through UAC will learn directly from stakeholders and communities about what aspects of the response is working well and what is not.
- Information will support decision-making and policy choices for improved service delivery. Data from the national score card will also inform how government is progressing towards the millennium development goals in this sector. Thus, this effort feeds into international and national long- term strategy that is necessary to achieve long-term agenda of getting to Zero New infections, Zero AIDS – related death and Zero Discrimination.

1.5 APPROACH/METHODOLOGY

This section presents the approach and methodology that were employed in undertaking this study and subsequent development of the Scorecard. It details the design and geographical study areas, study participants and methods of data collection, processing and analysis.

1.5.1 Design and geographical scope

This was a cross-sectional study employing mainly qualitative methods in selecting study areas, participants and data collection. The NSC study was nation-wide covering all the regions of the country with a focus on 14 purposively selected districts. See Table 1 for selected districts and criteria for inclusion.

Table 1: Study geographical scope

Sub-region	Districts	Reason for selection
East Central	1. Mayuge	▪ Heavy HIV and AIDS investment
East	2. Kapchorwa 3. Mbale 4. Kaberamaido 5. Moroto	▪ Presence of key populations- mainly fisher-folks; poor geographical access, presence of the Regional Referral Hospital
North Central (Lango sub-region)	6. Apac	▪ Presence of key populations- mainly fisher-folks
North West	7. Adjumani	▪ Inadequately served populations and other populations that face a higher HIV risk, near boarder district
North Central (Acholi sub-region)	8. Gulu	▪ Heavy HIV&AIDS investments, presence of the Regional Referral Hospital
South West	9. Sheema 10. Mbarara	▪ Heavy HIV and AIDS investment, presence of the Regional Referral Hospital
Mid-west	11. Kamwenge	▪ HIV prevalence, refugee community
Central	12. Wakiso 13. Luwero 14. Rakai	▪ HIV prevalence, urbanization

The selection of the above districts was further guided by the status of the district in terms of the period it was created, urban and rural dichotomy.

This was aimed at creating a balance between new and old districts, urban and rural areas. In the selected districts, the study covered 28 health centres including 4 referral hospitals, 5 district hospitals, 9 health Centres IV and 9 health centres III).

1.5.2 Study participants

Study participants included beneficiaries of HIV and AIDS services such as people living with HIV (PLHIV), most at risk populations (MARPs), persons with disabilities (PWDs) and young people Other study participants included key informants e.g., health service providers, health management committee members, Directors of hospitals, Local council officials and district/sub-county technical staff, VHTs, and PLHIV.

1.5.3 Data collection and analysis methods

Data was collected using qualitative methods that involved highly participatory techniques including, among others, desk review, focus group discussions (FGDs), key informant interviews, consultative/ interface meetings and direct observation.

a) Document review: UNASO Secretariat conducted a review of some key documents (see annex on References) such as national score cards from other countries to understand and appreciate the development process of national scorecards. With support from a consultant, a detailed document review (see attached a document review checklist annex II) was conducted to obtain information to score the response on selected indicators as well as preparing the national performance at glance (table 2). The scored elements and indicators are those largely contained in the national HIV&AIDS strategic plan 2011/12-2014/15. These are:

1. HIV prevention
2. Care and Treatment
3. Social Support and Protection
4. Systems Strengthening

In addition, input tracking and staffing norms were assessed using the MOH standards for the health centres reached.

b) Key informant interviews were conducted with local government leadership, CSO representatives as well as health management committee members. This method was mainly used to collect views on coordination of the response, district HIV&AIDS financing, community participation, human rights and gender mainstreaming, integration of response in other sectors and human resources for HIV&AIDS.

c) Focus group discussions. This method was used to collect feedback from various community members on 4 major thematic areas and their underling specific interventions in the NSP (HIV prevention, Care & Treatment, Social Support & Protection and Systems Strengthening). FGDs were conducted mainly at health facility levels involving at least 8-10 participants using standard procedures of conducting FGDs. Different community sub-groups (women, and men,PHAs, MARPs, people with disabilities etc) formed the FGD respondents. To score the performance of the services, the FGDs were introduced to the variables/areas of score and scores were also agreed on and expressed in ranges from 1 to 5. The scores were also meant to capture and provide perceived quality of services from the perspective of service recipients.

1. Very poor service
2. Poor Service
3. Average service
4. Good service and
5. Very good service

The health service providers were first oriented on the purpose of Community Score Card and briefed on the purpose of the meeting, which was to seek feedback on the quality and performance of services provided by the health facility. This was to ensure the facilitator guided the respondents to score the services using the framework of annex I

d) The Interface Meeting brought together both community members and service providers (facility staff) to discuss the results of the scorecards. Scores from FGDs were shared with justifications given by each group and then a final score was agreed upon. During this facilitated discussion using the combined score, a mutually agreed action plan was developed.

e) Facility Observation (Input Tracking)

The health facilities were visited and using the following checklist,the information was recorded:

- Conditions of the place
- Type of building
- Facilities available,
- Space for waiting
- Cleanliness

In addition to visual inspections, and collection of photographic data around the health centres were undertaken.

f) Key informant discussions with the health facility staff: the research team interacted with the health workers and recorded the following:

- Procedures of patient care
- Types of patients who usually visit the health facility
- Number of deliveries in day,
- Number of out-patients visits in a day,
- Facilities available and facilities required

g) A video documentary was recorded to capture all steps of implementing the community score card methodology and supplement the face-to-face and group interactions.

h) Validation meetings: One national level validation meeting was held to provide input int the NSC report. It attracted representatives from study districts, representatives of key populations, PHA networks, CSOs, line Ministries and Government Agencies representatives, ADPS and the private sector.

1.5.4 Data analysis and presentation of results

Qualitative data was transcribed and analyzed using a step-wise process; results themes and sub-themes were built, interpreted in line with the assessment conceptual framework. Data was presented in descriptive form backed with relevant quotations. This information was presented in form of tables and charts and later triangulated. The scores were captured from all respondents and individually and during interface meetings general/agreed scores were captured and presented in the table form represented by different colours. The findings of the study are presented using scales, traffic lights colors, percentages, bar charts.

1.7 MANAGEMENT AND IMPLEMENTATION OF THE STUDY

The study was executed by UNASO Secretariat team in close collaboration with key partners. A multi-sectoral TWG was constituted and appointed by UAC to provide technical oversight. The management of UNASO Secretariat as implementing partner provided any other support needed by the assessment team to carry out this task.

Four teams were constituted by UNASO Secretariat with each covering a region. Each team comprised of a Team Leader from UNASO Secretariat and four research assistants. The team spent 1 day at each health facility in a district. UNASO Secretariat technical team led the teams with the support of a Quality Assurance Advisor hired to support the process.

1.8 QUALITY CONTROL AND ASSURANCE:

A team of competent research assistants with expertise in qualitative data collection was recruited and trained to collect data. To enable the field staff conduct the assignment competently and efficiently, a half-day training session was conducted at national level covering study goals/objectives, qualitative research methods with a clear focus on administering the tools, and the community score card methodology, . To ensure quality of the data, a key informant guide was pre-tested in Mukono District on selected respondents to ensure content validity and reliability before actual data collection began.

The TWG met from time to time to provide overall technical guidance and oversight of the process. The TWG provided significant input in redefining the methodology and strengthening the tools. All the subsequent drafts by UNASA Secretariat were shared with the TWG members that provided invaluable technical input.

1.9 LIMITATIONS TO EVALUATION FINDINGS

The major limitation that the study team encountered was that of limited documentation and consistent

data at national level, which constrained getting the appropriate data to review as baseline and measuring performance against the set targets.

1.10 ETHICAL CONSIDERATIONS

UNASO secured an introductory letter from UAC for the data collection teams to present to authorities in the study districts as a way of securing clearance. All study participants were requested for their consent to participate voluntarily in the process. Thus, informed consent was sought and obtained before sessions or interviews began for all study participants. In particular, participants were assured of confidentiality and anonymity of their responses.

Admn block for Kigandalo HCIV-Mayuge

Ambulance Kalisizo Hospital-Rakai

Antinental Block Kakuuto HCIV-Rakai

SMC outreach camp in Rakai district

Dental clinic in Kalisizo hospital-Rakai

Theatre Kalisizo hospital-Rakai

New ambulance at Entebbe Hospital-Wakiso

Old ambulance at Entebbe hospital-Wakiso

Entebbe Hospital -Theatre-Wakiso

Drug store Kalisizo Hospital-Rakai

Drug store at Kigandalo HCIV-Mayuge

Entebbe Hospital -Theatre-Wakiso

Entebbe Hospital- Theatre-Wakiso

Entebbe Hospital-Wakiso

Female ward Entebbe Hospital-Wakiso

HIV Files for PLHIV at Malongo-Mayuge

Kabwohe HCIV-Toilets-Sheema

Kakuuto HCIV- Kitchen-Rakai

Kalisizo Hospital- Inpatient ward-Rakai

Kamwenge HCIII-Kamwenge

Kamwenge HCIII-main block-Kamwenge

Kalisizo Hospital- Kitchen-Rakai

Kitagata Hospital -Medical Superintendent emphazing how the laboratory has never had running water .

Kitagata Hopistal-Operating bed-Sheema

Kitagata Hospital Bathrooms-Sheema

Kitagata Hospital - Non functional sterilizing machine in the theatre

Kitagata Hospital Male ward-Sheema

Kitagata Hospital beds lacking matresses-Sheema

Kitagata Medical supretendant touring UNASO staff around the hospital to show its status

Kitagata hospital - Main Block

Kitagata hospital- Bathrooms in Maternity ward

Kitagata hospital-The very old hosiptal stuctures

Mwiizi HC IV Staff quaters-Mbarara

Motuary for Kapchwora Hospital-Kapchorwa

Luwero Kasana HCIV Ceiling In Patient ward

Mwiizi Health centre Delivery room-Mbarara

Mwiizi Hospital-Inpatient ward for both male,women and children

Notice board at Kapchwora Hospital-Kapchorwa

Siipi Kitchen-Kapchorwa

Notice board at Malongo HCIII-Mayuge

Siipi HC111 Ambulance-Kapchorwa

Toilets at Kigandalo HCIV-Mayuge

Some of the beds at Bufumbo HCIV-Mbale

Some of the drugs at Malongo HCIII-Mayuge

Zirobwe Inpatients ward-Luwero

Suggestion box Kakuto HCIII-Rakai

Tap Kalisizo Hospital-Rakai

Toilet for Malongo HCIII-Mayuge

Zirobwe HCIII -In Patient ward-Luwero

Chapter Two

FINDINGS

2.0 INTRODUCTION

This section presents the results of the document review at national level and community scores of the performance of the national response following the NSP thematic areas.

2.1 National Performance at Glance

From document review, it was noted that there has been significant achievements in the prevention interventions such as HIV Counseling and Testing, Prevention of Mother to Child Transmission and Safe Male Circumcision and safe blood transfusion. In addition, provider initiated testing and counseling (PITC) at health facilities has been scaled up. It was noted that PMTCT Option B+ has been rolled out countrywide in 2,138 health facilities since October 2012. The country adopted SMC in 2011 as part of the CPI. Almost 750,000 eligible males (74.2% of the annual national target of 1,000,000) have been reached with the SMC package, which includes prevention messages, and HTC services through September 2013.

Safe blood transfusion remains a key HIV prevention public health intervention in the national HIV response. Approximately 205,000 blood units (79% of the national target) have been collected and screened for HIV, syphilis, Hepatitis A and B.

Regarding prevention efforts among the key population, it was observed that while there has been some efforts through innovative approaches such as moonlight HCT for sex workers and truckers, the interventions are limited and its further affected by lack of information on size of the key populations.

As regards, treatment coverage has with more adults and children accessing the services. More health facilities have been accredited to provide ART services have been decentralized down to Health Center IIIs. The number of individuals accessing ART based on the 2010 WHO treatment guidelines, increased from 329,060 (57% coverage) to 577,000 (76.5%) between September 2011 and September 2013, with children comprising 8%. Treatment coverage among eligible children currently stands at 41% compared to 28,107 in June 2012 (28% eligible). Retention on ART is 86%, surpassing the target of 85%. It was further, noted that there has been considerable improvement in TB/HIV integration with a current HTC coverage of 87%, and cotrimoxazole prophylaxis coverage of 94% among TB/HIV co-infected individuals. However, TB case detection among HIV co-infected individuals is still low (1.5% vs expected 5-7%). However, TB case detection among HIV co-infected individuals is still low (1.5% vs expected 5-7%).

The review noted that social support interventions were still weak. For instance, the first Stigma Index Study in 2013 indicates that there is still a serious problem of stigma and discrimination among PLHIV that affects access to HIV and other services.

Furthermore, access to services by OVCs was improving although the health facility linkage of OVC to community support programs remains weak.

Health Systems have been strengthened to support delivery of evidence-based, cost-effective interventions: There has been considerable improvement in accreditation of health facilities in order to enhance capacity for scale-up o f comprehensive HIV services including ART and eMTCT

It was noted that country continues to conduct baselines and surveys for instance AIDS Indicator Surveys every five years and annual ANC sentinel surveys which provide critical data for national and district level programming. Additionally, a national roll out of District Health Information System (DHIS2) and Open MRS has been operationalized. However, the roll out is hampered by infrastructure and human resource limitations.

The review of national reports further revealed while the efforts have been made to recruit more health workers of various carder, the numbers remain insufficient and hence creating a lot of work load for available staff.

2.2 Findings from Community Scorecard

The results in this section are presented with the scores agreed on per programme intervention ranging from 1 to 5 with the five colours shown below.

1. Very poor	
2. Poor	
3. Average	
4. Good	
5. Very Good	

2.2.1 PREVENTION

2.2.1.1 Community Score Card for PMTCT

Globally there has been renewed commitment to reduce vertical transmission from mother to child, to less than 5% in order to end new pediatric HIV infections and improve the health of mothers. The NSP aimed to transition to use of PMTCT Option B+ (lifelong antiretroviral therapy) for pregnant and lactating women living with HIV. The Government adopted the strategy in April 2012, and phased roll-out began in October 2012. During the community score process, respondents were asked to rate the performance of the PMTCT at their health facilities.

Table 2a: PMTCT Performance percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	5	16	7	5	17.8
Good	11	10	15	18	64.3
Average	11	2	6	5	17.8
Poor	1	0	0	0	0
Very poor	0	0	0	0	0
Total	**28**	**28**	**28**	**28**	**100**

Table 2b: PMTCT community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
	Luwero	Kasana HCIV				
		Zirobwe III				
	Wakiso	Entebbe H				
		Wakiso HC IV				
	Rakai	Kalisizo H				
		Kakuuto IV				

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
PMTCT	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu HCIV				
		Kamwenge III				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido IV				
	Gulu	Layibi III				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

From the results presented in above table and graph, majority (64.3%) of respondents (men, women and health workers) rated performance of PMTCT as good while others (17.8%) rated it very good and (17.8%) rated it as average . The major reasons given for the good performance of the intervention included accreditation of more service delivery points that offer PMTCT, public education on PMTCT through radio programmes, provider initiated counseling and testing as well availability of drugs when mothers are tested sero-positive. However, it was noted that challenges of loss for follow-up, failure of mother to deliver in health facilities, and low male involvement are still affecting the uptake of the service. In addition, it was reported that there are weak linkages between health facilities and communities to facilitate referrals and follow-up of mothers.

"Large numbers of mothers are lost to follow up " most mothers get lost to follow up...there are no resources to follow up PCR which also leads to loss of of follow on children" Health Worker, Gulu District

Community Score Card for PMTCT

Low male involvement was singled out as one of the major challenge affecting the uptake of PMTCT because whenever some mothers reported their results, some men chased them from homes claiming that they are the source of HIV virus. This has resulted in instances where mothers either do not share their test results or fail to come to health centres for further support for fear of being harassed for their HIV positive status.

"Sexual-gender based violence (SGBV) is being increased by drug taking especially in secrecy by couples. People swallow drugs in hiding and once the other partners discover, it creates conflicts, which in turn perpetuates violence" FGD member at Mwizi HCIV, Mbarara District.

The respondents recommended strong involvement of men in the programme as well the PLHIV networks.

"Without involving PHAs, the eMTCT intervention will not be a success ...because we know how to do it, we know the attitude of the mothers ....they also respect us as fellow PLHIV than any other persons...why do you prevent HIV from the extreme end when you know the source of the virus... prevention efforts must begin with us" PLHIV KI Apac District.

