MADIPHA

MASAKA ASSOCIATION OF PERSONS WITH DISABILITY LIVING WITH HIV & AIDS (MADIPHA)

REPORT OF THE ACCESSIBILITY ASSESSMENT OF DISTRICT HEALTH FACILITIES OFFERING HIV AND TB SERVICES IN MASAKA, KALUNGU, LWENGO, BUKOMANSIMBI AND RAKAI DISTRICTS.

Stop TB Partnership UNOPS

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NOTE ON FORMATTING

The formatting for this report follows an accessible style that allows for easier reading for people with visual disabilities. It was made accessible for screen readers. Our intention is to make the content of this report available to all our community members who contributed to the content. With this design choice, we also want to raise awareness of the simple changes possible to create greater accessibility for people with disabilities.

The accessible formatting choices for this report include: a larger, sans serif font; 1.5 line spacing; left orientation; page width instead of two columns; use of endnotes instead of footnotes; and alt text for images. Unfortunately, the use of tables was unavoidable.

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The authors take full responsibility and exonerate MADIPHA of any misrepresentations in this report, which if found are not intentional but may have arisen from the challenge of analysing the sheer amount of information the respondents very generously provided.

It is our sincere hope that the findings contained in this report will add momentum to the advocacy for universal accessibility of TB and HIV/AIDS services for persons with disabilities.

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ABBREVIATIONS

BOD..... Board of Directors

CHWV..... Community Health Worker Volunteers

CRPD..... Convention on the Rights of Persons with disabilities

DRF..... Disability Rights Fund

FGD..... Focus Group Discussion

GOU..... Government of Uganda

HUMC..... Health Units Management Committees

IEC..... Information, Education and Communication

PLHIV..... People Living with HIV

MADIPHA..... Masaka Association of Persons with Disability living with HIV&AIDS

MDR-TB..... Multidrug-resistant tuberculosis

NRHs..... National referral hospitals

NTLP..... National Tuberculosis and Leprosy Programme

OPDs..... Organizations of People with disabilities

PHPs..... Private health practitioners

RPMT..... Regional Performance Monitoring Teams

RRHs..... Regional referral hospitals

SDG..... Sustainable Development Goal

TB..... Tuberculosis

TCMPs..... Traditional and complementary medicine practitioners

UN ..... United Nations

VHTs..... Village Health Teams

WAD..... World AIDS Day

EXECUTIVE SUMMARY

Health systems frequently fail to respond adequately to both the general and specific healthcare needs of people with disabilities. As a result, people with disabilities have worse health outcomes, and greater unmet health needs, than people without disability.

With funding from the Disability Rights Fund (DRF) and the STOP TB Partnership, Masaka Association of Persons with Disability Living with HIV&AIDS (MADIPHA) is implementing a project to strengthen advocacy for the implementation of seven pieces of local legislations for promoting disability inclusive HIV/AIDS and TB prevention and control. The local legislations include District Ordinance for Rakai District and six bilaws for Kyesiga Sub County, Lukaya Town

Council, Malongo Sub County, Kiseka Sub County, Lwengo Town Council and Kitanda Sub County.

The goal of the advocacy campaign for implementing the local legislations is to ensure universal access to health services for people with disabilities to realize equitable access and utilization of available services in accordance with Article 25 of the Convention on the Rights of Persons with disabilities (CRPD)[i] and Sustainable Development Goal 3 (SDG 3) – Quality Health services for all.[ii]

In pursuance of the advocacy objective for universal access to health services, MADIPHA Commissioned the Accessibility Assessments of five health facilities providing TB and HIV/AIDS services. The facilities

were Rakai Health Center IV (Rakai District), Butenga Health Center IV (Bukomansimbi District), Kyanamukaka Health Center IV (Masaka District), Kyetume Health Center III (Lwengo District) and Kalungu Health Center III (Kaluungu District).

The overarching aim of the Accessibility Audits was to ascertain barriers limiting people with disabilities from accessing equitable HIV/AIDS, TB, and other general health services in above five selected health facilities. The five facilities were selected through a consultative process between MADIPHA and the respective district health departments on account that the facilities were priority TB and HIV/AIDS services in the respective districts. Some facilities had just undergone major rehabilitation hence the need to confirm if needs of

people with disabilities had been addressed. MADIPHA already had a good working relationship with some of the facilities.

This aim was broken down into the following specific objectives:

- Assess the availability of TB and HIV/AIDS services at the five health centres.
- Assess the physical accessibility of the five selected health facilities providing HIV/AIDS, TB, and other general health services in five districts of greater Masaka sub region; and
- Establish whether information is provided in alternative formats for people with disabilities who have difficulty reading printed information.

The findings will be used to provide evidence of the state of physical accessibility of the health facilities, train peer monitors and leaders of peer support groups to conduct accessibility assessment audits in other health facilities and provide evidence for advocacy and awareness raising for the realization of universal accessibility through compliance with universal designs. 'Universal design' means the design of products, environments, programmes, and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.

FINDINGS

The findings of the Accessibility Assessments indicated that although all Health Centres III (health facilities

managed by a Clinical Officer), Health Centres IV (managed by a medical officer) and District Hospital in the Accessibility Assessment provide TB and HIV/AIDS services in accordance with the stipulations of the National HIV/AIDS Response plan (NHRP) and the National TB and Leprosy Control Program (NTLCP), there was no evidence of institutionalized strategies and interventions to manage the intersection of disability, TB and HIV/AIDS at the health facilities assessed. Such strategies and interventions are stipulated by the World Health Organizations (WHO)[iii] implying contravention of CRPD Art 25 provisions and inadvertent exclusion of people with disabilities from the efforts to realize SDG3.

Disability rehabilitative services are not integrated into TB and HIV/AIDS service delivery at the health facilities. People with disabilities that need TB and HIV/AIDS drugs along with other regular medication such as drugs for managing epilepsy cannot receive the drugs for their different conditions at the same service point. Most times they must travel to the respective hospital on different days thus increasing the cost of securing comprehensive disability and TB/HIVAIDS services. Assistive devices like wheelchairs, crutches, spectacles, white canes, etc. are not distributed as part of the TB and HIV/AIDS package even though it is well known that people with disabilities are vulnerable to TB and HIV/AIDS and Importantly, both TB and HIV/AIDS

have been well established as causes and aggravators of disability.

Findings regarding poor time management by health workers, harassment by health workers, and limited ability of health workers to understand the accommodation needs of persons with disabilities, especially those with invisible disabilities, document constrained equitable and satisfactory access to TB and HIV/AIDS services at health facilities for people with disabilities.

Direct and indirect costs including payments for drugs not provided free of cost and transport costs continue to limit access to TB and HIV/AIDS services for people

with disabilities due to their precarious economic and livelihood status.

The well-intentioned heart-felt, emotionally driven Reasonable Accommodations improvised by health workers at all health facilities are not institutionalized, often depended on the sensibility of the particular health worker. Simply put, provision of Reasonable Accommodations for people with disabilities follows a charitable model, rather than a human rights approach that requires a systems-change approach. In addition, the Reasonable Accommodations are mostly available for people with visible disabilities. People with invisible disabilities who require more systematized accommodations are left to their own ingenuity.

While the main treatment areas at the facilities were reasonably accessible, the connection between the main treatment area and the different sections of the health facility such as the pharmacy, laboratory and counselling room were broken at four out of the five health facilities, especially where these sections were operated in independent units detached from the main treatment area.

Latrines were the most inaccessible component of the Trip-Chain at the health facilities and none of the facilities scored half of the total points allocated to this component. Conspicuously, none of the latrines at the five health facilities in the assessment were considered

generally clean during the exercise. While good practice is that health facilities should have at least two disability accessible toilets/latrines (one for women and the other for male), None of the facilities had separate accessible latrines for men and women with disabilities.

RECOMMENDATIONS

1) The District Director for Health Services and the secretaries for health at District and Sub County level should ensure representation of people with disabilities on the Health Units Management Committees (HUMCs) in accordance with Affirmative Action Principles enshrined in the 1995 Constitution of Uganda so that they advise appropriate Reasonable Accommodations for people with disabilities.
2) The Ministry of health, Uganda AIDS Commission and the National TB and Leprosy Control Program should plan, finance organize regular disability awareness training for health workers and support staff at health

facilities with emphasis on “invisible disabilities” and the Reasonable Accommodations they need.

3) Elected councillors for people with disabilities and members of the District and Lower Disability Councils should intensify advocacy for the enforcement of the District Ordinance and Sub-County bi-laws on Disability inclusive TB and HIV/AIDS services, including appropriation of adequate budgets.
4) MADIPHA should strengthen the recently formed national TB and HIV/AIDS Disability Network to energize national level advocacy by the cross-disability movement.
5) The National Disability Network on TB and HIV/AIDS should coordinate continuous engagements with development partners that fund HIV and TB services

at local and national level to demonstrate the gaps in integration of services that cater to the intersection between disability, TB and HIV/AIDS.

6) The Uganda AIDS Commission and the Ministry of Health should develop guidelines for "One Stop Centres" to enable people with disabilities to receive drugs for disability conditions like mental health and assistive devices as part of the comprehensive service package at the TB and HIV/AIDS facility.

7) The Ministry of Health, the Uganda AIDS Commission and TB and Leprosy Control Program should include disability disaggregated indicators in national HIV/AIDS and TB routine data collection and national survey tools; and train facility health workers and

survey enumerators on disability-sensitive techniques.

8) The National TB Control Program, Uganda AIDS Commission and development partners should provide information in alternative formats for people with seeing difficulties and those with print disabilities in alternative formats as part of their information education and communication strategy.
9) The Ministry of Health, the TB and Leprosy Control Program and the Uganda AIDS Commission should allocate appropriate budgets and guidelines for HIV/AIDS and TB services to have on hand or be able to refer patients to assistive devices.
10) MADIPHA should continuously sensitize health workers on the different formats of information

dissemination that cater for the needs of people with difficulty seeing and other print disabilities.

11) The Ministry of Health, Ministry of Public Service, Uganda AIDS Commission and the National TB Control Program should create posts for sign language interpreters at health facilities.

12) MADIPHA should continuously provide refresher training for health workers and support staff at health facilities in basic sign language.

13) MADIPHA should present findings of the Accessibility Assessment to the management of the respective health facilities.

14) The management of the different health facilities should develop action plans for implementing the

suggestions for improvement contained in the facility-specific reports.

15) MADIPHA should build capacity of its District Clusters on conducting Disability Accessibility Assessments to ensure that all health facilities can be assessed in a cost-effective manner.

16) MADIPHA should conduct continuous sensitization of Building Control Committees, district engineers, health workers, procurement officers and HUMCS on universal designs and accessibility standards.

PART 1 INTRODUCTION

1.1 Background

Health systems frequently fail to respond adequately to both the general and specific healthcare needs of people with disabilities and as a result, people with disabilities have worse health outcomes, and greater unmet health needs, than people without disability.

To achieve universal access to health, health services must be disability-inclusive to ensure that all people receive the health services they need. This requires, among other considerations, that health facilities are physically accessible for all people with disabilities to allow them to physically access the facilities and receive the available services with independence, confidentiality, and dignity.

With funding from the Disability Rights Fund (DRF) and the STOP TB Partnership, Masaka Association of Persons with Disability living with HIV/AIDS (MADIPHA) commissioned the Accessibility Assessments of five health facilities in Masaka, Kalungu, Lwengo, Bukomansimbi, and Rakai districts. The findings of the study are intended to provide evidence of the state of physical accessibility of the health facilities and provide the basis for further advocacy and awareness raising for the realization of universal accessibility through compliance with universal designs of public buildings and facilities. The findings will be used to train leaders of MADIPHA clusters to conduct Accessibility Audits of other health facilities.

