

STRIDES for Family Health Monitoring & Evaluation Operations Manual

Management Sciences for Health

Revised 2013

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MONITORING AND EVALUATION OPERATIONS MANUAL

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ACRONYMS

ANC	Ante Natal Care
CDFU	Communication for Development Foundation Uganda
CHS	Center for Health Services
CoP	Chief of Party
CS	Child Survival
DHMT	District Health Management Team
DHO	District Health Officer
FFSDS	Fully Functional Service Delivery System
FP	Family Planning
DHIS	District Health Information System
GIS	Geographical Information Systems
GoU	Government of Uganda
HC	Health Center
HF	Health Facility
HMIS	Health Management Information System
HSD	Health Sub District
HF	Health Facility
LLINS	Long Lasting Insecticide Treated nets
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring & Evaluation
M&L	Management & Leadership
MIS	Management Information System
MoH	Ministry of Health
MoU	Memorandum of Understanding
MSH	Management Sciences for Health
PBF/C	Performance Based Financing / Contracting
PFP	Private For Profit
P&G	Proctor & Gamble
PIRS	Performance Indicator Reference Sheets
PM	Performance Management
PMP	Performance Monitoring Plan
PNFP	Private Not For Profit
RC	Regional Coordinator
RFP	Request for Proposal
RH	Reproductive Health
RO	Regional Office
S08	Strategic Objective # 8
SQL	Structured Query Language
USAID	United States Agency for International Development

ABOUT THE PROJECT

STRIDES for Family Health (also referred to as 'STRIDES') 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.

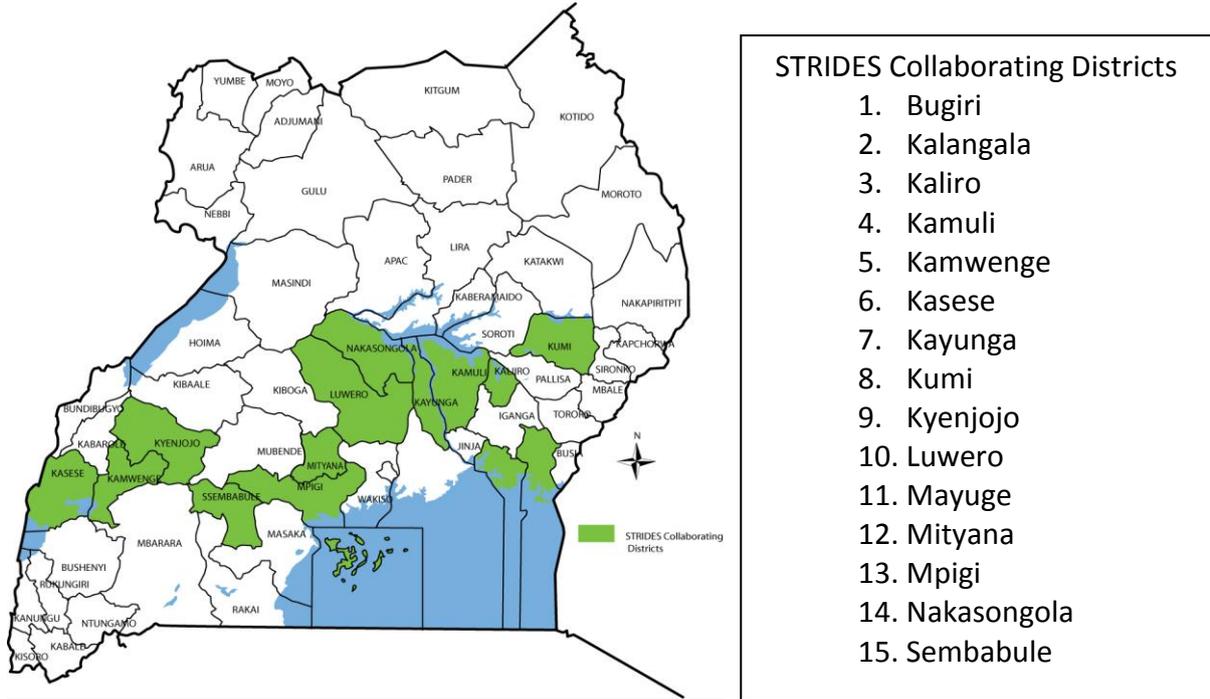
As stipulated in the Cooperative Agreement between MSH and USAID, STRIDES is contributing to the DO3 objective "Improved Health and Educational Status of Ugandans" through focusing on three results areas as follows:

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

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

- i) Application of the "fully functional service delivery system" (FFSDS) concept
- ii) Development of the management and leadership (M&L) capacity of local leaders and managers, and establish or increase community accountability for health
- iii) 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.

Figure 1: Map of Uganda showing STRIDES collaborating districts



1.0 INTRODUCTION

1.1 Background

Monitoring and Evaluation (M&E) and Performance Management (PM) are effective tools to enhance the quality of project planning and management. Monitoring helps the project managers and staff to understand whether the project is progressing on schedule and to ensure that project inputs, activities, outputs and external factors are proceeding as planned. Evaluation is a process to help planners and managers assess the extent to which the objectives have been achieved as stated in the project documents. An effective M&E system is essential for providing robust information upon which management decisions can be based.

1.2 Purpose of this manual

This manual describes the standard operating procedures for M&E, including data collection, processing, quality assurance, reporting, feedback and utilization. The manual contains descriptions of key functions of M&E that users will interact with as well as directions on how to perform the various functions highlighted. The purpose of the manual is to provide basic information and practical guidelines to enhance better understanding of project monitoring, evaluation and performance management in STRIDES. The manual is expected to enable STRIDES staff to plan and implement a robust monitoring and evaluation system as part of project implementation and management. This manual complements the STRIDES performance monitoring plan (PMP).

1.3 The M&E Department

The monitoring and evaluation (M&E) department of STRIDES is tasked with the collecting, processing, validating, analysing and disseminating of the acquired data and information. The STRIDES M&E team collects data to track and report on the performance monitoring plan. The STRIDES M&E team comprises 5 staff at head office and 3 regional M&E officers.

2.0 STRIDES' MONITORING AND EVALUATION SYSTEM

2.1 M&E system overview

STRIDES has set up a monitoring and evaluation (M&E) system to track progress towards the project objectives, and measure achievements. This includes data collection, data processing and analysis, quality assurance, data utilisation, and reporting.

STRIDES collects data from HMIS reports through the web based DHIS, training reports compiled per training, subcontractors' reports submitted on a quarterly basis and annual surveys that are conducted once a year. All data collected is entered into a data base at the STRIDES regional offices and at the head office in Kampala. Data is analysed and indicator statistics generated to inform management decisions. STRIDES is also utilising Geographic Information Systems, tools and applications to visually present and explore patterns in health indicators and identified service gaps related to staffing, drugs, equipment and infrastructure.

A quality assurance/ data verification plan was developed with focus on data reliability, validity, integrity timeliness and accuracy. HMIS data will be verified using a series of steps at health facility, district, STRIDES regional offices and head office level. Data from the subcontractors and trainings conducted by STRIDES is also verified. STRIDES is linking M&E with interventions for quality improvement and service expansion through the FFSD approach and with performance improvement using performance based principles in its agreements with the both the public and private.

2.2 STRIDES result frame work and indicators

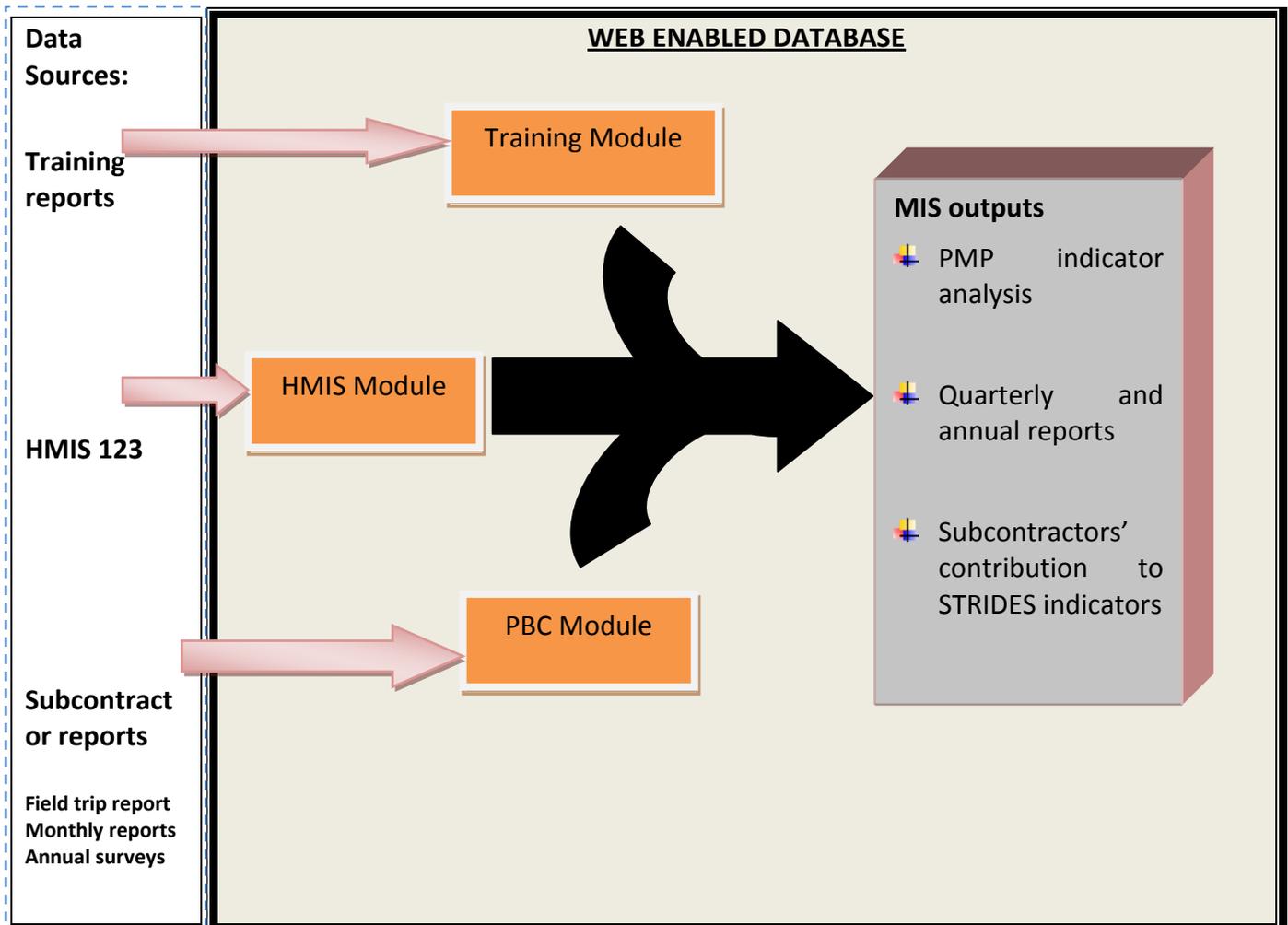
STRIDES results framework (Annex 1) is guided by the USAID/Uganda development objective number three (DO3) results framework and indicators. STRIDES contributes data to eleven (11) DO3 indicators and tracks sixteen (16) project-specific indicators considered important for decision-making by project management. Performance indicator reference sheets (PIRS) have been developed for all the indicators. The attached PMP table (Annex 2) provides the indicators that STRIDES uses to monitor and evaluate project performance and to report to USAID. The PMP table includes the definition of each indicator, frequency of reporting, data source, and baseline values where available, and targets. However, consistent with the Tiaht Amendment requirements, STRIDES does not set targets for indicators that track numbers of family planning clients and/or methods dispensed to clients.

Management Information System (MIS)

STRIDES MIS consists of a web database module is an integrated module offering data entry interfaces for the M&E data sources. The tables holding the data are designed using Microsoft Visual Studio that runs on SQL server. The tables are interrelated and have common field types, facilitating searching and reviewing the database. The web-enabled database is a decentralized system setup at both STRIDES regional offices and the head office in Kampala. The main interfaces of the database are: HMIS module capturing HMIS

data, PBC module capturing STRIDES subcontractors' data and the training module capturing training data. Users log in with a username and password in order to access the database with different levels of access assigned based on needs. The system has built-in quality checks and alerts the user if incoherent data is entered. It also shows which users are active at any given time.

Figure 2: STRIDES MIS



3.0 DATA COLLECTION

3.1 Introduction

STRIDES routinely collects data for its performance monitoring in relation to the PMP and for internal management purposes. STRIDES collects data from four major data sources i.e. HMIS 123 (Annex 3) through the DHIS; reports from trainings that are conducted and facilitated by STRIDES; STRIDES subcontractor's reports and annual surveys. STRIDES also collects facility level data through the application of the Fully Functional Service Delivery Systems (FFSDS) concept using a standardized checklist that is periodically administered.

3.2 Data sources and data collection tools

The project has various information needs hence different tools are used to collect data from the 15 collaborating districts. Implementing partners (CDFU, Jphiego and Meridian International), STRIDES subcontractors and project records. This section defines the primary and secondary data sources that provide information about each indicator, frequency of data collection, responsibility for data collection, methodology, reporting and presentation. The primary data sources where STRIDES routinely collects data include;

3.2.1 The Health Management Information System (HMIS) 123 reports/ DHIS

STRIDES has been given rights to access the district DHIS. At the end of every reporting period i.e. on a monthly basis, the STRIDES regional M&E officers log into the DHIS web based system to correlate data that is relevant to STRIDES using the HMIS 123 reporting template. Where inconsistencies are registered the M&E officer's will liaise with the respective district HMIS officers/focal persons to correct the inconsistencies.

The primary data sources at the health facility are: registers, tally sheets and the patient / client cards. Additional sources for the HMIS include surveys and special studies. The information in these primary sources is routinely entered by the health workers at the different health facilities. In addition, the health facility completes 7 reporting forms and these include those that do not directly pertain to clinical work or the three main STRIDES programmatic areas.

It is important to note that STRIDES relies on the HMIS to track its performance; however, even after STRIDES has prioritized support to HMIS strengthening (Annex 4) as part of health systems strengthening at both the district and facility level including distribution of HMIS tools such as registers, several challenges have been encountered during data collection and processing. These challenges include: errors and inaccuracies in the aggregation process due to limited record keeping skills of health personnel; erratic supply of the registers and forms which serve as the source documents for the HMIS data rendering the monthly summary figures inaccurate.

3.2.2 Training records from STRIDES supported activities

A copy of the training report with an annex of the signed attendance lists are kept at the STRIDES regional office. The regional M&E officers enter data in the STRIDES web based database at regional level and send an electronic copy of the training reports to the STRIDES

M&E department at the Kampala head office. Data is verified by the M&E team and entered in the USAID TraiNet data base. TraiNet is the official USAID training data base that facilitates performance tracking and analysis by training activity and by country. The data entered into TraiNet includes: names of training program; program start and end date; estimated cost and number of participants by gender. The guidelines on how to utilise and enter data into the TRAINET data is attached as Annex 4 of this manual.

3.2.3 Core partner reports

Since STRIDES for Family Health is a partnership project, one of the key sources of reporting data are reports from its core partners: CDFU, Jhpiego and Meridian International. Partner reports are summarized and submitted quarterly by the designated partner staff to the M&E Manager by the 7th day of the month following the end of the quarter.

3.2.4 Sub subcontractors reports

STRIDES supports private sector organizations and practitioners under the Performance Based Funding/Contracting (PBF/C) program to improve and increase RH/FP/CS services in the 15 collaborating districts. STRIDES subcontractors contribute to a standardized set of indicators, and their performance is monitored and evaluated against negotiated targets related to selected indicators. Payment depends on how a subcontractor performed during a given period. STRIDES subcontractors submit quarterly reports to the Contracts and Grants Director with a copy to the STRIDES M&E unit in Kampala through the regional offices by the 15th day of the month following the end of the reporting quarter. However if the 15th day falls during a weekend, the subcontractors are encouraged to submit reports earlier than the actual reporting date of 15th. Where it is not possible the subcontractors are advised to submit on the next working day after the weekend. Reports comprise the narrative and numerical components in agreed upon formats/templates (refer to annexes 6A and 6B). The data is usually entered into access data base customized for PBC reporting requirements.

3.2.5 Reporting tools for the new initiatives that include; Nutrition interventions, P&G water purifiers and ToMs shoes

During the course of project implementation, additional interventions came on board whose data could not be tracked through the existing data collection channels such as the HMIS. To collect the required data, specific tools were designed for this purpose and these include;

- BMT 001: Nutrition fairs monitoring tool (Annex 7)
- PGTL02: P&G purifier, Toms's shoes and LLINs distribution log (Annex 8)
- PGTL03: P&G purifier, Toms' shoes and LLINS monthly summary report form (Annex 9)

3.2.6 Other data sources

From time to time, the STRIDES M&E unit collects data from a number of other sources including monthly reports and field trip reports.

i) Monthly Reports

Monthly progress updates are prepared by the different department heads and or designated officers. These reports are submitted to the chief of party with a copy to the executive coordinator by the 7th day of the next month. The executive coordinator then compiles a general project monthly report and submits to the chief of party (CoP) by the 10th day of the next month. Data from monthly reports can be used to verify the quarterly totals. Monthly reports are also an important source of information for management decisions.

ii) Field Trip reports

Field visits are essential for monitoring, supervision, coaching, motivation and providing corrective action where need arises. Each staff member who undertakes a field activity ensures that a field trip report is written and submitted to his/her supervisor within 5 days after the field trip. If it is a field trip conducted by a team, then one field report is written by the whole team. The format of the field trip report is attached as Annex 7. Field trip reports provide information for either validating some records or additional information, for example outreach data not captured by the regular data collection tools.

iii) Surveys and other periodic reports

STRIDES undertakes special surveys such as annual surveys to collect performance data for indicators not captured by the HMIS, reviews, facility assessments and feedback from STRIDES beneficiaries e.g. on client satisfaction. STRIDES may also undertake other incidental efforts to collect information on specific issues identified during the course of project implementation.

Table 1: Summary presentation of STRIDES data sources for M&E

DATA SOURCE	TIMING	FREQUENCY	PERSON RESPONSIBLE	SUBMITTED TO
Health Management Information system (HMIS) 123/DHIS	By the 7 th day of the next month	Monthly	Regional M&E officers	Data management specialist
Training records – Training report with attendance sheets	Within 7 days after the training has ended	Per training	Training coordinator, Regional M&E officers	M&E specialist
Core partners reports	By the 7 th day of the next month following the quarter	Quarterly	CDFU, Jhpiego and Meridian International	M&E Manager
subcontractors' reports	By the 15 th day of the month following the quarter	Quarterly	STRIDES subcontractors	Grants and Contracts Director, M&E Specialist
Monthly reports	By the 5 th day of each following month	Monthly	Department heads	Executive coordinator/ CoP
Field reports	Within 5 days after the field trip	Per field activity	Staff undertaking field trips	Supervisor
Surveys and other periodic reports	As per need			CoP and a copy to M&E Specialist

4.0 DATA MANAGEMENT

4.2 Data processing and analysis

District HMIS 123 reports are downloaded from the DHIS, printed and utilized to input data into the STRIDES web based MIS. The STRIDES web based database enables multiple accesses at regional level. This data is pooled to a forthcoming main database resident on the server at STRIDES head office in Kampala. The regional M&E officer will ensure that data is accurately and promptly entered into the database. The M&E unit at the head office will ensure that the data is verified, analyzed and indicator statistics generated for progress reports and presentations. A critical analysis of each indicator will be conducted and presented to inform project management decisions on a quarterly basis or when need arises. After data aggregation is done, data is backed up on the server and a copy is also kept offsite at any of the regional offices.

4.3 Geographical Information System (GIS)

Geographical Information System (GIS) is utilized at both the district level i.e. selected districts that are supported by STRIDES. STRIDES procured GIS software for - districts and the relevant district staff, were trained in the use the utilization of GIS and will be followed up in PY5.

This section of the manual contains a description of how STRIDES utilizes the GIS to inform project interventions and also how it is utilized at the districts. GIS tools and applications will allow to visually explore patterns in health indicators and identify service gaps, such as staffing, drugs, equipment, infrastructure, underserved populations, and access to health facilities in order to prioritize resource allocations. The Health Analyzer tool within GIS allows using GIS data to inform decisions and visualize results. STRIDES works with the district health officials with a health facility atlas which includes maps of precise geographic locations, photos, and summary information about health facilities. Based on these maps district health officials will be able to use the GIS atlas, maps, viewers, and summaries to justify and reallocate resources in selected health facilities.

The GIS gives access to two users within the M&E unit i.e. the data management specialist and regional M&E officer for the central region. Information from the districts is compiled into datasets and later mapped into the system which shows various trends for specifically identified periods. Prior to utilization, STRIDES has provided training for GIS users. The training content was customized to meet the needs of STRIDES.

4.3.1 A step-by-step example of how STRIDES will use the GIS tool

Question: What are the gaps in availability and accessibility of immunization services in a given district?

Below is an example of a health GIS sample analysis that can be used to identify gaps in immunization services in a given district.

Step 1: Plot population area (district) by size and identify health facilities with immunization services and vaccine refrigerator using the Facility Survey Analyzer tool.

Step 2: Analyze the immunization services network by dividing area (district) according to closest proximity to service provider using Service Network Provider tool.

Step 3: Analyze 60-min walking accessibility/coverage area using the Facility Accessibility Mapper tool.

Step 4: Analyze population-weighted gaps in immunization coverage and target prioritized areas or health facilities for intervention using the Healthcare Gap Analyzer tool.

Step 5: Evaluate immunization gaps compared to an analysis of 60-min accessibility area for immunization services added to user-selected existing facilities and/or initiated at potential new facilities.

Possible Results:

Adding immunization services to the health facilities may appear worthwhile for rapid enhancement of the immunization coverage. Additionally, evidence-based justification for construction of a new health facility based on immunization coverage needs can be visualized by identifying a new location and mapping its 60-min accessibility area. As a result, district health officials/ STRIDES can more efficiently target limited resources to provide new immunization services at selected existing facilities. Duplication in adequate immunization services coverage areas may be revealed and could warrant reallocation of vaccine refrigerators combined with training of health care providers in facilities with new immunization service capacity. Tracking immunization resources and eliminating duplication in coverage could result in significant health care cost savings while at the same time increasing accessibility of vaccines. In addition, potential health facility site locations or areas that would greatly benefit from mobile vaccination campaigns/ outreaches can be identified.

