ASSESSING HEALTH FACILITY CAPACITY TO PROVIDE SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Results from a community scorecard pilot conducted in Kamuli district in eastern Uganda

September 2017

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ABBREVIATIONS

ANC	Antenatal care
COC	Combined oral contraceptive
CSC	Community score-card
CSMMUA	Coalition to Stop Maternal Mortality Due to Unsafe Abortion
DHO	District health office
EmOC	Emergency obstetric care
eMTCT	Elimination of mother-to-child HIV transmission
EWEC	Every Woman Every Child
FP2020	Family Planning 2020 (commitments)
GBV	Sexual and gender based violence
HC	Health centre
HEPS-Uganda	Coalition for Health Promotion and Health Development
HUMC	Health Unit Management Committee
IEC	Information, education and communication
MMR	Maternal Mortality Ratio
MVA	Manual Vacuum Aspiration
PAC	Post-abortion care
SRHR	Sexual reproductive health and rights
TBA	Traditional birth attendant
TFR	Total fertility rate
UBTS	Uganda Blood Transfusion Service
UHMG	Uganda Health Marketing Group
VHT	Village health teams

BACKGROUND

Introduction

This report tracks progress on a community-identified list of issues affecting access to information and services for prevention and management of unintended pregnancies, as well as to other sexual and reproductive health (SRH) services. It is part of a community score-card (CSC) process that aimed to kick start community level discussion and generate evidence for the Civil Society Coalition to Stop Maternal Mortality Due to Unsafe Abortion (CSMMUA) to undertake advocacy for improvement in access to essential medicines and commodities that prevent maternal mortality due to unsafe abortions.

This work builds on one of the pillars of the Coalition's work, which aims to increase access to safe services for prevention and management of unintended pregnancy, and was implemented by HEPS-Uganda as a community-empowerment project titled, "Advocacy for essential medicines and commodities to prevent maternal mortality due to unsafe abortions". The project was implemented between August 2016 to July 2017.

This report presents the results, achievements and lessons from the project.

2012
CSMMUA is a multidisciplinary, Ugandan civil society coalition, has since 2012 engaged in advocacy, education, research and legal analysis to tackle preventable maternal deaths caused by unsafe abortion

Situation analysis and rationale

Over the past few years, Uganda has made progress in promoting sexual reproductive health and rights (SRHRs). It has evaluated its maternal and child health interventions and reprioritised them into a strategy document titled, *The Sharpened Plan: A Promise Renewed,* and accordingly increased funding for family planning.[1]

There has accordingly been an improvement in key SRH indicators. According to findings from the Uganda Demographic and Health Survey of 2016, the Maternal Mortality Ratio (MMR) is estimated at 336 deaths[2] per 100,000 live births, down from 360 deaths per 100,000 live births in 2011. The total fertility rate (TFR) is also declining, reaching 5.4 children per woman in 2016. Married women who use a modern contraceptive method are estimated at 35%, up from 20.4% in 2011.[3] The unmet need for family planning has reduced to 28% among married women, and to 32% among sexually active unmarried women, reflecting a slight reduction from the 2011 estimate of 34%.

20.4%
Married women who use a modern contraceptive method are estimated at 35%, up from 20.4% in 2011

In spite of this progress, the overall state of sexual reproductive health remains poor in Uganda. While the 2016 Uganda Demographic and Health Survey shows a reduction in key indicators, they are still high in absolute terms, and the observed reduction is too slow to achieve targets set in national and international commitments, including under Family Planning 2020 (FP2020), which targets to reduce the unmet need for family planning to 10% by 2022, as well as under Every Woman Every Child (EWEC), and the UN Commission on Life-saving Commodities, and others. In addition, up to 26% of maternal mortalities are due to unsafe abortion.[4] The annual population growth remains high, estimated at 3%, while almost half (47.9%) of the country's population are children below 15 years.[5]

47.9%
There is progress but key SRHR indicators remain high; almost half of the population is below 15 years

A situation analysis conducted by HEPS-Uganda found a chronic failure to implement policies and a major funding gap for the implementation of the policy commitments made. At service delivery level, the analysis showed availability of essential SRH commodities to be generally low.

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1 Uganda's commitment to US$5 million was made at the London Family Planning Summit in 2012.
2 Uganda Demographic Health Survey 2016
3 UDHS 2016 and UDHS 2011
4 Prada E, et. al (2016): Incidence of Induced Abortion in Uganda, 2013: New Estimates Since 2003. PLOS. http://dx.doi.org/10.1371/journal.pone.0165812
5 National Population and Housing Census, 2014

8%
Emergency contraceptives were available in only 8% of public facilities, 30% of private and 4% of mission facilities

Combined oral contraceptives (COC) were found in 47% of public facilities, 52% of private and 27% of mission facilities; emergency contraceptives were found in only 8% of public facilities, 30% of private and 4% of mission facilities; Mifepristone, used in the management of abortions was found in just 2% of public facilities, 3% of private and in none of mission facilities; while Misoprostol, used in management of post-partum haemorrhage, was found in 57% public, 24% private and 46% mission facilities.

In Uganda, most women and youth do not appreciate sexual and reproductive health as a human right. Sexuality is surrounded by a culture of silence, stigma and discrimination and these limit women's and youth participation and choices for family planning. HEPS Uganda aimed to kick start community level discussions on SRHRs to feed into the ongoing national discourse spearheaded by the Coalition to Stop Maternal Mortality Due to Unsafe Abortion (CSMMUA). This project builds on and enriches CSMMUA's advocacy for improved access to, and uptake of, safe services for prevention and management of unwanted pregnancy.

Objectives

The overall objective of the project was to improve access to, and utilisation of, essential commodities and services for sexual and reproductive health to prevent mortality and morbidity caused by unsafe abortions. The specific objectives were:

1) To facilitate the community to identify and act on issues affecting access to SRH information and services in Kamuli district.

2) To increase awareness within the target communities of safe and comprehensive abortion and post-abortion care services for women within the reproductive age.

3) To contribute to a reduction in stock-outs of commodities for prevention and management of abortions at health facilities in Kamuli.

4) To engage national stakeholders to improve availability of commodities and services to prevent maternal mortality due to unsafe abortions.

METHODOLOGY

Project setting

Kamuli district is a rural district in eastern Uganda, bordered by Jinja district to the south; Luuka district to the east; Buyende district to the north, and Kayunga district to the west. The district is subdivided into 12 subcounties and one municipality (urban centre). The project was implemented in five subcounties of the district: Kitayunjwa, Bulopa, Wankole, Namwendwa and Bugulumbya.

5 The project was piloted in five of the 12 subcounties of the district: Kitayunjwa, Bulopa, Wankole, Namwendwa and Bugulumbya

The total population of Kamuli district was in the latest census (2014) estimated at 486,319 people, consisting of 236,389 males (48.6%) and 249,930 females (51.4%).[6] An estimated 78.6% of the households depend on subsistence farming as a main source of livelihood.

Nearly one third (31.4%) of the households in the district are beyond 5km to the nearest public health facility. In the project area, households that are beyond 5km to the nearest public health facility range from 20% in Wankole subcounty to 60% in Bulopa subcounty, which reflects a lack of geographical access to health facilities for a large proportion of the population.

There is a high prevalence of teenage pregnancy; the proportion of females aged 12-19 who have given birth is estimated at 16%.