1.2 Overview of the Masaka Association of Persons with disabilities Living with HIV/AIDS

MADIPHA is an association of Persons with disabilities who have tested positive for HIV or are affected by TB, together with their family members. The Association started its operations in 2009 in the districts of Masaka, Kalungu, Lwengo, Bukomansimbi, and Rakai. MADIPHA is arguably the first organized peer-support network of people with disabilities living with HIV/AIDS and people affected by TB in Uganda. The Association is in the process of scaling up its activities to include other districts outside its original districts of operations, and to organize other persons with disabilities living with and affected by HIV/AIDS

and TB in these districts to advocate for their rights in all national HIV/AIDS and TB programs in Uganda.

MADIPHA unites people with disabilities at the intersection of TB, HIV/AIDS, and disability in Uganda. MADIPHA links people with disabilities and their families to HIV/TB prevention, diagnosis, treatment, and care services. MADIPHA integrates the most marginalised people with high support needs into peer support groups to reduce stigma and discrimination. MADIPHA empowers the community of people with disabilities living with HIV and AIDS to participate in TB and HIV program design and delivery. MADIPHA spearheads advocacy for the recognition of the rights of people living at the intersection of disability, TB, and HIV to address healthcare, social and economic barriers.

With funding from the Disability Rights Fund (DRF) and the STOP TB Partnership, MADIPHA is implementing a project to strengthen advocacy for the implementation of seven pieces of local legislations for promoting disability inclusive HIV/AIDS and TB prevention and control. The local legislations include a District Ordinance for Rakai District and six bi-laws for Kyesiga Sub County, Lukaya Town Council, Malongo Sub County, Kiseka sub county, Lwengo Town Council and Kitanda Sub County.

The goal of the advocacy campaign for implementing the local legislations is to ensure universal access to health services for people with disabilities to realize equitable access and utilization of available services in accordance with Article 25 of the Convention on the

Rights of Persons with disabilities (CRPD)[iv] and Sustainable Development Goal 3 (SDG 3) – Quality Health services for all.[v]

1.3 Rationale for conducting the Accessibility Assessment of health facilities.

People with disabilities have greater unmet health needs and worse health outcomes than people without disability because Health systems frequently fail to respond adequately to their general and specific disability-specific health-care needs.

While Persons with disabilities have the same health needs as every other member of the population,

including TB and HIV screening, immunisation, sexual and reproductive health, family planning and all other aspects of regular healthcare, unfortunately, it is well established that people with disabilities have unequal access to health-care services, have greater unmet healthcare needs and experience poorer levels of health compared with the general population.[vi]

The rights of people with disabilities living with TB and HIV/AIDS are not adequately fulfilled within national and local TB responses due to limited deliberate targeting, stigma, and lack of awareness on Reasonable Accommodations to address their unique needs by service providers.

Apart from the need to access HIV and TB information and services, people with disabilities need access to other health information and services across the life course for the same reasons as people without disabilities (e.g., childhood vaccinations, contraception and family planning, disease prevention and treatment of illnesses, management of injuries, palliative care). People with disabilities may also need to access health services for reasons related to their disability. However, they are often excluded from efforts to promote health in the community. For example, studies have shown that: men and women with disability are less likely to receive HIV testing, TB and cancer screening services – for example, for prostate, breast and cervical cancer – than men and women without disabilities. People with

intellectual impairment are less likely to have health checks or to have their chronic health conditions monitored. Adolescents and adults with disabilities are less likely to be included in sex education programmes[vii] and people with disabilities – especially women and girls with disabilities – experience higher rates of violence but are often invisible in national responses to violence.[viii]

It is widely documented that the physical accessibility of health facilities is a major determinant of whether people with disabilities will be confident to seek for health services in the first instance[ix] thus making it imperative for organizations of people with disabilities (OPDs) pursuing health rights to monitor the physical accessibility of health facilities and implement

appropriate advocacy strategies to bridge the accessibility gaps.

1.4 Objectives of the Accessibility Audit of health facilities

The goal of the advocacy campaign for implementing the local legislations is to ensure universal access to health services for people with disabilities to realize equitable access and utilization of available services in accordance with Article 25 of the Convention on the Rights of Persons with disabilities (CRPD)[x] and Sustainable Development Goal 3 (SDG3) – Quality Health services for all.[xi]The research process meant to:

1) Assess the availability of TB and HIV/AIDS services at the five health centres.
2) Assess the physical accessibility of the five selected health facilities providing HIV/AIDS, TB, and other general health services in five districts of greater Masaka sub region; and
3) Establish whether information is provided in alternative formats for people with disabilities who have difficulty with reading printed information.

PART 2 LITERATURE REVIEW

2.0 Introduction

This section provides background information on the state of accessibility health services for people with disabilities with emphasis on TB and HIVAIDS.

2.1 The State of TB Services in Uganda

Uganda is one of the 30 countries with the highest burden of TB, with an estimated TB incidence of 200 cases per 100,000. The proportion of multidrug-resistant tuberculosis (MDR-TB) and rifampin-resistant TB among new and previously treated TB cases was estimated at 1 percent and 12 percent, respectively, in 2018. For the estimated 86,000 people who fell ill with TB in 2019, TB treatment coverage was 65 percent, and

the treatment success rate was 72 percent—both far below the 85 percent national target for 2019.[xii]

In response, the Government of Uganda gave the Ministry of Health, through the National Tuberculosis and Leprosy Programme (NTLP), a mandate to bring the disease under control by means of providing high-quality prevention, diagnosis, and treatment services to affected Ugandans. Specifically, TB incidence was to be reduced by 5 percent by 2019/2020, and the treatment success rate among notified incident cases was targeted to increase from 75 percent in 2015/16 to 85 percent by 2019/20.[xiii]

The TB response services are to be provided through the extensive government funded structure of health service delivery including National Referral Hospitals

(NRHs) that are semi-autonomous; Regional Referral Hospitals (RRHs) that are self-accounting under the Ministry of Health (MoH) oversight; District Health Facilities, Health Centre (HC) IVs, HC IIIs and HC IIs and Village Health Teams (VHTs, HC Is) managed by local governments. The government health structure is complemented by the private health sector consisting of private not-for-profit providers, private health practitioners (PHPs) and traditional and complementary medicine practitioners (TCMPs).[xiv]

According to the MoH Regional Performance Monitoring Teams (RPMT) structure in September 2014, the districts in the country are grouped into 12 regions. A Regional TB and Leprosy Focal Person (RTLFP)

support TB and leprosy care and prevention services in each of the 12 regions. Currently, all 12 regions are functional but at varying levels. Of the 12 RTLFPs, 6 positions are funded by the government, 5 by the Global Fund to Fight AIDS, Tuberculosis and Malaria and 1 by the German Leprosy and TB Relief Association.[xv]

At the district level, the District Health Officer (DHO) is responsible for the management of health service delivery including TB and Leprosy care and prevention services. The DHO appoints a District TB and Leprosy Supervisor (DTLS) to oversee TB and leprosy care and prevention services in the district. At the health sub-district level (HSD), the officer in charge of the HSD (usually a Medical Officer) is responsible for the

management of health service delivery including TB and leprosy care and prevention services. The HSD officer in-charge assigns a Health Sub-District Focal Person to oversee TB and leprosy care and prevention services at the HSD level. At the district, HSD and health facility levels, TB and leprosy care and prevention services are integrated into the general health services.

The responsibilities of District TB and Leprosy Supervisor include supervising health workers implementing TB and leprosy care and prevention services; ensure compliance to national policies and guidelines; train, support and supervise health sub-district focal persons and sub-county health workers; ensure availability of drugs at health facilities; validate data on TB and leprosy; update district registers; lead

advocacy, coordination and networking in health sub-district; diagnose TB and initiate treatment; follow up with patients; and record and report cases (through DHIS).

According to the 2021 report of the Uganda Quality of Tuberculosis Services Assessment,[xvi] TB diagnosis and treatment services were universally available at most health facilities. The facilities provided TB diagnosis services through both onsite or offsite laboratory services, and managed patients on TB treatment. Approximately 90 percent offered TB screening or treatment services for children. 98 percent of facilities had at least some onsite laboratory services available, such as smear microscopy (96%) and Xpert (42%) testing. 70 percent or more of the facilities had first-

line TB drugs and 90 percent or more of the facilities that provided services for DR-TB had the second-line TB drugs. 84 percent of facilities had isoniazid 100 mg, and 73 percent of facilities were found to have isoniazid 300 mg available on the day of the assessment.

VHTs/CHWVs played a major role in TB prevention and care by providing an array of services to support TB patients and facilities used these cadres in such roles as tracing patients who missed follow-up visits, bringing patients back into care, providing community education about TB, and making home visits. Despite having onsite laboratories, most facilities (83 percent) reported that they also used offsite laboratory services because their laboratories were not equipped to provide all the tests needed for TB diagnosis.

Despite the numerous strengths of the TB service delivery system shown in the and Uganda Quality of Tuberculosis Services Assessment,[xvii] several constraints were unearthed. For example, although the facilities provided a wide range of TB care, support and treatment services, patients reported experience of significant constraints to regular utilization of the services stemming from transport to the facility, nutritional insecurity, and need for additional rehabilitative services.

2.2 Incidence of TB among people with disabilities

While the population census of 2014 reported that 12.5 percent of Uganda's population lives with some form

of disability;[xviii] and the World Health Organization's 2010 Global Report[xix] ranked Uganda 16th among the 22 TB high burden countries, the actual number of people with disabilities affected by TB is not documented.

Rigorous research about the relationship between TB and disability in Uganda is lacking, but lessons can be drawn from the systematic review and meta-analysis of TB and disability which included a total of 131 studies involving 217,475 patients from 49 countries[xx] which revealed that there was a high frequency of disability among TB patients, includingmental health disorders (23.1 percent), respiratory impairment (20.7 percent), musculoskeletal impairment (17.1percent), hearing impairment (14.5 percent), visual impairment (9.8

percent), renal impairment (5.7 percent), and neurological impairment (1.6 percent), which were permanent and irreversible arising from the disease itself or side effects of TB treatment, resulting into long-term functional, social, economic, and psychological consequences for affected patients.

The study reported the highest frequency of disability among TB patients from low income countries (like Uganda), observing that the relationship between disability and TB may be specific to the socio -economic context or other factors such as healthcare affordability, with significant social-economic consequences and considerable effect on the quality of life, work, and social relationships due to stigma, discrimination and

loss of identity experienced by both TB patients generally and people with disabilities.

While Kefyalew et al (2021) recommended the addition of rehabilitation services as part of the TB management package and providing training for health care workers on monitoring TB and disability, such interventions are not yet part of Uganda's TB service package.

In 2018, United Nations (UN) member states including Uganda committed to prioritize human rights and gender in national TB responses;[xxi] yet, TB programs are not inclusive for people with disabilities. Their voice is not at the table, leaving them excluded from vital TB decision making processes.

2.3 State of HIV/AIDS service delivery in Uganda

According to the Annual Joint AIDS Review Report 2020-2021,[xxii] Uganda is one of 14 countries globally that achieved the 90-90-90 targets of ensuring that 90 percent of People Living with HIV/AIDS (PLHIV) are aware of their HIV-positive status, 90 percent of those who test HIV positive are on treatment and 90 percent of these are virally suppressed. Despite such tremendous achievements, the number of new infections remains high and in 2020 the estimated number of new infections was 38,000 of which 5,300 were children. The HIV prevalence was particularly higher key and priority populations with over 60 percent of the new HIV infections from adolescent girls and young women, young women accounting

for 73 percent of the new infections. Due to vulnerabilities created by unequal cultural, social and economic status, sexual and gender-based violence affected especially adolescent girls and young women.

In recognition of the role of social behaviour change interventions such as age-appropriate information, community mobilization and prevention programs among populations at greater risk of HIV exposure, the Uganda AIDS Commission (UAC) and partners developed a National HIV and AIDS Communication Strategy, expected to guide stakeholders in both government and non-government institutions to communicate accurate and culturally sensitive HIV

and AIDS messages to communities at high risk of HIV/AIDS.[xxiii]

Like all sectors, HIV/AIDS service delivery experienced COVID-19 disruptions during 2020 and 2021 COVID-19 had devastating effects on the National HIV/AIDS response including a decline in testing and treatment services, increase in Gender-Based Violence and increase in HIV stigma within communities.[xxiv]Moreover, some of the national and international events commemorated annually and used as platforms to convey and disseminate HIV information, such as the World AIDS Day (WAD) and the Candlelight Memorial were held with fewer participants in 2020 and 2021.