"There are low attendances for ANC in most of the health facilities ... these visits are a challenge for eMTCT uptake which require more visits" DHO, Kapchorwa District

2.2.1.2 Community Score Card for SMC

In 2007, WHO/UNAIDS recommended that male circumcision be included in the HIV prevention package. Thirteen Southern and Eastern African countries with high HIV prevalence, low levels of male circumcision and generalized heterosexual epidemics were identified as priority countries for male circumcision scale-up and Uganda is one of these countries. Uganda recognised male circumcision as a key intervention within the broader framework of male reproductive and sexual health that should contribute to a marked reduction in the new HIV infections. Modelling results revealed that the rate of HIV infection could be reduced by up to 40% with male circumcision as one of the HIV prevention interventions, compared with a decrease of 25% without male circumcision[1]. Thus the NSP 2011-15 targeted to increase the proportion of adult males circumcised to 80% from the estimated 25% in 2015. To achieve the above targets, the country rolled out Safe Male Circumcision programme across all districts.

Table 3a: SMC Performance percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	3	7	4	1	3.6
Good	6	9	9	11	39.3
Average	15	8	8	10	35.7
Poor	2	3	6	5	17.8
Very poor	2	1	1	1	3.6
Total	**28**	**28**	**28**	**28**	**100**

In this study, the community scored the performance of SMC as "Good" (39.3%) and "Average" (35.7%). The Community attributed the performance of the intervention to using a mix of service delivery models such as static sites, camps and outreaches, public education mainly through mass media. The gaps identified, however, included: stock-outs of kits, limited trained medical staff to undertake circumcision, inadequate one-on-one education of benefits of SMC beyond HIV prevention, lack of post-circumcision support from health workers as well as insufficient leadership in the community in support of SMC. SMC service providers hardly use the district structures during their implementation, yet these could work as avenues to strengthen accountability, monitoring and ownership of SMC services at community level. It was noted that relatively few political, civic, and community leadership at national or sub-national have become vocal champions for male circumcision. Religious leaders were singled out as some of the leaders decampaigning the intervention. In addition, stigma and misinformation were also noted as some of the challenges affecting the intervention. SMC quality was reported to be one of the major challenges because most clients are handled during the outreaches and camps, and thus do not have an opportunity to visit facilities again in case they develop post-circumcision effects.

1 The National HIV and AIDS Strategic Plana 2011-15

Table 3b: SMC community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
SMC	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

"SMC- interventions are donor or project driven, I am wondering how such interventions can be sustained when donors or project close" District leader, Gulu district.

"Leadership has always made the difference between winning and losing the battle against AIDS, and it's no different with male circumcision," said Ag. CAO, Kamwenge District.

"In the few places where leaders have helped make it a HIV prevention strategy during the community meetings, we're seeing impressive increases in male circumcision numbers. Where they haven't, it's no surprise that we see stigma and inaction" (Ag. CAO, Kamwenge District).

2.2.1.3 Blood Transfusion

Table 4a: Blood Transfusion

Score scale	Men	Women	S. Provider	Interface score	%
Very good	0	0	2	1	6.2
Good	2		4	0	0
Average	5	9	3	8	50
Poor	4	3	5	5	31.3
Very poor	5	4	2	2	12.5
Total	**16**	**16**	**16**	**16**	**100**

As per the study results, a half, 50% of the health centres reported that performance on blood transfusion was “average”, 31.3% was “poor” while 12.5% rated it “very poor”. Key reasons for the above rating were reported as; poor storage facilities, and poor mobilization of blood donors.

Table 4b: Blood transfusion and community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Blood Transfusion	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV	N/A	N/A	N/A	N/A
	Kamwenge	Rukunyu	N/A	N/A	N/A	N/A
		Kamwenge HCIII	N/A	N/A	N/A	N/A
	Mbale	Mbale RH				
		Bufumbo	N/A	N/A	N/A	N/A
	Mayuge	Kigalando HCIV	N/A	N/A	N/A	N/A
		Mulongo	N/A	N/A	N/A	N/A
	Kapchorwa	Kapchorwa H				
		Sipi HC III	N/A	N/A	N/A	N/A
	Moroto	Moroto H				
		Nadunget H	N/A	N/A	N/A	N/A
	Kaberamaido	Ochera HC III	N/A	N/A	N/A	N/A
		Kaberamaido				

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III	N/A	N/A	N/A	N/A

2.2.1.4 Provision of IEC

Table 5a: IEC Performance percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	5	8	2	2	7.1
Good	8	9	10	10	35.7
Average	5	4	12	11	39.3
Poor	7	5	3	4	14.2
Very poor	3	1	1	1	3.6
Total	**28**	**28**	**28**	**28**	

The results show that 39.3% of the respondents rated public education on HIV and AIDS as "average", 35.7% as good , 39.3% rated the service as average while 14.2% rated it poor The reasons given included: available IEC materials at health facilities, many channels of dissemination of information that include mass media, religious facilities, VHTs, and community support groups like PHA networks. However, the respondents noted that there were challenges rated to language in which some materials are produced, some are not in local languages', uncoordinated messages with too many implementers, limited/ targeted messaging , some messages are not cutting across the communities. At the health centres, there are limited counselors hence limiting the kind of education and messages the people get when they come to the health centres.

"The major issue is attitude to change (complacency).People know the causes but yet continue. Those positive do not live positively; they continue to spread it"...I don't know whether it is the message packaging that is not clear or people are now tired to live on earth or people look at AIDS not a threat now" (KI Adjumani District).

"Un -coordinated, un clear and confusing messages to people are a challenge e.g. messages on HIV...if you want to get rid of HIV just go and circumcise. This kind of information misleads the youth" (KI, Gulu District Local Government).

Table 5b: IEC performance comunity score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Provision of IEC	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCIII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.2.1.5 Condom supply (Male and Female condoms)

Table 6a: Condom Supply Performance percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	8	5	4	2	7.1
Good	9	10	7	7	25
Average	5	8	10	16	57.1
Poor	6	4	6	3	10.7
Very poor	0	1	1	0	0
Total	**28**	**28**	**28**	**28**	**100**

From the results above, more than fifty percent (57.1%) of respondents rated the performance of the intervention as average and this was attributed to low male involvement, lack of knowledge of female condom, limited supply of female condoms as well as rampant stock-out of male condoms. The community misconceptions and attitude of men towards condom use were singled out as key challenges to the delivery of the intervention. It was further, noted that there is inadequate community leadership support to condom

promotion and thus contributing to low condom utilization.

Table 6b: Condom Supply (Male and Female condoms) community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Condom supply (Male and Female condoms)	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.2.1.5 HIV Counseling and Testing

Table 7a: HIV Counseling and Testing percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	11	19	11	8	28.5
Good	10	5	11	14	50
Average	7	3	4	4	14.3
Poor	0	1	2	2	7.1
Very poor	0	0	0	0	0
Total	**28**	**28**	**28**	**28**	**100**

The results in the table above indicate that majority (50%) of the health facilities rated the performance of HCT good while (28.%) as very good . The respondents attributed the performance to increased opportunties for testing through provider-initiated testing and counselling, community outreaches, integration of HCT in ANC and SMC service delivery points. It was however, noted that stock outs of testing kits, limited human resources, lack of home-based support, having many re-testers, limited male and youth involvement and the fact that there is a big number of clients with limited staff to handle them, have undernied effective performance of HCT.

"To me the HCT is majorly affected by constant stock out of drugs, when people come for other drugs like anti-malarials and antibiotics and don't get them, they do not return next time thinking there are no testing kits". (FGD Member Kamwenge HCIII).

"Very few men visit health facilities, how will you use provider initiated testing and counseling to get them? ...we need health workers to find men where they meet such as community bars, otherwise this testing will remain an issue for women" (FGD respondent Kaberamaido)

Table 7b: HIV Counseling and Testing Services community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
HIV Counselling and Testing services	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.2.1.6 Sexual Gender Based Violence

Table 8a: GBVS performance percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	2	3	2	0	0
Good	7	5	7	7	25
Average	8	6	10	7	25
Poor	7	6	6	11	39.3
Very poor	4	8	3	3	10.7
Total	**28**	**28**	**28**	**28**	**100**

According to the results, 39.3% of responents indicate that social support to address sexual gender based violence was performing "poorly", while respondents in equal percentage (25%) indicated it as "good" and average respectively. The respondents attributed the poor performance to lack of delibarate intervetions focussing on linkages between gender and HIV and AIDS, lack of integration of SGBV in other services such as HCT, ANC and Family planning. In addition, weak community structures for referral and management of gender-based and domestic violence victims, weak /non functional legal systems at community level and corruption in the legal, police and LC system were reported as major challenges.

"The challenge with SGBV is that women are very silent about sexual gender based violence. When they are raped, they are quiet about the issue because they do not want to be embarrassed in the public". FGD Member Kapchorwa Hospital.

"SGBV is being increased by drug taking especially in secrecy by couples. People swallow drugs in hiding and once the other partners discover, it creates conflicts, which in turn perpetuate violence" FGD Member Kabwohe HCIV.

Table 8b: Sexual & Gender Based Violence Services community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Sexual & Gender based Violence services	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Sexual & Gender based Violence services	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.3 HIV CARE AND TREATMENT

2.3.1: Treatment for Adults

Table 9a: Treatment for Adults percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	14	22	16	14	50
Good	13	5	9	10	35.7
Average	1	0	3	4	14.2
Poor	0	1	0	0	0
Very poor	0	0	0	0	0
Total	**28**	**28**	**28**	**28**	**100**

According to the results in table above, 50% of the respondents rated the performance of treatment “very good” and 35.5% rated it “good”. The respondents attributed good performance on availability of drugs, and accreditation of more health facilities providing ART. However, it was noted that there were some challenges that include; low access to CD4 machines, lack of community systems and linkages to support adherence through tracking patients that are lost to follow-up. Where the VATs and Expert clients exist, they are not facilitated. In addition, non-disclosure especially among men was also noted as an issue for access to ART.

Table 9b: Access to ART for Adults

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Access to ART for Adults	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.3.2 Pediatric HIV Care and Treatment

Table 10a: Access for Pediatric HIV Care

Score scale	Men	Women	S. Provider	Interface score	%
Very good	12	18	11	8	28.5
Good	9	8	12	16	57.1
Average	1	2	4	2	7.1
Poor	3	0	1	2	7.1
Very poor	1	0	0	0	0
Total	26	28	28	28	100

From the table above, the performance of pediatric HIV care was reported to be “good” (57.1%) and “very good” (28.5%), this was noted to be as result of availability of drugs, public education, and counseling of mothers, and provider-initiated testing and counseling in young child clinics. In addition, integration of pediatric care in other services such as immunization has facilitated the performance. The noted challenges include loss to follow-up of the mother-infant pair, and stock out of Pediatric formulations.

Table 10b: Access to Pediatric HIV Care

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Pediatric HIV Care	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.3.3 Adolescent HIV Care and Treatment

Table 11a: Adolescent HIV Care and Treatment

Score scale	Men	Women	S. Provider	Interface score	%
Very good	3	7	5	2	7.1
Good	9	2	9	6	21.4
Average	6	14	10	15	53.5
Poor	7	3	3	5	17.8
Very poor	3	2	1	0	0
Total	**28**	**28**	**28**	**28**	**100**

From the table above, more than fifty percent (53.5%) and (21.4%) of the health facilities rated the performance of adolescent treatment and care as average and good respectively. They noted that while the drugs were available at health facilities, there was poor adherence and drop out of care by adolescents. In addition, there is lack of linkages between the health facilities, the community and schools to ensure that they are followed for support. Poor counseling skills among health workers for the adolescents were also noted as one of the challenges.

"My children are now grown up and have been growing up getting this service, they are also responding to the drugs well, and the drugs are readily available when they are in need of them" Female KI

Adolescents face difficulties and often confused emotionally and there are social pressures as they grow-up. They need health services and support, tailored to their needs. They are less likely to go for a test for HIV and often need more support than adults to help them adhere to treatment.....unfortunately, our health facilities are not designed to support them". KI Mbarara District

"One of the challenges facing us as young people living with HIV is disclosing the news to boy/ girl friends about our sero-status... how do I tell the boy/girl that I am HIV positive? Our counselors need to support us go through this" Young Positive KI.

Table 11b: Adolescent HIV Care and Treatment

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Adolescent HIV Treatment	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
	Apac	Aduku HC IV				
		Akokor HC III				

2.3.4 Integrated TB programme

Table 12a: Integrated TB programme percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	12	11	13	8	28.7
Good	7	14	13	16	57.1
Average	7	1	1	3	10.7
Poor	2	2	1	1	7.1
Very poor	0	0	0	0	0
Total	28	28	28	28	100

The results show that the integrated TB management is performing well and was rated as good by majority (57.1%) and (28.7%) rated it as "very good" in health facilities visited. The ratings were attributed to improved TB/HIV collaborative activities, training of health workers, and availability of drugs. However, it was reported that there are still some challenges which include; limited community structures to support TB interventions, inadequate infrastructure at health centres, admission of TB patients in same wards with other patients, and failure to detect of TB among people living with HIV and children due to lack of more sensitive diagnostic (GeneXpert) tools in the majority of health facilities.

Table 12b: Integrated TB services community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Integrated TB services	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Integrated TB services	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.4 PALLIATIVE CARE

Table 13a: Palliative Care performance percentage score

Score scale	Men	Women	S. Provider	Interface score	%
Very good	4	2	2	2	7.1
Good	5	10	6	3	10.7
Average	6	5	6	9	32.1
Poor	4	2	6	6	21.4
Very poor	2	3	2	2	7.1
Total	**21**	**22**	**22**	**28**	**100**

32.1% of the respondents rated the service average , while 21.4% indicated that the service was poor and 10.7% rated it “good”. The major reasons given were; limited coverage of the service, inadequate staff with palliative care skills and hence drugs cannot be supplied to health centres with not trained staff, poor knowledge about the service and the available drugs.

Table 13b: Palliative Care Services community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Palliative Care services`	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV	N/A	N/A	N/A	N/A
	Mbarara	Mbarara RH				
		Mwizi HC IV	N/A	N/A	N/A	N/A
	Kamwenge	Rukunyu	N/A	N/A	N/A	N/A
		Kamwenge HCII	N/A	N/A	N/A	N/A

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Palliative Care services`	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H	N/A	N/A	N/A	N/A
	Kaberamaido	Ochera HC III	N/A	N/A	N/A	N/A
		Kaberamaido	N/A			
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.5 FAMILY PLANNING SERVICES

Table 14a: Percentage of Family Planning services

Score scale	Men	Women	S. Provider	Interface score	%
Very good	6	14	8	2	7.1
Good	16	11	11	17	60.7
Average	5	3	8	8	28.5
Poor	1	0	1	1	3.5
Very poor	0	0	0	0	0
Total	**28**	**28**	**28**	**28**	**100**

Sixty percent (60.7%) of the respondents indicated that provision of family planning services was good while 28.5% indicated that the services were “Average” and only 7.1% rated the services as “very good”. The major reasons given included; availability of most of the family planning methods and integration of the service in other service delivery points. The respondents however, noted that low male involvement and limited types of FP services in some HCIII were still a challenge.

Table 14b: Family Planning Services community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Family planning services	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.6 PROVISION OF NUTRITION

Table 15a: Provision of Nutrition percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	5	10	3	1	7.1
Good	12	8	7	11	39.2
Average	6	5	10	9	32.1
Poor	4	3	7	7	25
Very poor	1	2	1	0	0
Total	**28**	**28**	**28**	**28**	**100**

Results from the table above indicate that this intervention was doing well and was rated as good (39.2%), 32.1% perceived the intervention as “average” while 25% rated it “poor”. The respondents attributed the performance to interventions such as nutrition and health education for patients, assessment and categorization of the nutritional status of patients, counseling to all patients and individualized counseling to malnourished patients, therapeutic feeding were that are provided to patients during clinic days and ANC and active follow up of malnourished patients, and community linkage of patients for continued care nutrition and health education

Table 15b: Provision of Nutrition community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Nutrition	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.7 HOME BASED CARE

Table 16a: Home Based Care performance percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	3	4	3	1	7.1
Good	6	4	4	4	14.2
Average	6	7	9	5	17.8
Poor	7	7	7	15	53.5
Very poor	6	6	5	3	10.7
Total	**28**	**28**	**28**	**28**	**100**

From the results in the table above, over fifty percent (53.5%) of the respondents reported that home based care services were poor , 17.8% average and 10.7% very poor . The issues raised for the ratings were, limited health workers to conduct HBC, non-trained and facilitated VHTs, and lack of PHA networks and where they exist, they are not facilitated. In addition, it was reported that inadequate funds to support HCWs to follow

up clients on adherence counseling, lack of support to the test clubs & PLHIV groups and lack of funds for post-test clubs leading to inactiveness of support groups, contributed to poor performance in home-based care.

