Uganda National Health Users/ Consumers Organization
UNHCO

Improving Maternal Health and Utilization of PMTCT Services through the Rights Based Approach in Nakaseke, Kamuli and Mbarara districts

Baseline Report

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Conducted by Associates Foundation Limited

For

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LIST OF ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
CBOs	Community Based Organizations
CSOs	Civil Society Organizations
DFID	Department for International Development
DHT	District Health Team
FGD	Focus Group Discussion
FY	Financial Year
HC	Health Centre
HRR	Health Rights and Responsibilities
HSSP	Health Sector Strategic Plan
KI	Key Informant
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MoH	Ministry of Health
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
TASO	The Aids Support Organization
UDHS	Uganda Demographic and Health Survey
UNHCO	Uganda National Health Users/ Consumer's Organization
UNMHCP	Uganda National Minimum Health Care Package

GLOSSARY OF TERMS AND DEFINITIONS

HCI- At the village level, the HCI is supposed to provide services for 1000 people. It provides community based preventative and promotive health services and is monitored by the village health committee or a group of a similar status.
HCII- At the parish level, the HCII is supposed to provide services for 5,000 people. It provides preventive, promotive, outpatient curative, maternity and in-patient health services and lab services, in addition to the services provided at an HCI.
HCIII- At the sub-county level, the HCIII is supposed to provide services for 20,000 people. In addition to services required at lower level health centers, it provides preventive, promotive, outpatient, curative, maternity, and in-patient health services and lab services.
HCIV- At the county level, the HCIV is supposed to provide services for 50,000 people. In addition to services provided at lower level health centers, it provides preventive, promotive, outpatient curative, maternity, in-patient health services, emergency surgery, blood transfusions, and lab services.
HCV- The HCV is a general hospital and serves 500,000 people. In addition to HCIV services, other general services will be provided. It will also provide in-service training, consultation and research to community based health care programs
HCVI- The HCVI is a regional referral hospital serving 2,000,000 people. In addition to general hospital services, special services such as psychiatry, ENT (Ear, Nose, Throat), Ophthalmology, dentistry, intensive care, radiology, pathology, and higher-level surgical and medical services.
HCVII- The HCVII is a National Referral Hospital and provides comprehensive specialist services as well as teaching and research.[1]
Health Rights- Health consumers have a right to be treated by a named health worker; right to confidentiality and privacy; right to treatment; right to non-discrimination; and right to continuity of care, among others.[2]
Health Responsibilities- The responsibilities of health consumers to take care of their own lives; provide accurate information when prompted by health workers; comply with instructions from health workers; and support the health care system/ institution, among others.[3]
Infant Mortality- is the death of infants in the first year of life.
Maternal Mortality- the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.[4]
Rights Based Approach to Health- The incorporation of human rights in the creation of appropriate health policies, programs, and legislation.[5] A human rights based approach identifies rights-holders and their entitlements (health consumers) and corresponding duty-bearers and their obligations (health workers and government) and works towards strengthening the capacities of rights-holders to make their claims and of duty-bearers to meet their obligations.[6]
Right to Health- The right to the highest attainable standard of health, not a right to be healthy. It requires governments and public authorities to put in place policies and action plans which will lead to available and accessible health care for all in the shortest possible time.[7]

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[1] HSSP I, 2000/01-2004/05
[2] Uganda National Health Users/Consumers Organization (UNHCO): Final Evaluation of the UNHCO Health Advocacy Program. Kampala, Uganda: 2008.
[3] Uganda National Health Users/Consumers Organization (UNHCO): Final Evaluation of the UNHCO Health Advocacy Program. Kampala, Uganda: 2008.
[4] Ministry of Health: Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda. Kampala, Uganda 2007-2015.
[5] World Health Organization (WHO): 25 Questions and Answers on Health and Human Rights. Geneva, Switzerland: 2002.
[6] Office of the United Nations High Commissioner for Human Rights: Frequently Asked Questions on a Human Rights Based Approach to Development Cooperation. New York and Geneva, 2006.
[7] World Health Organization (WHO): 25 Questions and Answers on Health and Human Rights. Geneva, Switzerland: 2002.

EXECUTIVE SUMMARY

The Uganda National Health Users/Consumer's Organization's (UNHCO) primary goal is to ensure improved access to quality public and private health care by all health consumers in Uganda through a rights-based approach by empowering health consumers and providers to participate in creating responsive and sustainable health services. A rights based approach to health involves the use of human rights to create health policies, programs, and legislation that incorporate care for both vulnerable and minority populations, such as women and children.[8] With support from Cordaid for 2008 – 2010; UNHCO is implementing activities in new intervention areas, with a special focus on maternal health and Prevention of Mother to Child Transmission of HIV (PMTCT) services, aimed at improving health standards in three targeted districts (Kamuli, Mbarara and Nakaseke). These activities require target setting and empirical benchmarks for focused implementation. The baseline had two objectives:

- Assessing the status quo in the operational districts regarding maternal health and PMTCT services.
- Assessing the extent to which the project risks and assumptions identified in the project proposal will be addressed.

The baseline employed both quantitative and qualitative methods of data collection and covered a total of 300 persons in the three districts. The first activity of the baseline was selection of entry points. The goal was to select three entry points per district. The criteria used in the selection in each district were:

- Spread of health facilities in terms of the sub counties or health sub districts.
- Maternal health services offered by the health facility, including PMTCT.
- The need to capture various levels of health service delivery in terms of levels of health facilities.
- The need to capture private and public health services providers/ facilities.

This exercise yielded Nankandulo (HC IV), Buyende (HC III), Balawoli (HC III) and Nabisambya in Kamuli district; St. Josephs- Rubindi, Ndeija (HC III) and St. Johns-Biharwe in Mbarara district and Kapeeka (HC III), Bidabugya (HC III) and Wakyato (HC III) in Nakaseke district.

The baseline empowerment indicators showed:

1. Average annual patient turnout per health facility (community utilization of health services) is 2,640 patients per year, assuming a seven-day workweek.
2. Out of every 26 community leaders only 5 (19.2%) were able to understand and acknowledge the importance of quality maternal health and PMTCT services; and, based on this knowledge, these leaders were deemed to have the ability to advocate for the provision of quality health services.
3. Consumer awareness of quality in all three districts averaged 13.5% on the basis of tracking for three quality aspects (time taken before service is received, drug stock outs and ethical conduct by providers).
4. 15% of the community members in all three districts involved in the survey could readily identify three quality issues; drug stock out, waiting periods and ethical conduct of service providers

It was also established that the above empowerment indicators are likely to be affected by:

- The extent to which UNHCO will have control of the process factors that would determine eventual empowerment.
- The track record of prospective partners with regard to offering quality health services.

Conversely, the baseline level advocacy indicators showed:

1. Few Community Based Organizations (CSOs) and Civil Society Organizations (CSOs) dedicated to promoting Maternal Health and PMTCT in addition to health rights and responsibilities (HRR) and functional feedback mechanisms, operate within the districts surveyed.
2. PMTCT is already high on the district health agenda. Health rights and responsibilities are not high on the agenda and are not viewed independently but as cross cutting.

[8] World Health Organization (WHO): 25 Questions and Answers on Health and Human Rights. Geneva, Switzerland: 2002.

3. Consumer awareness of health rights is 30%, however women who previously sought maternal health services have a higher awareness of health rights compared to those women who have not previously sought maternal health services. Overall awareness of PMTCT services is 20%.
4. Community member awareness of at least three health rights currently stands at 21.6%.
5. Community member awareness of at least three health responsibilities currently stands at 25.9%.
6. Although high on the district agenda, the rate of access to PMTCT services by women of reproductive age (13-50) was found to be 12%.

The advocacy indicators are likely to be affected by the level of qualitative knowledge and appreciation (understanding and acknowledgement) of the various stakeholders of the UNHCO intervention paradigm.

Support indicators, which mostly concerned providers, showed that:

1. Health worker awareness of quality standards is not holistic; emphasis is only put on a few work related aspects. Only 25% of health workers had a holistic understanding of quality standards.
2. Health worker awareness of patient health rights and responsibilities is selective and skewed to aspects that enhance their work. Only 31% of the health workers interviewed had a balanced understanding of health rights and standards.
3. From the consumer perspective, compliance (respect) to both quality standards and health rights and responsibilities is modest. Compliance to health rights and responsibilities is 32.9% while compliance to quality standards is 67.1%.
4. Most Health Unit Management Committee's (HUMC) exist but are generally dormant and it was unclear the extent to which they influenced planning, management and monitoring of health activities and services.
5. The prevalence of consumer complaints is 15.6% while the rate at which they are attended is 60.6%. Qualitatively ignorance is high with regard to what should be done when the need to express an opinion arises.

These indicators were likely to be influenced by:

- Functionality of the partnerships established by UNHCO and the capacity of both UNHCO and the partners to understand progress measurement dynamics and interpret them correctly.

Thus the baseline concludes that UNHCO has a relevant and timely intervention for maternal health and PMTCT services that will promote quality, access, community participation and accountability and foster a unique opportunity for providers and consumers of health services to interact for their mutual benefit. However, the baseline also recommends:

1. Careful revision of the baseline by the UNHCO implementation team to set annual milestones to guide the realization of overall positive performance on all indicators.
2. Informing partners (community leaders and entry point health facilities) of their monitoring responsibilities and developing simple tools to aid in this process.
3. Amending the health terms of reference of the district coordinators to include an aspect of actively monitoring and documenting program indicators for maternal health and PMTCT.
4. Interacting periodically at the district level, especially with the health services department, in order to establish UNHCO's continual presence in the intervention areas.
5. Formally launching the program in the intervention area. Although costly, this launch will create awareness, generate local stakeholder's support for the program, and mitigate the risk associated with perceived political opportunism as a result of UNHCO's interventions.

1.0 Introduction

Health is a fundamental human right paramount to the fulfillment of other basic human rights because the health of an individual determines their ability to function in other capacities. The international community first recognized the right to health in the preamble of the World Health Organization's 1946 Constitution and defined the right of "the enjoyment of the highest attainable standard of health" as one of the "fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition."[9] Since this first definition of the right to health, the concept has been further defined through several international charters and declarations, regional charters, including the Constitution of Uganda, which provides the necessary national legal framework for the right to health.[10] UNHCO has also been instrumental in the formulation of the patient's charter, a document detailing health rights and responsibilities of both patients and health workers. According to a Ministry of Health official, "the patient's charter is really UNHCOs' child. We took it on because by looking at institutional advantages, we are better placed to drive it forward."[11] The right to health however, is not a right to be healthy, but a right to have access to good quality facilities that provide access to appropriate healthcare. Governments therefore are not required to ensure the health of their citizens but are instead obligated to provide health facilities and conditions necessary for the realization of good health. On its most basic level, the right to health requires health services, goods, and facilities within a country to be 'available, accessible, acceptable, and of good quality'.[12]

Through the creation and adoption of the Millennium Development Goals (MDGs), Uganda and the international community have made commitments to improve the quality of life of people in developing countries by 2015. The MDGs have, among others, the following key targets: target 4 - reduction of child mortality, target 5- improvement of maternal health, and target 6- combating HIV/AIDS, Malaria and other diseases. The link between the MDGs and the Ministry of Health's (MoH) Second Health Sector Strategic Plan (HSSP II) is of particular importance to the work of UNHCO because of its focus on increasing access to quality health services, particularly for women and children[13]. The HSSP was created to help guide the policies and programs of the health sector so that the best possible outputs could be achieved within the given resource constraints. The HSSP II created the Uganda National Minimum Health Care Package (UNMHCP) to aid in realization of the MDGs through the reduction of maternal, neonatal and children under-five mortality levels, highlighted as sexual and reproductive health and newborn health and survival. The objectives of the HSSP II are similar to the aspirations of the Poverty Eradication Action Plan (PEAP) targets on continued investment in the health sector, which aims to reduce the overall poverty level of Ugandans through improving several target areas, including health.

