

KATINE COMMUNITY PARTNERSHIPS PROGRAM

COMMUNITY SURVEY

INFRASTRUCTURE, SERVICES AND RESOURCES AVAILABLE
IN KATINE SUB COUNTY

JANUARY 2008

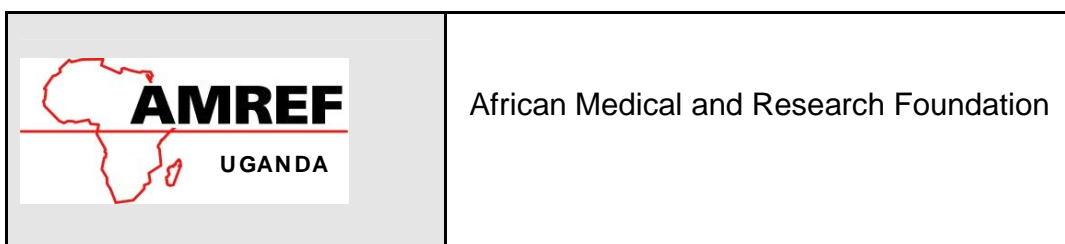


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ACRONYMS

AMREF	African Medical and Research Foundation
ANC	Antenatal care
ART	Antiretroviral therapy
CB-DOTS	Community-based directly observed treatment, short-course
CMD	Community medicine distributor
HBMF	Home-based management of fever
HMIS	Health management information system
HC	Health center
IPT	Intermittent preventive treatment
KCPP	Katine Community Partnerships Project
MOH	Ministry of Health
NGO	Non-governmental organization
OPD	Outpatient department
PLWHA	Person living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
RH	Reproductive health
U5	Under Fives (children)
UDHS	Uganda Demographic and Health Survey
VHT	Village Health Team

EXECUTIVE SUMMARY

The Guardian, Barclays and the African Medical and Research Foundation (AMREF) are partnering in a three-year community-based development project in Katine sub county, Uganda in order to improve the lives of the estimated 30,000 Katine residents while simultaneously giving Guardian readers and AMREF supporters the chance to see how long-term community development works throughout the lifetime of one project.

The project's approach to sustainable community-based development includes empowering the community to engage in local governance, providing the community with essential knowledge, skills and resources to improve health, water, sanitation, and agricultural production, and involving key local stakeholders in the design and implementation of activities to improve the quality of local health, education, and agricultural-support services. Efforts will focus on testing innovative approaches and documenting key lessons learned and best practices to share these widely with stakeholders.

The Katine Community Partnerships Project (KCPP) team carried out a rapid Community Survey in November 2007 to document the relevant community-level infrastructure, services and resources available in Katine sub county to obtain basic information for project planning and identification of priority intervention areas. Semi-structured interviews with village informants, record reviews, and observations were used to obtain a wide range of information in the 65 villages, 13 schools and three health facilities located in Katine sub county. The survey showed that there are important resources available and positive trends in some areas. It also clearly revealed the existing gaps in important areas such as water supplies, school conditions and agricultural support services and outlets.

Key Findings and Recommendations

Water

- Unprotected wells are the primary source of drinking water in almost half of the villages and the majority of villagers have to walk 1-2 km to fetch water. When wells dry up in the dry season (and boreholes breakdown) people have to seek water from other sources even if they do not produce water of good quality; a few villages have to use the swamp for their household water. The community has made clear that safe water is a top priority for them and the project is already in the process of drilling new boreholes at key locations as well as rehabilitating existing boreholes and protecting wells.
- As in all AMREF projects, the water facility improvements will be made more sustainable by equipping community members with the skills to maintain and operate their own water facilities, as well as introducing the use of simple and economical methods such as rainwater collection jars. This survey showed that few water sources appear to have trained water source committees and there are very few masons and hand pump mechanics living in the sub county.

Schools

- The material needs in the 13 schools are vast: to meet national standards an additional 1,437 desks, 43 classrooms, 2,000 sets of textbooks, 112 latrine stances, and 14 hand washing facilities are needed. Where project funds are not sufficient to close all the gaps identified, the

project team will have to work with the community and local school authorities to determine how and where the project's education funds will be allocated.

- One project aim is to encourage school attendance among more vulnerable children. Katine schools are doing well on this score with the number of girls equal to or outnumbering boy pupils in nine of the 13 schools. In addition, seven schools had pupils registered as orphans, representing 12 percent of the total pupils in those schools. According to a 2006 national survey, 12 percent of children under 18 years in the Eastern region were orphans and 90 percent were attending school, only slightly less than non-orphaned children. The Katine data indicate that school-age orphans have comparable access to schooling.
- Most schools have school health clubs and school health committees, structures that the national School Health Policy stipulates should be engaged in promoting student health through a variety of activities. AMREF's well-established experience in building the capacity of these structures to be effective players for the good of pupils and the wider community will be of great value and KCPP provides another opportunity to document and demonstrate the effectiveness of school-based models.

Health

- To improve household health status, the Ministry of Health recently introduced a strategy of Village Health Teams (VHTs) composed of trained resident volunteers at village level. Their role is to provide basic home-based care and mobilize communities for health action. Katine sub county officials say there are 323 VHTs covering all villages, but this survey showed that not all villagers were aware of VHTs, suggesting either that they did not have one or that the VHT was not very active. VHTs will be key partners in the Katine project and they will need support to fulfill their intended role in their communities. More outreach services and a reliable referral system are also essential to ensure better health coverage.
- The two government and one NGO-run health facilities in Katine play a very important role in health care as very few villages have a private practitioner (e.g. midwife, nurse) or even private drug shop. Fortunately for many Katine residents their closest health facility is the Atiriri HC IV facility; this facility is relatively well staffed, the laboratory had most of the required basic equipment, most essential medicines and supplies were in stock at the time of the visit, and HC IV level services (mandated by national policy) are provided except for antiretroviral therapy (ART) and emergency obstetric care. After equipping Atiriri with water and electricity facilities, the project's immediate priorities will focus on upgrading provider skills and overall capacity where needed (e.g. laboratory services) so they can provide the full package of quality malaria, TB, reproductive health, and HIV/AIDS services.
- Statistics from Atiriri HC IV show some services are well utilized such as malaria treatment, normal delivery, antenatal care, and the newly established PMTCT services. However, the statistics also reveal that utilization of TB treatment and family planning services are well below what should be expected; this is important as TB is the major cause of death among people with AIDS and family planning is key to reducing maternal mortality and improving child health. In addition to better provider skills, community outreach and sensitization are needed to address issues of stigma (in the case of TB) and to ensure that women have easy access to contraceptives to meet their family planning needs.

- To improve community access to basic health services, another priority will be upgrading and expanding the package of services offered by the two other small health units in Katine which basically only provide malaria treatment for children and adults. For example, the government health unit should be providing family planning services and could be linked to the community-based TB DOTS program. The second NGO-supported unit is comparatively well staffed and has a small laboratory, thus they too can increase their value to the community.

PART 1. INTRODUCTION

1.1 Background

Katine sub county is part of Soroti district, one of the poorest districts in the country with more than 77 percent of the population living on less than a \$US1 a day. Katine was selected because of the high levels of poverty, low health and education indicators, the negative impacts civil war and rural–urban migration are having on the area, and because, as an area reliant on agriculture, it is being badly affected by changing climate patterns. Furthermore, across rural Uganda, there is a gap between the formal services being provided by government structures and the local community.

AMREF identifies priorities and allocates resources on a pro-poor basis, giving priority to people and communities that are the most vulnerable. The project’s integrated approach will simultaneously address poverty reduction, better health, access to education, increased income and a role in local decision making. To improve the lives of those living in Katine, the project has five objectives:

- Improved community health
- Improved access to quality primary education
- Improved access to safe water, sanitation and hygiene
- Improved income generating activities
- Communities empowered to engage in local governance

The project will be implemented through partnering with local government structures (at district, sub county and parish level) and community organisations throughout the development, planning and implementation process. Partners will Farmers’ Groups, Village Health Teams, Parent Teacher Associations, and Water Source Committees. Across these groups the project will work to develop the skills of both formal workers (teachers, health workers, government employees) and the community volunteers who are delivering essential services to the community, for example the Village Health Teams. This project will strengthen and further develop AMREF’s model for community development.

1.2 Community Survey

This report presents the findings of a rapid survey that was carried out in all of the villages, schools and health facilities in Katine sub county in November 2007. The purpose of the Community Survey was to get an overview of what relevant infrastructure, services and other resources are available in Katine sub county in order to:

- have information for planning project activities
- identify priority areas in greatest need of inputs
- provide baseline measures that can be used to measure change over time as a result of KCPP activities

In developing the survey the KCPP team identified the key information they needed to know about the villages, schools and health facilities. The following areas were covered in the three areas:

A. Village Survey (65 villages):

- Population, number of households
- Water sources, community management committees, operation and maintenance capacity
- Household sanitation
- Village Health Teams (VHTs), bicycles, drug kits, private practitioners
- Farmer groups, animal health workers, food security crops, main income sources
- Markets, marketing associations, savings groups, agro input and processing units
- NGOs active in area

B. School Survey (13 schools):

- Pupils, teachers, orphans, disabled pupils
- Classrooms, desks, textbooks
- Water and sanitation facilities
- Health clubs and management committees

C. Health Facilities Survey (3 health facilities):

- Personnel, services offered, laboratory equipment
- Recent service statistics for malaria, HIV/AIDS, TB, reproductive health
- Availability of key commodities and supplies
- Medical waste disposal

The Community Survey tools show the details of the information that was captured (*Annex A*).

PART 2. SURVEY METHODOLOGY

2.1 Data collection

A combination of methods was used to obtain information in the survey, including interviews with key informants, record reviews, and observation. The specific methodology for each of the three surveys is described below.

For the Village Survey, ten local field interviewers were recruited and trained in a one-day training session by the KCPP M&E Officer with support from other project staff. The training included a detailed review of the tool, interview techniques, interpreting the tool in the two local languages, mapping of the field work, and finally pre-testing the tool in another local community outside of Katine sub county. Four key informants were interviewed in each of the 65 villages; four respondents were chosen for the purpose of checks and balances and to have a more representative range of responses. The respondents were to include the Local Council (LC1) and a member of the LC committee, and other two other community leaders (religious or clan leader). To ensure a balance of gender, two female and two male respondents were interviewed. In cases where the village did not have a structure like the LC1, other central village members were chosen.