Project design

The project was designed as a community intervention using the Community Scorecard (CSC) model. Interventions to address barriers to SRHR information, commodities and services were implemented using the Community Score Card (CSC) model. CSC is a qualitative model used for community-level problem identification, action planning, implementation and performance monitoring and evaluation of public services, projects and institutions. The model relies on the perceptions of community members and service providers, project implementers and public officials to identify gaps, agree and implement solutions, and monitor and evaluate progress.

CSC
The project used the Community Scorecard (CSC) model to address barriers to SRHR information, commodities and services

Steps of a score card process

6 Uganda Bureau of Statistics (2017). The National Population and Housing Census 2014: Area Specific Profile Series. Kampala, Uganda

5 Community training sessions were conducted, one pwer subcounty

Preparation

The CSC process started with the preparation stage which involved an inception visit to Kamuli district, where the project team visited the district health office (DHO) to introduce the project to the district health team. This followed a baseline survey conducted earlier in 2016 on the availability of SRH commodities and medicines in private and public facilities in the district. During the inception visit, the project team reached public health facilities in the target subcounties and held briefing meetings with service providers.

After the inception visit, a refresher training of community monitors[7] was conducted to prepare them for project activities. Each sub-county had three monitors which were already trained by HEPS and more monitors were to be selected during the training sessions depending on how active they are. All in all, each subcounty had three HEPS monitors, at least two health workers, five community members and a sub-county leader.

Input tracking

The facility assessment of service-provision readiness involved a survey of availability of human resources, medicines/ commodities, diagnostics and services for sexual and reproductive health (SRH). This is the development of a matrix of resources or inputs expected at a health facility through a consultative process. Input tracking involves an assessment of inputs/resources supposed to be allocated to a health facility to ensure effective and efficient provision of health services. The exercise is based on four key components: 1) identifying the major inputs; 2) the entitlement as per Ministry of Health standards; 3) actual availability/provision; and 4) the remarks on the status quo.

7 Community monitors, in the context of this project, are active community members selected, trained and facilitated by HEPS-Uganda to mobilise and empower members of their respective communities on health rights and responsibilities on a volunteer basis. As of June 2017, HEPS Uganda had a total of 200 community monitors in the different regions of the country where the organisation is active.

Table 1: List of health commodities and service inputs assessed

FAMILY PLANNING	MATERNAL HEALTH	STIs	NEWBORN AND CHILD	DEVICES	MALARIA
Combined oral contraceptive pills (e.g. Microgynon)	Fefolate 60mg (Iron & Folic acid)	Doxycycline	Child immunisation vaccines (BCG, DPT, OPV/IPV, PCV, MenC, MMR, HIB)	Resuscitation devices for newborn (Bag & mask, suction device, Mankin)	Insecticide treated mosquito nets
Progestin-only contraceptive pills (POP)	Oxytocin Inj	Ciprofloxacin	ORS/Zinc	Manual Vacuum Aspiration (MVA) kit	
Combined injectable contraceptives	Misoprostol 200mg		Amoxicillin DT 250mg	Speculum	
Progestin-only injectable contraceptives (Depo-Provera)	Mifepristone 200mg		Chlorhexidine 5g. 4%	Forceps	
Male condoms	Magnesium sulphate inj.			Ultra sound scan	
Female condoms	Ceftriaxone			HCG Kits	
Intrauterine contraceptive device (IUD)	Gentamicin Inj.			Fetal scope	
Implants	Metronidazole			Sterilizer machine	
Cycle beads				BP Machine	
Emergency contraceptive pills					
Male sterilization					
Female sterilization					

The assessment provided the data to complete an input tracking matrix tool developed by HEPS-Uganda to track availability of particular indicators at health facilities, based on Ministry of Health standards. A total of 36 essential medicines/ commodities for reproductive and maternal health were selected and categorized into three sets: 1) Prevention of unwanted pregnancies (family planning); 2) Childcare medicines; and 3) Maternal health/ post abortion care.

The assessment was undertaken at the main public health facility in each of the participating subcounties. Four level-three health centres (HC IIIs) and one level-four (HC IV) facility were assessed. Commodities were assessed for availability, not for stock levels.

Community score-card

The CSC process started with a sensitization training on sexual and reproductive health and rights (SRHR) of community representative and health service providers. The participants included subcounty (LC III) chairpersons, subcounty secretaries for health, community development officers, health providers from public health facilities within the respective subcounties, members of village health teams (VHTs), HEPS-Uganda community monitors, as well as community members.

The training was conducted using training manual developed earlier through consultative meetings, external and internal reviews from implementing partners, and stakeholders. The guide has four modules: SRHR; family planning; maternal health; and domestic violence. The training took two days: on day one, participants started with a pre-test to assess their knowledge and opinions on SRHR before the first session on SRHR. Different resource persons from HEPS Uganda facilitated different modules and the session was interactive and participatory. The training ended with a post-test exercise.

The training was conducted using training manual developed earlier through consultative meetings, external and internal reviews from implementing partners, and stakeholders.

The next stage involved identification of issues affecting access, scoring, prioritization and action planning. This was done on the second day of the session. The scorecard process involved men, women and health workers working in separate groups, broken down by subcounty. Leaders were also put in the women and male groups to represent duty bearers. The status of the issue or problem was evaluated in separate groups of service providers, community men and community women during the baseline sessions, using a five-scale score guide.

In the second round of sessions, in July 2017, the participants used the same guide to score the current status of the issue/challenge, as a way of evaluating progress achieved by the action plans that had been implemented over the period. During these sessions, the participants agreed a second round of actions to address the pending challenges.

They were facilitated by the resource persons to identify SRH inputs and issues affecting the provision and utilisation of SRH services in their community, both for women and men. The purpose of dividing them into these groups was to allow men and women express themselves freely in the process of identifying the issues affecting SRH services in their communities.

The groups later converged and presented the issues they had identified. After the presentations, they were scored the issues according to their urgency, importance and manageability. Issues were scored 1 for very bad, 2 for bad, 3 for fair, 4 for good and 5 for very good. Scoring was done by using beans. Each member of a group was given five beans and asked to cast one bean to each issue that they considered important and needed to be addressed urgently. The issue that had the most beans would be ranked first and taken as the priority issue to be addressed.

Status	Score
Very Bad	1
Bad	2
Fair	3
Good	4
Very Good	5

The groups converged to agree in the plenary by consensus on scores by subcounty/facility, which informed action planning for the five top most priority issues, including what they were to do, the timelines and the individuals/ institutions to take the action and those to follow-up on the progress. Community monitors were tasked to undertake the day-to-day follow-up of activity implementation. Monitoring of the implementation of community actions were conducted on an ongoing basis by the project team and HEPS Uganda M&E officer.

RESULTS AND DISCUSSION

This section discusses results from project, including the facility-level assessment of service-provision readiness, including availability of SRH human resources, medicines and commodities, diagnostics and services; as well as the community score-card (CSC) process in which community representatives and health providers evaluated the available services, identified and prioritized existing gaps, and implemented a consensus set of actions to address identified gaps.