The MDGs, HSSP II, and PEAP recognize that Civil Society Organization (CSOs) provide the link between government, the health facility level, and communities; and are therefore important actors in realizing the set targets for Maternal Health and PMTCT. CSOs have the cardinal role of enhancing efficient and effective utilization of resources by the government through fostering meaningful participation of the community in planning, monitoring and evaluation of the health sector. They can also play an important role in community mobilization and sensitization to promote health service utilization.

Maternal and infant mortality levels in Uganda have remained among the highest in the world over the last twenty years, despite the 5-7 % economic growth rate registered by the country over the same period. An estimated 45,000 newborns die each year in Uganda: the fifth highest number of newborn

[9] World Health Organization Constitution 1946

[10] UN Universal Declaration on Human Rights, International Covenant on Economic, Social, and Cultural Rights, UN Declaration on the Right to Development, Millennium Development Goals, African Charter on Human and People's Rights, Constitution of Uganda.

[11] Uganda National Health Users/Consumers Organization. Final Evaluation of the UNHCO Health Advocacy Program. April 2008, Kampala.

[12] Uganda Human Rights Commission Right to Health Toolkit

[13] HSSP II, Vol 1, 2005/2006

deaths in Sub Saharan Africa[14]. Recent Demographic and Health Survey data for Uganda reports a national neonatal mortality rate of 29 deaths per 1,000 live births from 2000 to 2005 compared to 33 and 27 from 1995-2000 and 1990-1995, respectively[15]. The correct management of Antenatal Care (ANC), Post Natal Care (PNC) and other related aspects of reproductive health are critical to the reduction of infant and maternal mortality levels.

ANC is a health service package that links the woman and her family to the health system during pregnancy through the provision of counseling and advice on nutrition and birth preparedness, the prevention and treatment of medical conditions and the initiation of PMTCT services if required. It also increases the chances of a facility birth with skilled medical assistance. PNC refers to measures undertaken after birth to ensure good health of the mother and child. According to the Uganda Demographic and Health Survey (UDHS) 2006, only 7% of mothers access postnatal services after the first day of birth. PNC is a part of the UNMHCP and is related to the National Reproductive Health Standards and Policy Guidelines; the Reproductive Health Strategy; Essential Maternal and Neonatal Care Clinical Guidelines for Health Workers; National Guidelines on Infant and Young Child Feeding and Guidelines for the Integrated Management of Childhood Illness (IMCI), among others. However, routine postnatal care, particularly during the first few days of life, is a major gap in the implementation of these policies' and guidelines[16].

1.1 Background

Uganda National Health Users/Consumer's Organization (UNHCO) is a Non-Governmental Organization (NGO) formed in 1999. UNHCO's main objective is to ensure improved access to quality public and private health care by all consumers of health services in Uganda through a rights-based approach to health, which ensures the incorporation of human rights in the creation of appropriate health policies, programs, and legislation.[17] Pursuant to this goal, UNHCO empowers health consumers and providers to participate in creating responsive and sustainable health services through sensitization about their health rights and responsibilities (HRR). At National and District level, UNHCO is involved in Policy advocacy doing research and contributing to policy development and Monitoring of service delivery. As member of the Health Policy Advisory Committee (HPAC) and Country Coordinating Mechanisms (CCM) UNHCO represents and provides leadership to Civil Society Organizations involved in the implementation of HSSP.

During the evaluation of the first stage of UNHCO activities supported by the Department for International Development (DFID) it was noted that women were among the most vulnerable groups whose health rights were frequently abused. This was deemed critical because women formed the majority of regular health consumers. It was further observed that the health rights holders (health consumers) were neither adequately informed nor sufficiently empowered to hold public and private health service providers accountable. The activities to be implemented from 2008 – 2010 aim at improving health quality standards with a special focus on maternal health and PMTCT services in the three targeted districts by sensitizing communities and health workers about their health rights and responsibilities and empowering them to demand and hold providers accountable. The activities target women as lead entry points for other target groups, including spouses of the women, health care providers, district health officials, CBOs and other local and national stakeholders.

The evaluation of the UNHCO programme at the end of DFID funded activities provided critical insights that guided expansion into new intervention districts and sub counties. New funding from Cordaid will support the initiative's expansion of UNHCO's work into new implementation areas. These new intervention areas (districts and sub-counties) require fresh target setting for maternal health and

[14] Lawn J, Kerber K, eds. Opportunities for Africa's Newborns: Practical Data, Policy and Programmatic Support for Newborn care in Africa. Cape Town: PMNCH, Save the Children, UNFPA, UNICEF, USAID, WHO, 2006

[15] Uganda Bureau of Statistics (UBOS) and Macro International Inc: Uganda Demographic and Health Survey 2006. Calverton, Mary land: 2007

[16] Ministry of Health: **Situation analysis of newborn health in Uganda:** *Current status and opportunities to improve care and survival,* Kampala: Government of Uganda. Save the Children, UNICEF, WHO; 2008.

[17] World Health Organization (WHO): 25 Questions and Answers on Health and Human Rights. Geneva, Switzerland: 2002.

PMTCT, which in turn requires new benchmarks for purposes of guiding implementation of programs and to form a basis upon which achievements can be gauged.

1.2 Objectives

The overall purpose of the baseline was to establish the level of access and quality of maternal health and PMTCT services in three pre-selected intervention districts of Nakaseke, Mbarara and Kamuli. The baseline specifically focused on:

- Assessing the status quo in the operational districts, regarding maternal health and PMTCT services.
- Assessing the extent to which the project risks and assumptions identified in the project proposal will be addressed.

2.0 Methods

2.1 Baseline Design

The baseline employed both quantitative and qualitative methods of data collection. These included Focus Group Discussions (FGDs), Key Informant (KI) Interviews and Individual Interviews[18]. All approaches were designed as rapid appraisals targeting various actors and stakeholders in maternal health and PMTCT services in the intervention districts.

The purpose for the rapid appraisal design was to allow a blend of both qualitative and quantitative approaches in a short period of time given that the data collection activity was being undertaken at a time when commencement of actual program activities was about to start.

Focus Group Discussions

These were designed to capture aggregate opinions of the communities in which UNHCO would be intervening. In each area the group consisted of 8 to 14 persons, with a combination of women and men of 18 years and above. These focus group discussions were conducted in a consensus-building manner. The aim of these guided discussions was to get respondents to agree on the average status quo of indicators and also to agree on the risks associated with performance on the indicator. These groups consisted of direct consumers of health services.

Key Informant Interviews

These were held with a higher level of respondents; the district officials, the sub county local government officials and health facility personal. The interviews were individually administered with the aim of testing the respondent's levels of knowledge, attitudes and practices with regard to maternal health, health rights and responsibilities, in addition to feed back mechanisms. These were exploratory interviews. This had an embedded records review perspective for health facility personnel, which aimed at understanding patient turnout.

Individual Interviews

These interviews were individually conducted with direct beneficiaries of the health services using an exit poll. Respondents were only interviewed after consuming a service at the facility. They were interviewed in private with the aim of capturing experiences with health services delivery with regard to the core investigation areas.

2.2 Baseline Respondents

The baseline had a total coverage of 300 persons. This baseline exercise was on a specialized subject of study and therefore the respondents were purposively sought because of their involvement with health services. At inception of the study, a list of probable respondents was developed by the baseline research team and discussed and agreed upon with the client (UNHCO). Despite specifically seeking

[18] The Data Collection Tools Used are Appended at the back of this Report.

respondents, care was taken to thematically triangulate data from different sources and tools to obtain a comprehensive understanding of the existing situation. Table 1 shows various categories of respondents reached in the course of data collection by district.

Table 1: Baseline Respondents

Respondents Coverage				Total
Category	**Kamuli**	**Mbarara**	**Nakaseke**	
District Local Government Officials	2	2	2	6
Sub County Local Government	3	3	1	7
Health Unit Staff (In charges and Other Providers)	14	8	11	33
Direct Maternal Health/ PMTCT Individual Consumers	78	70	68	216
Direct Maternal Health/ PMTCT stakeholders/ consumers in FGD	12	14	12	38
Total	109	97	94	300

The district coordinators of UNHCO were critical facilitators of the data collection process. They were responsible for appointment setting and mobilization but also participated in data collection, including FGDs and exit polls, which contributed to the understanding and appreciation of the baseline results. The program staff at UNHCO was crucial in providing interpretation of the various concepts and ensuring that the data collection tools were inline with the baseline objectives.

Challenges

The baseline research team encountered several challenges in the course of undertaking this task:

- The response levels were generally low on various aspects of the investigation; prompting had to be used for responses to be elicited. In part this was due to the combined (female and male) FGDs, which could have had an affect on the response levels of women in these discussions. However, response levels remained low even in instances of exclusive individual interviews. The research team had to go through the interviews with a lot of patience and prompting.
- Most health facilities had few health workers; many were often absent from their workstations. It the optimal staffing levels were not readily established, however, key informants at district level reported that most of their health facilities are understaffed.
- The exercise was conducted in the course of a rainy season and the roads, especially in Kamuli and Nakaseke, which were in very poor condition.

2.3 Data Analysis and Structure of the Report

Data obtained from Focus Group Discussions, Key Informant Interviews and Individual Interviews was analyzed using a triangulation approach. Qualitative results complemented and clarified the quantitative results. Quantitative results were generated using SPSS while qualitative results relied on grouping of thematic information from different sources. The report is structured according to the objectives and specific detail is organized according to groups of indicators, i.e. those concerning empowerment, advocacy and support as contained in the program proposal log frame. It should be noted that analysis is undertaken in the context of the overall program objective to improve maternal health and increase access to PMTCT services in Nakaseke, Kamuli and Mbarara districts by 40% by the year 2010 and the specific objectives that include:

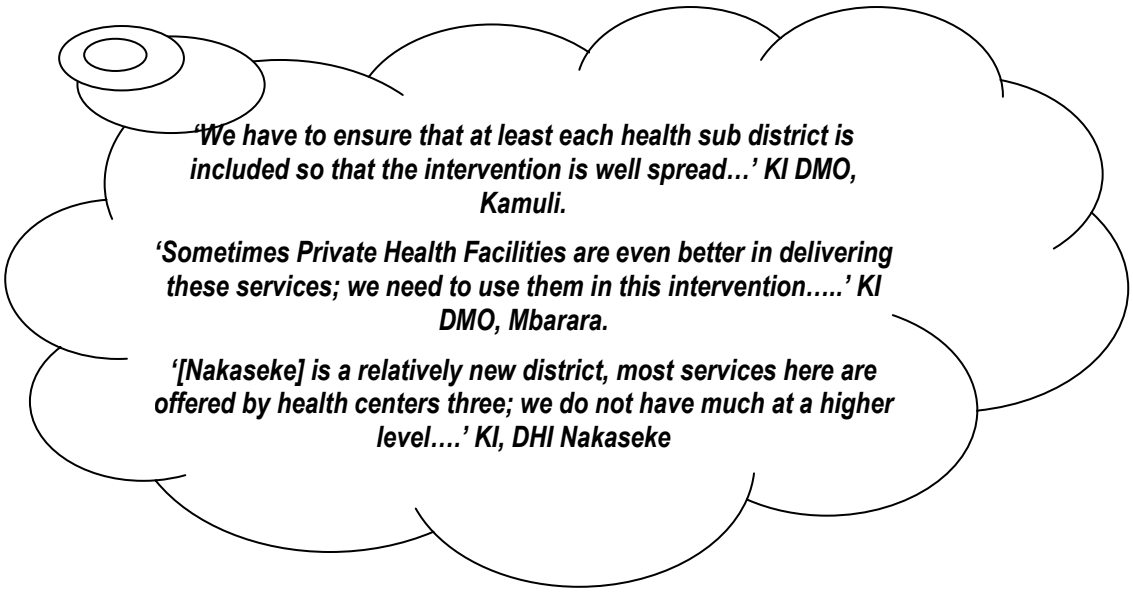
a) Advocating for a rights based approach to the policy environment to lead to enhanced demand for quality services through research, policy analysis and strategic communication
b) Strengthening UNHCOs institutional capacity to deliver its mandate of quality health services for all Ugandans.
c) Strengthening consumer redress and feedback mechanisms through functional networks and structures.
d) Improving health care provider's responsiveness to consumers' needs through information sharing on health rights and health policy related issues.

e) Promoting the right to health through providing leadership, coordination and capacity building of CSOs.