For the School Survey, information was collected by the Education Officer and Education Programme Assistant. Informants interviewed included head teachers and teachers available on the day of the interview. The lead respondent's name was recorded on the form. Information on the number of desks and textbooks were taken from the school inventory; in cases where such records were not available,

physical counting was performed. Observations were made to determine the presence and number of latrine stances and hand washing facilities. For pupil numbers, the source of information was enrolment records (on flip charts in all head teacher's offices). Schools' records were also used as the source of information on the numbers of orphans and pupils with physical disability.

For the Health Facility Survey, information was collected by the Health Officer and Health Programme Assistant. The facility in-charge provided information on the number of personnel and services available; service statistics were obtained from monthly health unit reports and annual service statistics; and observations were made to determine the availability of selected health commodities, laboratory equipment, and medical waste disposal methods.

2.2 Data processing

After completion of field work, the information collected was entered into pre-designed Excel spreadsheets. Data obtained from the School and Health Facility Surveys were used without modification; the Village Survey information however, had to be summarized across the four individuals' responses which were not always the same. For some items of information the range of responses was used as an appropriate summary, e.g. the closest water source to the village is 1-3 km because households in a village are located varying distances away from the water source. For the item village population, and other items like it where only one response was wanted, the four responses had to be summarized into the best single figure; the rule used was that if at least three of the four responses were the same then that number was used as the final answer; if there were only two or fewer similar answers, then the average of the responses was used as the final answer. If a respondent said that they did not know the answer, a zero was assigned and they were taken out of the equation. It is important to note that information collected in the Village Survey will be further verified by the project before being used for detailed planning.

PART 3. FINDINGS

In the next section a summary of the survey findings is presented. Where available, national standards and targets are used to identify gaps in existing resources and to calculate what inputs would be needed to close the gaps. The information will be used in consultations with local stakeholders to identify priority locations such as individual villages and schools that are most in need of project inputs (as the project cannot fill 100 percent of all gaps).

3.1 Village Survey

The estimated population of the 65 villages is 30,465. Village size ranged from the 133 to 963 residents, with the average village population size of 470. A total of 260 respondents were interviewed in the Village Survey. Ninety-six percent of the respondents said their occupation was peasant farmer and almost all had attended primary level or secondary level schooling (only six had no education). Half of the respondents were women.

3.1.1 Water sources and resources for management and maintenance

Water sources: The most common source for drinking water was unprotected wells (primary source in 29 villages) followed by boreholes (primary source in 20 villages). Many villages had two main water sources: during the dry season some of the wells dry up and many people switch to using boreholes even though some of them do not produce water of good quality, e.g. yellowish color. A few villages, mostly in Merok parish, mentioned using the swamp as their second water source.

The distance from the villages to the water sources ranged from 0.5 km to 4 km, with most villagers saying they had to walk 1-2 kms. Nine villages had the greatest distance of 3-4 kms to travel to collect water.

Very few respondents reported the use of rain water jars in homes; in only three villages did three or more respondents report that there were one - three jars in the village (it is not clear if respondents shared the same understanding of what a rainwater jar is). It is safe to say that this technology is not used in the programme area.

Water management committees: All boreholes should have water management committees that are responsible for the day to day running of the water source. Only three villages unanimously reported they had a trained water user committee. Strangely, some of the villages that did not have a trained WSC reported having to pay water user fees ranging from 500 to 2000 Ush, and even in the same parish villages paid different fee amounts; Adiwang village reported fees of 500 Ush and Katine village said they paid 1,500 Ush, both are in Katine parish.

Local operations and maintenance: Respondents were asked if the village had a mason, hand pump mechanic, and/or hand pump spare part dealer. Only one village (Obiol) had hand pump mechanics (although the respondents gave varying numbers of how many there are). It appears that the other villages have none of these categories of occupation; if they do exist they are not well known in their villages.

3.1.2 Community health care resources

Nearest health facility: The majority of villages reported Atiriri HC IV was their closest health facility. All four respondents in seven villages reported that they did not have a nearby health facility; two villages are in Merok parish, four in Ochuloi parish, and one in Olwelai parish. These villages, with a combined population of 3,400 people, need special attention from the project particularly because only one of the villages appears to have a Village Health Team (VHT).

Table 1. Villages with no nearby health facility

Village name	Estimated population	VHT
Ojwiny	690	Yes
Merok	650	No
Acam	625	No
Ajony A	376	Not sure
Ajony B	259	No
Ogur	257	No
Samuk	531	No

Village Health Teams: To improve household health status, the Ministry of Health recently introduced a strategy of Village Health Teams (VHTs) composed of trained resident volunteers at village level. Their role is to provide basic home-based care and mobilize communities for health action. Respondents in 24 villages (37%) were unanimous that they had a VHT and respondents in 15 villages (23%) were unanimous that they did not. In the 26 remaining villages the four respondents interviewed in each village gave different answers. In the 24 villages that unanimously agreed there was a VHT, most of them also gave the same answers as to the number of VHT members (from 1-5, most VHTs reportedly had 2 members) and said they had been trained in home base care by the MOH. There was little agreement among their responses about whether their VHTs had a bicycle or a drug storage kit

(although it appears as though very few of these VHTs have either item). KCPP will have to directly contact these VHTs and the District Health Office to gather this information.

Many of the villages, including those without VHTs, reported that they had trained Community Medicine Distributors (CMDs); again, there were varying responses among the respondents about the number of CMDs in their villages. CMDs have been primarily used to dispense anti-malarial medicine as part of the national Home-Based Management of Fever programme, which has been widely successful in improving access to approved treatment among young children; the CMDs are now being integrated into VHTs as part of the MOH health strategy for 2007-2010.

Traditional birth attendants: Respondents in 48 villages said that they had one or more TBAs in their village with some reporting having four to five TBAs. Only 17 villages gave unanimous responses that there was no TBA in their village.

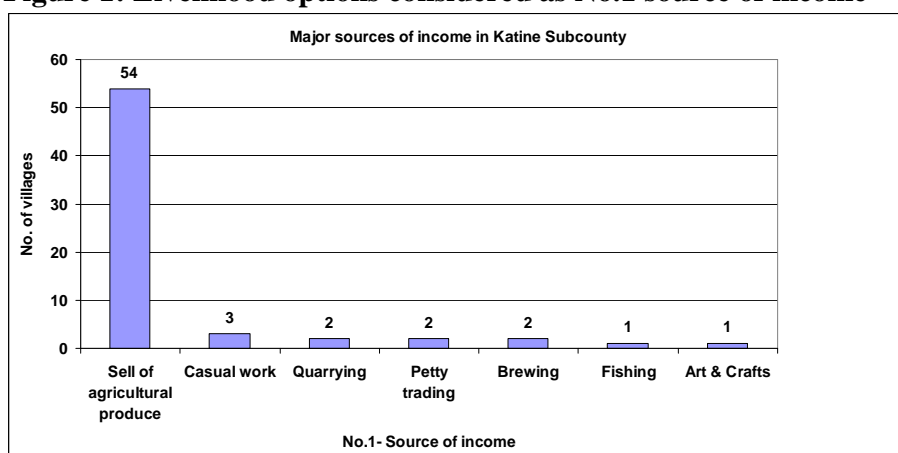
Private outlets: Private practitioners are very few; respondents in seven villages said they had one or more private practitioners (midwife, nurse, doctor) in their village. Nine villages consistently reported the presence of drug shops. Four villages said they had one drug shop, two had two shops, one had three, and two villages reported having four drug shops. The parishes where these shops are located include Katine, Olwelai, Ojom and Ojama.

3.1.3 Livelihoods

Key sources of income: The KCPP aims at having diversified sources of income amongst households. Thus, those villages with limited sources of income shall be of critical interest. The survey established that almost all villages had two or more sources of income. Forty-one villages (63%) had at least three sources of income, 23 villages had two sources of income and one village had only one source of income.

The sale of agricultural produce was the number one source of income in almost all of the villages (see Fig.1). Casual work, quarrying, petty trading and brewing were mentioned as the major sources of income in the remaining few villages. In the villages with only two sources of income, the first income source for all of them was the sale of agricultural produce; petty trading and brewing alcohol were the next most important sources of income.

Figure 1: Livelihood options considered as No.1 source of income



Farmer organizations: Half of the 65 villages (52%) have a farmer group and 17 of the villages have two or more. More than half (56%) of the farmer groups have received training.

Table 2. Summary of existing farmer groups in Katine sub county

No. of groups per village	No. of villages	Total No. of groups
0	31	0
1	17	17
2	8	16
3	7	21
4	1	4
5	1	5
Total	65	63

Presence of community animal health workers: Respondents from six out of 65 villages (9%) reported the presence of a community animal health worker in their village. The villages are Olocoi and Omulai (Katine parish), Kalela (Olwelai parish), Abari B (Ochuloi parish) Ojwiny (Merok parish) and Olusai (Ojom parish).

Village markets: Five out of 65 villages (8%) reported they hosted village markets. Three of these villages are in Ochuloi parish (i.e. Adamai, Olano and Omodoi) and the other two are Ogwolo (Olwelai parish) and Katine (Katine parish).

Residents reportedly walk a distance in the range of 1–10kms to access the nearest market. The longest distance of 10kms was reported from Abari B and Obyarai A (Ochuloi parish) and Olusai (Ojom parish).

Table 3. Distance to the nearest market

Distance range (km)	No. of Villages
0 – 3	14
3 – 6	34
>6	13
<i>No response</i>	4
Total	65

Food security crops grown: Almost all villages (97%) reported cassava to be the primary food security crop (97%). In what was considered the secondary food security crop, sorghum and sweet potatoes were ranked closely at 35% and 34% respectively. Other food security crops mentioned include millet, ground nuts and beans.

Table 4. Food security crops

No.1 food security crop	No. of villages	Percent
Cassava	63	97
Sorghum	2	3
Total	65	100
No.2 food security crop		
Sorghum	23	35
Potatoes	22	34
Millet	11	17
G. nuts	4	6
Beans	3	5
Green gram	1	2
Cassava*	1	2
Total	65	101

Marketing associations: Respondents in only two villages reported that they had a marketing association in their village. Marketing associations provide their members easy access to credit services for improved production and marketing

Savings groups: The survey did not reveal the presence of any savings and credit groups in the area. However, a previous appraisal conducted by FARM Africa had revealed that there are at least nine such groups in Katine sub county being supported by UWESO.

Agro-input services: Respondents from only two villages, namely Ajonyi B (Ochuloi parish) and Orechoi (Merok parish) reported the presence of agro-input dealers.

Agro-processing and value addition: Out of the 65 villages, 16 (25%) mentioned that there is at least one agro-processing unit in the area with a total of 20 units. The major products being processed include cassava, sorghum, millet and maize.