Although schools, which are a major platform of passing on key messages to in school adolescents and young people in the country remained closed, young people continued to receive HIV prevention messages through mass media, including radio, television, peers and social media.[xxv] Unfortunately, such mediums of communication were not adapted to the communication needs of persons with disabilities such as those with hearing impairments so they were locked out of the HIV/AIDS messaging during the Covid-19 lockdown.

2.4 Data about people with disabilities with TB and HIV/AIDS

Data and research on disability are crucial to inform disability-inclusive HIV and TB programming and there is

a need to improve routine data collection and focused research on disability with disability-disaggregated indicators in National HIV/AIDS and TB surveys.

The WHO estimates that, globally, more than 1 billion people (15 percent of the world's population) have a disability and disability is increasing in prevalence due to ageing populations, trauma, accidents and chronic health conditions, including HIV, TB and COVID-19.[xxvi]

The 2017 UNAIDS report on disability and HIV/AIDS observed that while HIV prevalence data among people with disabilities are scarce, data from sub-Saharan Africa suggest an increased risk of HIV infection of 1.48 times in men with disabilities and 2.21 times in women with disabilities compared with men and women without disabilities.[xxvii] The report further asserts that people with

disabilities are found in all key and vulnerable populations, including people who inject drugs; sex workers; lesbian, gay, bisexual and transgender people; men who have sex with men; children out of school; people experiencing violence; women and girls; adolescents; and migrants.Yet, due to Stigma and discrimination, people with disabilities, in particular women and girls, may be turned away from sexual and reproductive health and rights and HIV services or may be considered a low priority.

While there are no official statistics of people with disabilities living with HIV/AIDS and TB in Uganda, HIV/AIDS and disability are closely interwoven as HIV/AIDS often leads to disability and persons with disabilities, in particular women and girls with

disabilities, experience barriers to accessing HIV services and are left behind in HIV policy-planning, programme development, service delivery and data collection. For a long time, TB treatment options have been having significant impacts on people's bodies, leaving TB survivors with disabilities such as blindness or deafness due to TB treatment.[xxviii] There are high tendencies of inequitable access to HIV/AIDS services by persons with disabilities.Persons with disabilities were less likely than individuals without disabilities to return to receive results from their most recent HIV and TB test.[xxix]The client register of the AIDS Support Organization (TASO) lists more than 13,000 people with disabilities in Kampala and Wakiso enrolled into HIV care in 2020 of whom 70 percent were women and

the majority were homeless; a situation which was worsened by the COVID-19 pandemic which led to breakdown of follow up of clients due to government restrictions.[xxx]

2.5 Accessibility of TB AND HIV/AIDS services and facilities for people with disabilities

Although the Government of Uganda (GoU) has increased access to health services through various programs and projects including investment in health infrastructure, medicines and other health supplies, and human resource development over the last two decades, the 2019 Ministry of Finance and Economic Development (MoFED) policy brief concluded that despite the investments, the desired universal health coverage (UHC) is far from being

realized because some sections of the population including persons with disabilities fail to have easy access to basic health care services.[xxxi]

The policy brief highlighted the following issues pertaining to access to health services and facilities by people with disabilities:

- 9 percent of persons with disabilities felt disrespected or humiliated by the treatment and behaviour of staff at health facilities. 8 percent of males, and 7 percent of females were mistreated when seeking help for physical problems.
- Basic equipment such as examination and delivery beds were inappropriate for pregnant mothers living with disabilities. The weighing scales for

children and adults were also not appropriate for persons with disabilities, particularly those with physical impairments who could not stand.

- Information formats such as braille and easy-to-read formats for persons with disabilities were not available for either disease prevention, health promotion, and/or curative services.
- The health facilities neither had sign language interpreters, nor assistive hearing aids for those with hearing impairments, nor did health workers have the requisite skills to comprehend sign language. The visually impaired similarly did not receive prescriptions in braille to enable them to understand the medication requirements.

Abimanyi (2017) reported that one of the most significant barriers to accessing facility-based HIV and TB services for persons with disabilities in Uganda was related to physical accessibility of HIV services facilities for example, while the Outpatients Department (OPD) where patients first report might be accessible, the laboratory where HIV/AIDS testing is done might be physically inaccessible causing difficulties.[xxxii] Lack of accessible transportation and transport expenses required of a subpopulation who are routinely disproportionately poor was also reported to limit the ability of persons with disabilities to return for test results, compared to their peers without disabilities.

Noncompliance with Universal Design and Reasonable Accommodations during the construction of

infrastructure and procurement of equipment for health facilities where HIV/AIDS and TB services are provided presents significant challenges for persons with disabilities.For example, there no ramps at most health facilities, latrines are inaccessible, and furniture presents tremendous hardships for persons with disabilities at health facilities.[xxxiii] Service providers need to implement the CRPD principles of universal design and reasonable accommodation. Simple tools, such as a disability audit of services, can help to identify and then address issues of accessibility.

Communication challenges present significant obstacles for reaching disabled individuals with HIV/ AIDS and TB messages. Even when HIV/AIDS and TB messages reach disabled populations, low literacy levels

and disability-related conditions complicate comprehension of these messages and translating them into individual behaviour change. HIV and TB messages and communication are often inaccessible to people who are blind, deaf, and those with intellectual disabilities because such messages are not made available in sign language, Braille and plain language.[xxxiv] There are few rehabilitation services, especially in rural areas and it is estimated that only 3 percent of all disabled individuals get the rehabilitation services they need.[xxxv]

Support groups like those of people living with HIV (PLHIV) groups[xxxvi] and patients support groups for people on TB treatment[xxxvii] which are non-judgmental,

inclusive gathering of patients and caregivers who come together to share experiences, get information and provide emotional support to each other to cope with their condition through mutual support and experience-sharing play a major role in the community-based response to HIV/AIDS and TB by providing peer psychosocial support, identifying people in need of additional medical services, referring members for treatment, and serving as a linkage to the health facility.

Support groups of people living with HIV/AIDS and TB at the intersection of other vulnerability and marginalization like people with disabilities living with HIV/AIDS and TB perform critical advocacy roles for promoting inclusion of people with disabilities in national TB and HIV/AIDS responses which are usually

designed without consideration of the unique needs of people experiencing double stigmatization. In keeping with the "nothing about us without us" philosophy, MADIPHA emerged as one of the first organisation of people with disabilities and their care givers living with HIV/AIDS and TB and with support from development partners like the Stop TB partnership, the Disability Rights Funds (DRF), Treatment Action Group (TAG)and ADD International. Hundreds of people with disabilities and their care givers have benefited from the support provided by MADIPHA in terms of providing transport to health facilities, emergency support like food relief during the COVID-19 pandemic, training of health workers on reasonable accommodations for persons with disabilities seeking HIV/AIDS and TB services,

campaigning for equal rights including enactment and implementations of bi-laws and ordinances on disability inclusive HIV/AIDS and TB services, support for mental health, and training to find employment.[xxxviii]

2.6 Legal Framework underpinning the right to accessible health facilities.

The claim to the right of an accessible barrier-free environment, including at health facilities providing TB and HIV/AIDS services by people with disabilities in Uganda, is underpinned by international and national legal frameworks.

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) 2006:

The CRPD recognizes accessibility as an inherent right of persons with disabilities and a prerequisite for the achievement of all rights for persons with disabilities, detailing "the importance of accessibility to the physical, social, economic and cultural environment, to health and education and to information and communication, in enabling persons with disabilities to fully enjoy all human rights and fundamental freedoms."[xxxix]

Accessibility is both a general principle of the Convention (Article 3) and a standalone article (Article 9). Article 9 addresses the responsibility of state parties to ensure accessibility for persons with disabilities so they can "live independently and participate fully in all aspects of life," directing State

parties to “take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas.”

It further specifies that such measures are to include the identification and elimination of obstacles and barriers to accessibility, including in relation to:

- Buildings, roads, transportation;
- Other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces;

- Information and communications;
- Emergency services; and
- Other facilities and services open or provided to the public in both urban and rural areas, ensuring that accessibility is not only addressed in cities but also for persons with disabilities living in rural communities.

The scope of Article 9 is not limited to state actors, such as local and national governments or government agencies. Article 9 also implicates private actors, requiring states to "ensure that private entities that offer facilities and services which are open or provided to the public take into account all aspects of accessibility for persons with disabilities."[xl]

The Uganda Persons with disabilities Act No. 3 of 2020

The Persons with Disabilities Act (2020)[xli] is the principal legislation in addition to other mainstream laws dealing with the rights of people with disabilities. According to Section 10(1) of the Act, an owner or a person in charge of a building to which the public is allowed access shall subject to the requirements of the laws on building standards and other relevant laws provide appropriate access to person with disabilities to the building.

According to the Persons with Disabilities Act 2020, "appropriate accessibility for persons with disabilities to the building" means putting in place accessible and easy to find entrances which are connected to accessible pathways and parking areas; providing safe and accessible toilets, urinals, and bathrooms; providing

safe and well dimensioned staircases with appropriate railing, accessible elevators; and where necessary provide ramps.[xlii] In addition, the Act makes it mandatory for an owner or a person in charge of a building to which public is allowed access to provide parking space for vehicles driven by persons with disabilities or drivers of persons with disabilities which should be marked with a conspicuous sign or the acronym "PWD". Lastly, the Act creates an offence for any person who contravenes the law by not providing such parking and is liable on conviction to a fine not exceeding 25 currency points or a term of imprisonment not exceeding five months or both.

The Uganda Building Control Act No. 10 of 2013

The principal law which governs the building and construction industry in Uganda is the Building Control Act of 2013.[xliii] Section 2 of the Act defines "access" to mean the possibility for any person to reach a place, manoeuvre within it, use a service, and participate in activities provided in a public place; with dignity, independence, and safety on an equal basis with others. Section 2 also institutionalizes "accessibility standards" which are a practical guide to create a barrier-free physical environment in Uganda for all persons including persons with disabilities. Finally, Section 9 Subsection 1(b) mandates the Building Board to ensure that the design and construction of buildings and utilities to which the public is to have access cater to persons with disabilities.

The Uganda National Accessibility Standards of 2010

According to the Uganda National Accessibility Standards (NAS) developed by Uganda National Action on Physical Disability in conjunction with the Ministry of Gender, Labour, and Social Development, accessibility[xliv] means: "the universal possibility in a facility, where the general public is ordinarily invited, to be reached by all persons interested in and intending to enter; manoeuvre themselves within with ease, use the facility or the services therein without undue difficulty posed by inbuilt hindrances, with dignity and without a high risk of sustaining bodily injury in the process of entering or using the facility so entered".

Accessibility is underpinned by six doctrines which are:

1) "Universal Design- when designing and constructing any facility or building to which services are offered such as health centres, schools, offices, latrines/toilets, etc., due regard should be placed in the usability of the facility by all the population spectrum irrespective of disability and gender."
2) "General Invitation to the Public – Implies that by social design, a perpetual call and an offer, without segregation or discrimination has been made to every person who gets to know about the facility, that it is available to be used by all persons who are interested in and intending to benefit from the whatever legal service or ease to life is found therein."

3) "Reach, Enter and Use (REU) – Means that every person intending to benefit from whatever legal service or ease to life is found in a facility, can, without undue difficulty posed by inbuilt or hitherto naturally existing hindrances or barriers, reach, enter and use the facility independently and with ease."

4) "Manoeuvrability – Means that in order to use or benefit from the availability of a facility or building, every user has to make movements within that facility which are convenient for that person to gain comfortable use of the facility and successfully complete the legal business he or she intended accomplish therein."

5) "Dignity in the use of a facility – Means that every person going to use any facility or building where

the general public is ordinarily invited should not suffer any form of indignity in the use of the facility. Suffering indignity in the use of a facility includes but may not be limited to: (i)Becoming dirty or soiled in any way on the palms, feet, skin, or clothing;(ii) Obtaining bad smell in the cause of using a facility;(iii) Suffering shame, disgust, or horror."