"In addition, the people themselves do not want to be visited due to the associated stigma. They do not want their neighbors to notice the visits" FG Respondent, Mwizi HCIV

"Because of the non-visits, people default taking their drugs (ARVs). They do not want to be noticed in the community" FGD Respondent Kalisizo Hospital, Rakai District

Table 16b: Home Based Care community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Home based Care	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.8 PSYCHOSOCIAL SERVICES

Table 17a: Psychosocial Services performance percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	3	7	3	2	7.1
Good	6	7	10	10	35.7
Average	10	6	10	9	32.1
Poor	5	3	3	6	21.4
Very poor	4	5	2	1	3.6
Total	**28**	**28**	**28**	**28**	**100**

36% of the respondents indicated that provision of quality psychosocial services was good while 32.1% indicated that the services were average and only 7.1% rated the services as very good . The major challenges highlighted included; inadequate livelihood programmes targeting PLHIV and vulnerable groups and inadequate community systems for social support and protection.

Table 17b: Psychosocial Services community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Quality of Psychosocial services	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
	Apac	Aduku HC IV				
		Akokor HC III				

2.9 CAPACITY BUILDING OF CARE GIVERS

Table 18a: Capacity Building of Care Givers performance percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	1	7	1	0	0
Good	9	6	12	9	32.1
Average	6	8	10	14	50
Poor	5	5	4	5	17.8
Very poor	7	2	1	0	0
Total	**28**	**28**	**28**	**28**	**100**

The table above shows that half (50%) of the respondents visited reported that capacity building for care givers was average , 32.1% and 32.1% rated it good while 17.8% noted that it was poor . The major reasons given for its performance were that –health workers endeavor to educate care takers on how to manage the patients especially for the young ones and those with TB. However at times this becomes impossible due limited number of health workers. –

"They come and follow up with the patients at the grassroots for TB cases only not HIV. We are educated to remind our patients on the importance of good adherence to drugs" Female respondent Kapchorwa Hospital

Table 18b: Capacity building for caregivers community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Capacity building for care givers	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Capacity building for care givers	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.10 FOOD AND EDUCATION SERVICES

Table 19a: Food and education services performance percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	2	0	1	0	0
Good	2	1	1	0	0
Average	4	8	9	9	32.1
Poor	8	5	9	9	32.1
Very poor	12	14	7	10	35.8
Total	**28**	**28**	**28**	**28**	**100**

The results regarding the provision of food and education services indicate that 32.1% and 32.1% rated it as "average" and "poor" respectively, while 35.8% noted that the services were "very poor". The respondents attributed very poor performance to no food given to patients at the health centres. Some children in the community are accessing Universal Education Programmes.

"We just hear these in corridors that government promised food but we have never received any. I also pay for my children some money but they are in UPE schools. Some time back patients were given beans and soya but now this is not on ground" male FGD Luwero District.

Table 19b: Provision of Food & Education Services community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Provision of food & education services	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
Provision of food & education services	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.11 RIGHTS AWARENESS SUPPORT

Table 20a: Rights Awareness Support

Score scale	Men	Women	S. Provider	Interface score	%
Very good	2	2	1	2	7.1
Good	1	5	7	3	10.7
Average	7	9	8	6	21.4
Poor	9	2	8	13	46.4
Very poor	9	10	4	4	14.2
Total	**28**	**28**	**28**	**28**	**100**

Almost half of the respondents (46.6) reported that rights awareness services were poor . Respondents attributed the poor performance to inadequate IEC materials, limited number of implementing partners focusing on legal awareness while linking it to HIV and AIDS interventions.

Table 20b: Rights Awareness Support community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Rights awareness & Support	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
Rights awareness & Support	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.12 LEGAL SUPPORT SERVICES

Table 21a: Legal Support Services performance percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	1	1	3	2	7.1
Good	2	5	4	1	3.5
Average	7	3	7	8	28.5
Poor	8	5	6	12	42.8
Very poor	10	14	8	7	25
Total	**28**	**28**	**28**	**28**	**100**

The results in the table above show that legal support interventions were poor (42.8%) and 28% reported the service as “average” while 25% noted that the service was “very poor”. This was attributed to limited number of partners with a focus on legal Aid interventions in the communities.

Table 21b: Legal Support Services community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Legal Support Services	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.13 AVAILABILITY OF SUPPLY OF CLEAN AND SAFE WATER

Table 22a: Availability of Supply of Clean and Safe Water

Score scale	Men	Women	S. Provider	Interface score	%
Very good	2	4	6	2	7.1
Good	5	7	6	3	10.7
Average	5	4	7	7	25
Poor	8	4	5	6	21.4
Very poor	8	9	4	9	32.1
Total	**28**	**28**	**28**	**28**	**100**

The results in the above table show that majority of health facilities did not have constant supply of safe water. Thirty two percent (32.1%) rated this service as “very poor”, 25% mentioned that it was “average” while 21.4% rated as poor .

Table 22b: Availability of Clean and Safe Water community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Availability of good and safe water	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.14 AVAILABILITY OF EMERGENCY TRANSPORT

Table 23a: Availability of Emergency Transport performance percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	2	1	1	0	0
Good	1	2	2	0	0
Average	6	7	8	9	32.1
Poor	8	7	10	7	25
Very poor	11	11	7	12	42.8
Total	28	28	28	28	100

From the table above, majority (42.8%) of the respondents said that facilities have very poor emergency transport, while 32.1% reported that the available emergency transport was averagely performing while 25%

indicted that the service was poor. The clients reported that where it existed, patients are asked to contribute fuel which in most cases is expensive which they cannot afford.

Table 23b: Availability of Emergency Transport community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Availability of transport	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.15 AVAILABILITY OF TOILET, KITCHEN AND OTHER FACILITIES

Table 24a: Availability of toilet, Kitchen and other facilities

Score scale	Men	Women	S. Provider	Interface score	%
Very good	0	3	2	1	3.5
Good	5	3	2	0	0
Average	10	7	9	9	32.1
Poor	11	6	10	12	42.8
Very poor	2	9	5	6	21.4
Total	28	28	28	28	100

Regarding the availability of facilities such as kitchen and toilet facilities in the health centres (42.8%)of the respondents rated it poor , while32.1% rated it average conditions. In all health, facilities visited, only 3.5% ranked the facilities as “very good”. Observations further revealed the number of toilets were actually not enough with cases of patients (both females and males) including staff sharing the available facilities. There were no kitchens and shelters. Patient caretakers were preparing their meals from the open spaces and no shelters were available in majority of the facilities.

Table 24b: Adequate Toilets, Kitchen, and Shelter community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Adequate toilets, kitchen, and shelter	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
	Apac	Aduku HC IV				
		Akokor HC III				

2.16 AVAILABILITY OF STAFF HOUSING AT HEALTH FACILITIES

Table 25a: Availability of Staff Housing at Health Facilities

Score scale	Men	Women	S. Provider	Interface score	%
Very good	0	0	0	0	0
Good	3	2	2	0	0
Average	6	17	8	5	17.8
Poor	16	4	7	13	46.4
Very poor	3	5	11	10	35.7
Total	28	28	28	28	100

Ministry of health guidelines on staff accommodation require that every health worker should be housed at the health facility. The results in the above table illustrate the severity of shortage ofaccommodation for staff, with 46.4% of the respondents indicating that it was “poor” and 35.7% “very poor”. This was further validated in the observations and lamentations onshortage of houses. Even where accommodation facilities existed, they were either not enough or they had taken many years without renovation.

“The houses that were constructed for the staff, are not used becausae of the land wrangles on the land where there were constructed. Government officials came once to sort out this issue but it has never been reolved. the staff fear to accomodate these houses because of threats from the local community,” explains a nurse from Layibi HC III-Gulu.

Table 25b: Availability of Housing for Staff community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Availability of Staff Housing at Health Facilities	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Availability of Staff Housing at Health Facilities	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.17 ACCESS TO CD4 MACHINES

Table 26a: Access to CD4 Machines sperformance percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	8	7	7	7	25
Good	5	8	9	5	17.8
Average	4	4	3	5	17.8
Poor	5	2	2	4	14.2
Very poor	6	7	7	7	25
Total	28	28	28	28	100

From results in the above table, equal percentage (25%) of respondents ranked the access to CD4 machine as being Very good and Very poor respectively. The respondents attributed the ranking to lack of machines in some health facilities and the cost of transport to find the machines in facilities where they available.

Table 26b: Access to CD4 Machines community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Acess to CD4 Machines	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Acess to CD4 Machines	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.18 AVAILABILITY AND FUNCTIONALITY OF COMMUNICATION FACILITIES

Table 27a: Availability and Functionality of Communication Facilities

Score scale	Men	Women	S. Provider	Interface score	%
Very good	2	1	3	2	7.1
Good	2	7	6	3	10.7
Average	11	7	9	11	39.2
Poor	9	5	6	10	35.7
Very poor	4	8	4	2	7.1
Total	28	28	28	28	100

From the results above, the availability and functionality of communication facilities at health facilities visited was ranked as “average” (39.2% and “poor” (35.7%). The reasons given were that while most health facilities had notice boards, and suggestion boxes, clients were not aware of the purpose of these facilities.

Table 27b: Communication Facilities (Use & functionality of Notice boards, Suggestion box &Telephone booths)

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Communication facilities	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Communication facilities	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.19 AVAILABILITY OF CONSULTING ROOMS

Table 28a: Availability of consulting rooms percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	3	7	4	3	10.7
Good	12	10	5	6	21.4
Average	8	4	9	9	32.1
Poor	3	2	8	8	28.5
Very poor	2	5	2	2	7.1
Total	28	28	28	28	100

The above results show a variation of responses by facilities visited rating the availability of consulting rooms from being “poor” (28.5%), “average” (32.1%) to being “good” (21.4%). The respondents argued that while some rooms were available, they were either small, or were not providing enough privacy for patients.

Table 28b: Availability of Consultation Rooms community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Availability of consultation rooms	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Availability of consultation rooms	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.20 AVAILABILITY OF ELECTRIC POWER AND TYPE

Table 29a: Availability of Electricity-Power and Type percentage scores

Score scale	Men	Women	S. Provider	Interface score	%
Very good	2	8	1	1	3.5
Good	10	7	11	8	28.5
Average	7	4	8	6	21.4
Poor	8	5	7	11	39.2
Very poor	1	4	1	2	7.1
N	28	28	28	28	100

The results show that the availability of power was rated as being “poor” (39.2%) and “good” (28.5%) respectively. Where power supply existed, it was sometimes not available in all sections of the health facilities including staff quarters. The respondents also reported that regular load shedding of power was a challenge.

Table 29b: Availability of Electric Power & Type community score card

Variables	District	Health facility	Category of respondents			
			M	F	S. P	I.M.S
Availability of power & type	Luwero	Kasana				
		Zirobwe				
	Wakiso	Entebbe				
		Wakiso HC IV				
	Rakai	Kalisizo				
		Kakuuto				
	Sheema	Kitagata H				
		Kabwohe HCIV				
	Mbarara	Mbarara RH				
		Mwizi HC IV				
	Kamwenge	Rukunyu				
		Kamwenge HCII				
	Mbale	Mbale RH				
		Bufumbo				
	Mayuge	Kigalando HCIV				
		Mulongo				
	Kapchorwa	Kapchorwa H				
		Sipi HC III				
	Moroto	Moroto H				
		Nadunget H				
	Kaberamaido	Ochera HC III				
		Kaberamaido				
	Gulu	Layibi				
		Gulu H				
	Adjumani	Mungula				
		Adjumani H				
	Apac	Aduku HC IV				
		Akokor HC III				

2.21 INPUT TRACKING AND STAFFING STATUS

Thi sections presents an analysis of the input tracking and staffing status of all health facilities visited.The physical work environment often influences (positively or negatively) the mind-set of the service providers, their efficiency and ability to innovate in delivering expanded services. There are minimum infrastructure requirements set out for health centers in the MoH guidelines2 and the input tracking assessed the following areas; outpatient and inpatient departments, Dental and Gynecology and Obstetric departments, physiotherapy, operating theatre, clinical wards, maternity, pharmacy and administration sections as well as other infrastructure like kitchen. The results of the assessment as presented in the tables for regional and district hospitals, and health center IVs and IIIs (annex III) show that while the facilities had basic infrastructure, they were not in good condition. Most health facilities had not had any renovation and required facelift for they were generally characterised by worn out paintings, dust stained louvers, dirt stained and damaged screening meshes, stained and damaged ceilings, damaged doors, cracked walls, non-functional water taps. Inadequate supplies of beddings in health facilities were the other major problem that cut across all facilities visited. Cases of broken beds without replacements or even repair were prevalent in all facilities visited The was also inadequate provision of mattresses, the mattresses provided were worn out; some were very dirty for human use, while others were even torn. Tables presented in Annex III summarize the functionality of the health facilities visited.

2.22 STAFFING STATUS

Based on staff requirements outlined in the Ministry of Health human resource guidelines, tracking was conducted to ascertain the staffing levels in all visited health facilities. The tables in annex IV presents the staffing levels in all 28-health facilities visited. A1 – represents approved staffing levels, A2- represents actual staffing while G- represents the existing Gap. The results indicate that there were some health facilities that had more staff than what is provided in the guidelines while others lacked some of the critical staff.

2 Ministry of Health guidelines on Standard Equipment for Health Centres II- IV, District and Regional Referral Hospitals 2003

Chapter Three

CONCLUSION AND RECOMMENDATIONS

3.1 CONCLUSION

The assessment indicates that there have been improvements made in the implementation of biomedical HIV prevention interventions such as PMTC and SMC. The assessment further noted there has been continued improvement in ART access and uptake for both adults and paediatric. However, the report also notes that other thematic areas for the NSP have not been performing well and these include social support as well as health systems to support delivery of HIV /AIDS services. The average or poor performance continues to present the major bottlenecks in the scaling -up of HIV and AIDS interventions as well as improving the uptake of the services.

3.2 RECOMMENDATIONS

Prevention

- Support interventions and standardize prevention package for key populations.
- Promote partnership building between the public health sector and non-public sector to address the barriers to SMC uptake.
- Integrate gender services into the PMTCT program including male partner testing & linkage into SMC.
- Standardize prevention messages at all levels.
- Scale up support to therapeutic and supplementary feeding to mothers living with HIV and their babies.
- Strengthen community systems to ensure community mobilization and strengthen facility linkage including supporting PLHIV adherence and retention in care. Strengthen integration of nutrition assessment in ANC services.

Treatment care and support

- Mainstream HIV intervention in existing financial savings and credit opportunities for the moderately vulnerable households
- Strengthen linkages between formal health facilities and informal community based services
- Enhance Community-Facility Linkages through increasing use of peer mothers and community support (PLHIV Networks) to increase adherence and retention
- Build capacity of paralegals to provide legal aid to PLHIV and orphan and other vulnerable children (OVC)
- Promote community health insurance and co-save as sustainable structural interventions
- Support most vulnerable PLHIV households and their beneficiaries to meet immediate needs for proper nutrition and income-generating activity (IGA)

Systems

- Advocating for a National Health Trust Fund Levy that is ring-fenced for investment in HIV and AIDS response
- Support and invest in the civil society-driven advocacy, monitoring and accountability of treatment and prevention programs
- Promote community ownership of programme through citizen engagement in the HIV

response to enhance ownership and sustainability

- Identify alternative sources of financing for HIV and AIDS response such as community health insurance
- Support district based capacity-building interventions in stock management to improve availability of drugs and reduce leakages.
- Invest in renovation of structures
- Recruitment of more health workers
- Mainstream all development partners support in existing health facilities to ensure uniform service delivery and management.
- Institutionalize the Community scorecard approach and conduct it every 2 years
- Conduct an assessment on functionality of the governance mechanisms/systems for health facilities.

ANNEX I ASSESSMENT FRAMEWORK

COMMUNITY SCORE CARD – INTERPRETATIONS OF THE STANDARDS

We scored commitments in the National Priority Action Plan (NPAP) 2011/12- 2012/13. Below is a list of the commitments there in under each item in the column on your left. The salient issues are to guide you understand further the quality of service and reasons for the scores given.