2.4 Selection of Baseline Areas and Intervention Health Units

UNHCO's main goal in selecting the baseline areas was to select entry points and areas where the intervention would be most relevant and therefore have the potential to exhibit a positive change amongst both providers and consumers. The research team interfaced with the district medical office and the district planning office in each of the three intervention districts to rationalize the specific sub-counties and health units.

- The purpose of interfacing district officials was to create an opportunity for constructive engagement that would benefit both program implementers and beneficiaries. The other important aspect of the interface was to cultivate a sense of ownership and stake in the activities that UNHCO was to implement. The selected health units would be used for both a baseline and intervention entry points in the selected districts.



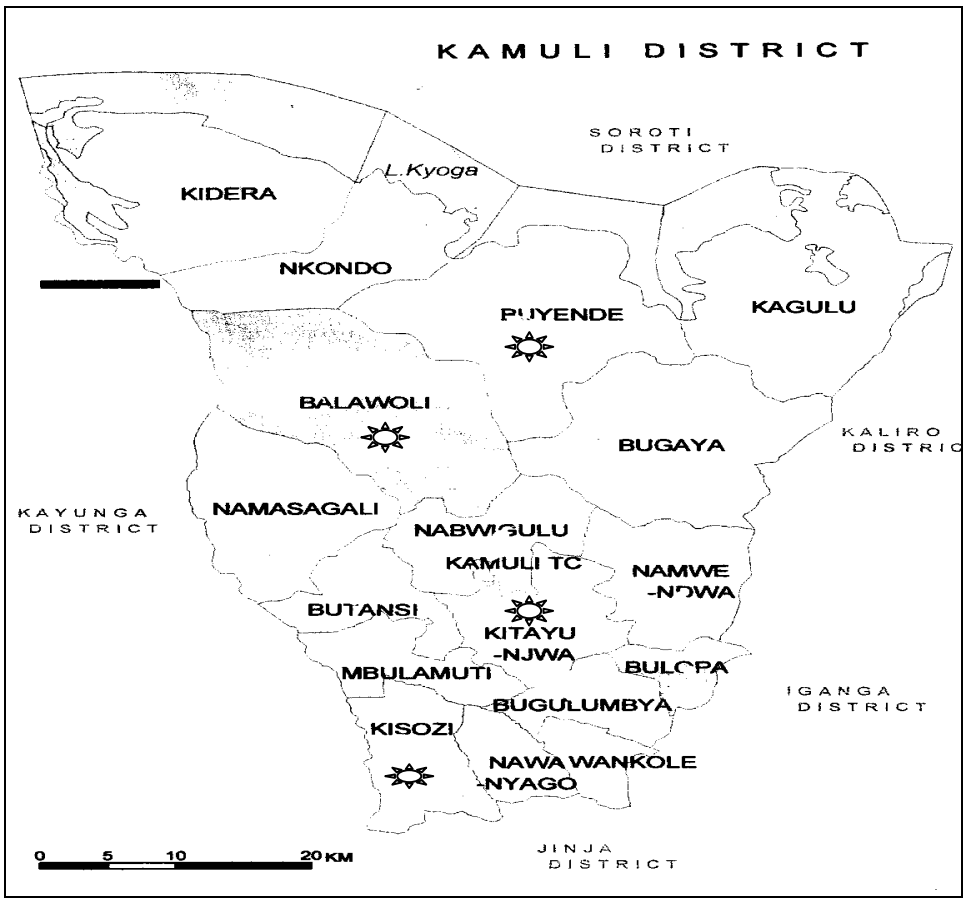
The main criteria used in the selection of health facilities were developed with the district officials and included:

- Spread of health facilities across the sub-counties or health sub-districts.
- Whether the health facility offered maternal health services including PMTCT.
- The need to capture various levels of health service delivery, in terms of levels of health facilities.
- The need to capture private and public health services providers and facilities.
- Performance on maternal health services delivery.

2.4.1 Selected Sub Counties/ Health Units in Kamuli District

Kamuli has four health sub-districts; from each, one health unit was chosen. The other selection considerations were level of service delivery and category of service provider. The chosen health units were Nankandulo HC IV, Buyende HC III, Balawoli HC III and Nabisambya HC II, which is private. The map below shows the relative locations of these health facilities within the district.

Map 1: Location of Selected Entry Point Health Units in Kamuli District



Key: ☼ Selected Sub-County Location of Entry Point Health Unit.

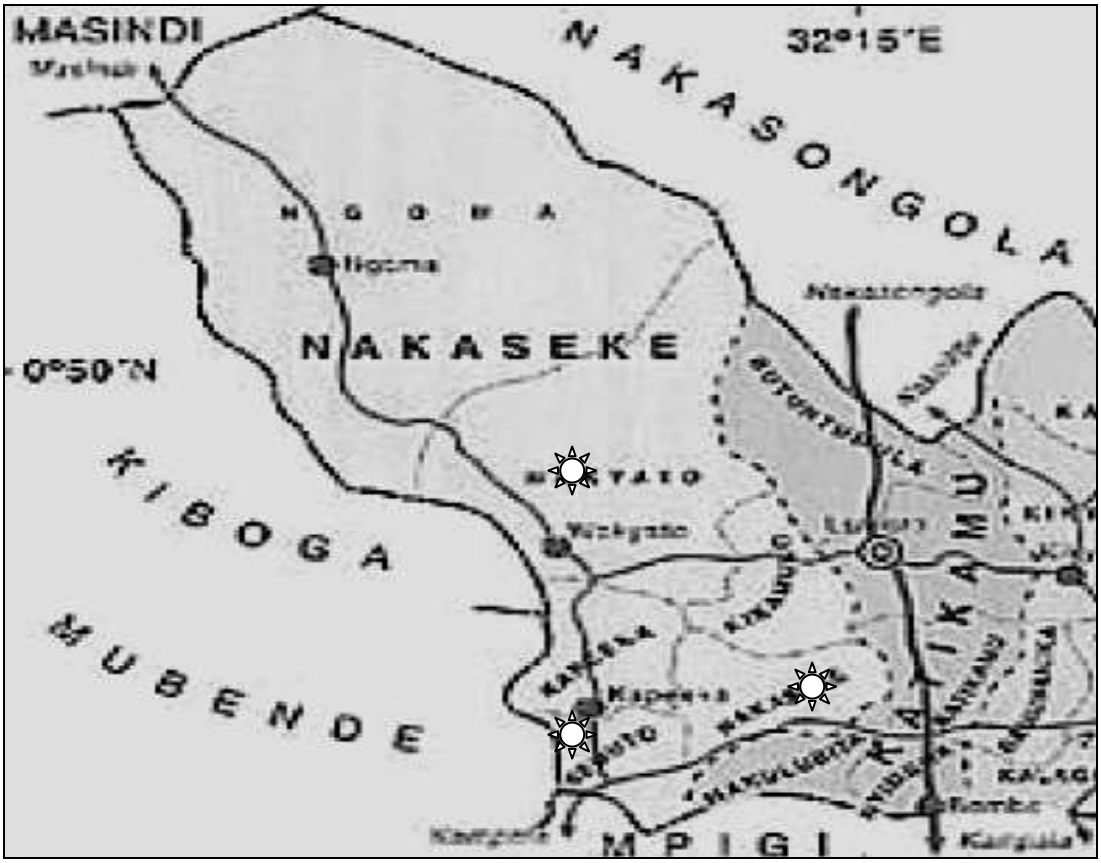
The baseline team found all the selected units to have reasonable intervention conditions as stipulated in section 2.4. The relative distances to the selected health units are shown below:

1. Nankandulo (HC IV): Located about 15Kms off Kamuli Road at Buwenge, which is about 20Kms from Jinja Town.
2. Buyende (HC III): Located about 48Kms from Kamuli Town in Budiope at Buyende Sub County Headquarters.
3. Balawoli (HC III): Located about 10 Kms from Kamuli Town at Balawoli Sub County Headquarters
4. Nabisambya (HC II): Located about 3 Kms off Kamuli-Jinja road at Kitayunjwa Trading centre in Kitayunjwa Sub County. This is private and operated by Church of Uganda, Busoga Diocese.

2.4.2 Selected Sub Counties/ Health Units in Nakaseke District

This is a relatively new district, considered remote in terms of the geographical spread of the health services delivery infrastructure and the general sparse distribution of the population. All health units selected in this district were at level health center III (HCIII) and were government health centers. The baseline visited 5 HCIII's with the intention of choosing the best three to include in the intervention. Kikamulo HCIII and Kilema HCIII were not recommended for inclusion in the intervention. Kikamulo HCIII is close in proximity to Kiwoko Hospital, which has a very high level of service delivery, almost at referral hospital level. Kikamulo HCIII also does not offering PMTCT. Kilema HCIII shares the same catchment area as Kapeeka HC III, yet the latter has better services and a higher turnout.

Map 2: Location of Selected Entry Point Health Units in Nakaseke District



Key: ☼ Selected Sub-County and Location of Entry Point Health Unit.

1. Kapeeka (HC III): Located in Kapeeka Sub County about 43 Kms from Luwero town
2. Bidabugya (HC III): Located in Kasangombe Sub County about 23 Kms from Luwero town
3. Wakyato (HC III): Located in Wakyato Sub County 23 Kms from Luwero town

2.4.3 Selected Sub Counties/ Health Units in Mbarara District

In Mbarara the selection considered levels of service delivery and a balance between private and public providers. A total of five sites were visited, but upon visitation, Bwizi-Bwera HC IV was deemed inappropriate because it has several projects similar to UNHCO's intervention, including those under Mulago and Mbarara hospital joint initiatives. This scenario would create confusion about attribution of impacts and create duplication of services. Biharwe HCIII was also considered inappropriate because of low turnout levels. St. Josephs Rubindi and St. Johns Biharwe, although private, should be evaluated since they have relatively high levels of turnout. Although these two health centers are considered to have a ranking of HCII, the level of service delivery was comparable to HC III.

'…ranking of HC1, HC2, or HC3 and so on depends on the levels of financing that the government gives but does not necessarily reflect level of service delivery especially among private facilities where many are graded as HC2 although the level of service is often equivalent or even better than the government HC3…'

KI DMO, Mbarara.

Map 3: Location of Selected Entry Point Health Units in Mbarara District

Key: ☼ Selected Sub-County and Location of Entry Point Health Unit.

1. St. Josephs- Rubindi: Located in Rubindi Sub county about 2Kms off Ibanda road at Rubindi Town, which is 25Km from Mbarara town. This is private and operated by the Catholic Church.
2. Ndeija (HC III): Located in Ndeija Sub County about 1Km off Kabale Road at Ndeija Trading Center which is about 45Km from Mbarara town.
3. St. Johns-Biharwe: Located in Biharwe Sub County about 0.5Kms from Biharwe Town which is 5 Kms from Mbarara Town on Masaka Road. The Uganda Protestant Medical Bureau, under the Province of the Church of Uganda, operates it.

Note: Although these were baseline sites, UNHCO can use the same criteria to incorporate additional partner health units, as permitted by available implementation resources. One cross cutting observation was the chronic lack of staff in government health facilities. However, both government and private health facilities had poor quality facilities. There was a lack of shade for clients waiting for services, many facilities had overgrown bushes in the compound, some labeled as HCIII could not admit patients, and some had no maternity wards, such as Biharwe HC III. It should also be noted that the selection criteria varied by district because of varying demographic and health profiles. Additionally, the district key informants had differing perspectives on health requirements for their areas.

3.0 Baseline Results

3.1 Empowerment Indicators

Community Utilization of Health Services:

Increased community utilization of health was measured using patient/ client turnout levels. This method was chosen because it is readily verifiable from the patient records at the various health facilities and can be periodically monitored by program implementation staff. The survey team found reasonable record keeping at the health facilities that can facilitate monitoring of this indicator.

