

Annual Report

Uganda STRIDES

October - September 2010

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Table of Contents

Table of Tables	- 4 -
Table of Figures.....	- 4 -
Acronyms	- 5 -
About the Project.....	- 7 -
Executive Summary.....	- 8 -
1. Introduction	- 10 -
2. Progress toward SO8 Results	- 11 -
2.1 Cross-cutting activities	- 11 -
2.2 Result Areas	- 14 -
Result 1: Increased quality and provision of routine RH/FP and CS services in facilities....	
.....	- 14 -
A. Key indicators	- 14 -
B. Detailed Year 2 Activities by Sub-result.....	- 23 -
Sub-result 1.1 Provider performance strengthened and supported to enhance the	
provision of RH/FP and CS services at facilities	- 23 -
Sub-result 1.2 Demand for RH/FP/CS services at facilities increased through BCC	
and counseling strategies	- 29 -
Sub-result 1.3 Improved availability of essential commodities at facility level .	- 32 -
Sub-result 1.4: Facilities strengthened to provide quality services.....	- 33 -
Result 2: Access to and demand for RH/FP and CS services at the community level	
improved and expanded.....	- 33 -
A. Key Indicators	- 33 -
B. Detailed Year 2 Activities by Sub-result.....	- 34 -
Sub-result 2.1: Increased ability of communities to provide RH/FP and CS services..	
.....	- 34 -
Sub-result 2.2 Demand for RH/FP and CS services at facilities increased through	
community-based BCC and IEC strategies.....	- 35 -
Sub-result 2.3: Improved availability of essential commodities at the community	
level.....	- 38 -
Result 3: Use of RH/FP and CS services advanced through supportive systems.....	- 38 -
A. Key Indicators	- 38 -
B. Detailed Year 2 Activities by Sub-result.....	- 39 -
Sub-result 3.1: Expansion of RH/FP and CS service in facilities and communities	
supported by contributing to development and implementation of positive	
policies	- 39 -
Sub-result 3.2: Districts revitalized to better manage RH/FP and CS services for	
scale-up.....	- 41 -
	- 2 -

Sub-result 3.3: Coordination with other implementing partners, the private sector, NGOs, and other partners leveraged to improve district coverage and impact	- 43 -
Sub-result 3.4: Information systems strengthened with data routinely analyzed and used for decision making at facility, community, and district levels.....	- 46 -
Sub-result 3.5: Transparency and accountability increased within district health systems	- 46 -
3. Project monitoring and evaluation	- 47 -
4 Project management.....	- 50 -
4.1 Human resources	- 50 -
4.2 Finance and Administration.....	- 50 -
5. Ongoing and emerging challenges.....	- 53 -
Annex I: Status of PMP Indicators.....	- 55 -
Annex II: STRIDES Implementation Plan - Leadership Development Program (LDP)	- 65 -
Annex III: Minimum Basic Standards for Service Delivery Points (FFSDP Checklist)	- 66 -

Table of Tables

Table 1: Timeframe for MoU negotiation and signing in the 15 collaborating districts	- 11 -
Table 2: Number of health facilities in each district with whom STRIDES worked in PY2 .	- 13 -
Table 3: Number of family planning users by method	- 15 -
Table 4: Number of people reached during the Child Days Plus in the districts of Mityana, Kamuli, Bugiri, Kyenjojo, Kamwenge, Kasese, Kumi and Nakasongola	- 17 -
Table 5: Number of facilities assessed by level and location	- 24 -
Table 6: Follow up of service providers trained	- 28 -
Table 7: Indicators for Result 2	- 33 -
Table 8: Indicators for Result 3	- 38 -
Table 9: Summary of RFP 001 proposals evaluation	- 45 -
Table 10: Cost share contribution.....	- 52 -

Table of Figures

Figure 1: Comparison of new and revisit clients for family planning by quarter and year	- 14 -
Figure 2: Couple Years of Protection	- 16 -
Figure 3: Number of children who at 12 months have received 3 doses of DPT	- 18 -
Figure 4: Number of children under 12 months of age who received the second dose of Vitamin A supplementation	- 19 -
Figure 5: Percentage of pregnant women who receive 4 ANC consultations.....	- 20 -
Figure 6: Percentage of pregnant women who received 2 doses of IPTp.....	- 21 -
Figure 7: Percentage of live births delivered from a health facility	- 21 -
Figure 8: Percentage of underweight children at measles vaccination	- 22 -
Figure 9: Percentage of live births with low birth weight	- 23 -
Figure 10: Percentage of health facilities assessed by level.....	- 25 -
Figure 11: Number of health personnel trained during PY2	- 27 -

Acronyms

AMREF	African Medical and Research Foundation
ANC	Antenatal Care
BCC	Behavior Change Communication
CAO	Chief Administrative Officer
CARMMU	Campaign for Accelerated Reduction of Maternal Mortality in Uganda
CDFU	Communication for Development Foundation Uganda
CS	Child Survival
CTS	Clinical Training Skills
DHMT	District Health Management Team
DHO	District Health Officer
DPT3	Diphtheria, pertussis and tetanus vaccine, 3 rd dose
EmONC	Emergency Obstetric and Neonatal Care
EOI	Expression of Interest
FFSDS	Fully Functional Service Delivery System
FHI	Family Health International
FP	Family Planning
GIS	Geographic Information Systems
GoU	Government of Uganda
HC	Health Center
HCP	Health Communication Partnership
HF	Health Facility
HMIS	Health Management Information System
HTSP	Healthy Timing and Spacing of Pregnancy
IEC	Information Education Communication
IMCI	Integrated Management of Childhood Illnesses
IP	Implementing Partner
IPC	Inter-Personal Communication
IPT	Intermittent Presumptive Treatment
IUD	Intra-Uterine Device
JHU/CCP	Johns Hopkins University/Center for Communication Programs
LDP	Leadership and Development Program
LAPM	Long Acting and Permanent Methods
LSS	Life-Saving Skills
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
M&L	Management and Leadership
ModCAL	Modified Computer – Assisted Learning
MoH	Ministry of Health
MoU	Memorandum of Understanding
MoES	Ministry of Education and Sports

MSH	Management Sciences for Health
MSU	Marie Stopes Uganda
MUAC	Mid-Upper Arm Circumference
NDA	National Drug Authority
NMS	National Medical Stores
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
PAC	Post-Abortion Care
PBC/F	Performance-Based Contracting/Financing
PPF	Private-for-Profit
PMP	Performance Monitoring Plan
PPP	Public Private Partnerships
PY	Project Year
QI	Quality Improvement
RFP	Request for Proposals
RH	Reproductive Health
SDP	Service Delivery Point
SO8	Strategic Objective 8
STTA	Short Term Technical Assistance
SURE	Securing Ugandans' Rights to Essential Medicines
ToT	Training of Trainers
UMEMS	Uganda Monitoring & Evaluation Management Support
UNFPA	United Nations Population Fund
UPMA	Uganda Private Midwives Association
USAID	United States Agency for International Development
VHT	Village Health Team
WHO	World Health Organization
WB	World Bank
YCC	Young Child Clinic

About the Project

STRIDES for Family Health works with the Government of Uganda (GoU) in its objective to reduce fertility and lower maternal and child morbidity and mortality. Specifically, the goal of the five-year project is to strengthen the capacity of the health system in fifteen (15) selected districts in Uganda to make them fully functional and able to deliver quality, integrated reproductive health/family planning (RH/FP) and child survival (CS) services to the people in need of these services. Management Sciences for Health (MSH) is implementing the project together with its core partners: Communication for Development Foundation Uganda (CDFU); Jhpiego; and Meridian Group International. STRIDES functions as a catalyst for the fifteen collaborating districts (refer to map below) to strengthen them in their role as service providers, regulators and stewards of the health system. It also supports private sector partners to complement the public sector in its service delivery task.

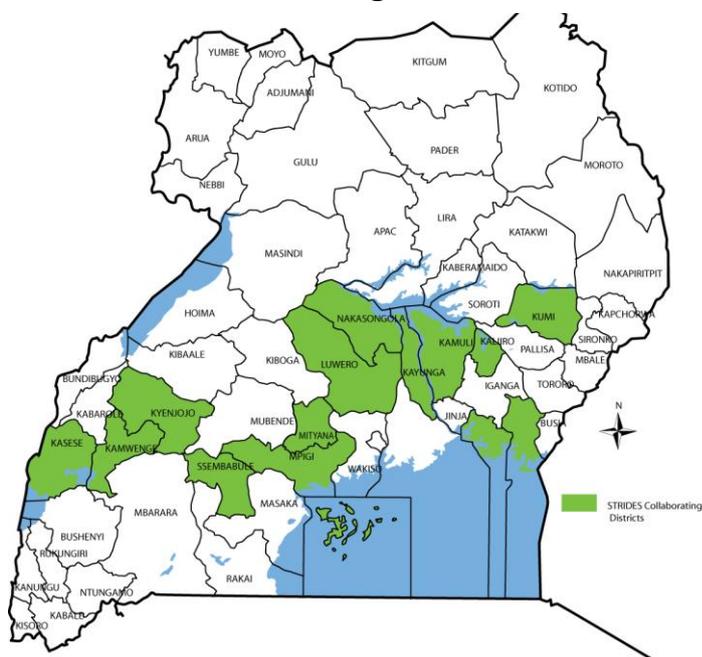
As stipulated in the Cooperative Agreement between MSH and USAID, STRIDES is contributing to the SO8 objective “Improved Health and Educational Status of Ugandans” through focusing on three results areas as follows:

- Increased quality and provision of routine RH/FP and CS services at facility level
- Access to and demand for RH/FP and CS services at the community level improved and expanded
- Use of RH/FP and CS services advanced through supportive systems

The project uses the following three key strategies to achieve its objectives:

- Application of the “fully functional service delivery system” (FFSDS)
- Development of the management and leadership (M&L) capacity of local leaders and managers, and establish or increase community accountability for health
- Performance-based financing/contracting (PBF/C) to engage government, nongovernmental organizations, and the private-for-profit sector to expand access to a package of essential health services

STRIDES collaborating districts



<p>Eastern region</p> <ul style="list-style-type: none"> -Bugiri -Kaliro -Kamuli -Kayunga -Kumi -Mayuge 	<p>Central region</p> <ul style="list-style-type: none"> -Luwero -Mityana -Mpigi -Nakasongola -Sembabule -Kalangala <p><i>Note: Though Kayunga district is geographically in Uganda's Central region, it has been placed in the STRIDES Eastern Region for coordination and operational purposes.</i></p>
<p>Western region</p> <ul style="list-style-type: none"> -Kyenjojo -Kasese -Kamwenge 	

Executive Summary

The USAID funded STRIDES for Family Health project started its operations in Uganda in early 2009 with a mandate to reduce fertility, morbidity and mortality among Ugandan women and their families, by strengthening and expanding health systems and services in fifteen districts. During project year 2 (PY2), various activities were conducted in relation to the intermediate results as follows:

Result 1: Increased quality, and provision of routine RH/FP and CS services in facilities

- CYP increased from 96,105 in PY1 to 107,257 in PY2, reflecting a 12% increase.
- A total of 204,740 children received a second dose of Vitamin A during PY2, reflecting a 4% increase from PY1.
- Overall, 30% of the live births were delivered at a health facility, an 11% increase from the previous year.
- A total of 483 service providers, including VHT trainers of trainers, were trained by STRIDES in PY2.
- The project training strategy was finalized, disseminated and is being implemented.
- 57 trainers for various skill areas participated in the clinical training course (CTS) to standardize their facilitation skills.
- 31 health facilities in the 15 districts were prepared as practicum training sites for basic and long-acting family planning, IMCI and LSS training courses.

Result 2: Access to and demand for RH/FP and CS services at the community level improved and expanded

- Sensitization meetings were held with sub county leaders in various districts on the village health team (VHT) concept.
- Formative research was conducted in the districts of Bugiri, Kalangala, Kaliro, Kyenjojo and Luwero. The findings informed the development of the communication strategy currently under implementation.
- Community dialogues on family planning were held in the districts of Kasese, Kyenjojo, Sembabule, Bugiri, Kumi, Kaliro, Kamuli, Mayuge and Luwero.
- A total of 124 interactive radio programs were broadcast in the Central, Eastern and Western regions.

Result 3: Use of RH/FP and CS services advanced through supportive systems

- STRIDES has taken an active role in several arenas that develop and influence RH/FP and CS policy, such as participation in the national newborn resuscitation manual development, and in maternal and child health (MCH) cluster and family planning (FP) technical working group meetings.
- Under the performance based contracting (PBC) program, 12 private sector organizations were awarded contracts following a competitive process, and implementation commenced during the last quarter of PY2.
- Health management information system (HMIS) strengthening activities were conducted at various levels of the system.

Key challenges facing the project include:

- Politically motivated district sub-divisions
- Significant shortages of contraceptives and other commodities
- Inadequate numbers, absenteeism and low morale of health staff in the districts
- Districts not fulfilling the commitments indicated in the Expressions of Interest (EOI) and Memoranda of Understanding (MoUs)
- Mixed signals from the MoH regarding VHT implementation policy
- “Workshop and allowance” culture
- Conventional approaches vs. risk-taking and creativity
- Performance issues with one of the STRIDES core partners

1. Introduction

The STRIDES for Family Health project began to operate in Uganda in early 2009 with a mandate to reduce fertility, morbidity and mortality among Ugandan women and their families, by strengthening and expanding health systems and services in fifteen districts.

Over the past ten to twenty years, many national and international projects and programs have aimed at achieving these or very similar objectives in Uganda and yet, Uganda's fertility, morbidity and mortality rates have remained high and virtually unchanged. Driven by the reasonable assumption that 'more of the same' would result in continued stagnation rather than a meaningful impact, STRIDES committed from its very beginning to questioning conventional approaches and beliefs, encouraging innovation while placing paramount importance on long-term impact and sustainability.

The focus of STRIDES' second project year was on implementation through public-private partnerships, management and leadership capacity development, community participation, and task shifting. This PY2 report is structured around the three result areas which contribute to the SO8 objective "Improved Health and Educational Status of Ugandans" against which STRIDES reports progress to USAID. The report also includes reviews of cross cutting activities including in monitoring and evaluation and operational management. The report ends with a brief section discussing the challenges and opportunities faced by STRIDES during this past project year.

2. Progress toward SO8 Results

2.1 Cross-cutting activities

Memoranda of Understanding (MoU)

Following the completion of the baseline survey, STRIDES negotiated MoUs with the fifteen collaborating districts. This process started in December 2009 and ended in March 2010. During the negotiations the districts were represented by the Local Council V Chairman, the Chief Administrative Officer (CAO), District Health Officer (DHO), Deputy District Health Inspector (DHI) and District Health Management Information System (HMIS) officer. On average, the MoU negotiations took two days per district with discussions focusing on:

- Public health needs and the gaps in the health system as shown in the STRIDES baseline report and other sources;
- Review of the district work plans and budgets, and agree on targets and deliverables;
- Introduction of the district teams to the concept of PBF/C, a key strategy of STRIDES;
- Review of the respective roles and responsibilities of STRIDES and the district; and
- The need to build partnerships with private for-profit (PFP) and private not-for-profit institutions in the district to improve delivery of health services.

Each district developed a work plan and budget which were reviewed by the STRIDES team. The MoUs were signed at different times due to the thorough and time-consuming review process undertaken. The table below shows the timeframe for MoU negotiation and signing for the different districts.

Table 1: Timeframe for MoU negotiation and signing in the 15 collaborating districts

District	Negotiation date	Date of signing (2010)
Bugiri	January 2010	March
Kalangala	March 2010	May
Kaliro	January 2010	March
Kamuli	March 2010	May/ June
Kamwege	December 2009	January
Kasese	February 2010	April
Kayunga	February	May
Kumi	March 2010	May
Kyenjojo	December 2009	January
Luwero	February 2010	January
Mayuge	January 2010	April
Mityana	February 2010	March
Mpigi	March 2010	May
Nakasongola	December 2009	February
Sembabule	February 2010	May

STRIDES regarded immediate coverage of an entire district as overly ambitious and therefore adopted the “pyramid” system in selecting facilities to work with. Under the STRIDES “pyramid” system, each district selects a number of facilities, picking a selection from each level of service delivery (i.e. H/C II, III, IV and hospitals) on which the project focuses its activities during the project year. The districts with hospital-level facilities included at least one hospital in the pyramid with its referring facilities. Regardless of whether a hospital was included, the selection included one to two health centers IV, along with the lower tiered health centers (III and II) that fall within the respective HC IV referral system. In most cases, this selection corresponds with a health sub-district.

The criteria used to guide the selection of facilities included:

- Service available at a given facility. Some districts such as Kayunga and Kumi selected more health centers III because of the type of services they considered important for their population.
- Availability of human resources at the facility to deliver services.
- Existing infrastructure for health care delivery.
- Accessibility of the facility to intended users or the community members and the project team during implementation. For example, Kalangala district selected facilities that are on the main island.
- Geographical location of the facilities in reference to the number of HSDs in the district.
- Number of available facilities in the districts.

STRIDES adopted the “pyramid” system to enable the project to work with selected facilities to implement the FFSD approach, document good practices and gain experience which STRIDES will then apply when gradually scaling up project activities to cover the entire district. During PY3, STRIDES will expand its support to include more health facilities in each district.