6) "Low Risk of Sustaining Bodily Injury - Means that there should be, within the limits of normalcy, very low risk or likelihood to users of a facility to suffer bodily injury arising from the presentation of a facility to the users."

PART 3: METHODOLOGY

3.0 Introduction

This section describes the data collection and analysis process that resulted in the final report.

3.1 Preparatory phase

The preparatory phase, which was aimed at ensuring clarity of the task between MADIPHA and the consultant, involved the following:

- Review of literature on disability, health, and accessibility audits to inform the Consultant's approach. The literature review covered relevant CRPD articles, Uganda National Accessibility Standards, the People with Disabilities Act (2020 – Uganda), action research reports on access to TB,

HIV/AIDS, and other health services by people with disabilities.

- Presentation of the proposed approach of the Consultants to representatives of MADIPHA's Board of Directorsand Senior Management to confirm alignment with the TOR, which helped to clarify expectations.
- After confirming the scope of the Accessibility Assessment, the Consultant guided the MADIPHA Board of Directors and Senior Management in a stakeholder mapping and identification exercise, which informed development of a list of diverse respondents drawn from key actors with responsibilities for promoting equitable access to

health facilities by the public, including people with disabilities.

- Guided by the stakeholder analysis and their responsibilities, the Consultant designed study data collection tools appropriate to the nature and responsibility of the diverse respondents.

3.2 Data collection methods

The Consultant used the combination of quantitative and qualitative data collection methods as described below:

Key Informant Interviews

Key informant interviews were administered with TB and HIV focal persons, Officers In-Charge of health

facilities and Secretaries for Health to obtain information on aspects like availability of certain services including sign language interpretation and provision of information in alternative accessible formats. 14 key informant interviews were administered.

Focus Group Discussion

Two focus group discussions were held. One with MADIPHA Board of Directors with 11 participants (six females and five males) and the second with MADIPHA staff made up of eleven participants (five females and six males).

Validation Workshop.

The validation workshop was attended by representatives of all respondent types. Participants

provided additional information which bridged the consultants' gaps and enriched recommendations.

Accessibility Assessment

An accessibility Assessment Tool was customized for the task based on the Concept of the Trip-Chain. The Trip-Chain envisioned for the purpose of this assignment included the following elements:

- Main Gate/Entrance
- Access path from the main gate to the TB/HIV main facility.
- Accessibility within the main facilities (OPD section if exist).
- Latrines/toilets
- Miscellaneous

The Accessibility Assessment employed the "Walk and Talk Assessment/route appraisal". The Walk and Talk Assessment was carried out in full company of the officers in charge of the health facilities or their delegates. During the Walk and Walk Assessment/route appraisal, the assessment team discussed the main positive and negative accessibility features instantaneously. At the same time, the assessment team informed the officers in charge of health facilities of the universal designs.

Trip-Chain: A typical Trip-Chain is the sum of all parts of movement from one place to another which must be accessible to ensure a barrier-free environment. For example, to be able to go from hometo a workplace a person must be able to: (I) Exit the home to a

sidewalk or pathway. (II) Enter a vehicle. (III) Alight from the vehicle to a sidewalk or a pathway near the workplace. (IV) Reach the entrance of the building. (V) Enter the building. (VI) Maneuver within the building. (VII) Enter the office or specific place in the building. (VIX) Reach the workstation. It takes only one inaccessible link in the Trip-Chain to make the journey impossible. Therefore, each link must be considered and improved upon to foster a barrier-free environment. These Standards aim to provide clear and concise guidance to guarantee an accessible Trip Chain. (Uganda National Action on Physical Disability and the Ministry of Gender, Labor and Social Development (2010) Accessibility Standards.)

3.3 Targeted Health Facilities

The Accessibility Assessment was conducted at the following health facilities confirmed to be providing TB and HIV/AIDS services: Rakai Hospital, (Rakai District), Buteenga Health Center IV (Bukomansimbi District, Kyanamukaka Health Center IV (Masaka District), Kyetume Health Center III (Lwengo District), and Kalungu Health Center III (Kalungu District).

3.4 Limitations of the study

The main limitation of the study is that there was no respondent with hearing difficulty. While the issues affecting people with hearing-related disabilities in accessing TB and HIV/AIDS services

were raised in the discussions, lived experience would have provided deeper insight.

There is limited research on the state of access to TB and HIV/AIDS services by people with disabilities in Uganda to provide a rich contextual analysis to the Accessibility Assessment.

The Trip-Chain developed for the Accessibility Audit was limited to TB and HIV/AIDS service delivery units within the health facilities. Yet, people with disabilities should ideally safely and independently access all sections of the facility.

PART 4: FINDINGS OF THE ACCESSSIBILITY ASSESSMENT

4.0 Introduction

This section presents the findings of the Accessibility Assessment in line with the objectives agreed between the consultant and BOD of MADIPHA. The report presents the summary of the findings from the five facilities, while the reports of the individual facilities in the annexes provide in-depth information about each respective facility.

4.1 Characteristics of Respondents of the Accessibility Assessment

Table 1: Presentation of respondents in the Accessibility Assessment

Please note that for the purposes of this report, disaggregation by sex focuses on individuals identifying as male or female only.

Category	Female		Male		Total
	With disability	Without disability	With disability	Without disability	
In-charge of health facilities	0	2	0	3	5
HIV FOCAL persons	0	2	0	3	5
TB focal persons	0	2	0	3	5
Secretary for health	0	1	0	3	4
MADIPHA Board	3	0	4	0	7
MADIPHA staff	2	2	1	2	7
Testimonies	5	0	5	0	10
Total	10	9	10	14	43

- The total number of respondents in the Accessibility Assessment was 43 (19 females and 24 male).
- Of the 19 female respondents, 10 were women with disabilities while 9 did not identify as women with disabilities. 10 men identified as persons with disabilities while 14 men did not have disabilities.
- There were no people with disabilities in the categories of Officers In-Charge of Health Facilities, TB and HIV/AIDS Focal Persons, and Secretary for Health.

Table 2: Presentation of respondents disaggregated according to the Washington Group of Questions on Disability Statistics (add footnote explaining Washington Group of Questions)

Category		Nodifficulty	Some difficulty	A lot of difficulty	Cannot at all	Total
Difficulty seeing	F	0	0	1	1	2
	M	0	0	0	0	0
Difficulty hearing	F	0	0	0	0	0
	M	0	0	0	0	0
Difficulty walking and climbing	F	0	0	3	3	6
	M	0	0	5	1	6
Difficulty remembering	F	0	1	1	0	2
	M	0	2	2	0	4

- People who reported having difficulty walking and climbing were the majority (12 – 6 female and 6 male), followed by those with difficulty remembering (6 – 2 male and 4 female).

- 2 females reported difficulty seeing.
- Notably, there was no respondent with difficulty hearing.

4.2 Availability of TB and HIV/AIDS services

According to the Service Availability and Readiness Assessment (SARA) health facility assessment tool designed by the World Health Organization (WHO), health service availability means the presence of a set of tracer indicators of service delivery "such as the availability of key human and infrastructure resources, availability of basic equipment, basic amenities, essential medicines, diagnostic capacities and general readiness of health facilities to provide basic health-care interventions relating to family planning, child

health services, basic and comprehensive emergency obstetric care, HIV, TB, malaria, and non-communicable diseases."[xlv]

Through key informant interviews with focal persons for TB and HIV/AIDS as well as Officers In-Charge of Health Facilities, the Assessment established that all five Health Centre IV provide the stipulated range of TB and HIV/AIDS services in accordance with the stipulations of the National HIV/AIDS Response Plan and the TB and Leprosy Control Program. The services available at the facilities include, but are not limited to:

- Testing for TB and HIV/AIDS
- Treatment according to the Uganda Clinical Guidelines

- Community Outreach
- Collection of samples right from the village level
- TB microscopy at hospital
- Referral of specimen of sputum samples to the district hospitals to reaffirm sink resistance
- Contact tracing
- Follow up on patients by the VHTs.

District Secretaries for Health, TB and HIV/AIDS focal persons stressed that TB and HIV/AIDS services are free and emphasized that both government health facilities and not-for-profit providers do not charge for TB and HIV/AIDS service because the central government, district local administration, and development partners finance the services, including

in terms of technical guidance, TB and HIV/AIDS commodities, drugs, and diagnostics. They also confirmed that drug supplies have significantly improved, and shortages are rare.

Quote: "Yes, we cry over certain shortages at the health centre, but I don't remember when we had shortages of those medicines for TB &HIV, and they are always available and free. For us here anything is free. The medicines and the diagnostics are all free. For example, if they take your sputum, or your blood or x-ray. We are lucky also that the government recently gave us an x-ray, so all those services are free."[xlvi]

While acknowledging increased availability of TB and HIV/AIDS services, MADIPHA members had some service delivery concerns. Several respondents commented about poor time management by health workers while some reported harassment by health workers. Some stated that some drugs are not provided free of cost. For example, one respondent said she must buy her own Septrin[xlvii] tablets at an average of UGs 10,000 per month for paying for the medicine. In addition, she also must find UGs 12,000 for transport to the facility implying she must have an average of UGs 25,000 for each monthly visit to the health facility which she cannot guarantee given her precarious livelihood status.

4.3 Availability of Disability-specific TB and HIVAIDS

While some facilities operate special services for certain population groups, for example the HIV/AIDS clinic for children at Rakai Hospital referenced by one key informant, there are no special service for people with disabilities at the TB and HIV/AIDS facilities.

Despite the absence of special TB and HIV/AIDS services for people with disabilities, several key informants described how they provide Reasonable Accommodations for People with Disabilities at HIV/AIDS and TB facilities. One respondent stated:

Quote: "In most cases when they are in the line you identify that there is someone with a disability either in a wheelchair or disabled somehow, so we usually

make sure they are given the first priority. We take them ahead of the cue just like we do with pregnant mothers."[xlviii]

Testimonies of MADIPHA members as well as FGD discussants confirmed Reasonable Accommodation as described. However, they noted this works only for those with visibly identifiable impairments.

Quote: "It works well for those of us who have physical impairments because the health workers and even other clients at the clinic can identify us and tell us to go ahead. But for our friends who are deaf, they can sit in the line without anyone noticing they are disabled. They can wait there until the end of the day because when they register, their names are shouted out, but they cannot hear when it is their turn to see

the health worker and even their neighbours might not recognize they are deaf."[xlix]

Several HIV/AIDS focal persons were aware of the unique challenges experienced by people with disabilities seeking HIV/AIDS services. However, they intervene from an individualized, charitable perspective without making the effort to change the system as recounted in the experience below:

Quote: "I felt touched when I saw a woman who was disabled, actually crippled [...] She did not have a wheelchair and she was attending to another mother who had come to give birth. I felt so much pity and I contacted my friend who was around here, and we

contributed some small money for them to meet some of the basics they needed during their hospitalization."[l]

Unlike the HIV/AIDS focal persons, most TB focal persons said they do not provide Reasonable Accommodations for people with disabilities. Some stated that services were generally available for anyone who showed up at the health centre. All TB focal persons also informed the assessment team they did not collect any disability-disaggregated data. Part of the reason is that according to the TB focal persons interviewed, there are "real" disabilities and not real disabilities, i.e., less important disabilities which confirms a limited understanding of disability.

Quote: "We just get these ones of maybe reduced hearing, those with minor disabilities which I think in one way or the other we may not be able to get to the actual people with disabilities."[li]

According to the FGD of MADIPHA BOD, limited awareness of disability concerns by TB focal persons is attributed to limited sensitization of this cadre of health workers.

Quote: "You know, MADIPHA launched the TB and disability awareness project in 2019 and then the lock downs of 2020 through parts of 2021 disrupted interactive activities of the project. Yet we have been working with HIV/AIDS focal persons, changing their attitude since 2009."[lii]

Disability rehabilitative services are not integrated into TB and HIV/AIDS service delivery at the health facilities. People with disabilities that need TB and HIV/AIDS drugs along with other regular medication such as drugs for managing epilepsy cannot receive the drugs for their different conditions at the same service point. Most times they must travel to the respective hospital on different days thus increasing the cost of securing comprehensive disability and TB HIV/AIDS services. Assistive devices like wheelchairs, crutches, spectacles, white canes, etc. are not distributed as part of the TB and HIV/AIDS package even though it is well known that people with disabilities are vulnerable to TB and HIV/AIDS.