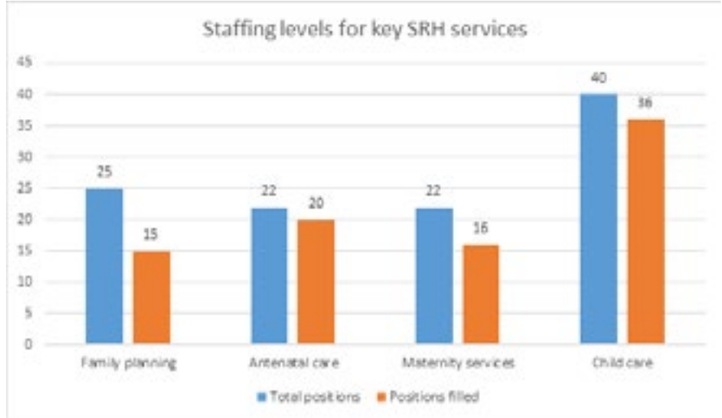
FACILITY READINESS TO PROVIDE SRH SERVICES

Five health facilities – one per subcounty – were assessed for resources or inputs expected at their respective levels as part of input tracking in a community scorecard process. Four of the participating facilities were level-three health centres (HC III), while one was at level-four (HC IV). Assessed were inputs/resources supposed to be allocated to the respective health facility level as per Ministry of Health standards. The assessment covered staffing levels for key SRH services; availability of key SRH commodities; capacity development of human resources for SRH; and service utilisation.

5 facilities were assessed for resources expected at their respective levels as part of input tracking

Staffing levels for key SRH services

Facility-level respondents were asked the number of staff that were assigned to the clinics for family planning, antenatal care (ANC), maternity services as well as to newborn, infant and child care, and what the staffing gaps were. They were further asked how many of the assigned staff were physically present on the day of the survey.



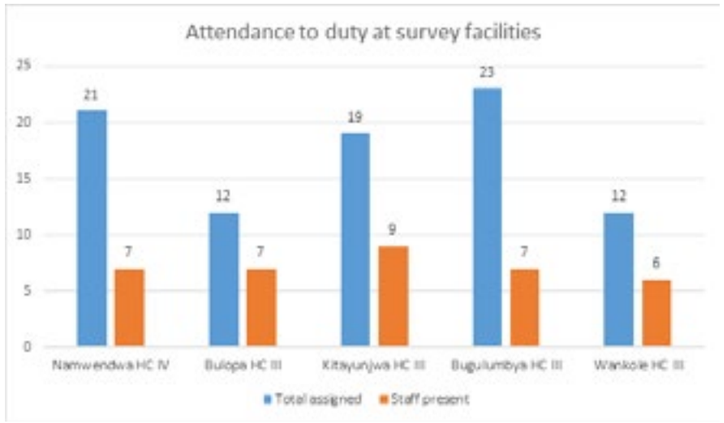
80% The self-reported number of staff positions stood at 109 for the 5 health facilities across ANC, EMoC, FP & maternity services, of which 87 positions were filled, reflecting a combined rough staffing rate of 80%.

The self-reported number of staff positions stood at 109 for the five health facilities across the four service categories, of which 87 positions were filled, reflecting a combined rough staffing rate of 80%. The staffing levels were higher for ANC and newborn/infant/child care (91% and 90% respectively), and poorest for family planning services (60%). At 41%, newborn, infant and child care services account for the highest proportion of staff deployed for the SRH cluster of services assessed.

The findings indicate that the number of staff assigned to the four categories of SRH services is not aligned to the level of the health facility. Bugulumbya HC III reported assigning 23 staff, higher than Namwendwa HC IV (21 staff); and much higher than facilities at its level – Bulopa HC III and Wankole HC III – each of which had 12 staff assigned to the SRH services assessed. At the same time, Bulopa HC III, with only 12 staff assigned to the services in question, had four staff assigned to family planning, while Namwendwa HC IV had only one.

It should however, be noted that facilities rarely assign a health worker to only one service, particularly because the skill-sets for a string of services may be similar and the fact that some services are offered only on specific days. Family planning, ANC and immunization tend to be offered on specific clinic days, allowing a health worker to be assigned across them all, while also providing ongoing services, such as OPD or maternity.

41% The findings suggest a high level of absenteeism. Overall, only 36 health workers (41%) out of the 87 assigned to the four services were available on the day of the survey. At Namwendwa HC IV, only one third (7 out of 21) were available, with only one health worker out of six assigned to maternity being present. The proportion was even less at Bugulumbya HC III, where overall only seven out of 23 assigned to the cluster of services were present, and only one out of four assigned to ANC was present.



Newborn, infant and child care services were best attended, with a total of 18 health workers present on the day of the survey. Absenteeism mostly affected ANC and maternity services. On the day of the survey, each of the facilities surveyed had only one staff for maternity services available. Hence, five staff were available overall, out of a total of 16 assigned, reflecting an overall attendance of less than one third.

The high level of absenteeism undermines the benefit of what otherwise appears to be a fair level of staffing for the SRH cluster of services surveyed. According to one health worker, staff tend to have informal arrangements in which they work on alternate days; with each staff involved serving their turn and standing in for colleagues who take time off to attend to non-official engagements.

Availability of commodities

A total of 36 commodities were surveyed: 12 for family planning; 8 for maternity health; two for sexually transmitted infections (STIs); three for newborn, infant and child health; nine medical devices; one disinfectant/anticeptic; as well as long-lasting insecticide-treated mosquito nets (LLIN) for malaria prevention in pregnant women.

Availability of family planning commodities was generally poor. While each facility surveyed had at least two of the 12 commodities assessed, the maximum number of commodities was registered at six, at Wankole HC III. Bugulumbya HC III, Bulopa HC III and Namwendwa HC III were particularly poorly stocked, with only two or three commodities.

The two commodities for family planning at Bugulumbya HC III were female and male condoms only, and nothing else. Indeed, the only commodity that was available at all facilities were male condoms. Commodities that were not available at all, included combined oral contraceptive pills (e.g. Microgynon), combined injectable contraceptives, and emergency contraceptive pills. The popular progestin-only injectable contraceptives (Depo-Provera) was only available at one health facility, Namwendwa HC IV. Yet this facility, which was the only referral level facility in the sample, did not have male and female sterilization, which services were ironically found at a lower health facility, Wankole HC III.

2 The two commodities for family planning at Bugulumbya HC III were female and male condoms only, and nothing else.

The limited availability of contraceptives undermines uptake because of limited choice, as women and men seeking family planning options that are unavailable may turn away if they are unwilling to take what is available.

Maternal health commodities were fairly available in all facilities. Four of the five facilities had at least five of the eight medicines for maternal health that were assessed. However, it is again ironical that the least stocked was Namwendwa HC IV, the only referral facility in the same, which had only half of the medicines assessed, when a lower facility like Kitayunjwa had all the eight assessed. This phenomenon undermines the functionality of the referral system, as it be clearly odd for a patient to be referred from a facility whose readiness is higher to one where it is lower.

Medicine for safe termination of early pregnancy was fairly available. Misoprostol was available in all facilities except Namwendwa HC IV, which also did not have mifepristone, which was in only two of the five health facilities in the sample.

The two medicines in the sample for STIs – doxycycline and ciprofloxacin – were available in all five health facilities. Newborn, infant and child health commodities were equally well-stocked; all three commodities assessed, including an assortment of vaccines, medicines for diarrhoea and antibiotics, were available in all five health facilities in the sample.