- Review of records and key informant interviews showed that in Mbarara, patient turnout averaged 10 patients on ordinary days to over 30 patients a day on immunization and first time antenatal days. In Kamuli and Nakaseke, where there were no specific antenatal days, there were no turnout peak days of patients. The health facilities sampled in these two districts averaged 8 patients on a daily basis. It should be noted that on Saturdays and Sundays it is almost impossible to find health workers, especially in government facilities. In instances where health workers are residents of the facility, they do not open for normal service delivery on the weekends although they are supposed to serve as the need arises.
- Using statistical inferences, the above finding implies a monthly turnout of 220 patients per health facility if a working week of 7 days is used in the determination. This produces an annual turnout per health facility of 2,640 patients. Given that the UNHCO program aims to achieve a 10% increase of community utilization of health services over the next three years; annual increases of about 3.4% in patient turnout have to be sustained throughout the implementation period. This result means that each health facility will need to increase its patient turnout by 89.8 new patients annually to help UNHCO achieve the 10% improvement in utilization over the next three years.
- ***Community Leaders Able to Advocate for Quality Health Care and PMTCT Services:***

The baseline team found that this indicator is dependant on the knowledge of the community leaders, their attitudes, and their eventual practices. It was also apparent that although UNHCO directly influences community leader and member's knowledge, there is not a clear way of influencing attitudes and practices. However, the intervention will seek to use these community leaders as change agents in the community to achieve a multiplier effect of changing perspectives on quality health care and PMTCT services.

The only measurable aspect of community leader's knowledge was their ability to appreciate (understand and articulate) the importance of quality health care and PMTCT. Aggregate analysis of key informant interviews and focus group discussions revealed that out of the 26 total community leaders included in the study, only 5 readily appreciated (understood and articulated) the importance of quality health and PMTCT services. This implies that at the time of the baseline, 19% of community leaders were capable of advocating for quality health care and PMTCT services based in their awareness of the importance of quality health and PMTCT.

Awareness of Quality Issues/ Aspects:

Women's awareness of the quality aspects of healthcare services was determined by directly asking the female health consumers during the individual interviews whether they had received quality health services. The rapid appraisal results from the individual interview showed that 78% of the female respondents attested to receiving quality maternal health care services. However, further qualitative review of the specific responses on their understanding of quality health services and the attributes of quality health services revealed that awareness levels were extremely low (13.5%).

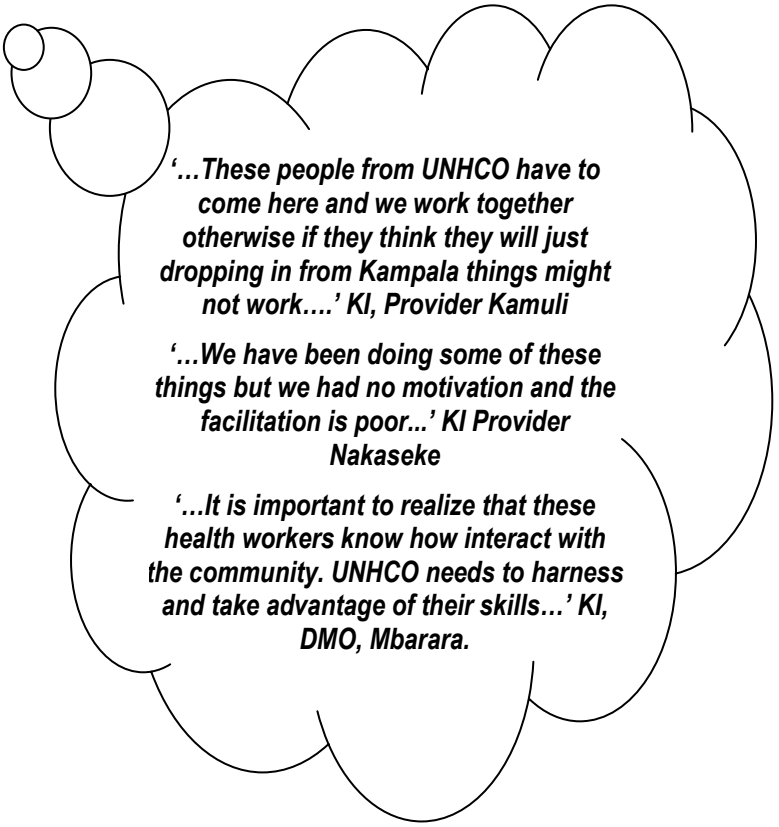
This statistic was determined by establishing the commonly mentioned attributes from the responses; including drug stock outs, waiting periods, and ethical conduct of service providers. Re-examination of the responses for these three commonly mentioned quality aspects showed that in the FGDs, only 2 out of every 13 community members (15%) were accurately aware of quality issues. The two results above (13.5% and 15%) show different scenarios: 13.5% is the knowledge and awareness level amongst

women while the 15% shows the knowledge and awareness level of the community. The indicator is almost the same but reflects a variation in awareness when viewed in different contexts.

Baseline Summary 1

Indicator	Baseline
10% increase of community utilization of health services.	Average annual patient turnout per health facility (community utilisation of health services) is 2,640 patients.
40% of community leaders able to advocate for quality health care and PMTCT services	Out of the 26 community leaders included in the baseline only 5 (19.2%) were able to understand and acknowledge the importance of quality maternal health and PMTCT services; and, therefore able to advocate on these issues.
40% of women aware of quality aspects of health services	Awareness averaged 13.5% on the basis of tracking for three quality aspects (waiting periods, drug stock outs and ethical conduct by providers).
40% of community members aware of quality issues	15% of the community members involved in the survey were found to be knowledgeable on quality issues

3.1.1 Risks and Assumptions on Empowerment Indicators



This section highlights the factors that will affect achievement of the empowerment indictors and also points out the opportunities for enhancing performance on these indicators. The range of intervention activities to be undertaken by UNHCO vis-à-vis what the intervention partners are offering will affect achievement of the empowerment indicators.

According to the documents reviewed, there is a disparity apparent which includes the UNHCO program proposal and schedule of activities in relation to the nature of services offered by the various probable implementation partners. This is elucidated by the result below. Consumers discussed what would help to stimulate increased community utilization of health services.

The result showed that UNHCO would have a strong influence on several factors that will determine performance on empowerment indicators. For example, the level of provision of information about health rights and responsibilities in local languages is currently rated at 14.6% (Table 2). This factor can be strongly influenced by UNHCO whereas the other factors such as availing drugs, improving availability of health workers, and improved equipping of health centers will be influenced by partners (entry point health facilities and community leaders). The result highlights a risk, embedded in the level of control UNHCO has on the process factors that will determine performance on these indicators. UNHCO has an opportunity to make partnerships an important element of its strategy, especially with the directorate of health services at the district level. Functional and mutually beneficial partnerships will require constant communication and effective management of expectations. UNHCO must lobby for the local government to honor its obligations in the intervention areas.

Table 2: Factors That Can Lead to Increased Utilization of Health Services

What is Needed to Better Access Maternal Health and PMTCT services (Analysis of Multiple Mentions)	District							
	Mbarara		Kamuli		Nakaseke		Total	
	n	Col%	n	Col%	n	Col%	n	Col%
Provision of information in local languages	10	10.5	19	20.9	2	7.4	31	14.6
Avail Drugs	21	22.1	17	18.7	6	22.2	44	20.7
Introduce Mama kit/ Give mosquito nets	16	16.8	1	1.1	0	0	17	8
Well equipped health centers	24	25.3	17	18.7	9	33.3	50	23.5
Improved availability of health workers	24	25.3	37	40.7	10	37	71	33.3
Total	95	100	91	100	27	100	213	100

In the intervention, UNHCO will work with entry point health facilities that health consumers feel have a host of problems regarding service delivery (Table 3). Health consumers frequently highlight unethical behavior and corrupt tendencies as two of the biggest problems. At a qualitative level there were accusations of health providers selling services that are supposed to be free as well as a general lack of trust in the manner in which they operate, especially those in government health units. This waning confidence is a risk UNHCO must properly manage. However, UNHCO must ensure that it is not perceived as interfering by working closely with both communities and health workers in order to build confidence and sustain improvement in utilization of health services and other empowerment indicators.

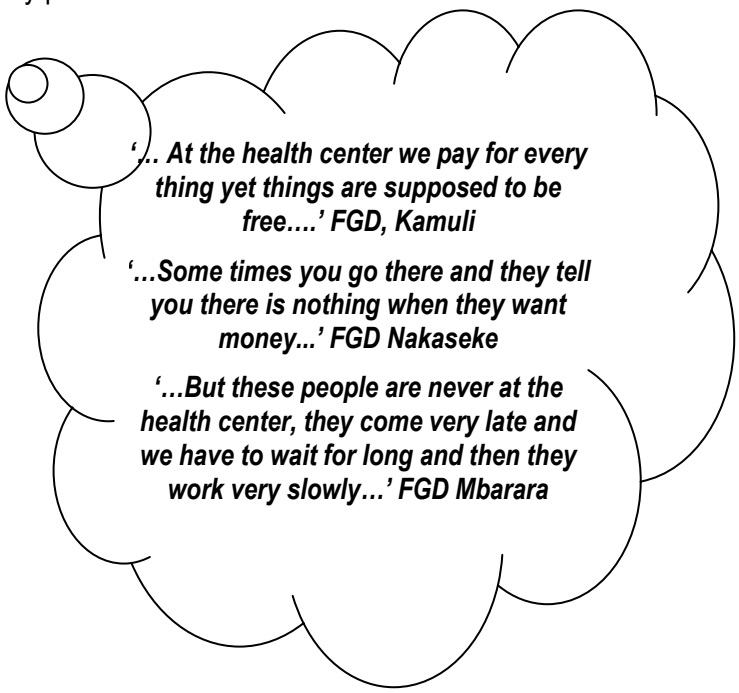


Table 3: Reasons Why Respondents Felt They Do Not Get Quality Maternal Health Services

Reasons Why Respondents Felt They Do Not Get Quality Maternal Health Services	District							
	Mbarara		Kamuli		Nakaseke		Total	
	N	Col%	N	Col%	n	Col%	n	Col%
Lack of drugs/sufficient services/equipment/facilities	13	59.1	12	70.6	12	75	37	67.3
Long waiting/Many patients/Delay in services	2	9.1	3	17.6	1	6.3	6	10.9
No doctors/No or few nurses	2	9.1	2	11.8	2	12.5	6	10.9
Unethical health workers	5	22.7	0	0	1	6.3	6	15.9
Total	22	100	17	100	16	100	55	100

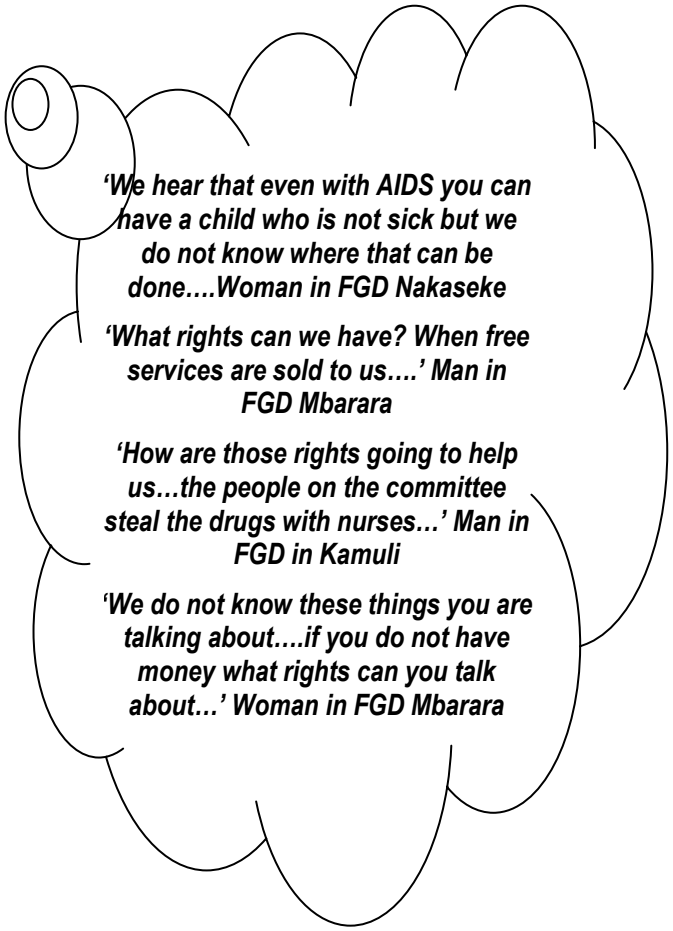
3.2 Advocacy Indicators

CBOs/CSOs Capable of Advocating for better Health Policies:

Advocacy forms a strong element of the planned interventions under this program. The baseline established that across all three districts there are hardly any Community Based Organizations (CBOs) and/ or CSO that have specific interventions inline with the UNHCO program. Therefore the indicator of 20 CBOs or CSOs capable of advocating for better health policies and practices will more or less be measured from zero. However, it should be noted that there were isolated mentions of Mothers Union and Mulago- Mbarara Joint HIV/AIDS Project in Mbarara, TASO in Nakaseke, and Plan International and an innovation termed Village Health Team in Kamuli, also initiated by Plan International.