Table 2 summarizes the number and level of facilities selected by district. It is important to note that in Kumi, Kayunga and Kyenjonjo districts, STRIDES selected more HC III than HC II because some of the districts did not have a functional HC II. In other cases HC III were selected since they provide a wider range of services considered a priority for the district population.

Table 2: Number of health facilities in each district with whom STRIDES worked in PY2

	Bugiri	Kalangala	Kaliro	Kamuli	Kamwenge	Kasese	Kayunga	Kumi	Kyenjojo	Luwero	Mayuge	Mityana	Mpigi	Nakasongola	Sembabule	Total
Hospital	1	0	0	2	0	1	1	3	0	0	1	1	1	1	1	13
Health centre IV	1	1	1	2	2	2	1	0	2	3	2	2	2	1	2	24
Health centre III	7	2	5	7	4	13	5	7	6	9	7	6	4	4	5	91
Health centre II	14	4	13	23	6	30	4	6	5	9	10	6	9	8	15	162
TOTAL	23	7	19	34	12	46	11	16	13	21	20	15	16	14	23	290

District launches of the project

In Mpigi district, the project was officially launched on May 3, 2010 in the presence of the district leadership, technical staff and community representatives. In the other districts, the project was launched through meetings with the district teams. The launch in Mpigi included a presentation about STRIDES, and speeches from district representatives such as the LC V Chairman, CAO and DHO. STRIDES shared information, education, and communication (IEC) materials with the district leaders and provided brochures containing vital information on family planning. Local and national media were invited and covered the event widely. In some districts, representatives from the sub counties where STRIDES works were present.



STRIDES staff and district officials who attended the project launch in Mpigi and signing of MOU

2.2 Result Areas

Result 1: Increased quality and provision of routine RH/FP and CS services in facilities

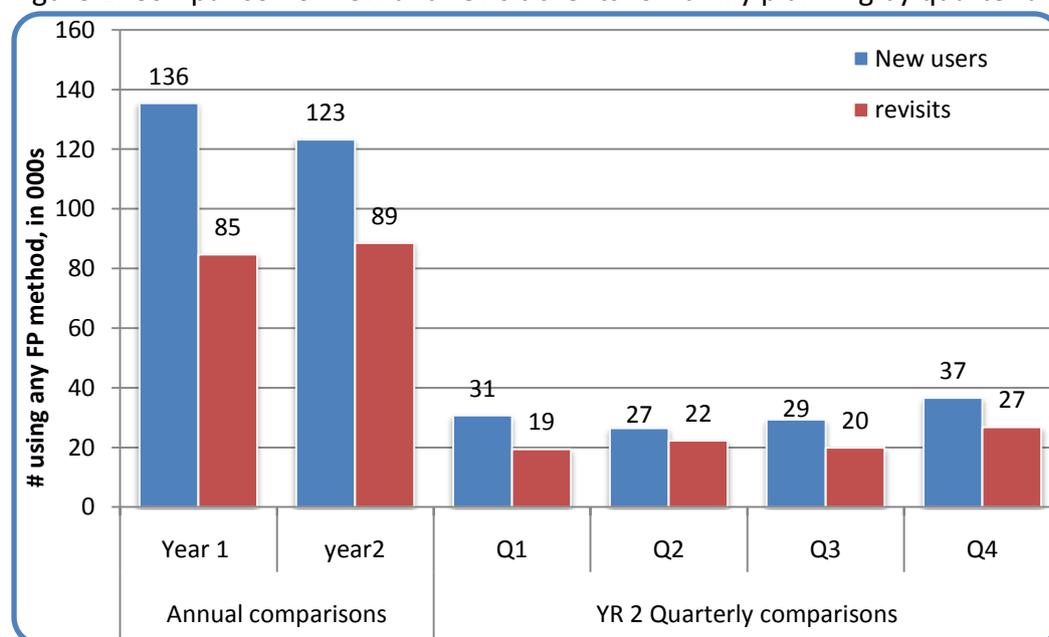
A. Key indicators

This section shows progress toward targets for key indicators in the STRIDES performance monitoring plan (PMP). See Annex I for summary charts on the status of the indicators.

Indicator: Number of clients using any family planning method

One of the FP indicators tracked by STRIDES is the number of clients using any modern family planning method. The FP methods include pills, injectables, condoms, implants, IUDs, tubal ligation and vasectomy. Figure 1 below shows a comparison of new clients and revisits for each of the quarters and an overall annual comparison.

Figure 1: Comparison of new and revisit clients for family planning by quarter and year



Note: The data labels displayed on the quarterly graphs have been rounded off.

Figure 1 above displays data on FP users, i.e. new users and revisits. New users are clients visiting the health facility for any modern family planning method for the first time whereas revisit clients are those who are currently using any of the modern FP methods or have switched to another method in the reporting period. The figure shows that the overall number of clients who received any modern family planning method in year two was lower than that of the previous year. The number of new visits dropped in year two by 10%. Further analysis of the users per method reveals that the decrease was mainly in short term methods and IUDs whereas users for implants and permanent methods increased (see Table 3 below).

Table 3: Number of family planning users by method

	FP methods	2008/2009	2009/2010	% increase	% decrease
Short-acting methods	Pills	43,271	36,782		15%
	Condoms	86,103	78,345		9%
	Injectables	79,684	74,187		7%
Long-acting & permanent methods	Implants	1,581	2,958	87%	
	IUDs	4,821	1,963		59%
	Tubal ligation	2,710	3,593	33%	
	Vasectomy	218	226	4%	

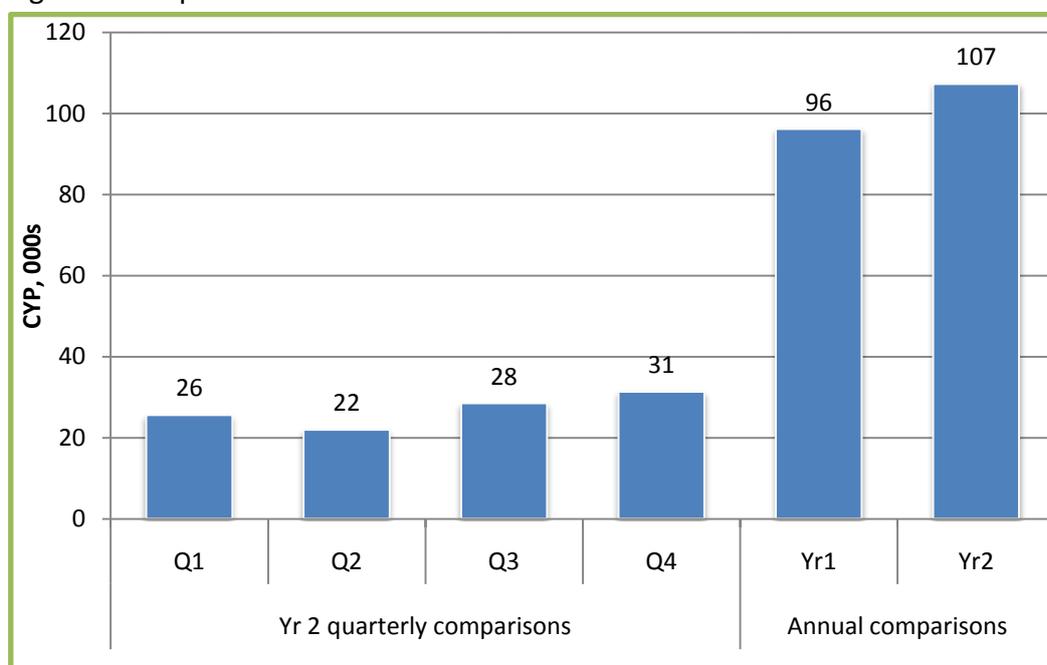
The reasons for the decrease in users for the short term methods could be that the FP clients of short term methods switched to LAPM, an explanation that at quick glance seems supported by the concurrent increase of the CYP (see below). However, the decrease in FP users overall also could point to other reasons, such as: (i) BCC messages are not adequately reaching the targeted users; (ii) a shortage of FP commodities in the facilities and/or in the country; (iii) a high number of discontinuing clients due to dissatisfaction with a method, possibly combined with lack of or inadequate counseling; (iv) dissatisfaction with attitudes of and services by health providers; and (v) a general problem with the accurate recording and reporting of FP service data. Most likely, there is no one single reason for the somewhat unusual statistics presented through the HMIS as shown in Figure 1. In a well functioning and high quality FP program one would not expect to see service data that show higher numbers for new FP acceptors than revisits, as follow up of both new and continuing clients would raise the number of “revisits” above that of the “new clients.” Compared to PY1 there was a 5% increase in reported revisits, which could be attributed to a small increase in “continuing” short-term method acceptors, or to follow-up visits by new long-term acceptors. Unfortunately, the HMIS does not provide this level of detail. Given the importance of this information STRIDES will conduct further analysis of the data during PY3.

To address the above problems, STRIDES has acted on various fronts in PY2, which are described later in this report. These include (i) the strengthening of the BCC component in PY3 aiming to increase the number of voluntary FP acceptors, and to maintain them; (ii) work with USAID and other partners to strengthen the commodity management systems at, particularly, the district level; (iii) strengthen the quality of service delivery and related systems, with special emphasis on counseling and privacy issues; and (iv) strengthening the capacity of district and facility staff to record and report accurately through the HMIS, and to use HMIS generated information for general management purposes.

Indicator: Couple Years of Protection (CYP)

As a measure of contraceptive coverage, STRIDES tracks CYP based on the volume of contraceptives dispensed. CYP increased from 96,105 to 107,257 in PY2 reflecting a 12% increase compared to CYP performance in PY1. The third and fourth quarters registered higher performance compared to the first and second quarters. There was an increase in the number of long acting and permanent method users as follows: implants dispensed increased by 87%, tubal ligation increased by 33% and vasectomy increased by 4%. The increase in permanent method users led to the overall increase in the CYP since they have higher conversion factors, even though the total number of FP users in PY2 decreased in comparison with the first project year. This is obviously an important observation which needs follow up and further action to increase access to modern FP methods among those in need of these services. STRIDES and others ultimately need to focus on increasing the number of voluntary FP method acceptors, and maintain these as acceptors, not necessarily and/or primarily aim for a high CYP.

Figure 2: Couple Years of Protection



Support to Child Days Plus

The MoH has designated the months of April and November each year for Child Days Plus (CDP) activities in order to accelerate delivery of an integrated package of key interventions including Vitamin A supplementation, de-worming of children 1-14 years, immunization, tetanus toxoid immunization, and mass drug administration for neglected endemic diseases. In addition to supporting the districts to plan, mobilize and offer the services during those months, STRIDES supported the districts of Mityana, Kamuli, Bugiri, Kyenjojo, Kamwenge, Kasese, Kumi and Nakasongola to conduct CDP outreaches in the hard-to-reach and poorly performing areas, as identified by the districts themselves. During these events, in addition to the services mentioned above, HIV counseling and testing, antenatal care, family

planning, growth monitoring and nutritional counseling were also provided. It was emphasized to the communities that a one-day activity of this nature does not replace the need for on-going service delivery at health facilities. Communities were reminded of the importance of consulting health providers at health facilities for routine health checks, preventive services, and when medical problems requiring treatment occur.

The events were attended by the district health officials and district leaders (LC V Chairpersons, Chief Administrative Officers and Resident District Commissioners). The leaders actively participated in the events. The events in some of the districts were reported on Uganda Broadcasting Corporation (UBC) television network.

Table 4: Number of people reached during the Child Days Plus in the districts of Mityana, Kamuli, Bugiri, Kyenjojo, Kamwenge, Kasese, Kumi and Nakasongola

	Service provided	Number of people reached
1	Immunization	3,977
2	Vitamin A supplementation	30,188
3	De-worming	30,455
4	Antenatal Care	471
5	Breast feeding and infant nutrition counseling and education for expected and breast feeding mothers	248
6	Family planning	86
7	HIV counseling & testing	804
8	Infant HIV testing	100

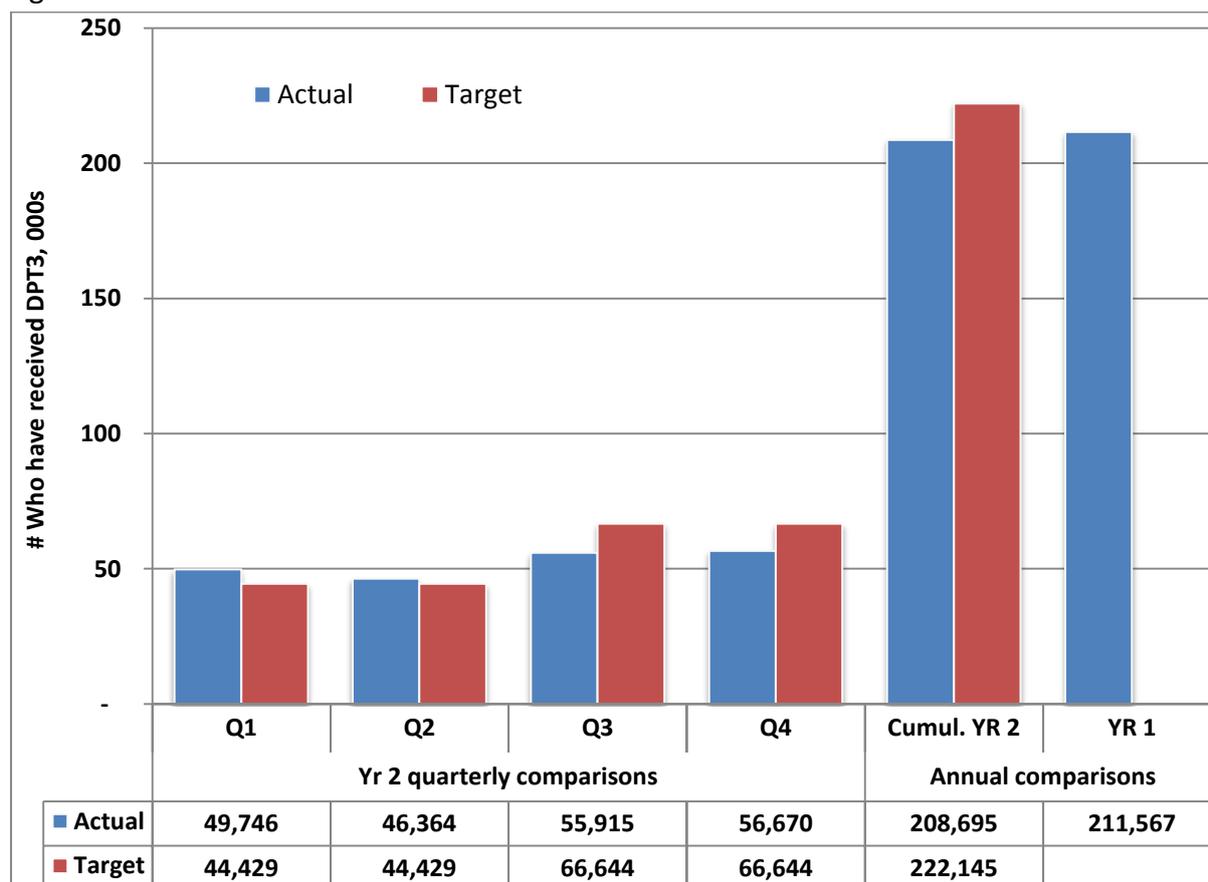


Child Days Plus in pictures

Indicator: Number of children who at 12 months have received 3 doses of DPT

A total of 208,695 children received DPT3 in PY2, which represents 94% of the target. This is attributed to the support given during the Child Days Plus campaigns and increased demand for immunization services as a result of BCC community mobilization activities. It is important to note that the actual numbers may be higher than what was reported due to poor record keeping practices of health personnel, lack of manpower at facility level and under reporting of outreach immunization. The data management challenges are being addressed by STRIDES in PY3.