Importantly, both TB and HIV/AIDS have been well established as causes and aggravators of disability.

Quote: "I became blind as a result of severe sickness from HIV. The hospital continued to give me medicine for HIV, but they did not tell me anything to do with blindness. It is until people from MADIPHA whom I did not know at that time came and brought for me a white stick and even taught me how to go to the toilet and nearby places to my home with the help of the white stick. When I got better, I imagined what happens to other people who get similar problems from HIV and are not reached by MADIPHA.[liii]

4.4 Provision of information in alternative formats for people with print disabilities

Although printed Information, Educational and Communication (IEC) materials play a major role in TB and HIV/AIDS service delivery, none of the five health facilities provided written information in alternative formats, e.g., Braille or large print for the visually impaired and other people with visual disabilities. When asked how clients who are blind benefit from the IEC materials provided in ordinary print formats only, one key informant stated that health workers feel that those who cannot see are compensated by verbal explanations during events like community outreach, during which health workers conduct health talks about a variety of health issues including TB and

HIV/AIDS. A participant at the validation workshop explained that IEC materials used at the health facilities are distributed by the Ministry of Health, TB and HIV/AID agencies, and development partners. The informant added that health facilities do not receive budgets for transcribing IEC materials into alternative formats.

4.5 Availability of Sign Language Interpretation services at TB and HIV service delivery facilities

None of the five health centres involved in the Accessibility Assessment operated an official program for providing sign language interpretation. That said, Officers In-charge of health facilities were aware of the

communication challenges when dealing with deaf clients. Several health workers acknowledged having received introduction to basic sign language by MADIPHA and other NGOs.

The only sign language interpretation services available were provided by people with disabilities and family members through the peer support networks established by MADIPHA. These peer support networks operate at varying levels of effectiveness, with the Peer Support Group of Kalungu District overall referred to as the most effective.

Quote: "When I was conducting a Community Health Talk in Lwanda Sub- County, I noticed there was a deaf person in the audience and the person he came with, I think the person was a relative of the deaf

person, was interpreting what I was saying to him in their language of signs. Of course, I could not confirm whether the way the message was being conveyed was accurate because personally I do not know sign language, but at least something was happening there and if the family member had not come, the deaf person would not have picked up anything from the Community Health Talk."[liv]

4.6 Physical accessibility of health facilities

4.6.1 Accessibility of main gates/entrances

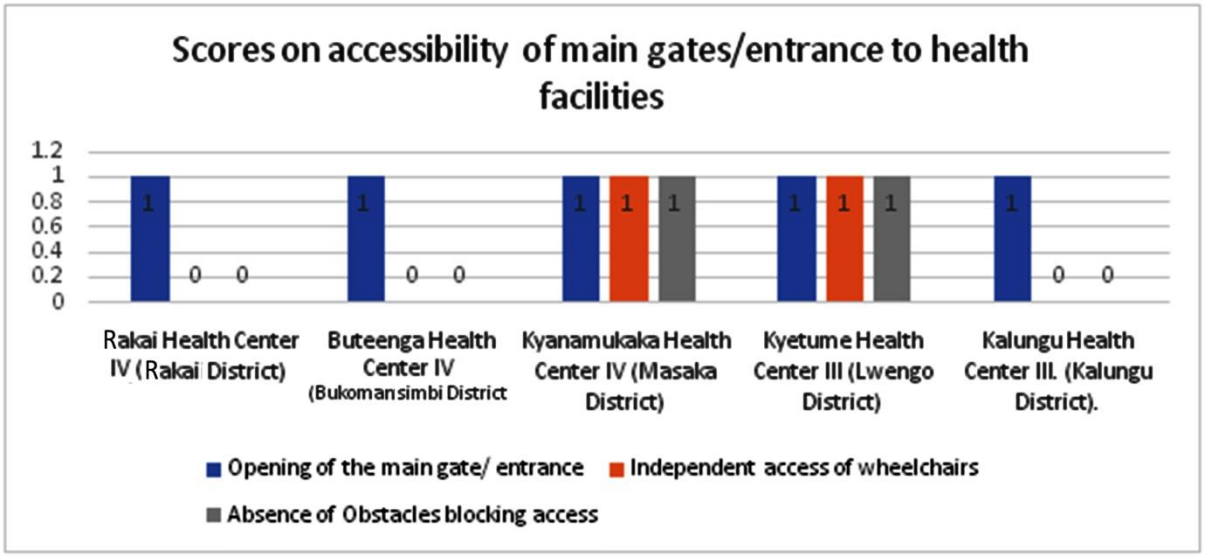
The accessibility of main gates and entrances to the health facilities was assessed in terms of

- Whether the opening of the main gate is 900mm, thereby allowing for wheelchair access.

- Whether the gate is flat enough to allow free access to wheelchair users and those using other walking devices (if raised, is there a standard ramp of a gradient of 1-10mm to facilitate independent movement).
- Whether there are no obstacles along the gate that block access for people with difficulty seeing.

Each of the above parameters was weighted at 1 score, thus the highest score of 3.

Graph showing scores on accessibility of main gates/ entrance to health facilities:



The main gate/entrances of 2 out of the 5 health facilities (Kyetume Health Center III in Lwengo District and Kyanamukaka Health IV) satisfied all the three accessibility parameters considered during the Accessibility Assessment.

The remaining gates fell short of full accessibility. For example, the main gate/entrance at Rakai Hospital was not flat. It had galleys and building materials in the opening of the gate.

While the main gate/entrance at Kalungu Health Center III and Butenga Health Center IV gates/entrances had the required opening width of 900mm, the entrance at both facilities were not free for independent access for wheelchairs due to galleys and rocks along the path

which present challenges for independent navigation of wheelchairs and even for people with difficulty seeing.

4.6.2 Accessibility of the access path from the main gate to the TB/HIV/AIDS facility

Assessment of the accessibility of access paths was based on:

- Whether the path is wide enough (1300mm) to allow easy movement for wheelchair users.

- Whether the path is flat with firm surface to facilitate easy movement of wheelchair users and those using other walking devices.
- Whether the path is free of obstacles that prevent easy movement for people with seeing difficulties.

Each perimeter was weighted 1 score, for a high score of 3.

Table 3: Table showing scores on accessibility of Access Paths to main TB/HIV/AIDS treatment points at the health facility:

	Rakai Hospital (Rakai District)	Buteenga Health Center IV (Bukomansimbi District	Kyanamukaka Health Center IV (Masaka District)	Kyetume Health Center III (Lwengo District)	Kalungu Health Center III. (Kalungu District).
Width of the path (1300mm) for easy movement of wheelchair	1	1	1	1	`1
Flatness and firmness of the path surface.	1	0	1	0	1
Freeness from	1	0	1	1	1

obstacles and protruding elements for easy movement for persons with seeing difficulty					
Total	3	1	3	2	3

The access path at three out of the five health facilities (Rakai Hospital, Kalungu Health center III and Kyanamukaka Health Centre IV) scored 3 out of 3 meaning they satisfied all the accessibility criteria assessed. Kyetume Health Centre III scored 2 out of 3 while Butenga Health Centre scored 1 out of 3. The

access path for Butenga Health Center was not flat and firm and the access path was covered by obstacles like grass growing under the stones along the path.

Figure 1: Simple fixes can make this path accessible.

4.6.3 Accessibility of the main treatment clinics (outpatient) at TB and HIV/AIDS facilities

The assessment focused on the following parameters:

- Whether the main entrance to the facility was flat for easy wheelchair access or serviced with standard ramp.
- Whether the access is wide enough (1300mm) for independent wheelchair movement.
- Whether corridors to the three major sections (laboratory, pharmacy, and counselling room) are wide enough.
- Whether the entrances to the different section of the facility (pharmacy, laboratory, and counselling room) are wide enough.

- Whether the entrances to the three main facilities were flat or serviced with standard ramps.
- Whether the main service area was well lit for people with difficulty seeing
- Whether public seats were accommodative for persons of short stature (not over 500mm off the ground.
- Whether the working tables for health workers were appropriate for people with short stature (not higher than 900mm).

This section had 13 weighted parameters i.e., a total score of 13.

	Rakai Hospital (Rakai District)	Buteenga Health Center IV (Bukomansimbi District)	Kyanamukaka Health Center IV (Masaka District)	Kyetume Health Center III (Lwengo District)	Kalungu Health Center III. (Kalungu District).
Flatness of main entrance	1	1	1	1	1
Width of access of the main entrance	1	1	1	1	1
Width of corridors to main sections	3	1	2	2	0
Width of entrance to main sections	3	1	2	3	1
Flatness of corridors to main facilities	3	2	0	0	1

Lighting of the main service area	1	1	1	1	1
Public seats Accommodation for little persons	1	1	1	1	1
Health workers' desks Accommodation for little 1persons	1	1	0	1	1
Total	**14**	**9**	**8**	**10**	**7**

Figure 4 Learning Centre: Demonstration of the continuum of accessibility between different facilities.

Rakai Hospital scored 13 out of 13 while Butenga Health Center IV, Kyanamukaka Health Center IV and Kyetume Health Center IV all scored 9 out of 13. Kalungu Health Center III scored 7 out of 13.

The main components of the trip-chain where accessibility was broken were the connections between the main treatment area and the different

sections of the health facilities, i.e., the pharmacy, laboratory, and counselling room. This was especially the case where these sections were operated in independent units detached from the main treatment area.

The difficulty of having to navigate between the main treatment area and the other facility sections was corroborated by respondents who shared their lived experience of seeking TB and HIV/AIDS services.

Quote: "In most cases, there is a ramp at the area where we first report when we go to the health center. But the problem comes when you have to go to the laboratory for CD4 counts. The places are sometimes far and there you find all other patients like those testing for malaria. I do not know why, but

many times they forget to put ramps at those units which are not part of the main building."[lv]

4.6.4 Accessibility of latrines/toilets

Accessibility of latrines/toilets was assessed from 13 parameters including:

- Whether the access path from the facility to the latrine was wide enough.
- Whether the path was flat and of rough surface to ease wheelchair movement.
- Whether the path is flat with no raised sections.
- Whether the path was free of obstacles.
- Whether the main entrance to the latrine is flat or outfitted with a standard ramp.

- Whether there were designated latrines for female and male people with disabilities.
- Whether the latrines designated for people with disabilities were of the recommended diameter.
- Whether there was a sitting toilet or twin latrine seats.
- Whether the latrine sits have been made of concrete and painted for easy cleaning
- Whether there are double hand rails at either sides of the latrine seat.
- Whether the latrine is well lit for easy navigation.
- Whether the latrine is generally clean.
- Whether the water point attached to the latrine is accessible.[lvi]

This part of the Trip-Chain at the health facility was weighted with a total of 15 scores.

	Rakai Hospital (Rakai District)	Buteenga Health Center IV (Bukoma Nsimbi District	Kyanamukaka Health Center IV (Masaka District)	Kyetume Health Center III (Lwengo District)	Kalungu Health Center III. (Kalungu District).
Width of Access path	0	0	0	1	0
Roughness and firmness of path	0	0	1	1	1
Flatness of path	0	0	0	0	0
Freeness of obstacles on the path	0	0	0	1	0

Flatness of main entrance or presence of standard ramp	1	0	0	0	1
Designated latrines for male and female latrines	1	0	1	0	1
Designated latrines for persons with disabilities meeting the recommended diameter	1	0	1	0	1
Sitting toilet or twin latrines sits	0	0	0	0	0
Concrete and painstakingly painted latrine seats.	0	0	0	0	0
Double handrails fixed at either sides of the latrine sit	1	0	1	0	1
Adequate lighting in the latrine	1	1	1	0	1
General cleanness of the latrine	0	0	0	0	0
Accessible water points nearest to the latrine.	1	0	0	0	1

Total	**6**	**1**	**5**	**3**	**7**

None of the health facility scored half of the total score. Kalungu Health Center III had the highest score of 7 followed by Rakai Hospital with 6 out of 15. Latrines at most health facilities presented inaccessibility right from the absence of demarcated paths from the treatment area, which is a major source of challenge for orientation for people with seeing difficulty and those using wheelchairs and crutches.