4.3.2 Practical ways in which STRIDES will use GIS

Below are three practical ways in which STRIDES will use GIS.

a) GIS as a presentation tool

Selected data will be transferred to a GIS. The GIS will produce maps of inventories of available community resources. GIS users will elaborate activity generated results and transfer detailed information into various maps. This information will be used for planning purposes and addressing district specific needs. Instead of presenting huge amounts of tables and lists, GIS will be used to present information in pictures.

b) GIS as a co-ordination tool

With the use of GIS, users will be able to connect different interventions in a more comprehensive framework. Uncertainty and surprise during planning and implementation shall be reduced because different opinions will have been taken into consideration.

c) GIS as a public participation tool

The STRIDES generated information load might be too dense for a general public that therefore keeps it passive. For this purpose GIS shall be used by STRIDES to further simplify and contain only the key information mindful of the information needs of varied users.

At district level, STRIDES will support the districts to: utilize data for analysis of trends in particular service delivery areas; monitor progress towards health facility and district targets and; improve health care delivery. At the national level, M&E data supports institutional learning, and triggers dialogue, and decision making by STRIDES leadership teams, and other stake holders such as MoH. STRIDES prepares and uses monthly, quarterly and annual progress reports as essential tools for management and accountability.

5.0 DATA QUALITY ASSURANCE AND VERIFICATION

5.1 Introduction

Data quality assurance refers to planned and systematic actions establishing assurance that STRIDES M&E data are reliable. It includes arrangements and activities for safeguarding, maintaining and promoting quality of the data. Quality data availability is a prerequisite for effective management decision-making. Quality of data is mainly affected during collection, compilation, analysis, reporting, storage and dissemination; hence data quality should be monitored and maintained at each stage.

This section highlights the quality assurance steps that will be followed at four levels of data handling namely:

- i) Health Facility
- ii) District
- iii) STRIDES regional office
- iv) STRIDES M&E unit

5.2 Quality assurance/data verification steps at health facilities (HFs)

STRIDES in collaboration with the respective district HMIS focal point persons perform data-verification in a number of randomly selected HFs in the districts on a bi-annual basis. The selection of facilities to be included in the data verification exercise will be done at each level of the health facility (HCII, HCIII, HCIV and hospitals).

Step-1 Obtain permission of the district health officer (DHO) to perform data verification in a given number of randomly selected health facilities (HFs). The M&E officer working closely with the district HMIS focal person will design a schedule for visiting the HFs. Before the data verification, hard-copies of the respective HMIS-123 reports will be made. The M&E officer also ensures that there are enough blank tally sheets to use at the HF level (e.g. tally sheets for ANC visits; immunisation; etc).

Step-2 At the HF, the STRIDES M&E staff will work together with the official HMIS-officer or the person who is tasked with that responsibility. The focus will be on those registers from where the information is taken for the 88 fields of STRIDES interest. For the respective month, the data-entry in these registers will be tallied and summarised. The HF-HMIS

person reads out and the M&E staff keeps the record on tally sheets. The totals are compared with the corresponding totals in the HMIS-105 and in case of discrepancies the possible causes are explored. The M&E staff makes a brief report on the visit to each HF, a copy of which is left for the in-charge of the HF. This procedure is repeated in all randomly selected HF. It is obvious that the higher the level of a HF, the more time it will take to complete this step.

Step-3 The results are shared with the District HMIS focal person and possible reasons for discrepancies are discussed, and the extent to which these discrepancies are particular for a HF or could be found in the other HFs as well. The possible consequences of the discrepancies for the validity of the HMIS-123 are discussed and STRIDES may decide to repeat the exercise in another set of HF in that district.

Step-4 The M&E department records the results of this data-verification process for two purposes. The first is to address the gaps in collaboration with the districts wherever possible in order to improve the quality and validity of data recording, processing and reporting, and secondly to use the results to provide specific on the job training for the facility or district staff who are responsible for HMIS.

5.3 Quality assurance/data verification steps at district level

The data-verification process at district level includes the following sequential steps:

Step-1 The M&E unit in close consultation with the district HMIS focal persons randomly selects a given number of districts in each region. The M&E team will also share with the HMIS focal person an explanation of the purpose and methodology of the data verification.

Step-2 Actual data-verification is done by two people, who include the STRIDES M&E staff and the HMIS focal person or designated district staff. The aim of this step is to compare data for the 88 fields in the hard copies of HMIS-105 reports with what has been entered in the HMIS data-base. This can be done in two ways, depending on the local circumstances:

In the **first** method, one person reads from the hard-copy of the HMIS-105 the value in each of the 88 fields and the second person compares that value with what has been entered into the electronic file. In case of discrepancies a note is made stating that in a particular field for a specified HF there is a difference between the value on the hard-copy and the one in the computer. Upon completion of each HF, these notes will be attested by the two persons. At completion of the data-verification for all HFs, the differences (+ or -) are summarised and the result is recorded on a hard-copy of the HMIS-123 that the M&E staff has carried to the district.

The **second** method is applied when the first one fails because access to the DHO computer is not possible. In that case one person reads from the hard-copy of the HMIS-105 and taps that value in the excel sheet with the 88 fields. When the data from all HFs have been entered, the aggregation is done and compared with the hard-copy HMIS-123 as submitted by the DHO that the M&E staff has carried to the district.

Step-3 This step involves reporting the findings to the HMIS focal person and STRIDES regional and Kampala-based teams. The team will do that by explaining where discrepancies have been found between values in the HMIS-105 reports and how this affects the total in the HMIS-123 for these fields.

Step-4 The M&E unit records the results of this data-verification process for two purposes. The first is to address the gaps in collaboration with the districts wherever possible in order to improve the quality and validity of data recording, processing and reporting. Secondly to use the results to provide specific on the job training for the district staff who are responsible for HMIS.

5.4 Quality assurance/data verification steps at STRIDES regional offices

At each regional office (RO) there will be one electronic master folder for each district with two sub-folders: for HMIS-123 and for the special M&E format comprising the 88 fields. Each file will bear the name of the district and the month to which the data refer. The regional M&E officer is responsible for ensuring that these folders are kept up-to-date.

It is the responsibility of the RO to ensure that the HMIS-123 is received every month from the district. The district HMIS focal person submits the HMIS-123 to the MoH latest the 28th of the month that follows the month of reporting. If submitted as an e-file, the RO can expect to receive it at the same time; if the RO has not received it seven (7) working days after the MoH submission deadline, the district(s) should be reminded.

The RO is responsible for the ongoing implementation of the following six steps. Whereas most of these steps will be implemented by the regional M&E officer, the overall responsibility rests with the M&E/PM director.

Step-1 Upon receiving the HMIS-123 report from a district, the regional M&E officer checks the report for completeness and consistency in the 88 fields. Inconsistencies can be found by comparing to previous reports and by comparing numbers in fields that are related (examples: the number of babies with a low birth weight should not be higher or even equal to the number of babies born; the number of children < 1 year with complete immunization cannot be higher or equal to the number of children < 1 year). In case of incompleteness or inconsistencies the regional M&E officer contacts the respective HMIS focal person and depending on the response will correct the field(s) in question.

Step-2 A hard copy is made of each HMIS-123. That copy is used for the data-entry (step 3) and will be filed. There will be one HMIS-folder per district that stores the hard copies. For each district the e-copy of each HMIS-123 will be stored in the sub-folder mentioned in the introduction.

Step-3 For each district the data from the 88 fields are manually entered into the web based database. This will be done on a monthly basis. After entry, the files will automatically be accessible at the head office staff.

Step-4 The data base system will be searched for any inconsistencies that may be in the data entered. All possible errors in the data entered will be viewed, printed and corrected. After the errors have been cleaned, a backup will be made.

5.5 Quality assurance/data verification steps at STRIDES head office

Step-1 On a monthly basis the data management specialist contacts the regional M&E officers to get up-to-date information on the implementation of data verification process at district and facility level and follow up on the data quality issues identified where necessary.

Step-2 The data management specialist performs verification of the HMIS data-entry and aggregation process at each RO for all districts' monthly reports. An analysis of possible errors is made and remedial action taken. The process involves two persons, the regional M&E officer and the data management specialist. During the process, the regional M&E officer will read out the figure on the hard copy of the HMIS form and the data management specialist crosschecks the figure read out with the database. In case of inconsistencies, the database figure will be changed to the figure on the hard copy and the field entry on the hard copy highlighted to show an error had been made during entry. At the end of each batch, the number of errors will be summed up together with fields in which they were made. The M&E department will make a schedule for this activity.

Step-3 Upon receipt of the files from the RO, the M&E unit at STRIDES headquarters will validate the aggregation that has been done by the system for at least 1 district per region and manually aggregate the data to compare with the results generated by the system.

6.0 Quality assurance/data verification steps of HMIS data using Lot Quality Assurance Sampling (LQAs)

In order to triangulate the findings with the routine data verification exercises, STRIDES explored the use of LQAs methodology to verify HMIS data. Verification of HMIS data was piloted in three districts i.e. one district per STRIDES region and these included; Luwero (central), Mayuge (East) and Kasese (West). This was implemented in close collaboration with the MSH LQAs project.

As part of the implementation process, STRIDES Regional M&E officers were trained in the fundamental principles of LQAs and the training lasted 4 days. After the training was concluded, 3 districts were purposively sampled as highlighted above based on performance in of the district in terms of quality reporting of the HMIS 105 data.

Through the District Health Office, LQAs district sensitisation meetings were conducted in all the three sampled districts. During these sensitisation meetings key issues to include the importance of data verification and more so verification with the of LQAs methodology. The

district teams were also sensitised on the basic principles of LQAs and its processes. It is during such meetings that selected district staff were identified to take part in the LQAs data verification as data collectors an average seventeen (17) data collectors were identified from each district and these mostly comprised of; district bio-statisticians, HMIS focal persons, STRIDES focal persons, district Health Educators, surveillance focal persons and health workers among others. The identified persons were trained by the STRIDES regional M&E officers in close collaboration with STAR E- LQAs team and the training focused on the fundamentals of conducting HMIS verification using LQAs methodology. The training lasted 5 days and during the trainings the following was agreed upon i.e. the sample size of the facilities' data to be verified; how to replace a missing sample, verification teams were formed per service area and the service areas included; ANC, FP, Deliveries and Immunisation and the focus was mostly HC IIIs and IVs on average 24 facilities were verified per district.

At the end of each day, the respective teams that were assigned the same health facilities would meet to compare results. All teams converged at an agreed upon central location to tally the findings and compile one report per service area per facility.

At the end of the verification of all facilities in the district, a district final reporting form was completed and findings disseminated at district level and this included both the technical and political wing of the district. Additionally, findings from the LQAs verification were utilised by the STRIDES regional M&E teams in designing tailored capacity building content for staff handling data in the respective districts and facilities. (A separate manual is in place the details the entire verification process by the use of LQAs).

5.6 Quality assurance for project training data

For each training organized by STRIDES, a record of the training venue and participants' details are obtained. Copies of participants' daily attendance lists and bio data forms are kept at the ROs. A copy of the training report with a summary of the participants' details is also being kept at the ROs.

In order to ensure that the correct training data is obtained, the regional M&E officers will monitor the attendance in the training and review attendance lists prepared with respect to the training activity. A trainee shall be counted as one having attended a training if there is evidence by way of registration for at least 75 percent participation in the training activity and attains the required scores detailed in the STRIDES training strategy as follows: when all subject areas have been covered, a score of 85 % or more in the mid course test for clinical trainings indicates knowledge-based mastery of the materials presented in the reference manual; for IMCI a score of 80% and above shows that knowledge has been acquired and for HMIS a score of 80 % is also considered a pass mark for the award of a certificate.

5.7 Quality assurance for data from STRIDES subcontractors

Data verification exercises will be conducted on a quarterly basis for data provided by each of the sub subcontractors before any payments can be disbursed. These assessments focus on reviewing data reliability, validity, integrity, timeliness and accuracy of the

subcontractors' data. A combination of methods will be used such as onsite observations of implemented activities, and physical counting off from the source documents. Data verification exercises will be conducted within one month after the submission of the quarterly reports by the subcontractors to enable quick disbursement of funds.

6.0 REPORTING

STRIDES M&E unit compiles monthly, quarterly and annual progress reports as follows:

Monthly report: The monthly report comprises an update of activities conducted during the month and is structured as follows: introduction; achievements; challenges; and planned activities for the next the month. The report is prepared by the department heads and submitted to the executive coordinator for onward submission to the CoP.

Quarterly report: The quarterly report is prepared every three months and is an essential accountability and management tool. The quarterly report includes progress made in relation to the indicators and targets as stated in the PMP, lessons learnt, challenges and opportunities. The report is prepared for the chief of party who reviews and submits to USAID by the last day of each month following the quarter.

Annual report: The annual report details the achievements, lessons learnt and challenges throughout the year including a PMP status update for each of the indicators. The report is prepared after every project year (October to September) and is submitted to USAID by the last day of the month following the year end, i.e. by 31 October.

Table 2: Summary of reporting schedule

TYPE OF REPORT	TIMING	FREQUENCY	PERSON RESPONSIBLE	SUBMITTED TO
Monthly reports	By the 5 th day of each following month	monthly	department heads	CoP with a copy to the Executive coordinator
Quarterly reports	By the 7 th day of each month following the end of quarter	quarterly	department heads	Manager M&E
	By the 16 th day of each month following the end of quarter	quarterly	Manager M&E	Chief of party
Annual reports	By the 7 th of October each year	annually	department heads	Manager M&E
	By the 16 th of October each year	annually	Manager M&E	Chief of party

Points to note when writing a report and planning for reporting

The reports should:

- ❖ Be sufficiently in depth on relevant details and provide analyses where needed
- ❖ Focus on activities and results being achieved as defined in the PMP
- ❖ Be prepared keeping in mind the specific audience(s) to ensure that the information is relevant for the intended reader

- ❖ Be well written using correct spelling and grammar, be concise, free from repetition, and generally be in plain language
- ❖ Provide a summary (1 page) at the beginning if it is a report of more than 5 pages
- ❖ Present a list of acronyms
- ❖ Be consistent in the use of terminology, definitions and descriptions of partners, activities and places
- ❖ Present complex data with the help of figures, summary tables, maps, photographs and graphs
- ❖ Highlight the most significant key points or words using bold, italics or other emphases
- ❖ Include references for sources and authorities

7.0 FEEDBACK, DISSEMINATION AND DATA UTILIZATION

7.1 Introduction

The purpose of feedback and dissemination of M&E information is to provide for rectification of errors, discuss trends, review progress and evaluate current implementation strategies and possibilities of change/modification as deemed necessary. Collecting data is only meaningful and worthwhile if it can and is subsequently used for evidence-based decision-making. To be useful, information must be based on quality data and be communicated effectively within STRIDES and MSH, with partners, district officials and other interested stakeholders. The project results need to be well understood. The key to effective data use involves linking the data to the decisions that need to be made and to those making these decisions.

7.2 Feedback and dissemination

7.2.1 Importance of feedback and dissemination

STRIDES M&E data needs to be manageable, timely, reliable, and specific to the activities and indicators in question. It is therefore important that feedback is given to those generating the data such as the district HMIS focal person and the records person at the health facility. Feedback is important for acknowledgment of receipt of information (tracking purposes), correction of errors, confirmation/clarification of information given, sharing analysis of trends and availing synthesized information needed to support management and decision making. It is therefore vital for STRIDES to cultivate a culture of feedback to both the internal and external stakeholders.

7.2.2 Nature of feedback and dissemination

Feedback can be:

- ❖ Verbal or written
- ❖ Immediate or of particular frequency e.g. weekly, monthly, quarterly
- ❖ Individual or to a group e.g. case studies or trends presented in a workshop/meeting context

7.2.3 Content of feedback

Feedback should include information on:

- ❖ Accuracy of data from the various sources
- ❖ Timeliness of data
- ❖ Completeness of data at all points of its collection and aggregation
- ❖ Evidence of data use

7.2.4 Content of dissemination

Information shared with stakeholders should include:

- ❖ Project progress versus targets
- ❖ Challenges faced during implementation
- ❖ Suggested solutions

- ❖ Review of targets and strategies for achieving them in the subsequent period(s)

7.2.5 Feedback and dissemination procedures for STRIDES

The STRIDES M&E team at all levels shall acknowledge receipt of progress reports and provide comments regarding accuracy, timeliness and completeness. After data aggregation, analysis and report compilation, the M&E unit staff and the coordinator of regional operations shall be responsible for disseminating the resultant information. This information shall be disseminated monthly, quarterly and annually including any feedback opportunity that may arise during adhoc meetings. The feedback mechanisms will at the minimum be provided at district, regional and national level, and these will be conducted both internally within STRIDES and with STRIDES collaborating districts for their information and use in decision making. The different feedback mechanisms are highlighted below:

(i) Review meetings: These shall be done quarterly and annually both within STRIDES including the centre for health services (CHS) review meetings, regional staff review meetings and district review meetings with STRIDES collaborating districts.

- **CHS review meetings:** These are coordinated and overseen by the CoP and attended by all members of the senior management team and or any other member as deemed necessary by the CoP. M&E Manager presents analysis of project progress against targets to the chief of party who leads discussion on trends, implementation strategies, processes and results.
- **Regional staff review meetings:** The M&E team presents analysis for progress against targets for the 15 districts to the coordinator regional operations and RC. The RC will lead discussion on trends, implementation strategies, processes, results and way forward.
- **Review meetings with the STRIDES collaborating districts:** These are coordinated by the coordinator regional operations in close collaboration with the regional coordinator. They shall be workshop based and conducted with representatives from the targeted districts and the STRIDES M&E team. The review meetings shall focus on discussing progress against targets by district as stipulated in the MoUs and identification of case studies/success stories for documentation purposes. The coordinator for regional operations in collaboration with the M&E department shall facilitate the meetings with the STRIDES collaborating districts.

(ii) Summaries of performance from the project quarterly and annual reports: Project quarterly and annual reports provide a record of activity implementation with factual information on activities, outputs, outcomes, challenges, lessons learned, and next steps. STRIDES shall produce summaries from these reports and share with key partners and stakeholders.

(iii) Stakeholders meetings: STRIDES shall engage in regular or adhoc meetings with stakeholders such as; USAID, Ministry of Health (MoH), other USAID implementing partners

and other stakeholders. During these meetings, stakeholders shall present and discuss issues identified during their implementation or monitoring. These meetings will also facilitate identification of areas of collaboration, challenges and recommendations.

(iv) Support visits to the health facilities and districts: Feedback and dissemination shall also be provided to the STRIDES collaborating districts. At health facility level, feedback on M&E data as well as the facility’s performance will be given during the support visits as well as on any other occasions. At district level, feedback shall be shared on a quarterly basis focusing on planned activities and performance of the agreed upon indicators and targets for each district.

For all the feedback mechanisms, the regional teams will work closely with the national team particularly the coordinator regional operations and the M&E/PM director to ensure quality and accuracy of the disseminated information. The table below highlights STRIDES feedback and dissemination mechanisms, frequencies and persons responsible.

Table 3: Feedback and dissemination mechanisms, frequencies and persons responsible

Feedback and dissemination mechanism		Level	Frequency	Target audience	Person (s) responsible
Review meetings	CHS review meetings	national	quarterly	STRIDES MT CHS home office staff	CoP
	Regional staff review meetings	regional	quarterly and annually	STRIDES staff	Coordinator regional operations M&E Manager
	Review meetings with STRIDES collaborating districts	district		DHO, district HMIS focal persons, selected HMIS contact persons from the STRIDES supported facilities, HF in charges, STRIDES subcontractors.	coordinator regional operations & regional coordinators
Summaries of performance from the quarterly and annual reports		district	quarterly	District staff – DHO, HMIS focal person, health facility in charges	Manager M&E
Stakeholder meetings		regional and/or national	quarterly, or monthly	USAID, MoH and others	CoP/DCoP
Support visits to health facilities and districts		health facility	monthly and/or quarterly	district HMIS focal persons and HMIS staff at HF level.	regional M&E officers and data management specialist.

7.3 Data utilization

During STRIDES baseline survey conducted in 2009 in the 15 collaborating districts, 10 of the 15 districts mentioned that they use HMIS data for planning purposes, including work planning, setting of health targets, planning for drug distribution, and planning for health

facilities. Only four districts reported using HMIS data for monitoring health trends, which also included surveillance.

Table 4: Use of HMIS information as reported by DHOs

Reported use of HMIS information in the last 1 year	# districts	Percent (%)
Planning	10	67
Monitoring trends	4	27
Feed back and decision making	3	20
Resource mobilization	1	7
Feeding into MOH report	2	13

There is no doubt that data is utilized by the districts, although this seems quite limited in scope. STRIDES is building capacity of the districts and HFs to make greater use of M&E information especially through utilizing the feedback and dissemination fora. STRIDES is enhancing district capacity through active engagement of the districts in using the M&E information as a basis for key decisions like allocation of resources during the annual work planning meetings.

7.3.1 Data utilization at HF, district, STRIDES and MoH levels

Table 5: Data utilization at health facility (HF), district, STRIDES and MoH levels

Use of M&E information	Applicable level			
	HF	District	STRIDES	MoH
Quick and easy data retrieval of patients information	√			
Recognition and analysis of trends in the particular service delivery area	√	√	√	
Assessment of the balance between resources and output	√	√	√	
Formulation, monitoring and evaluation of monthly, quarterly and annual work plans	√	√	√	
Monitoring and improving health care delivery	√	√		
Compilation of reports to various stakeholders e.g. the district, planning Unit of MoH, service organizations like STRIDES, donors	√	√	√	
Monitoring the national and international objectives and the strategic health sector strategic plan (HSSP). The information is used for formulating national health policies, strategic planning and decision making			√	√
Planning, monitoring, and evaluating progress towards health facility, district and national as well as service organization objectives and targets	√	√	√	√
Accountability	√	√	√	
Basis for revisiting implementation strategies to better performance.	√	√	√	√

7.3.2 Data utilization at national level

At the national level, data collected through monitoring and evaluation will support institutional learning and guide management decisions. The M&E unit shall therefore ensure that relevant monitoring and evaluation information triggers dialogue and decision-making by the various stakeholders. The STRIDES M&E generated information will therefore be utilized to:

- i) Make informed decisions regarding project interventions and service delivery based on objective evidence;
- ii) Ensure the most effective and efficient use of resources;
- iii) Objectively assess the extent to which the project is having or has had the desired impact, in what areas it is effective, and where corrections need to be considered;
- iv) Meet organizational reporting and other requirements, and convince donors that their investments have been worthwhile or that alternative approaches should be considered.

