

An Assessment of policy implementation in Uganda:

Application of a Policy Implementation Barometer

Findings from the second wave survey

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24th June 2020



science & innovation

Department:
Science and Innovation
REPUBLIC OF SOUTH AFRICA



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EXECUTIVE SUMMARY

Effective policy implementation is globally acknowledged as a hallmark for adequate service delivery, particularly in low and middle-income countries where systems are often burdened and resources are limited. Equally important is the periodic and continuous monitoring and evaluation of the effectiveness of the policies and the factors that account for their successes and failures, with a view to making the necessary improvements. Despite this widely acknowledged value, research on policy implementation in low and middle-income countries is very scant. Many policies are therefore implemented without systematic evaluations, which often contributes to their failure to achieve their intended objectives.

This report articulates the findings of the Wave 2 survey, a component of a larger project called *Supporting Policy Engagement for Evidence-based Decisions (SPEED) for Universal Health Coverage (UHC) in Uganda*. The project is aimed at supporting policymakers to monitor the implementation of vital programmes for the realisation of policy goals for UHC.

In Wave 1, a Policy Implementation Barometer (PIB) was conducted as a mechanism to provide baseline feedback about the implementation of a selected set of policy programmes to decision-makers and stakeholders. The PIB survey sought to establish the extent of implementation of family planning, malaria, and emergency obstetric care (EmOC) policies in Uganda. These results were used to support stakeholder engagements for corrective action.

Wave 2 of the PIB, which aimed to assess progress in policy implementation of the selected policy areas, was conducted in 2019. This wave maintained the research paradigm of the first one, and was primarily a descriptive and analytical study which employed mixed methods. Both quantitative and qualitative data were systematically collected and analysed. The wave focused on the following sampled districts: Gulu, Kitgum, Lira, Arua, Kibuku, Tororo, Mbale, Jinja, Kampala, Wakiso, Ibanda, Kabarole, Hoima, Kabale, and Masaka. The total sample size was 720, which included: 289 for Malaria, 208 for family planning and 233 for Emergency Obstetric Care (EmOC).

Using an integrated questionnaire, interviews were conducted to collect both quantitative data through Likert scale-type questions, and qualitative data through open-ended questions. Relevant secondary data was also extracted from the routine health information system. The questionnaire was divided into specific modules that sought respondents' views on the extent of the establishment of policy programmes; policy implementation; policy financing; policy workforce; policy medicines and products; and policy service delivery.

The Wave 1 survey established several systemic and resource capacity challenges which constrain policy implementation in the three domains, as well as enablers that can be capitalised on to facilitate effective policy implementation.

Following Wave 1, a wave 2 survey was conducted in 2018/2019 to track progress on policy implementation practices in the same domains. The survey was conducted in the same districts with an additional five districts

The following sections show the findings of Wave 2, based on the selected policy domains and tracks progress between PIB 1 and PIB 2.

Participant distribution

Data was collected from various levels, 22% (152) were government/district level implementers, 20% (136) implementing partners and the least were from Health Centre II with 4% (33). Table 1 below shows the distribution of respondents in each policy domain (malaria, EmOC, family planning) stratified by health facility levels.

Table 1: Percentage distribution of Respondents by policy and facility

Facility	Policy					
	PIB 1			PIB 2		
	Malaria	EmoC	Family Planning	Malaria	EmoC	Family Planning
	<i>n=99</i>	<i>n=79</i>	<i>n=85</i>	<i>n=289</i>	<i>n=233</i>	<i>n=208</i>
Regional referral	19.19	6.33	5.88	11.1	12.0	10.6
General Hospital	12.12	11.39	9.41	10.0	10.7	6.7
Health Centre IV	20.2	29.11	10.59	19.7	19.7	13.5
Health Centre III	20.2	15.19	12.94	17.7	19.3	12.5
National	28.28	37.97	61.18			
Health Centre II				6.2	-	6.7
Government/District				21.5	22.7	20.2
Partners				13.8	15.5	29.8
Total	100	100	100	100	100	100

In comparison with PIB 1 survey, the total number of respondents in PIB 2 had increased significantly, by 63%. While an increase in the total response rate was observed, the response at Health Centre IV decreased by 2.4 percentage points between PIB1 and PIB2.

Malaria

The involvement in selected activities, ranging from involvement in malaria control programmes to community-level programmes, was assessed through a set of six questions.

The results show that a majority of the respondents were involved in activities related to malaria control programs (72%), facility-level service delivery (68%), and community-level programs (54%).

Malaria policy

PIB2 focussed on six policy sub-domains within malaria policy, namely, (policy establishment; implementation; financing; workforce; medicines and products and service delivery). The survey found that malaria programmes were viewed as functioning optimally (average score of 3.41) by most of the participants. Table 3 below presents the average scores of six malaria policy subdomains, comparing PIB 1 and PIB 2 results.

Rapid diagnostic tests and prompt case management - The program for rapid diagnostic tests for malaria and programme for prompt malaria case management were viewed as functioning optimally while the programme for indoor residual spraying was viewed as initial steps taken (average score of 2.19). Overall respondents suggested that the establishment of malaria policy has slightly changed, from the average score of 3.19 to 3.41 in PIB1 and PIB2 respectively. This change was statistically insignificant because the views of the participants remain the same at 'partially established'.