Conspicuously, none of the latrines at the five health facilities in the assessment were considered generally clean during the exercise. Indeed, the inaccessibility of latrines came up repeatedly during the sharing of testimonies by people with disabilities using TB and

HIV/AIDS services and in FGD with MADIPHA Board members.

Absence of latrines designated for people with disabilities was another concern throughout the accessibility assessment because none of the facilities had separate latrines for women and men designated for people with disabilities.

Quote: "When you are at the hospital, you fear going to the latrine because you might pick up other diseases. The latrines are usually far from the facilities, the paths are bushy and muddy during the rainy season. But even if your relative carries you to the latrine, you cannot find anywhere to place your hand for those of us who move with our hands. It is really bad for us. "

(A person with disability using TB and HIV/AIDS services.)[lvii]

Figure 2: An example of inaccessible latrine outhouse

4.6.5 Other accessibility features

This section had the total of 8 weights and assessed the accessibility of several aspects of the facility including:

- Whether doors were easy to operate; (
- Whether ramps had the appropriate landing where required.
- Whether information and communication materials were placed at the recommended height.
- Presence of spare wheelchair at the facility.
- Placement of handrails where there are ramps at high elevation.
- Whether paint of walls and doors is contrasted.

- Whether windows open at an angle of 180 degrees to avoid creating obstacles along the corridors.

Table 4: Table showing scores for accessibility of miscellaneous accessories.

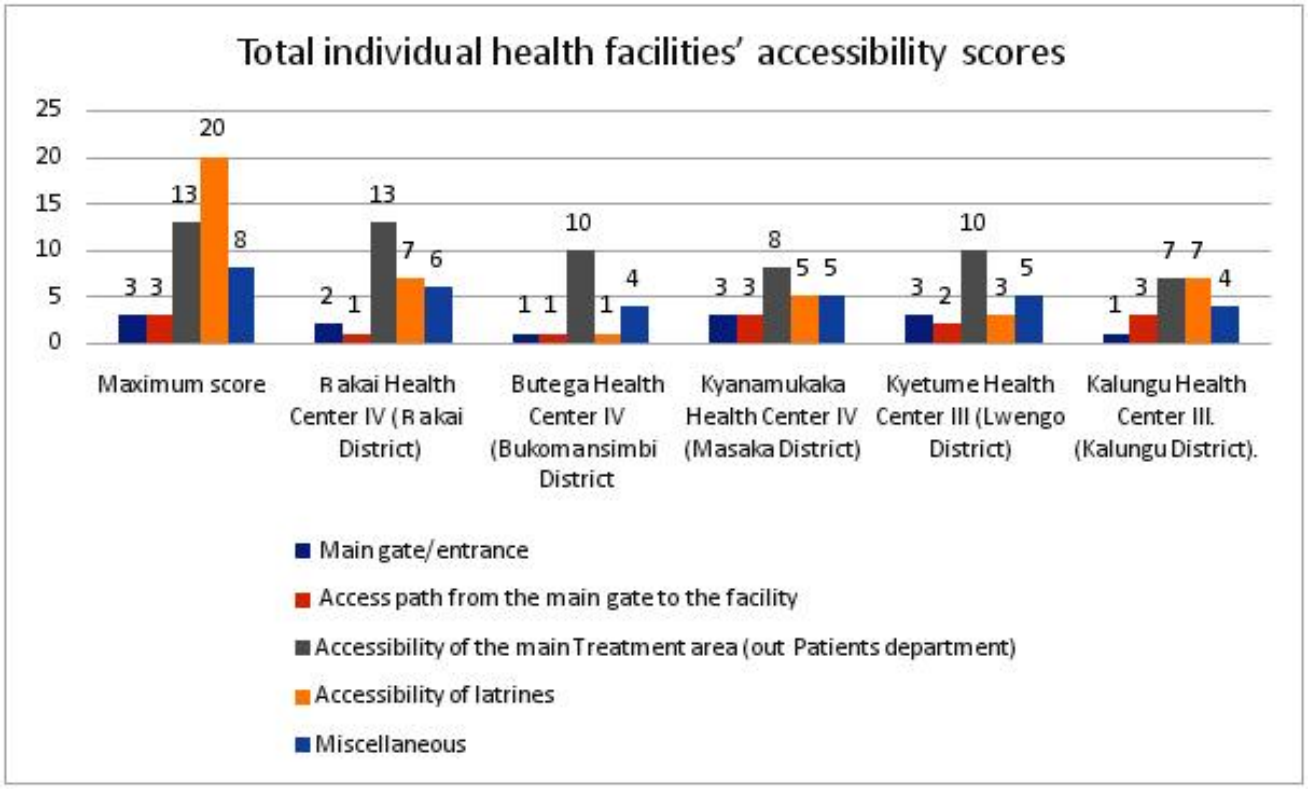
	Rakai Hospital (Rakai District)	Buteng a Health Center IV (Bukom a nsimbi District	Kyanamukaka Health Center IV (Masaka District)	Kyetum e Health Center III (Lweng o District)	Kalungu Health Center III. (Kaluung u District).
Ease of opening doors.	1	0	1	1	1
Presence Standard landing at ramps of 1700 by 1500mm.	1	0	1	1	0
Placement of Information and communicatio n materials at the height of 900mm.	0	1	0	0	0

Floor surface of facility generally non slippery	1	1	1	1	1
Presence of a spare wheelchair at the health facility	1	0	0	0	0
Placement of hand rails at ramps exceeding 1700mm.	0	0	0	0	0
Painting of doors and walls contrasted	1	1	1	1	1
Windows widely open along the wall to avoid accidents	1	1	1	1	1
Total	**6**	**4**	**5**	**5**	**4**

Rakai Hospital obtained the highest score of 6 in this section. Kyanamukaka Health Center IV and Kyetume Health Center III received scores of 5, while Butenga and Kalungu Health Centers received 4. The findings indicate that certain accessibility features, especially those that are specifically required by persons with disabilities like placement of handrails where they are required and availability of spare wheelchairs, are generally not being implemented. No implementation of such accessibility standards could be attributed to lack of awareness that leads to omission during design phases resulting into non allocation of appropriate budgets.

4.6.6 Summary of accessibility scores for the individual facilities

Bar-graph illustrating the total individual health facilities' accessibility scores:



Rakai Hospital had the highest score of 29 out of 47 (62%) while Butenga Health Center IV had the lowest score of 17 out of 47 (36%). While the accessibility assessment did not exhaustively examine the factors underlying the presence of or absence of accessibility

and safety standards at the different facilities, the general observation is that health facilities which have been recently renovated or constructed at the time of the accessibility assessment was conducted like Rakai District Hospital tended to demonstrate more compliance with accessibility and safety standards. This thus points to the possibility that generally, there is increased awareness and adoption of universal designs in public construction projects. Also, the category of health facility appears to influence the size of its budget allocation. For example, health facilities at hospital level seem to be able to finance most of the universal accessibility and safety designs.

PART 5 CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

Although all the five Health Centre IV provide TB and HIV/AIDS services in accordance with the stipulations of the National HIV/AIDS Response Plan and the TB and Leprosy Control Program, there was no evidence of institutionalized strategies and interventions to manage the intersection of disability and TB/HIV/AIDS at the health facilities assessed as stipulated by the World Health Organizations, implying contravention of CRPD Art 25 provisions and inadvertent exclusion of people with disabilities from the efforts to realize SDG3.

The assessment found that the major issues affecting accessibility of health facilities providing TB and

HIV/AIDS services by people with disabilities in the five districts include:

- Lack of institutionalization of Reasonable Accommodations for people with disabilities at Health Facilities in line with the human rights model.
- Lack of Integration of disability specific services to manage the Intersection between disability, TB, and HIV/AIDS.
- Lack of provision of information communication materials in alternative formats for people with difficulty seeing and other print disabilities.
- Lack of official programs for providing sign language interpretation at health facilities.
- Limited compliance with universal designs and accessibility standards for persons with disabilities.

- Direct and indirect cost limitation to access to TB and HIVAIDS services.
- The health facilities do not operate rehabilitative services including orientation and mobility for the visually impaired, there are no official programs for providing sign language interpretation.
- There is no scheme for providing assistive devices such as white canes, crutches, or wheelchairs despite the growing body of knowledge evidencing the vulnerability of people with disabilities to TB and HIV/AIDS and how TB and HIV/AIDS causes and/or aggravates impairments.
- Limited ability of health workers to understand the accommodation needs of persons with disabilities especially those with invisible disabilities.

Health facility governance issues cause further constrain to equitable and satisfactory TB and HIV/AIDS services for people with disabilities. The governance related issues that severally arose during the accessibility assessment include:

- Poor time management by health workers which possibly arises from ineffective supervision.
- Harassment by health workers which possibly arises from ineffective supervision and enforcement of appropriate ethical codes.

Direct and indirect cost-constraints including payment for drugs not provided free-of-charge, and transport to and from facilities continue to limit access to TB and HIV/AIDS services for people with disabilities due to their precarious economic and livelihood status.

The well-intentioned heartfelt, emotionally driven Reasonable Accommodations improvised by health workers at all health facilities are not institutionalized and often depended on the sensibility of the health worker. Simply put, provision of Reasonable Accommodations for people with disabilities follows a charitable model, rather than a human rights framework that requires a systems-change approach. In addition, the Reasonable Accommodations are mostly available for people with visible disabilities. People with invisible disabilities who require more systematize accommodations are left to their own ingenuity.

Three out of the five health centers were inaccessible right from the main gate/entrance because of placement of obstacles along the entrance, galleys

blocking the entrance, and other challenges implying that although the health workers may have been ready to serve people with disabilities, people with disabilities could fail to get past the gate.

Accessibility along the path connecting the main gate to the treatment facility, commonly the OPD at three out of the five facilities was restricted by overgrown grass, galleys, and placement of obstacles like building materials along the path.

While the main treatment areas at the facilities were reasonably accessible, the connection between the main treatment area and the different sections of the health facility like the pharmacy, laboratory, and counselling room - especially where these sections were operated in independent units detached from the

main treatment area - was broken at four out of the five health facilities.

Latrines were the most inaccessible component of the Trip-Chain at the health facilities and none of the facilities scored half of the total weights allocated to this component. Conspicuously, none of the latrines at the five health facilities in the assessment was considered generally clean during the exercise. None of the facilities had separate latrines for women and men designated for people with disabilities.

What is important to note is that many of the inaccessibility features could be fixed with minimal cost purely by vigilance of management. For example, removing obstacles like building materials dumped along the path, digging outgrown grass from access

paths, or supervising proper cleaning of latrines and the temporary wooden ramp. Regular visitations and engagement between MADIPHA and health center management could address some of the accessibility concerns before they become issues for example the issue of overgrown grass which restricts wheelchair accessibility can be raised during routine catch up.

Finally, despite gaps, Rakai Hospital can serve as a learning center where pockets of good practice in terms of compliance with accessibility standards are observed. Rakai Hospital too has areas for improvement, yet they have a lot of learning to demonstrate to other facilities which have significant gaps of compliance with universal accessibility and safety designs which are a

prerequisite for people with disabilities to enjoy equitable access to TB and HIV/AIDS services.

The accessibility audit revealed the need for strengthening MADIPHA's national advocacy campaigns because several issues identified at the facility level are informed and directed by national policy and program frameworks. For example, provision of information in alternative formats for people with difficulty seeing and those with print disabilities depends on the national Information and communication strategies of the National TB Control Program, the AIDS Commission, and Ministry of Health, while regular provision of sign language requires revisiting the staff structure of health facilities which is

the mandate of the Ministry of Public Service in consultation with the Ministry of Health.