Table 5. Distribution of agro-processing units among villages

No. of agro-processing units	No. of villages	Total no. of units
1	13	13
2	2	4
3	1	3
Total	16 (25%)	20

Other NGOs supporting livelihoods in Katine sub county: Eight NGOs were mentioned as supporting livelihoods in Katine sub county. The predominantly mentioned organizations include CCF, CIDI, NAADS, SOCADIDO, TEDDO, TPO, UN-WFP AND UWESO.

For more detailed information *Annex B* contains information on the above topic areas in each village (a summary of the four respondents in each village).

3.2 School Survey

Equality in educational attainment is one of the goals of the Government of Uganda’s Universal Primary Education (UPE) programme. A recent national survey showed the gender gap reducing but rural children are still less likely than those living in urban areas to attend school (UDHS, 2006). Schools still face many challenges in providing a good learning environment for their increasing number of pupils. Data available from Soroti county (where Katine sub county is located) show that perhaps only one in three children who enrolled in P.2 reaches P.7. ¹

Katine sub county has 13 primary schools, ten of which are government-owned three are community-owned which means they receive no government support. Together, the 13 schools have 7,531 pupils enrolled and 133 teachers. Children attending primary school in Katine are between the ages of six (recommended UPE age for joining primary) and sixteen on average. Completion age should be 12 years. Detailed information on each school is available in *Annex C*.

¹ Schools in Soroti District, Status of Teaching, learning, management and Governance, Uganda School Improvement Programme (Soroti) Link Development programme (LCD) – Uganda working in partnership with The Education Standards Agency (ESA) and Soroti District Education Department. September 2007

Learning environment: The learning environment in all 13 schools is poor. Classrooms are crowded with 11 of the schools exceeding the standard of 55 pupils per classroom. Seven exceed the standard of no more than 55 pupils per teacher, and all 13 have more than the standard of three pupils per desk (range was 4 to 22 pupils per available desk). None of the schools met the maximum standard of three pupils per textbook; in fact, four schools had no textbooks at all for their pupils

Table 6. School learning environment

	Pupil to teacher ratio LTE 55:1	Pupil to classroom ratio LTE 55:1	Pupil to textbook ratio LTE 3:1	Pupil to desk ratio LTE 3:1	Meet all four targets
Number of schools meeting national target	6	2	0	0	0
What is needed for all 13 schools to meet the target	12 teachers	43 classrooms	2,000 books	1,437 desks	

LTE = less than or equal to

For the 13 schools to meet all four targets an additional 1,437 desks, 43 classrooms and almost 2,000 sets of textbooks are needed to accommodate the 7,500 pupils. Twelve more teachers need to be recruited or if it were possible, “excess” teachers from one school could be transferred to another school that has too few (the numbers of excess and needed are about equal).

Girl pupils: Perhaps as a result of the UPE programme, girls equal or outnumber boy pupils in 9 of the 13 schools. Three of the schools with fewer girls than boys are UPE schools and one is a community school. The school with the lowest girl to boy pupil ratio was 0.85 in Olwelai Katine School.

Orphan pupils: Seven schools have pupils recorded as orphans, ranging from 6 to 18 percent of total pupil numbers. The other six schools did not have this data available. Orphans represented 12 percent of the pupils in the seven schools with available data. According to the 2006 UDHS, 12 percent of children under 18 in the Eastern region were orphans and they were only slightly less likely to be attending school than non-orphaned children (90% of orphans were attending school)². Using this percentage, Katine sub county would have an estimated 3,650 orphans. Respondents in all of the villages surveyed reported having orphans living in their villages, ranging in number from 15 to 100 orphans per village

Physically disabled pupils: All 13 schools have at least one pupil registered as physically disabled; one school (Katine Tiriri) had 20 disabled pupils. This same school also has the highest number of orphan pupils.

Latrine and hand washing facilities: No school currently meets the standard of a latrine stance for every pupils; calculated separately for boy and girl pupils. Three schools, with a total of almost 1,000 pupils, have no latrine stances at all making them unsuitable for operation. Two of these schools are community-owned.

Five schools had no hand washing facilities for boys or girls, including the three community schools. The table below presents data on school sanitation and hand washing facilities by parish. Some schools had one hand washing block shared by boys and girls while there are supposed to be separate blocks.

² The national definition of an orphan is a child under the age of 15 or 18 years with one or both parents deceased, UDHS 2006.

Rain water tanks: Eight schools already have rain water tanks (six of them 10,000 litre capacity), no doubt due largely to the AMREF-supported Personal Hygiene and Sanitation Education (PHASE) project. Of the five schools without tanks two are community schools and three UPE schools. Two of the UPE schools have alternative water sources (whether they are safe or unsafe sources were not determined) but the community schools do not.

The table below shows how many school sanitation and water facilities need to be constructed in each parish.

Table 7. School water facilities needed in Katine sub county

Parish	No. of schools in parish	No. of latrine stances needed	No. of hand washing facilities needed	No. of rain water tanks needed
Ojom	3	24	2	1
Olwelai	3	14	4	1
Merok	2	16	3	2
Katine	2	22	1	0
Ochuloi	2	26	3	1
Ojama	1	10	1	0
	13	112	14	5

School health clubs and committees: Ten of the 13 schools had a school health club for pupils and eight schools had a school health committee. The national School Health Policy stipulates that all schools should all have school health committees and class health clubs to support the promotion of school health and to optimize the educational achievement of learners.

School development plans: Only three schools currently had a school development plan, a document that stipulates the activities the school and the community intend to implement in a period of three years. It highlights priority areas for intervention. Development workers are expected to use such documents to see what the school priorities are and choose to support certain activities.

3.3 Health Facility Survey

Health personnel: A total of 23 health facility personnel work in the three facilities that serve Katine sub county: 16 in Atiriri HC IV, two in Ojom HC II and four in the NGO facility Katine HC II. The Local Government staffing norms for HC IIs and HC IVs are also shown in the table.

Atiriri is lacking a second medical officer and five nurses (all categories) but they have sufficient midwives and lab personnel. The other MOH facility, Ojom HC II, has only half the staff they should while the NGO facility Katine HC II meets the norms in terms of number of staff but has a slightly different mix of skills than the recommended norms.

Table 8. Health personnel in Katine health facilities

Health personnel currently on staff	Atiriri HC IV	HC IV Staffing norms	Ojom HC II	Katine HC II (NGO)	HC II Staffing norms

Health personnel currently on staff	Atiriri HC IV	HC IV Staffing norms	Ojom HC II	Katine HC II (NGO)	HC II Staffing norms
Medical officer	1	2			0
Clinical officer	2	2			0
Nurse (All categories)	4	9		1	2
Midwife	4	3			0
Nurse assistant	3	5	2	3	2
Lab technician	1	1			0
Microscopist/lab attendant	1	1		1	0

Health services offered: The table below shows the range of services offered by each of the health facilities. Atiriri serves a larger catchment area than Katine sub country, while Ojom and Katine HC IIs primarily serve the villages in Katine situated close to the health units.

The range of services at Atiriri meets the current national standards for HC IV level, although many HC IV level facilities also provide ART services (see more detail below). Ojom HC II provides the basic services that are expected at HC II level. Katine HC II provides a basic package of services but has the advantage of having a small laboratory for basic diagnostic tests.

Table 9. Health services offered in Katine health facilities

Services Provided	Atiriri HC IV	Ojom HC II	Katine HC II
Anti-retroviral therapy (ART)	N		
Voluntary counseling and testing (VCT)	Y		
Prevention of mother-to-child transmission (PMTCT)	Y		
Management of opportunistic infections (OIs)	Y	Y	Y
Diagnosis of sexually transmitted infections (STIs)	Y		Y
Treatment of STIs	Y	Y	Y
Diagnosis of malaria	Y		Y
Treatment of malaria	Y	Y	Y
Diagnosis of tuberculosis (TB)	Y		
Treatment of TB	Y		
Lab diagnostic tests	Y		Y
Family planning services	Y	Y	
Normal delivery care	Y		

Laboratory equipment and supplies: An inventory was taken of the laboratory equipment and supplies in the two health facilities that have laboratories. The inventory contained only those items required to perform tests for HIV, malaria and TB. The purpose of the specific inventory was to identify basic equipment needed by the laboratory and to get an idea of how their logistics management of laboratory supplies is performing.

Overall the results were satisfactory. The results showed that Katine HC II, which does only malaria testing, had all the required items on the day of visit. In Atiriri, two reagents needed for malaria testing were stocked out but they had all the items needed for HIV testing. Information on the equipment and reagents needed for TB diagnostic tests was incomplete and items marked with an asterisk (*) will have

to be collected at a later date. A complete inventory of Atiriri's laboratory equipment and their needs according to national standards will be made available in the next month.

Table 10. Laboratory equipment available for malaria, TB and HIV

Item	Required for testing	Atiriri HC IV	Katine HC IV
Functioning microscope	TB, malaria	Y	Y
Glass slides	TB, Malaria	Y	Y
Field stain A	Malaria		Y
Field stain B	Malaria		Y
Immersion oil	Malaria	Y	Y
Strong Carolfuchsin	TB	*	
20% Sulphuric Acid	TB	*	
0.5% Methylene Blue	TB	*	
Blood lancets	Malaria, HIV	Y	Y
Disinfectant	All	Y	Y
Disposable gloves	All	Y	Y
Wire loop and holder	TB	Y	
Spirit burner	TB	Y	
Ziehl Nielsen staining set	TB	*	
HIV algorithm test set	HIV	Y	
Vacutainers	HIV	Y	
Sleeves	Malaria, HIV	Y	
Needles	Malaria, HIV	Y	Y

HIV/AIDS diagnosis, prevention and treatment: Atiriri HC IV offers voluntary counseling and testing (VCT), prevention of mother-to-child transmission (PMTCT), management of opportunistic infections (OIs), and treatment for sexually transmitted infections. Cases requiring anti-retroviral therapy (ART) are currently referred to Soroti Hospital. The MOH 2007/08 plan is to establish ART services in all HC IVs; the project can support the Atiriri facility management to meet MOH requirements to provide the service. Social support/post-test services for HIV+ people and their families and home-based care are also part of the national HIV/AIDS prevention, treatment and care package. The project can provide the support necessary to enable Atiriri to provide these important services according to national standards.

