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Background

Action Group for Health Human Rights and HIV/AIDS (AGHA-UG), is a health rights advocacy organization that has used social accountability tools to advocate for quality health services in public health facilities. Social accountability continues to evolve as a peculiar non-conventional but organized accountability approach to making public services work for the least fortunate in communities who rely heavily on publically provided free cost health services.

The approach has gained traction in service delivery monitoring through a myriad of tools'. Conscious to the fact that no one single tool can guarantee excellent results, our experience so far shows that a combination of tools can increase the effect and impact of results. Through our practice, social accountability concept has provided us with a wide range of institutional innovations that have encourage and projected voices of the right holders' in a way that service users are directly involved in seeking for justifications and actions from duty bearers about public health services. In a growing sphere of accountability and the need to engage in a constructive way with technocrats, social accountability being highly embedded in community participatory process, has helped empower communities understand government commitments on health, monitor and assess performance of health services and provided a rich body of evidence to engage duty bearers.

This long but engaging process has stimulated systematic active citizen monitoring of health service delivery and provided a platform upon which citizens have influenced policy makers and duty bearers constructively. This has led to increased accountability and good governance in health service delivery. The perspective that a minimumof health inputs and good practices are expected at a given health facility provides a benchmark to elicit feedback from right holders who are service users.

As AGHA – Uganda, we have come to a tested conclusion that service delivery outcomes are influenced by the relationships of accountability between policymakers, service providers, and citizens. At the clinic: Inputs and infrastructure, medical personnel: effort and knowledge, funding, effort in the supply chain and the feedback from the users are critical determinants that shape the quality of health services. However, we also note that heavily centralized planning i.e. planning where the central government determines priorities and local government resources are released to local governments with conditionalities can drastically affect social accountability outcomes.

Project Overall Goal:

To contribute to improved access to quality health services for vulnerable populations in Uganda by 2017

Project specific objectives

a) To increase the level of awareness among communities, health workers in Pallisa and Lyantonde districts on patients' rights and responsibilities by 2017

b) To improve the capacity of Community Based Organizations (CBOs), communities in Pallisa and Lyantonde districts to monitor the quality of health services so as to demand accountability from duty bearers by 2017,

c) To advocate for improvements in the quality of health services for vulnerable populations in Pallisa and Lyantonde districts by 2017

Introduction

Action Group for Health Human Rights and HIV/AIDS (AGHA Uganda) is a national non-governmental organization engaged in health rights advocacy using an array of social accountability tools. Through funding from the Open Society Initiative for Eastern Africa (OSIEA), AGHA has been implementing a public health advocacy project in the districts of Pallisa and Lyantonde. The project entailed building capacity of key actors in health planning and monitoring, raising awareness about patients' rights and health workers' responsibilities, community monitoring of health services using the community score card tool and advocacy engagements at local government and national levels.

The community score card tool is a hybrid tool used across sectors to elicit feedback from end users the quality and access to services. It is a two-way and ongoing participatory tool for assessment, planning, monitoring and evaluation of health services bringing together the demand side ("service user") and the supply side ("service provider") to jointly analyze issues underlying health service delivery and find a common and shared way of addressing identified health service delivery bottlenecks. A community sore card is therefore a participatory community-based process that simultaneously (i) evaluates and improves public services and (ii) informs and empowers local actors.The tool was customized to monitoring health service delivery benchmarking on National Health Service standards per level of health care. The main goal of the Community Score Card was to positively influence the quality, efficiency and accountability with which health services were provided. The core implementation strategy to achieve this goal was using dialogue in a participatory forum that engages both service users and service providers to influence policy makers and duty bearers to improve planning and resourcing of the health sector

In each district, AGHA Uganda mobilized citizens by engaging them in health facility assessments using a community score card tool, and used the assessment findings to convene community driven advocacy meetings to improve health service delivery at local facilities. To this end, citizens have been able to influence local government plans and budgets to address service gaps identified. Citizens have also been able to develop a better understanding of their health rights andentitlements

2.0 Chapter Two

2.1 Methodology/Approach

A careful and systematic process was designed and implemented to ensure the effectiveness of the community score card exercises and mutual understanding of the purpose, processes for maximum participation of both communities and health workers. AGHA undertook the following steps in conducting the community score cards at the selected health facilities.