Malaria policy programmes implementation - The implementation of malaria policy programs was generally viewed favourably as respondents agreed with various issues regarding the implementation of malaria policy programmes. One of the chief issues that respondents agreed to, was that the strategies were adequate to control malaria if well implemented. This was evidenced by an average score of 4.2. However, respondents' views about the timely contribution of other sectors, or ministries, to the malaria programmes were moderate (3.23). This is similar to PIB 1 where 25% of the respondents disagreed that the malaria policy/programme enjoyed a fair and timely contribution from other sectors/ministries/departments.

Financing the malaria policy - Respondents generally disagreed with the current financial support status of malaria programmes. Most respondents disagreed that financing for malaria programmes was adequate, predictable and sustainable with average scores of 2.80, 2.74 and 2.34 respectively. This is consistent with the overall view of respondents on the financing of malaria programmes during the baseline survey, with the average score still ranging around 2.5 and 2.8. This indicates that perceptions about malaria financing have not changed much between PIB 1 and PIB 2.

Workforce for malaria policy programmes - In terms of issues related to the workforce of the malaria programme, the overall view of the respondents was moderate to general agreement. This was reflected with a high average score since most respondents agreed that the essential guidelines and directives for workforce were available but most respondents disagree with the adequacy of salaries for the workforce because this received the least agreement.

Malaria medicine and products - Most respondents agreed that the government was the main source of medicine products for malaria, while greater disagreement was expressed that most users were able to pay for the medicines out of pocket.

Service Delivery - In terms of malaria service delivery, participants at follow-up were more likely, than those at baseline, to indicate that there was good service delivery for malaria as they had a higher percentage on these service delivery questions. The results show that there were adequate service outputs for malaria (63% vs 74% baseline compared to the follow-up respectively); that there was satisfactory access to malaria services (49% vs 66%); that there were adequate prevention services (45% vs 64%); and that there was adequate clinical services' distribution (51% vs 65%).

Emergency Obstetric Care (EmOC)

PIB2 established that EmOC policies were viewed as functioning optimally (average scores that range from 2.8 to 3.57) by most of the participants. The results show improvements in most of the policy sub-domains when comparing PIB 1 and PIB 2 results. However, the domain of policy programme establishment shows a decline from an average score of 3.21 in PIB1 to 3.08 at follow up.

EmOC Policy Programme establishment - The overall view of participants about the establishment of the EmOC policy programmes lie within the partially established score. Most participants felt that birth preparedness (57.5%) was fully established, followed by policy awareness (45.9%). In comparing the opinions of respondents on the establishment of EmOC programme between PIB1 and PIB2 the results show that the difference between the average scores is not statistically different, so the opinions are the same.

EmOC policy programmes implementation – implementation of EmOC policy programmes was viewed favourably as most respondents agreed in their responses with various issues of the domain. Satisfaction with the programmes' strategies received the highest average score implying that most respondents agreed that EmOC strategies were adequate to achieve the policy objectives, if they were well implemented. The difference between the overall averages of PIB 1 and PIB 2 was not statistically significant, meaning there was no difference on the opinions that were expressed regarding the implementation of EmOC policy programme between the two surveys.

Financing the EmOC policy programmes – In terms of financing the EmOC programme, most respondents' scores expressed moderate agreement on key related factors. Optimal value and benefits from the funds made available for the EmOC programme received the highest scores by participants (3.36) followed by the acknowledgment of government as a source of funding (3.18). The lowest scores were for users' ability to pay (2.46) and funding adequacy (2.69), implying that there is still a need to invest more money into the programme. Similar to other EmOC programme subdomains, the overall average score for financing of the programme has remained the same between PIB1 and PIB2.

Workforce for EmOC policy programmes – Most of the responses on workforce for EmOC, on average, received moderate and agreement ratings. Most respondents agreed to the availability of guidelines (3.79) and adequate level of training and skills to support EmOC programme activities (3.61), but responses on the fact that the salaries for the workforce were reasonable, were moderate. Again there is no statistically significant difference between PIB1 and PIB2 on the average scores for workforce of the EmOC programme.

EmOC medicine and key products – A majority of respondents agreed that government was the main source of medicines and products. In addition, most respondents also agreed that private sources of medicines and products provided acceptable quality, with an average score of 3.89. Participants, however, disagreed that most users were able to pay out of pocket for their medicines (2.52) and that the costs were reasonable. (2.71). Even in this sub-domain, no statistically significant difference was observed between the baseline and the follow-up response.

Service delivery for EmOC - The results show that most respondents agree with many issues regarding service delivery of EmOC programme. More than 60% agreed that the service outputs or benefits of the programme were adequate and that priority communities for EmOC services had been identified for effective targeting (3.52). There was also an agreement that there was a satisfactory demand for the programme service in the communities. A comparison with PIB1 shows that the proportion of respondents disagreeing that priority communities for EmOC services have been identified for effective targeting, and those that disagree that the demand for the programme service in the communities was satisfactory has decreased by 18 percentage points from PIB1 to PIB2. Another significant shift is that there has been an increase in the number of individuals who agreed with most of the key issues between PIB 1 and PIB2. For instance, the number of respondents who agreed that community demand for EmOC services is satisfactory increased by 12.8 percentage points from PIB1 to PIB2.