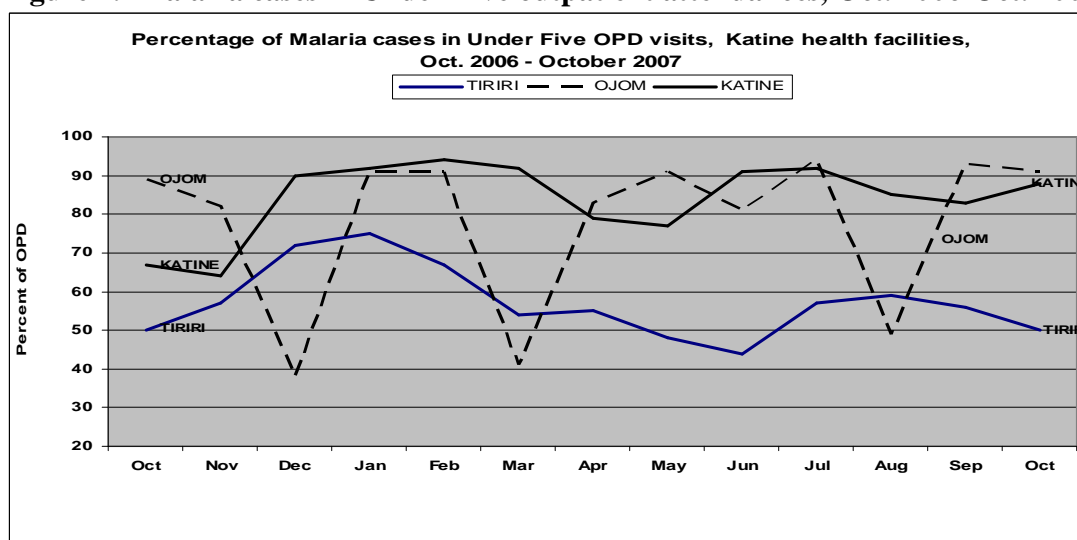
Atiriri's laboratory register showed that only 162 HIV tests were performed between October 2006-2007. This is incorrect if 423 ANC clients received HIV tests as part of PMTCT (see below). This discrepancy raises the issue of the need for accurate and complete record-keeping for all clinical and laboratory services.

In August 2007, Atiriri started offering PMTCT services including HIV testing, counseling, and provision of Nevirapine for positive cases. In three months of service, 423 ANC clients were reportedly tested representing 32 percent of new ANC clients in August, increasing to 78 percent by October. The MOH target is 80 percent. Of those tested, 18 tested positive (4.3%) but only three received ARVs (17%). Nationally, the current percentage of HIV positive pregnant women receiving ARVs is approximately 45 percent and the 2010 target is 80 percent.

The two HC II facilities also report they provide treatment for opportunistic infections and sexually transmitted infections. Service statistics on case numbers treated were not obtained during this baseline survey. Katine HC II reports they have the capacity to diagnosis STIs, but their actual capacity to provide quality testing services needs to be confirmed.

Malaria diagnosis and treatment: Malaria in young children is a burden throughout the year. The chart below shows that the disease makes up a large part of child cases seen at the health facilities, particularly the two small units which offer a limited range of other services. Almost 8,000 malaria cases, 63 percent of the total under-five (U5) outpatient department (OPD) visits in the three health facilities, were diagnosed between October 2006 and October 2007. The same seasonal trends of malaria cases are seen in Katine and Atiriri facilities. Interestingly, the data from Atiriri HC IV shows an apparent decline in the proportion of U5s diagnosed with malaria. Is this a real decline in malaria incidence, perhaps from increased use of ITNs?

Figure 2. Malaria cases in Under Five outpatient attendances, Oct. 2006-Oct. 2007



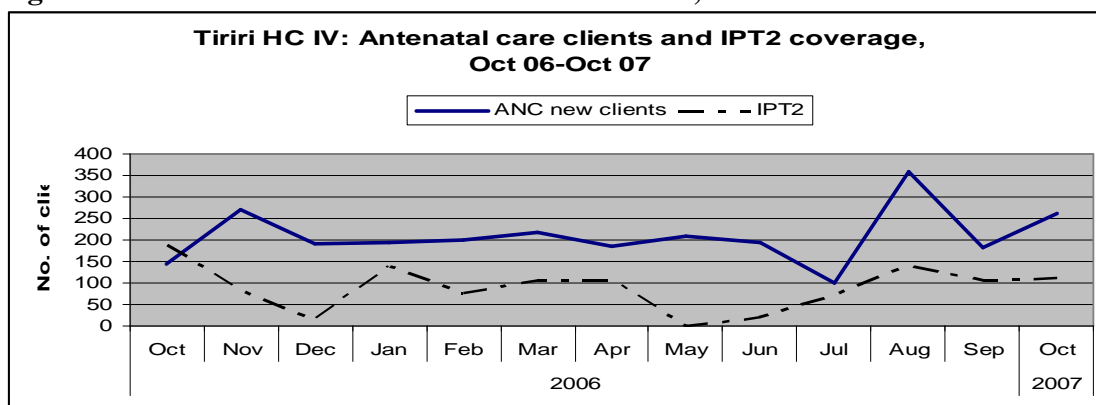
In Ojom HC II, fever/malaria accounted for 84 percent of all their U5 OPD visits (as they rely on symptomatic diagnosis rather than laboratory diagnostic tests some fever cases may be misdiagnosed as malaria) and between 70-90 percent of U5s seen at Katine HC II are also diagnosed with malaria (and they do malaria diagnostic tests).

Stock outs of anti-malarial medicines will disrupt services and therefore affect service statistics. Although all three facilities had Coartem for all ages in stock on the day of visit, the erratic pattern of cases seen in Ojom HC II (see above chart) is probably when they have the drugs in stock rather than actual disease patterns. Coartem availability is a problem country-wide but there are possibly some actions that can be taken to improve the situation locally once the issues have been identified.

Intermittent Preventive Treatment in Pregnancy (IPTp): To prevent malaria during pregnancy the malaria control guidelines in Uganda recommend the use of at least two doses of SP/Fansidar during the second and third trimester of pregnancy. The programme for Intermittent Preventive Treatment in Pregnancy (IPTp) began in 2002 and is being implemented in all districts as part of antenatal care (ANC) and is primarily facility-based. The programme target is to increase IPT2 coverage to at least 80 percent by 2010 and to increase the proportion of women attending ANC at least four times.

Atiriri is the only facility that provides ANC services and thus the only one to offer IPTp. Between October 2006 and October 2007, 74 percent of new ANC clients received IPT1 and only 47 percent received IPT2. If these service statistics are accurate, there is much work to do to reach the national IPT2 target of 80-85 percent by 2010 (National Malaria Control Programme).

Figure 3. Percent of ANC clients that received IPT2, Oct. 2006-Oct. 2007



In addition to IPTp, there is the broader malaria in pregnancy (MIP) programme, which can include training of supervisors and staff, supply of ITNs, community sensitization, mostly through facility-based health education. The project should seek ways to support Atiriri to implement the MIP package.

TB diagnosis and treatment: Only six TB cases received treatment from Atiriri in the previous year, showing that access to treatment is very low. In Katine alone there are an expected 75 TB cases, based on the estimated annual rate of TB infection in Uganda of 0.003 (MOH, 2005). Staff reported that many people are reluctant to seek treatment because of the stigma attached to TB.

Normal delivery services: Atiriri has a delivery room and four midwives. A total of 617 women delivered there in the previous 13 months, 53 percent of the expected births in the facility catchment area according to facility statistics. Atiriri does not currently manage complicated obstetric cases, they are referred to Soroti hospital because of a lack of an operational theatre and no blood transfusion capacity.

Family planning services: Only slightly more than 100 family planning (FP) clients were served in Atiriri in the previous year, a very low number for this level of facility. Although Ojom says they provide FP services they did not have a single FP client in the previous year. Both facilities had Depo-Provera injectables in stock on the day of visit, the most popular method in the country, and they also both had condoms available.

Infection prevention/control: None of the health facilities had safe medical waste disposal pits. Waste is burned in an open pit, and in the case of Atiriri, then buried. Disposable gloves and disinfectant were available in the two laboratories on the day of visit.

Detailed information on each health facility is available in *Annex D*.

PART 4. CONCLUSIONS AND RECOMMENDATIONS

This rapid Community Survey provides a useful overview of the infrastructure, services and other resources available in the 65 villages in Katine sub county. The survey revealed that there are some important resources available to the Katine community, such as the Atirii HC IV health facility, and other positive aspects such as a high level of school attendance of girls and orphans. It also revealed the poor conditions in schools, the lack of accessible and safe water, and services and outlets available for families to increase their income from agriculture or other sources. This information will be useful in planning and prioritizing the distribution of resources under KCPP.

This survey is complemented by information obtained through other baseline activities conducted by the project. A Household Survey will be conducted in January 2008 to obtain household-level data on health knowledge and practices, schooling, water, sanitation and hygiene, and livelihoods. Both the Community Survey and Household Survey will provide baseline measures that can be used to measure change over time as a result of KCPP inputs.

Key Findings and Recommendations

The Community Survey findings are summarized below with recommendations on how the project can address the issues raised.

Water Sources

- *Unprotected wells are the primary source of drinking water in almost half of the villages and the majority of villagers have to walk 1-2 km to fetch water. When wells dry up in the dry season (and boreholes breakdown) people have to seek water from other sources even if they do not produce water of good quality; a few villages have to use the swamp for their household water. The community has made clear that safe water is a top priority for them and the project is already in the process of drilling new boreholes at key locations as well as rehabilitating existing boreholes and protecting wells.*
- *As in all AMREF projects, the water facility improvements will be made more sustainable by equipping community members with the skills to maintain and operate their own water facilities, as well as introducing the use of simple and economical methods such as rainwater collection jars. This survey showed that few water sources appear to have trained water source committees and there are very few masons and hand pump mechanics living in the sub county.*

Community-based health resources

- *In Katine sub county residents have little access to private health-related services: very few villages have a private practitioner (e.g. midwife, nurse) or even private drug shops. Although the majority of villages (48) had one or more TBAs, 17 villages said they did not even have a TBA to provide basic delivery care,. In seven villages, respondents reported that they had no nearby government health facility. In these circumstances, VHTs are vital health care providers and provide an essential link to formal health services. More outreach services and a reliable referral system are also needed to ensure better health care coverage.*
- *Although Katine sub county states there are 323 VHTs covering all villages, this survey showed that in only 24 villages respondents were unanimous that they had a VHT; respondents in 15 villages were unanimous they did not, while the respondents in the 26*

remaining villages gave different answers. The project will have to confirm which villages have active VHTs and provide support to establish VHTs where they do not exist. Support will be needed for them to effectively fulfill their intended role in their client communities.