S.NO	PERFORMANCE CRITERIA	
1.0	**National Priority Action Plan 2011-13 (Commitments to be scored against)** **HIV PREVENTION**	**Salient issues to gauge the quality of the commitments we are scoring against**
1.1	**Quality of EMTCT (PMTCT)** a. Strengthen health facility capacity for quality PMTCT service delivery through training of staff, provision of equipment, supplies and other resources b. Provide uninterrupted PMTCT services in all health facilities that offer ANC services c. Introduce /scale up provider-initiated HCT and couple counselling and testing to all health facilities d. Improve linkages and referral between PMTCT and HIV care and treatment services e. Ensure increased access to more effective and feasible PMTCT regimens (option B plus) among HIV infected pregnant women (operationalize the new guidelines for option B Plus)	▪ Attitude of health workers toward HIV + women ▪ Are women counselled before taking their HIV tests (or is it mandatory to do a HIV test even when you don t want to) ▪ Is there follow up after delivery for women living with HIV & AIDS and their babies ▪ Are women denied the service until their spouses are brought to the health centre for HIV testing ▪ Is there confidentiality of one's results (is there segregation of women during Antenatal) ▪ Is priority given to couples during Antenatal clinics irrespective of the time they arrive at the centre (Health workers do this to encourage men to come for couple counselling and women are forced to get false husband so they can be attended to early = False HIV discordance recorded)
1.2	**Safe Male Circumcision (SMC)** a. Disseminate IEC/BCC messages and materials for the general and specific population groups using a mix of channels e.g. mass media, interpersonal Communication, peer network, campaigns, community dialogue, etc. b. Engage political, cultural, religious leaders, media & other stakeholders to promote/ advocate for SMC c. Sensitize HUMCs and health workers on appropriate communication and user friendly attitude d. Organize dissemination of SMC and avail platform for technical discussions e. Widely disseminate policy and technical guidelines on SMC f. Build capacity of service providers and service outlets to roll out SMC	▪ Are they (community) aware that SMC can prevent HIV acquisition up to 60% ▪ Is it provided – if yes, is it regularly provided? Do men line-up for long and at times give up waiting to be circumcised? ▪ Are men tested for HIV before circumcision ▪ Are the kits for circumcision always there at the HC ▪ Is there follow up done or care given to the circumcised men ▪ Are there cases of bad circumcision heard of in their community? Done by who?
1.3	**Blood transfusion** a. Ensure quality & standard adherence of blood supplies management b. Build capacity of service providers c. Ensure sustained campaigns for blood donations	▪ Is there adequate supply at the health centres (hospital) ▪ Is there good storage of the blood? Is it functional?

S.NO	PERFORMANCE CRITERIA	
1.4	**Provision of IEC** a. Update, launch and disseminate Information, Education, Communication/Behaviour Change Communication (IEC/BCC) communication strategy aligned to the drivers of the HIV epidemic b. Expand provision of HIV education for Key populations focusing on reduction of multiple sexual partnerships, cross-generational, transactional and early sex using curricular, life skills and peer network channels c. Expand provision of life skills training, peer networks and youth friendly SRH services for out of school youths d. Expand provision of quality educational, counselling and SRH services to all tertiary education institutions	Are the materials disseminated understood by majority? Are they translated in local language? Are they targeted? Are they harmonized?
1.5	**Condom supply (Male and Female condoms)** a. Quantify condom requirements, procure and distribute to outlets b. Expand condom distribution for the general population and key populations c. Conduct condom promotion campaigns using a mix of channels d. Conduct promotion, procurement and distribution of female condoms e. Expand social marketing of condoms to all urban areas and HIV hot spots	▪ Is there promotion & awareness on condom use ▪ Accessibility – knowledge of the service point of both male and female condoms – mention them ▪ Are they of quality, not expired
1.6	**Testing and Counselling services** a. Support health care providers and peer groups in the provision of counselling services at health care points and in communities b. Support community education and theatre through established existing structures e.g., VHTs in affected communities about the existing counselling services c. Implement interventions to address barriers to access counselling services at health care points and in communities d. Scale-up and support AIDS support clubs in schools and communities to provide psychosocial support to PLHIV and affected members of the community	Knowledge of HIV testing centres in their community Is there confidentiality Stigma and discrimination
1.7	**Sexual & Gender based Violence services** a. Hold countrywide community dialogues on factors that hinder behavior change and uptake of HIV preventive services b. Build capacity of cultural & community leaders to mobilize for change of harmful socio-cultural norms and gender practices c. Support communities to design and implement context specific interventions that address harmful socio-cultural and gender norms	▪ Is it common occurrence ▪ Is there quick response when SGBV is reported to relevant authorities ▪ Is the community aware of systems of redress in case of SGBV
2.0	**CARE AND TREATMENT**	

S.NO	PERFORMANCE CRITERIA	
2.1	**Access to ART for Adults** a. Scale up the implementation of provider-initiated HIV testing (PITC) within health facilities b. Increase ART facility coverage especially in under-served regions and populations such as prisons and other uniformed services, fishing communities, and some rural/hard to reach districts c. Improve ART eligibility screening and treatment monitoring d. Ensure uninterrupted supply of ARVs at the central and facility levels e. Increase resources towards treatment (especially GOU funding and other local resources) and improve the efficiency and effectiveness of available resources for treatment f. Recruit and train more health care providers in ART delivery and address staff retention and motivation; g. Advocate for policy for treatment for prevention h. Provide adequate uninterrupted supplies for basic HIV care (safe water, insecticide treated mosquito nets and cotrimoxazole prophylaxis) i. Promote utilization of the Basic Care Package including use of innovative distribution options	▪ Inquire if there are any forms of stigma and discrimination and from who? ▪ Are there shortages of drugs at health facilities?
2.2	**Paediatric HIV Care**	Are services for children available? Do mothers get conselling ?
2.3	**Adolescent HIV Treatment**	Are young people confident is asking for these services? Are there friendly services and time for adolescents?
2.4	**Integrated TB services** a. Expand linkages and referral between TB and HIV testing, care and treatment services to ensure early diagnosis and initiation of HIV treatment among TB patients b. Increase access to more effective TB diagnostic	Do patients with TB given treatment? Are they educated about the linkage between HIV and TB?
2.5	**Palliative Care services**	Are the Palliative services at the facility? Who provides the services?
2.6	**Family planning services** a. Integrate the full range of FP services for prevention of unplanned pregnancies, safer conception and access to PMTCT services. b. Enhance provider skills in FP counselling and scale-up innovative FP counselling approaches such as the use of expert clients in FP counselling c. Build capacity of PLHIV networks for delivery of FP services	▪ Knowledge of FP service points ▪ Are all types available (IUDs, pills, condoms, etc) ▪ What are men's perception about FP?
2.7	**Nutrition**	Is there education about nutrition? Are some supplements available for PLHIV?

S.NO	PERFORMANCE CRITERIA	
2.8	**Home based care programmes** a. Train and provide support for VHTs, PLHIV and other community networks to ensure delivery of quality home based and community based care b. Develop and disseminate tools and guidelines for coordination, documentation and reporting of home based and community based services. c. Enhance referral mechanisms between facilities and home based as well as community based providers	▪ Who provides HBC? ▪ It is priotized?
3.0	**SOCIAL SUPPORT & PROTECTION**	
3.1	**Quality of Psychosocial services**	
3.2	**Capacity building for care givers**	
3.3	**Provision of food & education services**	
3.4	**Rights awareness & Support** a. Support local governments, NGOs, and CBOs to integrate human rights in their HIV/AIDS programs b. Conduct advocacy campaigns on policies and laws on rights of PLHIV, OVC and other vulnerable categories c. Develop capacities for enforcing relevant laws and policies to ensure human rights and fundamental freedom of PLHIV and OVC. d. Engage cultural leaders to address cultural norms, practices and attitudes	
3.5	**Legal support & social services** a. Train and support community-based paralegals to carry out community education campaigns on human rights, legal and ethical needs of PLHIV, OVC and other HIV/AIDS affected groups b. Support enrolment and retention and completion of OVC, PLHIV of school-going age and other identified beneficiary groups. c. Promote informal education, vocational and life skills development for OVC, PLHIV of school-going age and persons most vulnerable to exposure to HIV d. Mainstream gender and disability into social support program initiatives	
4.0	**INFRASTRUCTURE, UTILITIES AND EQUIPMENT**	
4.1	**Availability of good and safe water** a. Is there constant flowing clean water b. Any cost involved	
4.2	**Availability of transport** a. Find the type of transport available (motorcycle at HCIII, IV ambulance at HC IV and hospital) b. Is it always there? Functional?	
4.3	**Adequate number of staff houses** a. Number? Adequacy? Condition in which there are in?	
4.4	**Adequate toilets, kitchen, and shelter** a. Number? Adequacy? Condition?	
4.5	**Availability of CD4 Count machines** a. Availability? Functional? Time taken to get test results.	

S.NO	PERFORMANCE CRITERIA	
4.6	**Communication facilities** a. Use & functionality of Note boards b. Suggestion box c. Telephone booth	
4.7	**Availability of consultation rooms** a. Presence of the room b. Privacy (are there window curtains, is door closed during consultations, are there interruptions from other staff during consultations)	
4.8	**Availability of power & type** a. Is there power? b. Is it solar/ hydro? c. Is it regular?	

ANNEX II: NSP PERFORMANCE -NPAP 2011/12-2012/13 AT GLANCE

National strategic areas	Baseline Value 2010/11	Target 2012/2013	2011-2012	2012-2013	Comment
			Status	Status	
HIV Prevention					
Reduction of the new estimated number of infections	129,0001,3	111,9171,3	Total:145,2941 68,097 Male 77,197 Female		
Percentage of HIV positive women who receive ART to reduce the risk of mother-to-child transmission of HIV	52%	75%	95,405 (96%) in 20122	53,451 pregnant women in 1276 sites2	
Number of HIV + pregnant women given prophylaxis			34533/40208 HIV positive women pregnant during the year2	53,451/64,015 HIV positive pregnant women during the year2	
Number of pregnant women on option B+	No data	No target	N/A	20,4852	The enrollment started February 2013
Percentage of HIV Positive pregnant and postpartum women receiving ARVs for PMTCT				70%	Latest performance as of December 2013
Number of male circumcised(14-49)	No baseline	1,000,000	380,0001	750,000(74.2%) of annual target	SMC coverage is not yet national- up to 14 districts had no SMC activities reported by March 20132.
%age of adults aged 15-49 years who are circumcised				30%	Latest data from MOH as of December 2013

National strategic areas	Baseline Value 2010/11	Target 2012/2013	2011-2012	2012-2013	Comment
			Status	Status	
Number of adults (women & Men)14-49 years counseled, tested and received results	25% (Male, Female)	3,500,0003	5.5 million adults	5,889,373 adults2	Procurement has not matched demand for HIV test kits, lack adequate staffing for the provision of HCT services. Linkage to treatment for identified clients is poor
Number of condoms distributed	68.8M Male 0.6M female	192 million forecasted in 2012	53M male 4.8M female	120 million procured 2.4 million female	
% of males and females 15-49 years reporting consistent condom use	82.3% males 76.4% females	80% in 2015 Males 80% in 2015 females		Men 38% Women 29% (Source: UAIS 2011)	Challenges noted: declining condom use, user concerns to condom quality weak Coordination of supplies
% of MARPS 15-49 years reporting consistent condom use		80% in 2015 CSW 80% in 2015 Fishermen 80% in 2015 Truckers		A one stop centre for learning about the delivery of HIV intervention to key populations has been initiated at MARPI clinic	
Care and Support					
Percentage of hospitals, HC-IVs and HC-III accredited for adult/ pediatric ART service	91% HC-IV1 6% HC-III	100% HC-IV3 10%HC-III	96% HC-IV1 8% HC-III(Dec 2011)1	100% hospital2 100% HC-IV 63% HC-III	
Percentage of HC-IVs and HC III performing / linked to CD4 and full blood count	54% hospitals	100% all accredited ART sites	76% accredited HC-IV(131/169)	100%, target achieved.	All HC-IV are equipped with PIMA machines, Hub network links, all accredited sites have CD4 and full blood count services

National strategic areas	Baseline Value 2010/11	Target 2012/2013	2011-2012	2012-2013	Comment
			Status	Status	
Number of active sites providing ART			Total: 5732 Pediatric: 400 sites	Total:10732 Pediatric: 520 sites	There has been tremendous progress in strengthening systems to support ART and health services in general
% of adults and children in need receiving ART	Total:50% (290,563) Adult:56% (266,422) Children: 25%(24,141)1	65% (375,065/ 577,024)1	By march 2012 Total: 62% (356,056) Adults:68% (327,949) Children: 29% (28,107)1	By September 20132 Total: (577,000) Adult: 69% (501,528) Children: 41%(41,520)	Retention on ART is estimated at 86% surpassing the targtet of 85%
% of estimated HIV positive incident TB cases that receive treatment for TB and HIV	24% in 2010	80%	34.2% in 20112	53.5% in 2012(NTLP report 60% Jan-June 20132	
% of HIV patients in care, receiving cotrimoxazole for prophylaxis	93%	95%	90% prescribed cotrimoxazole 82% taking cotrimoxazole	694,947 (DHIS2. Data on number in care is not available	There is under reporting, estimated patients
Unmet need for family planning among PLHIV	42%	Less than 10%	No data among PLHIV	No data among PLHIV	
Adolescent health					
% of estimated HIV positive adolescents on ART					In 2011, an estimated 127,000 adolescents (10-19yrs) to be HIV2
Home-based care					
% of health facilities linked to operational HBC services	No baseline	80%3	MOH trained VHTs in 85/112 districts1	90% of districts have one peer educator/VHT attached to health facility2	
Number of HIV infected individuals receiving care from VHT2	No baseline	400,000	250,000	400,000	
Systems strengthening					

National strategic areas	Baseline Value 2010/11	Target 2012/2013	2011-2012	2012-2013	Comment
			Status	Status	
% of facilities reporting stock outs of HIV test kits, ARVs and condoms	No baseline	No target	Cotrim 92% ARVs 71% Condoms 87%1	96% spars report on ARVs in 45 districts Jan-June 20132	stock-outs of STI drugs, condoms, and HIV testing kits have negatively impacted scale up efforts to reach key populations and the general population
% of filled health sector public posts	56%	No target	58%2 72% regional referral hospital 63% general hospital 60.2% HCIV 60% HC III 45% HCII	Total: 7619 HC IV and HC III Increase from 60% to 70% HC IV Increase from 60% to 70% in HC III4	Trained staff has permanently left facilities, leaving human resource gaps that have not yet been filled
Infrastructure development for enhancement of multi-sectoral HIV&AIDS service delivery			No of facilities SMC 239 No of facilities PEP 114 No of targeted condom outlets 4822		
Social Support and legal protection					
Percentage of PLHIV who received psychosocial support					
Number of children and Adults supported with legal aid services associated with domestic violence(SGBV)			3220 SGBV survivors 3,058 Young people 101 adults1		

[1]Annual Performance Report of the National HIV and AIDS Strategic Plan 2011/12-2014/15 (UA C October 2012)

[2]Annual Performance Draft Report 2012-2013, STD/HIV Control program, Ministry of Health

[3]National Priority Action Plan 2011/12-2012/13, UAC March 2011

[4]Overview of the Annual Health sector performance Report 2012/13, MOH, September 2013

ANNEX III INPUT TRACKING

Input tracking for Referral Hospitals

Areas	Indicators	Regional Referral hospital				Status
		Mbale	Mbarara	Gulu	Moroto	
OPD	Out Patients Clinics					Mbarara-There are outpatient clinics at the General OPD, Physiotherapy, and Occupational Therapy, Antenatal, postnatal, and Family Clinic.
	Special Outpatient Clinic					Mbarara-At the hospital there is an HIV Clinic, Neurology, Diabetes Clinic, Neurosurgery, Renal Clinic with dialysis, Eye hospital, ENT Clinic, Cancer Management Clinic, Cervix Cance Screening and Management Clinic, Epilepsy/psychiatry cases and Gynecology
	Examination room for clinical officer					Mbale- In an average state, however, lacks privacy, screens, Mbarara-The rooms are available in the general OPD, Physiotherapy, and Occupational, Antenatal, Post natal and FamilyPplanning departments and the ART clinics. Gulu- In good condition and well equipped Moroto- The room is small , not well ventilated and with one small bed
	Examination room for medical officer					Mbale- It s in a good state, have the basic equipment, however, lacks screens and there is no privacy - Mbarara-They are in existence in general OPD, ART Clinic and other departments in the hospital. Gulu- In a good state and fully equipped Moroto- The room is large, well ventilated and stocked with necessary equipment.
	Injection room					Mbale- The injection room is in an average state, small in size, equipment are inadequate, BP machine is old and sterilizers are not enough Mbarara-The rooms are available in OPD and other sections in the hospital. Gulu- It is clean and well equipped Moroto- There are 4 injections rooms. However, they are all small and not well ventilated
	Treatment room					Mbale- It s congested and very small in size Mbarara-Exists in the sections of the hospital, in diabetes clinic, Eye Clinic, Cancer Management Clinic, Outpatients Clinic, Hypertension Glinic, Neuron Surgery, ENT Clinic, Gynecology and Psychiatry Department. Gulu- Available and clean. Moroto- The treatment room is empty with no equipment.