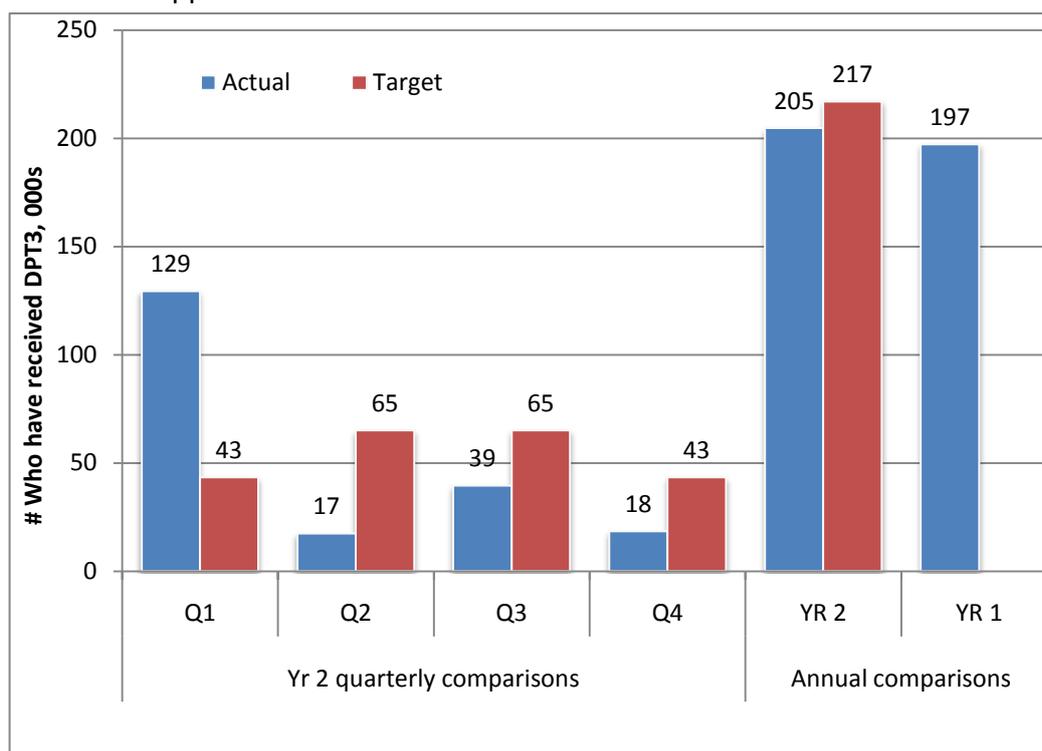
Figure 3: Number of children who at 12 months have received 3 doses of DPT



Indicator: Number of children under 12 months of age who received the second dose of Vitamin A supplementation

A total of 204,740 children received the second dose of Vitamin A during PY2. A comparison over the four quarters shows that 63% (129,414/204,740) of the children received their second dose during the first quarter. This is attributed to the support given during the Child Days Plus campaigns as discussed in the previous section. This year’s performance was higher than the previous year’s by 4%, but fell short of the planned target by 9%. It is important to note that the actual numbers may be higher than what was reported due to poor record keeping practices and lack of manpower at facility level and during the Child Days Plus. The annual number of children receiving the second dose of vitamin A came within 6% of the target that STRIDES had set for the year.

Figure 4: Number of children under 12 months of age who received the second dose of Vitamin A supplementation



Note: The data labels displayed on the quarterly graphs have been rounded off.

Indicator: Percentage of facility customers satisfied with health services received

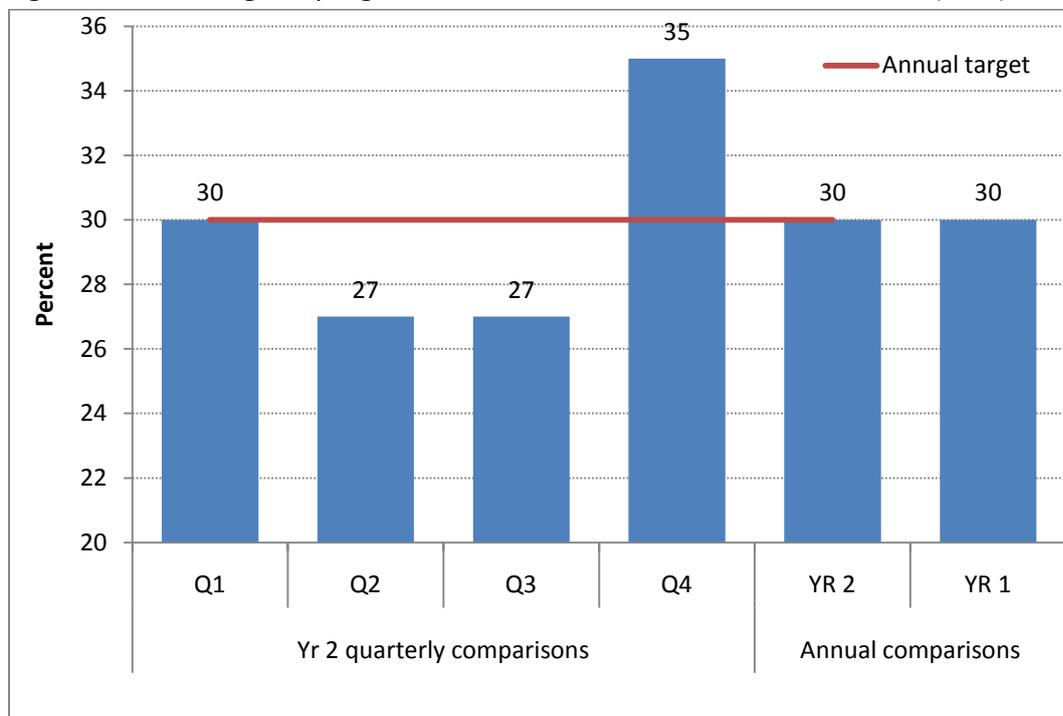
The most recent STRIDES annual survey found that on the day of the survey, (i) 88% of clients visiting private-for profit facilities were satisfied with the family planning services provided, (ii) 54% of public health facility clients were satisfied, and (iii) 50% of not-for-profit facility clients thought that the services were of satisfactory levels. A client was deemed satisfied with the services if at least 8 out of the 10 criteria for client satisfaction were met. On the other hand, a number of clients interviewed at the private-for-profit facilities expressed dissatisfaction with waiting time at the government facilities and thus preferred to visit private facilities where they were rarely asked to wait for long periods of time. Selected clients were also dissatisfied with the insufficiency of information given to them at public health facilities as most of them reported that the service providers rarely mention the side effects of a particular method. STRIDES will follow “performance” on this indicator with increased scrutiny as most anecdotal information points to widespread dissatisfaction among the public with the quality of public sector services. The subjectivity element inherent to this indicator also should not be ignored.

Indicator: Percentage of pregnant women who receive 4 antenatal care (ANC) consultations

The major objective of ANC is to identify and treat problems such as anemia and infections during pregnancy and other complications if any. It is during ANC visits that advice on a range of issues including place of delivery and referral of mothers with complications occurs. The MoH recommends that a pregnant woman attends at least 4 ANC visits. STRIDES is

promoting increased ANC attendance in its interventions. The figure below shows that the percentage of women who received 4 ANC consultations increased in quarter 4 (35%) compared to the previous quarters. Improvement in the fourth quarter is attributed to increased community mobilization by STRIDES. Overall, the PY2 target of having 30% of pregnant women receive 4 ANC consultations was achieved.

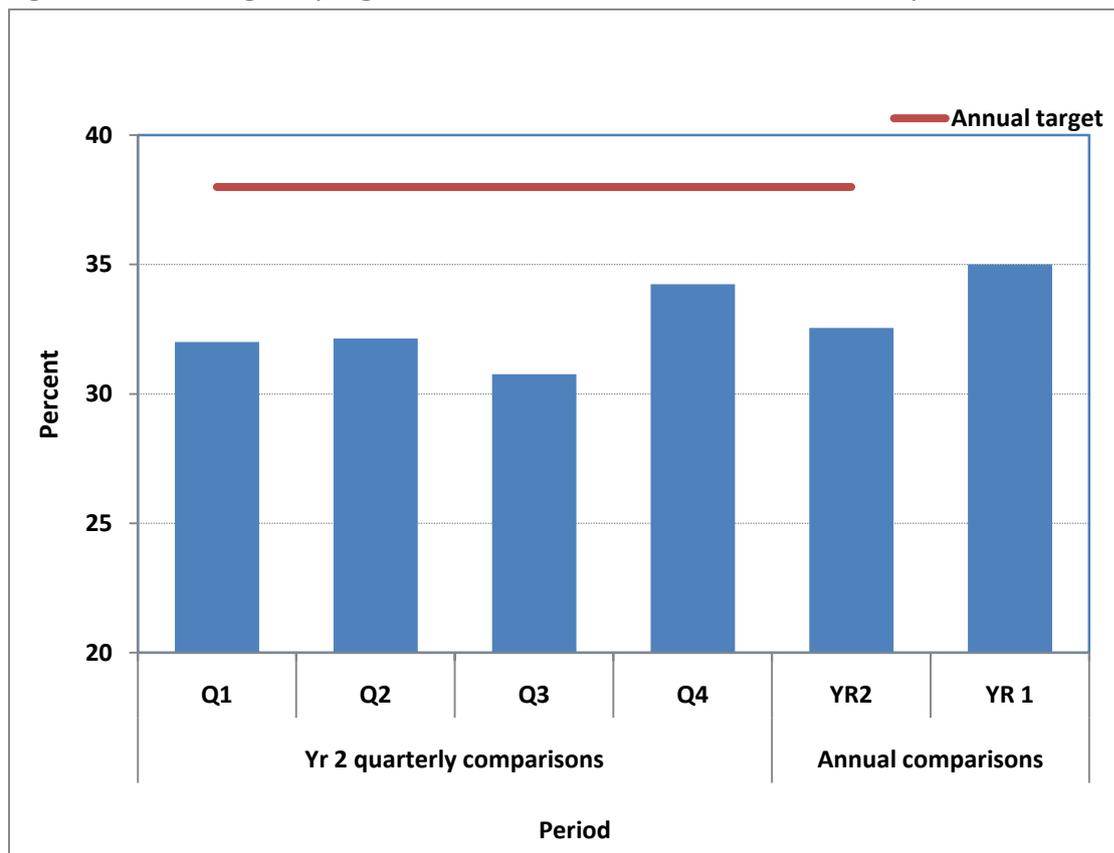
Figure 5: Percentage of pregnant women who receive 4 antenatal care (ANC) consultations



Indicator: Percentage of pregnant women who received 2 doses of IPTp

STRIDES tracks the percentage of pregnant women who received 2 doses of IPTp as part of the project’s child survival and maternal health indicators. During PY2, performance for this indicator was below target for all quarters. The fourth quarter registered better performance than the previous quarters but fell short of the quarterly and annual target (38%). Overall, performance declined by 2 percentage points (6%). The reasons for low performance include: general late attendance for ANC visits; inadequate supply of drinking water at facility level and stock out of SP (Fansidar). STRIDES is addressing this in PY3 by developing BCC messages aimed to further improve ANC attendance, supporting the district and private sector to ensure that integrated outreaches (RH/FP/CS) include ANC, and availing water purification products through social marketing partners such as UHMG and PACE.

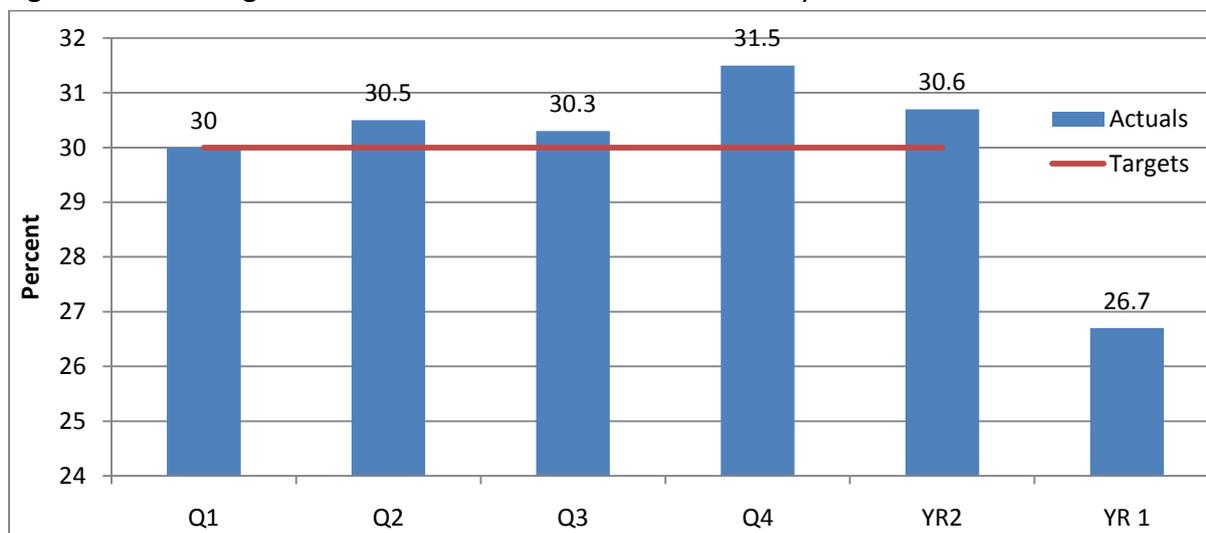
Figure 6: Percentage of pregnant women who received 2 doses of IPTp



Indicator: Percentage live births delivered at a health facility

As part of the child survival indicators, STRIDES tracks the percentage of live births delivered at health facilities. The total deliveries in a district, both in and outside facilities, are taken as projected estimates by the government for the year. Overall, in PY2 30.6% of the live births were delivered at a health facility, a 15% increase from the previous year which was at 26.7%. The 30% target was surpassed during most quarters.

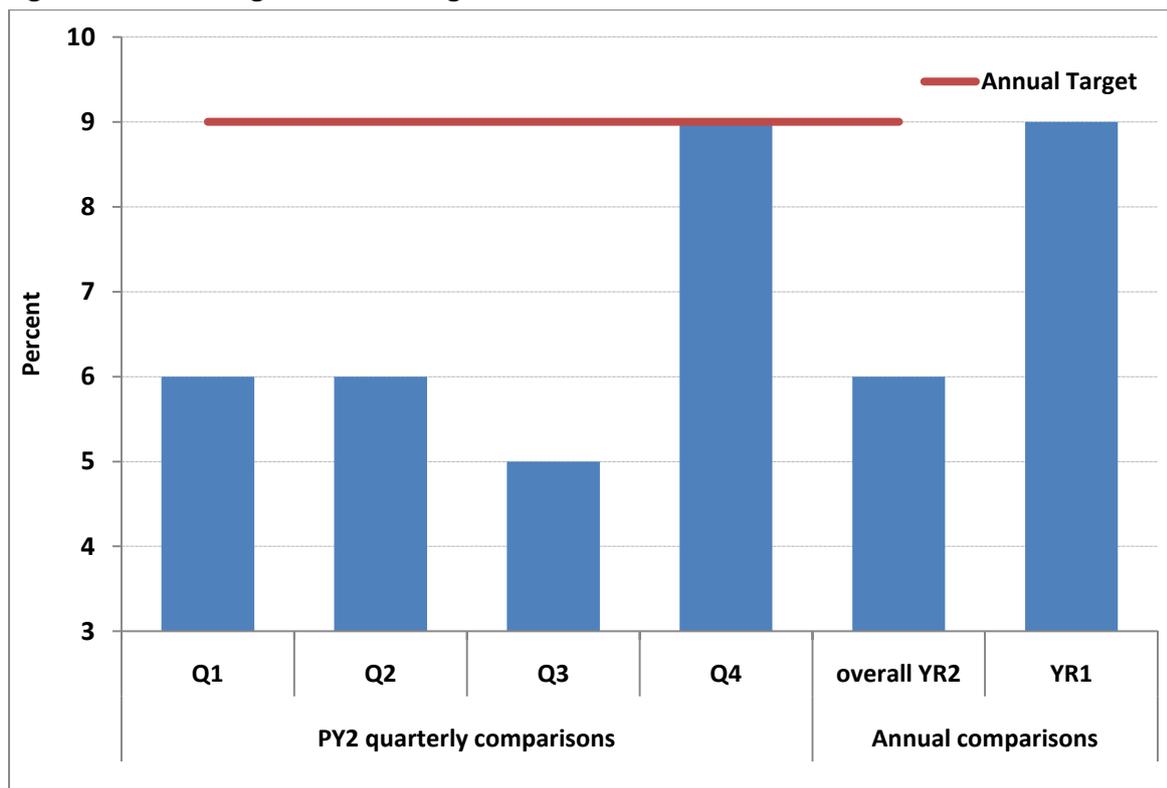
Figure 7: Percentage of live births delivered at a health facility



Indicator: Percentage of underweight children at measles vaccination

Adequate nutrition is critical to child development. The period from birth to two years of age is important for optimal growth, health and development. According to the 2006 UDHS, 38% of children under-five years of age in Uganda are stunted, 16% are underweight, and 6% are wasted. It is based on these figures that STRIDES is supporting interventions to reduce the number of underweight children in the 15 districts. During PY2, the targets were achieved for all quarters, with the best performance in quarter 3. Overall performance improved by 33% compared to the baseline and exceeded the target by 33%.