Livelihoods

- *The survey data confirm that the key source of income for majority of the population in Katine is the sale of agricultural produce; the other sources of income, namely brewing, petty trading and casual labour, also are related to agriculture. The priority of the KCPP livelihoods component will be agricultural production of both crops and livestock to improve production and productivity. Other income generating alternatives will be supported as a means of diversifying sources of households' income.*
- *Improved agricultural production and productivity cannot improve livelihoods without an organized agricultural marketing system. Although some farmer groups exist in Katine subcounty, they are not undertaking any marketing activity. To realize improved household incomes, the livelihoods component of the KCPP should organize the farmers into marketing groups to enable the farmers to enjoy the economies of scale as they undertake market oriented production of their selected agro-enterprises, including group storage and value addition.*
- *Access to financial services is one of the business development services that are key to improved production and effective marketing. The variation in the information gathered during this survey (and previous surveys) about presence of savings groups implies that if they exist, they are too weak to be easily recognized in the community. Under this project, community-based savings and credit groups should be established and strengthened and linked to the marketing associations for the members to easily access credit services for improved production and marketing.*
- *To maximize efficiency and achieve synergies, it is important that the livelihoods component of KCPP work closely work with other development organizations that are also working in Katine sub county.*

Schools

- *The material needs of the schools are huge: an additional 1,437 desks, 43 classrooms, almost 2,000 sets of textbooks, 112 latrine stances, 14 hand washing facilities, and five rainwater tanks. Project funds may not be sufficient to close all the gaps identified. Where this is the case, the project team will have to work with the community and school and other local authorities to determine how and where project's school funds will be placed. The three community-owned schools lack latrine and hand washing facilities; they should definitely receive first priority in construction of latrine stances.*
- *Most schools had school health clubs and school health committees, structures that the national School Health Policy stipulates should be engaged in promoting student health through a variety of activities. AMREF's well-established experience in building the capacity of these structures to be effective players for the good of pupils and the wider community will be of great value and KCPP provides another opportunity to document and demonstrate the effectiveness of school-based models.*
- *Girls, orphans and children with physical disabilities are often marginalized; this does not appear to be the case in Katine primary schools where girls outnumber boy pupils in nine of the*

13 schools and seven schools had pupils registered as orphans, representing 12 percent of the total pupils in those schools. According to a 2006 national survey, 12 percent of children under 18 years in the Eastern region were orphans and they were only slightly less likely to be attending school than non-orphaned children. The Katine data show that school-age orphans have comparable access to schooling.

Health Services

- *Family Planning is a priority problem area: contraceptives were available at two health units but between them they had only served 100 clients in a year. Unmet need for FP in the country is 41 percent (UDHS, 2006), so demand undoubtedly exists. The project needs to investigate the reasons behind the low uptake and take appropriate actions.*
- *The very small number of TB cases (6) receiving treatment at the HC IV indicates serious problems with detection and access/utilization of treatment. In addition to better provider skills, community outreach and sensitization is needed to address issues of stigma, and the project needs to identify other reasons for this poor performance at Atiriri and work with them to correct the problem.*
- *The PMTCT program in Atiriri HC IV is only three months old and thus it is too early to assess the performance of the PMTCT program. However, with only a 17 percent uptake of Nevirapine among HIV + pregnant women, this program should be closely monitored and support provided where needed so that it is on track to meet national targets.*
- *Only 47 percent of pregnant women received two doses of SP/Fansidar, well below the MOH target of 85 percent. The fact that 74 percent received the first dose shows the facility has the capacity to increase uptake. Community sensitization on IPTp should be undertaken.*
- *Availability of the anti-malaria medicine Coartem is a problem country-side and data from one facility indicate that it is a problem in Katine facilities. Stock outs in facilities means that VHTs will also be affected and thus the effects will be wide spread. Logistics management training and systems must be strengthened to alleviate disruption of treatment.*
- *Infection control appears to be poor, although only one indicator was included in this survey (waste disposal). A complete infection control assessment should be carried out in all three units using the MOH assessment tool.*
- *All facilities had updated stock cards for the key health products included in the survey. This suggests a level of good logistics management practices which makes possible more in-depth assessments of performance, e.g. tracking the number of days products are stocked out over three or six month periods. Refresher training on the various logistics management systems for HIV/AIDS, malaria and TB will be useful for all personnel involved in ordering, stock management and record-keeping.*

ANNEXES

ANNEX A

KATINE COMMUNITY PARTNERSHIPS PROJECT COMMUNITY SURVEY TOOL (MODULE 1)

VILLAGE PROFILE – AVAILABLE RESOURCES

Survey form completed by (Names)	_____	
Date of visit.....	_____	
Village.....	_____	
Population (and source of data).....	_____	
No. of households.....	_____	
People interviewed.....	_____	
	Response	Comments
1. Community health workers		
Does a VHT exist		
If yes, how many members		
If yes, have they been trained on home-based care		
If yes, when were they trained		
If yes, who trained them		
Has VHT been trained on management and planning		
Does the VHT have a bicycle to use for transport		
Does the VHT have a drug storage kit		
Number of active trained community medicine distributors (CMDs)		
How many traditional birth attendants live in the village		
2. Health providers		
Which MOH health unit is closest to the village		
Number of drug shops		
Number of private practitioners		
3. Water and sanitation		
What water sources do most households in this village use for drinking water: list them by type (borehole, well, spring) and whether protected or not		
Water source 1		
Water source 2		
Water source 3		
Does each water source have a trained water management committees trained		
Are water user fees collected each month from households		
If yes, approximately how much is collected from each household		
No. of households with rainwater collection jars		
No. of households with pit latrines		
7. Community O&M Capacity		
No. of local masons working in the village		
No. of hand pump mechanics working in the village		
8. Orphans		
No. of orphans living in the village		
9. Livelihoods		
No. of farmer groups in the village		
No. of farmer groups trained in agricultural related topics		
No. of community animal health workers in the village		
Is there a market in this village for selling agricultural products		
If no, which village markets are closest and how many		

kms away are they from village		
What are the three main sources of income for the village		
What are the three main food security crops in the village		
No. of marketing associations in village		
No. of savings and loans groups in village		
No. of registered savings and loans groups in village		
No. of agro-input dealers in village		
10. Active NGOs/CBOs		
Total no. of NGOs/CBOs currently engaged in livelihoods in the village		
No. of NGOs/CBOs currently engaged in water and/or sanitation activities in the village		
No. of NGOs/CBOs currently engaged in health promotion activities in the village		

KATINE COMMUNITY PARTNERSHIPS PROJECT
COMMUNITY SURVEY TOOL (MODULE 2)

SCHOOL PROFILE – AVAILABLE RESOURCES

Survey form completed by (Names)	_____	
Name of school.....	_____	
Village of School location	_____	
.....	_____	
Parish of School location.....	_____	
Date of Visit.....	_____	
People interviewed.....	_____	
Staff and pupil numbers	Response	Comments
Number of teachers		
Total no. of girls enrolled		
Total no. of boys enrolled		
No. of orphans enrolled		
No. of physically disabled pupils enrolled		
Infrastructure		
Number of classrooms		
Number of seats available:		
Number of seats needed		
Does school have health club		
Does school have health committee		
Does school have management committee		
No. of latrine stances for boys		
No. of latrine stances for girls		
Hand washing facilities near boys toilet		
Hand washing facilities near girls toilet		
Does school have rainwater harvesting tank		
If yes, tank is how many litres		

Does the tank function		
Number of water sources.		
Does the school have a development plan		
Ratio of pupils per text book		
Number of learning charts in school		

**KATINE COMMUNITY PARTNERSHIPS PROJECT
COMMUNITY SURVEY TOOL (MODULE 3)**

HEALTH FACILITY PROFILE – AVAILABLE RESOURCES

1. GENERAL INFORMATION			
Services provided at facility		Y/N	Health personnel currently on staff Number
Anti-retroviral therapy (ART)			Medical officer
Voluntary counseling and testing (VCT)			Clinical officer
Prevention of mother-to-child transmission (PMTCT)			Nurse
Management of opportunistic infections in HIV/AIDS patients			Midwife
Diagnosis of sexually transmitted infections (STIs)			Nurse assistant
Treatment of STIs			Lab technician
Diagnosis of malaria			Microscopist
Treatment of malaria			Comprehensive nurse
Diagnosis of tuberculosis (TB)			<i>Date of visit:</i>
Treatment of TB			
Lab diagnostic tests			
Family planning services			
Normal delivery care			
<i>Date of visit:</i>			

Laboratory equipment available for malaria, TB, HIV testing on day of visit		No. of lab tests performed in last 12 months	<i>Oct 2006- Oct 2007</i>
Item	Y/N	Test	<u>No.</u>
Functioning microscope		HIV tests	
Glass slides		TB sputum	
Field stain A		Malaria smear	
Field stain B			
Immersion oil			
Blood lancets			
Disinfectant			
Disposable gloves			
Wire loop holder			
Double strength wire (23 guage)			
Spirit burner			
Staining rack			

Ziehl Nielsen staining set	
HIV algorithm test set	
Vacutainers	

No. of lab supply orders submitted <u>on time in past 12 months</u>	
No. of orders submitted:	
No. submitted by NMS deadline:	

3. AVAILABILITY OF ESSENTIAL MEDICINES ON DAY OF VISIT

Check Y only if product has not expired or been damaged

Observations

Product	Y/N	Stock card?Y/N	Stock card entry w/in previous 30 days?Y/N
Coartem (ACTs):			
<i>Age groups:</i>			
3 Months to 3 Years			
3 Years to 7 Years			
7 Years to 12 Years			
12 Years and above			
HOMAPAK red			
HOMAPAK green			
RHZE blister strip			
EH blister strip			
Depo-Provera injectable vial			
Nevirapine tablets			
Nevirapine syrup			
SP/Fansidar tablets			
<i>Date of visit:</i>			

4. INFECTION CONTROL

How does this facility dispose of used safety boxes and other sharps containers? Put Y next to all that apply

Observations

Method	Y/N
Burned in incinerator	
Burned in open pit	
Burned and buried	
Buried	
Throw in trash/open pit	
Throw in pit latrine	
Thrown in covered placenta pit	
Transport offsite with municipal trash	
Transport offsite special disposal	
Sold to garbage collectors or recyclers	
<i>Date of visit 19/11/2007</i>	

5. SERVICE STATISTICS

Year	OPD visits <5 years		Malaria diagnosis <5 years		ANC new attendances		IPT 1 dose		IPT2 doses	
	Month		Month		Month		Month		Month	
2006	Oct		Oct		Oct		Oct		Oct	
	Nov		Nov		Nov		Nov		Nov	
	Dec		Dec		Dec		Dec		Dec	
	Jan		Jan		Jan		Jan		Jan	
	Feb		Feb		Feb		Feb		Feb	
	Mar		Mar		Mar		Mar		Mar	
	Apr		Apr		Apr		Apr		Apr	
	May		May		May		May		May	
	Jun		Jun		Jun		Jun		Jun	
	Jul		Jul		Jul		Jul		Jul	
	Aug		Aug		Aug		Aug		Aug	
	Sep		Sep		Sep		Sep		Sep	
2007	Oct		Oct		Oct		Oct		Oct	
	Total		Total		Total		Total		Total	