Functional District Network:

The baseline team found no evidence of district level networks. District officials indicated that they would welcome such a network, especially of consumers, although specific mobilization would have to be undertaken to create it. The only existing network in the three districts is the district health management team (DHMT), which is an umbrella coordinating initiative with persons from civil society in addition to regular district staff and district council officials. UNHCO envisages this team will be the end user of reports developed by the proposed district network. The best entry point would be to have a formal launch ceremony for the program in each of the districts. This would not only mobilize awareness but also bring on board several local actors in the health sector of each district that can form the backbone of such a network.



General Public Awareness of PMTCT Services and Health Rights and Responsibilities

The rapid appraisal and focus group discussions were used to establish the general public awareness of health rights and PMTCT services. The indicator was initially split to separate awareness of PMTCT services from awareness of health rights. The rapid appraisal, which covered mainly women (men comprised only 11.7% of the individual interviews), showed that the general level of awareness of PMTCT services was 63%, and was highest in Mbarara (75.6%), followed by Kamuli (65.7%) and lowest in Nakaseke (45.6%) while knowledge of health rights was at an overall average of 46.8%; and was highest in Nakaseke (52.9%), followed by Mbarara (48.7%) and least in Kamuli at 38.9% as shown in the Table below.

Table 4: Knowledge of PMTCT and Health Rights

Analysis of Yes Responses Only (Percentages are Calculated out of 216 respondents)		District							
		Mbarara		Kamuli		Nakaseke		Total	
		n	Col%	n	Col%	n	Col%	n	Col%
Ever Been Sensitized about PMTCT?	Yes	59	75.6	46	65.7	31	45.6	136	63
Know your health rights?	Yes	38	48.7	27	38.6	36	52.9	101	46.8
Ever Accessed PMTCT Services?	Yes	7	9.0	10	14.3	9	13.2	26	12.0

When the same questions were poised to the FGD participants; responses showed that only 2 out every 10 FGD participants were confident that they knew about PMTCT, while only 3 out of every 10 participants were confident that they knew about their health rights. Public awareness on health rights (30%) and PMTCT (20%) is generally low, although knowledge levels are higher among women of childbearing age who have visited a health facility seeking maternal health care.

PMTCT and Health Rights and Responsibilities Prioritized on the District Health Agenda

Review of the district strategic plans, including the sections on improved delivery of health services, did not reveal PMTCT to be high on the agenda, however, there was continual reference to the reduction of maternal and infant mortality levels.

Qualitative interviews with providers and district level Key Informants (KIs) clarified that PMTCT is a definitive strategy in achieving improved maternal and child survival rates. Health rights and responsibilities however, were not high on the agenda and it was revealed that they are generally viewed as crosscutting. Providers claimed that all initiatives in the health sector are aimed at respecting and promoting health rights and responsibilities. Consumers on the other hand had no clear conceptualization of health rights and responsibilities.

'We have some of the rights pinned on the wall but we never prompt people to read and understand them….' KI Provider Kamuli

'PMTCT is a standard, we now have to provide it…it is high on the agenda…it's only the roll out that is giving us a hard time…' KI DMO Mbarara

'PMTCT is offered by nearly all our health facilities at least from HC III…' KI DMO Kamuli

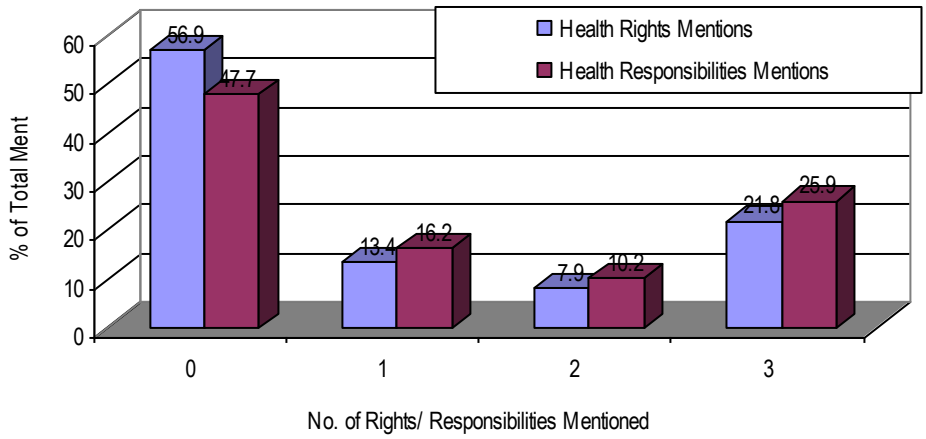
'When people come and we give them services we are respecting their rights…' KI Provider Nakaseke

'…. but we respect their rights all the time; every thing we do is respecting rights…' KI Provider Mbrarara

Awareness of at least Three Health Rights and Responsibilities

Awareness of at least three health rights and responsibilities was established during the individual interview of health consumers by asking them to mention any three health rights and responsibilities of which they were aware. Results show that awareness of at least three health rights was 21.6% and that awareness of at least three health responsibilities currently was 25.9% (Figure 1).

Figure 1: Levels of Mention of at least 3 Health Rights/ Responsibilities



Baseline Summary 2

Indicator	Baseline
20 CBOs/CSOs in each district capable of advocating for better health policies.	There are few CBOs and CSOs involved in promoting Maternal Health and PMTCT, Health rights and responsibilities, and functional feedback mechanisms.
One functional district network that advances health issues to the District Health Team (DHT) on a quarterly basis	No such networks exist. UNHCO will have to initiate this effort from scratch in all the three districts
HRR and PMTCT prioritized on the district health agenda	PMTCT is already high on the district health agenda. HRR are not high on the agenda and are not looked at independently but rather as cross cutting.
40% of the general public aware of their health rights	Awareness of health rights is 30%; though women who have previously sought maternal health services are comparatively more aware.
40% of the general public aware of PMTCT services	Awareness of PMTCT is 20%; though women who have previously sought maternal health services are comparatively more aware.
40% of community members aware of at least three health rights.	Awareness of at least three health rights currently stands at 21.6%
40% of community members aware of at least three health responsibilities	Awareness of at least three health responsibilities currently stands at 25.9%
60% of women of reproductive age (13-50) empowered to use PMTCT	The rate of access to PMTCT services by women of reproductive age was found to be 12%.

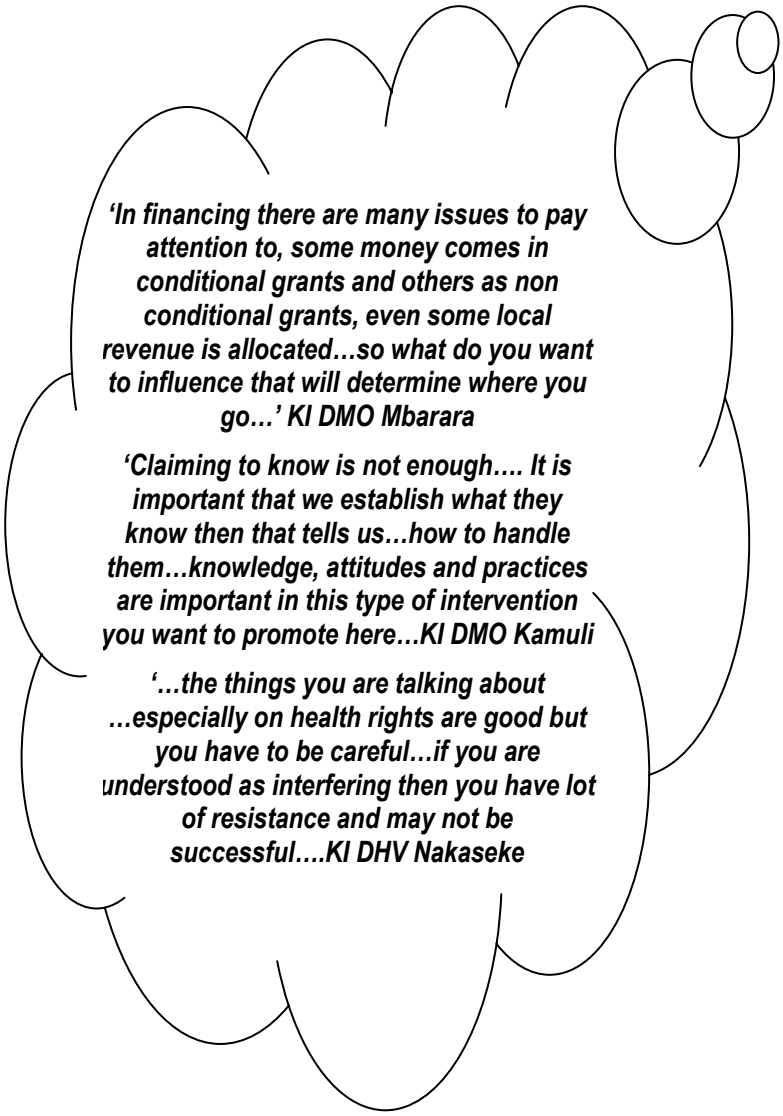
3.2.1 Risks and Assumptions on Advocacy Indicators

The baseline team established that the district budget committee, which relies on the district-planning unit, determines local government budget allocations. The district council also debates these proposals. However, most district financing is in the form of grants from the Central Government. The Ministry of Finance, Planning and Economic Development provides input through the local government budget framework workshops, which are held annually in conjunction with the Uganda Local Governments Association. These are all actors critical to this process.

The baseline research team felt this was a complicated issue to influence and therefore the indicator on budgets is recommended for removal. However, if UNHCO prefers to continue with this indicator the budget allocations for fiscal year 2006/2007 should be used as bench marks to measure change.

The performance of the other UNHCO advocacy indicators (baseline summary 2) is determined by the level of qualitative appreciation (understanding and acknowledgement) of the various stakeholders. This is demonstrated by the results on knowledge of health rights and responsibilities.

The statistic obtained when asking people whether they know health rights and responsibilities is quite misleading; one would think a reasonable proportion of people know about HRR and therefore UNHCO has no reason to intervene. However, review of actual knowledge of those who at least readily knew any three HRR highlights an inadequacy: consumers hardly knew their health rights and responsibilities. This observation embodies a key lesson from the baseline process: it is important to determine what the numbers are showing versus the actual knowledge of the communities.



Establishing a functional district level network is a strategic approach and although generally agreeable to most respondents, it must be handled carefully because there is great risk of political hijacking. It is important that the aims and intents of the district level network are well articulated because the districts have various stakeholders beyond those reached by the baseline. The perception of such a network as being intrusive instead of championing the cause of providers and consumers can be problematic.

3.3 Support Indicators

Support indicators generally focus on health facilities and health providers. The first group of support indicators was written in an aggregated manner combining awareness of quality standards and patients' health rights. These indicators were disaggregated to reflect awareness of quality standards separate from patients' health rights for ease of measurement and tracking.