2.1 Ground planning and preparation phase

a) District level consultative meetings: To ensure that there is a shared understanding of the process and support for the community score card assessments, AGHA conducted district level consultative meetings in December 2015 to share with district technical and political leaders the process of assessments, operational criteria for selection of facilities to be assessed and identify facilities to be assessed using the community score card tool.

b) Orientation meetings at selected health facilities: to be able to ensure support and effective participation of health workers, sub county leaders, health unit management committees and the wider community, orientation-meetings were conducted at selected health facilities. These meetings were used to harmonize expectations and allay fears about community score cards in assessing performance of health services.

c) Mobilization of participants: In planning for the assessments, stakeholders were identified to help mobilize participants in two groups composed of community members/representatives who often use health services provided in a given health facility and the service providers in this case health workers at the facility.

2.2 Development of the input tracking matrix

The input matrix is developed and derived from the minimum health care package for each level of care and other additional qualitative indicators suggested by both participating groups that could shape quality health service delivery.

2.3 Community score cards assessment

Communities then constitute a focus group and conduct an assessment of health services agreed indicators. The reason for the scores are carefully documented and become part of the message that is shared with duty bearers at health facility, sub county and district level.

2.4 Health workers self-assessment

Health workers as a focus group are also guided through the a process of assessing the input indicators in the matrix with justifications for the score upon which they develop their own reflective score card report on health service delivery.

2.5 Interface meetings

The two groups then come together to share each other's score card report, dialogue and harmonize the scores upon which an action plan is developed advocacy and follow with the relevant authorities. This session

2.6 Action planning

A joint action plan is then developed to help address the outstanding health service delivery issues harmonized during the interface meeting. Often the responsibility is spread to the community, the health workers and local government leaders with follow ups by community based organizations.

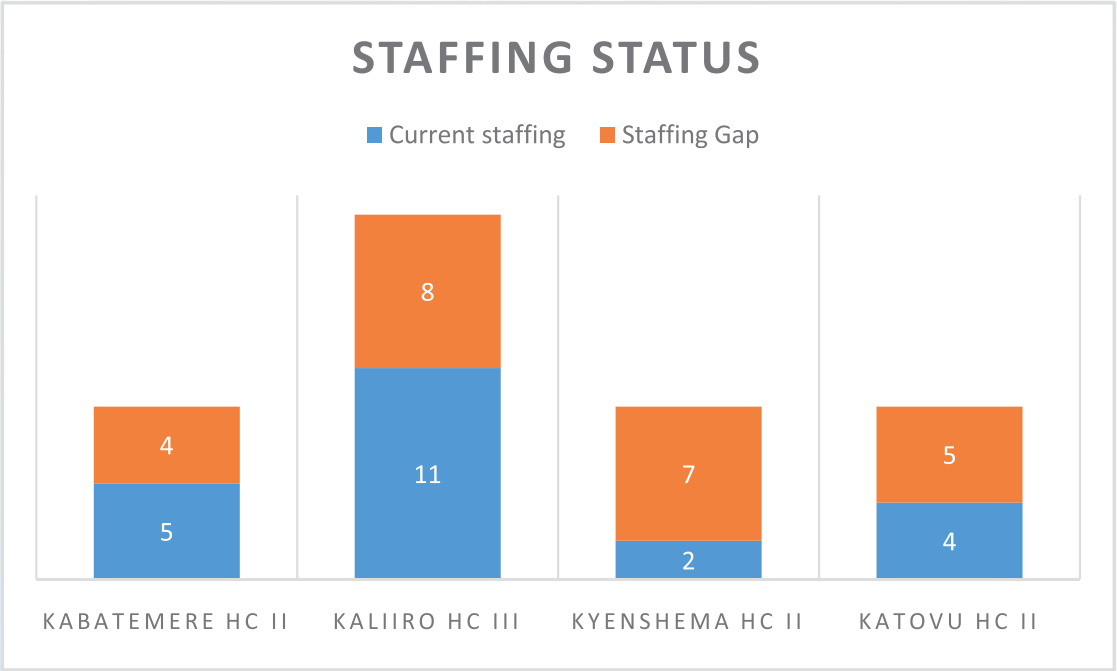
2.7 Action plan implementation, institutionalization and review

The action plan is reviewed every month to ascertain progress on the assigned tasks and where need be further actions are put into plan to ensure their successful implementation