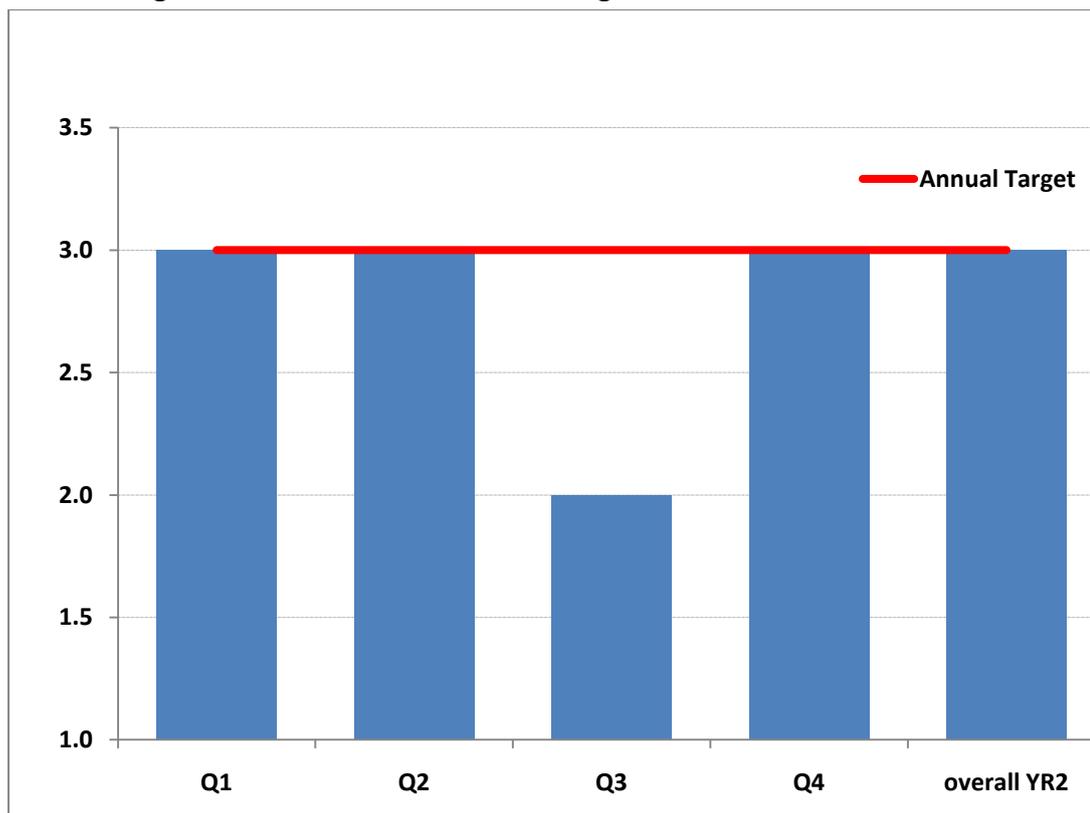
Figure 8: Percentage of underweight children at measles vaccination



Percentage of live births with low birth weight

STRIDES tracks the percentage of live births with low birth weight as part of the project's malaria and nutrition indicators. This indicator measures the percentage of live births with a birth weight of less than 2.5 kg among births occurring in health facilities. During PY2, performance was achieved for all quarters. Quarter 2 registered better performance with 2% of live births having low birth weight. Overall, the annual target of 3% was achieved.

Figure 9: Percentage of live births with low birth weight



B. Detailed Year 2 Activities by Sub-result

Sub-result 1.1 Provider performance strengthened and supported to enhance the provision of RH/FP and CS services at facilities

Building the capacity of facilities to deliver the full package of essential RH/FP and CS services is one of the strategies that STRIDES uses to address Uganda's high maternal and child morbidity and mortality. This is primarily done through training of various levels of service providers with specific emphasis on mentoring and on the job training approaches.

Development and dissemination of the training strategy

In order to address the challenges observed during STRIDES training activities, such as (i) ensuring that the right participants attend training; (ii) ensuring that workshops do not cause service delivery to be adversely affected; and (iii) trainees are prepared and equipped to provide the services they have been trained for, the STRIDES training strategy was developed and disseminated during the third quarter of PY2. The training strategy spells out the training approaches that are used by the project to strengthen and support provider performance to enhance the provision of RH/FP and CS services at the facility and community levels both in the public and private sectors. The strategy outlines trainee selection criteria which guide the districts in identifying and selecting suitable participants

for the planned trainings. Furthermore, the strategy defines the basic package of standards as per the MoH national minimum health package guidelines to be available at each of the service delivery points, and underscores the importance of pre-training site assessments. With the implementation of the training strategy, training will be more beneficial to the districts and their constituencies, and will ultimately lead to improved quality of, and increased demand for and use of the services.

Dissemination of the training strategy was done between 7th and 11th June 2010. Three regional meetings were held, and each district was represented by three members (the STRIDES district focal person, District Health Officer and a trainer. The strategy was received positively by the district teams across the three regions and they pledged full support in its implementation.

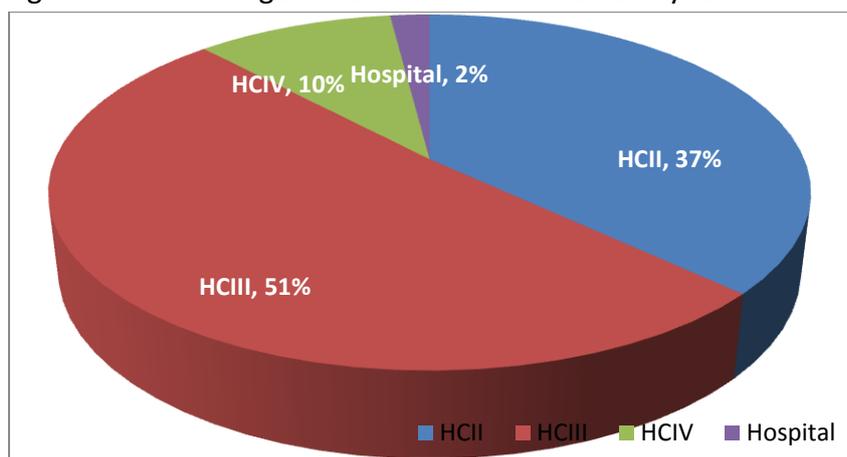
Facility assessments

As part of the implementation of the Fully Functional Service Delivery approach to health care, facilities of providers trained by STRIDES were assessed. The assessments were conducted by a team of three people (a district trainer, an external trainer, and the STRIDES district focal person). Using the facility assessment tool, information on strengths and gaps and recommendations were generated and shared with both the district and STRIDES teams for consensus building and mapping out a way forward with the objective to improve service delivery. Overall, 247 facilities at various levels were assessed. Figure 10 below shows the percentage of health facilities assessed by level.

Table 5: Number of facilities assessed by level and location

	Bugiri	Kalangala	Kaliro	Kamuli	Kamwenge	Kasese	Kayunga	Kumi	Kyenjojo	Luwero	Mayuge	Mityana	Mpigi	Nakasongola	Sembabule	Total
Hospital	1	0	0	0	0	1	0	1	0	0	0	1	0	1	0	5
HCIV	1	1	1	2	2	1	2	0	2	3	2	2	1	1	2	23
HCIII	9	2	5	6	7	14	4	11	8	18	5	7	10	11	4	121
HC II	14	5	13	7	9	10	2	3	5	2	13	1	2	8	4	98
Total	25	8	19	15	18	26	8	15	15	23	20	11	13	21	10	247

Figure 10: Percentage of health facilities assessed by level



The assessments generated the following findings:

1. The majority of the HC IIs were run by nursing assistants, who were often the only staff at the units at the time that the assessments were conducted.
2. In most of the HC IIIs there were two trained staff including a midwife and a clinical officer. In other cases, the two trained staff included a general comprehensive nurse and a midwife. In addition to the two trained staff, one or two nursing assistants were present.
3. Services at HC II and HC III are often, by necessity, integrated and provided in the same room by providers sharing the same equipment for measuring blood pressure, weighing clients, etc. This represents more often than not a weakness of the system.
4. There is a general shortage or absence of equipment in the facilities required for FP services. For example, in the eastern region, equipment such as a tenaculum, uterine sound, and tubal ligation and vasectomy kits were often not available in HC IVs or hospitals.
5. Most of the facilities assessed had inadequate supplies of drugs. For those with supplies, the stock could generally not last for more than one month. For instance, anti-malarial drugs such as Coartem for adults, IV fluids, and FP commodities were out of stock in most units. In addition, supplies such as gloves were also out of stock in many cases. However, gauze and cotton wool were mostly available.
6. Most facilities had antiseptics but an inadequate supply of chlorine solution. Proper processing of instruments, involving decontamination, cleaning, and sterilization/high level disinfection was found lacking in most facilities, and staff had inadequate knowledge on the correct process.
7. Counseling clients for FP was seen by many providers to lengthen the waiting time for other patients/clients. This often led to service providers attending to other clients first. As a result, FP clients get discouraged and depart prior to receiving the service.

8. Infrastructural issues such as the lack of incinerators and of placenta pits for facilities with maternity services, leaking roofs, absence of buckets for infection prevention, and an inadequate water supply were found in most of the facilities assessed.
9. Most facilities did not have the relevant IEC materials for health education.

Training service providers

Clinical training skills (CTS)

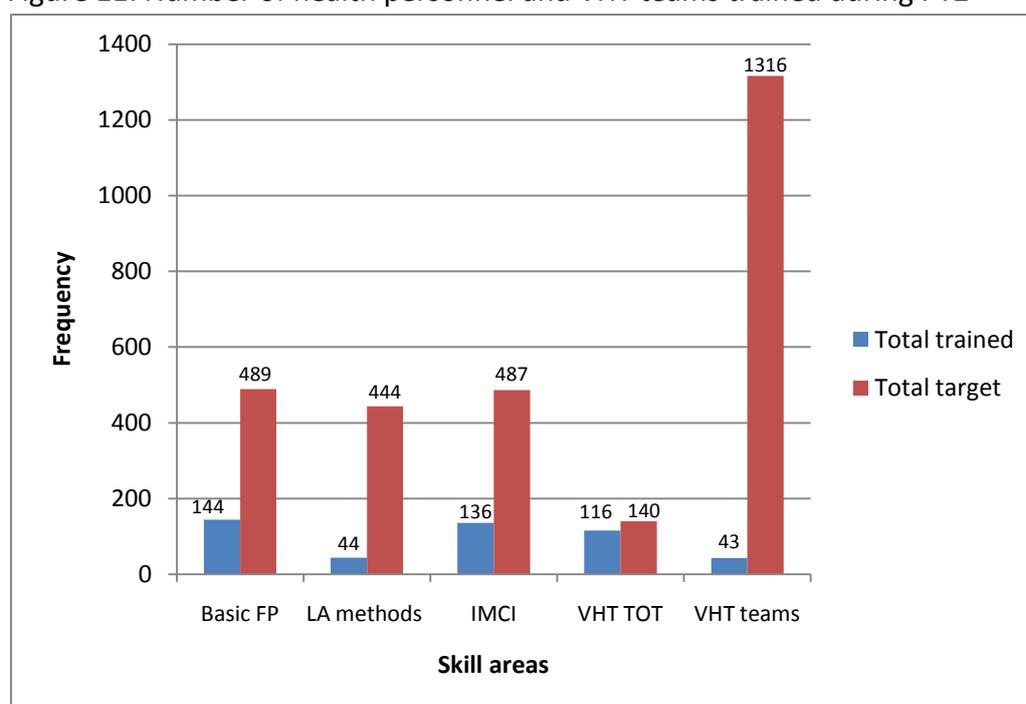
STRIDES trained, followed up and certified 57 trainers in the clinical training skills (CTS) training of trainers (ToT) course. These trainers are supporting the districts to conduct training in various skill areas including basic FP and IMCI. The trainees for the ToT course included trainers for family planning, EmOC, IMCI, VHT and HMIS. The CTS training consists of two modules: effective facilitation skills; and principles of training. The training covered seven key concepts: adult learning; skill competency; skill proficiency; mastery learning approach; standardization; coaching and mentoring. During the training, participants were divided into groups and practiced these concepts by giving presentations on EmONC, IMCI, family planning, VHT and HMIS. Presentations were videotaped and reviewed by the entire group to offer feedback. The training made use of Jhpiego's Modified Computer-Assisted Learning (ModCAL) program which allows for self-paced learning through video, audio and text. The program is pre-loaded on flash drives which were distributed to participants to serve as their reference material.

During PY2, a total of 31 practicum sites in the 15 districts were selected and STRIDES started preparing them to support various skills training such as IMCI, basic and long-acting family planning and LSS/PAC. This process continues during PY3.

A total of 324 facility-based services providers from the 15 districts were trained by the master trainers during PY2 (basic FP: 144; long-acting FP: 44; IMCI: 136). The healthcare providers selected to receive these trainings were from both the public and private sectors. Appropriate job aids, policy guidelines and services standards for the relevant areas were also disseminated during the trainings.

Figure 11 below illustrates the number of health personnel trained during the year. Note that the VHT trainings are discussed under sub-result 2.1.

Figure 11: Number of health personnel and VHT teams trained during PY2



Note: VHT refers to teams of 5 members, although in reality VHTs are sometimes composed of just 4.

Basic family planning

Overall, a total of 144 service providers were trained in basic family planning. Participants included clinical officers, registered nurse midwives, registered midwives, registered comprehensive nurses, enrolled nurses and enrolled midwives. Each participant was provided with and oriented in the use of: Basic Family Planning Clinical Skills Trainee Materials; Counseling Guide on Family Planning; and a Family Planning Global Handbook for Providers¹.

Long-acting methods

In order to develop the capacity for midwives and clinical officers to provide quality long-acting family planning methods (implants and IUD) as well as increasing access and availability of these methods in the districts, a seven-day training workshop was organized for the districts of Mayuge, Bugiri, Mityana and Sembabule during the last quarter of PY2. The trainers who had earlier undergone the Clinical Training Skills (CTS) course facilitated the training, and the practicum sessions were conducted at the selected practicum facilities in the four districts.

Forty four (44) participants (Bugiri - 8, Mayuge - 7, Sembabule - 14 and Mityana - 15) drawn from both public and private facilities attended the training. All participants had earlier been trained in basic family planning. Various training methodologies were used with emphasis on acquisition of skills on models before practicing on clients (humanistic approach to training). IUDs and implant learning guides and checklists were extensively used to ensure appropriate skill acquisition.

¹ USAID/Johns Hopkins Bloomberg School of Public Health/WHO publication

During the training a total of 186 clients received implants (Jadelle and Implanon), 17 had Norplant removed for various reasons including expiry of the seven-year period, and 17 IUDs were inserted.

Integrated management of childhood illnesses (IMCI)

IMCI training was conducted across the regions and a total of 136 participants were trained in managing common childhood illnesses including nutrition counseling. The participants were comprised of registered nurses, enrolled midwives, enrolled nurses, and nursing assistants. All participants received the modules to be used during the training and were supplied with IMCI treatment charts for use at their work sites. Participants developed application plans to apply what they had learned during the two weeks training.

Follow-up and mentoring of providers trained

Follow up of trainees who underwent the basic FP, long acting FP, and IMCI training was conducted in Sembabule, Kamwenge, Kyenjojo, Kamuli and Mityana districts. The follow up teams of two national trainers and two district trainers visited trainees' duty stations within the stipulated period of 2-6 weeks following training using both the MoH/IMCI and STRIDES/Jhpiego developed checklists. Sixty-seven trainees were visited, of whom 43 were providing services to standard as illustrated in the table below. Other trainees are scheduled for follow ups during PY3.

Table 6: Follow up of service providers trained

District	Type of training received	Number of trainees followed up	Number trainees performing to standard
Sembabule	Basic FP	20	15
Kamwenge	IMCI	8	5
Kyenjojo	IMCI	10	6
Mityana	Basic FP	20	16
Kamuli	IMCI	9	1
Total		67	43

Lessons learnt

- The CTS course for trainers allows for facilitation skills standardization among the trainers.
- Development of the pre-training service assessment tool is an important and helpful source of information to identify health system strengthening gaps to be addressed by STRIDES and the districts.
- During the trainee follow up visits, it was observed that 24 of the trainees were not providing the services as expected due to the following reasons: materials and supplies including thermometers for IMCI were not available in most of the facilities; most of the health facilities visited had no drugs (including essential drugs) and contraceptives; some

of the providers trained had left the units and joined other private health facilities. This was particularly the case in Kamuli. STRIDES will continue addressing these gaps in PY3 as part of implementation of the FFSDP approach.

PY3 Next steps

- Update and adopt training materials for adolescent friendly sexual and reproductive health (AFSRH) including cervical cancer prevention and pediatric HIV/AIDS and CEmONC.
- Create a checklist for provider prompting, based on clinical guidelines to support the integration of FP/HIV/YCC/AFSRH services.
- Conduct a TOT in permanent FP methods for 10 trainers.
- Conduct training for selected public and private midwives and comprehensive nurses in basic FP, long acting FP methods, life saving skills/post-abortion care, IMNCI and nutritional counseling, and AFSRH.
- Reprint and disseminate nutrition policies, guidelines and job aids to service delivery points.
- Conduct training for selected nurses and medical clinical officers (MCOs) in pelvic examination and insertion of IUD and implants.
- Conduct operational research in training of MCOs and nurses in LA methods.

Sub-result 1.2 Demand for RH/FP/CS services at facilities increased through BCC and counseling strategies

During PY2, the following activities were undertaken in the area of IEC/BCC:

Review of RH/FP/CS strategies and reports

STRIDES reviewed available Ministry of Health RH/FP/CS strategies and other MoH reports to identify and analyze existing gaps. The review identified the following:

- Lack of appropriate programs to address key issues such as male involvement and the unmet need for FP
- Failure to involve stakeholders at all levels right from the planning stage discourages ownership of the programs and activities
- Failure to integrate HIV/AIDS/STIs in the RH communication strategy
- Adolescent sexuality and reproductive health issues not fully addressed
- RH issues for special groups/ people with special needs not addressed
- Attitudes of health providers at public facilities still hinder access and utilization of FP in Uganda
- Failure to prioritize emergency obstetric care by the public health facilities
- Limited knowledge on some of the FP methods and related matters such as the fertile period, the female condom and the IUD
- Lack of RH messages targeting young people in school

Formative research

Formative research was conducted in five districts of Bugiri, Kalangala, Kaliro, Kyenjojo and Luwero. A cross-sectional design study was conducted, combining qualitative and quantitative methods. The methods used included key informant interviews, focus group discussions and a survey using a household questionnaire. 394 people responded to the household questionnaire while 20 focus group discussions and 33 key informant interviews were conducted.