8.0 MONITORING STRIDES' SUBCONTRACTORS

8.1 Introduction

STRIDES engages both for-profit and not-for-profit private sector organizations under its Performance Based Financing/Contracting program to increase access to family planning, reproductive health, child survival and nutrition services in the 15 collaborating districts. STRIDES subcontractors are selected through a competitive process involving STRIDES issuing of Requests for Proposals (RFPs), assessing applications by interested bidders, and subsequent selection by STRIDES supported by MoH and USAID. The selected subcontractors agree to a set of performance indicators with targets and on contract obligations, one of which is reporting. During the execution of these contracts, STRIDES monitors the subcontractors' progress towards the agreed upon targets and validates their reported data before payments and rewards can be effected. In compliance with the Tiahrt amendment, subcontractors cannot set targets for number of FP service clients¹.

8.2 Indicators and target negotiation

In the RFPs, a set of STRIDES PMP indicators (Annex 8) are stated from which the successful subcontractors are required to select those relevant to their project, and on which they report to STRIDES. During proposal submission, the prospective subcontractors provide baseline values and targets (quarterly and end of project) for each of the agreed upon indicators. Before the award of the contract, a pre-award survey is conducted to assess the operational capacity of the prospective contractor. Indicators and targets are negotiated with each contractor. The agreed upon final set indicators and targets (where appropriate) are presented in the PMP reporting template of each subcontractor and form an integral part of the contract.

8.3 STRIDES subcontractors' reporting process

At the end of every quarter, subcontractors shall submit progress reports by the 15th day of the month following the quarter. STRIDES requires subcontractors to submit a quarterly report which comprises three elements: the narrative report highlighting the achievements, lessons learnt and challenges faced during the quarter; the PMP reporting template that statistically presents progress against set targets; and a modified HMIS report form for private practitioners which the subcontractors use to report into the district HMIS.

Subcontractors submit the quarterly report in the agreed upon templates to the Grants/Contracts director with a copy to the respective STRIDES regional offices and M&E team at STRIDES headquarters in hard and soft copy. Data verification processes is conducted within one month after the subcontractors have submitted the reports. Monitoring of subcontractors' compliance with the Tiahrt amendment will also be conducted during this period. A standardized subcontractors' monitoring and data verification tool (Annex 9) is utilized for this purpose.

¹ More information about the provisions of Tiahrt can be accessed at **Website:** www.usaid.gov/policy/ads/300/303mab.pdf

8.4 Performance against targets

The proportion of budgeted funds paid to the contractor after each reporting period shall depend upon the performance against targets for indicators that are linked to payments. For each indicator, an appropriate weight is assigned in relation to their relative contribution to STRIDES PMP indicators. The overall performance on weighted indicators is computed on which actual payments to the subcontractors are based. A subcontractor that achieves all agreed upon deliverables/targets and exceeds some or all i.e. achieves more an overall of more than 100% qualifies for a performance reward valued up to a maximum of 10% of the total subcontractors' budget.

However as stipulated in all contracts STRIDES may terminate the contracts for the following reasons:

- i) Failure by contractor to achieve the agreed upon deliverables by a margin of 50% or larger, and without acceptable justification no earlier than by the end of Quarter III;
- ii) Misrepresentation of actual performance against deliverables by contractor, as determined through the PMP reporting template;
- iii) Repeated failure by contractor to submit reports according to the agreed upon schedule.

Below are the details for a step by step process prior, during and after the quarterly monitoring and data verification exercises. This process is facilitated by the subcontractors monitoring and data verification tool.

This section shall be of reference at all stages/levels of the monitoring and data verification exercise i.e. **prior to setting** off for the monitoring/verification, **during** (at the subsubcontractors head office; SDP/field level and at community/client) and **after** the monitoring/ verification exercise.

i. Prior/before setting off for the verification

- The teams must ensure that they **familiarize** with the **schedule** and **scope of work** i.e. number of subcontractors including their coverage and districts that have been assigned to the respective member.
- Touch base with **team mate** that one has been assigned to and together ascertain if the number of days are realistic given the scope of work – if not please get back to the person responsible for M&E PBC and related issues in time i.e. preferably before commencement of the exercise.
- Take time to understand the **subcontractors' narrative report** and have a clear **understanding of indicators** and **indicator** definitions as per the subcontractors PMP with reference to the STRIDES PMP.
- Read through the **subcontractors' last quarter's monitoring report** with focus on actions and determine whether actions proposed in the last reports are addressed.

- Ensure that you and your team mate(s) have **a copy of** the following **documents** for the respective subcontractors that you have been assigned to.
- The **approved travel itinerary** and the final Monitoring and data verification schedule.
- Subcontractors' **contact lists** especially the contact persons at the subcontractors head offices.
- **Previous** quarter monitoring and data verification reports for the respective subcontractors – identify the key issues highlighted in the previous quarter / action points for follow up.
- Respective subcontractor's **quarterly reports** i.e. the **narrative report** especially for the RFP001&002; **PMP reporting template**; and the **list of facilities** partnered with during the reporting quarter with numbers achieved as a result of this partnership for the quarter that you shall be verifying.
- Monitoring and data verification tools i.e. the overall monitoring tool (used at the subcontractor's head office; the field verification tool (used at the SDP), the client checklist and HMIS verification tool.
- Required sample size for social marketers; For the teams that shall be verifying the social marketers that (i.e. PACE; UHMG and Kyenjojo Pharmacy¹) ensure that you have the required sample of SDPs that you shall be required to verify per district – This sample shall be generated as soon as the respective subcontractors report and the team members to the respective districts shall be availed with the information about the required number of SDPs to sample – the field teams also need to touch base with the respective teams that verified the head offices to ascertain if there is need to do purpose sampling based on the findings from the head office.

ii. During the verification

At the subcontractors Head office

- Start by **introducing** yourself and the purpose of the exercise – please refer to the mail that was sent out by the head office M&E team about this activity.
- Explain the **process** of this monitoring visit and the estimated timeframe (remember that it an opportunity to hear from the subcontractor how the quarter has been i.e. the key achievements; challenges and lessons learnt – give them a chance to narrate and ask questions if required – this narration will give you background information to the data verification).
- Take time to **understand** the subcontractor's **implementation methodology** as this will too guide you on the required source documents. This is a point to understand the kind of support subcontractor provides to partnering facilities especially if not stand alone subcontractor/ service provider.
- In the discussion, review actions that were highlighted in the last monitoring report with the contractor and give guidance where necessary.
- After the discussion – introduce the session of the actual data verification and review of the **source documents**.

- vi. This should preferably be conducted **indicator by indicator** – mention the number that was achieved/reported as per the PMP table that forms part of their quarterly report – let them explain how these reported numbers were achieved as this will guide you to identify the source documents that you require to count off other than counting off everything including what may not be relevant. – Your understanding of levels of data aggregation/flow is important at this point.
- vii. Count off the source documents **together with representatives from the subcontractor** and ensure that **consensus is built** at this point – this is a partnership activity and not a policing event. This is where you also need to apply your correct knowledge and understanding of the indicator definition and be vigilant data sources outside the reporting period of focus.
- viii. **Sign off** the source documents that have been counted off/verified i.e. signature; date and the respective quarter – ask for **permission** if you need to include any comments on the source documents so that it is easy for the next teams to that shall verify or cross check.
- ix. **Summaries** all the data from all the **source documents** per indicator together with the representatives from the subcontractor and **gain consensus** even for negative comments/ numbers – do this with tact and patience and clearly explain the gaps that you have identified and reasons/facts why or why not certain numbers are not to be considered.
- x. Remember to **complete the Tiart** tool i.e. the section that is relevant to the staff at the head office.
- xi. During the head office verification, clearly **establish the respective SDPs** that need to be verified at field level – generate the list of SDPs based on the documents verified at the head office and ensure that this list also has the contact persons at the respective SDPs – send this list ASAP to contact M&E person for PBC at the head office and copy in the respective team members (as per the schedule) verified at field level.
- xii. Remember to also ask about and listen to the **success story** as documented in the submitted reports.
- xiii. Establish if data achieved as a result of the support from the respective sub contractor(s) was **included** in the respective **facility HMIS 105** monthly report

*Note: Ensure that the representatives from the subcontractors preferable the M&E and key staff implementing STRIDES activities **are on board for each step** during the head office verification*

At the subcontractors SDP/Field level

- i. If you were not part of the head office verification team for the respective subcontractor that you are verifying at field level, ensure that;
 - You **touch base** with the team (s) that verified the subcontractor’s head office. –
 - Ask them to **highlight the key issues** that were identified then that need to be followed up at SDP and field level in addition to the routine aspects that are verified at that level.

- Acquire the **list of SDPs** and contact persons to be followed up with at field/SDP level from the team that verified the head office.
 - Conduct a debrief meeting with the subcontractors representatives at the various level of the respective results found at the field level.
- ii. Remember to complete the **Tiahrt section** for the service providers at SDP level i.e. to staff offering FP services.
 - iii. With permission **sign off** the subcontractors' source documents verified at **SDP** level and include the data and the quarter for which the data is being verified.
 - iv. **Utilize** the data collection tool i.e. the **Field/SDP verification tool** to document data verified at SDP level – ensure that these are signed off and stamped at the respective SDPs – utilize your good rapport to ensure that this is done.
 - v. While at the **district** and **HSD** establish if the subcontractor and or the subcontractors partnering facility (ies) **submitted timely HIMS** reports within the referred to reporting period. Ensure that you also establish if the subcontractor's data was incorporated at in the final district HMIS report.

Sampling

- The sampling of the SDPs to be verified for the social marketers such as UHMG; PACE and Kyenjojo Pharmacy shall be done in close collaboration with the head office teams and final samples will be signed off and shared by the head office to the teams in the respective districts – Using the attached excel formatting.ⁱⁱ
- Ensure that you sample a minimum of **3 clients** per subcontractor per **district** for the **RFP 001** and **002** subcontractors and a minimum of **2 clients** per indicator for the **RFP 003** subcontractors.
- The sampling should be focused on indicators related to; ANC, deliveries, and vaccination for DPT3 and 2nd dose of Vitamin Aⁱⁱⁱ.

Note: For the other subcontractors other than the social marketers ensure that you visit all the SDPs (census) where activities were conducted as per the subcontractor's reports and the findings at the respective subcontractors head offices.

Note: Remember to **crosscheck** if you have visited all the **SDPs** and **districts** that you were assigned.

ii) After the monitoring and verification/ Report writing phase

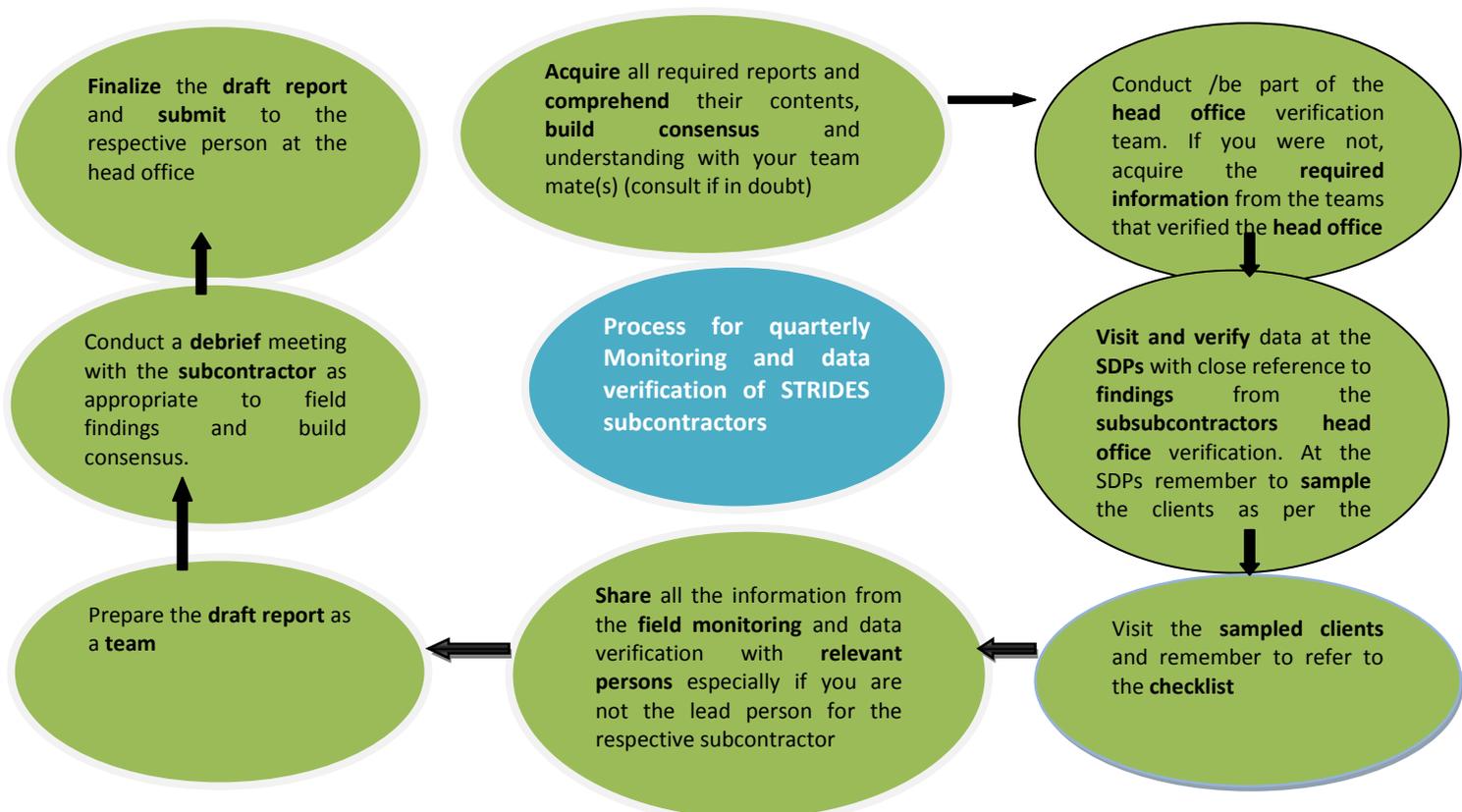
- Prior to completing the report – the **lead person** per subcontractor must ensure that they acquire all the data verified from the field i.e. respective SDPs in the different districts that were verified by the other teams.
- Ensure that you complete all the **required sections** of the report
- Tools from head office and field verification **signed off** by the relevant people at each level of verification.
- An **excel sheet** completed with verified data, outlining the district of operation, subcontractors partnering facility, date and site of outreach.

- Complete the report –utmost **within two days** after completing of the data verification exercise.
- Schedule a **debrief meeting** to share key findings from field verification with the subcontractors. The feedback/debrief meeting shall be conducted by the lead verification team member that shall be identified per verification team.^{iv}
- After the end of entire process, the lead person subcontractor must submit the following deliverables;
 - a. The draft subcontractor’s monitoring and data verification report submitted two days after verification completion.
 - b. The data collection tools utilized during all the monitoring and verification levels.
 - c. An excel sheet (soft copy) - template will be shared - clearly indicating numbers verified per subcontractor and per facility/outreach – where applicable.

Ensure that you clearly follow the monitoring and verification cascade right from the reports that are shared it the subcontractors Narrative and PMP reporting templates, Head office verification, SDP/Field verification to the sampled clients’ verification.

Note: Ensure that you consult where you are not sure.

Process/ flow chart of the monitoring and data verification of STRIDES subsubcontractors



9.0 PROJECT EVALUATION

Evaluation was conducted at midterm and will be conducted at the end of project. The evaluations will provide information that is credible and useful, enabling the incorporation of lessons learned into the decision making processes of both STRIDES and USAID. Evaluation heavily focuses on outcome and impact whereas monitoring focuses on outputs and to a limited extent outcome.

9.1 Mid-term evaluation

At midpoint of the five year project duration, a (formative) evaluation was conducted. An external evaluation team was contracted and together with a team from the MSH head office assessed the project's performance and reviewed strategies in order to track project progress, impact and sustainability. Based on the findings, STRIDES was able to make mid-course corrections necessary to help the project achieve its objectives and document project success stories as appropriate. The formative evaluation focused on the following questions, among others:

- i) What was or was not implemented? If some planned activities were not achieved, what are the reasons for this?
- ii) What is the difference between what was supposed to be implemented and what was actually implemented, and what are the possible reasons for this?
- iii) How appropriate and close to plan are the costs, time requirements, staff capacity, and district support?
- iv) What are the results (anticipated and unanticipated) that are emerging from implementation?
- v) Are realistic sustainability strategies in place? If no, why not?
- vi) What can be done better to facilitate accomplishment of STRIDES objectives?

9.2 End of Project evaluation

At the end of project a summative (end of project) evaluation will be conducted to assess efficiency, **effectiveness**, impact, relevance and sustainability.

9.3 Evaluation criteria

The following evaluation criteria will form the basis of STRIDES evaluation processes:

9.3.1 Relevance:

- ❖ To what extent are the objectives still valid?
- ❖ Are the activities and outputs of STRIDES consistent with the overall goal and the attainment of its objectives?
- ❖ Are the activities and outputs of the project consistent with the intended impact?

9.3.2 Effectiveness:

- ❖ To what extent were the objectives achieved?
- ❖ What were the major factors influencing the achievement or non-achievement of the objectives?

9.3.3 Efficiency:

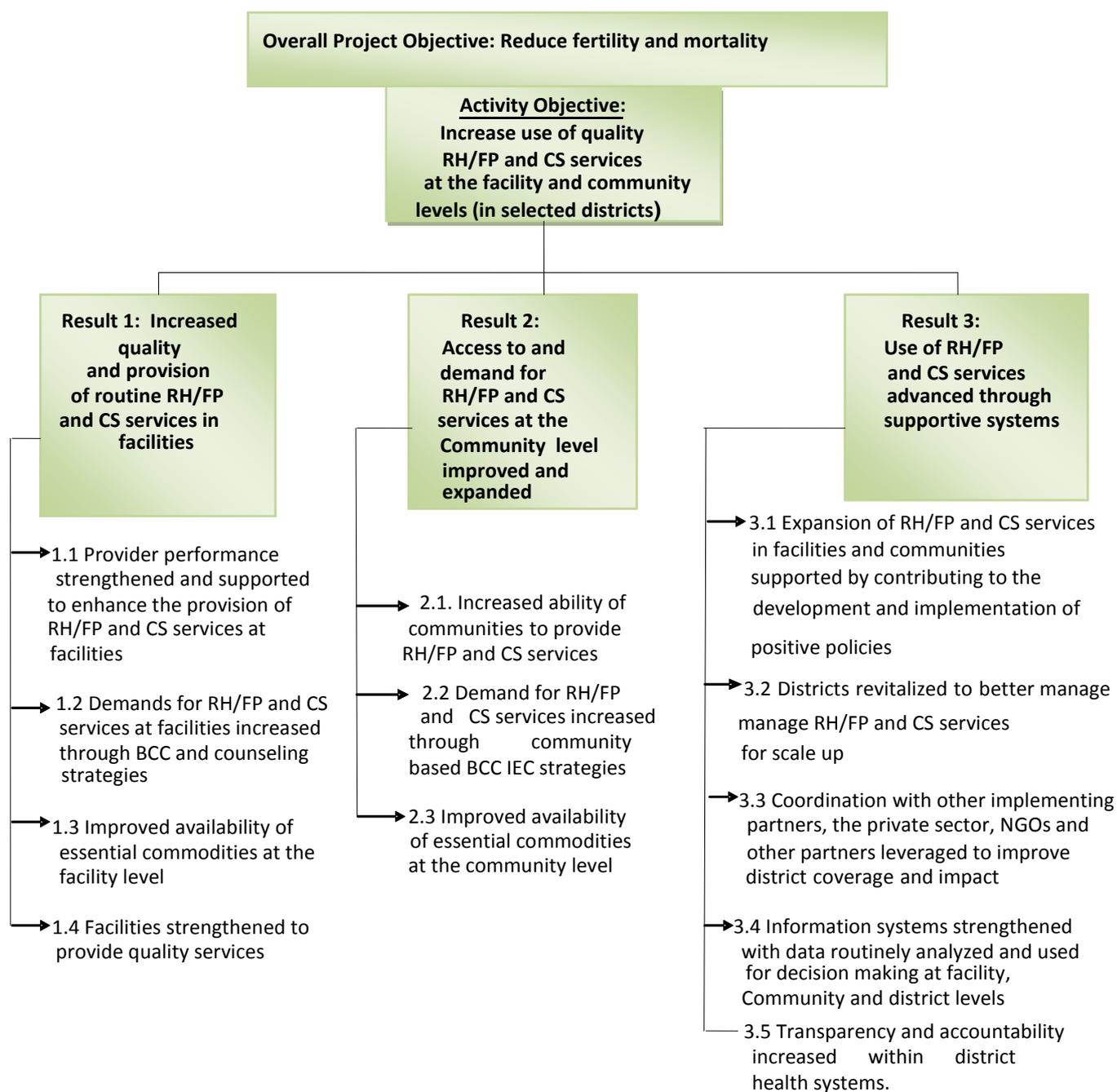
- ❖ Were activities cost-efficient? If no, why not?
- ❖ Were objectives achieved in time? If no, why not?
- ❖ Was the project implemented in the most efficient way compared to alternatives?

9.3.4 Impact:

- ❖ To what extent has the project contributed to its longer term goal?
- ❖ What unanticipated positive or negative consequences did the project have?
- ❖ What real difference have the project activities made to the beneficiaries?
- ❖ How many people have been reached?
- ❖ Has the application of the FFSDP concept led to improved quality of services delivered at facility level?