Year	Pregnant women tested for HIV		Pregnant women who tested HIV +		HIV+ women given ARVs		No. of deliveries performed in facility		No. of new FP clients (all methods)	
	Month		Month		Month		Month		Month	
2006	Oct		Oct		Oct		Oct		Oct	
	Nov		Nov		Nov		Nov		Nov	
	Dec		Dec		Dec		Dec		Dec	
	Jan		Jan		Jan		Jan		Jan	
	Feb		Feb		Feb		Feb		Feb	
	Mar		Mar		Mar		Mar		Mar	
	Apr		Apr		Apr		Apr		Apr	
	May		May		May		May		May	
	Jun		Jun		Jun		Jun		Jun	
	Jul		Jul		Jul		Jul		Jul	
	Aug		Aug		Aug		Aug		Aug	
	Sep		Sep		Sep		Sep		Sep	
2007	Oct		Oct		Oct		Oct		Oct	
	Total		Total		Total		Total		Total	

Year	No. of TB patients receiving drugs from facility		No. of AIDS cases receiving ART from facility	
	Month		Month	
2006	Oct		Oct	
	Nov		Nov	
	Dec		Dec	
	Jan		Jan	
	Feb		Feb	
	Mar		Mar	etc

ANNEX B VILLAGE SURVEY DATA

Village name	Population(Not sure=0).	VHT (Y=1/N=0)	HBC trained (Y=1/N=0)	No. bicycles (Y=1/N=0)	Drug storage kits(Y=1/N=0)	Trained CMDs	TBAs	Closet health unit	Primary water source	Trained Water Mgmt Comm. (Y=1/N=0)	Water fee	HH rain water jars	Distance to nearest water source	Masons	Hand pump spare part dealers	Handpump mechanics	No. of Orphans
Abari A	400	1	0	0	0	0	1 to 4	?	Borehole	1	1000	3-4	1km	4	1	1	30-100
Abari B	133	1	0	0	0	0	0	Atirir HCIV	Unprotected well	0	0	0	0.5-1km	0	0	0	25
Abarilela	769	0	0	0	0	0	0	Atirir HCIV	Unprotected well	0	500	0	1-4 km	0	0	0	not sure
Abata	478	0	0	0	0	1-2	2	none	unprotected well	0	500	0	2-4 km	0	0	0	60
Aber	250	0	0	0	0	0-2	?	Atirir HCIV	unprotected well	0	0	0	1-3 km	0	0	0	45-50
Abia	488	0	1	0	1	0-2	0	Ojom	Unprotected well	0	0	0	2km	0	0	0	19-25
Acam	625	0	1	0	0	0	0	Atirir HCIV	unprotected well	0	0	0	1-2km	0	0	0	26-35
Adamai	255	0	0	0	0	2	3	Tubur	Borehole	0	200-1000	0		0	0	0	30-100
Adamasiko	452	0	0	0	0	0	1	Atirir HCIV	unprotected well	0	0	0	1-4 km	0	0	0	19-60
Agaja	442	0	0	0	0	2	2	Ojom	unprotected well	1	0	0	2km	0	0	0	20- 50
Agora A	650	1	0	0	0	0-1	2	Atirir HCIV	unprotected well	0	0	0	1-3km	0	0	0	30-50
Agora B	498	1	1	1	0	2	0	Atirir HCIV	borehole	0	1000	0	3km	0	0	0	30-100
Agora C	387	1	1	0	1	2	0	Atirir HCIV	spring well	0	1000	0		0	0	0	17-19
Agule	314	1	0	0	1	2	0	Atirir HCIV	borehole	0	1000	0	1-2km	0	0	0	15-25
Ajobi	560	1	1	0	1	0	0	Atirir HCIV	borehole	0	1000	0	1-3km	0	0	0	35-40
Ajonyi A	376	0	0	0	0	0-2	1	None	unprotected well	0	0	0	2km	0	0	0	40-100
Ajonyi B	259	1	1	0	1	2	0	Ojom HC	borehole	1	500	0	1km	0	0	0	15-25
Alere	472	0	0	0	0	1-2	0	Atirir HCIV	unprotected well	0	0	0	2km	0	0	0	12
Alungar	403	1	1	0	0	0	1	Atirir HCIV	borehole	0	500	0	2km	0	0	0	20-25
Amorikot	500	0	0	0	0	0-2	?	Soroti hospital	borehole	0	1000	0	1km	0	0	0	10-Aug
Amutur	595	1	1	0	1	0	0	Ojom HC		1	2000	0	2km	0	0	0	30-50
Aputon	405	1	1	0	1	0-1	2	Ojom	spring well	0	0	0	2km	0	0	0	23
Atirir A	432	0	0	0	0	2	1	Ojom	unprotected well	0	0	0	2km	0	0	0	30-38
Atirir B	572	0	0	0	0	1-2	2 to 3	Agora clinic	unprotected well	0	0	0	1km	0	0	0	30-50
Awaca	452	0	0	0	0	0-2	0	Ojom HC	borehole	1	1000	0	1-3km	0	0	0	20-57

Village name	Population(Not sure=0).	VHT (Y=1/N=0)	HBC trained (Y=1/N=0)	No. bicycles (Y=1/N=0)	Drug storage kits(Y=1/N=0)	Trained CMDs	TBAs	Closet health unit	Primary water source	Trained Water Mgmt Comm. (Y=1/N=0)	Water fee	HH rain water jars	Distance to nearest water source	Masons	Hand pump spare part dealers	Handpump mechanics	No. of Orphans
Awidiang A	480	0	0	0	0	0-2	1 to 2	Ojom HC	unprotected well	0	1000	0	2-3km	0	0	0	40-100
Awidiang B	350	0	0	0	0	2	0	Ojom HC	unprotected well	0	0	0	2km	0	0	0	70-89
Kadinya	350	1	1	0	1	0	0	Ojom HC	unprotected well	0	0	0	1-2km	0	0	0	34
Kalela	362	1	1	0	1	0	1	Ojom HC	wells	0	0	0	2-3km	0	0	0	25
Katine	431	0	0	0	0	0-1	2	Ojom HC	wells	0	0	0	2-km	0	0	0	
Matali	507	1	1	0	1	0	1	Atiri HC	shallow well	0	0	0	1-2km	0	0	0	35-49
Merok	650	1	0	0	1		1	Atirir HCIV	borehole	1	500	1	1km	0	0	0	37 to47
Obalanga	424	1	1	0	0	1-2	0	Atirir	Unprotected well and borehole	0	0	0	1km	0	0	0	30-60
Obiol	617	1	1	0	1	0-5	0	none	open well and unprotected well	0	0	0	1km	0	0	0	22-26
Obochoi	507	0	0	0	0	2	0	none	swap	0	0	0	2-4km	0	0	0	25-50
Obongoi	598	0	0	0	0	0	1	Atiri HC	well	1	1000	1	1km	0	0	0	15-80
Oburitok	425	1	1	0	1	2-3	1	Atirir HCIV	borehole	1	500-2000	0	1-2km	0	0	0	50-100
Obyarai A	413	1	1	0	1	1	2	Ojom HC	unprotected well	0	0	0	2km	0	0	0	52-100
Obyarai B	379	1	0	0	0	2	3	none	unprotected well	0	1000	0	3km	0	0	0	20-29
Ocholai	480	0	0	0	0	0-2	4 to5	none	well	0	0	0	3km	0	0	0	50-56
Oderai	403	1	1	0	1	0-4	1 to 2	Soroti RH	borehole	0	1000	0	2km	0	0	0	26-35
Odwogai	963	1	1	0	1	0	2	Soroti RH	unprotected	0	0	0	3kms	0	0	0	8
Ogur	256	0	0	0	0	1-2	1	none	unprotected well	0	0	0	2-4km	0	0	0	28-40
Ogwolo	452	0	0	0	0	0	1	Ojom and Atirir	borehole	0	500	1	1-4km	0	0	0	20-50
Oimai	700	1	1	0	0	3	1	Ojom and Atirir	borehole	1	200-2000	2-6	2-km	0	0	0	50-100
Ojago	407	1	1	0	1	0	0	Atirir HCIV	Borehole and well	0	0	0	1-4km	0	0	0	20-50
Ojama	524	1	1	0	1	2	2	Ojom HC	well	0	0	0	2-3km	0	0	0	20- 50
Ojemorun	327	1	1	0	1	1	5	Atirir HCIV	borehole	1	1500	0	1-2km	0	0	0	18-20
Ojiji	413	1	1	0	0	2	1	Atirir HCIV	borehole and unprotected well	0	0	0	1-2km	0	0	0	30-100
Ojwiny	690	1	1	0	0	0-3	0	Atirir HCIV	unprotected well	0	0	0	1-5km	0	0	0	30-60
Olano	425	0	0	0	0	2	1	Atirir HCIV	unprotected well	0		0	1-2km	0	0	0	50-100
Olocoi	600	1	1	0	1	0	3	Atirir HCIV	borehole	0	0	0	1-4km	0	0	0	63-70

Village name	Population(Not sure=0).	VHT (Y=1/N=0)	HBC trained (Y=1/N=0)	No. bicycles (Y=1/N=0)	Drug storage kits(Y=1/N=0)	Trained CMDs	TBAs	Closest health unit	Primary water source	Trained Water Mgmt Comm. (Y=1/N=0)	Water fee	HH rain water jars	Distance to nearest water source	Masons	Hand pump spare part dealers	Handpump mechanics	No. of Orphans
Olusai	358	1	1	0	0	0-4	0	Atirir HCIV	borehole	0	0	0	2km	0	0	0	32-40
Olwelai	601	1	1	0	1	0-2	2 to 3	Atirir HCIV	borehole	0	0	0	2km	0	0	0	10-23
Omariai	726	1	1	0	1	0	1	Mission Hospital	borehole	0	0	0	1-3km	0	0	0	12-50
Ominit	301	1	1	0	0	0-2	0	Atirir HCIV	borehole	0	0	0	2km	0	0	0	70-200
Omodoi	210	1	1	0	0	0-2	0	Atirir HCIV	borehole	0	100-1000	0	1km	0	0	0	100
Omolokony	800	1	1	0	1	0	0	Atirir HCIV	spring well	0	0	0	1km	0	0	0	15-20
Omulai	500	0	0	0	0	0	0	Ojom HC	spring well	0		0	2km	0	0	0	10-100
Onongo	387	1	1	0	1	1-3	2	Atirir HCIV	Shallow well	0		0	3kms	0	0	0	50-77
Oomai	486	0	0	0	0	0	0	Atirir HCIV	unproteceted well	0	0	0	0.5-2km	0	0	0	50-70
Orechoi	420	1	1	0		0-2	0	Ojom HC	borehole	1	0	0	1-2km	0	0	0	35-40
Orieta	480	0	0	0	1	0	1	Soroti	borehole	1	5000	0	1-4km	0	0	0	35-45
Oyama	304	0	0	0	0	2	0	Atirir HCIV	borehole	0	250-500	0	1km	0	0	0	20
Samuk	594	1	1	0	1	2	0	Atirir	well	0	0	0	2-3km	0	0	0	30-35