3.0 Chapter 3 – Achievements, challenges and lessons

3.1.1 improved health workers' staffing in Pallisa and Lyantonde

According to the Ministry of health guidelines on staffing norms for level III health facilities are supposed to have a composition of 19 cadre mix while a health Centre II has 09 cadres mix i.e. both trained health workers and support staff. Staffing was tracked in the target health facilities to ascertain the level of staffing visa viz the staffing norms set by government for the given health facilities. From the input tracking matrix average district health department staffing had tremendously improved with over 70% filled in Pallisa and 82% filled in Lyantonde district. The staffing levels in Pallisa health centre IIIs assessment over this period have improved from 69% two years back to an average of 84% of the approved staffing levels a figure that is higher than the national average of 71%. However, the health centre IIs have not experienced improved staffing levels due to a government re-policy shift to community extension health workers as an alternative to health centre IIs as a mechanism of rationalizing health resources into a more effective, efficient and least cost method of delivering health services. This improved staffing in health facilities has been a big contributor to improved service delivery at health facilities.



- Improvements in patient satisfaction levels with health services
- Reduced waiting time by patients at the health facility
- Reduced health worker fatigue due to heavy patient workload

Gaps

- There are still staffing gaps yet to be filled across health facilities that were assessed averaging about 20% of approved positions in Pallisa district while for Lyantonde, staffing at health centre IIs was average.
- Health Center II's remain under staffed

Actions required

- Fill up the staffing gaps especially in the current positions not filled especially at the health facilities
- Re-align health worker re-distribution to health facilities where staff has gone for further studies like Katovu HC II where currently there is just one health worker.
- Increase support supervision especially to Kapuwai health Centre III and other health centre IIs in the districts to strengthen health service delivery

Attitude of health workers

The Health Service Act, 2001 (under Part IV) spells out the Code of Conduct for all health workers in Uganda. Under Section 30 of this Act, a health worker is obliged to take the health, safety and interest of patients to be of paramount importance at all times and in all circumstances, and to ensure that no health worker's action or omission is detrimental to the patient. Section 30(7) makes it illegal for a health worker to ask for, or accept, a bribe; while Section 30(9) provides that a health worker shall not abandon a patient under his or her care.

Over the project period there has been a noted improvement in relations between health workers and communities in some incidences health workers have had to be transferred away arising from poor workmanship. This improved relation is mainly a result of the feedback given by communities on health workers attitude to work and towards patients. Also the overall improvement of staffing levels is also one of the contributing factors for the improved relations between communities and health workers.

- With improved staffing levels in health facilities, attitude of health workers towards patients was scored

as being satisfactory

- Observing working hours was also assessed to have improved

A four in one staff house constructed at Agule health centre III

Through the efforts of community score card assessment and advocacy, additional 04 in one staff house has been constructed at Agule health centre III in Pallisa district. This brings to total 06 staff houses at the health facility that previously had onlya 02 in one dilapidated house. Once the new block is completed, it will go a long way in motivating health workers and improving health service delivery at the sub county as a result of more health workers residing within the health facility. At the start of the community score card joint assessments in Pallisa, Agule health centre III was noted to be one of the facilities with the lowest number of staff accommodated at the health facility compared to the other health facilities with just 02 in one dilapidated staff house accommodating the Midwifes.This comparative analysis of staff accommodation across the district health facilities that was presented during the community score card district dissemination and advocacy meeting became a major reason for the allocation of a staff house to Agule health centre II. These engagements made it possible for prioritisation of a staff house through funding from the northern uganda social action fund to which the sub county reflected in its budget and forwarded to the district for funding. A total of 80 million Uganda shillings were approved for construction of this 04 in 01 staff house and the health unit management committee of Agule health centre III tasked with ensuring the contractor does a good job on site.

Additional four in one staff house constructed at Agule Health Centre III

A new delivery bed provided for Nagwere HC III.