Although medical devices were generally fairly available, Namwendwa HC IV did not have 4 of the 9 key devices assessed; the facility did not have a single MVA kit, neither it is have an ultra sound scan

Medical devices were generally fairly available, except again, at Namwendwa HC IV, which did not have four of the nine key devices assessed. The facility did not have a single Manual Vacuum Aspiration (MVA) kit. It did not have an ultra sound scan, which is critical in diagnosis and monitoring of the growth of the foetus in expectant mothers. The only referral facility in the sample did not have HCG kits, feta scope and a sterilizer machine, all of which were available at several lower facilities. The biggest gap was on the MVA kits, which were not available at all, implying that all facilities did not have the sufficient readiness to provide comprehensive post abortion care.

Capacity building for SRH service providers

Kitayunjwa HCIII did not have any staff trained in provision of long-term family planning methods, while Bugulumbya HC III did not have any staff trained in EmOC, PAC and administration of magnesium sulphate

The assessment sought information on capacity building of staff in form of training in relevant SRH service provision: long-term family planning methods, emergency obstetric care EmOC, post abortion care, and the use of magnesium sulphate, among others.

No. of staff who received training in SRH service provision

Facility Name	Family planning	EmOC	PAC	Magnesium sulphate	Total
Kitayunjwa	0	1	1	1	**3**
Bugulumbya	1	0	0	0	**1**
Bulopa	1	1	1	1	**4**
Wankole	6	2	5	5	**18**
Namwendwa	3	3	2	3	**11**
Total	**11**	**7**	**9**	**10**	**37**

Kitayunjwa HCIII did not have any staff trained in provision of long-term family planning methods, while Bugulumbya HC III did not have any staff trained in EmOC, PAC and administration of magnesium sulphate. Administration of long-term family planning methods had the highest number of trainees (11), while EmOC had the least (7). Wankole HC III had the highest number of staff trained – half of the total – while Bugulumbya HC III had the least (only one). During further discussion, the team survey was informed that Village Health Teams (VHTs) are the ones commonly given training on FP but not permanent staff in facilities.

SRH service utilisation

The assessment solicited information on the number of women who had received ANC, maternity and post-natal care services at the different health facilities in the preceding six months.

Women tend to seek family planning services at lower health facilities than higher-level facilities.

Number of women accessing family planning services in the past six months

Facility Name	On-site		Outreach		Total
	Total	Below 18	Total	Below 18	
Kitayunjwa HC III	323	10	415	61	**738**
Bugulumbya HC III	892	400	-	-	**892**
Bulopa HCIII	912	21	53	10	**965**
Wankole HCIII	1312	246	115	25	**1,427**
Namwendwa HC IV	652	125	87	17	**739**
Total	**4091**	**802**	**670**	**113**	**4,761**

The findings suggest that women tend to seek family planning services at lower health facilities than higher-level facilities. For instance, during the period under review, Namwendwa HC IV serviced barely half of the family planning clients registered at Wankole HC III. It is also notable that outreaches are not a standard practice. Unlike the rest of the facilities assessed, Bugulumbya HC III did not conduct any family planning outreaches over the six-month period to the survey. Kitayunjwa HCIII reaches most of its clients through outreaches whereas it was observed that Bugulumbya HCIII does not conduct any outreach services.

Data suggest a high level of teenage pregnancy in Kamuli district. Overall, 20% of family planning clients recorded were teenagers, with that proportion being as high as 45% at Bugulumbya HC III.

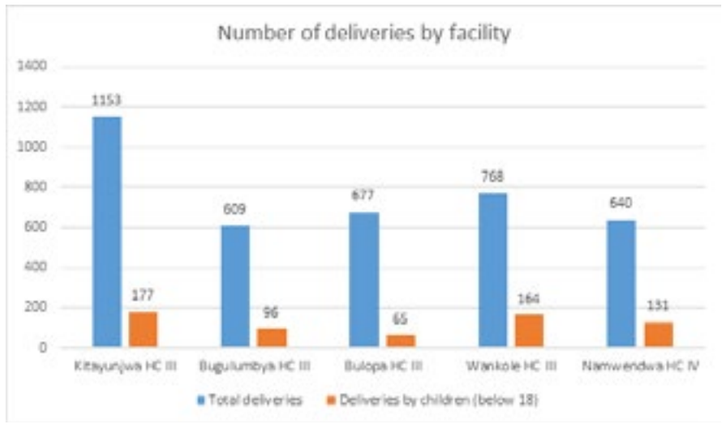
The data further show a high uptake of ANC but there was no expectant mother that completed the World Health Organisation-recommended eight-visit cycle.

16% A total of 3,847 women delivered over the six-month period at the five health facilities assessed. Of these, 633 (16%) were births by minors

Number of women attending ANC services over six months

Facility	ANC 1		ANC 4		ANC 8	
	Total	Below 18	Total	Below 18	Total	Below 18
Kitayunjwa HC III	524	116	707	211	0	0
Bugulumbya HC III	670	153	394	90	0	0
Bulopa HC III	240	75	350	47	0	0
Wankole HC III	779	126	338	47	0	0
Namwendwa HC IV	501	121	269	60	0	0
Total	**2714**	**591**	**2058**	**455**	0	0

A total of 3,847 women delivered over the six-month period at the five health facilities assessed. Of these, 633 (16%) were births by minors. Health worker reported that child pregnancies were a common phenomenon the communities they serve, with one testifying that she had delivered 9-year mother. Two of the facilities – Wankole HC III and Kitayunjwa HC III – reported that they did not have an adolescent/youth corner in the facility.



Utilisation records show that a total of 5,098 mothers (800 or 15.7% of child-mothers) received postnatal care services over the six-month period preceding the survey, far higher than the number that delivered at the health facilities in question (3,847). This suggests that many women delivered in the community – at home or at a traditional birth attendant.

OMMUNITY ACTION ON BARRIERS TO SRH INFORMATION AND SERVICES

Community interventions in Namwendwa subcounty

The key issues affecting access to SRH information and services as identified by community representatives and service providers during the baseline CSC session in Namwendwa subcounty were: understaffing, teenage pregnancies, limited family planning choices, lack of privacy the facility's in-patient ward, lack of onsite water, inadequate blood, insufficient beds in the maternity ward, limited male involvement in family planning, gender-based violence (GBV), and high HIV prevalence.

The CSC participants in Namwendwa agreed to implement the following key actions to address the issues above:

Issue	Intervention
Few beds and mattresses in maternity ward	The community development officer (CDO) at the subcounty to meet council leadership and lobby for inclusion of additional beds and mattresses specifically for the maternity ward at Namwendwa HC IV in the FY2017/18 subcounty budget
Facility has no onsite water	The In-charge of Namwendwa HC IV to write a concept on the issue and share it with potential sponsors in the corporate sector and lobby them to replace water harvesting tanks
Limited FP choices	Work with implementing partners to increase supply of family planning commodities
Understaffing	In-charge to write a letter to the subcounty administration to address the issue to the council and push it to the district, asking for more health workers
Shortage of blood for blood transfusion	Laboratory technician at Namwendwa HC IV to work with the Namwenda LC III chairperson to lobby Uganda Blood Transfusion Service (UBTS) to organize a blood donation camp; and to mobilise communities to donate blood
No privacy at the general ward	Resource mobilisation by the community members to expand the ward or construct one additional ward at the facility. In the short-term, curtain blinders will be sourced

In the end-line CSC session, participants assessed progress on these actions. Progress was scored by health workers, men and women in separate groups. Below are the results from the exercise.