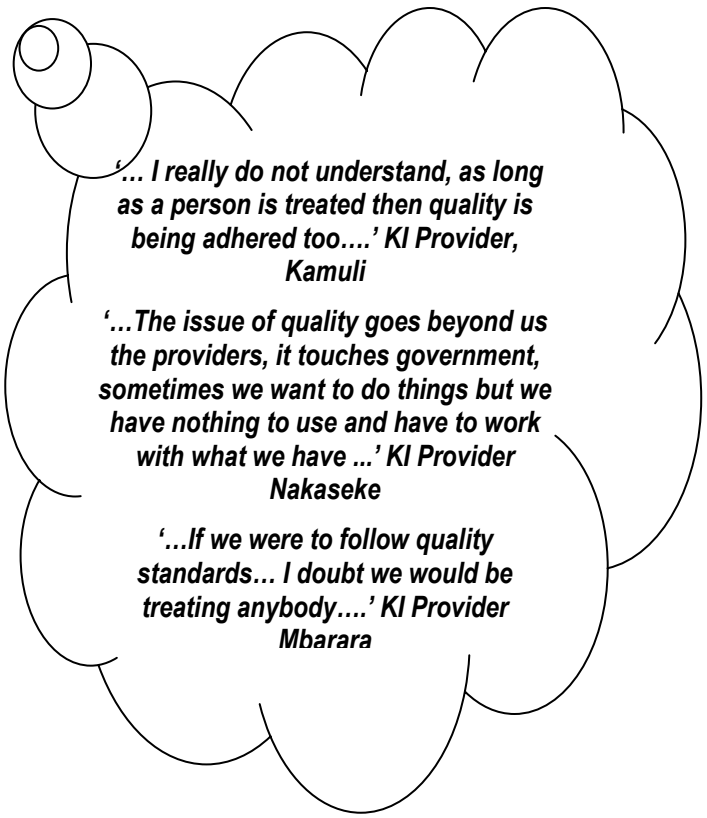
Awareness of Quality Standards Amongst Health Workers:

Providers were asked about their understanding of the concepts of quality maternal health and PMTCT services. Overall, three outstanding issues were mentioned by the providers as key attributes of quality standards. These were adequate equipment and accessories, (51.1%), provision of information to patients in terms of diagnosis and alternatives (24.5%) and access to adequate and qualified staff (11.1%). The variation by district is shown in Table 5. More generally, only 25% of the health workers interviewed had a holistic understanding of quality standards.

Table 5: Understanding of Main Attributes of Quality Maternal Health and PMTCT

What Providers Understood as Main Attributes of Quality Maternal Health and PMTCT services	District			
	Mbarara	Kamuli	Nakaseke	Total
	Col %	Col %	Col %	Col %
Adequate equipment and accessories	42.1	50	62.5	51.1
Accessibility in terms of short time spent at centre	15.8	0	6.3	8.9
Access to qualified/adequate staff	21.1	10	0	11.1
Non segregation/ Proper handling of patients	5.3	10	0	4.4
Provision of information (diagnosis and alternatives)	15.8	30	31.2	24.5
Total	100	100	100	100

The above results on quality standards shows a non-holistic understanding of quality standards. The awareness is narrow and reflects a clear gap among the providers in appreciating the range of quality standards in health services delivery. This was also apparent when providers were asked whether they felt they offered quality maternal health and PMTCT services; those answering in the affirmative averaged 51.5%, highest in Nakaseke (54%) while Mbarara and Kamuli were equal at 50%.



Awareness of Patient Health Rights and Responsibilities Amongst Health Workers:

The level of awareness of health rights and responsibilities amongst providers was tested by asking them to list any three health rights and any three health responsibilities. Results show health providers are aware of a number of health rights (Table 6). Most outstanding in awareness is respect for individual patients (16.8%), closely followed by the patient's right to information about their health (15.8%).

It should be noted that although providers are aware of these issues, they are not taken as critical aspects of health services delivery. These issues are therefore not considered to have the same conceptual meaning and importance in implementation as in the UNHCO intervention paradigm. This critical gap shows the need to re-orient thinking about these issues. The belief that providers are doing the consumers a favor needs to change, and the consumers have to realize that they have entitlements.

Table 6: Readily Mentioned Patient Health Rights by Providers

Readily Mentioned Patient Health Rights by Providers	District			
	Mbarara	Kamuli	Nakaseke	Total
	Col%	Col%	Col%	Col%
Respect for individual patients	21.4	4.2	20.7	16.8
Rights to receive equal treatment	11.9	4.2	10.3	9.5
Right to optimum treatment	16.7	8.3	6.9	11.6
Right to participate in treatment	0	0	6.9	2.1
Right to privacy	7.1	25	13.8	13.7
Right to know and get information about their health	16.7	20.8	10.3	15.8

Right to safety	7.1	12.5	0	6.3
Right to quality treatment	11.9	0	24.1	12.6
Right to choose treatment	7.1	25	6.9	11.6
Total	100	100	100	100

When asked about health responsibilities, providers were most aware of the cooperation and compliance expected of patients in the course of treatment (28.4%), followed by provision of accurate and complete information on health history (19.8%) (Table 7).

Table 7: Readily Mentioned Patient Health Responsibilities by Providers

	District			
	Mbarara	Kamuli	Nakaseke	Total
Readily Mentioned Patient Health Responsibilities by Providers	Col%	Col%	Col%	Col%
To provide accurate and complete information to providers	11.1	36.4	17.4	19.8
Cooperate and comply on treatment given and follow up action	27.8	13.6	43.5	28.4
Fulfill financial and contractual obligations	11.1	9.1	0	7.4
Follow rules and regulations of the health facility	16.7	13.6	8.7	13.6
Avoid personal injury and harmful behavior	2.8	0	0	1.2
Support the health care system and institution	5.6	0	17.4	7.4
Accept all preventive and curative measures sanctioned by law	2.8	22.7	4.3	8.6
Understand conditions, limitations and consequences	8.3	4.5	0	4.9
Respect the rights and well being of others	13.9	0	8.7	8.6
Total	100	100	100	100

Compliance (respect) to both Quality Standards and Health Rights and Responsibilities:

It should be noted that these health rights and responsibilities were not known and mentioned in the same manner that UNHCO presents them. The responses were more elaborate and interviewers had to discern meanings and implications in order to pick options on the pre-coded response form. Both results (Table 6 and 7) on patients health rights and responsibilities, show a one sided view of health rights and responsibilities. Providers tended to pay more attention to the aspects of patient health rights and responsibilities that facilitated their work and enhanced their ability to accomplish their tasks but were not knowledgeable on aspects of HRR that directly concerned patients. 32.9% of health consumers felt that overall, their rights were not respected. This belief was highest in Mbarara (42.3%), followed by Nakaseke (40.0%) and Kamuli (14.7%).

Health Unit Management Committees:

In terms of functional Health Unit Management Committee (HUMCs), the UNHCO program anticipates an intervention to change feedback mechanisms and empowerment to plan and monitor health facility services delivery. Most FGD participants were unaware of the existence of HUMCs and were therefore uneducated about their functions. In the health units surveyed, there was a clear sense of HUMCs as non-functional entities that occasionally meet and are elusive; only coming into action on national occasions including immunization days or the visit of a dignity.

To clarify this observation, health consumers were asked whom they contacted in the event that they desired to submit an opinion on health services delivery. In the response, 32% answered 'other patients' (Table 8). Kamuli respondents showed a unique difference, with a rating of 44.4% for HUMCs. According to Key Informant (KI) interviews, the response in Kamuli is a result of numerous interventions Plan International has initiated across the district; making HUMCs in this district very active.

Table 8: Usual Ways of Voicing Opinions about Health Services Delivery

How Respondents (health consumers) Usually Voice their Complaints about Health Services Delivery	District			
	Mbarara	Kamuli	Nakaseke	Total
	Col %	Col %	Col %	Col %
Approached person in-charge	16.7	22.2	0	16
Left a note in a suggestion box	25	0	0	12
Contacted Service Provider/ Nurse	16.7	0	25	12
Contacted Community Leader outside Health Facility	8.3	11.1	0	8
Contacted the HUMC	8.3	44.4	0	20
Talked to other patients about it	25	22.2	75	32
Total	100	100	100	100

The prevalence of complaints on health services delivery was found to be generally low (15.9%, n=33) across all three districts. The average mentions of issue resolution were 60.6%, not including Nakaseke. This result needs to be accurately interpreted, especially if examined in relation to the above result (Table 8).

There is a lot of ignorance among consumers about what to do with complaints. It should not be assumed that there is a functional system for complaints; qualitative evidence from focus group discussions suggested a high level of fear over issuing complaints. The UNHCO intervention on health rights and responsibilities would be beneficial and critical to this indicator.

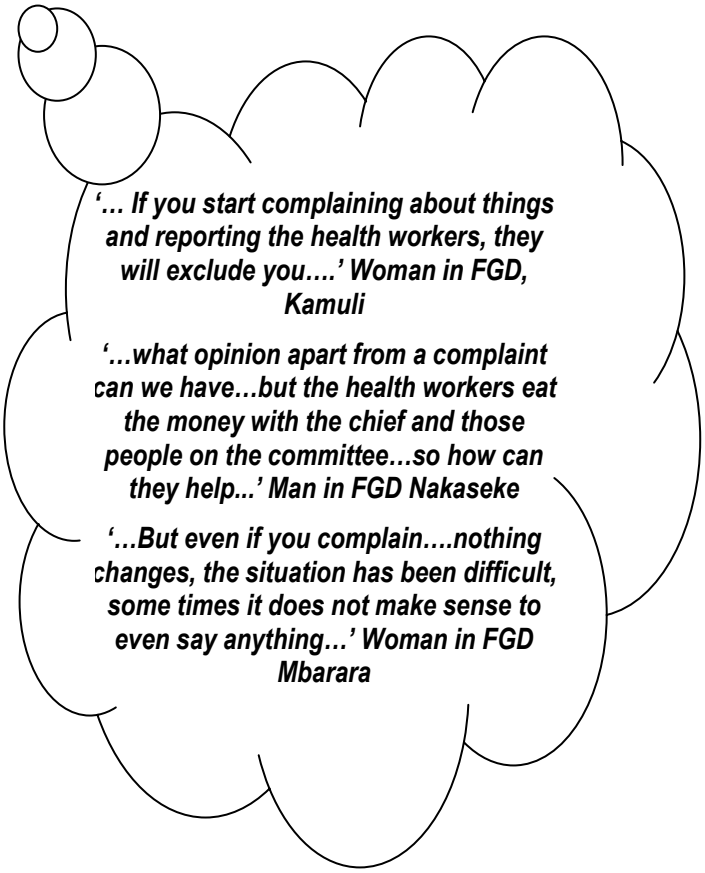
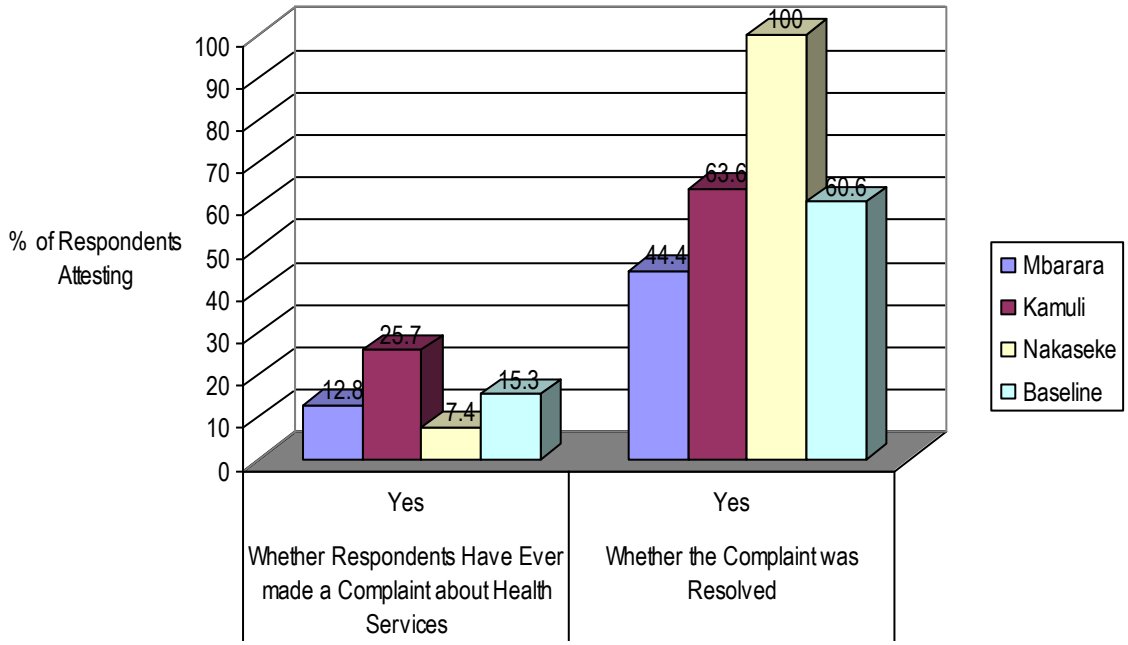