9.3.5 Sustainability

- ❖ To what extent will the benefits of the project continue after the end of project?
- ❖ What are the major factors which influence the achievement or non-achievement of sustainability of the project?



Annex 2: STRIDES Performance Monitoring Plan																	
#	USAID SO8 Indicator No. or project level	Indicator	Definition	Frequency of Reporting	Data source	Comments	Disaggregation	Data users	National Baseline	STRIDES Baseline (total of 15 districts)/ Year 1	End of Project	Year 4					Year 5
												Q1	Q2	Q3	Q4	Year 4	
Overall Objective: Reduce Fertility and Mortality																	
1	project level	Total Fertility Rate	Number of live births that a woman would have if she were subject to the current age specific fertility rates throughout her reproductive ages i.e. from 15-49 years. Estimate based on 3 years preceding the survey.	Yearly	UNFPA and/or STAR-E LQAS	UNFPA and LQAS project will reportedly conduct district level surveys. This is an impact indicator and tracks the overall project objective.		Government, donors, private sector	6,7 *	N/A							
Result 1: Increased quality and provision of routine RH/FP and CS services in facilities																	
2	SO8 # 63	# of FP clients using FP methods	Number of users of FP services who are currently using any contraceptive method. Modern methods are: pill, implant, IUD, injection. Natural methods are LAM, moon beads.	Quarterly	HMIS	Consistent with the Tiahr Amendment, STRIDES has not set targets for the number of clients receiving family planning services.	New users Revisits	STRIDES, USAID, DHMT, Service providers	N/A N/A	136,272 ^ 85,154 ^	35,195 27,969	29,978 31,862	33,524 24,094	39,245 35,746	137,942 119,671	142,770 123,859	
3	SO8 # 6	Couple-years of protection (CYP)	The estimated protection provided by FP in a one-year period, based upon the volume of contraceptives sold or distributed free of charge to clients during that period.	Yearly	HMIS	CYP has been projected to increase from 96,105 at baseline to 965,111 by the last project year(PY5), due to increased interventions in contraceptive availability and usage. The end of project target is the sum of PY2,3,4 and 5 targets.	Only modern methods considered (all oral pills, condoms, IUDs, injectable, implants, tubal ligation & vasectomy).	STRIDES, USAID, DHMT, Other IPs	361,080 **	96,105 ^	965,111	73,981	72,531	81,234	40,617	268,363	331,514
4	SO8 # 43	# implants and IUDs inserted	This is the number of implants and IUDs inserted	Quarterly	Project Records	Consistent with the Tiahr Amendment, STRIDES has not set targets for the number of clients receiving family planning services.	IUDs and Implants inserted by public and private facilities	STRIDES, USAID, DHMT, Other IPs	N/A	6,402	2,561	2,651	4,644	7,531	17,387	17,996	
5	SO8 # 65	# of children who at 12 months have received three doses of DPT vaccination from a USG-supported immunization program.	Number of children who at 12 months have received three doses of DPT vaccination from a USG-supported immunization program.	Quarterly	HMIS	DPT3 used as marker for full immunization. The targets have been set as follows: 1% increment per year from the baseline per year i.e. 1% increment in PY2, 2% increment in PY3, 3% increment in PY4 and 4% increment in PY5. The total number of children at 12 months in the 15 districts was 235,918 at baseline and a 3% increment is projected per year.		STRIDES, USAID, DHMT, Service providers (managers), Other IPs	193,453 ***	211,567	952,052	44,747	67,117	75,507	55,931	243,302	253,880
6	SO8 # 66	# of children under 5 years of age who received Vitamin A from USG-supported programs.	Number of children under 5 years of age who received Vitamin A from USG-supported programs.	Quarterly	HMIS	The targets have been set as follows: 5% increment for each year from the baseline i.e. 5% increment in PY2, 10% in PY3, 15% PY4 and 20% PY5.	1st dose 2nd dose	STRIDES, USAID, DHMT, Service providers (managers), other IPs	N/A N/A	278,735 197,259	1,393,675 986,295	66,642 47,162	99,960 70,741	112,454 79,583	83,300 58,951	362,356 256,437	390,229 276,163
7	SO8 # 36	% customers satisfied with health services received	An annual measurement. Numerator: # customers satisfied with at least 8 out of 10 of aspects of service. Denominator: Total # all clients interviewed.	Yearly	Annual survey	SDPs supported by STRIDES in a given project year will continually be supported in the preceding periods	RH,FP,CS	STRIDES, USAID, DHMT, Service providers	N/A	54	70				67	70	
8	SO8 # 60a	% targeted health units offering Young People-Friendly Services	Characteristics of Young People-Friendly Services (YPFS): (1) Providers trained in YRH issues; (2) Providers trained in communication; (3) Respectful; (4) Non-judgmental attitude; (5) Confidentiality; (6) Privacy; (7) Convenient hours. Young people are those aged between 12 and 24 years. A health facility will be considered to be offering YPFS if it meets at least 5 out of the 7 aspects of the service. Numerator: Number of targeted health units offering young people-friendly services. Denominator: Total number of USAID IP (STRIDES) supported health units.	Yearly	Annual survey	This is a new indicator. STRIDES is targeting to reach 72 facilities in PY3, 121 facilities in PY4 and 162 facilities in PY5 at HCIII and IV levels. The numbers targeted per district will vary based on health centers III & IV existing in each district. Only STRIDES supported facilities will be tracked.		STRIDES, USAID, DHMT, other IPs	N/A	9	45					35	45
9	project level	% pregnant women who receive 4 ANC consultations	Numerator: # pregnant women who received 4 antenatal consultations. Denominator: All pregnant women in the district.	Quarterly	HMIS	STRIDES will increase coverage with intense interventions in these areas by supporting more public and private facilities. STRIDES contractors will also increase coverage in PY3,PY4 and PY5.		STRIDES,DHMT other IPS	47 average (UDHS)	30	60	27	33	41	50	50	60
10	project level	% pregnant women who received 2+ doses of IPT	Numerator: # pregnant women who received 2+ doses of IPT. Denominator: All pregnant women in district.	Quarterly	HMIS			STRIDES,DHMT other IPS	32 average (UMIS)	35	60	40	44	48	52	52	60
11	project level	% live births delivered from a health facility	Numerator: # live births assisted by trained health personnel. Denominator: Total # live births in the district.	Quarterly	HMIS			STRIDES,DHMT other IPS	41 average (UDHS)	27	60	34	40	48	55	55	60

12	project level	% underweight children at measles vaccination	Numerator: # children < 5 years whose weight is below bottom line. Denominator: Total # children < 5 years weighed.	Quarterly	HMIS	STRIDES is scaling up the nutrition activities in PY3,4 and 5 to improve performance of this indicator.		STRIDES,DHMT other IPs	N/A	9		3	7.0	7.0	6.4	6.0	6.0	3.0
13	project level	% live births with low birth weight	Numerator: # live babies with birth weight < 2.5kg. Denominator: Total # live births in the district	Quarterly	HMIS	Given that the national baseline is at 11.5% and the STRIDES baseline is 3%. The target has been revised based on the national baseline. The target for PY4 has been set at 4%.		STRIDES,DHMT other IPs	11.5 (UBOS)	3		3	4.4	4.0	4.0	4.0	4.0	3.0
14	project level	% health facilities (HC III & above) providing Basic Emergency Obstetric Care (BEmONC)	Numerator: # health facilities (HC III & above) that provide ALL basic signal functions. The basic signal functions are: Parenteral administration of antibiotics, parenteral administration of oxytocic drugs, parenteral administration of anti convulsant drugs, manual removal of placenta, removal of retained products(MVA), assisted vaginal delivery,neo-natal resuscitation. Denominator: total # health facilities (HC III & above).	Yearly	Annual survey	The following percentage increments from the baseline have been applied: 150% increment for PY3, 250 % PY4 and 300%increment in PY5.		STRIDES,DHMT other IPs		10		40					35	40
15	project level	% health facilities (HC IV & above) providing	Numerator: # health facilities (HC IV & above) that performed caesarean sections and blood transfusions in addition to ALL the basic signal functions. The basic	Yearly	Annual survey	Targets have been set as 67% PY3, 122% PY4 and 178% PY5.		STRIDES,DHMT other IPs	N/A	9		25					20	25
16	SO8 #27	# of USG-assisted Service Delivery Points providing FP counseling or services	Service delivery points (excluding door-to-door CBD) providing FP counseling or services. An SDP is considered to provide the service when ALL the following conditions are met: 1) at least one staff member who has been trained in the service 2) the equipment is available 3) the SDP has offered the service in the last 3 months (as per facility records) and 4) the contraceptive has been in stock for at least 2 of the past 3 months.	Yearly	Annual survey	Only STRIDES targeted facilities will be tracked. STRIDES will in addition to those facilities targeted in PY3 add 50 facilities in PY4 and another 50 facilities in PY5. Targets have been set cumulatively for this indicator. STRIDES is targeting 254 SDPs for this indicator by EOP.	Public and private facilities (PPF and PNFP)	STRIDES, USAID, DHMT, Service providers (managers), Other IPs		104		254					204	254
17	project level	% health facilities (HC III & above) offering long acting and permanent methods (LAPM)	Numerator: # health facilities (HC III & above) offering LA (implant, IUD). Denominator: Total # all health facilities (HC III & above). Numerator: # health facilities (HC IV & above) offering PM (sterilization). Denominator: Total # all health facilities (HC IV & above).	Yearly	Annual survey	Targets for long acting methods have been set as follows: 22% increment PY3, 49% increment in PY4, 62% increment in PY5. For permanent methods increments are as follows: 23% for PY3, 50% for PY4 and 67% for PY5. All increments are from the baseline. STRIDES will increase coverage with intense interventions in these areas by supporting more public and private facilities and contractors in PY3,PY4 and PY5.	Long Acting Methods	STRIDES,DHMT other IPs	N/A	37		60					55	60
							Permanent methods		N/A	30		50					45	50
18	project level	# service providers trained by STRIDES in FP/RH/CS	FP includes Basic FP and Long acting and permanent methods. RH includes BEmONC, CEmONC & ARHS. CS includes IMCI, growth monitoring, nutrition counseling, new born health.	Quarterly	Training records	Only the service providers trained by STRIDES will be tracked. Training targets have been revised because in PY2 the training activities were halted to prepare the training strategy. In order to catch up, the number of service providers to be trained in PY4 has been revised upwards as follows: FP- from 683 to 935 and RH from 182 to 425. CS targets have been revised upwards from 248 to 580. The PY5 targets have been revised downwards because the project is significantly reducing its training activities in the last year of implementation. PY5 targets have been revised as follows: FP from 751 to 225; RH from 200 to 90 and CS from 273 to 100. Consequently, the EOP targets have reduced: FP from 2,724 to 1,855; RH from 864 to 819 and CS from 2,168 to 1,165.	Family Planning (Basic FP, LAPM)	STRIDES,DHMT other IPs	N/A	0	1,855	255	260	280	140	935	225	
							RH(BEmONC, CEmONC) and ARHS		N/A	0	819	65	170	150	40	425	90	
							CS (IMCI, New Born Health)		N/A	0	1,165	100	160	160	160	580	100	

19	S08 #42	% USAID supported Service Delivery Points offering any modern contraceptive method	Modern Contraception Methods include female and male sterilization, oral hormonal pills, the intra-uterine device (IUD), the male condom, injectables, the implant (including Norplant), vaginal barrier methods, the female condom and emergency contraception. <u>Numerator:</u> This is the number of USAID IP (STRIDES) supported SDPS offering any modern contraceptive method. <u>Denominator:</u> This is the total number of USAID IP (STRIDES) supported SDPs.	Yearly	Annual survey	STRIDES will gradually increase coverage in the districts. Only STRIDES supported SDP will be tracked. STRIDES will increase coverage with intense interventions in these areas by supporting more public and private facilities. STRIDES contractors will also increase coverage in PY3, PY4 and PY5.	Public and private facilities	STRIDES, USAID	N/A	46	92						90	92
20	S08 # 34	% Service Delivery Point complying with national norms and standards	Percentage of family planning units providing adequate counseling to clients. Adequacy of counseling includes counseling sessions with new acceptors in which provider discusses all methods, family planning commodities are available and job aids are available during the counseling session. For a family planning unit to be counted as having provided adequate counseling, at least 80% of the individuals observed must have been provided with adequate counseling. Adequate counseling means: all methods are discussed with the clients; job aids are used in the counseling session; and FP commodities are in stock. <u>Numerator:</u> Number of family planning units providing adequate counseling to clients. <u>Denominator:</u> Total Number of family planning units supported by USAID IP (STRIDES).	Yearly	Project Records	Data will be collected from public facilities and STRIDES contractors. The national norms and standards are specific to FP counseling. The targets have been based on the following increments: 29% PY3, 65% PY4 and 88% PY5.		STRIDES, USAID, DHMT, Service providers (managers), Other IPs	N/A	17	32						28	32
Result 2: Access to and demand for RH/FP and CS services at community level improved and expanded																		
21	project level	% villages with functional VHTs	A VHT will be considered to be functional when all the following conditions are met: regular meetings are held at least once a month, VHT members are trained, availability of job aids, submit reports to the nearest health facility, registered with health facility and VHT members provide services to the community at least once a month. <u>Numerator:</u> # villages with functional VHTs. <u>Denominator:</u> Total number of villages	Yearly	Annual survey	Based on the current and planned VHT coverage, targets for PY4, PY5 and EOP have been adjusted as follows: PY4 from 45% to 35%; PY5 and EOP from 50% to 40%.		STRIDES, USAID other IPS	N/A	21	40						35	40
22	project level	% VHTs with stock-outs of FP tracer commodities	<u>Numerator:</u> # VHTs experiencing stock-outs of specific FP commodities at any time during the survey. <u>Denominator:</u> Total functional VHTs in the collaborating districts. (The commodities include: condoms, pills and moon beads).	Yearly	Annual survey	The targets have been set as follows: 23% reduction for PY3, 72% reduction for PY4 and 115% reduction for PY5.		STRIDES, USAID, DHMT, Other IPs	N/A	43	20						25	20
Result 3: Use of RH/FP and CS services advanced through supportive systems																		
23	S08 # 62	# of clients receiving services from a USAID-affiliated private sector service provider	Number of unique clients receiving services from a USAID-affiliated STRIDES contracted private service provider. The services include FP, CS and nutrition services. An increase in number of clients demonstrates an increased role of private sector in health service provision. Adjusted for population growth.	Quarterly	PBC Reports	STRIDES has not set targets for the number of clients receiving FP services but has set targets for CS services. Targets may be reviewed after negotiating contractors targets. Indicator is restricted to STRIDES contractors. Targets in year 4 double because more RFA/P will have been issued. Overall, STRIDES has targeted to reach approximately 2,379,545 clients by EOP.	CS -maternal and new born health, nutrition	STRIDES, USAID, DHMT, Service providers (managers), Other IPs	N/A	0	2,379,545	118,977	178,000	327,420	327,421	951,818	951,818	
24	project level	% facilities submitting timely HMIS reports to HSD/district	<u>Numerator:</u> # health facilities from which the HSD/district received HMIS report within 7 days of end of reporting period. <u>Denominator:</u> Total facilities supported by STRIDES in the district.	Bi annually	District HMIS records	Facilities are required to submit HMIS reports to the health sub-district (HSD) within 7 days after the reporting period. However, sometimes the HSD is not functional and the facilities submit directly to the district.		STRIDES, DHMT, other IPs	N/A	72	90						85	90
25	project level	% districts submitting timely HMIS reports to MoH	<u>Numerator:</u> # districts from which the national MoH received HMIS report by 28th day of month following reporting period. <u>Denominator:</u> # project districts.	Bi annually	MoH Resource Center	The MoH resource centre shares information on timeliness of HMIS reports from the 15 districts. Targets have been set based on the baseline figures provided in the national HMIS data base at the MoH.		STRIDES, other IPs	N/A	78	93						90	93
26	project level	% public health facilities clearly displaying pertinent information to clients	Facilities will be counted when at least 4 of the following are displayed: opening hours, fees where applicable, daily/weekly staffing, services that are being offered, evidence of service statistics. <u>Numerator:</u> # public health facilities displaying pertinent information. <u>Denominator:</u> Total facilities supported by STRIDES during the project year.	Yearly	Annual Survey	STRIDES will in addition to those facilities targeted in PY3 add 50 facilities in PY4 and another 50 facilities in PY5. Targets have been set cumulatively for this indicator. STRIDES is targeting to reach 213 facilities by EOP.		USAID, STRIDES	N/A	16	59						47	59
Nutrition Indicators																		

HMIS FORM 123: DISTRICT/HSD MONTHLY REPORT

DESCRIPTIONS AND INSTRUCTIONS

- Date due:** 28th of the month
- Objective:** Reports the attendance figures on OPD, Laboratory tests, MCH/FP, stock outs of essential drugs and supplies, management meetings for the District, and financial flows.
- Copies:** **One.** It is sent to Ministry of Health Resource Centre Division. The District will have a record of all information in the District Database file.
- Responsibility:** DHO

Monthly Procedures:

ON DISTRICT/HSD MONTHLY REPORT (HMIS 123)

1. Page 1 contains two sections. **Section 1** is a summary of the OPD attendances. The values are obtained from Table 2A (Curative and Preventive Attendance). **Section 2** contains a summary of OPD diagnoses; the values are obtained from Table 1A and 1B (OPD diagnoses). If the district wishes to include additional diseases of local interest, they may do so. The DHT will be responsible for ensuring all the health units in the District are aware of the chosen additional diagnoses.
2. Page 2 contains Section **3** for summary of MCH, Family Planning, Immunisation, **Exposed Infant** Diagnosis (EID) services. The values are obtained from Table 2 (Curative and Preventive Attendance Summary), Table 3 (EPI Attendance Summary, Table 4 (Family Planning Summary) and Summary of the Operating theatre procedures for Family Planning from Table 4. Information on HOMAPAK is obtained from reports sent every month by Health Units (in HOMAPAK implementing sub-counties).
3. Page 3 contains a continuation of **Section 3** covering Prevention of Mother To Child Transmission (PMTCT), HIV Counseling & Testing (HCT) and Ante Retro Viral Therapy (ART) activities. The values are obtained from Table 2A (Curative, Preventive Attendance and Laboratory Tests Summary), Table 3A (EPI Attendance Summary) and Table 4A (Family Planning Summary).
4. Page 3 has three sections. **Section 4** covers a summary report on essential drugs, vaccines, contraceptives and supplies that ran out of stock during the month. This information is obtained from the District Stockouts recorded on Table 9. (The storekeeper should also report verbally all stock outs as they occur.). **Section 5** is on management with information on meetings conducted or attended by the DHT. This

information is obtained from Table N2 (District Record of Management Meetings).

5. Page 4 has 4 sections. **Section 6** is for summary of health workers that did not receive their monthly salary. This information is obtained from Table 8 (Record of staff not receiving a salary). **Section 7** is for summarizing the financial transactions for the District. Financial information is obtained from Table 5 (Financial monthly summary). **Section 8** is for monthly monitoring of whether the district is attaining the target set for selected indicators. **Section 9** is for inclusion of comments by the DHT in regard to that particular month's HMIS report. A copy of the comments should be written in the District's LOGBOOK.
6. All the information is transcribed from the tables in the District Database file. It is therefore not necessary to keep a copy of the District Monthly HMIS 123 report at the District.