Areas	Indicators	Regional Referral hospital				Status
		Mbale	Mbarara	Gulu	Moroto	
OPD	Waiting room					Mbale- Patients wait from two places (causality and the OPD). However, the space is small. Mbarara-The waiting rooms are available in the OPD and other departments Gulu- It is in good condition and large enough. Moroto- There is no waiting room. Patient wait in the hospital compound
	MCH(ANT/FP)					Mbale- It s in a good state, there are portions, privacy is available, there are screens and well ventilated Mbarara-The Antenatal Department is in place. Gulu- It is in good condition. Moroto- The room is large and well ventilated.
	Multifunctional room					Mbale- It is in a poor state, very old, it needs renovation, machines for demonstrating for mothers on how to feed their children are available. Mbarara-It is in place. Gulu- It is large enough. Moroto- The room is clean and well furnished.
	MCH store					Mbale- No MCH store. Mbarara-Store is in place. Gulu- The store is available & big enough. Moroto- The store is fully stocked however it is small, poorly ventilated.
	Laboratory Cater					Mbale- It s in a good state, its spacious and big, space is enough, equipment are there, reagent is on and off, and there is inconsistent supply by Medical Stores. Mbarara-The laboratory exists in the hospital with required equipment. Gulu- It is well equipped and big. Moroto- The laboratory is large, clean and well equipped.
	Laboratory store					Mbale- It is in a good state, it is spacious and big, well ventilated, and equipped with enough lighting. Mbarara-It exists but space is limited. Gulu- It is well stocked. Moroto- The store is well stocked, clean but small.
	Blood bank					Mbale- It s in a good state, and there is enough space, blood is in stock and its well equipped. Mbarara-There is a blood bank and storage fridge. Gulu- It is big and well ventilated thus the blood is safe. Moroto- The blood bank is clean , but no blood in stock.

Areas	Indicators	Regional Referral hospital				Status
		Mbale	Mbarara	Gulu	Moroto	
Dental Department	Treatment room					Mbale- It s in an average state, have 2 working chairs and 1 is spoilt, no adequate dental chairs. Mbarara-The treatment room is available & equipment. Gulu- Has a dental chair and the lighting is good. Moroto- The room is large and clean but no furniture.
	X ray					Mbale- Use a general x-ray, don t have a specialized X-ray. They use the men X-ray. Mbarara-The X-ray machine is in place. Gulu- There is a general X-ray. Moroto- the room is clean and has 2 X-ray machines.
	Radiology					Mbale- It s in a good state, machines are available, and supplies are available. however sometimes supplies get out of stock. Mbarara-The radiology section exists. There is a CT scan, X-ray machine, Echocardiography, ultra sound scan, spirometer, ECG (electrocardiogram). Gulu- Machines and reagents are available. Moroto- The room is clean and well equipped.
	Radiology film processing					Mbale- It s in a good state, there is enough space, so far no complaints from the users. Mbarara-It is carried out in the Radiology Department. Gulu- It is big enough. Moroto- 1 out of the 3 Radiology film processing is working.
	Radiology waiting area					Mbale- It s in an average state, the space is inadequate, very small room, patients twait from the verandas and corridors. Mbarara-It is in place. Gulu- The department is big and well furnished. Moroto- The room has no furniture.
GYNA & OBS DEPT	Treatment room					Mbale- It s in a good state well renovated since it has been under construction, adequate equipment e.g. the general speculum. Mbarara-The treatment room is in the obstetric and gynecology department. Gulu- The room is large enough and has the required equipment. Moroto- The room is small, not well ventilated and poorly equipped.
PHYSIOTHERAPY	Treatment room					Mbale- It s in an average state, there is privacy, screen and windows are there, well ventilated. However there is need for new coaches Mbarara-There is a clinic and treatment room for the physiotherapy department. Gulu- The room is large enough. Moroto- The room is dirty and looks abandoned.

Areas	Indicators	Regional Referral hospital				Status
		Mbale	Mbarara	Gulu	Moroto	
OPERATING THEATRE	Changing room					Mbale- The space is big enough, well ventilated with enough lights, there is privacy, and screens are there. Mbarara-The changing rooms are available in all the 8 big operating theatres. The changing room is available in the major theater, Safe Male Circumcision Theatre and also the Cervix Cancer Screening Theatre Gulu- The room is large enough Moroto- The room is dirty and paint is spilling off the walls.
	Locker area					Mbale- It s in a good state, it is clean and spacious, well ventilated. Mbarara-The locker area is available. Gulu- The room has good lighting with enough space. Moroto- The locker area is well furnished.
	Operating theatre					Mbale- It s in a good state, it is clean and spacious, well ventilated. Mbarara-There are 8 big operating theatres. There is also the Safe Medical Male circumcision Theatre and Cervix Cancer Screening Theatre. Gulu- It is in a good state with the required instruments and the lighting is good. Moroto- The theatre is new, fully stocked with equipment. However, there is no power installed as yet.
In Patient Department						
CLINICAL WARDS	Medical ward					Mbarara-The the male and female wards exist, although sometimes the population is bigger. Since neighboring districts also refer patients to the main hospital.
	Surgical Ward					Mbarara-The surgical wards for the men and women are available in the hospital.
	Obstetrics and gynecology wards					Mbarara-Antenatal and maternity ward, the post natal, delivery wing and gynecology wards exist.
	Pediatric Ward					Mbarara-The pediatric ward has sections for Acute side, chronic side, neonatal, and nutritional problems.
	Psychiatry ward					Mbarara-The psychiatry ward is available and services are offered to those seeking them.
	Tuberculosis Ward					Mbarara-The wing and ward are there. There is also a multi-drug resistance TB section.

Areas	Indicators	Regional Referral hospital				Status
		Mbale	Mbarara	Gulu	Moroto	
MATERNITY (DELIVERY UNIT)	First stage labor					Mbale- The labor ward serves as the first stage for labor. Mbarara-This section is available. Gulu- The room is large enough to accommodate a number of women. Moroto- The room is small with no incubators.
	Mid wife office					Mbale- It is crowded and small , equipment are there e.g. mama Kits, scissors and cotton. Mbarara-The office is available at the Maternity Section. Gulu- It is large enough and equipped with mama kits and scissors. Moroto- There is no office space for the midwife.
	Premature room					Mbale- The premature room is not in existence. Mbarara- Available. Gulu- It is small and sometimes crowded. Moroto- It is large, clean but no incubators.
	Store					Mbale- Midwife's office acts as the store and its overcrowded since it is small in size. Mbarara-Available. Gulu- Not big enough but has good lighting system and is well ventilated Moroto- It is clean, well- stocked but Small.
	Nurse duty station room					Mbale- It s in an average state Mbarara -It is available at the Maternity Wing Gulu- It is in good condition and there is privacy Moroto- Its improvised using card boards in the Maternity Ward
	Central sterilization department					Mbale- They are just improvising, using a corner in the corridor to accommodate sterilizing equipment. Mbarara- The sterilization is done in the departments. Gulu- It is well equipped and it is large enough. Moroto- The room is large and clean, but the equipment e.g. fridge, and water heaters are not functioning.

Areas	Indicators	Regional Referral hospital				Status
		Mbale	Mbarara	Gulu	Moroto	
PHARMACY	Pharmacy dispensary					Mbale- It s in a good state, there is enough space, there are serving windows, staff are few thus high work load Mbarara -There is pharmacy in the ART Section, at the Out Patients Department. Gulu- It is in a good condition and clean with serving widows. Moroto- The room is improvised with card boards in the treatment room and small, with no ventilation.
	Preparation room					Mbale- Not available. Mbarara- It is available. Gulu- The room is small but in good condition and clean. Moroto- The room is small with one small window and very few equipment.
	Store					Mbale- In a good state, there is enough space, well protected for drugs not to get spoilt, lighting is good. Mbarara The store is available. Gulu- It is large enough to store all drugs. Moroto- The store is small with temporary shelves.
	Mortuary					Mbale- It s in a good state. There is electricity , mortuary attendants, and shelves. Mbarara The mortuary is available. Gulu- There are shelves and the lighting is good. Moroto- The mortuary is available however not in good condition
	Office					Mbale- It s in a good state, well equipped with computers and furniture, there is enough space. Mbarara There is an office and records department for HMIS reports and other reports. Gulu- it is large enough and well furnished. Moroto- The office is clean and well furnished.
	Store					Mbale- It s in a good state, there is enough space, well protected for drugs not to get spoilt, lighting is good. Mbarara The store for the drugs is available. Gulu- It is large enough. Moroto- the store is large, well-organized & stocked.

Areas	Indicators	Regional Referral hospital				Status
		Mbale	Mbarara	Gulu	Moroto	
ADMINISTRATION	Conference room					Mbale- Just improvising. It also serves as a board room, it s supposed to be a patients room, there are few chairs and tables. Mbarara There are departmental rooms at the hospital. Gulu- Furnished and well ventilated. Moroto- The room is large and clean with only 4 chairs and 1 small table.
	Library					Mbale- Offices serve as library. Staff keep their materials in their offices. Mbarara The library is available. Gulu- staff keep their materials in their offices. Moroto- There is no library.
	Office matron					Mbale- It's in an average state, the room is small, and office equipment like chairs, computer, tables, printer and cabins are there. Mbarara Available. Gulu- The office is big and furnished with a computer. Moroto- The office is large, clean, furnished and equipped with a computer.
	Office secretary					Mbale- It's in an average state, the office is just in a corner and its very small. Mbarara Office is available. Gulu – The office has furniture, a computer and filling cabins. Moroto- The office is large, clean, furnished and equipped with a computer.
	Reception					Mbale- It s in a good condition, there is enough space, well ventilated, equipment like computer, chairs for the visitors are also in place. Mbarara The Major reception is available in all the hospital departments, OPD, ART section and other areas. Gulu- The reception is big and has chairs for visitors. Moroto- There is no reception area.
	Staff tea room					Mbale- Staff take their tea from offices. Mbarara The tea room is available. Gulu- It is improvised at a corner of an office though most staff take their tea from their offices. Moroto- There is no staff tea room.
	Stores					Mbale- Staff keep their equipment in their offices. Mbarara They exist.
	Medical director office					Mbale- It s in an average state, the room is small well equipped with office equipment e.g. chair, table and the office cabinet. Mbarara The office is available. Gulu- The office is large enough and well furnished with table, chair and cabinets. Moroto- The office is large, clean, furnished and equipped with a computer.

Areas	Indicators	Regional Referral hospital				Status
		Mbale	Mbarara	Gulu	Moroto	
KITCHEN	Preparation area					Mbale- Patients cook under a tree and its near the toilets. Mbarara Kitchen preparation is available, although there is need for extension since there are many caretakers at the Inpatients ward. Gulu- it is small, overcrowded and dirty. Moroto- There is no preparation area.
	Store					Mbale- Patients keep their stuff when they come because there is no general kitchen for the hospital. Mbarara The kitchen store is available. Gulu- It is in a an average state, small but clean. Moroto- There are two large stores, stocked with food supplements for mothers during antenatal visits.
	Wet area					Mbale- They instead use the laundry to serve as the wet area Mbarara It is in existence Gulu- it is in a good condition, enough space and clean Moroto- No designated wet area- they use the laundry
	Laundry					Mbale - It s in a good state, it is big enough but inadequate for the whole hospital. It only serves Masaba wing. Mbarara Laundry store in place. Gulu- It is big enough and clean. Moroto- The room is small with a poor drainage system.
	Laundry store clean					Mbale- The laundry is cleaned on a daily basis by the hired personnel. Mbarara It exists. Gulu- It is in a good condition and clean. Moroto- There is no laundry store clean.
	Laundry store dirty					Mbale- The laundry store is not dirty Mbarara There is a central place where dirty linen is gathered from Gulu- It is a little bit small but very clean Moroto- There is no laundry store dirty
	Generator room					Mbale- It s in a good state, it has just been constructed, have only one generator which only serves in the maternity and the theater, causality is not catered for. Mbarara The generator room is available. Gulu- It is large and the ventilation is good. Moroto- There are two generator rooms.

Indicators	Hospital					Status
	Entebbe	Adjumani	Kitagata	Kapchorwa	Kalisizo	
OPD						
Examination room for clinical officer						Entebbe- It is big enough for the doctor and the patients Adjumani- Has developed minor cracks and in need of more examination equipment Kitagata- The examination room exists but the beds are very old, including the mattresses. There is no running water in the room. Kapchwora-It s in good condition, and all the equipment are there. e.g. the chair , tables and the cupboards where files are kept, it is well ventilated. Kalisizo-It is rated on average ,it doesnot have a dustbin and water is always on and off.
Examination room for medical officer						Entebbe-. It is in a very good condition and well situated. Adjumani- The room is spacious but there is need for more examination equipment. Kitagata- There is an examination room although the beds and mattresses are very old. -There is no water in the room. Kapchwora- It is average, there is a cupboard and there screens Kalisizo-Well ventiled with enough space
Injection room						Entebbe- Is in good condition and the space for injections is clean and spacious. Adjumani- It is good but needs two more tables. Kitagata- The room exists. Kapchwora- It s in a poor state, it has a small part ion and privacy is not up-to-date e.g. there are no curtains and the doors are not well made. Kalisizo-Injection bed is old
Treatment room						Entebbe- In a good condition, well ventilated, and has privacy. Adjumani- It is good but needs two more tables. Kitagata- The treatment room is available but has no running water. Kapchwora- It s in average state because they just improvised. They use the injection room to act as the treatment room. Kalisizo-Well equipment but tends to be crowded by patients
Waiting room						Entebbe- In good conditions but in an open space that would have been veranda. Adjumani- It s not adequate Population is crowned. Kitagata- The waiting room is available. Kapchwora- It s in a good state, The sitting arrangement is good i.e. there are permanent seats and there is enough space for the clients. Kalisizo-Area has permanent seats (Cemented) space big enough to accommodate out patients.