Health workers' scores

Issue	Baseline scores	Current score	Reason	Suggestions
Understaffing	2	2	The health workers are still few. Out of 8 recommended midwives the facility has only 4, yet the population of mothers seeking ANC, FP and immunization services continues to rise	There is need for the District Health Office to recruit more midwives to the recommended staffing norm to meet the demand
Teenage pregnancies	2	1	The problem is still high; many young girls are getting pregnant. A lot of teenagers are attending ANC services	There is still need for health education and support from sub county political leadership to address the problem
Limited FP choices	3	4	The facility has most of FP commodities being supplied by Marie Stopes, which has stationed a service provider at the health centre	There is need for continuous community sensitization to increase the demand for FP services
Privacy	1	1	Men, women and children use one ward (general ward)and the ward is not partitioned to separate these groups, which increases chances of infection to children, and also there is no privacy	The sub county should partition the ward or put curtains for privacy
Water system	1	1	The facility lacks water; the borehole at the facility broke down	The sub county leaders and the in charge should engage the district leadership to ensure the borehole is repaired
Inadequate blood	3	3	The facility receives many children in need of blood transfusion but the blood available is not enough	There is need for the facility to work with UBTS to mobilize the community for blood donation
Inadequate beds in maternity ward	3	3	Expectant mothers coming to deliver have to share beds and others sleep on the floor	More beds are needed in the maternity ward

Health workers' scores indicate that there was no change in most of the issues at hand. Only family planning choices improved, from "fair" to "good". The problem of teenage pregnancies deteriorated from "bad" to "very bad". The problems of understaffing, lack of privacy in the ward, lack of water, inadequate blood and insufficient beds in the maternity ward continued unabated. At the facility level, lack of privacy and water were biggest concerns and health workers consider them the biggest concerns, while at the community level teenage pregnancies are the biggest concern for health workers, as evidenced by the reported high numbers of teenage expectant mothers seeking ANC services.

Men's scores

Issues	Baseline score	Current score	Reason	suggestion
No privacy at the health facility	1	2	The facility has one ward for all patients	Put curtains as immediate action
Limited FP choices	3	4	Most of the commodities needed are available	Sensitize community members to demand for FP services
Understaffing	2	2	The HF has few health personnel	Recruit more health workers to meet the facility standard
Inadequate beds in maternity ward	3	2	Beds are very few but mattresses are somehow available; majority sleep down on the floor	Need to buy more beds for mothers
The facility has no water	1	2	The borehole is not functional	The in-charge should take action
Blood transfusion	2	3	The facility received some blood from UBTC	The community should be mobilized to donate blood
Teenage pregnancy	2	2	The problem is still at high rate due to lack of sensitization in the community	Need to have sex education in schools and to sensitize community on parenting
Low male involvement in FP		2	Men's cultural attitudes are negative	Need to sensitize men on their role in FP through action groups
Gender based violence		2	Poverty has contributed to high GBV by increasing early marriages	
HIV/AIDS prevalence is high		2	There is prevalence of sex work, multiple partners. There is low disclose among people living with HIV	Sensitization on the dangers sex work and multiple partners. Encouraging people to go for HIV testing.

The men's scores indicate an improvement in family planning choices as well as in blood transfusion. They also indicate an improvement in privacy and water availability, even though they acknowledge one ward serving men, women and children, and the borehole not yet being operational, respectively. The challenges relating to privacy, staffing and water at the facility are rated "bad"; just as GBV, HIV/AIDS, male involvement, and teenage pregnancy are, in the community.

Women's scores

Issues	Baseline score	Current score	Reason	Suggestion
Understaffing	2	2	The health workers are not enough at the facility	There is need to recruit more health workers, especially midwives.
No privacy in the general ward	1	1	Men and women are admitted in the same ward	There is need to separate men and women or put curtains for privacy.
Limited FP choices	3	4	Most of the FP commodities are available	More sensitization is needed in the use of FP and male involvement
Inadequate blood	3	3	The blood is there but not enough for the patients	Community awareness on the importance of donating blood
The facility has no water	1	1	The facility has no water and the borehole no longer working	Provision of alternative water supply
Inadequate beds in maternity ward	1	2	Mothers and their new born children sleep on the floor	Need to provide more beds in the maternity ward.
Teenage pregnancy	2	1	There is a high rate of teenage pregnancies due to rape	There is need for health education in the community

The women's group in Namwendwa Subcounty noted an improvement in family planning choices as well as stagnation in the rest of the areas.

Namwendwa subcounty consensus scores

Issues	Health workers		Men		Women		Consensus score	
	Baseline	current	Baseline	Current	Baseline	Current	Baseline	Current
Limited FP choices	3	4	3	4	3	4	3	4
Inadequate beds in maternity ward	3	3	2	2	1	2	2	2
No privacy in the general ward	1	1	2	2	1	1	1	1
understaffing	2	2	2	1	2	2	2	2
Inadequate blood transfusion	3	3	3	3	3	3	3	3
Teenage pregnancy	2	1	2	2	2	4	2	2
The facility has no water	1	1	1	2	1	1	1	1
Low male involvement				2				2
HIV/AIDS preference rate is high				2				2
Gender based Violence				2				2

Participants from Namwendwa Subcounty unanimously highlighted an improvement in family planning choices, from "fair" to "good". In the period under review, there was no improvement in the number of beds in the maternity ward, privacy in the general ward; staffing, blood transfusion, or water. The worst challenges are lack of privacy at the health facility, and teenage pregnancy in the community, both of which were rated "very bad".

Community interventions in Bulopa subcounty

The key issues in Bulopa subcounty were: Lack of awareness of sexual and reproductive health (SRH) rights and responsibilities; high prevalence of teenage pregnancies; limited family planning choices; stock-outs of medicines; and increased sexual and gender-based violence (GBV). The status of these challenges was scored by health workers, men and women in separate groups.

The CSC participants in Bulopa subcounty agreed to implement the following key actions to address the issues above:

Issue	Intervention
Ignorance on SRH rights and responsibilities	Use gatherings, schools, door to door and at health facilities to sensitize communities on their SRH rights and responsibilities
Limited FP choices	The In-charge of Bulopa HC III to write a letter to the district health officer (DHO) on the issue. To engage implementing partners to supplement supplies of FP commodities, especially long term and permanent methods
Gender-based violence	Meeting with partners to come up with a strategy. Multi-stakeholder collaboration, including police, health workers and subcounty leaders. Sensitization communities in village gatherings and door-to-door on the dangers of GBV
Medicine stock-outs	In-charge of Bulopa HC III to write to the DHO to inform and advocate for change from push to pull system.
Teenage pregnancy	Meeting with partners to come up with strategy. Community sensitization on the dangers of teenage pregnancy. Multi-stakeholder collaboration to fight teenage pregnancies. Integrate the interventions in school programmes and through community dialogues.

In the end-line CSC session, participants assessed progress on these actions. Progress was scored by health workers, men and women in separate groups. Below are the results from the exercise.

Health workers' scores

Issue	Baseline score	Current Scores	Reason	Suggestion
Lack of awareness of SRH rights and responsibilities	1	3	Reduced cases of gender based violence reported to the facility	Increased sensitization of communities about SRH rights and responsibilities
Increased teenage pregnancy	1	2	Increased number of teenagers at the health facilities receiving ANC, ART and eMTCT services	Establish youth corners at all health facilities. Sensitize in-school and out-of-school youth about the dangers of teenage pregnancy
Limited choices of FP commodities	3	4	There is increased uptake of FP at the facility	Work with partners (Marie Stopes, etc.) to bring more choices, esp. long term methods
Stock-outs of medicines	3	4	The facility receives medicines through the push system; it does not order according to need.	
Increased domestic violence	1	3	Reduced cases of GBV at the unit, the facility has not recorded any case of GBV from police	Sensitize community on GBV; collaborate with police, health workers and subcounty leaders; sensitize communities on the dangers of alcohol and substance abuse

Health worker scores indicated an across-the-board improvement, with a two-point improvement on awareness of SRH rights and responsibilities, and on GBV. They reported a reduction in GBV cases received from police.

