The PEPFAR Local Capacity Initiative Supports the Community Scorecard to Improve HIV Services for Key Populations in Uganda

Mary Freyder, MPH, LMSW
Eve Namisango, PhD
Tory M. Taylor, MPH
Annie Glover, PhD, MPH, MPA
Katherine Andrinopoulos, PhD, MPH

The Local Capacity Initiative (LCI) strengthened the capacity of civil society organizations (CSOs) to support policy advocacy, with the ultimate goal of improving health services for key populations (KPs) affected by the HIV epidemic.[1] The United States President's Emergency Plan for AIDS Relief (PEPFAR) funded the initiative from 2013–2018 to help local CSOs create an enabling environment for PEPFAR's objectives.

Under the LCI, the United States Centers for Disease Control and Prevention (CDC) worked in Uganda between 2015 and 2018 to strengthen the policy advocacy capacity of CSOs that worked with men who have sex with men (MSM), transgender women, and sex workers and develop the capacity of public health officials (PHOs) to consider gender

[1] Key populations include men who have sex with men, sex workers, people who use injectable drugs, and transgender people.

and sexual diversity issues. MEASURE Evaluation, which is funded by the United States Agency for International Development (USAID) and PEPFAR, conducted an evaluation of LCI Uganda (referred to hereafter as LCI) between 2017 and 2018.

This brief provides an overview of the community scorecard (CSC) strategy to improve HIV clinical services in Uganda. Additional briefs summarize the main interventions that LCI employed to create an enabling environment for policy advocacy,[2] efforts to support KPs in coalition building,[3] and the methods used by the evaluation team to study the efficacy of LCI's work and measure change resulting from it.[4]

LCI employed the CSC strategy to improve access to HIV services for KPs, including men who have sex with men (MSM), transgender women, and sex workers. This evaluation brief describes the CSC intervention from the perspectives of CSO workers and PHO participants, and using facility-level CSC program data. Ultimately, the LCI CSC strategy expanded the availability of HIV services for KPs, as documented by in-depth interviews, a CSO worker survey, a PHO survey, and the CSC data. At the time of this evaluation, HIV service data by KP had not been collected at facilities.

Data presented here indicate high levels of feasibility and acceptability of CSC-related activities among participating clinics. CSO capacity development, CSO networking, PHO engagement at the district level, and gender and sexual diversity training served as the backbone for successful implementation of the CSC as a community accountability mechanism.

What Is a Community Scorecard?

The CSC is a vehicle for community engagement in the improvement of clinical health services. CDC implemented the CSC intervention to "increase participation, accountability, and transparency between service users, providers, and decision-makers."[5] CSCs bring providers and clients together to better understand each other's service delivery experiences and develop a shared action plan. The CSC is a snapshot performance-assessment tool that facilitates strategic dialogue between KPs (as HIV service users) and health workers (as HIV service providers). Figure 1 illustrates the CSC process.

Figure 1. CSC process

*Community-generated performance refers to scores provided by community members.

With financial support from PEPFAR, LCI implemented the CSC between April 2015 and March 2018 in six clinics in Mukono, Wakiso, and Kampala: (1) Mukuno Health Center (HC) IV; (2) Kojja HC IV; (3) Kawaala HC III; (4) Kisenyi HC IV; (5) Kiira HC III; and (6) Kijjansi HC IV. A survey conducted in 2018 of PHOs (N=120) found that 53 (44%) had participated in a CSC meeting recently. Among

[2] Freyder, M., Namisango, E., Taylor, T., Glover, A., Andrinopoulos, K. (2020). The PEPFAR Local Capacity Initiative Interventions in Uganda. https://www.measureevaluation.org/resources/publications/fs-19-362

[3] Andrinopoulos, K., Namisango, E., Taylor, T. Glover, A., & Freyder, M. (2020). The PEPFAR Local Capacity Initiative Supports Key Population Coalition Building in Uganda. https://www.measureevaluation.org/resources/publications/fs-19-412