Village name	Farmer groups	Animal health wrkers	Village market (Y= 1/N=0)	Distance to nearest market	Income source 1	Income source 2	Food Security crops 1	Food Security crops 2	No.of marketing Associations
Abari A	1-2	0	0		Mixed		mixed	mixed	0
Abari B	1-5	0	0	7-11km	casual lbr	selling firewood	cassava	potatoes	0-1
Abarilela	0-3	0	0	5 to 7km	Agric products	causal work	Cassava	Millet	0
Abata	0-1	0	0	3km	Agric products	petty trade	cassava	mixed	0
Aber	1-3	0	0	1-2km	Agric products	petty trade	cassava	sorghum	2
Abia	0-1	0	0	6kms	Agric products	Petty trade	Cassava	sorghum	0
Acam	0	0	0	3-7km	Mixed	Agric products	cassava	mixed	0
Adamai	0-1	0	-	3km	Quarrying	fishing	cassava	mixed	0
Adamasiko	0-4	0	0	7km	Agric products	petty trade	cassava	mixed	0
Agaja	3	0	0	5km	Agric products	crafts	cassava	mixed	0
Agora A	1	0	0	7km	Agric products		cassava	sorghum	0
Agora B	0	0	0	not sure	Agric products	causal work	cassava	mixed	0
Agora C	0	0	0	none	casual lbr	agriculture	cassava	potatoes	0
Agule	2	0	0	8km	Agric products	burning charcoal	cassava	potatoes	0
Agule	2	0	0	6kms	Agric products	fishing	cassava	potatoes	0
Agule	2	0	0	8km	Making mats	Charcoal trade	cassava	potatoes	0
Agule	2	0	0	5kms	Agric products	fishing	cassava	sorghum	0
Agule	2	0	0	8kms	Agric products	Charcoal trade	cassava	potatoes	0
Ajobi	0	0	0	2-3km	Agric products	Petty trade	cassava	G/Nuts	0
Ajonyi A	0	0	0	6-11km	Agric products		cassava	mixed	0
Ajonyi B	0	0	0	7km	Petty trade	sale of Agric products	cassava	sorghum	0
Alere	0-1	0	0	3km	Agric products	petty trade	cassava	Beans	0
Alungar	0-1	0	0	2 to 6km	Agric products	Selling fire wood	Cassava	Millet	0

Village name	Farmer groups	Animal health workers	Village market (Y=1/N=0)	Distance to nearest market	Income source 1	Income source 2	Food Security crops 1	Food Security crops 2	No. of marketing Associations
Amorikot	0-3		0	3-6km	Agric products	Mixed	cassava	mixed	0
Amutur	0	0	0	7km	Agric products	Mixed	cassava	potatoes	0
Aputon	0-1	0	0	3km	Agric products	petty trade	cassava	mixed	0
Atirir A	0-1	0	0	3-4km	Agric products	Brewing	Cassava	Millet	0
Atirir B	0-1	0	0	4km	Agric products	charcoal sale	Cassava	sorghum	0
Awaca	0-2	1	0	1 to 4km	Agric products	Mixed	Cassava	mixed	0
Awidiang A	3	0	0	4km	Agric products	brewing	cassava	mixed	0
Awidiang B	0-2	0	0	5km	Agric products	petty trade	cassava	potatoes	0
Kadinya	0-1	0	0	5km	art & crafts	agric products	cassava	mixed	0
Kalela	0-1	1	0	5- 10km	Agric products		cassava	mixed	0
Katine	3	0	1	1km	Agric products	Petty trade	cassava	mixed	0
Matali	0	0	0	3-8km	Agric products	casual work	Cassava	mixed	0
Merok	0	0	0	3-4km	Fishing	petty trade	cassava	potatoes	0
Obalanga	1-3	0	0	not sure	Agric products	Mixed	cassava	mixed	0
Obiol	1-3	1 to 2	0	3-4km	Agric products	Mixed	cassava	mixed	0
Obochoi	0	0	0	5-6km	Agric products	petty trade	cassava	potatoes	0
Obongoi	0	0	0	2-3km	Mixed	sale of firewood	cassava	millet	0
Oburitok	0	0	0	3-8km	Agric products	Mixed	sorghum	mixed	0
Obyarai A	0	0	0	8km	Mixed	petty trade	cassava	potatoes	0
Obyarai B	0-1	0	0	7km	Mixed	arts and crafts	cassava	sorghum	0
Ocholai	0-2	0	0	Not sure	Agric products	Mixed	sorghum	mixed	0
Oderai	0-1	0	0	3- 11km	Agric products	Mixed	cassava	mixed	0
Odwojai	0-1	0	0		Agric products		cassava	mixed	0
Ogur	2	0	0	5-8 kms	Agric products	Brewing	Cassava	Potatoes	0

Village name	Farmer groups	Animal health workers	Village market (Y=1/N=0)	Distance to nearest market	Income source 1	Income source 2	Food Security crops 1	Food Security crops 2	No. of marketing Associations
Ogwolo	1-5	0	1	3-7km	Agric products	Mixed	cassava	mixed	0
Oimai	0-4	0	0		Agric products		cassava	sorghum	0
Ojago	0	0	0	1- 10km	Agric products	Selling fire wood	cassava	mixed	0
Ojama	0-1	0	0	3-7km	Agric products	Brewing	cassava	Millet	0
Ojemorun	0	0	0		Agric products	crafts	cassava	mixed	0
Ojiji	0-2	0	0	7km	Agric products	petty trade	cassava	mixed	0
Ojwiny	3	1	0	4kms	brewing	petty trade	cassava	sorghum	0
Olano	0-6	0	1		Quarrying		cassava	mixed	0
Olocoi	0	0	0	6kms	Agric products	Petty trade	cassava	mixed	0
Olusai	1-4	1	0	6- 24km	Agric products		cassava	mixed	0
Olwelai	0-2		0	4km	Agric products		cassava	mixed	0
Omariai	0-1	0	0	4km	Agric products	casual labour	Cassava	Potatoes	0
Ominit	0	0	0	4km	Agric products	rearing animals	cassava	mixed	0
Omodoi	0-2	0	1	1km	Agric products	Brewing	cassava	mixed	0
Omolokony	0	0	0	4km	Mixed		cassava	mixed	0
Omulai	0-1	1	0	2-4km	Agric products	none	cassava	sorghum	0
Onongo	0-2	0	0		Agric products		mixed	mixed	0
Oomai	0-3	0		4km	Agric products	brewing	cassava	mixed	0
Orechoi	0-2	0	0	Not sure	Agric products	Mixed	Cassava	sorghum	0
Orieta	0-1	0	0	3-6km	Agric products	Petty trade	Cassava	mixed	0
Oyama	0	1	0	5-9 kms	Agric products	brewing	cassava	sorghum	0
Samuk	0-4		0	3km	Agric products	petty trade	cassava	potatoes	0

ANNEX C SCHOOL SURVEY DATA

School name	Parish	Village	Type of school	Number of teachers	Total no. of pupils	Girl to boy pupil ratio	No. of orphans enrolled	Proportion orphans to total pupils	No. of physically disabled pupils enrolled	Number of classrooms	Average pupils to classroom	Additional classrooms needed	No. of desks available	Pupils to desk ratio	3:1 ratio desks needed	25:1 desks needed	Pupils to text book ratio	Approximate no. of textbooks available	Number learning charts in school
Ochuloi	Ojom	Odwogai	UPE	16	836	1.00	51	0.06	2	4	209	11	166	5	113	0	no text books	0	0
Adamasiko	Ojom	Adamasiko	UPE	15	655	1.06	68	0.10	7	8	82	4	60	11	158	65	1:10	66	0
Ojom	Ojom	Obocei	Community	2	169	1.25	No data		1	2	85	1	0		56	50	no text books	0	0
Olwelai Katine	Olwelai	Olwelai	UPE	13	540	0.85	67	0.12	7	4	135	6	75	7	105	25	1:10	54	0
Kadinya Katine	Olwelai	Kalela	Community	6	368	0.98	48	0.13	2	2	184	5	36	10	87	14	1:10	37	0
Amorikot	Olwelai	Amorikot	Community	7	364	1.09	No data		5	7	52	0	0		121	125	no text books	0	0
Oimai	Merok	Oimai	UPE	9	628	1.08	84	0.13	7	7	90	4	99	6	110	126	not sure	not sure	0
Merok	Merok	Omolokony	UPE	8	563	1.01	No data		7	8	70	2	157	4	31	43	1:10	56	0
Katine	Katine	Katine	UPE	12	653	1.02	No data		14	7	93	5	100	7	118	75	1:10	65	0
Katine Tiriri	Katine	Omaria	UPE	18	831	0.95	149	0.18	20	15	55	0	170	5	107	107	1:20	42	0
Obyarai	Ochuloi	Abari A	UPE	12	796	1.05	No data		1	9	88	5	37	22	228	188	1:10	80	0
Ojago	Ochuloi	Ojago	UPE	7	460	0.92	No data		1	8	58	0	68	7	85	120	no text books	0	0
Ojama katine	Ojama	Ojama	UPE	8	668	1.07	76	0.11	0	8	84	4	105	6	118	95	1:10	67	0
Subtotals					7531		543	0.121	74	89		43	1073		1437	1033		466	0