The study found that 77% of respondents reported discussing FP/RH and CS issues with their spouses/sexual partners and 42% had used RH/FP services in the last three months. 93% of mothers had attended an antenatal care (ANC) visit during the last completed pregnancy and 77% of mothers had delivered their last child under the care of a trained health worker in a health facility.

The main barriers to utilization of RH/FP services, according to the household survey, were lack of appreciation of the importance of the RH/FP and CS services and fear of side effects of the methods. There is a lack of knowledge about the available services and ways of accessing them. In addition to this lack of knowledge, there is also misinformation in the community, which can make it difficult for individuals to be willing to access these services. Some perceived service providers to be rude and unfriendly, which scares off many potential service seekers. Some people feel fearful or ashamed to be seen using some of the RH/FP services. For example some felt that others would see people who use condoms as sexually immodest. These same feelings of fear and shame also apply to those seeking CS services for conditions that lead to loss of weight and stunted growth of children. Some parents feel ashamed to be identified as having unhealthy children, and therefore would rather keep the children in the privacy of their homes. Some groups, especially youth, tend to shy away from RH/FP services when the provider is of the opposite sex.

Development of the STRIDES communication strategy

The communication strategy was developed following the review of available literature and the formative research. The primary audiences for the BCC interventions include men and women within the reproductive age group, young people, people living in fishing communities and health workers in the public and private sectors. STRIDES anticipates that implementation of the communication strategy will contribute to the following: higher knowledge levels on RH/FP/CS among the population of the 15 districts; increased support, promotion, and utilization of RH/FP/CS services; strengthened health facility community partnerships; greater male involvement in RH/FP/CS services; and improved client-provider relationships.

Innovative approaches in the strategy include promotion of the “model families” concept, working with “male champions” and the media, greater involvement of leaders and promotion of provider initiated counseling for RH/FP/CS services. With sustainability in

mind, the strategy addresses how to build community volunteer capacity to conduct BCC activities and how to involve the community in monitoring change.



STRIDES staff participating in developing the communication strategy

Disseminating the communication strategy at the district level

STRIDES disseminated the communication strategy to key stakeholders in all collaborating districts. During the dissemination meetings, districts provided input into the strategy. Worth noting among their contributions are: the promotion of client initiated counseling to complement provider initiated counseling for FP/RH and CS services; identification of locally available resources such as drama groups and “bibandas” (video houses) that could be used to disseminate messages. In addition, they suggested the need to incorporate *food security* in the “model family concept” so people can be encouraged to have demonstration gardens in some homes. In this regard, STRIDES recognizes that good nutrition is critical in promoting maternal and child health and has expanded nutrition activities in its PY3 work plan. Relevant ideas generated from the participants during the dissemination meetings were incorporated in the communication strategy.

Provider training in inter-personal communication (IPC) and use of adapted BCC materials

STRIDES continued to orient health workers in BCC, IPC and use of IEC materials during the various trainings conducted in the districts. Participants were able to appreciate the importance of the behavior change communication concept that goes beyond awareness, and emphasizes the need to prioritize problems as well as analyze underlying causes. This is critical in promoting specified behaviors such as use of modern family planning methods. Health workers also appreciated the importance of good interpersonal communication skills in provision of quality RH/FP and CS services.

Distribution of IEC materials

STRIDES coordinated dissemination of IEC materials to health facilities, community members and other stakeholders. The IEC materials produced and disseminated include:

- Family planning flipcharts for health workers
- Family planning flipcharts for community health volunteers
- Fact sheets on reproductive health, family planning and child health for leaders
- STRIDES flyer

- Child health fact sheet for parents and caretakers of children which gives information about immunization, child nutrition, de-worming and vitamin A supplementation.
- Fact sheets on FP/RH and CS for lower level leaders
- Wall chart and gestation wheel on prevention of malaria during pregnancy
- “What Every Man Should Know” Booklet on Family Planning
- “Every Day” Health Matters on Family Planning
- Global FP Handbook
- Family planning signposts

PY3 Next steps

- Orient health workers to BCC and use of IEC materials as part of the clinical training and on-the-job training.
- Develop mechanisms and strengthen health facility – community partnerships.
- Develop/reproduce and disseminate job aids.
- Conduct health facility-based activations and discussions.
- Establish toll free telephone counseling.
- Produce quarterly newsletter.
- Launch STRIDES website.

Sub-result 1.3 Improved availability of essential commodities at facility level

STRIDES intends to use the procedures and tools for ordering, receiving and inventory control of commodities at the central, facility and community levels currently being developed by the Securing Ugandans Rights to Essential Medicines (SURE) project. During PY2 STRIDES had a number of meetings with the SURE project to lay the groundwork for collaboration and plan for activities in PY3. With technical assistance from SURE, STRIDES will use the adapted/developed tools to train HMIS supervisors within its collaborating districts to improve commodity management at facility level. The trained supervisors will roll out training in the districts.

PY3 Next steps

- Partner with SURE to provide appropriate support to DHMTs and facilities to order, deliver and redistribute commodities in time to avoid stock outs.
- In consultation with SURE, begin the strengthening of supply chain mechanisms at the district level, involving the training of district and facility-based staff.
- Ensure that providers are fully trained in basic family planning service delivery skills, with heavy emphasis on the importance of counseling, and on offering a broad method mix.

Sub-result 1.4: Facilities strengthened to provide quality services

STRIDES has started preparations to begin initiation of the fully-functional service delivery system (FFSDS) approach. This is the comprehensive systems strengthening approach which starts with the most basic system: the service delivery point (SDP), where provider and client meet. A SDP need not be a health center or hospital; it might be VHT member making a home visit to provide FP information or distributing oral rehydration solution (ORS) packets to enable home-based care of a child sick with diarrhea. The FFSDS approach also allows for a family-focused and holistic approach to quality improvement that can be supported with local resources, along with accreditation of services as “fully functional.”

STRIDES developed minimum basic standards in line with the MoH basic minimum health package that must be met at each of the service delivery areas by level of facility (refer to annex II). During PY3, STRIDES will work with the districts to assess the service areas in the selected facilities to ensure compliance and availability of those standards as part of its FFSD strategy.

PY3 Next steps

- Develop a performance improvement/quality assurance plan to be used in both public and private health services.
- Implement the quality improvement plan and document lessons learnt for both public and private sector.
- Conduct on-the-job training on quality improvement and quality assurance.
- Support establishment of private wings in HCs IV to generate resources for supplementing daily supplies and commodities.
- Pilot a program to engage transportation associations to facilitate transport for referral in the districts as social responsibility such as Uganda Taxi Operators and Drivers Association (UTODA) and ‘boda-boda’ driver associations.
- Remodel selected facilities and repair equipment to accommodate improved quality service delivery (privacy, lighting, water harvesting, storage of drug and other supplies, furniture).

Result 2: Access to and demand for RH/FP and CS services at the community level improved and expanded

A. Key Indicators

Table 7: Indicators for Result 2

Indicator category	Indicator	Baseline
Project level	% villages with functional VHTs	21%
Project level	% VHTs with stock-outs of FP tracer commodities	43%

The concept of a “Village Health Team” became part of Uganda’s national health strategy in 2001. Village Health Teams (VHTs) are meant to serve as the primary, village-level health contact for all villages in Uganda, the equivalent of a low-level health center. STRIDES measures the functionality and effectiveness of VHTs using the two indicators in the table above. However, baseline data for these indicators could only be established with the recently concluded STRIDES annual survey. Findings from the survey reveal that 21% of the villages in STRIDES collaborating districts had *functional* VHTs and of these, 43% of VHTs registered stock outs of FP tracer commodities (condoms, pills and moon beads) within the last three months prior to the survey. In this regard, STRIDES has planned for interventions in PY3 that will strengthen the VHT model and contribute to improving and expanding access to and demand for RH/FP and CS services.

B. Detailed Year 2 Activities by Sub-result

Sub-result 2.1: Increased ability of communities to provide RH/FP and CS services

Functional VHTs could be an important instrument in mobilizing communities for RH/FP and CS services. While the VHTs are part of the public health system, most STRIDES collaborating districts do not currently have functioning VHTs (see above). During the reporting period, STRIDES held sensitization meetings with sub-county leaders in Kasese, Nakasongola, Sembabule and Mityana districts on the VHT concept.

Participation in VHT task force committee meetings

STRIDES continued to participate in the MoH task force committee meetings on VHTs which identified the materials to be included in the VHT kit. Various issues have not yet been resolved. Also, the proposed items for inclusion made the VHT kit expensive and unaffordable. STRIDES management agreed to produce a simple kit which consists of a pair of gum boots, STRIDES branded bag, branded raincoat, FP flip chart for community health workers, fact sheets on FP, RH and CS, T-shirt, and writing materials. Messages for the VHT materials were translated in the respective district local languages of Ateso, Lukhondo, Luganda, Luruli, Lusoga, Runyankole-Rukiga, Runyoro-Rutooro and Swahili.

Training of Village Health Teams

This year, STRIDES trained 116 VHT Trainers of Trainers in Kayunga, Kaliro, Kumi, Kamuli, Mayuge, Bugiri, Nakasongola, Kalangala, Kasese, Kyenjojo and Kamwenge districts. In addition, STRIDES trained 43 VHT teams in Nakasongola district. While STRIDES had anticipated that 1,316 VHT teams would be trained in PY2, the project was not able to meet that target due to delays of the MOH in revising required VHT materials (kits, manuals and job aids). Also noteworthy is that during the third quarter STRIDES management suspended all training workshops in order to allow for the project to develop the comprehensive training strategy referred to above, among other addressing the important issue of candidate selection.

PY3 Next steps

- Conduct sensitization and selection of VHTs.
- Train selected VHT members in basic RH/FP/CS including commodity management; referrals; data management; IEC; immunization; and social mobilization; and provide them with VHT kits.
- Reproduce and disseminate VHT job aids (FP flip chart, malaria, nutrition, immunizations and other skill areas).
- Train drug sellers in basic FP (including management of side effects), child survival, RH and malaria.
- Participate in quarterly review meetings for VHTs at the sub-county level.

Sub-result 2.2 Demand for RH/FP and CS services at facilities increased through community-based BCC and IEC strategies

As outlined in the STRIDES communication strategy, several demand-generating activities have been implemented as follows:

Orienting drama groups in Forum Theatre

Selected drama groups in the 14 districts that expressed interest were oriented on forum theatre and community education. Forum theatre is an active form of drama that emphasizes participation of the audience. The drama is “driven” by a moderator who keeps intervening as the plot of the play develops to stimulate dialogue, provoke action and invite the audience to act out what they think they would do in such a situation being dramatized in the play. In the Western region 80 participants were oriented, in Central 75, and 183 in the Eastern region, for a total of 338 participants. The drama groups will hold forum theatre performances aimed at increasing demand for RH/FP and CS services in PY3.

Interactive radio programs

Outlines for interactive radio talk shows were developed and radio stations reaching the target district were selected based on discussions with district representative and data from Synovate, a radio listenership monitoring agency. STRIDES oriented staff from the selected radio stations and radio programs targeting all collaborating districts were broadcast. A total of 124 interactive radio programs were held across all regions. The programs focused on family planning and reproductive health. Basic facts about family planning, modern methods and side effects as well as family planning for vulnerable groups such as people living with HIV and AIDS were discussed. The programs addressing RH focused on antenatal care and delivery under skilled attendance among others. During each talk show, listeners were provided opportunity to call in and ask FP or RH related questions which the resource persons/guests speakers responded to. The numbers of callers will be available in PY3 following analysis of the data.

World Cup radio and TV advertisement

STRIDES supported the production of two radio spots and one TV commercial on family planning. These were aired during the 2010 FIFA World Cup season as a way to establish a playful link between family planning and football, and were aired during the World Cup season. The radio spots were translated and pre-tested in eight local languages widely spoken in the collaborating districts (Ateso, Lukhonzho, Luganda, Luruli, Lusoga, Runyankole-Rukiga, Runyoro-Rutooro and Swahili).

Mobilizing clients for long acting FP methods

Mobilization of communities to access long acting family planning methods was undertaken in Mityana, Sembabule, Mayuge and Bugiri districts. This was in advance of the long acting family planning clinical trainings to allow for adequate clientele during the training. The aim of the training was to develop competencies of nurses, midwives and clinical officers to enable them to provide quality integrated basic FP services so as to maximize availability and accessibility of the services at all levels of service delivery. Clients were mobilized and counseled about long-acting methods. Channels used to mobilize the clients included radio announcements and “one on one” interactions during child immunization clinic days and outreaches.

Community dialogues

Community dialogues on family planning were held in the districts of Kasese, Kyenjojo, Sembabule, Bugiri, Kumi, Kaliro, Kamuli, Mayuge and Luwero. The most critical issues that emerged regarding family planning are the fear of side effects, the lack of partner support, and misconceptions that hinder access to family planning methods. The importance of undertaking community sensitizations, especially at the grassroots level, was highlighted in all dialogues held. In addition, community and facility health workers were oriented to BCC, interpersonal communication (including IPC at the community level), customer care and use of IEC materials. During the sessions, health facility-community partnerships were also discussed.



Community discussions about family planning and how to increase the use of family planning services at the grassroots level

Lessons learnt

- Involvement of the government community development officers (CDOs) is a good practice that helps mobilizing the community and should be carried forward in implementation of community based BCC interventions.
- Dissemination of IEC materials and any other documents, which includes informing the targeted audiences through meetings, radio, and other channels, is critical in order to get the best outcomes; there is need to desist from mere distribution.
- Pre-testing of materials should not be omitted even when there are constraints with timing.
- Sensitization of local leaders is very important if they have to advocate for issues the project is promoting. Equipping them with key facts facilitates them to better articulate issues being addressed.
- Participating in health networking events is important for fostering partnerships and increasing organizational visibility.
- Grassroots community discussions are crucial because they give the community members an opportunity to discuss issues which are sensitive yet critical. In addition, they facilitate the dispelling of dangerous misconceptions that inhibit service utilization.
- The use of radio and TV spots during the FIFA World Cup increased STRIDES visibility. However, the ultimate objective of attracting more Ugandans to practice family planning and/or child spacing is not easily measured.
- The development and dissemination of fact sheets on RH, FP and CS supported the district leaders to ably sensitize communities about available services and also create demand for them.

PY3 Next steps

- Orient community based drama groups in forum theatre and monitor forum theatre performances.
- Implement community based events such as sports days, health fairs, market day activations, film shows, puppet show and teen bashes.
- Identify and orient CBOs/potential district based partners to implement community based BCC activities in selected locations.
- Identify and implement strategy to increase male involvement in RH/FP/CS.
- Produce/reproduce and disseminate IEC and advocacy materials.
- Work with MoES and District Education Offices to support school based programs and ensure age appropriate packaging of information on RH, FP & CS.
- Participate in 'special days' such as Safe Motherhood, Child Days Plus and Youth Day district-based events.
- Conduct community dialogues on RH/FP and CS.
- Develop and implement the 'model family' concept.

Sub-result 2.3: Improved availability of essential commodities at the community level

During PY2, STRIDES held discussions with the SURE project and the MoH in relation to improved commodity availability and management at community level. STRIDES also learned from partners such as Family Health International (FHI) that Depo Provera can be safely distributed by the VHTs contrary to the MoH policy. However, the MoH has not finalized defining the package of contraceptive commodities that can be distributed by the VHTs at community level. In PY3, STRIDES is supporting FHI as one of its contractors to continue exploring this strategy and will carefully document experiences and share with other partners and MoH in order to influence policy change. In addition, STRIDES will continue to work with the SURE project to explore strategies and provide appropriate support for health centers to conduct systematic monitoring of VHT performance in commodity and data management.

PY3 Next steps

- STRIDES will seek expertise from the MoH, the SURE project and other stakeholders such as UNICEF (UNICEF is taking the lead to pilot the Integrated Community Case Management of a sick child using the VHT approach) to assist in developing appropriate systems and tools that the VHTs can use to ensure continued availability of essential commodities and drugs at the community level.
- In collaboration with social marketing groups and other IPs help the districts to develop a transparent ITN distribution mechanism.
- Avail RH/FP/CS commodities such as Mama Kits, MUAC tapes, contraceptives, ORS/zinc in collaboration with social marketing partners.
- Support integrated outreach activities (child survival, LA methods, outreach to hard-to-reach areas, additional outreach during Child Days Plus and other special days).

Result 3: Use of RH/FP and CS services advanced through supportive systems

A. Key Indicators

Table 8: Indicators for Result 3

Indicator category	Indicator	Baseline	Overall year 2 actual	Year 2 target
Project level	% facilities submitting timely HMIS reports to HSD/district	72%	72%	78%
Project level	% districts submitting timely HMIS reports to MoH	78%	78%	80%

As part of system strengthening, STRIDES tracks the two HMIS indicators above as a measure of strengthening the Health Management Information System (HMIS) which it relies upon to monitor most of its interventions. According to the table above, 72% of

facilities supported by STRIDES in the 15 districts were submitting timely reports to the health sub district or district. 78% of the 15 collaborating districts were submitting timely reports to the MoH. In PY3 STRIDES will address completeness of the HMIS reports and other data quality issues.