5.2 Recommendations

Issue 1: To promote institutionalization of Reasonable Accommodations for people with disabilities at health facilities based on the human rights framework and grounded in CRPD.

Recommendation 1.1: The District Director for Health Services and the secretaries for health at District and Sub Country level should ensure representation of people with disabilities on the Health Units Management Committees (HUMCS) in accordance with Affirmative Action Principles enshrined in the 1995 Constitution of Uganda which calls for representation

of People with disabilities in all decision-making structures so that they advise appropriate Reasonable Accommodations for people with disabilities.

Recommendation 1.2: MADIPHA should continue organizing disability awareness training for health workers and support staff at health facilities with emphasis on "invisible disabilities" and the Reasonable Accommodations they need. While the training can take a refresher mode for health workers in the HIV/AIDS facilities, orientation training is still required for TB focal persons who have not interacted with MADIPHA for a long time compared to their counterparts in HIV/AIDS service delivery.

Issue 2: To improve integration of disability specific services to manage the intersection between disability, TB and HIV/AIDS.

Recommendation 2.1: Elected councillors for people with disabilities and members of the District and Lower Disability Councils should intensify advocacy for the enforcement of the District Ordinance and Sub-County bi-laws on Disability inclusive TB and HIV/AIDS services, including appropriation of adequate budgets.

Recommendation 2.2: MADIPHA should strengthen the recently formed national TB and HIV/AIDS Disability Network through regular information sharing and regular issues-based meetings to energize national level advocacy by the cross-disability movement.

Recommendation 2.3: The National Disability Network on TB and HIV/AIDS should coordinate continuous engagement, including dissemination of this Accessibility Assessment report with development partners that fund HIV and TB services at local and national level to demonstrate the gaps in integration of services that cater to the intersection between disability, TB, and HIV/AIDS.

Recommendation 2.4: The Uganda AIDS Commission and the Ministry of Health should develop guidelines for "One Stop Centres" to enable people with disabilities to receive drugs for disability conditions like mental health and assistive devices as part of the comprehensive service package at the TB and HIV/AIDS facility.

Recommendation 2.5: The Ministry of Health, the Uganda AIDS Commission and TB and Leprosy Control Program should include disability disaggregated indicators in national HIV/AIDS and TB routine data collection and national survey tools; and train facility health workers and survey enumerators on disability-sensitive techniques.

Recommendation 2.6: The Ministry of Health, the TB and Leprosy Control Program and the Uganda AIDS Commission should allocate appropriate budgets and guidelines for HIV/AIDS and TB services to have on hand or be able to refer patients to assistive devices.

Issue 3: To improve accessibility of information communication materials in alternative formats for people with difficulty seeing and other print disabilities.

Recommendation 3.1: The National TB Control Program, Uganda AIDS Commission and development partners should provide information in alternative formats for people with seeing difficulties and those with print disabilities in alternative formats as part of their information education and communication strategy.

Recommendation 3.2: MADIPHA should continuously sensitize health workers on the different formats of information dissemination that cater for the needs of people with difficulty seeing and other print disabilities.

Issue 4: To strengthen official programs for providing sign language interpretation at health facilities.

Recommendation 4.1: The Ministry of Health, Ministry of Public Service, Uganda AIDS Commission and the National TB Control Program should create posts for sign language interpreters at health facilities.

Recommendation 4.2: MADIPHA should continuously provide refresher training for health workers and support staff at health facilities in basic sign language.

Issue 5: To promote compliance with universal designs and accessibility standards for persons with disabilities.

Recommendation 5.1: MADIPHA should present findings of the Accessibility Assessment to the management of the respective health facilities.

Recommendation 5.2: The management of the different health facilities should develop action plans for implementing the suggestions for improvement contained in the facility-specific reports.

Recommendation 5.3: MADIPHA should build capacity of its District Clusters on conducting Disability Accessibility Assessments to ensure that all health facilities can be assessed in a cost-effective manner.

Recommendation 5.4: MADIPHA should conduct continuous sensitization of Building Control Committees, district engineers, health workers,

procurement officers and HUMCS on universal designs and accessibility standards.

Recommendation 5.5: MADIPHA should organize a learning visit for district engineers, Officers In-Charge of TB and HIV/AIDS health facilities to Rakai Hospital for a peer learning visit to draw practical lessons on implementation of universal designs.

Issue 6: Direct and indirect cost limitation to access to TB and HIV/AIDS services.

Recommendation 6.1: MADIPHA with support of the National TB and HIV/AIDS Disability Network in collaboration with other TB and HIV/AIDS civil society organizations and organizations of people living positively with TB and HIV/AIDS should intensify joint

national advocacy for total cost-free TB and HIV/AIDS services.

Recommendation 6.2: MADIPHA should intensify advocacy for affirmative action in all economic empowerment programs to improve income status of people with disabilities living with TB and HIV/AIDS and their family members.

ANNEX 1 ACCESSIBILITY ASSESSMENT OF KALUNGU HEALTH CENTER III

Access through the main gate/entrance				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Opening of the main gate/ entrance	1	Opening of the main gate is wide enough (900mm) allowing free access for wheelchair users.		
Flat for independent access of wheelchairs	0		Soil deposited along the entrance of the main gate creates a stiff slope which prevents easy movement by people with disabilities using	Level the entire opening area of the main gate to allow easy navigation by people using wheelchairs and other devices.
Absence of obstacles blocking access	0			

			wheelchairs and other devices.	
Total	1 out of 3			

Accessibility of the main access path from the main gate/entrance				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Width of the path (1300mm) for easy movement of wheelchair	1	The access path from the main gate to the OPD is wide enough (more than 1300mm)		
Flatness and firmness of the path surface.	1	The path is also flat and firm making it		

		easy for wheelchair users.		
Freeness from obstacles and protruding elements for easy movement for persons with difficulty seeing.	1	The access path was free of obstacles and presented no challenge for easy mobility by persons with difficulty seeing.		
Total	3 out of 3			

Accessibility of the main treatment area (outpatients department) at TB and HIV/AIDS facilities				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications

Flatness of main entrance	1	The main entrance to the OPD unit is flat and is serviced with a standard ramp.	The assessment team observed obstacles adjacent to the ramp at the main entrance to the OPD presenting an obstacle to people with seeing difficulty.	Ensure that the ramp area and the main entrance are free of obstacles at all times. Vehicles and other forms of transport such as bicycles should be parked away from the main access to the ramp and main entrance.
Width of the main entrance	1	The opening of the entrance to the OPD Is 1400MM which complies with the minimum opening space of 1300mm.		

Width of corridors to main sections	0		The corridors are narrow: for example, the corridor connecting the laboratory to the counselling room measured 950mm, i.e., short of the required minimum of 1300mm.	Future construction projects should comply with the minimum width of corridors connecting different sections of the health facility.
Width of entrance to main sections	1	The entrance to the pharmacy was 1050mm wide, meeting the minimum of 900.	The entrance to the laboratory and counselling room were 780mm, i.e., below the minimum of 900mm.	
Flatness of entrance to main facilities	1	Entrance to the pharmacy is serviced with a standard ramp.	There is no ramp at the entrance of the laboratory; the step at the entrance to the laboratory is broken. The door has a sharp end.	Create a standard ramp at the entrance to the laboratory.

			The entrance to the counselling room is too narrow, 780 instead of 900mm wide.	
Lighting of the main service area	1	While there is adequate natural lighting throughout the treatment area, artificial lighting is also provided.		
Public seats accommodating for little persons	1	The seats are 450mm high, i.e., meeting the acceptable standard of not more than 500mm.		

Health workers' desks accommodating for little persons	1	Health workers' desks are 750mm high, i.e., in compliance with the requirement 900mm maximum height.		
Total	7 out of 13.			

Figure 3: An accessible entrance

Figure 4: Accessibility broken at the laboratory

Accessibility of latrines				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Width of access path to the latrine	O		The path was 1200mm, i.e., below the minimum of 1300mm.	Widen the path in compliance with 1300mm width.
Roughness and firmness of path	1	The path was rough and firm for easy wheelchair movement.		
Flatness of path	0		There was a manhole along the path	Level the path and create a ramp connecting the path to

			The end of the path towards the latrine has a long step without a ramp	the main entrance to the latrine.
Freeness of obstacles on the path	0		There were broken bricks along the path.	Clear the path of all broken material and ensure they're not put back.
Flatness of main entrance to the latrine or presence of standard ramp	1	The entrance to the latrine was flat.		
Designated latrines for male and female latrines	1	There is a designated latrine for	There is one latrine for persons with disabilities, but not separately	There should be separate designated latrines for female and

		persons with disabilities.	designated for male and female persons with disabilities.	male persons with disabilities.
Designated latrines for persons with disabilities meeting the recommended diameter	0	The room was measuring 2700mm by 1850mm, meeting the minimum standard.		
Sitting toilet or twin latrines seats	0		There were no latrine seats.	Construct latrine seats in the designated latrine for people with disabilities.
Concrete and painstakingly painted latrine sits.	0			

Double hand rails fixed at either sides of the latrine seat	1	Hand rails placed on both sides of the latrine hole.		
Adequate lighting in the latrine	1	The latrine has adequate natural lighting.		
General cleanness of the latrine	0		The latrine was wet, and indicated it had not been cleaned for some time.	Ensure good cleanliness of the latrine.
Accessible water points nearest to the latrine.	1	The water point was placed accessibly.	The water point did not have water.	Ensure the water point has water at all time to promote good hygiene.
Total	7 out of 20.			

Figure 5: Not so hygienic latrine

Figure 6: The manhole is a big challenge along this path.

Figure 7: The stones present a real barrier.

ANNEX 2 ACCESSIBILITY ASSESSMENT OF KYANAMUKAKA HEALTH CENTER IV

Access of the main gate/entrance				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Opening of the main gate/ entrance	1	The opening was 1370mm, i.e., meeting the minimum requirement of 900mm.		
Flat for independent access of wheelchairs	1	The opening area of the gate was flat.		

Absence of obstacles blocking access	1	There were no obstacles in the opening area of the main gate.		
Total	3 out of 3.			

Accessibility of the main access path from the main gate/entrance				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Width of the path (1300mm) for easy	1	The path measured 1500mm, complying		

movement of wheelchair		with the minimum of 1300mm.		
Flatness and firmness of the path surface.	1	The path was sufficiently flat and firm for wheelchair access.		
Freeness from obstacles and protruding elements for easy movement for persons with seeing difficulty	1	The path did not present any obstacle to free and independent movement of persons with disabilities.		
Total	3 out of 3			

Accessibility of the main treatment area (outpatients department) at TB and HIV/AIDS facilities				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Flatness of main entrance	1	There is a ramp of 1-15mm connecting the main access path to the entrance of the facility.	The ramp connecting the main access path to the entrance of the OPD is stiff without a protective rail.	Place a hand rail on either sides of the ramp at the entrance to the main OPD section.

Width of the side main entrance	1	The width is 1500mm compared, complying with the minimum standard of 1300mm.		
Width of corridors to main sections	0		The services are provided in different buildings far from the OPD section.	Widen the connection corridors/path between the different units of the facility.

			The connecting corridors between the OPD and the different units such as the laboratory are very narrow.	
Width of entrance to main sections	2	The entrances to the pharmacy were 950mm and the entrance to the laboratory was 1500mm, complying with the	The entrance to the counselling room was 780mm, i.e., below the 900mm minimum.	Future constructions should comply with standards.

		minimum of 900mm.		
Flatness of entrance to main facilities	0		The ramp connecting to the laboratory and counselling ramp is very steep and broken. The ramp connecting to the pharmacy is also very steep.	Repair the broken ramp at the laboratory and counselling room. Extend the ramp at the pharmacy to meet the minimum of 1-10mm[lviii]and place protective

				handrails on either side of the ramp.
Lighting of the main service area	1	There is adequate natural lighting at the main treatment area.		
Public seats accommodating for little persons	1	The seats are at a height of 450mm, i.e., in compliance with the maximum of 500mm.		