Family Planning (FP) policy programmes

FP Policy Programme establishment - It was observed that the overall views of respondents on the establishment of FP programmes lie between *initial step taken* and *partially established*. The creation of awareness of the policy objectives among key stakeholders (at 3.48) was viewed as being fully established, while the programme for collaboration with private/drug shops for the distribution of contraceptives (2.17) was considered as not yet established. The difference between the overall averages of PIB 1 and PIB 2 are indicated as not being statistically significant.

FP policy programmes implementation – Family planning policy implementation was generally viewed favourably as respondents agreed with various issues. Respondents mainly agreed that strategies to address family planning issues were adequate if well implemented with an average score of 4.08. Respondents mostly disagreed that there was timely contribution from the various sectors for the implementation of the family planning policy implementation, evidenced by an average score of 3.24. There was no statistical significance between the overall averages of PIB 1 and PIB2.

Financing the FP policy programmes – Financing of the FP programmes was on average viewed as least satisfactory with responses indicating disagreement and moderate agreement on key related factors. Most respondents agreed that there was optimal benefit and value derived from the funds made available to the programme (average score of 3.27), while there was disagreement that the users of the FP programme are able to pay for the services/ benefits of the FP programmes (2.32) and that funding was sustainable (average of 2.61). However, the differences between the two overall averages for both surveys are not significant.

Workforce for FP policy programmes – Aspects of the workforce for FP programmes were generally received moderate to disagreement ratings. Most respondents agreed to the availability of essential guidelines (average 3.73) and directives for workforce, while affordable salaries for workforce received the lowest ratings (average of 2.82). There was no significant difference between the overall averages of the baseline survey and the follow-up survey.

FP medicines and key products – Average ratings in relation to medicines and products ranged between disagreement and moderate agreement. Most respondents agreed that private sources of medicines and products were of acceptable quality (average 3.80), while most respondents disagreed that users were able to pay for medicines out of their pockets (average 2.46) and that the costs were reasonable (2.78). As in other sub-domains, there was no statistical significance between the PIB1 and PIB2 overall averages in relation to medicines and products

Service delivery for FP - Service delivery, received an overall moderate rating. In this domain, respondents agreed (average of 3.63) that FP services were adequate, but most respondents moderately agreed to the statement that contraceptive services are continuously provided with no major gaps or delay (average 3.02). The overall average scores between PIB1 and PIB 2 in terms of service delivery are significant. This could indicate that there has been a slight improvement in the service delivery of the family planning programme.

PIB2 shows specific areas that have had some significant improvement in the different domains although there are issues that still need attention. The issue of inadequate financing and resource availability seems to be a concern that cuts across all the policy domains. There is also a general agreement that the workforce is inadequate to implement the programmes and that salaries in the sector are inadequate. These resources are essential for the successful implementation of the programmes. There is, therefore, a need for government to engage other stakeholders to address these issues and make notable changes across all the policy domains in these particular areas.

Conclusion

The uptake of the PIB 2 survey increased significantly from baseline to the second wave of the survey suggesting that the PIB methodology is applicable and acceptable in the context of assessing policy implementation in data-limited contexts. The survey shows that the selected three policy domains have variable levels of implementation and the study was able to establish the specific sub-areas for there is need for stakeholder engagements and further investments. The policy norms and standards were generally well understood. This suggests that communication from the centre to the periphery, and within the periphery, amongst partners was good. Although there was no clear evidence of limited enforcement of policies, family planning provides an example where such might not have occurred as evidenced by the drop in implementation scores across many policy domains. Availability of quality resources was indeed a cross-cutting issue, particularly as it relates to levels of funding and its predictability and sustainability, as well as the availability of medicines and key products for malaria, family planning and EmOC. The government needs to look at additional innovative ways of mobilising resources to at least maintain and improve service coverage and its quality. The existence of cost-sharing for such critical services goes against the vision of universal health coverage. Nonetheless, notable changes have occurred between the baseline and the follow-up survey which suggests that malaria, emergency obstetric care and family planning remain policy and programmatic priorities for Uganda.

1.0 Introduction

This report presents the findings of the second wave of the policy implementation barometer (PIB) survey conducted in 15 districts in Uganda: Gulu, Kitgum, Lira, Arua, Kibuku, Tororo, Mbale, Jinja, Kampala, Wakiso, Ibanda, Kabarole, Hoima, Kabale, and Masaka. The report begins by providing the background context of health systems in Uganda and problematising the challenge of public health in the country. In this section, the aim and objectives of the study are presented. An outline of each section of the report is also included.

1.1 Background

Like many other low and middle-income countries, Uganda seeks to achieve Universal Health Coverage (UHC). UHC is a cornerstone for the attainment of Sustainable Development Goal 3 of the global development agenda. This goal embodies the aspirations and visions of populations that are largely poor and marginalised. Uganda is a relatively small country covering an area of 241 000 square kilometres, with an estimated population of approximately 45 741 people in 2020. However, it has one of the highest fertility rates in the world at 5.4 children per woman which contributes to a population growth of 3% per annum. The majority of the population lives on less than US\$1 a day which is largely spent on food. Population growth will certainly increase demand for health services. Uganda's health system comprises of public, private for-profit, private not-for-profit providers, traditional and complementary medicine practitioners.