B. Detailed Year 2 Activities by Sub-result

Sub-result 3.1: Expansion of RH/FP and CS service in facilities and communities supported by contributing to development and implementation of positive policies

STRIDES will continue to actively participate in various meetings, working groups and conferences that influence RH/FP and CS policies as discussed below.

Monthly maternal and child health (MCH) cluster meetings: The MCH cluster is one of the four MoH clusters and is mandated to vet new concepts and develop new policies and guidelines relating to maternal and child health before they are presented to the senior management of the MoH. STRIDES attended the monthly MCH cluster meetings held at MoH headquarters.

Quarterly family planning technical working group meeting: STRIDES has continued to actively participate in the FP technical working group meeting coordinated by the MoH. This is the MoH forum where FP implementing partners review the performance of the FP program in Uganda. While in the earlier arrangement NMS had suspended the direct supply of contraceptives to private sector organizations, the most recent development as result of these meetings allowed some of the larger private sector organizations to access FP commodities directly from NMS. However, most organizations still have to go through the districts.

Newborn care meetings: Initially, this was under the MCH cluster. Given that neonatal deaths contribute 23% of the under five mortality² in Uganda there is a need to handle neonatal issues separately. STRIDES has been an active member in these meetings.

BCC technical working group meetings: This is the forum for all implementing partners working in health projects. On a quarterly basis, STRIDES has been participating in these meetings in which IPs share experiences, BCC materials and identify best practices.

Reproductive health and commodity security (RHCS) meetings: This is the forum for all implementing partners working in RH to discuss RH commodity security issues. The specific areas of discussion include forecasting contraceptives, stock levels at NMS and an update on issues related to commodity security. The meetings take place every two months and are facilitated by SURE in close collaboration with NMS and the MoH.

² Child survival strategy for Uganda, 2008-2015

Additionally, towards the end of the year, the MoH also invited STRIDES to be part of the malaria and nutrition technical working groups because of the project's increased involvement in the areas of nutrition and malaria.

International family planning conferences: STRIDES staff attended and actively participated in the international family planning conference held in Uganda from November 15 - 18, 2009. The conference attracted well over 1,300 participants including researchers, policy makers and health workers from the world. STRIDES also attended the USAID regional meeting on family planning in Kigali, Rwanda which discussed experiences and ideas for accelerating the implementation of existing or modified FP programs. During the reporting period, STRIDES actively participated in the RH/FP technical exchange network meetings via a teleconference bridge, organized by home office for MSH programs working in RH/FP around the world and shared experiences.

Presidential Global Health Initiative: The US Government through the Presidential Global Health Initiative (GHI) will invest \$63 billion over six years from 2009 to help partner countries improve health outcomes through strengthened health systems with a particular focus on improving the health of women, newborn and children through programs including infectious disease, nutrition, maternal and child health and safe water. The design team for the GHI visited Uganda during the month of May 2010. STRIDES was invited to make two presentations to the group, one focusing on what the project is supporting in the area of nutrition and the other on malaria. On May 25, 2010, the nutrition group of the GHI design team accompanied by STRIDES staff visited Luwero district to acquaint themselves with nutrition activities in the district. As a result, STRIDES has acquired additional funding for nutrition activities to be implemented in PY3.

The campaign for accelerated reduction of maternal mortality in Uganda (CARMMU):

STRIDES serves on the MoH task force of the campaign for accelerated reduction of maternal mortality in Uganda (CARMMU). In 2008, Uganda launched the roadmap for accelerating reduction of maternal and neonatal mortality and morbidity. The CARMMU goal is to mobilize the political, civic and socio-cultural leaders, the private sector, civil society, the service providers and development partners to address maternal and neonatal health in Uganda. On May 05, 2010, at Namboole Stadium, the Ministry of Health in partnership with development partners, civil society organizations and the media launched a two-month campaign for accelerated reduction of maternal mortality in Uganda under the theme '*Healthy Mothers and Babies, Everyone is Responsible.*' The event was a national response to the African Union initiated campaign for accelerated reduction of maternal mortality in Africa (CARMMA), which was launched at continental level in July 2009.

During the event, various activities were conducted such as: stall exhibitions by organizations and private sector working in the area of maternal health; a football match; interludes with songs and traditional dances with messages promoting maternal health and launch of "Save the Mothers Fund" (a fundraising mechanism for additional resources to

support specific activities to accelerate maternal mortality reduction). STRIDES displayed materials and also explained the project's work to those who visited the stall. The CARMMU strategy provides the basic framework for some of STRIDES interventions in the 15 districts.



STRIDES participation in the CARMMU launch

Lesson learnt

- Field visits with USAID teams provide a better forum for informing the mission about the success and challenges during project implementation.

PY3 Next steps

- Identify strategies that address policy and legislative gaps concerning nutrition.
- Disseminate and promote adherence to MoH policies and regulations on RH/FP and CS with public and private partners through distribution and DHMT meetings.
- Continue to participate in the meetings to positively contribute to expansion, use and quality of RH/FP and CS services through the exchange of ideas and lessons learnt, and influencing national policies and strategies.
- For all campaigns and other initiatives, STRIDES support will focus on the districts where it works, to ensure that campaigns lead to improved service delivery and, ultimately, a healthy population.

Sub-result 3.2: Districts revitalized to better manage RH/FP and CS services for scale-up

Advocacy events/meetings

Advocacy meetings were held successfully in a number of districts in the three regions. These meetings focused on sensitizing the district and local leaders about STRIDES activities. Participants included technical staff, the local council (LC) leaders, CAOs, religious leaders, and DHMT. Topics covered included the following among others:

- Overview of STRIDES project with emphasis on its mission, vision, scope, objectives strategies and district specific activities

- The MoH's RH, FP and CS policy guidelines
- Highlights of the STRIDES baseline survey findings
- Fact sheets on RH, FP and CS services and STRIDES BCC activities

In addition, district, religious and opinion leaders from all fifteen districts were sensitized about the STRIDES project and its implementation plans. The following issues were raised during the sensitization meetings:

- Participants inquired whether the STRIDES child survival strategy catered for food and nutritional security for children. STRIDES staff informed participants that additional food and nutrition activities will be included in its PY3 work plan depending on availability of funds.
- Concerning the splitting of Mpigi district, participants wanted to know whether STRIDES will co-opt the new districts from July 1, 2010. Participants were informed that discussions are being held with USAID to address this issue and the outcome will be communicated.
- Participants inquired whether training for both natural and modern family planning methods will be conducted. They were informed that STRIDES family planning training curriculum covers both natural and artificial methods.
- Participants were interested in knowing whether STRIDES would support infrastructural development. They were informed that this is beyond the scope of the project.

Planning meetings

Teams from all three regions participated in a planning meeting which was held in June at the Kampala head office. The meeting generated simple planning guidelines to be used when developing work plans and budgets with the districts for PY3. All regions were requested to carry out a review of the activities implemented in each district against what was planned. The regional team held planning meetings with the districts and the district work plans informed the STRIDES planning and budgeting process held in August. The STRIDES work plan was submitted to USAID by the deadline.

Leadership Development Program (LDP)

Seven STRIDES staff were trained as facilitators for the MSH's leadership development program organized by MSH's Center for Leadership and Management. STRIDES started rolling out the LDP in three regions by organizing five Senior Alignment Meetings (SAMs).

Objectives for the SAMs were to:

- Create a shared vision about LDP with the districts;
- Share key terminologies and enlighten the districts about LDP and its objectives and requirements; and
- Enable the districts select suitable candidates for participation in the LDP program and make preparations in the districts for its implementation.

Participants included CAOs, LC V Chairpersons, DHOs, District Health Educators (DHE), District Nursing Officer (DNO), hospital and health centre IV In-Charges, District Secretary for Health, representatives of development organizations in the districts and other district officials interested in the LDP. All districts except Mpigi participated in the SAMs and expressed interest in having the LDP. They also pledged to support this program by advocating for it in the districts and making budgetary provisions in their district budgets. LDP will be implemented in 14 of the 15 districts in PY 3, Mpigi not having participated in the SAMs – a key component of LDP. Each district will start with four teams of 3-4 members each, selected at different levels in the district i.e. one district-level team, one hospital team, and two HSD teams (refer to annex I for the detailed implementation approach).

PY3 Next steps

- Strengthen the skills of DHMTs, supervisory teams and managers at all levels in management and leadership including planning, coordination, budgeting, resource allocation, and financial management, through the LDP.
- Assist the DHMT to arrange quarterly meetings between the public and private sector to discuss guidelines, standards, new information, referrals between public and private facilities, and data for decision making.
- Identify several districts to pilot new models of PPP and support learning and implementation through exchange visits and meetings.
- Renew MoUs with significantly more emphasis on performance based management components in MoUs, and including conditions on cost share commitments and coordination of district based events.
- Create regional/district training consulting firms (private-for-profit) through the performance-based contracting program, to support training, mentoring, follow up, and possibly other tasks.
- Develop PY4 work plan and budget bringing together project staff, core partners, and representatives from the MoH, USAID, and other relevant partners such as the SDS and SMP projects, and other IPs.

Sub-result 3.3: Coordination with other implementing partners, the private sector, NGOs, and other partners leveraged to improve district coverage and impact

Performance-based contracts with private sector providers

During the past year, STRIDES issued its first Request for Proposals (RFP) soliciting bids under its PBF/C program. The RFP was designed following the PBF/C approach as indicated in the Cooperative Agreement. It targeted both for-profit and not-for-profit private sector organizations to support strengthening of family planning, reproductive health, and child survival services in Uganda.

The RFP was developed in multiple-lots for each functional area based on the results of the baseline/needs assessment as follows:

- Lot 1: Community-Based Service Delivery
- Lot 2: Delivery of Long Acting and Permanent Methods (LAPM) for Family Planning
- Lot 3: Private Sector Distribution Channels for RH/FP/CS products
- Lot 4: Public-Private Partnership for Health
- Lot 5: Basic Reproductive Health/Family Planning and Child Survival Equipment for both Public and Private Sectors

Over 200 requests for the RFP package were received. The project conducted a pre-bidders workshop in each of the three STRIDES regions to answer questions from potential bidders about the RFP, and a total of 230 participants attended the workshops. STRIDES also provided answers in writing to all questions received during the workshops as well as by email to a special STRIDES email address set up for this purpose. In the end, 120 proposals were received on time for the deadline.

All proposals were screened for eligibility, followed by a technical evaluation of those that passed the eligibility test. Of all bids received, 34% (41 proposals) did not meet the minimum eligibility criteria and were therefore not processed for technical review. This left seventy nine (79) proposals for review by the technical evaluation committee, comprised of representatives from USAID, MoH, and STRIDES staff.

None of the proposals submitted for Lot 5 (equipment) were adequately responsive to the RFP, requiring STRIDES to issue a Request for Quotations (RFQ) towards the end of May. Eleven (11) bids were received. An evaluation process was conducted and the successful bidder was awarded a contract to supply the equipment. Delivery is expected in November 2010.

The technical review of the 79 proposals submitted for the remainder of the lots further narrowed down the list to 27 proposals. Best and final offer (BAFO) questions were generated for all 27 final bidders which led to a further reduction to 20 shortlisted proposals.

The 20 shortlisted organizations were then invited to participate in a pre-award survey to establish their operational capacity. This led to the final selection of 12 organizations that were awarded contracts. They started implementation during the last quarter of PY2.

The table below summarizes the entire evaluation process in terms of the number of proposals that were evaluated at different stages.

Table 9: Summary of RFP 001 proposals evaluation

Category	Submitted proposals	Technical evaluation proposals	Pre-award survey	Final selection
Lot 1: Community-based service delivery	52	17	13	6
Lot 2: Delivery of LAPM	8	4	4	2
Lot 3: Private sector distribution channels for RH/FP/CS products	5	5	2	3
Lot 4: Public - private partnership for health	6	1	1	1
Lot 5: Basic reproductive health/family planning and child survival equipment for both public and private sectors	8	0		
Ineligible proposals	41			
Total proposals	120	27	20	12

Lesson learnt

- The process leading to the award of performance based contracts is time-consuming if conducted rigorously.

PY3 Next steps

- Issue RFP soliciting proposals from private for profit and not-for-profit organizations to increase access to, improve quality of, and create demand for RH/FP and CS services provided through the private sector using PBC.
- Issue an RFP to solicit bids from small private sector practitioners to establish and/or expand private sector service delivery within STRIDES participating districts.
- Support public-private partnerships between STRIDES partners from both the public and private sector.
- Mobilize resources from Uganda-based manufacturers and service organizations.

District capacity to coordinate with the private sector

In order to support the districts' ability to regulate and oversee the activities of private providers, and to support the creation of public-private partnerships, STRIDES supports district coordination meetings between the public and private sector in all districts. It is noteworthy that all MoUs with the districts, and each contract with private sector partners, include performance targets that link both sectors. STRIDES also requires its private sector partners to report their service data into the district HMIS. To facilitate this, an abbreviated version of the HMIS reporting form that accommodates the different needs of private facilities was developed by STRIDES and is being introduced widely.

Coordination with other implementing partners and USAID

STRIDES has identified potential collaboration with other organizations and USAID implementing partners, among those the Stop Malaria Project (SMP) with which STRIDES eventually will overlap in fourteen districts. The two projects have collaborated on various activities and will conduct training and district-level meetings collaboratively. At the request of USAID, STRIDES and SMP arranged a field visit for USAID staff to Mpigi and Nakasongola where various activities undertaken by the two projects are ongoing. Some opportunities for collaboration with other organizations include:

- The Ventures group has delivered Misoprostol to Nakasongola, Kayunga and Bugiri districts, and STRIDES was requested to support the training of the providers in Misoprostol. This component has been included in the LSS training.
- Collaboration with the University of Washington on the use of a portable ultrasound machine in the life saving skills training for midwives is now making good progress, and a partnership is being established.

Sub-result 3.4: Information systems strengthened with data routinely analyzed and used for decision making at facility, community, and district levels

During the reporting period, STRIDES worked with a consultant to develop a plan for HMIS training, routing and processing data and quality assurance for HMIS data. It identified four HMIS trainers that would conduct trainings for district staff. These trainers underwent the facilitation skills training course. However, due to the review of the entire HMIS by the MoH, the HMIS training was put on hold at the MoH's request until the review had been completed, and the revised forms have been disseminated. The MoH has concluded the review process and STRIDES has been requested to support some of the roll out activities which will include HMIS training in the 15 collaborating districts.

PY3 Next steps

- Conduct training for the HMIS staff and other key personnel like health facility in-charges responsible for data processing.
- Continue to conduct on-the-job mentorship of HMIS staff.
- STRIDES will liaise with the districts to reduce the costs of supplies such as stationery, HMIS forms and some appropriate registers for the facilities.
- Continue liaising with AMREF, the STAR EC project, SMP, SDS and other organizations supporting district level HMIS to synchronize activities and avoid duplication of efforts.

Sub-result 3.5: Transparency and accountability increased within district health systems

STRIDES continued to emphasize transparency and accountability in all interactions and interventions within the districts. Transparency and accountability are built-in features of the performance-based contract model that STRIDES applies to its partnerships with the private sector, and increasingly with the public sector. It is important for STRIDES staff to

actually insist that interventions follow the new STRIDES approach with performance-based principles at the core. This has proven to be challenging, but progress is being made.

PY3 Next steps

- Through MoUs with districts, ensure facilities display opening hours, available services, staff on duty, and clients' rights.
- Monitor compliance with Tiahr regulation at all levels.

3. Project monitoring and evaluation

During this reporting period, STRIDES focused on a number of monitoring and evaluation (M&E) tasks that include: revising and finalizing the performance monitoring plan (PMP); conducting the annual survey to collect baseline data for new indicators and performance data for the annual indicators; establishing a functional M&E system at national and regional levels; developing a web based database; ensuring data quality; strengthening the HMIS; and conducting data verification exercises among others.

Performance monitoring plan (PMP)

STRIDES participated in several meetings between USAID and implementing partners to assist the Mission in refining and defining the SO8 PMP indicators. The mission introduced new indicators and dropped some of the required indicators. As a result, STRIDES had to revise its PMP to align it with the new SO8 M&E framework. In addition, STRIDES reviewed its targets and project level indicators and indicator definitions, and a revised PMP was submitted to USAID.

Annual Survey 2009/2010

STRIDES conducted a survey in the 15 collaborating districts in September 2010. The purpose of the survey was to collect data for selected performance monitoring indicators in order to track progress made toward achieving the annual targets and to generate baseline data for the indicators that have been recently added in the performance monitoring plan. The survey process has been completed. Both performance data and baseline data for the new indicators informed the PMP and annual reporting. STRIDES will share the final survey report in the 1st quarter of PY3.

Establishing the M&E system in the regional offices

Three M&E officers were recruited to support M&E processes at regional level. The regional M&E staff was oriented on the PMP, routine data requirements, HMIS data collection processes, data verification procedures, and use of project databases. As part of the STRIDES routine activities, technical support meetings and visits to support data verification processes were conducted. The M&E system at the regional level is fully functional.