At the introduction of a community score card assessments at Nagwere Health centre III, the midwife continued

to use an examination couch as a delivery bed visibly old and rusted having served for a very long period. Usually community score card assessments start with the usual protocol issues and harmonization of expectations. Two focus group discussions (FGDs) are then constituted - health workers on one side and community members on another side. Facilitators identified from community based organizations (CBOs) and trained by AGHA-Uganda on community score card methodology carefully guide the two FGDs into a scoring process often exhaustive, objective and reflective of the realities at the health facility. These two groups generate independent score card reports that form part of the discussions during the interface meeting. The interface usually starts with each FGD presenting its score card report. The indicator on availability of a good functional delivery bed was noted to be bad with midwife and women delivering at the facility describing the bed as disgustingly old and rusty with a tilting right hand stand merely kept firm on floor surface by a stone. A report was presented to the district describing the state of the bed. At the time of the review of the action plan, though noted that the district had made good on its promise on delivery bed, it remained un-assembled at the health facility.Through efforts of the health Unit management committee HUMC), attempts to use local area artisans to assemble the bed failed. Given that the area councilor representing the sub county at the district council was in attendance during the dialogue, the meeting agreed to give the responsibility of follow-up with district health office to have the delivery bed assembled. Todate the delivery bed has been assembled and currently being used to conduct deliveries at the health facility.

Delivery bed provided and assembled at Nagwere Health Centre III

Electricity finally connected to Agule Health centre III

Upto the period before the community score card in Agule health centre III, the maternity section, Outpatient department and staff quarters lacked lighting and according to an eye witness account of the local council chairperson III of the sub county, she had had encounters where deliveries were conducted using a mobile phone flash light. During the community score card assessment at the health facility, the newly voted in area local council three chairperson of Agule sub county narrated an ordeal of how she witnessed a midwife conducting delivery using a phone flash light. Though the electricity wires and pole is extended up to the health facility compound, the health facility lacked power source at the maternity ward. An action plan was then developed together with the sub county to ensure that the maternity ward especially gets a source of power. In the short term, the sub county was tasked to purchase a medium solar panel able to light 04 bulbs while in the medium term, the sub county was tasked with prioritizing electricity wire installations at the maternity building and connection of electricity to the rest of the health facility buildings. At the review of action plan after 03 months of implementation, the sub county purchased a solar panel for the maternity and in financial Year 2016/17, the sub county budgeted 08 million for wiring and connection of electricity to the health centre III –covering the outpatient department, maternity ward and staff quarters, this has improved the work enviroment of the midwife with adequate lighting.

Power connected to the maternity ward

Community member donates land for development and expansion of Kyenshema health centre II

Located just 30kms away from Lyantonde town headquarters, Kyenshema health centre II is a community identified and rented facility that provides basic health services. Owing to the long distance to the nearest health centre III of about 18 Kms, the district health officer then Dr. Katumba now working with the medical and dentists practitioners council together with the community agreed on a simple modality of providing health services to the community. The community was tasked to identify rentable space while the district planned for health workers and drugs. Being a rural setting tacked away in adulating hills, the community identified a semi-permanent structure within which health services would be delivered to the community. The district then posted 02 health workers and dispatched drugs to the community rented health facility. The facility is just but a semi-permanent structure partitioned into two rooms

By every measure of health facility infrastructure, the facility does not meet the basic minimum standards of a public health facility. Together with the local leadership, the score card assessment rated every indicator on infrastructure Bad. The action plan focused on brainstorming strategies to develop the facility infrastructure most. The current arrangement of renting space and posting 02 health workers was merely a stop gap measure to bring health services closer to communities living in a hard to reach place. The strategies entailed from acquiring land to developing the land by at least putting up a modest structure befitting of a level II. For the success and community ownership of the initiative, the area local leaders were put at the forefront of leading the discussion. From the three community meetings conducted so far, the community has been able to contribute two Acres of land, 10 pieces of iron sheets and 17 bags of cement and 03 trips of sand. The sub county has assumed responsibility of the initiative of this community initiated project that will help elevate the poor infrastructure at kyenshema health centre II to kick start the construction process that will relieve the community from monthly rent for the current structure but also provide additional modest accommodation for the 02 health workers at the facility.