Indicators	Hospital					Status
	Entebbe	Adjumani	Kitagata	Kapchorwa	Kalisizo	
MCH(ANT/FP)						Entebbe- It is in good conditions. Adjumani- It is available and adequate. Kitagata- Need renovation. Kapchwora- It s in an average state, there is enough light, the space is small Kalisizo-Has stayed for ages and needs to be renovated
Multifunctional room						Entebbe- It is in good conditions as it has some good space that can be used for any medical activity such as small meeting with a few patients. Adjumani- There is need to provide one. Kitagata- Need renovation. Kapchwora- Does not exist Kalisizo Room was re-allocated top FP clinic
MCH store						Entebbe- It is good and habitable. Adjumani- It is adequate but needs shelves Kitagata- In bad state and requires renovation Kapchwora- It s in average state, the room is very small compared to the population it serves, not well ventilated, there is light and there are tables Kalisizo-Well equipped with enough space
Laboratory						Entebbe- It is good and functioning. It has the equipment, working fridge for storing blood, and it is clean. However, it has an old ceiling that needs renovation. Adjumani- Spacious but it requires more Binocular microscopes, Distiller, Elisa, Hot air oven and two refrigerators. Well ventilated Kitagata-There was old equipment in the laboratory. The sterilizers were very old and others are not functioning. -There is no running water in the laboratory. -There are some missing reagents for instance cannot test for syphilis -The lab is a BC center -There are no testing kits for HIV Kapchwora- It s in average state, the room is very small, there is no privacy at all, no screens. However there is a plan to enlarge it Kalisizo-In good condition although more lab technicians needed
Laboratory store						Entebbe- Small and it is also used as a room for backup power Adjumani- It is available and serves the purpose Kitagata- Availabe Kapchwora- It s in a good state, its equipped with shelves well ventilated, there is light Kalisizo-Well equipped and properly managed with drug listing forms
Blood bank						Entebbe- It is clean and well maintained Adjumani- It s a mini blood bank kept in refrigerator Kitagata- The blood bank is available but the refrigerator is small and old Kapchwora- It s in an average state, it s not well stocked with blood thus most times blood is picked from Mbale Hospital Kalisizo-Room available but samples are never there ,patients are always refered to Masaka hospital to pick the samples

Indicators	Hospital					Status
	Entebbe	Adjumani	Kitagata	Kapchorwa	Kalisizo	
DENTAL DEPARTMENT						
Treatment room						Entebbe- Clean and habitable Adjumani- It is reasonable Kitagata-No response Kapchwora- They just improvise and it serves as the treatment room, very small in size and can t accommodate the large population served at the Hospital Kalisizo-Available but too small and this denies pateints of their privacy
X ray						Entebbe- In good working conditions and it also looks new and functioning Adjumani- Non-functional, needs major repair Kitagata- The X-ray is available and functioning Kapchwora- No dentalXx-ray at the Hospital Kalisizo-Available but there is need for another machine due to congestation in numbers serving many sub-counties i.e kirumba,lwagule etc
Radiology						Entebbe- Also in good working conditions Adjumani- Non-functional Kitagata- They are available Kapchwora- Not in existence Kalisizo-Available but lacks a power step down to support it once power goes off.
Radiology film processing						Entebbe- Also in good working conditions. Adjumani- Non-functional. Needs to be equipped. Kitagata- It is available. But the equipments are very old. Kapchwora- It s not in existence. Kalisizo-Still working but sometimes produces unclear films.
Radiology waiting area						Entebbe- It is also good it is clean and have enough space and furniture for patients. Adjumani- It is adequate but needs to be equipped. Kitagata- It is available although the structure is very old. Kapchwora- It s in a good state, there is space for people to wait if they are many, it is well ventilated, and the seats are enough for patients to sit on. Kalisizo-Only few chairs provided
GYNA & OBS DEPT						
Treatment room						Entebbe- It is good and well cleaned. Adjumani- It is adequate but requires tables. Kitagata- It is available. Kapchwora- There is no treatment room for GYNA and OBS Department. Kalisizo-Not available ,general OPD waiting area is used
PHYSIOTHERAPY						

Indicators	Hospital					Status
	Entebbe	Adjumani	Kitagata	Kapchorwa	Kalisizo	
Treatment room						Entebbe-It s not available. Adjumani- Not equipped at all. Everything is missing yet the hospital has got the personnel. There is need for Ice Packs, Parallel bars, Grip trainers, standing frame, Therapeutic Jelly etc. Kitagata- There are beds but they are old. The screens are very old. Kapchwora- There is no treatment room for physiotherapy Kalisizo- Patients use general OPD waiting area
OPERATING THEATRE						
Changing room						Entebbe- It is well arranged and very clean. Adjumani- It is size is good but needs more patient traps Kitagata- The changing room is available but old. Kapchwora- It s in an average state, the room is small in size, and all the equipment are there e.g. tables, there is enough light, well ventilated. Kalisizo- In good state ,well ventilated and not in access to every staff
Locker area						Entebbe- Also well taken care of. Adjumani- The lockers need to be replaced. Kitagata- Locker area available but also in an old state. Kapchwora- It s in a poor state because all the equipment that are there are old, e.g. the chairs, tables cupboards etc. Kalisizo-Not big enough to accommodate all machines for safety, need for another locker
Operating theatre						Entebbe- Well organized sterilized and very well arranged. Adjumani- Spacious need for more operating table and lights are spoiled. Theater boots, sandal and knives all needed replacement. Kitagata- The theater exists but the equipment were very old, the sterilizer was very old, and the operating table was very old and broken. Kapchwora- In an average state, most of the equipment are old, operational table is old, and portion is not up to date. Kalisizo-Well positioned although machines are getting old due to over use by whelming numbers
MATERNITY (DELIVERY UNIT)						
First stage labor						Entebbe- Good and clean. Adjumani- Mothers are taken to the General Ward. Kitagata- With two old beds only. Kapchwora- It serves as a ward, it s in a poor state, the lighting system is poor, the room is small, patients are normally congested and mixed. Kalisizo-Small only serves the emergence cases, other patients take use of trees in compounds

Indicators	Hospital					Status
	Entebbe	Adjumani	Kitagata	Kapchorwa	Kalisizo	
Mid wife office						Entebbe- Spacious and clean. Adjumani- It needs to be equipped with office items Kitagata- It acts as a store as well. Kapchwora- It s in an average state, it also serves as a duty room, well ventilated but it is a small room. Kalisizo-Serves as FP consultancy room
Premature room						Entebbe- It is in good condition. Adjumani- It does not exist. Kitagata- It is not available. Kapchwora- There is no room for pre-matures. Kalisizo-Fair but incubator needs more support life machines
Store						Entebbe- Well arranged. Adjumani- It is good and adequate. Kitagata- Needs renovation. Kapchwora- In average state, very small room, well ventilated and all the drugs are in stock. Kalisizo-Very small
Nurse duty station room						Entebbe- In good condition but it seems to be very busy with activity. Adjumani- It is available but needs to be equipped. Kitagata- Needs renovation. Kapchwora- It is average, serves as the nurse office, chairs are there, tables, and the room is well ventilated, there is power Kalisizo-Fair ,only that is used by many nurses
Central sterilization department						Entebbe- It is also very clean. Adjumani- Need to be provided and equipped. Kitagata- No equipment. Kapchwora- Use the theater to sterilize equipment. Don t have a special place for sterilizing equipment. Kalisizo-In use, but machines are fewer and looks outdated by observation
PHARMACY						
Pharmacy dispensary						Entebbe- But this is very small for this hospital and it is less stocked. Adjumani- Good state but needs to be equipped. Kitagata- Oldand needs renovation. Kapchwora- It s in a good state, there is enough space for patients to wait for the dispensers> However, there are no benches and patients just sit in the corridors and on the veranda. Kalisizo-Well stocked with enough space
Preparation room						Entebbe- It s not available. Adjumani- Good state but needs to be equipped. Kitagata- Old and needs renovation. Kapchwora- It s in a good state, well arranged. There is enough space Kalisizo-Its clean, well-organized and logically placed closer to the Pharmacy

Indicators	Hospital					Status
	Entebbe	Adjumani	Kitagata	Kapchorwa	Kalisizo	
Store						Entebbe- Well- rranged .Adjumani- Good state but needs to be equipped. Kitagata- Old and need renovation. Kapchwora-It is available Kalisizo-In a good state
Mortuary						Entebbe- Good condition Adjumani- Good state but needs to be equipped Kitagata- Small and old, no fridges Kapchwora- It s in a very poor state, very old, old tables , old shelves, no electricity and thus don t keep bodies for long Kalisizo-Sub-standard ,quite small and less equipped
Office						Entebbe- It is well situated and big enough Adjumani- No office Space Kitagata- Old and needs renovation Kapchwora- It's in a good state, well ventilated, office equipment are there e.g. the chair, table and the filling cabinet Kalisizo-Needs more chairs but the rest of the items are available
Store						Entebbe- Its available Adjumani- Its small but adequate needs to be equipped Kitagata- Old, Need renovation Kapchwora- It s in average state, well ventilated, small in size, there is enough lights, drugs are well arranged and seen Kalisizo-Okay but needs more equipment s
ADMINISTRATION						
Conference room						Entebbe- Very well organized and functioning Adjumani- It s not available Kitagata- There is no conference room at the hospital Kapchwora- It also serves as the board room, very old, they just improvise, it used to be the DP ward Kalisizo-Doesnot exist, In case of meetings, outside venue is sourced ,if it is a smaller meeting the board room is used
Library						Entebbe- It s not available Adjumani- It s not available Kitagata- It s not available Kapchwora- There is no enough space, there is no special place for the library, every office acts as a library Kalisizo-Not available

Indicators	Hospital					Status
	Entebbe	Adjumani	Kitagata	Kapchorwa	Kalisizo	
Office matron						Entebbe- It s not available. Adjumani- Good state but needs to be equipped. Kitagata- Needs renovation. -very old almost inhabitable Kapchwora- There is no office Kalisizo-Not in place
Office secretary						Entebbe- Well equipped with a full computer set. Adjumani- It needs to be well equipped. Kitagata- Need renovation. It is old. Kapchwora- Good state, well ventilated, the lighting is enough, filing cabinet is there, chairs and tables are also there and there is enough space. Kalisizo-Small space, but has a full set of computer, printer and placed next to in charges office
Reception						Entebbe- Very clean and welcoming with a notice board with some good information. Adjumani- Small and poorly equipped Kitagata- Needs renovation. Kapchwora- Askaris and other health workers at the hospital act as receptionists. Kalisizo-It`s small secretary small room serves the purpose
Staff tea room						Entebbe- It s not available. Adjumani- It does not exist at all. Kitagata- The tea room does not exist. Kapchwora- Staff buy tea from outside the hospital and take it from their offices. Kalisizo-Every staff carries her tea to his/her own department
Stores						Entebbe- Not very bad they lack a few shelves to make it very good. Adjumani- Too small and does not serve the purpose. Kitagata- Need renovation. Kapchwora- It s in a good state, and it s under renovation. Kalisizo-Fair ,no support equipment s i.e. Chair for specialized store keeper
Medical Director Office						Entebbe- Very good. Adjumani- It is sizable but needs office equipment. Kitagata- The office is available but it is old. Kapchwora- It s a available and well equipped. Kalisizo-Reasonable size ,does not have internal toilet ,positioned on the main administration block
KITCHEN						

Indicators	Hospital					Status
	Entebbe	Adjumani	Kitagata	Kapchorwa	Kalisizo	
Preparation area						Entebbe- Very good with a sink and running water. Adjumani- It is spacious and in good state. Kitagata- Not functional. Kapchwora- They have set up a small structure for the people in maternity and other clients to prepare from. However there is no general kitchen for the hospital. Kalisizo-Not in place
Store						Entebbe- Clean and good. Adjumani- It is good but small. Kitagata- Non functional. Kapchwora- There is no store for the kitchen at the hospital. They just set up a small structure for the clients to cook from. Kalisizo-Not available
Wet area						Entebbe- Clean Adjumani- Need to equip it Kitagata- Non functional Kapchwora- The wet area is in a Average state, the space is small Kalisizo-Not available
Laundry						Entebbe- It s not available Adjumani- Need to equip it Kitagata- The laundry is available but it is non-functional Kapchwora- It s in an average state, it s a small area, only 1 person , using man power and not machinery like in Mulago and other Government Hospitals Kalisizo-Laundry is accesses by a few clients, patients use the compound
Laundry store clean						Entebbe- It s not available. Kitagata- Non functional. Adjumani- Need to equip it. Kapchwora- The laundry is cleaned on a daily basis by the hired personnel. Kalisizo-In a very poor state
Laundry store dirty						Entebbe- It s not available. Adjumani- Need to equip it. Kitagata- Non functional. Kapchwora- Since there is little man power at times the place is dirty. Kalisizo-Not hygienically clean.

Indicators	Hospital					Status
	Entebbe	Adjumani	Kitagata	Kapchorwa	Kalisizo	
Generator room						Entebbe- It is available Adjumani- It s an open space but roofed Kitagata- It is old Kapchwora- It s in a good state; the room has just been under construction. It s well ventilated, and it accommodates 2 generators. However, sometimes they run short of fuel Kalisizo-Properly set up in a place far from daily use .

INPUT TRACKING (EQUIPMENT FOR DISTRICT HOSPITALS)

Input tracking for health centres IV

Areas	Indicators	Health Center IV										Status
		Kaberamaido	Aduku Apac	Mungula Adjumani	Kasana Luwero	Kigandalo Mayuge	Rukunyu Kamwenge	Kabwohe Shema	Kakuto Rakai	Mwizi Mbarara	Bufumbo Mbale	
	Health education											Kaberamaido- Equipped
												Aduku Apac- Health education is done by the Medical Officer on duty and it is done in the areas of health, hygiene and HIV&AIDS.
												Mungula Adjumani- Health education is provided on general health, hygiene and HIV&AIDS.
												Kasana Luwero- We try as much as possible but sometimes funds for facilitation are the reason we don t do health education so much.
												Kigandalo Mayuge- Health education is conducted by the Public Dental Officer on general health, hygiene/ sanitation, nutrition, rehabilitation and on HIV&AIDS.
												Rukunyu Kamwenge- Health education is done at the OPD Section and during the ART days on (Tuesday and Thursdays).
												-The health education is offered by qualified personnel at the health facility.
												They educate patients on several issues like hygiene, nutrition, HIV&AIDS prevention and awareness and prevention of other opportunistic diseases.
												- However the available health education space is only enough for the ART section unlike at the OPD section which has a high population of the patients.
												Kabwohe- There is no schedule for health education, but its available.
												Kakuto Rakai- We do it so much with the help of Mama Club.
												Mwizi Mbarara- Done in the OPD and it has limited space.
												Bufumbo Mbale- Health education is given by the health workers who are always on duty. The health education is normally on nutrition, hygiene and family planning services
												-Health education is done 4 times a week.

Areas	Indicators	Health Center IV										Status
		Kaberamaido	Aduku Apac	Mungula Adjumani	Kasana Luwero	Kigandalo Mayuge	Rukunyu Kamwenge	Kabwohe Shema	Kakuto Rakai	Mwizi Mbarara	Bufumbo Mbale	
	Counseling room											Kaberamaido- Not labeled, improvised
												Aduku Apac- It is in average state and has furniture.
												Mungu Adjumani- It is small and crowded most of the time.
												Kasana Luwero- counseling is done in the clerks room simply because we lack space, it is actually congested.
												Kigandalo Mayuge- When counseling they just improvise a consultation room in the in charge's office.
												Rukunyu Kamwenge-There is no specific counseling room for patients. The available clinical room which is a very small room has been improvised as a counseling room.
												The space is inadequate and this increases the waiting time for patients due to long queues.
												Kabwohe Shema- Use the tent for HIV counseling and other different rooms.
												Kakuto Rakai- the OPD burnt down.
												Mwizi Mbarara- Counseling is done in the OPD.
												Bufumbo Mbale- It s in a poor state, small room, the chairs and tables are there. However this room serves as the ART Clinic
OPD	Dental clinic											Kaberamaido- Machines not working.
												Aduku Apac- In good state and well equipped.
												Mungula Adjumani- It is small and fully stocked.
												Kasana Luwero- It is ok no big problem.
												Kigandalo Mayuge- The improvised room and it not fully equipped, the equipment needed are expensive ad can t be requisitioned for, they don t have power in the improvised room, sometimes work under a tree.
												Rukunyu Kamwenge- The Dental room is available but the major challenge is the limited space. The room is very small with old infrastructure.
												Kabwohe Shema- The clinic is available but the equipment was old.
												Kakuto Rakai- It is ok but in an improvised place.
												Mwizi Mbarara- Referred to Mbarara.
												Bufumbo Mbale- It s in a poor state, there is a gap for chairs, it also lacks some instruments e.g. for removing the premolars and the chair for extraction.
	Dispensing room											Kaberamaido- Small and not furnished.
												Aduku Apac- It has the necessary equipment and is well ventilated.
												Mungula Adjumani-It is in a good condition and has screens, chairs and tables.
												Kasana Luwero- It is available but sometimes the nurses use it as their office.
												Kigandalo Mayuge- It s in a good state, well ventilated with screens, chairs and tables are there is a cupboard.
												Rukunyu Kamwenge- The dispensing room is in existence but the space is very limited.
												Kabwohe Shema- The dispensing room is available.
												Kakuto Rakai-It is very small.
												Mwizi Mbarara- It is limited by space and there is only one attendant.
												Bufumbo Mbale- It s in a poor state, there is no window for closing when staff are going for lunch, it's an open place there is no privacy , no screens