[4] Freyder, M., Namisango, E., Taylor, T., Glover, A., & Andrinopoulos, K. (2020). The PEPFAR Local Capacity Initiative Supports a Coalition of Civil Society Organizations Serving Key Populations in Uganda. https://www.measureevaluation.org/resources/publications/fs-19-411

[5] CDC. (n.d.) Community engagement: Enabling a future of meaningful collaboration at all levels of health and human rights decision-making. Atlanta, GA, USA: CDC. Retrieved from https://www.cdc.gov/globalhivtb/who-we-are/resources/keyareafactsheets/Ensuring-Quality-Health-Systems-and-Human-Resources.pdf

the officials who attended CSC meetings, nearly half (26) reported that these meetings were at the health facility level, 23 percent were at the district level, and 28 percent were at another unspecified level. Out of 132 CSOs surveyed, 90 (68%) also participated in a CSC meeting.

The Community Scorecard Worked to Expand Key Population-Friendly HIV Services in Health Facilities

In interviews, both CSO workers and PHOs reported a marked change in KP-friendly HIV services after clinics underwent the CSC process. A CSO worker described this improvement as follows:

> *The most significant change for me is that at least now, sex workers can go to public health facilities and get treatment because of this scorecard. Now, even the government recognizes it. We have got contact people in some of the health facilities (Kisenyi; Kawaala) to whom we can send sex workers and other key populations groups. Initially, it would take a long process, and at times we had to give bribes to health workers to get a service. But these activities that were done opened up healthcare providers' minds to realize that we are people and we need these services. To me, this changed a lot.*

A PHO working at the facility level said the following:

> *For me, what I think has been most significant* [about the CSC], *before we would take a whole month without seeing any KP coming for services. But ever since that advocacy was done, we now have quite a very big number coming in, and they freely disclose and they are very open. So for me, that is a very significant change, because before that, they would tell you, "I won't come to the HC, but you bring for me drugs." And yet, some tests are supposed to be done at the facility. But the fact that they can come freely and get the services, that is a significant change, since that was not the case two years back. You would bring the drugs, and now one would come to get them. . . . This change happened because we started having the dialogues and the community scorecard. Through dialogues and the community scorecard, that is when we saw that there was a need for ABC, and that was done that is why the change is there. if we didn't have the dialogues and the community scorecard, we would not know that the KPs are not accessing care.*

Evaluation survey results demonstrated that this positive assessment was also shared by other PHOs who had participated in the CSC process. PHOs who participated in CSC meetings were asked about the effects of these meetings on their thinking and policy priorities. Nearly all PHOs (98%) said the CSC made a difference in their policy priorities, with 72 percent saying that it made a big difference. A majority of PHOs (70%) said the CSC process made a difference in their thinking about sex workers, and 94 percent said it made a difference in their thinking about MSM (Figure 2).

Figure 2. Assessment of community scorecard intervention 2018 (N=53)

PHOs were also asked to identify which service delivery gaps addressed during CSC meetings were the most important. The service delivery gap that was cited most often was treatment for sexually transmitted infection (STI), followed by the need to improve the availability of lubricants and female condoms. Additional service delivery gaps identified by PHOs are listed in Table 1.

Table 1. Service delivery gaps addressed in CSC meetings and identified as most important by PHOs (2018) (N=51)

	Number	Percentage
STI treatment	23	45
Lubricants	10	20
Female condoms	10	20
Condoms	8	16
Stigma and discrimination	7	14
Postabortion care	3	6
Voluntary male circumcision	2	6
Peers are misinformed	2	4
Services are not comprehensive	2	4
Client attitude	2	4
Health promotion	2	4
Other	8	17

PHOs also assessed how fully the issues they identified were addressed through the CSC process. Of the 53 PHOs who participated in CSC meetings, 11 (21%) thought these issues were completely addressed, 38 (72%) thought they were somewhat addressed, and four (8%) thought they were not at all addressed.