Community at Kyenshema Health Centre II

Brainstorm on how to develop the Facility

Community demarcates land donated for health centre II

Strengthened capacity of health unit management committees

At the initiation of the community sore cards in Pallisa and Lyantonde districts, assessment of the health unit management committees as oversight bodies of the health facilities showed weak capacities to play their roles and responsibilities effectively. Some committees were not fully constituted, lacked previous minutes of their meetings and did not provide regular updates to the sub county councils that constituted and approved them. Across the facilities assessed, only 20% had documented records of committee meetings and in all facilities assessed, none of the committees provided regular reports to the sub county leadership. Together with the respective district health offices, partnership plans were developed to conduct training of HUMCs at respective health facilities on the roles and responsibilities of health unit management committees and where they were not fully constituted, the sub counties were tasked with fully constituting the committees at health facilities. A two week's training schedule was then developed and facilitated by both the district health office and AGHA Uganda. To date, 95% of HUMC committees have reported improvements in their oversight functions and have verifiable reports of their meetings. Health unit management committees now provide regular updates to the sub county councils about the status of health facilities and according to a poll question survey conducted by AGHA in partnership with the local radio stations in the districts, when communities were asked where they prefer reporting their complaints about health services 75% preferred reporting to the health unit management committees due to the improved capacity to play oversight roles in health service delivery and handle complaints

Assistant DHO Lyantonde orients HUMCs on their roles and responsibilities

HUMCs conducting a review meeting at Kaliiro Health Centre III

Re-orienting radio programing towards community radios to promote health rights

"I did not know that segmenting a program can give you command amongst your audience, but now i see how important it is" are the first words from Kadyama Robert, a station manager at Bugwere fm when asked about the radio partnership with AGHA Uganda community radio programme training funded by Open Society Initiative for Eastern Africa.The training aimed to strengthen the social accountability engagements of AGHA using the local media. The training covered aspects of radio presentation, segmentation, production, and interactive sessions and tools. Kadyama Robert emphasizes that the training tickled his mind to think creatively on how to enhance radio programs to make them more community centered. As a follow up task, they had been tasked to do quick action research on community health needs and develop health content that married with the health interests of the community and therefore re-align radio programming and content to scale up advocacy for quality health service delivery.

Mr. Koire Fredrick as an outcome of the training action plan creatively introduced a new weekly program hosted on Sunday evening called "health corner". The program is specifically designed to discuss community experiences with health services in their areas. He designed it in a way that community voxpops shape topics of discussions with duty bearers.

While David Omoding a news editor and reader at Bugwere fm, noted that ever since the training, the packaging of news has greatly improved as a result the training supported by OSIEA. To further this engagement, Bugwere fm and radio Kaaro embraced trac fm poll question as a tactic to promote greater community feedback, participation and engagement with local leaders on issues of health service delivery using local area radio stations. Topical questions were generated with the radio stations and supported by technical staff from Trac fm which are run on community radio stations monthly to elicit feedback from communities on issues of health service delivery. This feedback is used to promote engagement with duty bearers

Training local radio journalist on Trac FM tool for community feedback

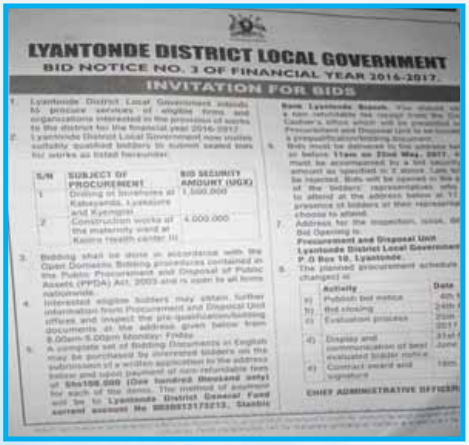
Other notable plans resulting from community score card engagements

- Fencing of health facilities undertaken in Nagwere and Apopong Health centre IIIs in Pallisa district. As of May 2017, all the health facilities assessed had been completely fenced

- Apopong Sub County has budgeted and planned for extension of electricity to the health centre III. In the meantime the sub county through locally generated revenues has purchased and installed a solar lighting system at the maternity ward. At the beginning of the health facility assessment, the maternity ward was nonfunctional with a major reason being lack of power connectivity and the deliveries continued to be conducted in the outpatient department rooms. Women particularly complained of a lack of privacy during deliveries as the outpatient department was concurrently being used for other outpatient activities.

- Maternity ward set for construction at Kaliiro health centre III in financial year 2017/18. Kalliro health centre III is a community initiated health facility with just a single building structure of 04 rooms one room reserved as both male and female-post-delivery ward/children's' ward, other is a laboratory, another as a drug store doubling also as the ART clinic and the consultation room is improvised with the corridor. Often, the facility is congested with a no guarantee of patient's privacy.