Uganda recognises health as a human right and that every citizen should have access to quality health care. It is against this background that the country has made a major commitment by developing its second National Health policy that is guided by the updated Health Sector Development Plan for 2015/16 – 2019/20 [1]. The policy aims 'to attain a good standard of health for all people in Uganda in order to promote healthy and productive lives' and is guided by the principles of public health care, decentralisation, evidence-based policy making, gender-sensitive and responsive health care, pro-poor and sustainability, partnership, minimum health care package, integrated health care delivery, mainstreaming of health in all policies, and consideration of the international context.

In 2001, direct user fee for public healthcare services was abolished in Uganda with a view to eliminate financial access barriers, thereby making healthcare services accessible to everyone [2]. Despite scale-up of intervention programmes towards the goal of controlling and eliminating the burden of diseases in Uganda, the incidence of malaria remains high and is a leading cause of morbidity and mortality with over 1.4 million cases reported in 2019, primarily in children under five years of age [3]. Uganda ranks third in the number of malaria infections in Sub-Saharan Africa and has the highest reported number of transmitted malaria cases in the world [3]. Moreover, the reports indicate that severe anaemia as a result of malaria remains a public health problem in the country. However, the country has made progress in improving public health with regards to preventing the disease through the malaria control programme as evidenced by more than 80% coverage with long-lasting insecticidal nets (LLINs) or in-door residual spray for mosquitoes which has been recorded since 2018 [4]. As a result of these interventions, the number of deaths due to malaria has declined by 39% between 2010 and 2017 in Uganda [4].

Uganda also has one of the fastest-growing populations in the world, partly due to low contraceptive use among fecund married or unmarried and sexually active women who desire contraception. Only 31% of these women use modern contraceptive methods, while 61% lack access and 8% use traditional methods [5]. According to the 2016 Uganda Demographic Health Survey (UDHS) as referenced by Cisek et al. [6], Uganda's modern contraceptive prevalence rate (mCPR) has improved significantly, increasing from 26% in 2011 to 35% in 2016. Despite the high knowledge and awareness of modern contraceptive methods (90%), use remains low due to low levels of education, lack of knowledge of the side effects of different contraceptive methods, and prohibitive cultural, social and religious norms [7]. Hence, the Government of Uganda has pledged to increase uptake of modern contraception to 50% and reduce the unmet need to 10% by increasing access to family planning information, targeting youth, and addressing the social and cultural misconceptions about contraception [7]. The Ugandan Ministry of Health has set a Family Planning 2020 (FP2020) goal of reaching a modern contraceptive prevalence rate of 50% among women (married and in a union) by 2020.

This study, therefore, aims guide the implementation of various health policies in Uganda. However, policy implementation remains an under researched area in most countries and it is not surprising that several policies are implemented without a systematic follow up of why, and how, they are working or failing [8,9]. Uganda has developed several acclaimed health policies to transform the wellbeing of its population. However, inadequate implementation has impacted negatively on the effectiveness of the policies [10]. The identification of policy implementation failures and sub-optimal performance through monitoring and accountability for policy implementation is mostly downward looking – mainly identifying frontline failings at service delivery levels. There is limited research and tools to monitor upstream actions (e.g. financing, partnerships and support systems) that are vital to the performance of frontline functions. This arises partly from the result-orientation in research funding and methodologies that are well established for the downstream outcomes and less well-tuned for upstream and mid-level actions. Upstream monitoring is predominantly relational and process-oriented with fewer research tools to make meaning of the complex relationships that underlie up-stream functions. The health system research agenda has brought to the fore processes that support service delivery [11]. Once a policy is passed, there are often weak mechanisms to provide systematic feedback to the decision-makers about implementation progress[8,9]. Where it exists, it is often about what frontline actors should do to improve policy outcomes but less focused on the upstream actions that support implementation processes that may constrain implementation such as organisational architecture and partnerships, workforce capabilities, costs and financing, mobilisation and compliance of policy beneficiaries. There are a few tools that allow upstream policymakers and policy advocates to monitor implementation and to mobilise appropriate and continued policy support during the implementation phase.

There is limited research that tracks the implementation phase of policies for the benefit of informing corrective actions [8,9]. This gap manifests in delayed corrective actions for policy implementation processes or gradual abandonment of policies that would otherwise transform the health and welfare of communities. Although some programme monitoring tools exist, these mostly serve a technocratic objective, mostly organised on the basis of project silos and internal indicators of project management. Evidence emerging from HIV programmes show that active implementation tracking of project indicators has a tendency to divert the health systems capabilities towards a couple of projects to the neglect of other vital policy programmes [5].