ON TABLE 16: DISTRICT TOOL FOR MONITORING TIMELINESS AND COMPLETENESS OF HMIS REPORTING

- Indicate monthly Timeliness/lateness/No report by Health Units for the whole year.
- Calculate the percentage Timeliness (Total Health Units that reported timely "T" ÷ total Health Units in the District X 100); Lateness (Total Health Units that reported Late "L" ÷ total Health Units in the District X 100); and No report (Total Health Units that did not report "N" ÷ total Health Units in the District X 100).
- Calculate the percentage Completeness of reporting (Total Health Units that reported "T" plus "L" ÷ total Health Units in the District X 100)



HMIS FORM 123: DISTRICT/HSD MONTHLY REPORT

District/HSD Name _____ Code _____ Total number of functioning Health Units in the District /HSD _____ Number of Health Units that reported _____ Month _____ 20 _____
 Total No. of Civil Society Organisations (CSOs) registered in the District /HSD _____ No. of CSOs that reported _____

1. OPD ATTENDANCES, REFERRALS AND DIAGNOSES TOTALS FOR THE MONTH

1.1 OUTPATIENT ATTENDANCE

Category	0-4 years		5 and over	
	Male	Female	Male	Female
New attendance				
Re-attendance				
Total Attendance				

1.2 OUTPATIENT REFERRALS

Category	0-4 years		5 and over	
	Male	Female	Male	Female
Referrals to unit				
Referrals from unit				

1.3. OUTPATIENT DIAGNOSES

Diagnosis	0-4 years		5 and over	
	Male	Female	Male	Female
1.3.1 Epidemic-Prone Diseases				
01 Acute flaccid paralysis				
02 Cholera				
03 Dysentery				
04 Guinea worm				
05 Bacterial Meningitis				
06 Measles				
07 Tetanus (Neonatal) (0 –28 days age)				
08 Plague				
09 Rabies				
10 Yellow Fever				
11 Other Viral Haemorrhagic Fevers				
12 Severe Acute Respiratory Infection (SARI)				
13 Adverse Events Following Immunization (AEFI)				
14 Other Emerging infectious Diseases, specify e.g. small pox, ILI, SARS				
1.3.2 Other Infectious/Communicable Diseases				
15 Diarrhea- Acute				
16 Diarrhea- Persistent				
17 Ear Nose and Throat (ENT) conditions				
18 Ophthalmia neonatorum				
19 Other Eye conditions				
20 Urethral discharges				
21 Genital ulcers				
22 Sexually Transmitted Infection due to SGBV				
23 Other Sexually Transmitted Infections				
24 Urinary Tract Infections (UTI)				
25 Intestinal Worms				
26 Leprosy				
27 Malaria				
28 Other types of meningitis				
29 No pneumonia - Cough or cold				
30 Pneumonia				
31 Skin Diseases				
32 Tuberculosis (New smear positive cases)				
33 Other Tuberculosis				
34 Typhoid Fever				
35 Tetanus (over 28 days age)				
36 Sleeping sickness				
37 Pelvic Inflammatory Disease (PID)				
1.3.3 Maternal and Perinatal Diseases				
38 Abortions due to Gender-Based Violence (GBV)				
39 Abortions due to other causes				
40 Malaria in pregnancy				
41 High blood pressure in pregnancy				
42 Obstructed labour				
43 Puerperal Sepsis				
44 Haemorrhage in pregnancy (APH and/or PPH)				

Diagnosis	0-4 yrs		5 and over	
	Male	Female	Male	Female
1.3.4 Maternal and Perinatal Diseases				
45 Neonatal septicemia				
46 Perinatal conditions in newborns (0-7 days)				
47 Neonatal conditions in newborns (8 – 28 days)				
1.3.5 Non Communicable Diseases				
48 Anaemia				
49 Asthma				
50 Periodontal diseases				
51 Diabetes mellitus				
52 Bipolar disorders				
53 Hypertension				
54 Depression				
55 Schizophrenia				
56 HIV related psychosis				
57 Anxiety disorders				
58 Alcohol abuse				
59 Drug abuse				
60 Childhood Mental Disorders				
61 Epilepsy				
62 Dementia				
63 Other forms of mental illness				
64 Cardiovascular diseases				
65 Gastro-Intestinal Disorders (non-Infective)				
66 Severe Acute Malnutrition (Marasmus, Kwashiorkor, Marasmic-kwash)				
67 Jaw injuries				
68 Injuries- Road traffic Accidents				
69 Injuries due to Gender based violence				
70 Injuries (Trauma due to other causes)				
71 Animal bites				
72 Snake bites				
1.3.6 Minor Operations in OPD				
73 Tooth extractions				
74 Dental Fillings				
1.3.7 Neglected Tropical Diseases (NTDs)				
75 Leishmaniasis				
76 Lymphatic Filariasis (hydrocele)				
77 Lymphatic Filariasis (Lymphoedema)				
78 Urinary Schistosomiasis				
79 Intestinal Schistosomiasis				
80 Onchocerciasis				
81 Other diagnoses (specify priority diseases for District)				
82 Deaths in OPD				
83 All others				
Total Diagnoses				



HMIS FORM123: DISTRICT/HSD OUTPATIENT MONTHLY REPORT

2.9 TETANUS IMMUNISATION (TT VACCINE)			
Doses	Pregnant women	Non-pregnant women	Immunisation in School
T1-Dose 1			
T2-Dose 2			
T3-Dose 3			
T4-Dose 4			
T5-Dose 5			

2.10 HPV VACCINATION	
Vaccination of girls	Number
V1-HPV1-Dose 1	
V2-HPV2-Dose 2	
V3-HPV3-Dose 3	

Doses	Under 1		1-4 Years	
	Male	Female	Male	Female
I1-BCG				
I2-Protection At Birth for TT (PAB)				
I3-Polio 0				
I4-Polio 1				
I5-Polio 2				
I6-Polio 3				
I7-DPT-HepB+Hib 1				
I8-DPT-HepB+Hib 2				
I9-DPT-HepB+Hib 3				
I10-PCV 1				
I11-PCV 2				
I12-PCV 3				
I13-Rotavirus 1				
I14-Rotavirus 2				
I15-Rotavirus 3				
I16-Measles				
I17-Fully immunized by 1 year				
I18-DPT-HepB+Hib doses wasted				

3. HIV/AIDS COUNSELING AND TESTING (HCT)

Category	No. of individuals 0- <2 years		No. of individuals 2-<5 years		No. of individuals 5 - <15 years		No. of individuals 15 - 49 years		No. of individuals >49 years		Total
	M	F	M	F	M	F	M	F	M	F	
H1-Number of Individuals counseled											
H2-Number of Individuals tested											
H3-Number of Individuals who received HIV test results											
H4- Number of individuals who received HIV results for the first time in this financial year											
H5-Number of Individuals who tested HIV positive											
H6-HIV positive individuals with suspected TB											
H7-HIV positive cases started on Cotrimoxazole preventive therapy (CPT)											
H8-Number of Individuals tested before in this financial year (Re-testers)											
H9-Number of individuals who were Counseled and Tested together as a Couple											
H10-Number of individuals who were Tested and Received results together as a Couple											
H11-Number of individuals with Concordant positive results											
H12- Number of individuals with Discordant results											
H13-Individuals counseled and tested for PEP											
H14-Number provided with Safe Male Circumcision											

4. OUTREACH ACTIVITIES

Category	Number Planned	Number Carried out
OA1-EPI outreaches		
OA2-HCT outreaches		
OA3-Environmental health visits		
OA4-Health education/promotion outreaches		
OA5-Other outreaches		
Martemal & Perinatal Death Audits		

HMIS FORM 123: DISTRICT/HSD OUTPATIENT MONTHLY REPORT

5. ESSENTIAL DRUGS, VACCINES AND CONTRACEPTIVES

5.1 STOCK-OUTS

Note: Out of stock means that there was NONE left in your health unit STORE.

Enter the number of stock out days for the following tracer items (in order for the HSD and DHT to follow up the issue)			Add the name of other drugs, vaccines, contraceptives or supplies that suffered a stock out during the month					
Name	Tick if out of stock	No. of days of stock out	Number of Days of Stockout (DOS)					
HSSP indicator Item: Tracer Medicines found in all level of health facilities (HC II to Hospitals)			No.	Name	DOS	No.	Name	DOS
First Line drug for Malaria *			1			21		
Quinine tabs			2			22		
Cotrimoxazole			3			22		
ORS sachets			4			23		
Measles Vaccine			4			24		
Fansidar			5			25		
Depo-Provera			6			26		
To be filled by all Health Facilities offering HIV/AIDS and TB treatment			7			27		
HIV testing kits	Screening		8			28		
	Confirmatory		9			29		
	Tie-breaker		10			30		
ARVs First line	AZT/3TC/NVP		11			31		
	AZT/3TC		12			32		
	TDF/3TC		13			33		
	FTC		14			34		
	NVP		15			35		
1 st line Anti TB medicine	EFV		16			36		
	HRZE		17			37		
	EH		18			38		
	RH		19			39		
			20			40		

*This refers to the drug recommended in the National policy at the time

5.2 CONSUMPTION DATA

Please indicate the total number of doses consumed for each category of drugs under the respective age group.

Drug Item	4months – 3yrs	3+ - 7yrs	7+ - 12yrs	12+	TOTAL
No. of Yellow ACT doses dispensed					
No. of Blue ACT doses dispensed					
No. of Brown ACT doses dispensed					
No. of Green ACT doses dispensed					
Quinine					
Cotrimoxazole tabs					
Amoxicillin Capsule					
ORS sachets					
Measles Vaccine					
Fansidar					
Depo-Provera					

HMIS FORM 123: DISTRICT/HSD OUTPATIENT MONTHLY REPORT
6. LABORATORY TESTS

Laboratory Tests	Number Done		Number Positive				
	0-4 years	5 and over	0-4 years	5 and over			
Haematology (Blood)							
01 HB							
02 WBC Total							
03 WBC Differential							
04 Film Comment							
05 ESR							
06 RBC							
07 Bleeding time							
08 Prothrombin time							
09 Clotting time							
10 Others							
Blood Transfusion							
11 ABO Grouping							
12 Coombs							
13 Cross Matching							
Parasitology							
14 Malaria microscopy							
15 Malaria RDTs							
16 Other Haemoparasites							
17 Stool Microscopy							
Serology							
18 VDRL/RPR							
19 TPHA							
20 Shigella Dysentery							
21 Syphilis Screening							
22 Hepatitis B							
23 Brucella							
24 Pregnancy Test							
25 Widal Test							
26 Rheumatoid Factor							
27 Others							
HIV tests by purpose							
Type of test	HCT		PMTCT		Clinical Diagnosis	Quality Control	Total
55 Repeat testers							
56 Determine							
57 Statpak							
58 Unigold							

Laboratory Tests	Number Done		Number Positive	
	0-4 years	5 and over	0-4 years	5 and over
Immunology				
28 CD4 tests & others				
Microbiology (CSF Urine, Stool, Blood, Sputum, Swabs)				
29 ZN for AFBs				
30 Cultures and Sensitivities				
31 Gram				
32 Indian Ink				
33 Wet Preps				
34 Urine Microscopy				
Clinical Chemistry				
Renal Profile				
35 Urea				
36 Calcium				
37 Potassium				
38 Sodium				
39 Creatinine				
Liver Profile				
40 ALT				
41 AST				
42 Albumin				
43 Total Protein				
Lipid/Cardiac Profile				
44 Triglycerides				
45 Cholesterol				
46 CK				
47 LDH				
48 HDL				
Miscellaneous				
49 Ikaline Phos				
50 Amylase				
51 Glucose				
52 Uric Acid				
53 Lactate				
54 Others				

HMIS FORM 123: DISTRICT/HSD OUTPATIENT MONTHLY REPORT

7. FINANCIAL SUMMARY

	Budget line	Funds budgeted	Funds received	Funds spent
1	PHC Wage			
2	PHC Non-Wage Recurrent			
3	PHC (NGO)			
4	PHC Development			
5	Local Governments			
6	Credit Lines (Drugs)			
7	Donor projects			
8	Others specify			
	TOTAL			

8. COMMENTS BY DHO/HSD Incharge

Date of Report: _____

Name of DHO/HSD i/c _____ Title _____ Signature _____

Witness Name _____ Title _____ Signature _____

----- (MOH use below this line) -----

Date received		
Received by 28th of next month	Yes	No
Checked by (signature)		
Date processed		

Technical Module 7: Information Systems and Routine Reporting

HMIS FORM 105: HEALTH UNIT OUTPATIENT MONTHLY REPORT

DESCRIPTION AND INSTRUCTIONS

- Objective:** Reports the monthly attendance figures for MCH/FP and OPD, diagnoses for OPD, Lab, HIV/AIDS service data, stockouts of essential drugs and supplies and financial data.
- Timing:** 7th of the following month
- Copies:** Two Copies. One sent to the HSD and another one sent to the DHO. For General Hospitals, Regional Referral Hospitals, and National Referral Hospitals, a copy should also be sent to the Ministry of Health Resource Centre Division.
- Responsibility:** Health Unit In-Charge

PROCEDURE:

1. All health units must submit the HEALTH UNIT OUT-PATIENT MONTHLY REPORT (HMIS 105).

Page 1 contains:

Section 1 with three sub-sections (1.1-OPD ATTENDANCES, 1.2-REFERRALS AND 1.3-OUTPATIENT DIAGNOSES). The values are obtained from tables 1a, 1b, 1c and 1d (Health Unit Outpatient diagnoses). If the district wishes to include additional diseases of local interest, they may do so under the variable of other diagnoses. The DHMT will be responsible for ensuring all the health units in the district are aware of the chosen additional diagnoses.

3. Page 2 contains:
Section 2, shows a summary of Maternal and Child Health Services, it includes sub-sections (2.1-Antenatal, 2.2-Maternity, 2.3-Postnatal, 2.4-Exposed Infant Diagnosis services, 2.5-Family Planning Methods, 2.6-Contraceptives dispensed, 2.7-Operating theatre, 2.8-Child Health and immunisation data in sub-sections 2.9, 2.10 and 2.11 on page 3. The values are obtained from Table 2 (Health Unit Maternal Health Attendance Summary), Table 3 (Health Unit EPI Attendance Summary), Table 4 (Health Unit Family Planning Summary) and Table 5 (HIV/AIDS Services Summary). Information on ACTs is obtained from reports sent every month by the VHT to the Health Unit.
4. Page 3 contains:
Sub-section 2.9-Tetanus Immunisation, 2.10-HPV vaccination for girls and 2.11-Child Immunisation, section 3 (HIV Counseling & Testing (HCT), and section 4 (Outreach Activities). Information is obtained from Table 3 (Health Unit EPI Attendance Summary), Table 5 (HIV/AIDS Services Summary) and the Health Unit Workplan for outreach activities.

Note: DPT-HepB+Hib vaccine doses wasted = doses accessed – doses administered to children in a given reporting period (in this case a month) where:

Technical Module 7: Information Systems and Routine Reporting

- Doses accessed = (Start of month Balance + Total doses received in a month) – (End of month balance + Doses given to other Units)
- Doses administered = Total Number of children (under and above 1 year) immunized in a reporting period

For BCG, children above one year receive twice as many doses of vaccine as the under one year olds and therefore total number of doses administered = No of children <1yr immunized + No of children >1yr immunized x 2.

5. Page 4 contains:
Section 5: Includes sub-section 5.1-Stock-outs and 5.2-Consumption data. These values are obtained from the Table 9 (Health Unit Record of Stock-out) and Table 16 (Health Unit Consumption Summary).

Note: The storekeeper should also report verbally when the stock levels reach minimum stock level.

6. Page 5 contains:
Section 6: Includes a summary of laboratory tests. The information is obtained from Table 17 (Laboratory Tests Monthly Summary).

7. Page 6 contains:
Sections 8 (financial summary): The information for the financial summary is obtained from Table 14a (Monthly Financial Summary).

Section 9 (comments by the health facility in-charge): A copy of the comments should be written in the health unit's LOGBOOK. Comments by Health Sub-district should be written at the end of the health unit monthly report.



HMIS FORM 105: HEALTH UNIT OUTPATIENT MONTHLY REPORT

Health Unit _____ Level _____ Code _____ District _____ Health Sub-district _____

Sub-county _____ Parish _____ Reporting month of _____

1. OPD ATTENDANCES, REFERRALS AND DIAGNOSES TOTALS FOR THE MONTH

1.1 OUTPATIENT ATTENDANCE

Category	0-4 years		5 and over	
	Male	Female	Male	Female
New attendance				
Re-attendance				
Total Attendance				

1.2 OUTPATIENT REFERRALS

Category	0-4 years		5 and over	
	Male	Female	Male	Female
Referrals to unit				
Referrals from unit				

1.3. OUTPATIENT DIAGNOSES

Diagnosis	0-4 years		5 and over	
	Male	Female	Male	Female
1.3.1 Epidemic-Prone Diseases				
01 Acute flaccid paralysis				
02 Cholera				
03 Dysentery				
04 Guinea worm				
05 Bacterial Meningitis				
06 Measles				
07 Tetanus (Neonatal) (0 –28 days age)				
08 Plague				
09 Rabies				
10 Yellow Fever				
11 Other Viral Haemorrhagic Fevers				
12 Severe Acute Respiratory Infection (SARI)				
13 Adverse Events Following Immunization (AEFI)				
14 Other Emerging infectious Diseases, specify e.g. small pox, ILI, SARS				
1.3.2 Other Infectious/Communicable Diseases				
15 Diarrhea- Acute				
16 Diarrhea- Persistent				
17 Ear Nose and Throat (ENT) conditions				
18 Ophthalmia neonatorum				
19 Other Eye conditions				
20 Urethral discharges				
21 Genital ulcers				
22 Sexually Transmitted Infection due to SGBV				
23 Other Sexually Transmitted Infections				
24 Urinary Tract Infections (UTI)				
25 Intestinal Worms				
26 Leprosy				
27 Malaria				
28 Other types of meningitis				
29 No pneumonia - Cough or cold				
30 Pneumonia				
31 Skin Diseases				
32 Tuberculosis (New smear positive cases)				
33 Other Tuberculosis				
34 Typhoid Fever				
35 Tetanus (over 28 days age)				
36 Sleeping sickness				
37 Pelvic Inflammatory Disease (PID)				
1.3.3 Maternal and Perinatal Diseases				
38 Abortions due to Gender-Based Violence (GBV)				
39 Abortions due to other causes				
40 Malaria in pregnancy				
41 High blood pressure in pregnancy				
42 Obstructed labour				
43 Puerperal Sepsis				
44 Haemorrhage in pregnancy (APH and/or PPH)				

Diagnosis	0-4 yrs		5 and over	
	Male	Female	Male	Female
1.3.4 Maternal and Perinatal Diseases				
45 Neonatal septicemia				
46 Perinatal conditions in newborns (0-7 days)				
47 Neonatal conditions in newborns (8 – 28 days)				
1.3.5 Non Communicable Diseases				
48 Anaemia				
49 Asthma				
50 Periodontal diseases				
51 Diabetes mellitus				
52 Bipolar disorders				
53 Hypertension				
54 Depression				
55 Schizophrenia				
56 HIV related psychosis				
57 Anxiety disorders				
58 Alcohol abuse				
59 Drug abuse				
60 Childhood Mental Disorders				
61 Epilepsy				
62 Dementia				
63 Other forms of mental illness				
64 Cardiovascular diseases				
65 Gastro-Intestinal Disorders (non-Infective)				
66 Severe Acute Malnutrition (Marasmus, Kwashiorkor, Marasmic-kwash)				
67 Jaw injuries				
68 Injuries- Road traffic Accidents				
69 Injuries due to Gender based violence				
70 Injuries (Trauma due to other causes)				
71 Animal bites				
72 Snake bites				
1.3.6 Minor Operations in OPD				
73 Tooth extractions				
74 Dental Fillings				
1.3.7 Neglected Tropical Diseases (NTDs)				
75 Leishmaniasis				
76 Lymphatic Filariasis (hydrocele)				
77 Lymphatic Filariasis (Lymphoedema)				
78 Urinary Schistosomiasis				
79 Intestinal Schistosomiasis				
80 Onchocerciasis				
81 Other diagnoses (specify priority diseases for District)				
82 Deaths in OPD				
83 All others				
Total Diagnoses				

HMIS FORM105: HEALTH UNIT OUTPATIENT MONTHLY REPORT

2.9 TETANUS IMMUNISATION (TT VACCINE)			
Doses	Pregnant women	Non-pregnant women	Immunisation in School
T1-Dose 1			
T2-Dose 2			
T3-Dose 3			
T4-Dose 4			
T5-Dose 5			

2.10 HPV VACCINATION	
Vaccination of girls	Number
V1-HPV1-Dose 1	
V2-HPV2-Dose 2	
V3-HPV3-Dose 3	

2.11 CHILD IMMUNISATION				
Doses	Under 1		1-4 Years	
	Male	Female	Male	Female
I1-BCG				
I2-Protection At Birth for TT (PAB)				
I3-Polio 0				
I4-Polio 1				
I5-Polio 2				
I6-Polio 3				
I7-DPT-HepB+Hib 1				
I8-DPT-HepB+Hib 2				
I9-DPT-HepB+Hib 3				
I10-PCV 1				
I11-PCV 2				
I12-PCV 3				
I13-Rotavirus 1				
I14-Rotavirus 2				
I15-Rotavirus 3				
I16-Measles				
I17-Fully immunized by 1 year				
I18-DPT-HepB+Hib doses wasted				

3. HIV/AIDS COUNSELING AND TESTING (HCT)

Category	No. of individuals 0- <2 years		No. of individuals 2-<5 years		No. of individuals 5 - <15 years		No. of individuals 15 - 49 years		No. of individuals >49 years		Total
	M	F	M	F	M	F	M	F	M	F	
H1-Number of Individuals counseled											
H2-Number of Individuals tested											
H3-Number of Individuals who received HIV test results											
H4- Number of individuals who received HIV results for the first time in this financial year											
H5-Number of Individuals who tested HIV positive											
H6-HIV positive individuals with suspected TB											
H7-HIV positive cases started on Cotrimoxazole preventive therapy (CPT)											
H8-Number of Individuals tested before in this financial year (Re-testers)											
H9-Number of individuals who were Counseled and Tested together as a Couple											
H10-Number of individuals who were Tested and Received results together as a Couple											
H11-Number of individuals with Concordant positive results											
H12- Number of individuals with Discordant results											
H13-Individuals counseled and tested for PEP											
H14-Number provided with Safe Male Circumcision											

4. OUTREACH ACTIVITIES

Category	Number Planned	Number Carried out
OA1-EPI outreaches		
OA2-HCT outreaches		
OA3-Environmental health visits		
OA4-Health education/promotion outreaches		
OA5-Other outreaches		
Marternal & Perinatal Death Audits		



HMIS FORM 105: HEALTH UNIT OUTPATIENT MONTHLY REPORT

5. ESSENTIAL DRUGS, VACCINES AND CONTRACEPTIVES

5.1 STOCK-OUTS

Note: Out of stock means that there was NONE left in your health unit STORE.

Enter the number of stock out days for the following tracer items (in order for the HSD and DHT to follow up the issue)		
Name	Tick if out of stock	No. of days of stock out
HSSP indicator Item: Tracer Medicines found in all level of health facilities (HC II to Hospitals)		
First Line drug for Malaria *		
Quinine tabs		
Cotrimoxazole		
ORS sachets		
Measles Vaccine		
Fansidar		
Depo-Provera		
To be filled by all Health Facilities offering HIV/AIDS and TB treatment		
HIV testing kits	Screening	
	Confirmatory	
	Tie-breaker	
ARVs First line	AZT/3TC/NVP	
	AZT/3TC	
	TDF/3TC	
	FTC	
	NVP	
	EFV	
1 st line Anti TB medicine	HRZE	
	EH	
	RH	

Add the name of other drugs, vaccines, contraceptives or supplies that suffered a stock out during the month					
Number of Days of Stockout (DOS)					
No.	Name	DOS	No.	Name	DOS
1			21		
2			22		
3			22		
4			23		
4			24		
5			25		
6			26		
7			27		
8			28		
9			29		
10			30		
11			31		
12			32		
13			33		
14			34		
15			35		
16			36		
17			37		
18			38		
19			39		
20			40		

*This refers to the drug recommended in the National policy at the time

5.2 CONSUMPTION DATA

Please indicate the total number of doses consumed for each category of drugs under the respective age group.