Men's scores

Issue	Baseline score	Current Score	Reason	Suggestion
High rate of teenage pregnancies	2	2	Poverty-stricken girls looking for money end up in early marriages. There is a high prevalence of unsafe abortions among girls	Continuous Sensitization to parents and young people about the dangers of teenage pregnancy by local leaders and community monitors
Lack of awareness of SRH rights and responsibilities	1	2	This is attributed to youth and men not attending community meetings	Continuous sensitization on SRH rights and responsibilities by community monitors
Domestic violence is on increase	2	3	Poverty and food shortages in the community contribute to violence whereby young girls look for money	Increased sensitization on the dangers of GBV in families. People should try to keep food after harvest instead of selling all
Stock outs of medicines	2	3	The facility does not receive sufficient supply.	In-charge should inform the district authorities about the stock outs and request
Inadequate FP commodities	2	3	Family planning methods are there but people don't go for it because of the myths and misinformation	Continuous sensitization by community monitors and local leaders

The men's group in Bulopa Subcounty reported improvements, except on the issue of teenage pregnancies. They attributed the persistent problem of teenage pregnancies to high levels of poverty, which they also blamed for GBV.

Women's scores

Issue	Baseline score	Current score	Reason	Suggestion
Limited FP choices	3	4	There is increased consumption of the FP commodities at facility as more women are using FP; more men are becoming supportive	Continuous sensitization and involvement of men to support their partners to go FP by community monitors
Medicines stock out	2	2	The medicines supplied to the HF are not enough for patients	Increase medicines supplied to the HF
Limited SRHR awareness	1	3	Many women do not go to facilities for ANC and deliver in the community. There is persistence of unsafe abortion cases	Sensitization community members on their SHR rights and responsibilities.
Domestic violence	1	3	Physical domestic violence can lead to death and some men mistreat their partners	Sub county leaders should sensitize families on the dangers of GBV
Teenage pregnancies	-	2	Increased unsafe abortions which leads to death; high rate of school dropout; and increased mortality	Establish youth corners at all health facilities, and sensitize community on the dangers of teenage pregnancies in schools and reach out to those out of school

Women in Bulopa subcounty reported an improvement in family planning choices, SRH rights awareness, and GBV. They reported that a rising number of men are becoming supportive of their partners to access family planning. The challenge of medicine stock-outs persists and was rated "bad" for the reason that the medicines the health facility received through the "push system" are not enough for the patients.

Bulopa subcounty consensus scores

Issue	Health workers		Men		Women		Consensus	
	Baseline score	Current score	Baseline score	Current score	Baseline score	Current score	Baseline score	Current score
Limited awareness of SRH rights and responsibilities	1	3	1	2	1	3	1	3
Limited FP choices	3	4	2	3	2	4	3	4
Medicines stock out	3	4	2	3	2	2	2	2
Domestic violence	1	3	2	3	2	3	2	3
Teenage Pregnancies	1	2	2	2	1	2	1	2

Overall, participants in Bulopa subcounty scored progress in four of the five issues. The biggest improvement was seen in SRH rights awareness, from "very bad" to "fair". The best score was on family planning choices, rated "good". There was no improvement in the challenge of medicine stock-outs.

Community interventions in Bugulumbya subcounty

Community concerns in Bugulumbya subcounty centred on high prevalence of GBV, teenage pregnancies, rudeness of midwives; while health-worker concerns focused on shortage of essential medicines, limited family planning choices, and limited involvement of men. The CSC participants in Bugulumbya subcounty agreed to implement the following key actions to address these issues.

Issue	Intervention
Teenage pregnancy	To lobby subcounty council to make a bylaw concerning defilers
	Health workers to encourage FP use among teenagers
Domestic violence	The Subcounty Secretary for Health to identify and reach out affected families.
	Hold dialogues with affected communities
Myths and misconceptions on FP	HEPS community monitors to sensitize communities on FP
Male involvement	Sensitize communities in village gatherings, places of worship (mosques, churches)
Traditional birth attendants (TBAs)	HEPS community monitors to discourage expectant mothers from giving birth at home and at TBAs'.
	Village health team (VHT) members to monitor TBA births

In the end-line CSC session, participants assessed progress on these actions. Progress was scored by health workers, men and women in separate groups. Below are the results from the exercise.

Health workers' scores

Issue	Baseline score	Current Score	Reason for score	Recommendation
Domestic violence	2	3	Domestic violence has slightly decreased due to sensitizations done by VHTs and monitors.	There should be more education on domestic violence through community dialogues.
Myths & misconceptions about FP	3	3	Community members especially men have some knowledge on family planning and SRH issues.	Sensitization should continue through health talks in the community.
Tradition birth attendants	2	4	Most women are now delivering from health facilities. There are enough midwives at the health centres now.	Health workers continue to tell community on dangers of giving birth at home.
Teenage pregnancy	2	4	FP methods are now available at the Health facilities and youth corners are active.	Continued sensitization in communities and schools done by health workers too.
Male involvement	1	3	Even though men escort their wives, they don't escort them on all visits especially for ANC visits.	Men still need more sensitization on supporting their partners especially on SRH related issues.

Health workers scored improvements in four of five issues identified. They noted an improvement in facility deliveries and improved availability of midwives. Improved availability of family planning commodities and the reported functionality of youth corners at health facilities were seen to contribute to a reduction in teenage pregnancies. There was improvement in male involvement as indicated by increasing numbers of men accompanying their spouses for ANC, even though not on all the visits.

Men's scores

Issue	Baseline score	Current score	Reason for score	Recommendation
Teenage pregnancies	1	2	Information on family planning is still low	Extend the trainings of peers in schools
Domestic violence	2	2	Information on SRH rights is limited.	More sensitization and dialogues on SRH is needed
Myths & misconceptions on FP	1	3	Information on SRH has reached but it hasn't reached everywhere in the desired communities due to distance.	More sensitization and training on SRH is needed as well as more outreaches in the communities is needed.
Male involvement	2	3	Men are still adamant to escort their wives to health centres while they are pregnant or when seeking family planning	Need for sensitization on SRH issues in men and health rights and responsibilities
Traditional birth attendants	3	3	The use of TBAs has decreased among women but some are using TBAs which is not good	More sensitization on the dangers of using TBAs is still needed.

The men's group in Bugulumbya Subcounty scored slight improvements in three of the five issues of concern – teenage pregnancies, male involvement, and myths and misconceptions on family planning. Even with these indicated one-point improvements, they refer to limited awareness of SRH rights, especially in remote locations; and continued refusal of some men to accompany their partners for ANC services.