Areas	Indicators	Health Center IV										Status
		Kaberamaido	Aduku Apac	Mungula Adjumani	Kasana Luwero	Kigandalo Mayuge	Rukunyu Kamwenge	Kabwohe Shema	Kakuto Rakai	Mwizi Mbarara	Bufumbo Mbale	
	OPD drug store											Kaberamaido- Small in size and no separate sections for specific drugs.
												Aduku Apac- It is small and poorly ventilated. However, the drug storage facility is good.
												Mungula Adjumani- The room has good storage facilities though small and the ventilation is poor.
												Kasana Luwero- We improvise and use the general drug store. Also the medicine for the day is locked in one case and that is what we use.
												Kigandalo Mayuge- It s in a poor state, have 1 store for the whole facility and drugs are well kept in the cupboard, the store is small and not well ventilated.
												Rukunyu Kamwenge- The drug store is available but it is very small.
												Kabwohe Shema- Have a cupboard in the dispensing room.
												Kakuto Rakai- But here we don't have it specifically for OPD we use the general store
												Mwizi Mbarara- It is very small. However some drugs are kept in the maternity ward.
												Bufumbo Mbale- It s in a very good state. There are shelves and doors. In other wards there is privacy, well ventilated with big space and there is enough lights.
	Examination room											Kaberamaido-Has 4 examination rooms.
												Aduku Apac- It has tables, chairs and it is clean.
												Mungula Adjumani- It is in good condition and has beds, chairs and tables.
												Kasana Luwero- It is available but we need more rooms because sometimes the patients are many and we lack space.
												Kigandalo Mayuge- It s in a good state, lacks an ultra sound, recently MARIE STOPES provided us with the examination coach, tables, cupboards, chairs and beds. A few things are lacking
												Rukunyu Kamwenge- There is no specific examination room, the clinical room is also used to examine patients at the health center due to inadequate space.
												Kabwohe Shema- It exists.
												Kakuto Rakai- It is also small because our main OPD burnt down.
												Mwizi Mbarara- Use the ART room.
												Bufumbo Mbale- It s in a very good state, there is a health worker, examination chair, there is enough water, have 3 examination rooms and they are enough

Areas	Indicators	Health Center IV										Status
		Kaberamaido	Aduku Apac	Mungula Adjumani	Kasana Luwero	Kigandalo Mayuge	Rukunyu Kamwenge	Kabwohe Shema	Kakuto Rakai	Mwizi Mbarara	Bufumbo Mbale	
	HSD office											Kaberamaido- Exists and well furnished.
												Aduku Apac- It has chairs, 1 table and a side board.
												Mungula Adjumani- The office is well furnished with chairs and tables.
												Kasana Luwero- It is not the best, we need it renovated and at least well ventilated.
												Kigandalo Mayuge- It s not well equipped e.g. the cupboards are lacking.
												Rukunyu Kamwenge- The HSD office is available but it is very small.
												Kabwohe Shema- The HSD office available but small.
												Kakuto Rakai- It is lacking furniture
												Mwizi Mbarara- Use the treatment room and it has limited space.
												Bufumbo Mbale- It s in a good state, well equipped with files, chairs, tables, cupboards. The space is big enough and well ventilated.
	Laboratory											Kaberamaido- Well equipped with CD4 Count Machine, but lacks reagents
												Aduku Apac- It has a microscope, fridges for handling blood, 1 table and 2 chairs
												Mungula Adjumani- There are two microscopes, chairs and fridges for handling blood
												Kasana Luwero- It is ok, I think for our level we are still fine
												Kigandalo Mayuge- It s in a good state, except equipment are few i.e. there is 1 microscope and other fridges for handling blood cannot operate on solar power thus they are redundant and not functional.
												Rukunyu Kamwenge- The laboratory is in existence, it is functional but it is very small for a health center IV standards.
												Kabwohe Shema- Has limited space.
												Kakuto Rakai- We have it but sometimes power goes off and we get problems.
												Mwizi Mbarara- Limited space with no equipment.
												Bufumbo Mbale- It s in a very poor state, the room is too small, there is no running water and there is no power.
	Treatment room											Kaberamaido- Walls with human blood stains.
												Aduku Apac- It has 1 bed and it is small.
												Mungula Adjumani- it is in good condition with privacy and has two beds though sometimes congested.
												Kasana Luwero- It is ok even our nurses like it so much but it lacks some paintings
												Kigandalo Mayuge- It s in an average state, have a coach instead of a bed, it is so congested, serves as a consultation room as well as for other activities
												Rukunyu Kamwenge- There is no specific treatment room. Have only created an examination room
												Kabwohe Shema- Under OPD, its multiple used as a treatment room and dispensing room.
												Kakuto Rakai- Since our OPD burnt down we have never had it. We just improvise and treat people.
												Mwizi Mbarara- Small in size.
												Bufumbo Mbale- It s in a poor state, the screens are lacking, the springs are all broken, and there is a problem of drugs.

Areas	Indicators	Health Center IV										Status
		Kaberamaido	Aduku Apac	Mungula Adjumani	Kasana Luwero	Kigandalo Mayuge	Rukunyu Kamwenge	Kabwohe Shema	Kakuto Rakai	Mwizi Mbarara	Bufumbo Mbale	
	UNEPI records											Kaberamaido- It act as a store
												Aduku Apac- There is a refrigerator, cabinet and files.
												Mungula Adjumani- It is in good condition with good storage facility for the files.
												Kasana Luwero- They even have shelf in our store.
												Kigandalo Mayuge- We took almost a whole year with no refrigerator. However, we borrowed from Bunya South sub-District. There are also files showing that we dint conduct immunization.
												Rukunyu Kamwenge- UNEPI Records are available.
												Kabwohe Shema- The records are available and kept in their office.
												Kakuto Rakai- We have them and they are well kept.
												Mwizi Mbarara- No space.
												Bufumbo Mbale- Well recorded and up to date.
	Operating theater											Kaberamaido- Connected with generator and Solar power
												Aduku Apac- It is in a good state and is equipped with beds, oxygen etc
												Mungula Adjumani- The theater is in a good condition has two beds with lights and oxygen. It is very clean.
												Kasana Luwero- It is good and in a very good state.
												Kigandalo Mayuge-It s in an average state, there is the theater bed, lamps, scissors, oxygen. The equipment are also used for SMC.
												It s not up to date for serious activities requires some repair on the doors since they are broken.
												Rukunyu Kamwenge--The theatre room exists, the equipment are available.
												-There is a small auto-crave used for sterilization.
												-However there are only 2 beds which are very old.
												-The major challenge is that there is no recovery space in the theater.
												Kabwohe Shema- It s very functional.
												Kakuto Rakai- It is good enough for our standard and we always operate patients here.
												Mwizi Mbarara- Patients are referred to Mbarara Hospital
												Bufumbo Mbale- It s in a very good state well equipped. Surgery and operation is always functional , there is oxygen and they had a problem with power they got a generator.

Areas	Indicators	Health Center IV										Status
		Kaberamaido	Aduku Apac	Mungula Adjumani	Kasana Luwero	Kigandalo Mayuge	Rukunyu Kamwenge	Kabwohe Shema	Kakuto Rakai	Mwizi Mbarara	Bufumbo Mbale	
IPD	Delivery room, linen store, 1st stage labor, waiting room, Ward Nurse duty station, Sterile store(Maternity)											Kaberamaido- No shelter, less equipment in the 1st labor ,linen store exists, ward nurse duty station exists bed with no beddings and delivery room in existence
												Aduku Apac- Improvised linen Room, No waiting Room, the rest are there.
												Mungula Adjumani- All the rooms are there and the required equipment.
												Kasana Luwero-There is a delivery room, there is no specific linen store, first stage labor is also not available, waiting room we use our front office veranda, ward nurse duty station.
												It is there both for night and day and they are just good. There is no sterile store
												Kigandalo Mayuge-The Health facility lacks an IPD, the linen store is in existence, its well equipped with beds.
												However, there are old sheets, the 1st stage labor ward has just been under construction and not yet well complete, the water system is in a mess in the labor,
												in the Ward nurse duty station they are just improvising, there are permanent concrete seats and the room is big enough to accommodate the nurses, there is no specific area for the sterilizing equipment in the maternity.
												Rukunyu Kamwenge-- The delivery room is very small, & very squeezed with only two beds
												-There is no linen store
												-There is no waiting room in the maternity section.
												-The sterile store is in existence but it is very tiny.
												-There is no ward nurse duty station.
												-The nurses use the same sterile store in the maternity.
												-There is even no infrastructure and duty table and chair.
												-The nurses operate while standing.
												Kabwohe Shema-Delivery room is very small, no linen and linen store, patients come with their own linen. No 1st stage labor, but use the maternity ward separated by ply wood.
												Waiting room is antenatal and ward nurse duty station exists.
												Kakuto Rakai- The delivery room is ok. But the linen store we don t have, 1st stage labor we use any space available at that time but it is not there.
												Waiting room we use our shade. Ward nurse on duty station we don t have it but they have table in the ward.
												Mwizi Mbarara- One delivery bed, there is a first labour but it s very small, ward nurse duty doesn t exist. They use the antenatal section. There is a sterile store but its limited by space.
												Bufumbo Mbale-The delivery room is under repair, there is no linen store at the health facility, No first stage labor, for the waiting room there are chairs for patients to sit on and there is enough space, ward nurse duty station,
												is also well equipped with tables and cupboard for drugs and there are buckets to put in the waste , there is no sterile store for maternity. They sterilize near the theater by using a generator.

Areas	Indicators	Health Center IV										Status
		Kaberamaido	Aduku Apac	Mungula Adjumani	Kasana Luwero	Kigandalo Mayuge	Rukunyu Kamwenge	Kabwohe Shema	Kakuto Rakai	Mwizi Mbarara	Bufumbo Mbale	
	General Ward (Duty room)											Kaberamaido- Exist with cracked walls and floor.
												Aduku Apac- There is one with two chairs and a table.
												Mungula Adjumani- In good state with duty room in place.
												Kasana Luwero- It looks deserted.
												Kigandalo Mayuge- There is no duty room at the health facility.
												Rukunyu Kamwenge- The General ward exists but it houses the male, female and the TB patients. The ward is very congested
												Kabwohe Shema- Has all male, female, and children s ward separated by ply wood
												Kakuto Rakai-- It needs improvement for example with furniture and curtains
												Mwizi Mbarara- Use the 1st labor ward
												Bufumbo Mbale-It s in a good state well equipped with a cupboard for drugs, chairs for patients to sit on and tables. There is power which is used for lighting and its well ventilated with enough space for patients.
	Children s ward											Kaberamaido- Improvised, with less beddings.
												Aduku Apac- There are 6 beds but no sheets.
												Mungula Adjumani- There are 5 beds and over crowded.
												Kasana Luwero- Though it is available the beds are also not good and it also lacks beddings.
												Kigandalo Mayuge- Just improvising, there are only 4 beds in the children s ward. The building is still under construction and once in a while they put their patients to rest.
												Rukunyu Kamwenge-- The children s ward exists but there are no mattresses.
												-There are very old beds in the children s ward.
												Kabwohe Shema- The ward is available but the structure is very old. The screens were limited.
												Kakuto Rakai- It needs beds and curtains and screens. There is no privacy.
												Mwizi Mbarara- Referrals and the 1st labor
												Bufumbo Mbale- It s in an average state, there are few mattresses. However, there are enough beds
	Female ward											Kaberamaido- No beddings
												Aduku Apac- There are 8 beds but no mattresses.
												Mungula Adjumani- There are 8 beds, lights and a water tap outside.
												Kasana Luwero- Lacks beddings
												Kigandalo Mayuge- They have constructed a new block and it s not yet in use, it lacks the water system and the flow is bad, beds are not enough and thus share beds for maternity.
												Rukunyu Kamwenge-- There is no specific female ward; men, women and TB patients share the same ward.
												Kabwohe Shema- The ward is available although the space is inadequate.
												Kakuto Rakai- It also has a problem of having very bad beddings
												Mwizi Mbarara- Use 1st labor maternity.
												Bufumbo Mbale- It s in average state, few mattresses and the beds are broken.

Areas	Indicators	Health Center IV										Status
		Kaberamaido	Aduku Apac	Mungula Adjumani	Kasana Luwero	Kigandalo Mayuge	Rukunyu Kamwenge	Kabwohe Shema	Kakuto Rakai	Mwizi Mbarara	Bufumbo Mbale	
	Male ward											Kaberamaido- Has no beds and bed sheets.
												Aduku Apac- There are 7 beds, with lockers and it is clean..
												Mungula Adjumani- There are few beds though not occupied and there are lights.
												Kasana Luwero- It also have the same challenges of lack of beddings.
												Kigandalo Mayuge- Female and Male ward are on the same block, lack equipment e.g. patients locker, beds and mattresses.
												Rukunyu Kamwenge-- There is no specific male ward. Men and Women were sharing the ward
												Kabwohe Shema- There are few beds. The ward was not very clean due to lack of water. It also lacks beddings and renovation
												Mwizi Mbarara- patients from neighboring sub counties come to the same hospital
												Kakuto Rakai- It lacks curtains and the roof is about to fall it in Bufumbo Mbale- It s in a good state, beds and mattresses are there, well ventilated with enough space

Staffing status for referral hospitals

Job title	Mbale			Gulu			Mbarara			Moroto		
	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G
MEDICAL OFFICERS												
Principal Medical officer	1	1	0									
Medical officer special grade	1	0	1	1	1	0				12	0	12
Senior medical officer	1	2	+1									
Medical officers	4	14	+10	10	4	6	10	13	+3			
ALLIED HEALTH PROFESSIONALS												
Senior clinical officer	1	1	0	3	3	0	1	2	+1	2	2	0
Clinical officer	5	5	0				7	6	1	6	2	4
Psysc. clinical officer	1	4	+3	4	2	2	7	6	1	2	1	1
Ophthalmic clinical officer	1	2	+1	2	1	1						
Health inspector	1	0	1									
Medical Entomology officer	1	0	1									
Radiographer	2	1	1	1	0	1	3	2	1	3	2	1
Physiotherapist	1	2	+1				2	2	0	1	0	1
Occupational therapist	1	0	1	1	1	0	2	2	0	1	0	1

Job title	Mbale			Gulu			Mbarara			Moroto		
	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G
Orthopedic officer	2	2	0									
Health Educator	1	0	1									
Assistant Health Educator	1	0	1									
Anesthetic officer	2	2	0	3	2	1	1	0	1			
Thearter Attendant	2	5	+3	9	5	4	2	3	0	4	1	3
Senior Lab. Technologist	1	0	1	2	1	1	1	2	+1	2	0	2
Lab Technologist	1	1	0	4	1	3	1	1	0	2	2	0
Lab Technician	2	0	2	2	2	0	6	6	0			
Lab Assistant	1	6	+5	4	2	2	3	3	0	6	3	3
DENTAL												
Dental Surgeon	1	1	0				1	0	1			
PDHO	2	2	0	5	2	3	1	2	+1	2	0	2
Dental Attendant	1	2	+1	8	5	3				2	0	2
PHARMACY												
Pharmacist	1	1	0	1	0	1	1	1	0	1	0	1
Dispenser	2	2	0	3	1	2	3	2	1	4	1	3
ADMINSTRATIVE STAFF												
Senior Hospital Administrator	1	1	0	1	0	1	1	0	1	1	1	0
Hospital Administrator	1	1	0	1	1	0	1	0	1	1	0	1
Personnel officer	1	0	1	1	0	1						
Medical Social Worker	1	2	+1	4	2	2	1	0	1	2	0	2
Nutritionist	1	1	0				1	0	1	1	1	0
Supplies officer	1	3	+2							1	1	0
Office Typist	1	1	0	1	1	0	1	0	1	2	1	1
Stores Assistant	2	2	0	4	4	0	1	1	0	2	2	0
Medical Records Asst.	2	2	0	4	2	2	4	3	1			
Senior Accounts Assist.	1	1	0				2	0	2			
Accounts Assist.	1	3	+2				2	2	0	2	0	2
NURSING												
Principal Nursing officer	1	1	0				1	1	0	1	1	0
Senior Nursing officer	5	18	+13				1	1	0	15	4	11
Nursing officer/Nursing	17			47	45	2	25	26	+1			
Nursing officer/midwifery	3	24	+21	15	8	7	12	9	3			
Nursing officer/psyc.	1	4	+3	5	1	4	2	1	1			
Enrolled Nurse	46	45	1	55	49	6	52	54	+2	40	21	19
Enrolled Midwife	25	31	+6	20	16	4	24	15	9	20	8	12
Nursing Assistant	15	18	+3	30	23	7	20	24	+4	20	19	1
SUPPORT STAFF												

Job title	Mbale			Gulu			Mbarara			Moroto		
	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G
Darkroom Attendant	1	2	+1	7	4	3	2	1	1	2	0	2
Driver	2	4	+2				4	4	0	7	2	5
Askari	2	18	+16	22	17	5	8	8	0	12	7	5
Mortuary Att.	1	2	+1	3	3	0	2	1	1	3	0	3
Cook	3	7	+4	15	15	0	8	6	2	20	3	-17
Artisan	3	2	1				1	1	0	1	0	1
Total	179	241	113	298	224	75	227	211	44	204	85	118