Figure 2: Prevalence and Rate of Resolution of Complaints



Baseline Summary 3

Indicator	Baseline
50% of the health workers in the districts of operation aware of quality standards and patients health rights, and respect them	Awareness of quality standards amongst health workers is not holistic; emphasis is put on a few aspects (only 25% of health workers had a holistic understanding of quality standards). Awareness of patient health rights and responsibilities amongst health workers is selective and skewed to aspects that enhance their work (only 31% of the health workers interviewed had a balanced understanding of health rights and standards). From a consumer perspective, compliance (respect) to both quality standards and health rights and responsibilities is modest. For health rights and responsibilities it is 32.9% while for quality standards it is 67.1%.
50% of health facilities with functional HUMCs	Most HUMCs exist but are generally dormant and it was not clear to what extent they influenced planning and monitoring.
At least 20% of complaints brought to the attention of health centre should be addressed	The prevalence of complaints is 15.6% while the resolution rate of those complaints is 60.6%. Qualitatively, there are high levels of ignorance regarding what should be done when the need to complain arises.

3.3.1 Risks and Assumptions on Support Indicators

As pointed out earlier, from an interventionist perspective, advocacy indicator awareness concerns not the numbers claiming to be aware but what those numbers are aware of, i.e. what the people surveyed know and how that translates into rights and improved quality of services. A similar situation pertains to health workers with regards to quality standards, health rights and health responsibilities. It should be noted that achievement on the support indicators strongly depends on the extent to which mutual working partnerships are established within the entry point health units. There is a strong need for UNHCO to be seen and understood not as an intrusive but a facilitating entity seeking to bridge the gap between consumers and providers.

The baseline established that there is little demand amongst consumers for the services of HUMC that directly concern them. Only 15.3% of the consumers involved in the rapid appraisal expressed ever wanting to raise an opinion about health services delivery (Table 9). This result shows a lack of appreciation for the importance of interfacing amongst providers, HUMCs, and consumers. This implies that performance on indicators concerning feedback mechanisms will therefore be achieved by influencing both the HUMCs and consumers instead of just one of them. The result by district is shown below.

Table 9: Demand for Functional Feed Back Mechanisms

Whether Respondents Have Ever Wanted to Make a Complaint about Health Services	District							
	Mbarara		Kamuli		Nakaseke		Total	
	n	Col %	n	Col %	n	Col %	n	Col %
Yes	14	17.9	13	18.6	6	8.8	33	15.3
No	64	82.1	57	81.4	62	91.2	183	84.7
Total	78	100	70	100	68	100	216	100

The indicator on prevalence of complaints and rate at which complaints are attended should be carefully watched. This critical indicator will highlight effectiveness of the UNHCO intervention on the side of both the provider and consumer.

4.0 Key Conclusions and Recommendations from Baseline

This baseline provided a unique opportunity to interact with both providers and consumers of health services in UNHCO's proposed intervention areas of maternal health and PMTCT. This section gives the key emerging issues and recommends actions that will help UNHCO contribute to improved maternal health and utilization of PMTCT services through the rights based approach.

1. Through its sensitization programs, UNHCO has crafted an innovative way of fostering a mutually rewarding relationship between providers and regular consumers of health services. The appropriateness of this intervention lies in its capacity to bridge health consumers' needs and expectations with capacity of the health system. There is no better time for this intervention than in this era of fast changing health conditions, especially in the face of HIV/AIDS. There are serious needs for this intervention to be implemented in the selected intervention districts and sub counties.
2. The indicators put forward in the project log frame were generally aggregated, often combining two or three separately measurable issues; this has been responded to at this level of baseline. The indicators have been split and aligned in a measurable manner. However, given that this intervention is strongly based on knowledge, attitudes and practices, the need for meticulous periodic monitoring for information that can guide management and implementation decisions is a challenge. This calls for an organized and functional monitoring and evaluation (M&E) framework within UNHCO. It is thus recommended that:
    2.1. Careful revision of the baseline by the UNHCO implementation team to set annual milestones to guide the realization of overall positive performance on all indicators.
    2.2. Integrate the rights based approach into national and district level health policies. UNHCO has broken ground on health and human rights and consumer empowerment and participation including initiation of the patients charter. However, considering the need and the gaps, this information needs to be translated into action plans, and information distributed on a national level and financial support needs to be raised to this effect.
    2.3. The partners (community leaders and entry point health facilities) need to be informed of and supported in their monitoring responsibilities in their partnership with UNHCO. Simple tools should be developed to this effect.

2.3.1. Community members should be involved in the monitoring process through the creation of community positions to monitor health services.

2.4. Amending the health terms of reference of the district coordinators to include an aspect of actively monitoring and documenting program indicators for maternal health and PMTCT.

2.5. Sensitization programs for community members should be expanded to include information about issuing complaints to address the issue of the low level of consumer complaints about health services, due to fear of retribution or other issues.

2.5.1. UNHCO should work with health workers, HUMCs, and district health officers to ensure the existence of functional systems for issuing complaints. Community members must be sensitized about proper utilization of complaints systems to alleviate their fears of filing complaints.

3. This intervention has embedded risks in terms of the intervention environment and the intervention partners. This intervention promotes access, quality and accountability, especially for the health services delivery system. Different stakeholders can perceive this intervention differently, depending on the manner in which intents and purposes are articulated. Risks in the intervention environment include the entry point health facilities' perception that UNHCO is interfering to increase consumer awareness of health rights, leading to the creation of demands, sometimes unrealistic, or even litigation against the health providers. There is a possibility of fear of political hijack since UNHCO will conduct grass roots mobilization to culminate into a district network. The other risk is operational, through relying on partners, UNHCO will lack control on several process factors that will determine the success of the intervention. It is thus recommended:

Clearly outlining the commitments of partners through memoranda of understanding, where expectations and performance targets are set. This should not only apply to institutional partners but also to individuals; they must be trained and further utilize their training.

UNHCO must have periodic interactions at the district level, especially through participation in the health services department's implementation review meetings, to establish UNHCO's constant presence in the intervention area. This will also be essential for the establishment and success of the network envisaged in implementation.

The program needs a formal launch in the intervention districts and at each selected health unit. Although this launch will be costly, it is an ideal approach to create awareness of the intervention agenda known. This will also help mitigate the risk associated with perceived political opportunism through educating the community members about the function of UNHCO's involvement.

Community members should be involved in the planning process of the formal launch so that they can take ownership of the new intervention from the beginning of the process.

4. This baseline study has highlighted many issue areas, including the provision of HRR in local languages. UNHCO needs to take note of these gaps in their program areas in order to improve upon them with the help of local partners.

The provision and dissemination of information (media, literature) in local languages should be increased from 14.6% to at least 50%. UNHCO can have direct control over this indicator by translating materials and distributing them. Once HUMCs and district monitoring teams are fully functional, they will also be able to assist in the dissemination of information.

Examine health workers curriculum and integrate further training about HRR and quality standards to increase health worker's knowledge and improve the quality of services offered.

UNHCO should organize community meetings with both health consumers and providers to ensure mutual understanding on policy, quality, rights and responsibilities. This also presents an educational opportunity for further learning, joint planning, monitoring and evaluation, promoting ownership for a shared vision for all stakeholders.

3.4 DATA COLLECTION TOOLS

THE UGANDA NATIONAL HEALTH USERS'/ CONSUMERS' ORGANISATION

PRE-INTERVENTION BASELINE

Qualitative Interview Guide

Introduction:

Hello. My name is _____. And my colleagues are…….. We are part of a team from the Uganda National Health Users/Consumer's Organization, UNHCO. We are here to learn from you the status of PMTCT and Maternal Health services. We are interested in the services available, their quality, and levels of access and effective use.

We would like to ask you questions about your experience with regard to accessing PMTCT and Maternal health services. We would like to assure you that all the information you give will help us and other actors in the health sector improve services delivery to you and others in need of these services. The information obtained is confidential and no reference will be made to you as a persons.

Instruction to Note Takers:

1. Capture Locational Information (District/ Sub County/ and Exact Venue)
2. Record the Position of the Interviewee in case of KI and the Occupations of FGD Participants
3. For FGD participants a form to socio-demographics already made

Instruction to FGD Facilitator:

1. Introduce your self and the group…….allow participants to introduce themselves
2. Explain the purpose of data collection and give a brief commentary on UNHCO
3. Request participants to give information on the form being circulated

SECTION A (Only District KI)

(District Health Inspector and District Health Officer)

This district was selected by UNHCO as a beneficiary for their intervention on maternal health including PMTCT and health rights and responsibilities:

1. What issues need particular attention while implementing a project on PMTCT and maternal Health Services in this district?
2. Comment on the Existence of CBOs/ CSOs that can advocate for better health policies and approaches in the selected areas and district
3. Comment on the possibility of a functional district health network that advances health issues to the District Health Team (Obtain from the CDO a list of various actors and services especially rights and PMTCT)
4. Comment on the level of prioritization of 1) Feedback and Redress 2) Health Rights and Responsibilities and 3) Maternal Health and PMTCT services on the district health agenda
5. Comment on feedback mechanisms that exist in various health facilities in the communities?
6. Comment on the performance of the district with regard to the league table….what influences that position
7. What information concerning maternal health and PMTCT exists (obtain as much from the records)

SECTION B (Only Sub County KI)

(Sub County Chief) and Chairman LC III

1. What is the level of Knowledge of health rights and responsibilities in the community?
2. How can community leader's best be used to improve this knowledge?
3. What are the common mechanisms of handling health services complaints in the community?
4. How can they be improved and made more functionally beneficial health services consumers?
5. Impact of health rights on service?

SECTION C (Only FGD)

(Mixed Group of 12: 3 women and 3 men above 18 below 24, 3 women and 3 men above 24)

1. What health rights and responsibilities do you know?
2. How many in the FGD know at least 3 health rights and responsibilities?
3. What are PMCT services? (Comment on availability, acceptability and quality)
4. How can access to these services be improved?
5. According to the consumers:
    a. What are quality maternal health services?
    b. What is the variety of maternal health services that they know?
6. How can access to health care be enhanced in the community? / What would you want improved?

THE UGANDA NATIONAL HEALTH USERS'/ CONSUMERS' ORGANISATION (UNHCO) PRE-INTERVENTION BASELINE
September 2008
Health Facility Client Exit (Post Use/ Consumption) Interview

Introduction:

Hello. My name is _____ am part of a team from UNHCO. We are here to learn from you the status of PMTCT and Maternal Health services. We are interested in the services available, their quality and levels of access and effective use. We would like to ask you questions about your personal experience with regard to accessing PMTCT and Maternal health services. I would like to assure you that all the information you give will help us and other actors in the health sector improve services delivery to you and others in need of the services. This interview and information obtained are confidential and no reference will be made to you as a person.