Women's scores

Issue	Baseline score	Current Score	Reason for score	Recommendation
Teenage pregnancies & unwanted pregnancies	1	2	Family planning and SRH information has not reached many girls in schools. Health workers attitudes has slightly improved so girls are slowly coming though not yet many	Sensitization on FP and SRH among the youth is still needed. HEPS should continue support by reviewing the status in school.
Domestic violence	3	2	Men still feel they have authority on everything in the family. Most of them lack information.	Continuous sensitization is needed.
Myths and misconceptions	1	3	At least sensitization by monitors has been going on to inform people on FP.	Continuous sensitization is needed. Health workers should be involved
Traditional birth attendants	3	4	Even though some women are still using TBAs, most mothers now go to hospitals and have been sensitized on the dangers of giving birth out of hospital without a skilled birth attendant.	More sensitization is needed. Health workers should be involved in the sensitizations and radio programs to tell people on the advantages of giving birth in a health facility.
Male involvement	2	3	These days men escort their wives to seek SRH services especially antenatal care since sensitization started.	Continuous sensitization is still needed in order to change their attitudes towards SRH issues

The women's group in Bugulumbya subcounty scored improvements in four of the five issues at hand – teenage pregnancies and unwanted pregnancies; myths and misconceptions; delivering at TBAs; and male involvement. They acknowledge the contribution of HEPS community monitors to a reduction in myths and misconceptions through their community sensitization effort.

Bugulumbya subcounty consensus scores

Issue	Health workers		Men		Women		Consensus	
	Baseline score	Current Score	Baseline score	Current score	Baseline score	Current Score	Baseline score	Current score
Teenage pregnancy	2	3	1	2	1	2	2	4
Domestic violence	2	3	2	2	3	2	2	1
FP myths and misconceptions	3	4	1	3	2	3	3	2
Male involvement	3	3	2	3	2	3	2	3
Traditional birth attendants	2	4	3	4	3	4	2	4

Overall, three of the five issues were scored to have improved: teenage pregnancy; delivery at TBAs; and male involvement. Family planning myths and misconception were scored to have deteriorated from "fair" to "bad".

Community interventions in Kitayunjwa subcounty

The key issues for health workers and the community in Kitayunjwa Subcounty included domestic violence, commodity stock-outs, limited awareness on family planning, early pregnancies, and limited awareness on women's rights. The CSC participants in Kitayunjwa subcounty agreed to implement the following key actions to address these issues.

Issue	Intervention
Domestic violence	VHTs, health workers to sensitize community on dangers of domestic violence through churches, mosques, trading centers.
Drug stock out	To write a letter through HUMC to DHO about inconsistencies in medicine supply.
People not informed on FP	Midwives and monitors to carry out health education talks in the community/health centres.
Early pregnancies	To convene teenage awareness sessions on dangers of early pregnancies.
Women's rights	Monitors to carry out community dialogues on gender related issues.

In the end-line CSC session, participants assessed progress on these actions. Progress was scored by health workers, men and women in separate groups. Below are the results from the exercise.

Health workers' scores

Issue	Baseline score	Current score	Reason for score	Recommendation
Domestic violence	3	4	Due to sensitization efforts about FP in the community. It has helped health workers and men to have a choice with women together. However, men are still not supportive enough.	Encourage men to involve more in FP counselling in order to prevent frequent pregnancies and un wanted pregnancies with their women.
Drug stock out	1	3	Partner organizations like Rights EC supplied some FP methods to sustain the patients. However, there is still limited supply of commodities like syringes and lignocaine.	Timely supply of commodities.
People not informed on FP	2	4	Health workers have been trained on how to give long term methods of FP by Marie Stopes. However, more health workers need to be trained.	We request for more supplies and trainings on FP methods.
Early pregnancies	1	2	Youth have failed to cope up with the misconception issues	-More sensitizations on FP and out reaches conducted to the youth in the communities
Women's rights	2	4	Health workers have been trained on counselling services on FP. However, some FP methods are not available at particular times.	More trainings need to be conducted and mentorship programs rolled out

The health workers' group scored improvements on all the five issues, with two point improvements on three of the issues – medicine stock-outs, limited awareness on family planning and women's rights. They noted the contribution of implementing partners for supplementing commodities, as well as training health workers on long-term methods.

Men's scores

Men's Issue	Baseline score	Current score	Reason for score	Recommendation
Domestic violence	1	2	Due to dialogues conducted between monitors and the community ,however there is still some level of violence due to lack of support from men	Dialogue meetings and awareness campaigns be conducted
Drug stock out	2	2	Nothing is there in the health facilities in terms of FP medicines	Advocacy is needed from HEPS, monitors and political leaders
People not informed on FP	3	4	Due to community awareness done by monitors. The number of FP users has increased, however a gap still remains	There is need for more support to monitors to continue conducting the awareness and dialogue meetings in terms of transport and allowances.
Early pregnancies	1	2	Improved use of FP services by the youth due to awareness created by health workers and monitors. However, the plight is still rampant.	Functional youth corners are needed Planning to visit schools to create awareness about the dangers of teenage pregnancy.
Women's rights	3	4	There is full participation of women, however they have not participated fully in FP	More training and awareness needed about FP rights

The men's group in Kitayunjwa subcounty scored one-point improvements in four of the issues in the action plan, except commodity stock-outs, which stagnated at "bad".

Women's scores

Issue	Baseline score	Current score	Reason for score	Recommendation
Domestic violence	2	3	Due to awareness carried out in the community by the VHTs, monitors and health workers, however cases of domestic violence still persist	Continuous awareness is needed
Drug stock out	1	2	Some NGOs like Rights EC have supplemented government's efforts in the supply of medicines	Need for increased lobbying efforts from partners to supply the health facilities with FP commodities.
People not informed on FP	4	4	-Due to sensitizations conducted by the VHTs, monitors and health workers.	Need for financial and material support to monitors ,VHTs and health workers during sensitization
Early pregnancies	2	4	-Due to school visits conducted by health workers to sensitize the teenagers about the dangers of teenage pregnancy. However, there is still insufficient guidance from parents and guardians	Need for parents to encourage the youth to engage in FP methods and usage.
Women's rights	3	4	Due to the free, full and informed choice by the monitors	Need for continuous sensitization efforts

The women's group in Kitayunjwa Subcounty scored improvements in four of the five issues, with a notable two-point improvement in early pregnancies. They attributed the reduction in early pregnancies to school visits by health workers and sensitization on the dangers of early pregnancies. They urged parents to support family planning use among adolescent girls.

Kitayunjwa subcounty consensus scores

Issue	Health workers		Men		Women		Consensus	
	Baseline score	Current score	Baseline score	Current score	Baseline scores	Current score	Baseline score	Current score
Domestic violence	3	4	1	2	2	3	1	3
Drug stock out	1	3	2	2	1	2	1	3
People not informed on FP	2	4	3	4	4	4	3	4
Early pregnancies	1	2	1	2	2	4	1	2
Women's rights	2	4	3	4	3	4	3	4

In the consensus scores, participants indicated an improvement on all the five issues, with awareness on family planning and women's rights reaching the score of "good". On all issues, early pregnancies remained below average score, improving only slightly from "very bad" to "bad".

Community interventions in Wankole subcounty

The key issues identified by participants from Wankole subcounty were: Domestic violence, insufficient medicines, early pregnancies, poor attitude of men towards ANC and family planning and poor planning for expected babies. The CSC participants in Wankole subcounty agreed to implement the following key actions to address these issues.

Issue	Interventions
Domestic violence	VHTs to sensitize community members at zonal levels.
Lack of enough medicine at the health units	To write a letter through In-charge to DHO on inconsistencies in supply.
Early pregnancies	Health workers to sensitize adolescents dangers of teenage pregnancy in 3 secondary and 7 primary schools.
Poor attitude by men towards ANC	VHTs and counselors to sensitize men about the benefits of accompanying their women to hospitals.
Ignorance about preparation for the coming baby	VHTs and Health workers to sensitize community about preparation for baby.