Drug Item	4months – 3yrs	3+ - 7yrs	7+ - 12yrs	12+	TOTAL
No. of Yellow ACT doses dispensed					
No. of Blue ACT doses dispensed					
No. of Brown ACT doses dispensed					
No. of Green ACT doses dispensed					
Quinine					
Cotrimoxazole tabs					
Amoxicillin Capsule					
ORS sachets					
Measles Vaccine					
Fansidar					
Depo-Provera					



HMIS FORM 105: HEALTH UNIT OUTPATIENT MONTHLY REPORT

6. LABORATORY TESTS

Laboratory Tests	Number Done		Number Positive					
	0-4 years	5 and over	0-4 years	5 and over				
Haematology (Blood)								
01 HB								
02 WBC Total								
03 WBC Differential								
04 Film Comment								
05 ESR								
06 RBC								
07 Bleeding time								
08 Prothrombin time								
09 Clotting time								
10 Others								
Blood Transfusion								
11 ABO Grouping								
12 Coombs								
13 Cross Matching								
Parasitology								
14 Malaria microscopy								
15 Malaria RDTs								
16 Other Haemoparasites								
17 Stool Microscopy								
Serology								
18 VDRL/RPR								
19 TPHA								
20 Shigella Dysentery								
21 Syphilis Screening								
22 Hepatitis B								
23 Brucella								
24 Pregnancy Test								
25 Widal Test								
26 Rheumatoid Factor								
27 Others								
HIV tests by purpose								
Type of test	HCT		PMTCT		Clinical Diagnosis	Quality Control	Total	
55 Repeat testers								
56 Determine								
57 Statpak								
58 Unigold								
Laboratory Tests					Number Done		Number Positive	
					0-4 years	5 and over	0-4 years	5 and over
Immunology								
28 CD4 tests & others								
Microbiology (CSF Urine, Stool, Blood, Sputum, Swabs)								
29 ZN for AFBs								
30 Cultures and Sensitivities								
31 Gram								
32 Indian Ink								
33 Wet Preps								
34 Urine Microscopy								
Clinical Chemistry								
Renal Profile								
35 Urea								
36 Calcium								
37 Potassium								
38 Sodium								
39 Creatinine								
Liver Profile								
40 ALT								
41 AST								
42 Albumin								
43 Total Protein								
Lipid/Cardiac Profile								
44 Triglycerides								
45 Cholesterol								
46 CK								
47 LDH								
48 HDL								
Miscellaneous								
49 Ikaline Phos								
50 Amylase								
51 Glucose								
52 Uric Acid								
53 Lactate								
54 Others								



HMIS FORM 105: HEALTH UNIT OUTPATIENT MONTHLY REPORT

7. FINANCIAL SUMMARY

	Budget line	Funds budgeted	Funds received	Funds spent
1	PHC Wage			
2	PHC Non-Wage Recurrent			
3	PHC (NGO)			
4	PHC Development			
5	Local Governments			
6	Credit Lines (Drugs)			
7	Donor projects			
8	Others specify			
	TOTAL			

8. COMMENTS BY HEALTH FACILITY IN CHARGE

Date of Report: _____

In - Charge Name _____ Title _____ Signature _____

Contacts of the HU in-charge Phone No.: _____ e-mail address: _____

Witness Name _____ Title _____ Signature _____

----- (HSD use below this line) -----

Date received		
Received by 7th of next month	Yes	No
Checked by (signature)		
Date processed		

COMMENTS BY HSD:

ANNEX 4: HMIS STRENGTHENING STRIDES' SUPPORT TO HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS) IN STRIDES COLLABORATING DISTRICTS

STRIDES support in strengthening HMIS in the districts will focus on four main components and these may be implemented concurrently. These components include: (i) training in HMIS; (ii) ensuring ongoing presence of HMIS formats; (iii) ensuring support supervision and (iv) providing technical assistance for quality assurance for HMIS data.

Approaches to HMIS support

HMIS-support 1: capacity building/training for HMIS staff

This section presents the guiding principles for training and the subsequent training plan for staff in health-facilities and districts that are responsible for preparing the monthly HMIS reports. STRIDES in collaboration with the Ministry of Health-Resource Centre will conduct training for three categories of people as follows;

- The staff-member¹ in the HF that is responsible for reporting on HMIS to the district HMIS focal person
- Data officers to be trained on data-recording and reporting in the clinical trainings
- District HMIS focal persons

Guiding principles of the HMIS training

STRIDES has developed a number of guiding principles to be followed during the training of staff that are responsible for HMIS reporting. According to the STRIDES baseline conducted in September 2009, many of the official HMIS-positions in HC-III and higher levels are not filled. This means that the HMIS tasks are implemented by staff that have not been trained in data recording, collating and reporting. In addition to this, at the level of HC-II, it is the HF in-charge who is responsible for completing the required HMIS reports. The in-charge often is a health worker who has had no specific training in HMIS.

In view of the above, the guiding principles for training HMIS-staff include the following:

- a. Training sessions will be conducted at regional or district level for all cadres that have the responsibility for HMIS at HF and district levels.

¹ In a HC-II this is the in-charge of the HU. In the higher level HU there are HMIS-specific staff; in a HC-III it is a records-assistant; in a HC-IV it is a records-officer; in a hospital there are two records-assistants and at district level there is a HMIS focal person. The District Baseline study by STRIDES in September 2009 found that there are a large number of vacancies with just fewer than 50% of all the required HMIS positions filled.

- b. All health facilities in the selected health sub district (HSD) will be included in the training.
- c. All HMIS staff will be trained in the revised HMIS regardless of whether they had received HMIS training before the revised HMIS was introduced.
- d. For different districts, the training sessions may be pooled according to numbers and or qualification of participants.
- e. The content and duration of the training shall be tailored to the needs of the trainees and they will have interactive exercises during the training.
- f. The MoH HMIS training manual shall be used to conduct the training. The training will concentrate on HMIS sections on RH, FP and CS.
- g. Selected MoH trainers at district or national levels will facilitate the training.
- h. The experiences during the first training for each level will be used to fine-tune the design for further training.
- i. The STRIDES M&E unit will organize a one-day orientation for the facilitators/trainers that shall participate in the entire STRIDES supported training sessions.

Summary of training content

Overall STRIDES, will use or adapt as appropriate the MoH HMIS training manual. The specific training for HMIS-staff will mainly focus on three subject areas and these include;

- a. Utilizing and filling in the registers, records and formats that are used by health workers working in the service delivery areas of; reproductive health, family planning and child survival.
- b. Compiling and writing the facility based monthly report that is submitted to the district.
- c. Conducting data verification of compiled data and ensuring data utilization at health facility and district levels.

The number and timing of trainings

In project year 3, STRIDES is working with the following HFs: 230 HC-II, 125 HC-III, 28 HCIV and 14 hospitals and the number will increase in project years three and four. The total number of persons to be trained and actual number of trainings will be based on the project annual work plans and identified needs in the district.

Time-schedule of residential training for HMIS-staff

Time	Training content
Day one	
8:00 – 9:00 am	8:00 am: Registration and Introduction.
9:00 - 1:00 pm	Key-messages on HMIS, registers, records and formats on ANC and maternity.
2:00 – 5:00pm	Discussions on the registers, records and other related formats on RH/FP and CS
Day two	
8:00 – 9:00 am	Review of previous day.
9:00 - 11:00 am	The HMIS-123 report.
11:00 - 1:00 pm	Exercise on data verification and use of HMIS data for management purposes. Presentation and discussion.
2:00 - 4:00 pm	Presentation and discussion continue in plenary.
4:00 - 5:00 pm	Action points and closure.
5:00 pm	Departure of participants.

HMIS-support 2: Ensuring ongoing presence of HMIS formats

In addition to training of HMIS staff at various levels, STRIDES will wherever possible ensure the steady supply of the HMIS registers records and formats. The absence of these HMIS reporting formats is a hindrance by HF staff to provide information required for the HMIS.

HMIS-support 3: Ensuring support supervision

STRIDES will also assist in improving the quality of HMIS by ensuring that the HFs receives support supervision in HMIS from the district health office. Budgets at the district health office are constrained and it is often supervision that bears the consequences in terms of a decreased frequency and hasty visits by too many health office staff at the same time. STRIDES can do this by insisting that this supervision is guaranteed by the district as part of the MoUs.

HMIS-support 4: Technical assistance for quality assurance for HMIS data

Technical assistance may be provided during field support visits, meetings, on-the-job training and mentoring, and during data verification exercises as described in section 5.0 of the manual. Technical assistance will be provided on a needs basis and as identified by STRIDES during the training and data verification exercises.



ANNEX 5

GUIDELINES FOR THE TRAINING RESULTS AND INFORMATION NETWORK (TRAINET) DATABASE

Monitoring and Evaluation Unit

Version 1, June 2010



Background

Training Results and Information Network (TraiNet) is the official USAID's training database that facilitates performance tracking, analysis, and reporting training by country and by activity. Originally, primary interest was in training in the U.S. and third-country, now the use of TraiNet is required for in-country training as per USAID ADS 253.3.1.5. It is not necessary to list each individual that will attend/attended the in-country training activity, just the number split by gender (i.e. 100 participants - 80 females and 20 males). The information may be entered after training activity takes place. However, Mission recommends that it is entered within the month of the training activity taking place. The data required to enter into TraiNet for in-country are:

- Name of training program
- Program start and end date
- Estimated cost
- Number of participants by gender

Note: STRIDES M&E team opted to use the “third country” option to permit for entry of training participant details, rather than just the total numbers disaggregated by gender. The data required to enter into TraiNet for third-country program are:

- **Program Information**
 - Program name
 - Start and end dates
 - Method of training
 - Training type
- **Top Tier Data**
 - Activity
 - Strategic objective
 - Intermediate result
 - Training provider address
- **Training Provider Address**
 - Training Provider Name and address
-



This document and the guidelines herein focus on data entry into the third-country program option.

Accessing the database

Every organization submits two staff members who are then issues with passwords to access the database. STRIDES authorized staff members at the moments are

1. Rachel Kagoya Kibuule, National M&E Coordinator, as the primary staff
2. Celia Kakande, Director M&E as the backup liaison staff (*yet to get password in replacement of Elke*)

Data entry (all fields)

Section 1: Program Information

Program Instructions

1. Enter a name for this Training Program.
2. Enter the date the training will begin and end.
3. Choose a Training Type from the Training Type List.

Click the Help button beside the Training Type List for an explanation of the different Training Types.

4. Select the Method of Training for this program. The method of training represents how the training is being delivered. For help on the different types of Methods of Training, click the Help button next to the Method of Training List.
5. Select the Mission site that this program will support. This selection will determine which top tier data this program can use.

The information entered into this wizard will not be saved until the final page. Clicking the cancel button will remove all data previously entered during the course of the wizard.

Program Name

Start Date

 (MM/DD/YYYY) 

End Date

 (MM/DD/YYYY) 



Method Of Training Help

Note: Method of Training Help

Traditional

The Traditional method of training represents training that is done in person.

Distance Learning

The Distance Learning method of training represents training that is not done in person. Examples of this method of training may include courses completed on-line and video conferences.

For this particular section, select Traditional method as it is the most applicable option for most of STRIDES planned trainings.

Training Type Help

Note: Training Type Help

Degree Programs

Two-year degree

Associate or other degree received after successfully completing a two-year academic course of study

Four-year degree

Bachelor or other degree received after successfully completing a four-year academic course of study

Masters Degree

Masters degree in any field

Doctoral degree

Doctor of Philosophy (PhD) or equivalent degree

Professional degree

A non-academic program that results in a professional certificate or other certification

Non-Degree Programs

English Language Training

English language courses outside of or in addition to some other course of study: for example, in preparation for academic study.

Other Academic

Training that includes academic coursework but does not lead to an academic degree

Short course

A shortened survey or overview course of a given discipline or skill area

Tailored Program



A set of courses or a program of study designed specifically for the unique needs of the participant(s)

Internship

A short-term, unpaid position in a business or other establishment for the purpose of learning a job or skill

On-the-job Training

Training program organized to allow participants to learn new knowledge, skills, or attitudes in the course of performing their jobs

Meetings/Tours

Conference

A gathering of participants from government, academia, or the private sector for the purpose of exchanging ideas about a particular topic, issue, or problem

Observational Study Tour

A trip organized to allow participants to observe real-world approaches to policy implementation, business processes, or other topics through the direct observation or interaction with businesses, government agencies, or other establishments.

Seminar

A series of classes or courses on a specific topic taught by experts in the subject matter

Workshop

An informal meeting or series of sessions organized to allow participants to learn about a particular subject in an informal setting

For this particular section, select tailored program as it is the most applicable option for most of STRIDES planned trainings.

Mission Site (USAID office that is sponsoring this program)



There is only one option “UGAMIS” so select that.

Section 2: Top Tier Data

Top Tier Data Instructions

1. Select an activity from the dropdown for this Training Program.
2. Select a strategic objective from the list for this Training Program. Use the button to view a list of intermediate results for the selected strategic objective.
3. Select an intermediate result from the list or select No Intermediate Result if there is not one for this Training Program.



The information entered into this wizard will not be saved until the final page. Clicking the cancel button will remove all data previously entered during the course of the wizard.

Activity

STRIDES (Family Planning/Reproductive Health and Child Survival) (FP/RH/CS)



Select STRIDES (Family Planning/Reproductive Health and Child Survival) (FP/RH/CS) option in drop down menu.

Strategic Objective

SO8 Improved Human Capacity (Education, Health, HIV/AIDS)



Select SO8 improved Human Capacity (Education, Health, and HIV/AIDS) from the drop down menu

Display Intermediate Results

Strategic Objective

SO8 Improved Human Capacity (Education, Health, HIV/AIDS)



Display Intermediate Results

- No Intermediate Result
- IR. 8.1.1 Improved Quality of Social Sector Services
- IR. 8.1.2 Increased Availability of Social Sector Services
- IR. 8.1.3 Increased Accessibility of Social Sector Services
- IR. 8.1.4 Increased Acceptability of Social Sector Services
- IR. 8.1 Effective Use of Social Sector Services
- IR. 8.2.1 Improved Decentralized Financing, Planning, Management and Monitoring Systems
- IR. 8.2.2 Increased Private Sector Role in Service Delivery
- IR. 8.2 Increased Capacity to Sustain Social Sector Services
- IR. 8.3.1 Increased Transparency, Accountability and Ownership of Social Sector Processes and Outcomes
- IR. 8.3.2 Improved Leadership in the Social Sectors
- IR. 8.3.3 Evidence based Sectoral Policies and Programs Implemented
- IR. 8.3 Strengthened Enabling Environment for Social Sector Services



Select appropriate IR from the list, based on the nature of the training and which indicator it is satisfying.

Section 3: Training Provider Address

Training Location Instructions

1. Select a Training Provider from the dropdown list.

If the required Training Provider is not in the list, click the Create Provider button to create a new Training Provider.

2. Select how you would like to input the address of the Provider

Select the first button to input the address information yourself.

Select the second option to view the last three addresses associated with the selected provider.

Training Provider Name

Tentatively, STRIDES project was entered / created as the provider because it is the unifying factor for all training facilitation; given the diversity of trainers engaged who include Jhpiego, National trainers, district trainers, private trainers and technical project staff

- Add new Training Provider address
- Search previous Training Provider addresses for the selected provider

For training provider address, select the “search previous training provider address as the STRIDES project address has already been entered in the database.

Section 4: Training Provider Address

Choose Training Provider Address Instructions



1. Select one of the previously entered Training Provider addresses.

If none of the addresses listed are the address for this program, select the last option and you will be able to create a new address.

Training Provider Address

- STRIDES For Family Health, MSH Uganda
Kampala P. O. Box 71419,
Uganda
+256 414 235 038/43, +256312303100
- STRIDES For Family Health, MSH Uganda
Kampala P. O. Box 71419,
Uganda
+256 414 235 038/43, +256312303100
- None of the addresses listed are a match and I would like to enter the address information manually.

For this section, choose the STRIDES project address for the time being. (This is still under discussion)

Section 5: Program Subject

Subject Instructions

1. Select a Subject Field Category from the Subject Field Category dropdown.
2. Click the Display Subject Field Codes button. A list of relevant Subjects will be displayed for the selected Subject Field Category.
3. Select the appropriate Subject from the list.

Subject Field Code Category

Health-Related Knowledge And Skills  

Select Health-Related knowledge and skills from the drop down menu. This was considered the applicable category for most of the trainings. Otherwise, select category as found appropriate to the type of training.

Display Subject Field Codes



Subject

- Addiction Prevention and Treatment
- Birthing and Parenting Knowledge and Skills
- Health-Related Knowledge and Skills, Other
- Personal Health Improvement and Maintenance

Select the option of Health Related Knowledge and skills, other for subject field code. This was found to be most applicable based on unit discussions.

Section 6: USAID Funding

USAID Funding Instructions:

1. Enter the amount of money budgeted for this Program that comes from USAID funding sources. Enter the amounts in U.S. Dollars. The total budget from USAID funding sources must be greater than 0.00.

Budget amounts must be identified using the following expense types:

Instruction expenses include those costs directly incurred to convey knowledge or impart training, such as:

- Books, equipment, supplies, course handouts;
- Seminar/Conference/Workshop registration fees;
- Published academic tuition and fees.

Trainee expenses include those costs directly incurred to meet the personal needs and Program requirements of the individual Participant, such as:

- Per diem, medical examinations, visa fees;
- Health and accident insurance premium;
- Federal, state and local income taxes.

Travel expenses include those costs directly incurred transporting the Participant from the home country to the training country and back, as well as costs related to travel within the training country.

Funding format example: 1400.00 please note that commas and dollar signs are not allowed, and decimal places are not required. Negative funding amounts are not permitted and the maximum funding amount for each line item is 4000000.



Name	Budgeted Amount	Actual Amount
USAID Instruction	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text" value="0.0"/>
USAID Trainee	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text" value="0.0"/>
USAID Travel	<input type="text"/> <input checked="" type="checkbox"/>	<input type="text" value="0.0"/>

Insert budgeted amounts of USAID funding for the particular training. No actual amounts may be entered since this is optional.

Section 8: Non-USAID Funding

Non-USAID Funding Instructions:

Programs may be funded by sources other than USAID. If your program is funded by any of the sources listed below, please answer Yes to the question on this page. Otherwise, please answer No to the question on this page. Clicking the Next button on this page will take you to the next appropriate screen based on your answer.

- Host Country Government funding is money made available by the Participant's government;
- Private funding is money made available from private sources (such as the Participant's employer);
- Other funding is made available by other non-USAID sources that do not fit in another category.

Is this program also funded by Non-USAID sources?

- Yes
- No

Note: This would be on a case-by-case basis.

STRIDES could enlist other sources of funding for each training which could include cost share. These will have to be categorized according to the list provided.

Section 9: Non-USAID Funding (In case you stated “yes” in the previous section. This is optional and no data may be entered for USAID reporting.

Non-USAID Funding Instructions:



1. Enter the amount of money budgeted for this Program that comes from non-USAID funding sources. Enter the amounts in U.S. Dollars.

Non-USAID funding sources can be:

- Host Country Government funding is money made available by the Participant's government;
- Private funding is money made available from private sources (such as the Participant's employer);
- Provider funding is money made available by the entity providing the training.
- Other funding is made available by other non-USAID sources that do not fit in another category.

Budget amounts must be identified using the following expense types:

Instruction expenses include those costs directly incurred to convey knowledge or impart training, such as:

- Books, equipment, supplies, course handouts;
- Seminar/Conference/Workshop registration fees;
- Published academic tuition and fees.

Trainee expenses include those costs directly incurred to meet the personal needs and Program requirements of the individual Participant, such as:

- Per diem, medical examinations, visa fees;
- Health and accident insurance premium;
- Federal, state and local income taxes.

Travel expenses include those costs directly incurred transporting the Participant from the home country to the training country and back, as well as costs related to travel within the training country.

Funding format example: 1400.00 please note that commas and dollar signs are not allowed, and decimal places are not required. Negative funding amounts are not permitted and the maximum funding amount for each line item is 4000000.

Name	Amount
Host Country Government Instruction	<input type="text"/>
Host Country Government Trainee	<input type="text"/>
Host Country Government Travel	<input type="text"/>



Private Instruction

Private Trainee

Private Travel

Provider Instruction

Provider Trainee

Provider Travel

Other Instruction

Other Trainee

Other Travel

STRIDES could enlist other sources of funding for each training, which could include cost share. These will have to be categorized according to the list provided.

Pre-selected answers (project options/ choices) - *see highlighted sections*

Saving data entered: Click on the save box as seen on each page

Editing: Click the appropriate section on the start page. Select the section for which you want to edit information. Update the information and click "save".

ANNEX 6A: STRIDES Subcontractors' narrative reporting template

TEMPLATE FOR QUARTERLY REPORTING FOR PERFORMANCE BASED SUBCONTRACTORS

Name of contractor / contracting agency / organization: _____

Lot number: _____

District(s) of operation: _____

Reporting period: _____ to _____ 20__
 Start and end month of the quarter Year

Section 1: Introduction

(Content limit: NOT exceeding 500 words, Font - Times New Roman; Font size - 12)

- 1.1 Brief description of the project (give an overview of what you are focusing on)
- 1.2 Brief description of target beneficiaries, sub counties and district(s)

Section 2: Progress towards objectives

2.1 Objective:	
Results	Comments**
2.2 Objective:	

**Comments: Explain over or under achievement of targets

2.2 Challenges and actions taken / proposed.

2.3 Good practices or case studies

Give one or two success stories related to the project. Each story should not exceed half a page with a caption where applicable.

Section 3: Partnerships (also include public-private partnerships where applicable)

- 3.1 Brief description of partnerships (**NOT exceeding 100 words**)
- 3.2 List of partners by key service and service location (*Use the table format provided below*)

Key service area (FP/ RH/ CS)	Name of partner agency	District	Name of Service site	Sub county where site is located
1.				
2.				
3.				

Section 4: For outreach / distribution points (applicable to Lot 1 subcontractors)

4.1 Brief description of kind of outreaches conducted during the reporting period
(NOT exceeding 100 words)

4.2 List of service sites by district and sub county (Use the table format provided below)

District Name	Name of Outreach Site / distribution point	Name of Sub-County	Number of clients served	
			Male	Female
1.				
2.				
3.				

Section 5: PMP report template (required)

Subcontractors must attach the PMP reporting template (annex 5), clearly indicating the achievements against targets for the reporting period under consideration.