<table>
<tr><td>NO.</td><td colspan="3">Locational Particulars:</td><td colspan="3">User/ Consumer Personal Information:</td></tr>
<tr><td>1.</td><td colspan="3">District: 1. Mbarara 2. Kamuli 3. Nakaseke</td><td colspan="3">4. Gender of the Respondent (Observe)
1. Female 2. Male</td></tr>
<tr><td>2.</td><td colspan="3">Sub County (Write Down the Name)</td><td colspan="3">5. How old is the respondent? (State Only Whole Years)</td></tr>
<tr><td>3.</td><td colspan="3">Name of Health Facility (Interview Site)</td><td colspan="3">6. What is your Highest Level of Education
1. P.1- P. 4 2. P.5- P. 7 3. O-level 4. A-Level and Tertiary</td></tr>
<tr><td></td><td colspan="3">Access to Maternal Health and PMTCT Services:</td><td colspan="3"></td></tr>
<tr><td>7.</td><td colspan="3">How many children do you have (Biological)?</td><td colspan="3">8. How many of your children were born in a Health Facility?</td></tr>
<tr><td>9.</td><td colspan="3">If some children were not borne in health facility; why? (Probe for any 3 important reasons)
1. Distance 2. Lack of Money
3. Occurrence was sudden 4. Others:</td><td colspan="2">10. Were all your children normal deliveries?
1. Yes
2. No (Skip to 13)</td><td>11. How many were Not normal deliveries?</td></tr>
<tr><td>12.</td><td colspan="2">When you were faced with deliveries that were not normal what services did you need; but were not readily available?</td><td colspan="4">(Probe for any 3 important reasons)</td></tr>
<tr><td>13.</td><td colspan="4">What service have you come for today at this health Facility?
1. ANC 2. PNC
3. Birth
4. Immunization
5. Others:</td><td colspan="2">14. What have you found unpleasant about the service you have received at this facility today? (Probe for any 3 Important Issues)</td></tr>
<tr><td>15.</td><td>Have you ever been counseled/ sensitized on PMTCT services
1. Yes
2. No (Skip to</td><td colspan="2">16. Where did this take place?
1. In VCT session of ANC
2. In VCT session of PNC
3. Other visit to health facility
4. Attended workshop
5. Others:</td><td>17. Have you ever accessed PMTCT services?
1. Yes
2. No</td><td colspan="2">18. Have ever tested for HIV/AIDS
1. Yes
2. No</td></tr>
<tr><td>19.</td><td colspan="3">What would you need to better access Maternal Health and PMTCT services? (Probe for any three Key Issues)</td><td colspan="3"></td></tr>
<tr><td>20.</td><td>Why did you opt for this facility to access Maternal Health and PMTCT services?</td><td colspan="5">(Multiple Responses Circle all that apply)
1. Is nearest home (Short Distance) 2. Efficient services/ spend less time at the facility
3. Has good health workers 4. Has good health facilities
5. Charges reasonable amounts 6. Only facility with PMTCT
7. Services are free
8. Other Specify:</td></tr>
<tr><td>21.</td><td colspan="3">From your perspective do you feel you receive quality health services?
1. Yes (Skip to 23) 2. No</td><td colspan="3">22. If no, why do you say you do not get quality health services?</td></tr>
<tr><td></td><td colspan="4">Health Rights and Responsibilities</td><td colspan="2"></td></tr>
<tr><td>23.</td><td>Do you know your health</td><td colspan="5">24. Mention any three health rights you know?
1. Individual Patients Respect 2. The rights to receive equal treatment
3. The Right to optimum treatment 4. The right to participate in treatment</td></tr>
</table>

	rights? 1. Yes 2. No **(Skip to 25)**	5. The right to privacy 6. The Right to know/get information about their health 7. The right to spiritual and moral comfort 8. The right to receive redress and have grievances addressed 9. The right to Die in Dignity 10. The right to participate and be represented in planning and management of health affairs 11. The right to safety 12. The right to quality treatment 13. The right to choose treatment		
25.	Do you know your responsibilities when seeking health services? 1. Yes 2. No **(Skip to 28)**	**26.** Mention any three responsibilities you readily exercise while seeking health services 1. To provide accurate and complete information to health care providers 2. Cooperate and comply on treatment given and follow up actions 3. Fulfill financial and contractual obligations 4. Follow rules and regulations of the health facility 5. Avoid personal injury and harmful behaviour 6. Support the health care system and institution 7. Accept all preventive and curative measures sanctioned by law 8. Respect for public and personal property 9. Understand the conditions, limitations and consequences in the process of seeking and provision of health Care 10. Respect the rights and wellbeing of others (Including health workers and other patients)		
27.	How did you get to know about your health rights and responsibilities?		**28.** Mention any three aspects of health rights and responsibilities you feel you need to know?	
29.	Do you feel your rights are often respected when you seek health services? 1. Yes 2. No	30. Are health rights and responsibilities important? 1. Yes 2. No	**31. If yes, how are they important?**	**32. If No, why aren't they important?**
	<u>Feedback Mechanisms:</u>			
33.	Have you **<u>ever made</u>** a complaint about health services you receive 1. Yes **(Skip to 27)** 2. No	**34.** Have you **<u>ever wanted</u>** to make a complaint about health services? 1. Yes 2. No	**35.** What was the complaint about? **(Probe for any 3 considered important)**	
36.	What did you do to make your complaint	**(Multiple Responses Circle all that apply)** 1. Approached the in-charge 2. Slotted a note into the a suggestion box 3. Contacted service provider / nurse 4. Contacted community leader outside health facility 5. Contacted a health unit management committee 6. Other specify:		
37.	Was the complaint resolved? 1. Yes 2. No	**38.** Are there CSOs and/ or CBOs in the Community that are advocating for improved access to health rights and services 1. Yes 2. No	**39.** What are the names of these CSOs/ CBOs?	

Thank You

THE UGANDA NATIONAL HEALTH USERS'/ CONSUMERS' ORGANISATION (UNHCO) PRE-INTERVENTION BASELINE

Health Facility In-Charge/ Service Provider Interview

September 2008

Introduction:

Hello. My name is _____ am part of a team from UNHCO. We are here to learn from you the status of PMTCT and Maternal Health services. We are interested in the services available, their quality and levels of access and effective use. We would like to ask you questions about your personal experience with regard to accessing PMTCT and Maternal health services. I would like to assure you that all the information you give will help us and other actors in the health sector improve services delivery to you and others in need of the services. This interview and information obtained are confidential and no reference will be made to you as a person.

<table>
<tr><th>NO</th><th>Locational Particulars:</th><th>Provider Personal Information:</th></tr>
<tr><td>1.</td><td>District:
1. Mbarara 2. Kamuli 3. Nakaseke</td><td>6. Gender of the Respondent (Observe)
1. Female 2. Male</td></tr>
<tr><td>2.</td><td>County (Write Down the Name)</td><td>7. Position at Health Facility?
1. I n-charge 2. Other Technical Service Provider</td></tr>
<tr><td>3.</td><td>Sub County (Write Down the Name)</td><td rowspan="2">8. What is your qualification?
1. Registered Nurse 2. Registered midwife 3. Enrolled nurse 4. Enrolled midwife 5. Clinical officer 6. Medical doctor 7. Counselor 8. Nutritionist 9. Social worker
10. Other specify:</td></tr>
<tr><td>4.</td><td>Name of Health Facility (Interview Site)</td></tr>
<tr><td>5.</td><td>Level of facility? 1. District Hospital
2. HC IV 3. HC III 4. HC II</td><td>9. For How long have you been working at this facility?</td></tr>
<tr><td></td><td colspan="2">Access to Maternal Health and PMTCT Services:</td></tr>
<tr><td>10.</td><td>Which of the following services are not offered by your health facility: (Multiple Responses Circle all that apply)
1. Child survival/IMCI 2. Basic counseling
3. Antenatal care 4. HIV testing
5. PMTCT Management 6. Nutrition counseling
7. Family planning 8. Postnatal care
9. Support for HIV-positive women 10. ARV management
11. Provision of PT for OIs in infants 12. Patient follow up
13. Optimal/ safer obstetric practices
14. Voluntary Counseling (Pre and post test)
15. C-sections as alternative to PMTCT
16. Information on Health Rights and Responsibilities</td><td>11. What limitations does your health facility face in giving adequate Maternal Health and PMTCT Services? (Mention any three key Limitations)</td></tr>
<tr><td>12.</td><td>What efforts have been made to encourage women to seek maternal health services from health centers/ units?
1. None 2. community outreach
3. use of local radio 4. local language brochures
5. Mobilization of community leaders
6. sensitization of women groups</td><td>13. What is the focus of these efforts?
1. Information on HIVAIDS transmission
2. Information on HIVAIDS Prevention
3. Condom distribution 4. Health Education
5. Information on PMTCT services available at Health facility
6. Information on Health Rights and Responsibilities</td></tr>
<tr><td>14.</td><td>What kind of help and support is needed to improve effectiveness of these efforts in rallying both women and men to be more proactive in seeking maternal health and PMCT services? (Mention any three important issues)</td><td>14. What do you understand as quality maternal health and PMTCT services? (Mention any three key attributes)</td></tr>
<tr><td>15</td><td>Given these attributes, do you feel your health facility offers quality maternal health and PMTCT services
1. Yes 2. No</td><td>16. If yes why?</td><td>I7. If No, why?</td></tr>
</table>

18.	On average; out of every 10 female patients seeking maternal health services; how many volunteer for PMTCT?	**19.** On average; out **of** every 10 female patients seeking maternal health services how many are accompanied by their husbands/ partners?	**20.** Out of every 10 children borne from this health facility; how many die out of preventable causes before their second birth day?	Out of every 10 mothers who come here seeking maternal health services; how many die out of preventable causes?

	Health Rights and Responsibilities					
21.	Do the people who come here seeking health	**22.** Out of every 10 persons, you	**23.** Do the people who come here seeking health	**24.** Out of every 10 persons, you handle how many do you think	**25.** Have you had any initiative to help	**26.** Do you know of any initiative in this community to

	services know their rights? 1. Yes all 2. No 3. Yes some	handle how many do think know their health rights?	services know their responsibilities? 1. Yes all 2. No 3. Yes some	know their health responsibilities?	service seekers know their rights? 1. Yes 2. No	promote awareness of rights and responsibilities of the health seeking persons? 1. Yes 2. No
27	**If yes, in either qn. 23 or 24;** what initiatives are these**?**			**28.** What problems were experienced in these initiatives**?**		
29.	Mention any 3 health rights of health service consumers that you know? 1. Individual Patients Respect 2. The rights to receive equal treatment 3. The Right to optimum treatment 4. The right to participate in treatment 5. The right to privacy 6. The Right to know/get information about their health 7. The right to spiritual and moral comfort 8. The right to receive redress and have grievances addressed 9. The right to Die in Dignity 10. The right to participate and be represented in planning and management of health affairs 11. The right to safety 12. The right to quality treatment 13 the right to choose treatment			**30.** Mention any 3 health responsibilities of health service consumers that you know? 1. To provide accurate and complete information to health care providers 2. Cooperate and comply on treatment given and follow up actions 3. Fulfill financial and contractual obligations 4. Follow rules and regulations of the health facility 5. Avoid personal injury and harmful behaviour 6. Support the health care system and institution 7. Accept all preventive and curative measures sanctioned by law 8. Respect for public and personal property 9. Understand the conditions, limitations and consequences in the process of seeking and provision of health Care 10. Respect the rights and wellbeing of others (Including health workers and other patients)		
31	Are health rights and responsibilities important? 1. Yes 2. No		**32. If yes, how are they important?**		**33. If No, why aren't they important?**	
	<u>Feedback Mechanisms:</u>					
34.	How do your clients make their opinions known to you or your management? 1. Approach the in-charge 2. Slot a note into the a suggestion box 3. Contact service provider / nurse on duty 4. Contact community leader outside health facility 5. Contact Health Unit Management Committee 6. Community Interface Meetings 7. Other specify:			**35.** What do the common opinions concern? **(Probe for any 3 main issues)?** 1. Drug availability 2. Health workers availability 3. Conduct of health workers 4. Service rates/ charges 5. Quality of service rendered 6. Others specify:		
36.	How do you or management handle / respond to these Opinions? **(Probe for any three things usually done)**			**37.** What would you suggest as a way of enhancing functional feedback with your clients/ the community? **(Probe for any 3 main issues)**		

Thank You