ANNEX IV: STAFFING STATUS

Staffing status for District Hospitals

Job title	DISTRICT HOSPITALS														
	Entebbe Wakiso			Adjumani			Kitagata Shema			Kapchorwa			Kalisizo Rakai		
	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G
MEDICAL OFFICERS															
Principal Medical officer	1	0	1	1	0	1	1	0	1	1	1	0	1	0	1
Medical officer special grade	1	0	1	1	0	1	1	0	1	1	0	+1	1	0	1
Senior medical officer	1	1	0	1	1	0	1	1	0	1	1	0	1	2	+1
Medical officers	4	2	2	4	2	2	4	2	2	4	3	1	4	2	2
ALLIED HEALTH PROFESSIONALS															
Senior clinical officer	1	1	0	1	1	0	1	2	+1	1	2	+1	1	4	+3
Clinical officer	5	6	+1	5	5	0	5	4	1	5	4	1	5	1	4
Psysc. clinical officer	1	0	1	1	1	0	1	2	+1	1	1	0	1	1	0
Ophthalmic clinical officer	1	0	1	1	1	0	1	1	0	1	1	0	1	1	0
Health inspector	1	0	1	1	1	0	1	0	1	1	1	0	1	1	0
Medical Entomology officer	1	0	1	1	0	1	1	0	1	1	1	0	1		
Radiographer	2	0	2	2	0	2	2	1	1	2	1	1	2	1	1
Physiotherapist	1	0	1	1	1	0	1	0	0	1	0	+1	1	0	1

Job title	DISTRICT HOSPITALS														
	Entebbe Wakiso			Adjumani			Kitagata Shema			Kapchorwa			Kalisizo Rakai		
	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G
Occupational therapist	1	1	0	1	1	0	1	0	1	1	0	+1	1	0	1
Anesthetic Officer	2	0	2	2	2	0	2	1	1	2	1	1	2	1	1
Orthopedic officer	1	0	1	1	1	0	1	0	1	1	1	0	1	1	0
Health Educator	1	0	1	1	0	1	1	0	1	1	0	+1	1	0	1
Assistant Health Educator	2	2	0	2	1	1	2	2	0	2	2	0	2	2	0
Anesthetic officer	2	2	0	2	2	0	2	0	2	2	2	0	2	1	1
Theater Attendant	1	o	1	1	0	1	1	0	1	1	0	+1	1	0	1
Senior Lab. Technologist	1	0	1	1	0	1	1	1	0	1	1	0	1	0	1
Lab Technologist	2	2	0	2	2	0	2	1	1	2	1	1	2	4	+2
Lab Technician	1	0	1	1	3	+2	1	0	1	1	1	0	1	4	+3
Lab Assistant	1	1	0	1	1	0	1	1	0						
DENTAL															
Dental Surgeon	1	1	0	1	1	0	1	1	0	1	1	0	1	0	1
PDHO	2	2	0	2	1	1	2	0	2	2	1	1	2	1	1
Dental Attendant	1	1	0	1	1	0	1	0	1	1	1	0	1	0	1
PHARMACY															
Pharmacist	1	0	1	1	0	1	1	0	1	1	0	1	1	1	0
Dispenser	2	1	1	2	1	1	2	1	1	2	1	1	2	1	1
ADMINSTRATIVE STAFF															
Senior Hospital Administrator	1	1	0	1	0	1	1	1	0	1	1	0	1	1	0
Hospital Administrator	1	1	0	1	0	1	1	0	1	1	1	0	1	1	0
Personnel officer	1	1	0	1	1	0	1	0	1	1	0	1	1	0	1
Medical Social Worker	1	0	1	1	1	0	1	0	1	1	1	0	1	1	0
Nutritionist	1	0	1	1	0	1	1	1	0	1	0	1	1	0	1
Supplies officer	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1
Office Typist	1	0	1	1	1	0	1	1	0	1	1	0	1	1	0
Stores Assistant	2	2	0	2	1	1	2	0	+2	2	2	0	2	1	1
Medical Records Asst.	2	2	0	2	2	0	2	2	0	2	2	0	2	1	1
Senior Accounts Assist.	1	1	1	1	0	1	1	1	0	1	0	1	1	0	1
Accounts Assist.	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
NURSING															
Principal Nursing officer	1	1	0	1	1	0	1	1	0	1	0	1	1	1	0

Job title	DISTRICT HOSPITALS														
	Entebbe Wakiso			Adjumani			Kitagata Shema			Kapchorwa			Kalisizo Rakai		
	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G
Senior Nursing officer	5	4	1	5	5	0	5	3	2	5	5	0	5	1	4
Nursing officer/ Nursing	17	7	10	17	24	+7	17	6	11	17	12	5	17	17	0
Nursing officer/ midwifery	3	4	+1	3	3	0	3	1	2	3	4	+1	3	8	0
Nursing officer/ psyc.	1	1	0	1	0	1	1	0	1	1	1	0	1	1	0
Enrolled Nurse	46	24	22	46	24	22	46	4	42	46	28	18	46	27	19
Enrolled Midwife	25	26	+1	25	10	15	25	6	-19	25	15	10	25	18	7
Nursing Assistant	15	24	+9	15	13	2	15	8	7	15	12	3	15	16	+1
SUPPORT STAFF															
Darkroom Attendant	1	1	0	1	1	0	1	0	1	1	1	0	1	1	0
Driver	2	1	1	2	2	0	2	1	1	2	2	0	2	2	0
Askari	2	0	2	2	5	+3	2	4	+2	2	6	+4	2	2	0
Cold Chain Att.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mortuary Att.	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
Cook	3	1	2	3	3	0	3	0	3	3	2	1	3	2	1
Artisan	3	0	3	3	3	0	3	2	1	3	1	2	3	1	2
TOTAL	179	127	78	179	199	72	179	65	122	179	128	63	179	134	69

Staffing status for Health centres IV

Job title	Health Center IV																														
	Kaberamaido			Aduku Apac			Mungula Adjumani			Kasana Luwero			Kigandalo Mayuge			Rukunyu Kamwenge			Kabwohe Shema			Kakuto Rakai			Bufumbo Mbale			Mwizi Mbarara			Wakiso		
	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G
Sen. Medical Officer	1	1	0	1	1	0	1	0	1	1	2	+2	1	0	1	1	1	0	1	1	O	1	1	0	1	1	0	1	0	1	1	1	0
Medical Officer	1	1	0	1	1	0	1	1	0	1	1	0	1	0	1	1	O	1	1	0	1	1	1	0	1	1	0	1	0	1	1	1	0
Senior Nursing Officer	1	3	+2	1	1	0	1	1	0	1	1	0	1	1	0	1	O	1	1	1	0	1	1	0	1	1	0	1	0	1	1	1	0
Public Health Nurse	1	0	1	1	1	0	1	0	1	1	1	0	1	1	0	1	0	1	1	0	1	1	1	0	1	0	1	1	0	1	1	2	1
Clinical Officer	2	1	1	2	0	2	2	1	1	2	6	+4	2	3	+1	2	2	0	2	3	+1	2	5	+3	2	3	+1	2	1	1	2	1	0
Ophthalmic Clinical Officer	1	1	0	1	0	1	1	0	1	1	1	0	1	1	0	1	0	1	1	1	0	1	1	0	1	0	1	1	0	1	1	0	1
Health Inspector	2	1	1	2	2	0	2	2	0	2	2	0	2	1	1	2	1	1	2	1	1	2	1	1	2	1	1	2	0	2	2	1	1
Dispenser	1	0	1	1	1	0	1	1	0	1	1	0	1	1	0	1	0	1	1	0	1	1	0	1	1	0	1	1	1	0	1	1	0
Public Health Dental Officer	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	0	1	1	1	0
Lab. Technician	1	1	0	1	2	0	1	2	0	1	1	0	1	0	1	1	0	1	1	1	0	1	1	0	1	2	+1	1	0	1	1	2	1
Ass. Entomological Officer	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	0	1	1	0	1	1	1	0	1	0	1	1	1	0	1	0	0
Nursing Officer(Nursing)	1	2	+1	1	4	+3	1	3	+2	1	1	0	1	1	0	1	1	0	1	2	+1	1	2	+1	1	0	1	1	1	0	1	2	1
Nursing Officer(Mid-Wifely)	1	0	1	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	2	+1	1	3	+2	1	1	0	1	2	+1	1	1	0
Nursing Officer(Psychiatry)	1	0	1	1	0	1	1	0	1	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
Ass. Health Educator	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	0	+1	1	2	0	1	1	0	1	0	0
Anesthetic Officer	1	2	+1	1	0	1	1	0	1	1	1	0	1	0	1	1	1	0	1	2	1	1	1	0	1	1	0	1	0	1	1	1	0
Theatre Assistant	2	2	0	2	1	1	2	1	1	2	1	1	2	1	1	2	2	0	2	1	1	2	2	0	2	1	1	2	0	2	2	1	1
Anesthetic Assistant	2	0	2	2	0	2	2	1	1	2	1	1	2	0	2	2	0	2	2	0	2	2	2	0	2	2	0	2	0	2	2	1	1

Job title	Health Center IV																														
	Kaberamaido			Aduku Apac			Mungula Adjumani			Kasana Luwero			Kigandalo Mayuge			Rukunyu Kamwenge			Kabwohe Shema			Kakuto Rakai			Bufumbo Mbale			Mwizi Mbarara			Wakiso		
	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G
Enrolled Psychiatric Nurse	1	1	0	1	1	0	1	1	0	1	0	1	1	0	1	1	1	0	1	0	1	1	1	0	1	1	0	1	1	0	1	1	0
Enrolled Nurse	3	4	1	3	4	1	3	3	0	3	5	+2	3	2	1	3	5	0	3	2	1	3	10	+7	3	10	+7	3	3	0	3	5	+2
Enrolled Mid-Wife	3	3	0	3	4	+1	3	1	2	3	3	0	3	2	1	3	5	0	3	4	+1	3	5	+2	3	6	+3	3	2	1	3	6	+3
Cold Chain Assistant	1	0	1	1	1	0	1	1	0	1	1	0	1	0	1	1	0	1	1	0	1	1	1	0	1	0	1	1	0	1	1	0	1
Office Typist	1	1	0	1	0	1	1	0	1	1	1	0	1	0	1	1	1	0	1	1	0	1	1	0	1	0	1	1	0	1	1	0	0
Lab. Assistant	1	0	1	1	2	+1	1	2	0	1	3	+2	1	3	+2	1	1	0	1	2	+1	1	2	+1	1	1	0	1	1	0	1	1	0
Stores Assistant	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
Accounts Assistant	1	1	0	1	1	1	1	1	1	1	1	0	1	1	0	1	0	1	1	0	1	1	1	0	1	0	1	1	0	1	1	1	0
Health Assistant	1	1	0	1	2	+1	1	0	1	1	2	+1	1	1	0	1	0	1	1	0	1	1	1	0	1	1	0	1	1	0	1	0	0
Health Information Assistant	1	1	0	1	2	+1	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	0	1	1	1	0
Nursing Assistant	5	5	0	5	3	2	5	4	1	5	7	+2	5	1	4	5	5	0	5	3	2	5	5	0	5	3	2	5	1	4	5	6	0
Driver	1	0	1	1	1	0	1	1	0	1	1	0	1	1	0	1	0	1	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
Askari	3	2	1	3	2	1	3	2	1	3	2	1	3	2	1	3	3	0	3	2	1	3	5	+2	3	1	2	3	1	2	3	1	2
Porter	3	4	+1	3	2	1	3	3	0	3	3	0	3	2	1	3	4	+1	3	3	0	3	3	0	3	2	1	3	2	1	3	4	+1
Total	48	42	18	48	44	22	48	38	17	48	56	17	48	32	22	48	38	15	48	38	22	48	63	21	48	46	27	48	22	28	48	46	16

Staffing Status for Health Centre III

HEALTH CENTER III STAFFING NORMS																					
	HEALTH CENTER III																				
	Zirobwe			Siippi			Malongo			Kamwenge			Layiibi			Akokoro			Ochera		
	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G	A1	A2	G
Senior Clinical officer	1	1	0	1	1	0	1	1	0	1	0	1	1	1	0	1	1	0	1	1	0
Clinical officer	1	1	0	1	0	1	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
Nursing officer	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	2	+1	1	3	+2
Lab. Technician	1	1	0	1	1	0	1	0	1	1	0	1	1	1	0	1	1	0	1	0	1
Enrolled mid-wife	2	3	+1	2	3	-1	2	2	0	2	2	0	2	2	0	2	3	+1	2	2	0
Enrolled nurse	3	3	0	3	3	0	3	2	1	3	0	3	3	3	0	3	3	0	3	3	0
Lab. Assistant	1	1	0	1	3	+2	1	2	+1	1	0	0	1	1	0	1	1	0	1	1	0
Health assistant	1	1	0	1	1	0	1	1	0	1	2	+1	1	1	0	1	2	+1	1	1	0
Nursing assistant	3	1	2	3	3	0	3	2	1	3	3	0	3	3	0	3	3	0	3	2	1
Health information Ass.	1	1	0	1	0	1	1	0	1	1	1	0	1	1	0	1	2	+1	1	1	0
Askari	2	1	1	2	2	0	2	1	1	2	2	0	2	1	0	2	1	1	2	2	0
Porter	2	1	1	2	2	0	2	2	0	2	3	+1	2	1	0	2	1	1	2	1	1
Total	19	16	3	19	20	-1	19	15	4	19	15	3	19	19	0	19	20	-1	19	18	1

KEY

A1 – Approved staffing levels

A2- Actual staffing

G- Gap

ANNEX V SUMMARY OF NSC RESPONDENTS

	FGD's		INTERFACE MEETING		TOTAL
District Name	**Female**	**Male**	**Female**	**Male**	
MBALE					
Mbale Hospital	16	13	19	13	61
Bufumbo HCIV	19	18	20	14	71
KAPCHWORA					0
Siipi HCIII	17	22	22	25	86
Kapchwora Hospital	14	11	15	16	56
MAYUGE					0
Kigandalo HC IV	14	11	14	15	54
Malongo HCIII	16	11	16	11	54
TOTAL	**96**	**86**	**106**	**94**	**382**
ADJUMANI					
MAIN HOSPITAL	18	12	20	14	64
MUNGULA HC IV	14	16	16	19	65
GULU					0
REFERRAL HOSPITAL	16	15	17	19	67
LAYIBI HC III	18	12	19	15	64
APAC					0
ADUKU HC IV	20	14	22	17	73
AKOKORO HC III	16	14	19	17	66
Total	**102**	**83**	**113**	**101**	**399**
LUWERO					
Zirobwe HCIII	17	15	16	17	65
Kasana HCIV	15	19	12	23	69
RAKAI					0
Kakuuto HCIV	18	12	14	17	61
Kalisizo Hospital	11	10	11	22	54
WAKISO					
Entebbe Hospital	18	12	18	9	57
Wakiso HC IV	18	14	14	11	57
TOTAL	**97**	**82**	**85**	**99**	**363**
MOROTO					
Moroto R. hospital	16	13	16	15	60
Nanduget HC III	18	18	14	16	66
KABERAMAIDO					
Kaberamido HC IV	16	19	16	17	68
Ohero HC III	15	16	16	18	65
Total	**65**	**66**	**62**	**66**	**259**
KAMWENGE					
Rukunyu HCIV	15	12	17	15	59
Kamwenge HC III	15	11	14	11	51
SHEEMA					

	FGD's		INTERFACE MEETING		TOTAL
District Name	**Female**	**Male**	**Female**	**Male**	
Kitagata Hospital	19	15	17	14	65
Kabwohe HC IV	16	15	11	10	52
MBARARA					
Mbarara Hospital	16	16	12	16	60
Mwizi HC III	15	12	17	18	62
Total	**96**	**81**	**88**	**84**	**349**
Grand Total	**456**	**398**	**454**	**444**	**1,752**

ANNEX VI: REFERENCES

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ANNEX VII. LIST OF NATIONAL SCORE CARD TWG MEMBERS

Name	Sector
Dr. Watiti Stephen (Chairperson)	PLHIV
Lillian Mworeko	Gender & Human Rights
Jacquelyne Alesi	Young People/PLHIV
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