CSOs also characterized the CSC activities as meaningful to their work. In all, 70 CSOs were trained in implementing the CSC; of these, 65 (93%) reported that they used CSC-generated material in their day-to-day work sometimes, often, or always. Most CSOs also reported that the CSC intervention improved the availability of HIV services for KPs and the quality of these services. Table 2 details these survey results.

After the Community Scorecard Intervention, Geographic Access to HIV Services Expanded for Key Populations

The LCI program targeted three health districts in the Central Region of Uganda: Kampala, Mukono, and Wakiso. CSC interventions were conducted at six Level III and IV HCs. Health centers operating at Level III are designed to serve a population of 20,000 and provide laboratory services and preventive, promotive, outpatient curative, maternity, and inpatient health services. Level IV HCs serve a population of 100,000 and provide all Level III services, adding emergency surgery and blood transfusion.[6] Figure 3 lists health facilities involved in the CSC intervention by health district.

Figure 3. Uganda Central Region health facilities in the LCI CSC program

[6] The Republic of Uganda Ministry of Health Division of Health Information. (2018). National health facility master list. Kampala, Uganda: Ministry of Health. Retrieved from https://health.go.ug/content/national-health-facility-master-list-2018

Table 2. Assessment by CSO workers of the effect of CSC on HIV services for KPs (2018) (N=132)

As a result of using a scorecard:	Completely true (%)	Somewhat true (%)	Not at all true or don't know (%)
HIV services for MSM are now available at the health facility	52	42	6
District/city division health managers are now aware of required quality of HIV services for MSM and are making efforts to make these services available	52	42	5
HIV services for sex workers are now available at the health facility	61	35	4
District/city division health managers are now aware of required quality of HIV services for sex workers and are making efforts to make these services available	59	36	5

CSO workers began CSC meetings and assessments of health facilities in January 2017, and continued these assessments quarterly until March 2018. As illustrated below in Figure 4, access and availability of HIV and reproductive health services increased across the board for health facilities engaged in the CSC process.

The most dramatic improvement in service access and availability was observed for pre-exposure prophylaxis (PrEP) and other HIV-prevention services, including provision of female and male condoms, condom-compatible lubricants, post-exposure prophylaxis, voluntary medical male circumcision, behavioral change communication, and information and education communication materials.[7] As illustrated in Figure 5, this dramatic increase in service availability and accessibility was observed for every HC that participated in the CSC intervention, with the greatest increase occurring in Mukono District.

[7] Although PrEP services received additional support from CDC through a concurrent program in these clinics, all HIV prevention services experienced significant improvement in CSC scores.

The availability and accessibility of HIV treatment services for KPs (specifically antiretroviral treatment [ART] services) also increased through the CSC process, but this increase varied across districts (Figure 6). In Kampala, accessibility and availability of HIV treatment services were high at the start of the intervention, and the CSC assessments showed that these services were maintained at high levels. On the other hand, HCs in Wakiso had low availability and accessibility of HIV treatment services. At Kajjansi HC IV, scores in this domain showed small improvements; however, scores at Kira HC III dramatically improved. At the start of the CSC intervention, HIV treatment services were not available in this HC; by the end of the intervention, services had expanded to reflect a perfect score in this service domain. In Mukono, both HCs improved their HIV treatment service scores by three points over the term of the CSC intervention.

The CSC process also measured the availability of facility-based and community-based HIV counseling and testing and found improvement across all HCs involved in this intervention (Figure 7). As with PrEP and other prevention services, the most dramatic improvement was observed in Mukono District.