It is against this background that a project entitled “Supporting Policy Engagement for Evidence-based Decisions (SPEED) for Universal Health Coverage (UHC) in Uganda” was launched by the School of Public Health at Makerere University (MakSPH) in 2015. The overall objective of SPEED project is to strengthen capacity for policy analysis, implementation monitoring and analysis of impact and thereby contribute to accelerating progress towards UHC in Uganda. In addressing the objective of implementation monitoring and analysis of impact, the SPEED project developed an approach called the policy implementation barometer (PIB). This PIB draws from political science practices where voter barometers have been used to gauge campaign messages, popularity of policy options and satisfaction with political reforms. It also draws heavily from the business and policy implementation research literature which emphasises the importance of understanding the theory of change (TOC) of a policy, determinants of change, implementation objectives, networks of implementers, targets, contexts, strategies for implementation and implementation impact.

The first wave of the policy implementation barometer was conducted in 2016/17. This report is based on the study findings of wave two of the PIB survey which was also conducted to reveal gaps in policy implementation. Feedback was also provided to the decision-makers about progress in implementation of a selected set of policy programmes for UHC. The findings are intended to elicit policy engagements and foster corrective action in required areas. This report further provides a comparative analysis of the two PIB surveys’ results.

1.2 Study purpose and questions

The PIB seeks to unravel the complex issues that facilitate or constrain policy implementation and, more importantly, to explore how stakeholder engagements using the generated evidence can enhance policy implementation. Moreover, this study aimed to collect data to address the following questions:

- How is Uganda mobilising local and international resources to ensure that the health system better responds to people's needs and therefore contribute to better health outcomes?
- Are existing health policies and related health programmes (malaria, family planning and emergency obstetric care) being implemented?
- If existing health policies and related health programmes are being implemented, are they being implemented in ways that enhance health systems performance and population health?

1.3. Objectives of the study

Primary objective

The primary objective of the study was to assess the implementation of malaria, family planning and emergency obstetric care policies for Universal Health Coverage (UHC) in Uganda.

Specific objectives include:

- The assessment of the perceived appropriateness of implementation programmes to the identified policy problems (i.e. malaria, family planning & EOC).
- The assessment, using priority parameters, of the perceived extent of implementation for selected policies (i.e. malaria, family planning & EOC).
- The determination of the enablers and constraints to the implementation of the selected policies (i.e. malaria, family planning & EOC).

1.4. Report Outline

Section 1 describes the background context, purpose, aim and objectives of the study. Section 2 details the methodology of this study. Section 3 presents the study findings on three elements of the PIB - malaria, emergency obstetric care and family planning. The report then concludes with key issues and offers some recommendations for further study. The report also includes two annexures: Annexure 1 is a tool for family planning, Annexure 2 is a tool for malaria, Annexure 3 is a tool for EMO.

2.0 Conceptual framework

The acknowledgement that policy implementation is a complex process is the initial step in developing an approach of assessment. It is important to first get a good understanding of what a policy is. Secondly, one must understand the various approaches to translating policy into programmes and activities towards the expected results. It is this approach that informed the survey PIB in Uganda and may have applicability to other low and middle-income countries.

What is policy?

Policy is variously defined to mean “statement of intent” (e.g. to eradicate Ebola by year 2020). The definition of policy also needs to be understood in terms of its context and perspective, for example, whether it is at government or organisation level. At governmental level, a policy could be defined as the declared objectives that the government seeks to achieve for the benefit of its citizenry. The commonly used definition by health policy scholars is that policy is a product of ‘the interplay between institutions, interests and ideas’ (12). There are different levels of policy, often referred to as: macro that relates to governmental or systemic level with a broader or national reach; meso that relates to organisational or programmatic levels (e.g. at district or hospital level); and micro that relates to the clinical or professional practice level guidelines and controls (13).

What is policy implementation?

Policy implementation is described as what happens between policy expectations and policy results (14-16). What happens between ‘what is expected’ from a policy and the outcomes of the policy includes actions and inaction by public and private individuals that lead (or not) to the realisation of the policy objectives (17, 18). A proposed conceptual model (Figure 1) was developed by Mazmanian and Sabatier (year?) (18) which aids in the analysis of the variables that shape the relationship between policy as intent and policy as practice, and these are briefly described below:

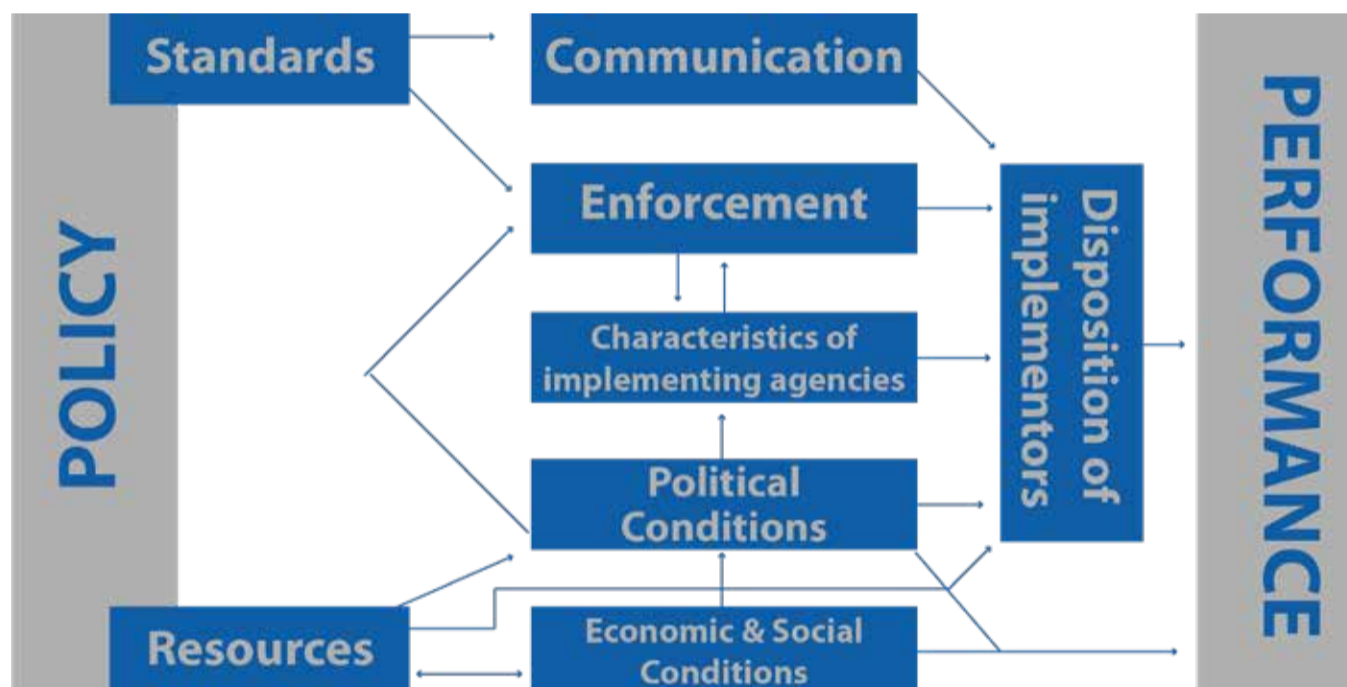


Fig. 1 The 8 factors influencing of Policy Implementation

Policy resources

Policies require resources, such as financial and human, for the administration, support, and enforcement of the implementation process. The availability and nature of policy resources influence the predisposition of policy implementers, who are responsible for executing the policy objectives (19).

Policy standards

Policy standards specify the expected policy goals and what is expected of each actor within the policy implementation process. They also determine requisite tools for the enforcement to ensure compliance with policy objectives and may therefore, take the form of legislation, regulations, technical guidelines, and standard operational procedures. They also describe how the policy will be enforced. To aid the implementation process, these need to be adequately and timeously communicated, understood, and accepted by the implementers.

Communication

This is important in ensuring that the policy standards are clearly understood by the implementers. The policy standards should be articulated in such a way that the implementers are clear as to the expectations, leaving no room for ambiguity.

Enforcement

Mechanisms and procedures for monitoring the enforcement of the policy should be in place with deviations promptly attended to. Policy enforcement may be normative, remunerative or coercive depending on the context. The level of enforcement will be determined by factors such as power relations amongst the different policy actors, access to political resources, ability to monitor progress of the policy implementation process as defined by the availability of technical staff and financial resources to do so, reporting structures and mechanisms (20, 21).

The characteristics of the implementing agencies

These relate to the nature of the organisations and their relationships or interdependencies. Whether private or public, the organisational network for policy outcomes may work through collaboration or competition.

Disposition of implementers

The implementers assume the role of street-level bureaucrats that determine the fidelity of the policy implementation process. There are many factors that influence the disposition of implementers such as their beliefs and attitudes towards the policy, their level of training, their level of cognition of what the policy requires, and whether or not there are policy champions in their midst.

Political environment

The level of political support for policies will have a significant influence on whether or not a policy is implemented and the ways in which the implementation takes place. For example, the extensive support and political will to combat HIV in Uganda is often cited as the main reason for the dramatic reduction of HIV prevalence between 1990 and 2008. The political environment creates a conducive space, avails policy champions, and makes resources and community mobilization feasible.

Economic and Social conditions

The level of economic development and the fiscal space within a country will determine the level of resources that are available to implement any policy. Fiscal space is the budgetary room for a country or government to allocate funds from the national fiscus in a sustainable way (22). These elements guided the development of this PIB as reflected by the data collected and analysed.

3.0 Methods

3.1 Study setting

The policy implementation barometer focused on three levels of policy implementation namely national (macro), district (meso) and facility (micro) levels. The fundamental assumption is that most policies in Uganda require engagement and supportive actions at these three levels. This frames the policy setting and hence the expected implementation variables of interest for the barometer survey.

3.2 Criteria for choosing policies to assess

There are many health policies in Uganda but this barometer focused on policies related to family planning, emergency obstetric care and malaria policies (See Box 1), which were selected based on the criteria summarised below.

3.3 Criteria for selection of policy for assessment

1. It is a topical policy under implementation in the country,
2. The policy has a specific policy history or age (based on when it started),
3. The policy is a priority to the SPEED project target group in terms of the need for evidence to support implementation decisions and or scaling up of activities,
4. The policy is clearly articulated and / or written, and
5. The policy is multidimensional to allow for multiple stakeholder engagements around a set of related themes rather than a narrow or vertical programming with less integration in the general health system.