School name	Does school have health club (Yes=1, No=0)	Does school have health committee (Yes=1, No=0)	Does school have management committee (Yes=1, No=0)	No. of latrine stances for boys	Stance to boys ratio	Boy stances needed	No. of latrine stances for girls	Stance to girls ratio	Girl stances needed	Hand washing facilities near boys toilet (Yes=1, No=0)	Hand washing facilities near girls toilet (Yes=1, No=0)	Does school have rainwater harvesting tank (Yes=1, No=0)	if yes, tank is how many litres	Does tank function (Yes=1, No=0)	No. of water sources	Does school have a development plan (Yes=1, No=0)
Ochuloi	1	1	1	5	83	5	3	140	7	1	1	1	5,000	1	1	0
Adamasiko	1	1	1	4	80	4	5	67	3	1	1	1	10,000	1	1	0
Ojom	0	0	1	0	0	2	0	0	2	0	0	0	0	0	0	0
Olwelai Katine	1	1	1	4	73	3	4	62	2	1	1	1	10,000	1	1	0
Kadinya Katine	1	0	1	1	186	4	1	182	4	0	0	1	10,000	0	0	0
Amorikot	0	0	1	0	0	4	0	0	5	0	0	0	0	0	0	0
Oimai	0	0	1	3	101	5	2	163	6	0	0	0	0	0	1	0
Merok	1	1	1	4	70	3	5	57	2	1	0	0	0	0	1	0
Katine	1	1	1	3	108	5	2	165	6	1	0	1	10000	1	1	1
Katine Tiriri	1	1	1	5	85	6	5	81	5	1	1	1	10000	1	1	1
Obyarai	1	1	1	4	97	6	2	204	8	0	0	1	0	1	0	0
Ojago	1	0	1	0	0	6	0	0	6	1	0	0	0	0	0	0
Ojama katine	1	1	1	3	107	5	4	87	5	1	0	1	10,000	1	2	1
Subtotals	10	8	13	36			33			8	4	8		7	9	3

ANNEX D HEALTH FACILITY SURVEY DATA

District	SOROTI DISTRICT
Sub-County	KATINE
Parish	
Health Facility	TIRIRI HC IV

BASELINE FACILITY SURVEY (Time 1)

LABORATORY SERVICES

Observations

Laboratory equipment available for malaria, TB and HIV on day of visit

Item	Y/N
Functioning microscope	Y
Glass slides	Y
Field stain A	N
Field stain B	N
Immersion oil	Y
Blood lancets	Y
Disinfectant	Y
Disposable gloves	Y
Wire loop holder	Y
Double strength wire (23 guage)	N
Spirit burner	Y
Staining rack	N
Ziehl Nielsen staining set	N
HIV algorithm test set	Y
Vacutainers	Y
Sleeves	Y
Needles	Y
<i>Date of visit 19/11/2007</i>	

NMS records or copy of orders

No. of lab supply orders submitted on time in past 12 months

No. of orders submitted:	
No. submitted by NMS deadline:	
<i>Time period used: Oct 2006-Oct 2007</i>	

Annual deadlines at NMS:

Lab registers

No. of lab tests performed in past 13 months

HIV tests	162
TB sputum	111
Malaria blood smear	2135
<i>Time period used: Oct 2006-Oct 2007</i>	

AVAILABILITY OF ESSENTIAL MEDICINES ON DAY OF VISIT

Check Y only if product has not expired or been damaged

Observations

Product	Y/N	Stock card? Y/N	Stock card entry w/in previous 30 days? Y/N
Coartem (ACTs):	Y	Y	Y
<i>Age groups:</i>			
3 Months to 3Years	Y	Y	Y
3Years to 7Years	Y	Y	Y
7Years to 12Years	Y	Y	Y
12Years and above	Y	Y	Y
HOMAPAK red	Y	Y	Y
HOMAPAK green	Y	Y	Y
RHZE blister strip	Y	Y	Y
EH blister strip	Y	Y	Y
Depo-Provera injectable vial	Y	Y	Y
Nevirapine tablets	Y	Y	Y
Nevirapine syrup	Y	Y	Y
SP/Fansidar tablets	Y	Y	Y
<i>Date of visit 19/11/2007</i>			

SERVICE STATISTICS

Malaria cases among children under five

<u>OPD visits <5 years</u>			<u>Malaria diagnosis <5 years</u>			<u>Malaria percentage of OPD visits</u>
Year	Month		Year	Month		
2006	Oct	945	2006	Oct	470	50%
	Nov	817		Nov	467	57%
	Dec	472		Dec	339	72%
	Jan	395		Jan	297	75%
	Feb	378		Feb	255	67%
	Mar	555		Mar	299	54%
	Apr	477		Apr	263	55%
	May	741		May	356	48%
	Jun	609		Jun	266	44%
	Jul	768		Jul	416	54%
	Aug	930		Aug	547	59%
	Sep	583		Sep	324	56%
2007	Oct	793	2007	Oct	395	50%
	Total	8463		Total	4694	55%
Popn under five years		5000				
OPD utilization rate		169				

HMIS 075 Maternal Health Tally Sheet

<u>ANC new attendances</u>			<u>IPT1 treatments</u>			<u>IPT2 treatments</u>			<u>IPT% of ANC clients</u>		
Year	Month		Year	Month		Year	Month		IPT1	IPT2	
2006	Oct	144	2006	Oct	141	2006	Oct	189	98%	131%	
	Nov	271		Nov	174		Nov	81	64%	30%	
	Dec	191		Dec	20		Dec	16	10%	8%	
	Jan	193		Jan	187		Jan	138	97%	72%	
	Feb	201		Feb	260		Feb	75	129%	37%	
	Mar	218		Mar	170		Mar	105	78%	48%	
	Apr	184		Apr	175		Apr	105	95%	57%	
	May	208		May	0		May	0	0%	0%	
	Jun	193		Jun	21		Jun	22	11%	11%	
	Jul	100		Jul	85		Jul	71	85%	71%	
	Aug	358		Aug	393		Aug	140	110%	39%	
	Sep	181		Sep	187		Sep	107	103%	59%	
2007	Oct	262	2007	Oct	206	2007	Oct	113	79%	43%	
	Total	2704		Total	2019		Total	1162	960%	607%	
									Avg.	74%	47%

HU monthly report

<u>Pregnant women tested for HIV</u>			<u>Pregnant women who tested positive</u>			<u>Pregnant women given anti-retrovirals for PMTCT</u>		
Year	Month		Year	Month		Year	Month	
2006	Oct	0	2006	Oct	0	2006	Oct	0
	Nov	0		Nov	0		Nov	0
	Dec	0		Dec	0		Dec	0
	Jan	0		Jan	0		Jan	0
	Feb	11		Feb	0		Feb	0
	Mar	0		Mar	0		Mar	0
	Apr	0		Apr	0		Apr	0
	May	0		May	0		May	0
	Jun	0		Jun	0		Jun	0
	Jul	0		Jul	0		Jul	0
	Aug	114		Aug	5		Aug	2
	Sep	105		Sep	5		Sep	0
2007	Oct	204	2007	Oct	8	2007	Oct	1
	Total	434		Total	18		Total	3

No. of deliveries performed in facility			No. of new family planning clients (all methods)		
Year	Month		Year	Month	
2006	Oct	52	2006	Oct	26
	Nov	44		Nov	0
	Dec	48		Dec	8
	Jan	49		Jan	11
	Feb	42		Feb	1
	Mar	46		Mar	1
	Apr	38		Apr	8
	May	72		May	19
	Jun	52		Jun	13
	Jul	37		Jul	4
	Aug	32		Aug	10
	Sep	55		Sep	3
2007	Oct	50	2007	Oct	9
	Total	617		Total	113
Expected deliveries		1175			
% deliveries		53			

No. of TB patients receiving drugs from facility		
Year	Month	
2006	Oct	0
	Nov	1
	Dec	0
	Jan	0
	Feb	0
	Mar	3
	Apr	0
	May	1
	Jun	0
	Jul	0
	Aug	0
	Sep	0
2007	Oct	1
	Total	6
Expected TB cases		75

District	SOROTI DISTRICT
Sub-County	KATINE
Parish	Ojom parish
Health Facility	OJOM HC II

3. AVAILABILITY OF ESSENTIAL MEDICINES ON DAY OF VISIT

Check Y only if product has not expired or been damaged

Observations

Product	Y/N	Stock card?Y/N	Stock card entry w/in
Coartem (ACTs):	Y	Y	
Age groups:			
4 months to 3 years	Y	Y	Y
3Years to 7Years	Y	Y	Y
7Years to 12Years	Y	Y	Y
12Years and above	Y	Y	Y
HOMAPAK red	Y	Y	Y
HOMAPAK green	Y	Y	Y
RHZE blister strip	NA	Y	Y
EH blister strip	NA	Y	Y
Depo-Provera injectable vial	Y	Y	Y
Nevirapine tablets	NA	Y	Y
Nevirapine syrup	NA	Y	Y
SP/Fansidar tablets	Y	Y	Y
Condoms	Y	Y	Y
Date of visit: 16/11/2007			

5. SERVICE STATISTICS

Malaria cases among children under five

OPD diagnoses summary

OPD visits <5 years		Malaria diagnosis <5 years		Malaria percentage of OPD visits
Year	Month	Year	Month	
2006	Oct	2006	Oct	89%
	Nov		Nov	82%
	Dec		Dec	38%
	Jan		Jan	91%
	Feb		Feb	91%
	Mar		Mar	41%
	Apr		Apr	83%
	May		May	91%
	Jun		Jun	81%
	Jul		Jul	94%
	Aug		Aug	49%
	Sep		Sep	93%
2007	Oct	2007	Oct	91%
	Total		Total	75%
	Average		Average	75%

District	SOROTI DISTRICT
Sub-County	KATINE
Parish	
Health Facility	Katine HCII dispensary

BASELINE FACILITY SURVEY (Time 1)

3. AVAILABILITY OF ESSENTIAL MEDICINES ON DAY OF VISIT

Check Y only if product has not expired or been damaged

Observations

Product	Y/N	Stock card?Y/N	Stock card entry w/in
Coartem (ACTs):	Y	Y	Y
<i>Age groups:</i>			
3months to 3Years	Y	Y	Y
3Years to 7Years	Y	Y	Y
7Years to 12Years	Y	Y	Y
12Years and above	Y	Y	Y
HOMAPAK red	N	N	N
HOMAPAK green	N	N	N
RHZE blister strip	N	N	N
EH blister strip	N	N	N
Depo-Provera injectable vial	N	N	N
Nevirapine tablets	N	N	N
Nevirapine syrup	N	N	N
SP/Fansidar tablets			
<i>Date of visit 20/11/2007</i>			

5. SERVICE STATISTICS

Malaria cases among children under five

OPD diagnoses summary

<u>OPD visits <5 years</u>		<u>Malaria diagnosis <5 years</u>		<u>Malaria percentage of OPD visits</u>
Year	Month	Year	Month	
2006	Oct	2006	Oct	66.9
	Nov		Nov	64.3
	Dec		Dec	90.0
	Jan		Jan	91.5
	Feb		Feb	94.1
	Mar		Mar	91.9
	Apr		Apr	79.1
	May		May	77.0
	Jun		Jun	91.2
	Jul		Jul	92.1
	Aug		Aug	84.7
	Sep		Sep	83.0
2007	Oct	2007	Oct	87.8
	Total		Total	84.2