Health workers' desks accommodating for little 1persons	1	The work desks for the health workers are 780mm high and in compliance with the maximum height of 900mm.		
Total	8 out of 13.			

Figure 8: Ramp at the pharmacy

Figure 9: Ramp needs repair.


HALL

Figure 10: Widen these beautiful paths to 1300mm.

Accessibility of latrines				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Width of access path to the latrine	0		The path connecting the main treatment area to the latrine is very narrow.	Widen the path from the main treatment area to the latrine. (adda standard here?)
Roughness and firmness of path	1	The path is firm for wheelchair use.		

Flatness of path	0		Some sections of the path were overgrown with grass.	Level the path and ensure the grass is removed at all times.
Freeness of obstacles on the path	0		Building materials incl. stones and sand were covering parts of the path.	Ensure there are no materials deposited along the path at any time.
Flatness of main entrance to the latrine or presence of standard ramp	0		The ramp at the latrine entrance is very stiff and not continuous.	Repair the ramp to be continuous and in compliance with the

				minimum standard of 1-10mm.
Designated latrines for male and female latrines	1	There is a designated latrine for people with disabilities.	There is only 1 designated latrine for people with disabilities placed at the side for female users.	Construct a disability-designated latrine for male persons with disabilities. Future constructions should take into account all the accessibility features,
Designated latrines for persons with disabilities meeting	0	The interior of the latrine meets the	The corridor leading to the entrance of the disability-	

the recommended diameter		standard diameter. It measured 2700mm by 19000mm.	designated latrine is very narrow and does not allow for independent movement of wheelchair users.	including width of corridors.
Sitting toilet or twin latrines seats	0		No latrine seats.	Please construct latrine seats in accordance with standards.
Concrete and painstakingly painted latrine seats.	0			

Double handrails fixed at either side of the latrine seat	1	Handrails were placed on either side of the latrine hole.		
Adequate lighting in the latrine	1	The latrine interior has adequate lighting.		
General cleanness of the latrine	0		The latrine lacked in all aspects of cleanliness.	Please ensure the latrine is cleaned regularly.

Accessible water points nearest to the latrine.	0		There was no water can at the place demarcated as the hand washing point.	Ensure a disability-friendly water point at the latrine to promote hygiene.
Total	5 out of 20			

Figure 11: This well-intentioned ramp can be a death sentence.

Figure 12: No wheelchair accessibility.

Figure 13: Inaccessible entrance to the pit latrine.

ANNEX 3 ACCESSIBILITY ASSESSMENT OF KYETUME HEALTH CENTER III

Access of the main gate/entrance				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Opening of the main gate/ entrance	1	The opening was 2000mm.		
Flat for independent access of wheelchairs	1	The opening of the wide gate is flat.		
Absence of obstacles blocking access	1	There were no obstacles along the main entrance.		
Total	3 out of 3.			
Accessibility of the main access path from the main gate/entrance				

Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Width of the path (1300mm) for easy movement of wheelchair	1	The path is 1500mm, complying with the minimum of 1300mm.		
Flatness and firmness of the path surface.	0		Some sections of the path were raised while others were sunken.	Level the path.
Freeness from obstacles and protruding elements for	1	The path was free from obstacles.		

easy movement for persons with seeing difficulty				
Total	2 out of 3.			

Figure 14: Inaccessible landing preventing use of the ramp.

Figure 15: An example of a well-constructed ramp.

Figure 16: An example of a good accessible path.

Accessibility of the main treatment area (outpatients department) at TB and HIV/AIDS facilities				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Flatness of main entrance	1	The entrance is serviced with a standard ramp.	The ramp is beginning to crack.	Effect timely repair of the ramp to avoid deterioration.
Width of the main entrance	1	The width is 1900mm, i.e., in compliance with the minimum.		

Width of corridors to main sections	2	The corridor to the pharmacy and counselling room was 1490mm.	The corrido to laboratory was 1090mm, i.e., below the required 1300mm	Future construction should consider accessibility standards at all levels.
Width of entrance to main sections	3	All met the minimum		
Flatness of entrance to main facilities	0		The connections to the different	Level the connection paths to the different sections of the TB/HIV facility.

			facilities were not flat. The access ramps were damaged, for example to the counselling room.	Repair the broken ramps in compliance with standards.
Lighting of the main service area	1	Adequate natural lighting.		

Public seats accommodating for little persons	1	Public seats were at the height of 480mm, in compliance with the minimum of 500mm.		
Health workers' desks accommodation for little persons	1	The health workers' desks were at the height of 780mm,complying with the minimum of 900mm.		
Total	10 out 13.			

Accessibility of latrines				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Width of Access path to the latrine	1	The path was wide.		
Roughness and firmness of path	1	The path was firm.		
Flatness of path	0		The path was not very flat.	Level the path.
Freeness of obstacles on the path	1	The path was free of obstacles.		
Flatness of main entrance to the latrine or presence of standard ramp	0		The entrance to the latrine was not flat and not serviced with a ramp.	Construct a ramp at the entrance of the latrine.

Designated latrines for male and female latrines	0		There were no latrines designated for people with disabilities.	Construct at least two latrines, one each designated for male and female persons with disabilities in accordance to the standards.
Designated latrines for persons with disabilities meeting the recommended diameter	0			
Sitting toilet or twin latrines sits	0			
Concrete and painstakingly painted latrine seats.	0			
Double handrails fixed at either side of the latrine sit	0			

Adequate lighting in the latrine	0		The latrines were dark and poorly ventilated.	Future constructions should consider minimum standards.
General cleanliness of the latrine	0		The latrines were not clean.	Ensure effective cleanliness of latrines at all times.
Accessible water points nearest to the latrine.	0		Water point not accessible.	Install an accessible water point to improve accessibility.
Total	3 out of 20			

ANNEX 4 ACCESSIBILITY ASSESSMENT OF BUTENGA HEALTH CENTER IV

Access of the main gate/entrance				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Opening of the main gate/ entrance	1	Very wide over 1300mm.		
Flat for independent access of wheelchairs	0		The opening area is not flat due to soil accumulating in	Level the opening area of the main gate.

Absence of obstacles blocking access	0		the opening area, possibly due to soil erosion.	
Total	1 out of 3.			

Accessibility of the main access path from the main gate/entrance				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Width of the path (1300mm) for	1	The path is 1700mm – in		

easy movement of wheelchairs		compliance with standards.		
Flatness and firmness of the path surface.	0		The path is not flat with variation of levels along the path.	Level the path.
Freeness from obstacles and protruding elements for easy movement for persons with seeing difficulty	0		There were stones and other materials deposited along the path.	Clear the path of all obstacles.

Total	1 out of 3.

Accessibility of the main treatment area (outpatients department) at TB and HIV/AIDS facilities				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Flatness of main entrance	0	There is a good ramp at the entrance of the building.	Grass was overgrowing the stones at the entrance to the main facility	Remove the grass and level the connecting areas.
Width of the main entrance	1	The entrance is 1700mm, in		

		compliance with the minimum standard.		
Width of corridor to main sections	3	The corridor to the pharmacy is 1500mm wide. The corridor to the laboratory is 1480mm wide. The path to the counselling room is also adequate.		

Width of entrance to main sections	1	The entrance to the pharmacy meets the minimum.	Entrance to the counselling room and laboratory are not wide enough.	Future constructions should comply with standards.
Flatness of entrance to main facilities	2	The pharmacy and laboratory are serviced with standard ramps.	Entrance to the counselling room does not have connecting ramp and is overgrown by grass	Construct a ramp at the counselling room.

Lighting of the main service area	1	Adequate natural lighting.		
Public seats accommodating for little persons	1	Seats at a height of 450mm, within the recommended 500mm maximum.		
Health workers' desks accommodating for little persons	1	The stations are 780mm, within the recommended of 900mm maximum.		
Total	10 out of 13.			

Figure 17: An example of a good ramp. (left)

Figure 18:An example of a good continuous ramp linking different sections of the facility. (right)

Accessibility of latrines				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Width of access path to the latrine	0		There is no demarcated path to the latrine.	Establish a demarcated path to the latrine in line with standard measures at a minimum of 1300mm wide.
Roughness and firmness of path	0			
Flatness of path	0			
Freeness of obstacles on the path	0			
Flatness of main entrance to the latrine or presence of standard ramp	0		The entrance to the latrine is overgrown with grass, there are stones along the path.	Clear the area to the entrance to the latrine and level the area.

Designated latrines for male and female latrines	0		There is no designated latrine for people with disabilities.	Construct two designated latrines for people with disabilities according to gender in compliance with standards.
Designated latrines for persons with disabilities meeting the recommended diameter	0			
Sitting toilet or twin latrines seats	0			
Concrete and painstakingly painted latrine seats.	0			
Double handrails fixed at either sides of the latrine seat	0			
Adequate lighting in the latrine	1	The latrine was well light.		

General cleanness of the latrine	0		The latrine was not clean.	
Accessible water points nearest to the latrine.	0		Water points not functional.	Establish an accessible and functional water point to promote hygiene.
Total	1 out of 20.			

Figure 19: Path needs clearing.

ANNEX 5 ACCESSIBILITY ASSESSMENT OF RAKAI HOSPITAL

Access of the main gate/entrance				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Opening of the main gate/ entrance	1	The opening of the main entrance is 1350mm, complying with the minimum of 1300mm.		
Flat for independent	0		Building materials	

access of wheelchairs			such as stones and sand were all over the opening area of the path.	Level the opening area of the main entrance.
Absence of obstacles blocking access	0			
Total	1 out of 3			

Accessibility of the main access path from the main gate/entrance				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Width of the path (1300mm) for easy movement of wheelchair	1	Path is wide measuring 1450mm, complying with the		

		standard of 1300. The path is evenly paved.		
Flatness and firmness of the path surface.	1	The path is well paved.		
Freeness from obstacles and protruding elements for easy movement for persons with seeing difficulty	1	There are no obstacles along the path.		
Total	3 out 3			

Accessibility of the main Treatment (outpatients department – OPD) at TB and HIV/AIDS facilities				
Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Flatness of main entrance	1	The path is well paved.		
Width of the main entrance	1	The path is 1450mm wide, complying with the minimum of 1300mm.		
Width of corridors to main sections	3	All corridors measure 1400mm wide.		

Width of entrance to main sections	3	Entrances the counselling room, pharmacy and laboratory were wide enough.		
Flatness of entrance to main facilities	3	All are flat.		
Lighting of the main service area	1	Adequate natural lighting		
Public seats accommodating for little persons	1	At a height of 450mm, i.e., in compliance to		

		the maximum of 500mm.		
Health workers' desks accommodation for little persons	1	At a height of 780mm, i.e., in compliance with the 900mm height maximum.		
Total	13 out of 13.			

Accessibility of latrines

Trip-chain element	Score	Strengths	Gaps	Proposed modifications
Width of access path to the latrine	0		There is no demarcated path to the latrine.	Dig a demarcated path and pave it in line with the minimum standards.
Roughness and firmness of path	0			
Flatness of path	0			
Freeness of obstacles on the path	1			
Flatness of main entrance to the latrine or presence of standard ramp	1	The main entrance is serviced with a standard ramp.		
Designated latrines for male and female latrines	1	There is one designated latrine for people with disabilities.	The latrines designated for people with disabilities are	Construct a second latrine for people with disabilities to ensure they

			not separated by gender.	are separated for male and female genders.
Designated latrines for persons with disabilities meeting the recommended diameter	1	The latrine meets the diameter requirement, it measures 2700mm by 1900mm.		
Sitting toilet or twin latrines seats	0		There are no twin latrine seats.	Construct latrine seats in accordance with the standards.
Concrete and painstakingly painted latrine seat.	0			
Double handrails fixed at either side of the latrine seat	1	Handrails exist on both sides of the latrine hole (?)		

Adequate lighting in the latrine	1	Adequate natural lighting.		
General cleanliness of the latrine	0		The latrine was not clean; the floor was wet.	Ensure cleanliness of the latrine at all times.
Accessible water points nearest to the latrine.	1	Accessible functional water point.		
Total	7 out of 20.			

Figure 20: An example of a good accessory for the water point.

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