In the end-line CSC session, participants assessed progress on these actions. Progress was scored by health workers, men and women in separate groups. Below are the results from the exercise.

Health workers' scores

Issue	Baseline score	Current score	Reason for score	Recommendation
Domestic violence	1	2	Due to community sensitization efforts, however there is still some violence due to women accessing FP	Men need to be sensitized more.
Lack of enough drugs at the health units	4	4	Services are available at the health centres although more are still needed	Need more empowerment from the Ministry of Health
Early pregnancies	2	3	Due to sensitization efforts on the dangers of teenage pregnancy	Need youth corners at the health facilities with expert health workers
Poor attitude by men towards ANC	4	3	Due to the sensitization efforts in the community but there is still need for more counselling.	Need for more counselling of men in the community
Limited knowledge on how to prepare for coming baby	2	3	Due to the sensitization efforts in the community	Men need to be more sensitized

The health worker group scored slight improvements in three of the issues: domestic violence, early pregnancies, and in preparation by parents for the expected baby – all due to some community sensitization efforts. The challenge of shortage of commodities, which was rated "good" in the baseline scores, remained at the same level in the current scores, but was nonetheless the best rated. The attitudes of men deteriorated from "good" to "fair", with the participants calling for more counselling for men.

Men's scores

Men's Issue	Previous Score	Current Score	Reason for score	Recommendation
Domestic violence	1	2	Due to sensitization efforts made by the VHTs and monitors. However, some men are still not supportive of women to go for FP services.	Increased sensitization efforts
Lack of enough drugs at the health units	3	5	Government fully stocked the health centres.	We encourage the DHO to always report drug stock outs in time
Early pregnancies	3	4	Due to sensitization and awareness campaigns to both girls and boys. However, some girls and boys have negative attitude towards family planning methods	More sensitization and awareness campaigns plus provision of commodities needed to reduce teenage pregnancy like condoms.
Poor attitudes by men towards ANC	2	3	Due to awareness campaigns to the community especially men. However, some men pretend to be too busy to escort their wives for ANC.	More awareness is needed on the side of men
Ignorance about preparation for the coming baby	3	4	Due to the awareness campaigns run to the people. However, some men say that they are still poor and can't afford paying for the services.	More awareness is needed to both men and women in the community

The men's scores indicate that the shortage of medicines was fully resolved, giving it the maximum score of "very good". They stated that government had "fully stocked" health facilities. The men also scored improvements on the rest of the issues, giving early pregnancies and limited preparation for the coming baby scores of "good" apiece.

Women's scores

Issue	Baseline score	Current score	Reason for score
Domestic violence	2	3	Due to the community sensitizations conducted, although some men are still adamant to support their women
Lack of enough drugs at the health units	3	4	Commodities are currently available in the health centres
Early pregnancies	2	2	Teenagers lack knowledge about FP
Poor attitude by men towards ANC	1	3	Men are beginning to be responsive by escorting their wives to the health facilities, however some still don't care about their wives
Ignorance about preparation for the coming baby	2	4	-VHTs have done a good job of teaching women about the delivery preparations, however some women don't not want to attend the sessions

The women group scored progress on four of the five issues at hand, giving the "good" score to shortage of medicines as well as to limited preparation for the coming baby. They noted the "good job" done by VHTs in sensitizing women on how to prepare for delivery.

Wankole subcounty consensus scores

Issue	Health worker's		Men's		Women's		Consensus	
	Baseline score	Current score	Baseline score	Current score	Baseline scores	Current score	Baseline score	Current score
Domestic violence	1	2	1	2	2	3	1	2
Lack of enough drugs at the health units	4	4	3	5	3	4	3	4
Early pregnancies	2	3	3	4	2	2	2	3
Poor attitude by men towards ANC	4	3	2	3	1	3	2	3
Ignorance about preparation for the coming baby	2	3	3	4	2	4	2	4

The consensus scores show an improvement on all issues. Two of the issues were scored "good": medicine shortages and limited knowledge about preparation for the coming baby.

Comparing the consensus scores

Issues	Namwendwa		Bulopa		Bugulumbya		Kitayunjwa		Wankole	
	Baseline	Current	Baseline	Current	Baseline	Current	Baseline	Current	Baseline	Current
SRHR awareness			1	3			3	4		
Privacy	1	1								
FP choices	3	4	3	4						
Stock-outs			2	2			1	3	3	4
Understaffing	2	2								
Inadequate beds	2	2								
Water	1	1								
Blood	3	3								
Teenage pregnancies	2	2	1	2	2	4	1	2	2	3
Low male involvement		2			2	3			2	3
Gender based violence		2	2	3	2	1	1	3	1	2
HIV prevalence is high		2								
Myths and misconceptions					3	2				
Traditional birth attendants					2	4				
Women's rights							3	4		
Preparation for the baby									2	4

Teenage pregnancies and GBV featured across all sub-counties as issues in access to family planning information and services. The two issues remained major concerns during the second round of scores, with only participants in Bugulumbya subcounty giving it a score of 4 (good). The rest rated it 3 (fair) and below. GBV was scored 3 (fair) and below across all subcounties.

Medicine stock-outs an issue in three of the five subcounties, while limited family planning choices was a concern in two subcounties.

KEY ACHIEVEMENTS

Built community capacities: The capacities of communities were enhanced through training and awareness. A total of 125 community members were trained, including local leaders, health workers, community monitors and community members from five sub-counties. Of these, 75 were community monitors, who will continue to sensitize their communities in SRH rights and responsibilities. As of the end of the project, they had reached out to 450 people with messages on SRH rights and responsibilities. Information, education and communication (IEC) materials, including fact sheets, banners and t-shirts, continue to carry messages in the community. Partly as a result of increased awareness and empowerment, community leaders report an increase in the number of women reporting sexual assault and domestic violence cases to police.

Improvement in service uptake: Community stakeholders and health providers report an increase in numbers of expectant mothers attending ANC, even though those coming for the 4th ANC are reported to be still few. The number of mothers delivering at health facilities and those attending postnatal services has also increased. Improvement was also reported in family planning uptake and facility deliveries.

Improvement in SRH appreciation and consciousness: This project has improved community and service provider appreciation of SRH rights and responsibilities, and are making efforts to exercise them. The CSC process enabled the community and service providers to carry out a self-assessment as well as a critical examination of the services and resources available at local health facilities, including their constraints.

Improvement in service provider-patient relations: The CSC process enabled service providers and members of the community to work together in identifying gaps, implementing remedial interventions and evaluating progress, allowing them to appreciate each side's abilities and challenges. By the end of this process, the two sides were closer to each other than before.

CHALLENGES

Limited service provider capacity: Choice of methods continued to be a challenge due to non-availability of some family planning commodities, as well as the limited skills in the provision of long-term methods.

Negative cultures, beliefs and myths: While service providers reported an overall improvement in uptake of family planning, sustainability of gains may be hampered by an environment of negative cultures, beliefs and myths which may require a long time to change. The project was implemented in a highly patriarchal, religiously and culturally conservative society in which male chauvinist views combine with unsupportive religious dogma, cultural attitudes and misinformation to create a generally hostile environment for sexual and reproductive health rights generally and family planning in particular.

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