To ensure coverage of the whole health value chain, policies were selected on the basis they represented (A) prevention, (B) communicable diseases (treatment), and (C) emergency care.

1) Family Planning

- Prevention of unplanned pregnancies e.g. contraceptive security
- Treatment of involuntary pregnant patients e.g. counselling, reproductive rights awareness
- Follow up policies e.g. service delivery and access, financing, management and stewardship

2) Malaria policies

- Prevention of malaria policies e.g. **insecticide-treated nets** (ITNs) and Insecticide Residual Spraying (IRS)
- Treatment of malaria policies e.g. Antimalarial drug policies
- Follow up policies e.g. financing, management

3) Maternal mortality policies

- Prevention of maternal mortality e.g. maternal mortality reviews
- Treatment of pregnant patients e.g. Emergency obstetric care
- Follow up policies e.g. Policy on skilled birth attendance, financing, management

Box 1: Policies for the Barometer

3.4 Study design

This study was a cross sectional and descriptive survey where both qualitative and quantitative data collection methods were employed focusing on multiple assessment domains.

3.5 Data and data collection methods

Both qualitative and qualitative data were collected through a structured questionnaire with both open and close ended questions administered to relevant stakeholders for policy implementation. The questionnaires for the three policies were standard in terms of the key domains with some variations based on the specificities of the policy. The questionnaire structure included six modules addressing objectives 1 to 3, viz: establishment of policy programs, policy implementation, financing, workforce, medicines and products, and service delivery (Figure 2).



Figure 2: Policy domains (modules) assessed

Quantitative data was collected through questions with Likert scale-type options capturing key measures of implementation status in each module, while qualitative data was captured through open-ended questions at the end of each module. A general question soliciting respondent ideas or suggestions was posed in the form of 'what are the main issues, factors and actions needed to improve the shortcomings in the issues assessed?'

3.6 Sampling procedure

Purposive sampling was employed to identify respondents with a formal mandate for implementing the selected policies at the national level – i.e. programme officials and national committees for 1) Malaria Control Programme and 2) Maternal and Child Health and Family Planning, and district level respondents comprising the district health management teams (DHMT) and from the selected health facilities.

3.7 Data analysis and displays

Descriptive and comparative statistics were calculated to show implementation progress by policy/program areas by using STATA, SPSS, and Excel for quantitative data. Qualitative data was analysed using the conventional content analysis (CCA) to establish the main underlying factors contributing to or constraining the implementation of specific policies. Opinion questions that had the following options, 1- strongly disagree; 2 - disagree; 3 - moderate; 4 - agree; 5 - strongly agree, were collapsed into three options, 1 & 2 = Disagree, 3 = Moderate, 4 and 5 = Agree to aid in easier interpretations. Responses required a "Don't know" option were left out of the analysis.

4.0 Results

Table 1 shows the distribution of respondents in each policy domain (malaria, EmOC, family planning) stratified by health facility levels. In PIB 2, a total of 720 participants were interviewed, with 289 respondents interviewed on malaria policy implementation, 233 on emergency obstetric care and 208 on family planning. Data was collected from various levels, 22% (152) were government/district level implementers, 20% (136) implementing partners and the least were from Health Centre II with 4% (33). In comparison with PIB 1 survey, the total number of respondents in the study had significantly increased by 63%. While an increase in total response rate was observed, the response at Health Centre IV fell by 2.4 percentage points between PIB1 and PIB2.

Table 1: Percentage distribution of Respondents by policy and facility

Facility	Policy					
	PIB 1			PIB 2		
	Malaria	EmoC	Family Planning	Malaria	EmoC	Family Planning
	<i>n=99</i>	<i>n=79</i>	<i>n=85</i>	<i>n=289</i>	<i>n=233</i>	<i>n=208</i>
Regional referral	19.19	6.33	5.88	11.1	12.0	10.6
General Hospital	12.12	11.39	9.41	10.0	10.7	6.7
Health Centre IV	20.2	29.11	10.59	19.7	19.7	13.5
Health Centre III	20.2	15.19	12.94	17.7	19.3	12.5
N/A	28.28	37.97	61.18			
Health Centre II				6.2	-	6.7
Government/District				21.5	22.7	20.2
Partners				13.8	15.5	29.8
Total	100	100	100	100	100	100

Extent of involvement in policy domains

The extent of involvement in selected activities ranging from involvement in malaria control programs to community-level programs was assessed through a set of six questions. Table 2 below summarises these results and also shows the extent to which participants work across the three policy domains.