Report compiled by: _____ (Name)
(For contractor) _____ (Signature)
_____ (Date)

Report received by: _____ (Name)
(For STRIDES) _____ (Signature)
_____ (Date)

BCC ACTIVITY MONITORING TOOL-TALLY

This tool should be use to capture the number of people reached during the implementation of the following activities:
Nutrition fairs, Facility activations, community dialogue and other BCC activities

Tally [1]

Date of Activity: ___/___/___

Section A: Estimate of Adults attending the nutrition-focused activity

Instructions:

1. Identify a convenient time when to tally/take count of adults present at the activity, this time should not be at the beginning or towards the end of the activities.
2. Divide the crowd into two or 4 groups, assign two people per group to do a physical count of adults in each group, one person counts the male while another females. Add up all the females and males separately and record the result in the table below.

Adults	Estimated/actual number counted
Male	
Female	
Total A:	

Section B: Sampling of Adults with children

Instructions

1. Using a random procedure select sample of 30 adults and ask each of them question B-1 to B-4 when necessary. Select every 2nd person after randomly selecting the first adult until the sample of 30 is reached. To simplify this task identify 5 persons (preferably VHTs) and allocate each a segment of the crowd to count from.
2. If the response for question B-1 is No. do not ask any more question s and drop that person from the sample, but if the response is yes, ask question B-2 through B-4 .
3. If the response to question B-2 is Zero, record No in column B1 and a zero in column B2 ,B3 and B4. Else record yes in column B1 and a number mentioned in column B2 and in B3 and B4 respectively.
4. Record a Yes in Column B5 if the respondent confirms that his/her partner (Wife or husband) has also come alone to attend the activity.

Questions:

B-1: Do you have children under your care?

B-3: How many are boys/girls?

B-2: How many are less than 5years of age?

B-4: Did you come here today with your partner /spouse?

Sample No.	Has Children Under-5 (Yes/No)	Number of Children Under-5	Children's Gender		Came with Partner (Spouse) (Yes/No)
			B3	B4	
A	B1	B2	Boys	Girls	B5
1.					
2.					
3.					
4.					
5.					
6.					
	Total B1Y ^a	Total B2	Total B3B	Total B3G	Total B4Y ^a

^a add up only the Yes responses

Section C: Name & Signature VHT/Volunteer or participating STRIDES staff

Please sign this form after Assigned to estimate and take a sample for a specification location

Name of the VHT/Volunteer: _____ Sign: _____

PGTL 02: P&G, TOM'S SHOES AND NET DISTRIBUTION

Health Facility:

Health Sub-District:

District:

Sub-County:

DESCRIPTION OF COLUMNS:

Write the date on the first blank row. Nothing else is written on that row.

1. SERIAL NUMBER (S/No.):

The numbers should start with "1" on the first date of each month. A new serial number is given to a patient who comes with a new diagnosis and those who come as re-attendances.

2. CLIENT ID NUMBER:

Write the client's ID number that is written on the client's P&G, TOM's Shoes and LLITN distribution card. Note the client distribution card is issued to every eligible client who is to receive either the P&G Kit or TOM' shoes or Nets

3. NAME OF CLIENT:

Write the client's surname and the first name/others names in full as appropriate

4. AGE:

Write the client's age in complete years if the patient is over one year of age. Write the Client's age in months if the client is under one year of age and write clearly "MTH" after the age. Write the patient's age in days if the patient is less than one month of age and write clearly "Days" after the age.

5. SEX:

Write the Sex (Gender) of the patient. Indicate M for male and F for female.

6. VILLAGE/PARISH:

Write the either village or parish name where the client is known to residence in.

7. TEL CONTACT:

Record the telephone number of the client. If the client has no telephone number, ask the client to give the telephone number of a relative or friend from whom s/he can be contacted.

8. P&G ITEMS:

Write the number of Hygiene kit given to the client. Note that each client i.e. pregnant women shall be issued a Hygiene kit at the first ANC contact visit, and this Kit shall contain

- 2 plastic buckets
- 1 wooden stick
- 1 cotton cloth
- 1 tab Meditex Soap
- 30 sachets P&G Purifier

OR write the number of P&C Purifier sachets given as a refill to the client who already received a hygiene kit. Note that pregnant women coming for the 2nd, 3th or 4th ANC visit receive 30 sachets of Purifier if they had already received 1 hygiene kit else they receive a full hygiene kit. On Delivery the mother receives a refill of 45 Sachets of P&G purifier and at PNC the mother receives a refill of 180 sachets.

9. TOM'S SHOES

Write the number and size of the Shoes given to the client

10. LLITNS

Write the number of Nets given to the client.

11. VISIT STATUS

Write the code for visit status of the client. The following codes are used.

ANC1 - 1st ANC visit

ANC2 - 2nd ANC visit

ANC3 - 3rd ANC visit

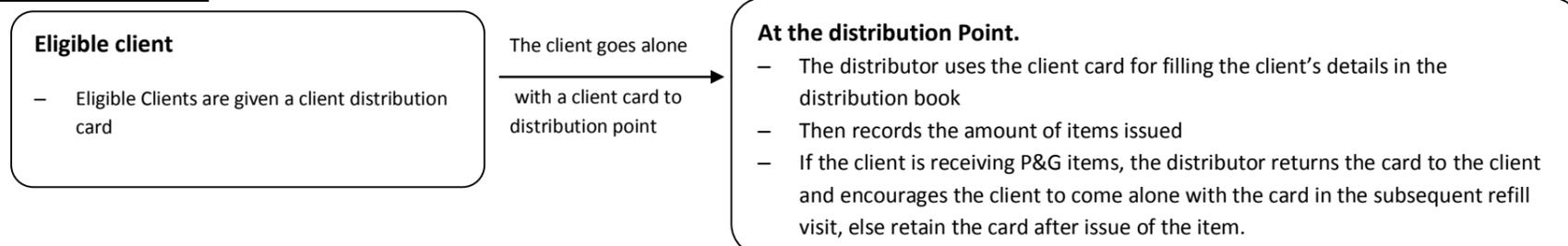
ANC4 - 4th ANC visit

DEL - Delivery

PNC - PNC Visit

OUT - Outreach/Others

Client – Data Flow:





PGTL 03: P&G PURIFIER, TOM'S SHOES AND LLITNS DISTRIBUTION MONTHLY SUMMARY REPORTS

Health Facility: _____ Health Sub-District: _____

Sub-County: _____ District: _____

Reporting month: _____

Visit Status	P&G Purifier				LLITN	
	Number of Clients		Quantity of P&G Issued		# Client given Nets	# Nets given out
	New (received Hygiene Kits)	Revisit (Received a refill of P&G Sachets)	Hygiene Kits	Refill of P&G Sachets		
1st ANC Visit						
2nd ANC Visit						
3rd ANC Visit						
4th ANC Visit						
Delivery						
PNC Visit						
Outreach						
Total						

SUMMARY OF TOM'S SHOES DISTRIBUTION

	Number of Clients who received TOM'S Shoes by Age group				TOTAL
	<5Yrs	5 -12 Yrs	13 - 17 Yrs	18Yrs & above	
Male					
Female					
Total					
Pairs of shoes given out by age group					
Total pairs of Shoes given out					

Name of reporting Officer: _____

Title: _____

Signature: _____

Date of Submission: _____

Health Facility In charge

Names: _____

Signature: _____

Date: _____

ANNEX 10: Field trip report template

TRIP REPORT

Note: A trip report is required for all MSH-related travel outside a staff member’s workstation. MSH Uganda staff travelling together should only complete one trip report. The trip report should be submitted to the Supervisor for review and approval together with the accountability for advance or reimbursement of expenses.

Location(s) visited:.....

Start date:**End date:**

1. Objectives: (Clearly state the objectives of the trip).

.....

2. MSH Uganda Staff participating in the trip: (State the names and titles of all MSH Uganda staff traveling.)

.....

3. Persons met or contacted during the trip: (State the names, titles and contact information of the main individuals met or contacted for official work purposes.)

	NAMES	TITLE	CONTACT
1.			
2.			

4. Accomplishments: (State which objectives identified in No. 1 were met; clearly state all other accomplishments of the trip).

.....

5. Issues Raised, Constraints, and Other Matters Arising: (State issues or concerns arising from the trip, constraints in achieving stated objectives, and any other matters arising).

.....

6. Way Forward: (State the decisions that were reached regarding actions and next steps for the way forward.)

.....

7. Lessons Learned/New or Emerging Opportunities: (Describe important lessons learned from the trip. Describe areas that present innovative opportunities for building synergies, increasing collaboration, and/or or improving operations and performance.)

.....

8. Photographs taken: (List the photos taken or justification why it was not relevant or possible)

ANNEX 11: Standard list of subcontractors indicators

Standard list of contractors' indicators			
#	Indicator	Disaggregation	Indicator definition
1	# of new FP clients using FP methods	(New users)	Number of users of FP services who are currently using any contraceptive method. Modern methods are: pill, implant, IUD, injection. Natural methods are LAM, moon beads. Consistent with the Tiaht amendment, targets have not been set for the number of clients receiving family planning services.
		Revisits	
2	# of products dispensed/distributed by STRIDES contractor	Condoms	Number of FP, CS & RH products dispensed or distributed by STRIDES contractor, disaggregated by type (e.g. for FP - pills, condoms, DMPA)
		Injectables	
		Emergency contraceptives	
		Implants	
		Iron	
		Folic acid	
		Zinc	
		Mama kit	
		Water Guard	
		Fansidar	
		ORS	
		Cotrimazole	
		ACTs	
		Lonalt	
ZINKID			
Aqua safe			
3	# of implants and IUDs inserted		This is the number of Implants and IUDs inserted by STRIDES contractor. This is the number of implants (including Norplant, Jadelle, Sinoplant, Implanon) and Intra-Uterine Devices (IUDs) inserted into family planning clients. Consistent with the Tiaht amendment, targets have not been set for the number of clients receiving family planning services.
4	# of children who at 12 months have received three doses of DPT vaccination		Number of children who at 12 months have received three doses of DPT vaccination from a STRIDES contractor supported immunization program.
5	# of children under 5 years of age who received Vitamin A	1st dose	Number of children under 5 years of age who received Vitamin A supplementation from USG-supported programs.
		2nd dose	

6	# of pregnant women who receive 4 ANC consultations		# Pregnant women who received 4 antenatal consultations. First visit-early in first trimester (0-16 weeks); second visit 16 >28 weeks; third visit between 28>36 weeks and fourth visit after 36 weeks.
7	# of pregnant women who received 2+ doses of IPT		# pregnant women who received 2+ doses of IPT. This indicator measures the percentage of pregnant women who received at least 2 or more doses of IPTp with a recommended anti-malaria drug. Malaria control guidelines in Uganda recommend the use of at least 2 doses of SP/Fansidar during the 2nd (16-24 weeks) and 3rd (28-36 weeks) trimester of pregnancy.
8	# of live births delivered at a health facility		# live births assisted by trained health personnel. A skilled birth attendant is an accredited health professional—such as a midwife, doctor or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.
9	# of underweight children at measles vaccination		# children < 5 years whose weight is below bottom line. The underweight indicator reflects body mass relative to chronological age and is influenced both by the height of the child, and weight-for-height.
10	# of live births with low birth weight		# live babies with birth weight < 2.5kg. Birth weight is the first weight of the fetus or newborn obtained after birth. For live births, birth weight should ideally be measured within the first hour of life before significant postnatal weight loss occurs.
11	# of health facilities (HC III & above) offering long acting and permanent methods	Long acting methods	# health facilities (HC III & above) offering LA methods (implants, IUD).
		Permanent methods	# health facilities (HC IV& above) offering vasectomy and tubal ligation
12	# of health facilities providing Basic Emergency Obstetric Care (BEmONC)		Number of health facilities (HC III & above) that provide ALL basic signal functions. The basic signal functions are: Parenteral administration of antibiotics, parenteral administration of oxytocic drugs, parenteral administration of anti convulsant drugs, manual removal of placenta, removal of retained products (MVA), assisted vaginal delivery, neo-natal resuscitation.
13	# of health facilities providing Comprehensive Emergency Obstetric Care (CEmONC)		Number of health facilities (HC IV & above) that performed caesarean sections and blood transfusions in addition to ALL the basic signal functions. The basic signal functions are: parenteral administration of antibiotics, parenteral administration of oxytocic drugs, parenteral administration of anti convulsant drugs, manual removal of placenta, removal of retained products (MVA), assisted vaginal delivery and neo-natal resuscitation.
14	# of STRIDES supported Service delivery points (SDPs) providing FP counseling or services		Service delivery points (excluding door-to-door CBD) providing FP counseling or services. An SDP is considered to provide the service when ALL the following conditions are met: 1) at least one staff member who has been trained in the service 2) the equipment is available 3) the SDP has offered the service in the last 3 months (as per facility records) and 4) the contraceptive has been in stock for at least 2 of the past 3 months.

15	# of STRIDES supported service delivery points offering any modern contraceptive method		This is the number of USAID IP (STRIDES) supported SDPS offering any modern contraceptive method. Modern Contraception Methods include female and male sterilization, oral hormonal pills, the intra-uterine device (IUD), the male condom, injectables, the implant (including Norplant), vaginal barrier methods, the female condom and emergency contraception.
16	# of service providers trained by STRIDES in FP/RH/CS	FP	FP includes Basic FP and Long acting and permanent methods. RH includes BEmONC, CEmONC & ARHS; CS includes IMCI, growth monitoring, nutrition counseling, and new born health.
		RH	
		CS	
17	# of targeted health units offering Young People-Friendly Services		Characteristics of Young People-Friendly Services (YPFS): (1) Providers trained in YRH issues; (2) Providers trained in communication; (3) Respectful; (4) Non-judgmental attitude; (5) Confidentiality; (6) Privacy; (7) Convenient hours. Young people are those aged between 12 and 24 years. A health facility will be considered to be offering YPFS if it meets at least 5 out of the 7 aspects of the service.
18	# of Service Delivery Points complying with national norms and standards		The norms and standards are specific to FP. Number of FP units providing adequate counseling to clients. Adequacy of counseling includes counseling sessions with new acceptors in which provider discusses all methods, family planning commodities are available and job aids are available during the counseling session. For a family planning unit to be counted as having provided adequate counseling, at least 80% of the individuals observed must have been provided with adequate counseling. Adequate counseling means: all methods are discussed with the clients; jobs aids are used in the counseling session; and FP commodities are in stock.
19	# of clients receiving services from a USAID-affiliated/STRIDES contractor private sector service provider		Number of unique clients receiving services from STRIDES contracted private service provider. The services include RH, CS and nutrition services. An increase in number of clients demonstrates an increased role of private sector in health service provision.
20	# of health facilities submitting timely HMIS reports to HSD/district		STRIDES supported facilities/ contractors are required to submit HMIS reports to the health sub-district (HSD) within 7 days after the reporting period. The private sector HMIS form will be used by the contractors who may not use the MoH HMIS forms.
21	# of people trained in child health and nutrition through USG supported programs		This indicator measures the number of health professionals, primary health care workers, community health workers, volunteers and non health personnel trained in child health and child nutrition through USG supported programs during the reporting year.
22	# children under five years reached by USG/STRIDES supported nutrition programs		Number of children under five years reached during the reporting period by the nutrition program. The nutrition activities may include BCC, home or community gardens, micronutrient fortification or supplementation, anemia reduction packages, growth monitoring and promotion and management of acute malnutrition.

TOOL FOR MONITORING STRIDES SUB CONTRACTORSⁱ

NAME OF CONTRACTOR:	
DISTRICT(S) & SUB COUNTIES OF OPERATION:	
QUARTER:	
MONITORING DATE(S):	
STRIDES MONITORING TEAM – Names & designation	
SUBCONTRACTOR TEAMS – Names & designation	

1. Purpose and instructions: The purpose of this tool is to assess STRIDES contractors' data management systems, verify data submitted by contractors in the quarterly reports and monitor contractors' compliance with the Tiahrt amendment. This tool comprises three sections:

Section 1 will be used to assess the data management systems of the contractors and will be administered during the first and third monitoring visit during any contractual year;

Section 2 will be used to verify data contained in the contractors' quarterly reports before disbursement of funds for the next quarter. Data verification shall where appropriate take place at two different levels i.e. at the contractor's headquarter level and at the subcontractors' supported service delivery point(s) and clients shall too be sampled as per the guidelines – Tools that are used at SDP level and for client verification form Annex I and II of this tool. The tool focuses on quality assurance of data received from sub contractors and places emphasis on data *reliability, validity, integrity, timeliness and accuracy*. Depending on the findings, each subcontractor shall be categorized and ranked as follows;

Assessment areas	Scores		
	Adequate	Acceptable	Inadequate
Data management system	90% and above	60% - 89	59% and below
Data verification (percentage difference between what is reported and verified)	0- 5%	5 –10 %	> 10 %

Section 3 is aimed at monitoring contractors' compliance with the Tiahrt amendment and will be administered biannually.

SECTION 1: CONTRACTOR'S DATA MANAGEMENT SYSTEM

Data quality criteria		Issues considered	Response options	Contractor's score	Comments
1.	Adequacy & consistency of the data collection methodology (Validity)	a. Does the contractor have data collection tools for tracking STRIDES indicators? (Does the instrument capture all required information about the indicator e.g. definition, unit of measure, etc. Ask to see a copy)	Tools available & captures all STRIDES required data = 10		
			Captures some of the STRIDES required data = 5		
			Does not capture STRIDES data/ tools not available =0		
		b. Is there any training / orientation conducted for field and new staff in the use of the Data Collection Tools (DCTs).	Well planned and implemented (with evidence such as schedule, training report) = 10		
Ad hoc training/orientation conducted (no evidence that it was conducted) = 5					
No training/ orientation at all = 0					
Total score on validity			Total score = 1a +1b		
2.	System of transmitting data from the field/ field offices to head office? (timeliness)	a. Periods of submission well outlined and known to all relevant staff.	Both outlined criteria met =10		
			Only one criteria met= 5		
			No system established=0		
		b. Contact and responsible person established both at service delivery point and at contractor's Head Office (HO)	Both outlined criteria met =10		
Only one criteria met= 5					
No system established=0					
Total score on timeliness			Total score = 2a +2b		
3.	Potential for transcription errors i.e. errors in copying or transferring figures. (Integrity)	a. How many stages of transcription does the data go through?	Direct electronic capture of data = 10		
			Transcription? minimal, occurs at 1 or two levels = 5		
			Transcription at more than two levels = 2		
		b. Are there procedures for minimizing transcription errors?	Adequate checks for minimizing errors = 10		
Some checks but not adequate for minimizing errors = 5					
No checks for minimizing errors = 0					
Total score on integrity			Total score = 3a +3b		
4.	Data completeness & data filing system	a. Based on the DCTs, how complete is the data collected for indicators. (Observe files- either electronic, manual or both).	complete = 5		
			incomplete = 2		
		b. Is there an established mechanism to cater for incompletely filled DCT?	Adequate mechanism in place = 5		
			Inadequate mechanism =3		
No established mechanism = 1					
c. Adequacy of filing system.	Registers/forms labeled, serialized & stored in a central location = 5				
	Appropriate electronic filing protection & backup = 2				

Data quality criteria		Issues considered	Response options	Contractor's score	Comments	
			Filing system inadequate = 1			
5.	Existence of procedures for avoiding double counting of clients.	a. Is there procedure for aggregating number of new and revisit clients served at service delivery points?	Adequate Procedures in place = 5			
			Procedures in place but not enforced appropriately = 3			
			Not applicable / No established procedures = 0			
	Total score on accuracy		Total score = 4a +4b+4c+5a			
6.	Existence of data handling procedures This also includes simple notes of procedures and process such as flow charts (Reliability)	Does the contractor have documented procedures for dealing with:				
		a. Data collection?	Adequate documentation = 3			
			Procedures inadequate /Partially Documented = 2			
			Procedures not documented = 1			
		b. Data storage/ processing?	Adequate documentation = 3			
			Procedures inadequate /Partially Documented = 2			
			Procedures not documented =1			
		c. Data quality checks/ verification?	Adequate documentation = 3			
			Procedures inadequate /Partially Documented = 2			
			Procedures not documented = 1			
		d. Data aggregation/analysis?	Adequate documentation =3			
			Procedures inadequate /Partially Documented = 2			
			Procedures not documented = 1			
		e. Data reporting?	Adequate documentation = 3			
			Procedures inadequate /Partially Documented = 2			
			Procedures not documented = 1			
		6.1 Are the available procedures available to relevant staff?		Procedures appropriately displayed /Accessible to all relevant staff = 2		
				Procedures not accessible to all relevant staff =0		
		Total score on accuracy		Total score = 6a +6b+6c+ 6d+ 6e + 6.1		
OVERALL ASSESSMENT OF DATA MANAGEMENT SYSTEM (DMS)						

SECTION 2A: CONTRACTORS PMP DATA VERIFICATION *(The rows may be adjusted as required)*

#	Indicator	Indicator definition	Disaggregation	Planned	Reported	Verified	Comments/Notes (this includes source documents verified per indicator e.g. FP register, invoices... and other comments as appropriate)	Verification checklist per indicator
1	# of new FP clients using FP methods	Number of users of FP services who are currently using any contraceptive method. Modern methods are: pill, implant, IUD, injection. Natural methods are LAM, moon beads. Consistent with the Tiahrt amendment, targets have not been set for the number of clients receiving family planning services.	(New users) - a client who is using a family planning contraceptive for the first time in their life					<ul style="list-style-type: none"> Indicator definition by the contractor should be consistent with STRIDES PMP - (ask contractor to define) of new and revisit clients for FP should be as per the stated indicator definitions. Ask for the source documents that clearly track and document the new and revisit users for FP, examples of source documents may include: FP registers, VHT registers, FP client cards among others. For clients reported as a result of referral, ensure the following: <ul style="list-style-type: none"> Ask for documents of complete referrals and these may include: copies of referral slips that have a return slip with evidence of the client reaching the service delivery site and receiving the service The records of complete referrals should also include the name of the facility where the client received the service Establish if reported clients as verified from the subcontractor's head office registers/referral documents and verify at the facility where services were received to identify if these clients are included in the facility records/registers and you may also interact with the service provider(s) to ascertain if these clients were reached as a result of the contractor's interventions.
			Revisits - a client that has used a family planning contraceptive before and is returning either to re-initiate use of a method or obtain a re-supply.					
2	# FP products distributed by STRIDES contractor	Number of FP, CS & RH products distributed by STRIDES contractor, disaggregated by type (e.g. for FP - pills, condoms, DMPA)	FP products					<ul style="list-style-type: none"> This indicator tracks distribution of products. Distribution of products may include to the VHTs: health facilities including private service delivery points such as - the pharmacies, drug shops, clinics, maternity homes among others. Examples of source documents may include: <ul style="list-style-type: none"> A receipt of sale
			Condoms (pieces)					
			Injectables (vials)					
			Pills (cycles)					
			Emergency contraceptives					
			Implants					
			IUDs					
RH/MH products								