Geographical Information System (GIS)

GIS software was procured and installation was done. Technical support from the USAID GIS specialist was received. Training on GIS for selected STRIDES staff is planned for the first

quarter of PY 3. STRIDES will use the GIS to help interpret information generated through the HMIS and use the analyses for making its interventions better targeted and more efficient and effective.

Data verification

In an effort to ensure sustained quality of data entry, data validation exercises have been incorporated as an integral part of overall data quality monitoring. A data quality improvement system was developed comprising routine data quality processes at all stages of the data transmission process i.e. health unit, district, and STRIDES regional and head offices. During the project year, the M&E unit conducted data verification exercises to assess the error rate in data entry for each quarter. During the first two quarters, a total of 90 reports containing 8,280 field entries were cross-checked for data entry errors. Among those only 16 errors were made (0.2%). In the third quarter of PY2, 903 entries from 22 reports were crosschecked. Only 1 entry level error was found representing a reduction in the error rate to 0.1%. Health facility data quality support visits by the M&E unit will be conducted in PY3.

Web-based project database

During the last quarter, STRIDES designed a web-based database to capture HMIS data, PBC and training-related data. The database will provide a decentralized system and will ease data entry, provide for automatic inbuilt checks for ensuring data quality, and also enable automatic data aggregation, analysis, and sharing between staff at headquarters and regional levels. This database shall be operational in the 1st quarter of PY3 after users have been trained.

Lot quality assurance sampling (LQAS)

The collaboration with the STAR-E LQAS team is ongoing. The LQAS team is actively pursuing this collaboration which fits well with their mandate to train users at a national level. STRIDES project staff, including the M&E team, took part in a 3-day (June 22 - 24) training conducted by the STAR-E LQAS team. In the revised PMP, indicators which are LQAS appropriate have been identified.

STRIDES M&E manual

STRIDES is developing a manual to guide the M&E processes and the effective functioning of the M&E system. The manual describes the standard operating procedures for M&E, including data quality, data analysis, data utilization and feedback among other. The manual is currently in draft form and shall be finalized and pretested in the first quarter of PY3.

M&E support to contractors under performance based contracting program

STRIDES reviewed contractors' respective M&E plans, analyzed the baseline and targets, and participated in the pre-award survey to assess the operational capacity of the contractors. Reporting tools which will be utilized by the contractors to report progress towards their objectives on a quarterly basis were developed and form part of the contracts. STRIDES will continue to provide technical M&E support to contractors and ensure that the M&E components of the next RFP/RFA are strengthened.

PY3 Next steps

- Implement a data quality assurance/data verification plan including utilization of LQAS to strengthen data verification procedures.
- Utilize the GIS and share information generated from GIS to inform project interventions.
- Strengthen the HMIS at district level and explore other areas of HMIS support.
- Provide technical M&E support to STRIDES contractors under the PBC program.
- Coordinate the project mid-term evaluation.
- Strengthen private sector providers to report using the HMIS.
- Finalize pretest and utilize the M&E manual.
- Introduce and maintain the web-based project database at STRIDES national and regional levels.
- Map private organizations and single practitioners undertaking FP, RH and CS activities to identify concrete activities that can be done to strengthen PPP.
- Identify, document, and disseminate best practices.
- Conduct annual surveys to collect key indicator data to report on the performance monitoring plan.

4. Project management

4.1 Human resources

The MSH Human Resources department is committed to ensuring a diverse, qualified, healthy, and highly motivated staff that is focused on achieving the MSH goals through the development and administration of cost-effective and competitive results-oriented human resource policies, services, and best practices.

Staffing: During PY2 all vacant positions in STRIDES were filled. Staffing including those assigned by the core partner organizations is at 48, with 55 percent located in the regions. The expansion of the roles of the executive coordinator in the last quarter to include HR administrative duties has added strength to the current MSH Uganda HR team of two.

Performance plan review and development (PPRD): Training was organized to refresh staff on the performance planning review and development process prior to the commencement of the process. The process was completed with a few new learning points, especially the implementation of the 360 degree feedback. A salary review also was completed. The job evaluation exercise introduced a new grading structure, increased the number of bands from 8 to 15, allowing for a more rational grouping of positions and their desired salary band.

MSH Uganda employee handbook

MSH recruited a consultant to assist develop a MSH Uganda employee handbook. The consultant held meetings with key staff and developed a draft document which was reviewed and approved by the MSH Chiefs of Party. The draft handbook was sent to the MSH home office for approval. It is expected to be rolled out in PY3.

PY3 Next steps

- Introduce the MSH employee handbook.
- Coordinate HR and other activities across all MSH Uganda projects.
- Streamline provision of HR services such as sharing a leave database and HR with the regional field staff for easy access to information.

4.2 Finance and Administration

The main activities of the second year of the project for Finance and Administration (F&A) continued to be providing orientation to the new staff members, purchasing required furniture/equipment, providing staff members an enabling working environment and submission of regular financial reports.

New office for MSH Kampala operations

As a result of MSH's expansion during the first year of STRIDES' project MSH moved the projects' office from Plot 6, Kafu Road, Nakasero to Plot 15, Princess Ann Drive, Bugolobi in August 2009. During the first quarter of PY2, several activities to enable staff settle in the

new offices in Bugolobi continued. These included purchasing more furniture/equipment, marking parking spaces and installation of air conditioners in some of the offices. In addition, a storage container was moved from the MSH main office in Bugolobi to the central regional office in Bugolobi in order to create more parking space at the main office. During the reporting period, MSH changed the internet service provider from AFSAT to Warid to accommodate the increased demand for internet band width by the growing number of staff.

Support to regional offices

STRIDES set up the regional offices in Bugolobi, Jinja and Fort Portal and procured all the required furniture and equipment. In addition, security service providers for all the three offices were identified and contracted. The project also identified service providers to put in place a Local Area Network in each of the three regional offices. By the end of the first quarter, staff members were settled in their new offices. A financial system for the regional offices was established and the regional staff trained during the course of the year. Bank accounts for each of the regional offices were also opened to facilitate the smooth flow of funds.

Service agreements

Several service agreements were put in place, in consultation with the MSH lawyer. These included agreements with security agencies for the MSH Head Office and the three regional offices. Other agreements were signed with service providers for maintenance of photocopiers. These agreements require the companies to carry out regular service of the machines and to send technicians whenever there is a technical fault. For supply of fuel and oil on credit, an agreement was established with a petrol station in Bugolobi. Drivers are provided with orders signed by authorized staff in order for them to obtain fuel. Similar arrangements were established at the regional offices in Fort Portal and Jinja.

Technical support to STRIDES partners

The F&A department provided technical support to the STRIDES partners and, in particular, UPMA and CDFU in assisting them to provide timely and acceptable budgets and financial reports.

Pipeline preparation

After one year of operation, it was found necessary to do a pipeline analysis of the STRIDES budget in order to program the project funds in line with the project priorities. The preparation of the analysis was handled jointly by the field and home office staff.

Internal audit

A successful internal audit of all MSH projects was conducted in March 2010 by MSH's Director of internal Audit. Implementation of the audit recommendations started from April, 2010.

Prequalification of suppliers

The F&A department worked in conjunction with the MSH's projects under the umbrella of the MSH Uganda Country Operating Management Unit (COMU) and put in place a system for pre-qualification of suppliers for routine goods and services. An advert was put in the New Vision and Monitor newspapers to solicit proposals from any interested vendors. An evaluation committee was set up under the approval of all the MSH Chiefs of Party. A selection of the vendors was made and MSH started using the prequalified suppliers with effect from 1 September, 2010.

Financial reports

STRIDES submitted timely monthly reports and requests for funds to the home office ensuring sufficient availability of funds to support the STRIDES activities. In addition, the quarterly accrual reports that are required by USAID were also submitted as required.

Cost share

Discussions were initiated with Barclays bank regarding providing cost share contributions to STRIDES project. Barclays Uganda is awaiting news from the head office whether its proposal can be implemented. Meanwhile, opportunities for support from Barclays locally on a smaller scale are being explored, as well as with other corporate contacts. STRIDES project has also held discussions with United Bank of Africa (UBA) to explore opportunities for STRIDES to tap into UBA's corporate social responsibility program, and indeed the possibility to use UBA as STRIDES banking partner.

Information collected from the districts on cost share contribution by the districts has amounted to a total of 27,193,450/= as indicated in the table below:

Table 10: Cost share contribution

STRIDES Region	Cost share contribution	Percentage
Eastern	7,561,450	27.8
Central	13,420,000	49.4
Western	6,212,000	22.8
Total in UGX	27,193,450	100.0

Note: The figures in the table above are pending verification by STRIDES

From the above table, the central region has contributed about half of all the cost share contribution reported for PY2. More activities have been implemented in this region in PY2 with more opportunities for the districts in the region to make contributions. The cost share contributions are expected to increase in PY3 given the planned activities with more clearly identified avenues for collecting the cost share.

MSH global conference

MSH held a global conference in Ghana in June which was attended by Chiefs of Party/Project Directors and COMU Directors. The purpose of the conference was to review MSH methods of operation with an aim of reorganizing in order to achieve greater effectiveness and efficiency. Following the conference, MSH embarked on a process of decentralization.

MSH integrated business information system (IBIS)

Effective 1 October, 2010, MSH changed its business information system globally to a new integrated system, Integrated Business Information System (IBIS). This required making prior arrangements including training of the MSH Uganda Finance team. The team attended a 3-day regional training which took place in Nairobi from 22-24 September, 2010.

5. Ongoing and emerging challenges

District sub-divisions

Politically motivated district subdivisions continue to challenge the STRIDES project. So far, five of the STRIDES collaborating districts, Kumi, Bugiri, Kamuli, Mpigi and Kyenjojo, have been sub-divided. STRIDES will focus on original district first and consider adding new districts later if and when they meet criteria as stated in the original EOI. Support to new districts has become a discussion point at USAID, and STRIDES is an active participant.

Significant shortages projected for contraceptives commodities especially LAPM

STRIDES will continue working with USAID, and take a lead role in addressing the problem with other major stakeholders such as SURE. Although the shortage of contraceptives commodities continues to be a point of discussion in FP technical working group meeting coordinated by the MoH on a quarterly basis, no structural solution has been found at the national level. The private sector therefore continues to face obstacles to access commodities from national medical store (NMS), although some larger provider organizations have reportedly been able to access the stock directly at NMS more recently. STRIDES has obtained authorization from USAID to draw on stock stored at UHMG as needed.

Lack of commitment from districts

The resources committed by the districts in the EOIs and MoUs have not been sufficiently forthcoming. Some of the resources committed are no longer available hence the district contributions have continued to reduce significantly. The next MoU negotiations will include performance based components, and districts that do not achieve agreed upon targets may be terminated as a STRIDES partner.

Reduced government funding

According to the 2010/2011 GoU budget, districts have been allocated less financial resources as a result of resource mobilization for 2011 presidential and parliamentary elections. This implies that resources at district level will further be constrained and some of

the challenges that could have been addressed by the districts will most likely not be addressed.

Inadequate numbers, absenteeism and low morale of health staff in the district

In the 15 collaborating districts where STRIDES works, it has been noted that the health facilities staff are overwhelmed with numerous tasks and appear demoralized which impacts on the quality of services provided. This is not unlike the situation in the country overall, and STRIDES believes that the overwhelming gaps in the public sector health system can be addressed only by assigning an appropriately significant role to the private sector in health service delivery.

Mixed signals from the MoH regarding implementation of VHT concept

USAID asked that STRIDES refrain from integration of ICCM activities into the VHT concept pending the outcome of UNICEF's pilot in that matter. In addition, the MoH has not formally decided either to proceed with this integration and relies entirely on donor support to put it in practice if it were to go ahead. The challenges affecting the implementation of the VHT concept, with or without ICCM, are delaying the roll out of the concept in STRIDES' districts. The project has decided to proceed cautiously, and test this resource-intensive concept in selected districts and HSDs prior to a possible broader implementation.

“Workshop and allowance” culture

Workshops and related allowances have clearly become means for district staff to earn additional income. STRIDES has taken an approach whereby the number of workshops is being drastically reduced which should improve providers' presence at facility level. However, STRIDES' strict interpretation of the instructions received from USAID regarding allowances have caused some frustration among district partners who had become accustomed to payment of sometimes generous allowances by other IPs and/or donors.

Underperforming partner

The Uganda Private Midwives Association (UPMA) has been a weak link within the STRIDES for Family Health partnership. From the onset, the organization required far too much attention for routine matters and expectations as to what the partnership should produce were diverging between MSH as the lead agency and UPMA. STRIDES had offered various options to the UPMA management that could benefit both UPMA and STRIDES, but the interest of the management at UPMA to work with STRIDES on strengthening the association appeared limited. MSH/STRIDES eventually had no other option than to terminate the partnership, after ascertaining that the original UPMA mandate under the project could be absorbed by STRIDES. The project took over the employment of the sole UPMA employee who had been assigned to STRIDES.

Annex I: Status of PMP Indicators

No	USAID SO8 Indicator No. or project level	Indicator	Disaggregation	Baseline	Overall year 2 actual	Year 2 target	Indicator status	Comments
Overall Objective: Reduce Fertility and Mortality								
1	Project level	Total Fertility rate		6.7				
Result 1: Increase the quality and provision of routine RH/FP and CS services in facilities								
2	S08 # 63	# of FP clients using FP methods	New users	136,272	123,280		Performance declined by 10% from PY1.	Reasons for under-performance include: lack of trained providers especially for LAPM; inconsistent availability of contraceptives and services; poor quality of services. Performance is expected to improve in PY3 because: -contractors such as MSU and PACE will increase coverage. -Training service providers has resumed. - More BCC activities will

No	USAID SO8 Indicator No. or project level	Indicator	Disaggregation	Baseline	Overall year 2 actual	Year 2 target	Indicator status	Comments
								be conducted to increase demand. - The impact of strengthening supply management should become apparent.
			Revisits	85,154	88,614		Performance improved by 4%	
3	S08 # 6	Couple Years of Protection (CYP)		96,105	107,257	105,716 ³	PY2 CYP increased by 12% from baseline and 1.5% above target	This is an indicator that by itself has limited analytical value, and must be interpreted in combination with user data.
4	S08 # 43	# implants and IUDs inserted		6402	4,921		Performance declined by 30%. Decrease is for IUDs, while implants actually increased.	Refer to comments under # 2 above.

³ CYP targets were revised upwards in October 2010. Performance for PY2 is based on the old targets

No	USAID SO8 Indicator No. or project level	Indicator	Disaggregation	Baseline	Overall year 2 actual	Year 2 target	Indicator status	Comments
5	S08 # 65	# of children who at 12 months have received three doses of DPT vaccination from a USG- supported immunization program.		211,567	208,695	222,145	94% of target achieved. PY2 performance declined by 1.4% from baseline.	The actual numbers may be higher than what was reported due to poor record keeping practices and lack of manpower at facility level and during the Child Days Plus.
6	S08 # 66	# of children under 5 years of age who received Vitamin A from USG-supported programs.	1 st dose	278,735	322,470	306,609	PY2 performance increased by 16% from baseline, and exceeded PY2 target by 5%	Refer to comments under # 5 above.
			2 nd dose	197,259	204,740	216,985	# 2 nd dose improved in PY2 by 4% from baseline. 94% of PY2 target achieved.	

No	USAID SO8 Indicator No. or project level	Indicator	Disaggregation	Baseline	Overall year 2 actual	Year 2 target	Indicator status	Comments
7	S08 # 36	% facility customers satisfied with health services received		54	54	60	90% of target achieved.	This indicator requires further scrutiny as most anecdotal information points to widespread dissatisfaction among the public with the quality of public sector services.
8	S08 # 60a	% targeted health units offering Young People-Friendly Services		9	--		This is a new USAID required indicator, baseline data was obtained in Q4 PY2.	
9	Project level	% pregnant women who receive 4 ANC consultations		30%	30%	30%	Target achieved.	
10	Project level	% pregnant women who received 2+ doses of IPTp		35%	33%	38%	PY2 performance declined by 6%, and is below target.	Reasons for low performance include: Late attendance for ANC visits; inadequate supply of drinking water at facility level and stock out of SP.

No	USAID SO8 Indicator No. or project level	Indicator	Disaggregation	Baseline	Overall year 2 actual	Year 2 target	Indicator status	Comments
11	Project level	% live births delivered at a health facility		27%	31%	30%	PY2 performance increased by 16%, target exceeded by 1 percentage point (3%).	
12	Project level	% underweight children at measles vaccination		9%	6%	9%	PY2 performance greatly improved, % underweight reduced by 33%, exceeded target by 33%.	
13	Project level	% live births with low birth weight		3%	3%	3%	Target achieved.	
14	Project level	% health facilities (HC III & above) providing Basic Emergency Obstetric Neonatal Care (BEmONC)		10%	--		Baseline data was obtained in PY2, Q4.	Performance data will be reported in PY3.