Figure 4. CSC score changes, by service category across all clinics after one year of quarterly assessments

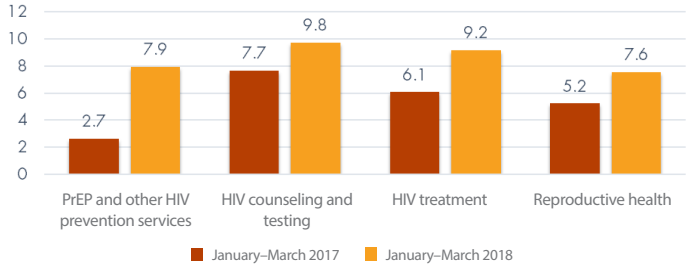


Figure 5. PrEP and other HIV prevention CSC score changes after one year of quarterly assessments

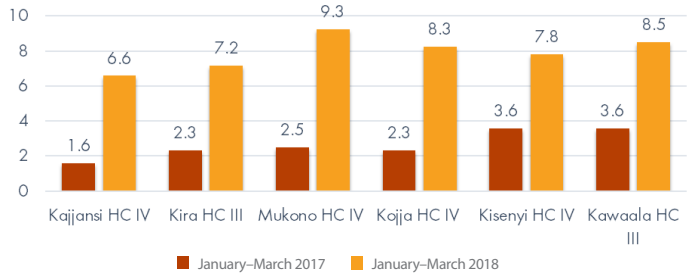


Figure 6. HIV treatment CSC score changes after one year of quarterly assessments

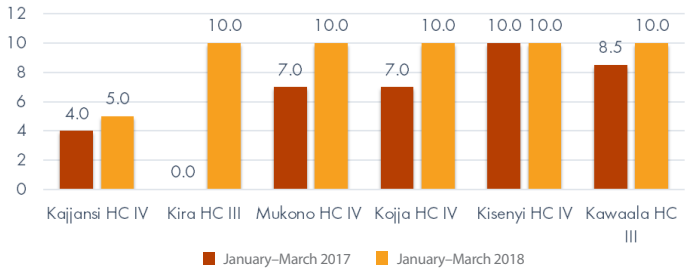
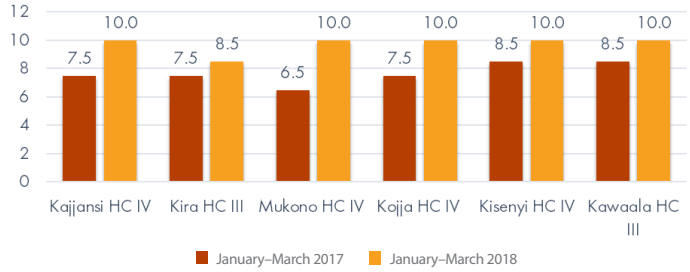
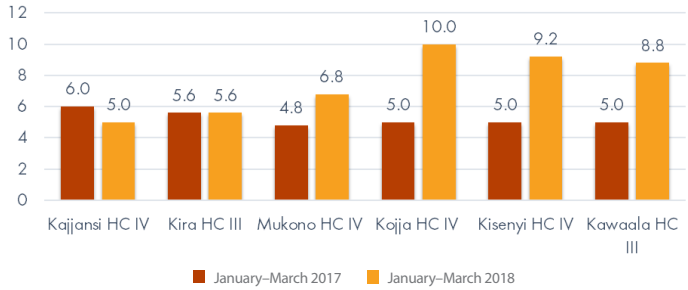


Figure 7. HIV counseling and testing CSC score changes after one year of quarterly assessments



Finally, progress was assessed in the availability and accessibility of reproductive health services, including family planning, postabortion care, and sexual and gender-based violence screening and management (Figure 8). The effect of CSC interventions in these service domains varied across health districts. In Wakiso, the availability and accessibility of reproductive health services did not improve during the facilities' involvement with the CSC; in fact, at Kajjansi HC IV, the reproductive health service score went down by one point. In Mukono and Kampala Districts, reproductive health service scores increased during the CSC intervention period.

Figure 8. Reproductive health CSC score changes after one year of quarterly assessments



This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government. FS-19-413