#	Indicator	Indicator definition	Disaggregation	Planned	Reported	Verified	Comments/Notes (this includes source documents verified per indicator e.g. FP register, invoices... and other comments as appropriate)	Verification checklist per indicator
			Iron					<ul style="list-style-type: none"> ○ Stock cards ○ Distribution lists of the items ○ Delivery notes among others ● Any source document presented should include; <ul style="list-style-type: none"> ○ Source of the product (contractor name) ○ Date of distribution (date should be within the reporting period) ○ Name and quantities of the product – quantities should be according to the STRIDES acceptable counting methodologies e.g condoms – pieces: injectables - vials: pills – cycles among others.
			Zinc					
			Mama kit					
			Fansidar					
			Cotrimaxazole					
			ACTs					
			CS products					
			Folic acid					
			Water Guard					
			ORS					
			ZINKID					
			Aqua safe					
			Lonalt					
3	# FP products dispensed by STRIDES contractor	Number of FP, CS & RH products dispensed by STRIDES contractor, disaggregated by type (e.g. for FP - pills, condoms, DMPA)	FP products					<ul style="list-style-type: none"> ● Count off products dispensed. Dispensed implies products provided to the final user. ● Examples of source documents may include FP registers; OPD books among others. However any source document presented should have; <ul style="list-style-type: none"> ○ Evidence of dispensing to the client such as client names/numbers; name of product, quantity of products as per STRIDES accepted counting methodologies as described above i.e. pills – cycles: Condoms – pieces and injectables – vials among others
			Condoms					
			Injectables					
			Emergency contraceptives					
			Implants					
			IUDs					
			RH/MH products					
			Iron					
			Zinc					
			Mama kit					
			Fansidar					
			Cotrimaxazole					
			ACTs					
			CS products					
			Folic acid					
			Water Guard					
			ORS					
			ZINKID					
			Aqua safe					
			Lonalt					
4	# implants and IUDs inserted	This is the number of Implants and IUDs inserted by STRIDES contractor or through a contractor supported intervention. This is the number of implants (including Norplant, Jadelle, Sinoplant, Implanon) and Intra-Uterine Devices (IUDs) inserted into family planning clients.						<ul style="list-style-type: none"> ● Examples of source documents may include: FP registers, dispensing books, OPD books, theatre registers among others. ● Document the specific type of implants provided since not all have the same CYP conversion factors
5	# of children	Number of children						<ul style="list-style-type: none"> ● Examples of source

#	Indicator	Indicator definition	Disaggregation	Planned	Reported	Verified	Comments/Notes (this includes source documents verified per indicator e.g. FP register, invoices... and other comments as appropriate)	Verification checklist per indicator
	who at 12 months have received three doses of DPT vaccination	who at 12 months have received three doses of DPT vaccination from a STRIDES contractor supported immunization program.						documents may include; Child registers at the facility; immunization tally sheets and emphasis is on DPT 3 and vitamin A respectively; <ul style="list-style-type: none"> The source documents presented should be tracking the each of the DPT dose and Vit. A per child i.e. DPT 1: DPT 2 and DPT 3 and count off DPT 3 from the records; Vit A 1st dose and 2nd dose per child.
6	# of children under 5 years of age who received Vitamin A	Number of children under 5 years of age who received Vitamin A supplementation from USG-supported programs.	1st dose					<ul style="list-style-type: none"> The source documents should specify the age of the child since the DPT 3 tracks children less than 1 year and Vitamin A less than 5 years. The sources documents should also have the dates when the immunization was undertaken/ provided – dates should be within the reporting period. If numbers reported by contractor were achieved partnership with a government facility, please confirm this with the facility; find out if numbers are included in the facility register on the specific dates as presented by the contractor. Also check out for contractors who may fund the same activity in the same geographical area to avoid double counting. Cross check if numbers reported are not as a result of the government funded routine outreach programs/interventions. Sample some of the homes at least 5 district in areas where outreaches were conducted as reported by the contractor and cross check with the children's health cards the dates of the immunization if consistent with presented dates for immunization.
			2nd dose					
7	# pregnant women who receive 4 ANC consultations	# Pregnant women who received 4 antenatal consultations as follows; First visits early in first						<ul style="list-style-type: none"> Example of source documents may include: Antenatal (ANC) registers; mother passports, OPD books among others.

#	Indicator	Indicator definition	Disaggregation	Planned	Reported	Verified	Comments/Notes (this includes source documents verified per indicator e.g. FP register, invoices... and other comments as appropriate)	Verification checklist per indicator
		trimester (0-16 weeks); second visit 16 >28 weeks; third visit between 28>36 weeks and fourth visit after 36 weeks						<ul style="list-style-type: none"> • The presented source documents should include; <ul style="list-style-type: none"> ○ The names/ unique identification per pregnant woman. ○ The number and dates of ANC visit per woman ○ The gestation period at each of the ANC visits – 4 ANC visits must be in accordance with MoH guidelines i.e. at least once per trimester. ○ The source documents should also include the IPT doses administered to the women if any and should mention at which stage and date the IPTp was received. <p>In case of clients reported as a result of referrals;</p> <ul style="list-style-type: none"> • Ask for source documents of complete referrals and these may include; a copy of the referral slips and return slips which should include the names of the clients and referral clinic, where the service was provided and the date • For the clients reported as a result of referrals, verify these reported clients, visit the service delivery points where the service is reported to have been provided establish; • If the reported clients are included the partnering facility registers/record books. • Find out of the data is consistent with what is reported by the contractor in terms of numbers and dates served among others. • Where possible sample some of the names of particular clients and villages they come from, visits some of the clients home and if possible check out their ANC cards/mother passports and ascertain if the facility names and dates on the ANC visit as reported by the contractor are
8	# pregnant women who received 2+ doses of IPTp	# Pregnant women who received 2+ doses of IPT. This indicator measures the percentage of pregnant women who received at least 2 or more doses of IPTp with a recommended anti-malaria drug. Malaria control guidelines in Uganda recommend the use of at least 2 doses of SP/Fansidar during the 2nd (16-24 weeks) and 3rd (28-36 weeks) trimester of pregnancy.						

#	Indicator	Indicator definition	Disaggregation	Planned	Reported	Verified	Comments/Notes (this includes source documents verified per indicator e.g. FP register, invoices... and other comments as appropriate)	Verification checklist per indicator
								consistent.
9	# live births delivered at a health facility	# Live births assisted by trained health personnel. A skilled birth attendant is an accredited health professional—such as a midwife, doctor or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.						<ul style="list-style-type: none"> Examples of source documents may include: Maternity/delivery registers where the client delivered. In case of clients reported as a result of referrals – look out for evidence of complete referrals such as copies of referral and return slips. <ul style="list-style-type: none"> These should include the facility of delivery Establish reported clients as a result of referrals, establish if these numbers exist in the referral point delivery register Sample some of these clients to establish if their delivery at a health facility was as a result or was contributed to by interventions of the contractor.
	# live births with low birth weight	# Live babies with birth weight < 2.5kg. Birth weight is the first weight of the fetus or newborn obtained after birth. For live births, birth weight should ideally be measured within the first hour of life before significant postnatal weight loss occurs.						<ul style="list-style-type: none"> The indicator definition should be consistent with STRIDES PMP in terms of low birth weight. Examples of source documents may include; the delivery registers and or other documents that illustrate the weight of children at birth Count off the children whose weight was below 2.5kgs at birth.
10	# underweight children at measles vaccination	# Children < 5 years whose weight is below bottom line. The underweight indicator reflects body mass relative to chronological age and is influenced both by the height of the child, and weight-for-height.						<ul style="list-style-type: none"> The indicator definition should be consistent with STRIDES PMP in terms of underweight and age of the child. Examples of source documents may include; the immunization register that tracks the number of children including their age at measles immunization. Count off the children whose weight is below bottom line as per the indicator definitions.
12	# health facilities (HC III & above) offering long acting and permanent methods	# health facilities (HC III & above) offering LA methods (implants, IUD). # health facilities (HC IV & above) offering vasectomy and tubal	Long acting methods					<ul style="list-style-type: none"> Examples of source documents may include a list of facilities the contractor has partnered with during the reporting period. There should be evidence
			Permanent methods					

#	Indicator	Indicator definition	Disaggregation	Planned	Reported	Verified	Comments/Notes (this includes source documents verified per indicator e.g. FP register, invoices... and other comments as appropriate)	Verification checklist per indicator
		ligation						that there were clients served in the reported facilities for either LA or PM of FP during the reporting period.
15	# STRIDES supported Service delivery points (SDPs) providing FP counseling or services	Service delivery points (excluding door-to-door CBD) providing FP counseling or services. An SDP is considered to provide the service when ALL the following conditions are met: 1) at least one staff member who has been trained in the service 2) the equipment is available 3) the SDP has offered the service in the last 3 months (as per facility records) and 4) the contraceptive has been in stock for at least 2 of the past 3 months.						<ul style="list-style-type: none"> Examples of source documents may include a list of facilities the contractor has partnered with during the reporting period. There should be evidence that there were clients for FP during the reporting period. Sample at least 50% of the reported SDPs to ascertain if they meet the criteria as per the indicator definition.
16	# STRIDES supported service delivery points offering any modern contraceptive method	This is the number of USAID IP (STRIDES) supported SDPs offering any modern contraceptive method. Modern Contraception Methods include female and male sterilization, oral hormonal pills, the intra-uterine device (IUD), the male condom, injectables, the implant (including Norplant), vaginal barrier methods, the female condom and emergency contraception.						<ul style="list-style-type: none"> Examples of source documents may include a list of facilities the contractor has partnered with during the reporting period. There should be evidence that there were clients for modern FP services reported during the reporting period. Sample at least 50% of the reported SDPs to ascertain if they meet the criteria as per the indicator definition.
17	# service providers trained by STRIDES in FP/RH/CS	FP includes Basic FP and Long acting and permanent methods. RH includes BEmONC, CEmONC & ARHS; CS includes IMCI, growth monitoring, nutrition counseling, and new born health. Nutrition	FP					<p>The source documents may include but not limited to training reports. The source documents should include;</p> <ul style="list-style-type: none"> Very clear training objectives. Participants list with signature, telephone contacts and works stations. Assessment results for each participant – before and after the training. Sample at least 40% of the participants and confirm if
			RH					
			CS					
			Nutrition					

#	Indicator	Indicator definition	Disaggregation	Planned	Reported	Verified	Comments/Notes (this includes source documents verified per indicator e.g. FP register, invoices... and other comments as appropriate)	Verification checklist per indicator
								they attended the training as reported by the contractor – ask for some of the training content to confirm consistency with what was reported by the contractor.
19	# Service Delivery Points complying with national norms and standards	The norms and standards are specific to FP. Number of FP units providing adequate counseling to clients. Adequacy of counseling includes counseling sessions with new acceptors in which provider discusses all methods, family planning commodities are available and job aids are available during the counseling session. For a family planning unit to be counted as having provided adequate counseling, at least 80% of the individuals observed must have been provided with adequate counseling. Adequate counseling means: all methods are discussed with the clients; jobs aids are used in the counseling session; and FP commodities are in stock.						<ul style="list-style-type: none"> • Source documents may include a list of the service delivery points partnered with by the contractor during the reporting period. • Verify at the field level if ALL reported facilities and visit them to ascertain compliance as per the indicator definition.
20	# of clients receiving services from a STRIDES contractor	Number of unique clients receiving services from a STRIDES contractor. A unique client is one reported once during the year even if they have been reached in all the subsequent quarters	<p>Clients receiving adequate counseling on FP</p> <p>Young people reached with RH information.</p>					<ul style="list-style-type: none"> • Source documents may include; FP registers and or any improvised counseling register and or attendance lists • Any provided register should have; <ul style="list-style-type: none"> ○ Lists of clients counseled/ reached with RH information with evidence of individual attendance such signatures or thumbprints. ○ IEC materials should have been used during the counseling sessions (ask to see sample of IEC materials used – should have all methods of FP, their use advantages and

#	Indicator	Indicator definition	Disaggregation	Planned	Reported	Verified	Comments/Notes (this includes source documents verified per indicator e.g. FP register, invoices... and other comments as appropriate)	Verification checklist per indicator
								<p>disadvantages per method – for FP counseling and also ask to see IEC materials used during provision of RH information – where appropriate - (you may also talk to the providers and sampled clients to ascertain if these were used)</p> <ul style="list-style-type: none"> ○ Should have been reached during one on one or in small groups of not more than 25 people (talk to providers and sampled clients if this was so). ○ Their source documents should have dates of the exercise (these should be within the reporting period). ○ Should also have evidence/ documentation for new and revisit clients for FP clients/ reached with RH information. ○ Count off clients reached with adequate counseling on FP and count off those reached with RH information. ○ The lists of RH young people reached with RH information should include the age since this requires YP between the ages of 10-24years. ○ Attendance lists of YP reached with RH information should have the school stamp/LC stamp with comments that the YP were reached as per defined criteria. ○ Avoid double counting especially for contractors reporting on both disaggregations – a particular client should not be reported under both categories i.e. adequate counseling on FP and YP reached with RH information.
			Young people reached with RH services					<ul style="list-style-type: none"> ● Source documents may include registers specifically for YFS and the YFS should meet the following criteria: ● Characteristics of Young People-Friendly Services

#	Indicator	Indicator definition	Disaggregation	Planned	Reported	Verified	Comments/Notes (this includes source documents verified per indicator e.g. FP register, invoices... and other comments as appropriate)	Verification checklist per indicator
								<p>(YF/S): (1) Providers trained in YRH issues; (2) Providers trained in communication; (3) Respectful; (4) Non-judgmental attitude; (5) Confidentiality; (6) Privacy; (7) Convenient hours. Young people are those aged between 12 and 24 years. A service will be considered to be YF if it meets at least 5 out of the 7 aspects of the service.</p> <ul style="list-style-type: none"> • Sample some of the reported clients to ascertain if the received service was according to standard. Indicator definition. • Visit some of the YF service delivery sites to establish if the facilities are as per the defined criteria • The source documents should illustrate the service received per clients and services should be within the category of FP/RH and CS • Confirm if these clients are included in other indicators of the contractors' PMP or not.
			Children receiving DPT.	DPT 1				<ul style="list-style-type: none"> • Refer to the standards on the indicator related to DPT 3 and count off children that have received DPT 1 and 2 during the reporting period.
				DPT 2				
22	# children under 5 years of age who are receiving nutrition assessment or screening at STRIDES supported health facilities and communities	This indicator measures Number of children (0-59 mths) who have received nutritional services from health facilities and communities providing nutritional services with STRIDES support. Nutritional services tracked include; assessment, categorization, nutritional counseling, follow up on rehabilitation of malnutrition. Rehabilitation considers ITC/OTC and those treated at community level using the PD/H						<p>Source documents to consider include OPD register with columns for Age, Weight, height/length, MUAC and categorization, Child Health Cards, immunization registers and referral forms.</p>

#	Indicator	Indicator definition	Disaggregation	Planned	Reported	Verified	Comments/Notes (this includes source documents verified per indicator e.g. FP register, invoices... and other comments as appropriate)	Verification checklist per indicator
		model/approach.						
23	# Children cured at STRIDES supported facilities or STRIDES supported community PD/Hearth sessions (Cure Rate).	This indicator measures the percentage of malnourished children under 5 years of age who were rehabilitated either at the Inpatient Therapeutic Care (ITC) or Outpatient Therapeutic Care (OTC) or through community PD hearth sessions. Follow up children treatment and rehabilitation records shall be used to compute cure rate as a performance outcome. Numerator: Number of children cured; Denominator: Total number of malnourished children enrolled and treated at STRIDES supported facilities or STRIDES supported community PD/Hearth sessions.						Source documents to consider include; OPD Register, ITC/OTC registers, referral forms, medical form 5, discharge forms, OTC/ITC Client cards, clinical monitoring forms, ITC/OTC monthly reports and HMIS reports plus VHT reports, PD Hearth/Growth monitoring and reporting (GMP) reports.
27	# of malnourished children (under the age of 3 years) identified and referred for nutrition services.	Referred children will be followed up in the home by the nutrition scouts within two weeks of referral to ensure that they have visited the referral center						Source documents to consider include; OPD Register, ITC/OTC registers, referral forms, medical form 5, VHT reports, PD Hearth reports, Growth monitoring (GMP) reports.
28	# of malnourished children (under 3 years of age) with completed referrals and have received care/nutritional service at a public health or public-supported facility	# of malnourished children (under 3 years of age) referred by a trained private sector provider who receive care at a public health or public-supported facility						Source documents to consider include; OPD Register, ITC/OTC registers, referral forms, medical form 5, VHT reports, PD Hearth reports, Growth monitoring (GMP) reports and client cards.

#	Indicator	Indicator definition	Disaggregation	Planned	Reported	Verified	Comments/Notes (this includes source documents verified per indicator e.g. FP register, invoices... and other comments as appropriate)	Verification checklist per indicator
29	# children under five years reached by USG supported nutrition programs	Number of children under five years reached during the reporting period by the nutrition program. The nutrition activities may include BCC, home or community gardens, micronutrient fortification or supplementation, anemia reduction packages, growth monitoring and promotion and management of acute malnutrition.						Ensure that this evidence for the reported numbers as per the indicator definition and as specified in the respective subcontractor's PMPs.
30	# health facilities submitting timely HMIS reports to HSD/district	STRIDES supported facilities/ contractors are required to submit HMIS reports to the health sub-district (HSD) within 7 days after the reporting period. The private sector HMIS form will be used by the contractors who may not use the MoH HMIS forms.						<ul style="list-style-type: none"> Source documents include; Copies of facility HMIS reports that the contractor and or the contractor partnering facilities submitted to the district. The copies of the presented HMIS reports should only be authentic if they have a district stamp with the date the HMIS report was received at the district. Utilize attached HMIS verification template and establish; If the contractor's data is incorporated into the partnering facility service register; HMIS (105) report and if report was submitted to the district. If yes if the reported was submitted timely.

Note: For field/SDP: client and HMIS verification please refer to annex 1: 2 and 3 respectively as attached.

SECTION 2B: HMIS verification at facility and district level

(Please insert additional rows if required and revise the districts as per the subcontractor)

SN	District	Name of facility partnered with	Subcontractors data incorporated into the	Status (Private/Government)	Contractor data incorporated into the facility based HMIS report (105) – Yes: No	HMIS reporting status by the partnering health facility to the HSD/district (submitted timely/submitted late/Not submitted)	Comments if any (if significant variance please comment)
1.	Kalangala						
2.	Luweero						
3.	Mityana						
4.	Nakasongola						

SN	District	Name of facility partnered with	Subcontractors data incorporated into the	Status (Private/Government)	Contractor data incorporated into the facility based HMIS report (105) – Yes: No	HMIS reporting status by the partnering health facility to the HSD/district (submitted timely/submitted late/Not submitted)	Comments if any (if significant variance please comment)
5.	Ssembabule						
6.	Mpigi						
7.	Kayunga						
8.	Kamuli						
9.	Mayuge						
10.	Kaliro						
11.	Bugiri						
12.	Kumi						
13.	Kyenjojo						
14.	Kasese						
15.	Kamwenge						

Summary calculation on timely HMIS reporting (*this is monthly HMIS reporting – First calculate the monthly average for all facilities and then calculate the quarterly average*)

General comments and observations related to HMIS reporting

SECTION 3: CHECKLIST FOR MONITORING CONTRACTORS' COMPLIANCE WITH THE TIAHRT AMENDMENT

Specific objectives

- To establish whether FP acceptors are generally receiving comprehensive information on the risks and benefits of the method chosen;
- To find out if the contractors are in compliance with Tiaht provisions, laws and policies relating to voluntarism in FP.

3.1 Contractors' head office

1. Do the relevant staff at this office have information on Tiaht provisions? (probe for key highlights)

2. Does the contractor have any relevant documents that spell out the Tiaht provisions? If yes ask to see some copies.

3. In your project monitoring tools and work plans have you set any targets for FP clients to be reached by your partners at different levels in specific periods of time?

4. Does the contractor have suitable job aids and IEC materials used by service providers during FP counseling sessions?

3.2 Service providers & service delivery points (SDP)

1. Do you feel there is pressure to reach more clients with FP services?

2. Do you have job aids and IEC materials to help you with family planning counseling? (ask to see a copy)

3. Do you have enough time to spend with FP clients to give them the information that they need?

4. Have you heard of any incidents where family planning clients said they were coerced to use a contraceptive method?

5. _____
Do you persuade people to use the family planning services?
6. _____
If someone does not want to use any FP method after the counseling session on FP, how do you respond?
7. _____
Does the service delivery point have a wall chart displaying various contraceptive methods clearly posted and in languages that clients are able to see and read?

8. *Social Marketers*-Do the packages have inserts with the information pertinent to that method?

3.3 Clients - Exit interviews at SDP

1. Why have you decided to seek family planning counseling/services?

2. Did the provider give you the information you needed to make a decision about the best method for you?

3. Did anybody influence your decision to seek family planning (i.e. referral agent) and/or your decision about which method to use? If yes, please describe.

4. Did anybody give you anything in exchange for accepting family planning services? If yes, please describe.

5. In your understanding, what are the risks/possible side-effects of using the method that you chose?

SECTION 4.0

Success **story/case study**: Ask about the success story (refer to the guidelines for writing success stories) and recommend if it requires further documentation where possible request to visit and observe the actual site of success story while taking note of the situation before, the interventions and the results.

4.1 Key Findings

Achievements

Challenges

Lessons learnt

Action points/recommendations for the way forward

Action point (s)/recommendation (s)	Responsible person (s)	Due date

Name & Signature for and on behalf of STRIDES

Name, signature and stamp of contractor

ⁱ The monitoring and data verification teams should always use this tool in close reference to the monitoring and data verification guidelines/checklist.