No	USAID SO8 Indicator No. or project level	Indicator	Disaggregation	Baseline	Overall year 2 actual	Year 2 target	Indicator status	Comments
15	Project level	% health facilities (HC IV & above) providing Comprehensive Emergency Obstetric Neonatal Care (CEmONC)		9%	--		Baseline data was obtained in PY2, Q4.	Performance data will be reported in PY3
16	S08 # 27	# of USG-assisted Service Delivery Points providing FP counseling or services		104	--		This is a new USAID required indicator, baseline data was obtained in PY2, Q4.	
17	Project level	% health facilities (HC III & above) offering long acting and permanent methods (LAPM)	Long acting	37%	--		Baseline data was obtained in PY2, Q4.	Performance data will be reported in PY3
			Permanent	30%	--		Baseline data was obtained in PY2.	Performance data will be reported in PY3

No	USAID SO8 Indicator No. or project level	Indicator	Disaggregation	Baseline	Overall year 2 actual	Year 2 target	Indicator status	Comments
18	Project level	# service providers trained in FP/RH/CS in previous 3 months	Family Planning	0	188	669	28% of target achieved	During Q3 STRIDES management suspended all training workshops to allow for the project to develop a comprehensive training strategy, among other addressing the important issue of candidate selection. Training resumed in Q 4.
			Reproductive health	0	0	317	No trainings conducted.	
			Child survival	0	136	1,422	10% of target achieved.	
19	S08 # 42	% USAID supported Service Delivery Points offering any modern contraceptive method		46%	--		This is a new USAID required indicator, baseline data was obtained in PY2, Q4.	
20	S08 # 34	% Service Delivery Point complying with national norms and standards		17%	--		This is a new USAID required indicator, base-line data was obtained in PY2, Q4.	

No	USAID SO8 Indicator No. or project level	Indicator	Disaggregation	Baseline	Overall year 2 actual	Year 2 target	Indicator status	Comments
Result 2. Improve and expand access to and demand for RH/FP and CS services at community level								
21	Project level	% villages with functional VHTs		21%	--		Baseline data was obtained in PY2, Q4. Performance data will be reported in PY3	
22	Project level	% VHTs with stock-outs of FP tracer commodities		43%	--		Baseline data was obtained in PY2, Q4. Performance data will be reported in PY3	
Result 3: Supportive systems advance the use of RH/FP and CS services								
23	S08 # 62	# of clients receiving services from a USAID-affiliated private sector service provider		0	0		Contractors identified in PY2 Q4.	Contractor's started implementation in Q1 of PY3. Targets set for PY3.
24	Project level	% facilities submitting timely HMIS reports to HSD/district		72%	72%	78%	92% of target achieved.	

No	USAID SO8 Indicator No. or project level	Indicator	Disaggregation	Baseline	Overall year 2 actual	Year 2 target	Indicator status	Comments
25	Project level	% districts submitting timely HMIS reports to MoH		78%	78%	80%	98% of target achieved.	
26	Project level	% public health facilities clearly displaying pertinent information to clients		16%	--		Baseline data was obtained in PY2, Q4. Performance data will be reported in PY3.	

Table 1: Indicator performance based on indicators with assessment data

Indicator status	Indicator category		Total
	USAID SO8 indicators	Project level indicators	
Target achieved	4 (67%)	6 (75%)	10 (71%)
Target not achieved	2 (33%)	2 (25%)	4 (29%)
	6 (100%)	8 (100%)	14 (100%)

Table 2: New USAID required indicators

No	USAID SO8 Indicator No.	Indicator	Baseline
1	S08 # 60a	% targeted health units offering Young People-Friendly Services.	9%
2	S08 # 27	# of USG-assisted Service Delivery Points providing FP counseling or services.	104
3	S08 # 42	% USAID supported Service Delivery Points offering any modern contraceptive method	46%
4	S08 # 34	% Service Delivery Point complying with national norms and standards.	17%
5	S08 # 62	# of clients receiving services from a USAID-affiliated private sector service provider.	0%

Table 3: Indicators whose baseline data were obtained during Q4, PY2

No	Indicator category	Indicator	Disaggregation	Baseline
1	Project level	% health facilities (HC III & above) providing Basic Emergency Obstetric Neonatal Care (BEmONC)		10%
2	Project level	% health facilities (HC IV & above) providing Comprehensive Emergency Obstetric Neonatal Care (CEmONC)		9%
3	Project level	% health facilities (HC III & above) offering long acting and permanent methods (LAPM)	Long acting	37%
			Permanent	30%
4	Project level	% villages with functional VHTs		21%
5	Project level	% VHTs with stock-outs of FP tracer commodities		43%
6	Project level	% public health facilities clearly displaying pertinent information to clients		16%

Annex II: STRIDES Implementation Plan - Leadership Development Program (LDP)

Concept

STRIDES project will be conducting LDP workshops in collaborating districts. For this to work well, the approach is to start off with few teams from each district. Each district will send a maximum 4 teams (1 from district HQs, 1 hospital and 2 Health Centre IV), each having 3 – 4 members. Teams from three districts have been combined to form a cohort, hence 5 cohorts. (See table below). Trainings / workshops will be done for each cohort.

Table showing LDP cohorts

COHORT NUMBER	DISTRICTS	Proposed venue for LDP workshops
COHORT #1	Bugiri	Jinja
	Kamuli	
	Mayuge	
COHORT #2	Kumi	Jinja
	Kayunga	
	Kaliro	
COHORT #3	Nakasongola	Kampala
	Luwero	
	Mityana	
COHORT #4	Kasese	Fort Portal
	Kyenjojo	
	Kamwenge	
COHORT #5	Kalangala	Masaka
	Sembabule	
	Mpigi	Missed the SAM hence not considered in the LDP program.

Training workshop for cohorts #1 and #2 will be conducted by a combination of the STRIDES facilitators and the LDP Master trainer. The MSH trainers will then replicate similar training workshops # 3, 4, and 5 under the supervision of the Local LDP trainers as shown in the table below. All MSH trainers will have a chance to actively facilitate in a training workshop for the LDP. Following up activities will be done following the standard follow-up plan for the LDP.

Annex III: Minimum Basic Standards for Service Delivery Points (FFSDP Checklist)

Background:

There are many factors that affect the performance of healthcare workers. It is often hard to know why healthcare workers are not providing high-quality services. A site visit may identify performance gaps or problems and give one the information needed to determine what can be done to improve job performance.

The work site evaluator must understand the work environment to determine how far the training will close the performance gap.

- “What is the health worker expected to do?”
- “Under what conditions?”
- “With what frequency?”

In the evaluation, one should:

- Conduct a site visit prior to the training. Share information about the course with learners and their supervisors before the course begins.
- Make sure that workers know what they are expected to do (have clear job expectations).
- Assess whether job expectations are realistic, given the current working environment.
- Check that appropriate motivation and incentives for the learner are in place and that barriers to performance have been identified.
- Determine whether interventions other than training are needed to improve job performance, and that the need for these interventions is taken into account to help ensure application of learning on the job.

Adequate Infrastructure, Equipment, and Supplies:

Name of Trainee/ Respondent: _____ Date of Visit: _____

By whom: _____ Name of Healthy Facility: _____

HSD: _____ District: _____

Instructions: Please fill in Y for Yes available; N for Not available or NA Not Applicable.

Service areas:	Components of a Fully Functional Service Delivery Point
OPD	<ul style="list-style-type: none"> • Adequate Infrastructure • Equipment • Trained and motivated staff • IEC/BCC • Job Aides • Community support • Administrative Support • Client satisfaction • Gender sensitiveness • Medicines/contraceptives • Supplies
FP Clinic	
ANC	
Maternity ward	
Delivery room	
Postnatal ward	
Theatre	
Female ward	
Pediatric ward	
IMCI corner	

Department	Items	Available	Not Available	Not Applicable	Remarks
OPD	Trained (Within the last 3 years in the selected area of service delivery)				
	Motivated staff (self driven and proactive in service provision)				
	Staff in uniform (recognized dress code by the institution)				
	Sheltered waiting area with seats				
	Privacy				
	Water source				
	Weighing scales: Adult				
	Infant				
	Thermometer				
	Examination couch				
	Stretcher				
	Wheel chair				
	BP machine				
	Stethoscope				
	Hand washing facilities				
	ORT container; mugs and spoons				
	HMIS forms and registers (relevant to OPD)				
	Sign posts: services offered				
	IEC materials (relevant to the service area)				
	Job aids				
Room labels/signs (to guide the user on where to access services e.g. doctor's room)					
Medicines					
Anti malarial drugs					

Department	Items	Available	Not Available	Not Applicable	Remarks
	Antibiotics (oral/parenteral)				
	Emergence tray with emergence drugs				
	PEP facilities				
	Contraceptives				
	IV fluids				
	Cotton				
	Gauze				
	Strapping				
	Syringes				
	Needles				
	Buckets for Infection Prevention				
	Antiseptic lotion				
	Jik				
	Gloves -surgical				
	Gloves - non surgical				
	Suggestion box				
	Toilets (gender separated)				
	Community outreach schedule				
	Minutes of the HUMC meetings for the last quarter available				
	Minutes for staff meetings for the last 3 months available				
	Duty rooster				
	Waste pits				
	Incinerator				
	Clean environment				

Department	Items	Available	Not Available	Not Applicable	Remarks
FP clinic	Privacy in the counseling rooms				
	Screens for physical examination				
	Seats in waiting area				
	Sheltered waiting area				
	Examination couch				
	Clean environment				
	BP machine				
	Stethoscope				
	Weighing scale				
	Cusco's/Graves' vaginal speculum				
	Sterilizer/ boiling facilities				
	Kidney dishes				
	Gallipots				
	Sponge-holding forceps				
	Tenaculum				
	Uterine sound				
	BTL kit				
	Vasectomy kit				
	Supplies				
	Surgical gloves				
	Non surgical gloves				
	Cotton wool				
	Gauze				
	Antiseptic lotion				
	Jik				
	Infection prevention buckets				
	Waste bins (3) with liners.				
Safety boxes					

Department	Items	Available	Not Available	Not Applicable	Remarks
	Trocars for implant insertion				
	Relevant HMIS forms and register, client cards, referral notes and stock cards				
	Sign for services offered				
	Relevant job aids				
	Trained service provider in Uniform(recognized dress code by the institution)				
	Outreach schedule				
	Outreach reports				
	FP commodities				
	Lignocaine				
	Analgesics				
	Antibiotics				
	Water source				
	Syringes and needles				
	Accessible toilets				
	Light source				
	Hand washing equipment				
Department	Items	Available	Not Available	Not Applicable	Remarks
ANC	Trained provider				
	Uniformed provider				
	Duty roster				
	Infrastructure:				
	Privacy				
	Screens				
	Seats in waiting area				
	Sheltered waiting area				
	Clean environment				
	Counseling rooms with privacy				

Department	Items	Available	Not Available	Not Applicable	Remarks
	Suggestion box				
	Equipment:				
	BP machine				
	Examination couch (with steps)				
	Gestation wheel				
	Stethoscope				
	Weighing scale				
	Infection prevention buckets				
	Waste bins (3) with liners				
	Cusco's/Graves' vaginal speculum				
	Sterilizer/ boiling facilities				
	Kidney dishes				
	Gallipots				
	Fetoscope				
	Cups and mugs				
	Clean drinking water				
	Sponge-holding forceps				
	Tape measure MUAC tape and height measure.				
	Supplies				
	Surgical gloves				
	Disposable gloves				
	Cotton wool				
	Gauze				
	Antiseptic lotion				
	Jik				
	Lab facilities:				
	HIV Kits				
	Malaria Kits				

Department	Items	Available	Not Available	Not Applicable	Remarks
	Syphilis Kits				
	Pregnancy test kit				
	HB and blood group				
	Urinalysis				
	Stationary				
	Relevant HMIS register and client cards				
	Relevant IEC/BCC materials				
	Relevant job aids				
	Medicines				
	Iron and folic acid				
	Fansidar (SP)				
	Coartem				
	Mebendazole				
	Antifungal				
	ARVs				
	Antibiotics				
	Cotrimoxazole				
	Antihypertensive				
	Supplies				
	Mama kits				
	LLITN				
Department	Items	Available	Not available	Not Applicable	Remarks
Maternity	Trained provider (within the last 3 years in a selected area of service delivery)				
	Uniformed provider				
	Duty roster				
	Sign for services available				
	Clearly Labeled rooms				

Department	Items	Available	Not Available	Not Applicable	Remarks
	Infrastructure:				
	Privacy				
	Screens				
	Seats in waiting area				
	Clean environment				
	Suggestion box				
	Delivery beds				
	Resting beds with LLITN				
	Stretcher				
	Patient trolley				
	Wheel chair				
	Examination couch				
	Examination lamp / light source.				
	Water source				
	Equipment:				
	Delivery kits				
	Episiotomy repair kits				
	Perinea /Cervical tear repair kits				
	Sterilizer or boiler				
	BP machine				
	Stethoscope				
	Weighing scale				
	Baby weighing scales				
	Newborn resuscitation kit				
	Incubator				
	Adult resuscitation kit				
	Vacuum extractor				
	MVA kit				
	Hand washing facilities				
	Infection prevention buckets				

Department	Items	Available	Not Available	Not Applicable	Remarks
	Waste bins (3) with liners				
	Placenta pit				
	Cusco's/Graves' vaginal speculum				
	Sterilizer/ boiling facilities				
	Kidney dishes				
	Gallipots				
	Fetoscope				
	Cups and mugs				
	Clean drinking water				
	Sponge-holding forceps				
	Tape measure				
	Protective wear				
	Oxygen supply				
	Oxygen masks for newborn and the mother				
	Supplies				
	Gynecological gloves				
	Surgical gloves				
	Disposable gloves				
	Cotton wool				
	Gauze				
	Antiseptic lotion				
	Jik				
	Needles and syringes				
	Cord ligatures				
	IV Canulae and butterflies for the neonate				
	Lab facilities:				
	HIV test Kits				
	Malaria Kits				
	Syphilis Kits				

Department	Items	Available	Not Available	Not Applicable	Remarks
	HB and blood group				
	Urinalysis (Uristix at minimum)				
	Stationary				
	Relevant HMIS register and client cards, partograph, child health cards				
	Relevant IEC/BCC materials				
	Relevant Job Aides				
	Medicines				
	Iron and Folic acid				
	Fansidar				
	Coartem				
	Mebendazole				
	Antifungal				
	Antibiotics				
	Antihypertensive				
	Tetracycline eye ointment				
	Analgesics				
	ARVs				
	VIT A				
	Ergometrine				
	Oxytocin				
	Misoprostol				
	Hydrocortisone				
	Dexamethasone				
	Lignocaine				
	Magnesium Sulphate				
	Calcium Gluconate				
	IV fluids with IV sets				
	5% Dextrose, 50% Dextrose				
	Ringer's lactate				

Department	Items	Available	Not Available	Not Applicable	Remarks
	Darrow's' solution				
	Normal saline				
	Oxygen				
	Sutures				
	Blood for transfusion				
	Contraceptives for postpartum or post abortion care.				
Theatre	Operating room with enough space				
	Trained staff (LAPM and CEmONC)				
	Protective wear				
	OP table				
	Operating light/ stand-by light source				
	Patient trolley				
	Wheel chair				
	C-section kits				
	Laparotomy Kits				
	MVA kits				
	Vacuum extractor				
	Suction machine				
	Anesthetics equipment				
	Anesthetic drugs				
	Oxytocin				
	Sterilization drums				
	Resuscitation equipment for newborn				
	Resuscitation equipment for adult				
	Sterilizer or autoclave				
	Checklist in theatre for instruments				
	Protective wear: linen, caps, masks, gowns and boots				
	Water supply				

Department	Items	Available	Not Available	Not Applicable	Remarks
	Supplies				
	Gynecological gloves				
	Surgical gloves				
	Non surgical gloves				
	Cotton wool				
	Strapping				
	Gauze				
	Antiseptic lotion				
	Jik				
	Needles and syringes				
	Oxygen				
	IV Canulae and butterflies for the neonate				
Department	Items	Available	Not Available	Not Applicable	Remarks
Pediatric ward	Trained self motivated				
	Staff in uniform				
	Screens				
	Sufficient number of pediatric beds for the client load with LLITN				
	Infrastructure and equipment				
	Weighing scales (Infant)				
	Otolaryngoscope				
	Thermometer				
	Examination couch				
	Pediatric wheel chair				
	BP machine(infant)				
	Stethoscope				
	MUAC tapes				
	Hand washing facilities				
	ORT container; mugs and spoons				
Relevant HMIS forms and					

Department	Items	Available	Not Available	Not Applicable	Remarks
	registers, referral forms				
	Sign posts: services offered				
	Relevant IEC materials				
	Relevant job aids				
	Room labels/signs				
	Supplies				
	IV Fluids: darrows				
	Dextrose 50%, Dextrose 5%				
	Normal saline				
	Ringers lactate				
	Cotton				
	Gauze				
	Strapping				
	Oxygen				
	Syringes and needles				
	Cannulae and butterflies				
	Nasal gastric tube				
	Suction machine				
	Ambu bag				
	Medicines				
	Antibiotics (oral/parenteral				
	ACTs				
	Paracetamol				
	Quinine tabs				
	Amoxyl				
	Septrin				
	Mebendazole				
	ORS				
	Folic acid				
	Iron				
	Diazepam				

Department	Items	Available	Not Available	Not Applicable	Remarks
	Zinc				
	Vit. A				
EPI	Refrigerator in good working condition				
	Vaccine carriers				
	Ice packs				
	Weighing pants				
	Thermometers				
	Vaccine monitors				
	Stand-by gas cylinder				
	Vaccines:				
	BCG				
	Polio				
	Pentavalent vaccines				
	Tetanus toxoid				
	Measles				