- Placenta Pit construction planned for Agule health centre III in financial year 2017/18. During the sub county budget consultations held in November 2016 a number of priorities were fronted for funding. Two contentious ones came to the fore, protection of a community spring well or construction of a placenta pit at the health facility. With a concerted effort of the health unit management committee and the facility in-charge, the sub county was able to prioritize construction of a placenta pit at the health facility in its sub county plans and budget 2017/18 since the current one is filled up and could halt deliveries at the health facility if a new one is not constructed.


LYANTONDE DISTRICT LOCAL GOVERNMENT
BID NOTICE NO. 3 OF FINANCIAL YEAR 2016-2017.
INVITATION FOR BIDS

Bid Advertisement for a Maternity ward at Kaliiro Health Centre III

Community installs a water harvesting tank in Katovu health centre II

During the community score card assessments at Katovu health centre II in Lyantonde district on the 16th/ March/2016, the facility in charge reported that the facility had received a water tank from the district local government for rain water harvesting for use at the health facility. However, after delivery to the health unit, it remained redundant lying on the facility compound. Yet during the community score card assessment, access to clean and safe water for use by both patients and health workers was rated as bad because according to the community, though the tank was delivered, it remained not performing the intended function. The tank was delivered to the health facility with no water gutters and basement for the rain water harvesting tank. Accordingly the HUMC was tasked to design a community resource mobilization strategy to collect funds to raise a basement and gutters for the water tank. From this endeavor, communities were able to collect 205,000 Ushs that was used to construct a basement for the water tank and procurement of water gutters to channel water to the tank to enable patient's access clean water in the facility. This improved access to water for both the health workers and patients in the health facility. Suffice to say that even piped water has been extended to the health facility

Community installs a water harvesting tank to serve patients and health workers

1.2 Lessons learnt

- If effectively implemented a community score card approach provides a powerful systematic process to understand and reveal the structural and operational bottlenecks to quality health service delivery in health facilities.
- The score card tool provides for an organic participatory and multi-level stakeholder engagement thus bringing about collective efforts to address health service delivery bottlenecks
- Over the community score card implementation process, there has been a great improvement in relations between the healthy workers and the patients and as such brought together to contribute towards addressing some health service delivery bottlenecks
- The community score card reports have plaid an instrumental role in shaping health priorities in lower local governments and have been used to influence both health plans and budgets leading to improved health planning and decision making at all levels. Social accountability approach of using community score cards has proven to be a catalyst for community mobilization, participation, empowerment and grassroots advocacy for better health services.

4.3 Recommendations

4.3.1 District local government level

- There is need for local governments to prioritize health infrastructure especially for lower level health facilities in districts targetingespecially staff accommodation, expansion of existing structures to be able to accommodate the equipment supplied from the centre and sanitation facilities like pit latrines and bathrooms. Currently only 24% of health workers have modest staff accommodation in Lyantonde district.
- A vote line should be created within the health budget specifically for health equipment in health facilities to be able to deliver quality health services effectively. Experience in districts is that most of the health equipment needs lack a clear budget line within the health sector and burden largely shouldered by development partners inform of donations.
- To be able to meet the staffing norms, there is need to fill up the staffing gaps in health facilities especially the lower health facilities nearest to the communities. District health Officers should also increase support supervision and mentoring in especially lower health facilities to be able to effectively deliver health services.

- Connect the health facilities to the national electricity grid. Improve the Solar capacity in health facilities to be able to provide adequate power throughout
- Strengthen the capacities of health unit management committees at health facilities. Conduct orientation of HUMCs on their roles and responsibilities so that they play their role of oversight effectively. As a matter of also strengthening their role, we suggest that sub county councils provide sessions for discussion of HUMC reports in sub county council meetings

4.3.2 National level

- As a matter of streamlining planning and budget, there is a need for creation of a budget vote within the health budget to cater for health equipment that is independent of the development budget or essential medicines budget. Largely the equipment that districts receive is distributed by donor partners.
- Improve the planning and budgeting framework to effectively provide health services based on available health information systems. The population projection for allocation of budget for drugs needs to be reviewed to a rather need – based model. Disproportionately some health facilities with a high patient load receive the same allocations as those with low patient load. It is imperative that government adopts a performance based financing model in health if the country is to achieve more with the current resource envelop.
- Factors such as the availability of accommodation for service providers and the lack of ambulances and other emergency transport services were identified, but are largely beyond the ability of most local governments given the fact that most of the resources they do receive are largely composed of conditional grants with clear and specific outputs