Table 2: Extent of engagement in selected activities by policy category n (%)

Activity	Malaria (n=289)			EMOC (n=233)			Family Planning (n=208)		
	Low	Moderate	High	Low	Moderate	High	Low	Moderate	High
To what extent is your job engaged in activities related to malaria control programs/activities?	9 (3.1)	73 (25.3)	207 (71.6)	29 (12.4)	76 (32.6)	128 (54.9)	42 (20.2)	71 (34.1)	95 (45.7)
To what extent is your job engaged in activities related to family planning program/activities in your position?	110 (38.2)	104 (36.1)	74 (25.7)	47 (20.2)	74 (31.8)	112 (48.1)	12 (5.8)	49 (23.7)	146 (70.5)
To what extent is your job engaged in activities related to emergency obstetric care programs /activities in your position?	137 (47.4)	99 (34.3)	53 (18.3)	23 (9.9)	65 (27.9)	145 (62.2)	68 (32.7)	76 (36.5)	64 (30.8)
To what extent is your job engaged in activities related to district level health system?	54 (18.7)	104 (36.0)	131 (45.3)	37 (15.9)	74 (31.8)	122 (52.4)	45 (21.6)	61 (29.3)	102 (49.0)
To what extent is your job engaged in activities related to facility level service provision?	27 (9.3)	65 (22.5)	197 (68.2)	9 (3.9)	45 (19.4)	178 (76.7)	15 (7.2)	38 (18.3)	155 (74.5)
To what extent is your job engaged in activities related to community-level health programs?	35 (12.1)	98 (33.9)	156 (54.0)	50 (21.5)	76 (32.6)	107 (45.9)	33 (15.9)	60 (28.8)	115 (55.3)

The data shows that in relation to malaria policy, a majority of respondents were involved in activities related to malaria control programs (72%), facility level service delivery (68%), and community-level programs (54%). For emergency obstetric care policy, a large part of job engagements were related to facility level service delivery (77%) followed by emergence obstetric care programs (62%) and malaria control programs (55%). The level of job engagement in facility level service delivery was high for all policy domains. In order to get deep insights into the status of, as well as the drivers and constrainers of the policy programme implementation, six sub-policy domains were investigated in each domain. These are policy establishment; implementation; financing; workforce; medicines and products and service delivery. The results by specific policy domain are presented below.

4.1 Malaria policy

A total of 289 participants responded to issues related to malaria control. A majority of this group are from government / district (21.5%) and referral facilities (19.7%). Also, a large number of respondents were involved in malaria control programmes (71.6%). Table 3 below presents average scores of the six policy sub-domains in malaria (policy establishment; implementation; financing; workforce; medicines and products and service delivery). The average scores are based on the opinions of respondents on each question/issue in the policy module. The scales of the opinions are presented under each specific table of the policy domain. Finally, a comparison of scores is made across the policy domains.

The average score for different components of policy domains ranged from 2.82 (financing) to 3.67 (implementation). All components of the domains except one, policy awareness (average score 3.28), implementation (3.67), workforce (3.39), medicines and products (3.38) and service delivery (3.50) showed that the malaria policy domain had at least gained optimum coverage, Table 3 and Figure-1.

When compared to baseline, although not statistically significant, all average component scores for the malaria policy domain had increased with the on overall increase of 0.8 (3.28 vs 3.19 for follow-up and baseline respectively).

Table 3: Average score for each Malaria policy domain

Policy programmes establishment		Implementation		Financing		Workforce		Medicines and Products		Service delivery	
Question items	Av score	Question items	Av score	Question items	Av score	Question items	Av score	Question items	Av score	Question items	Av score
Policy awareness	3.69	Targets' knowledge	3.87	Funding adequacy	2.80	Adequate workforce	3.00	Adequate stocks	3.52	Adequate service outputs	3.74
Mapping programme	3.06	Strategies' satisfaction	4.20	Timely availability	2.77	Adequate time devotion	3.40	Timely availability	3.57	Identified priority groups	3.68
IRS programme	2.00	Political support	3.69	Favourable allocations	2.85	Adequate training and skill	3.56	Government main source	3.76	Satisfactory access	3.58
LLINs programme	3.70	Visibility champions	3.81	Government source	3.19	Adequate deployment	3.19	Reasonable costs	2.83	Favourable attitudes	3.60
Larval source management	2.5	Political oversight satisfaction	3.46	Predictable funding	2.74	Guidelines availability	3.74	Acceptable quality	3.31	IEC wide reception	3.24
Prompt case management	3.97	Participatory process	3.28	Sustainable funding	2.34	Government workforce source	3.67	Predictable flow	3.58	Adequate preventive services	3.58
RDTs programme	3.98	Organisations' coordination	3.54	Users' ability to pay	2.55	Affordable salaries	2.79	Sustainable supply chain	3.44	Continuous preventive services	3.14
iCCM programme	3.37	Private sector contribution	3.76	Optimal value	3.33	Sufficient tools	3.33	Users' ability to pay	2.63	Adequate clinical services' distribution	3.56
		Community advocacy	3.75			Optimal supervision	3.51	Optimal quality	3.80	Satisfactory community demand	3.77
		Sectors' timely contribution	3.23			Contribution by community workers	3.68			Community prevention responsibility	3.11
		Clear M&E information	3.86								
		Organisations' relationships	3.73								
		Conducive environment	3.49								
Overall averages PIB 2	3.28		3.67		2.82		3.39		3.38		3.50
Overall average PIB 1	3.19		3.51		2.51		3.21		2.99		3.24
T-test	0.26		0.22		0.67		0.19		0.08		0.10

Note: the scale for the policy programme establishment domain: 1- Not yet established; 2-Initial steps taken; 3-Partially established; 4- Gained optimum coverage -; 5- Fully established

The scale for implementation, financing, workforce, medicines and products and service delivery: 1-strongly disagree; 2-Disagree; 3-Moderate; 4-Agree; 5- Strongly agree

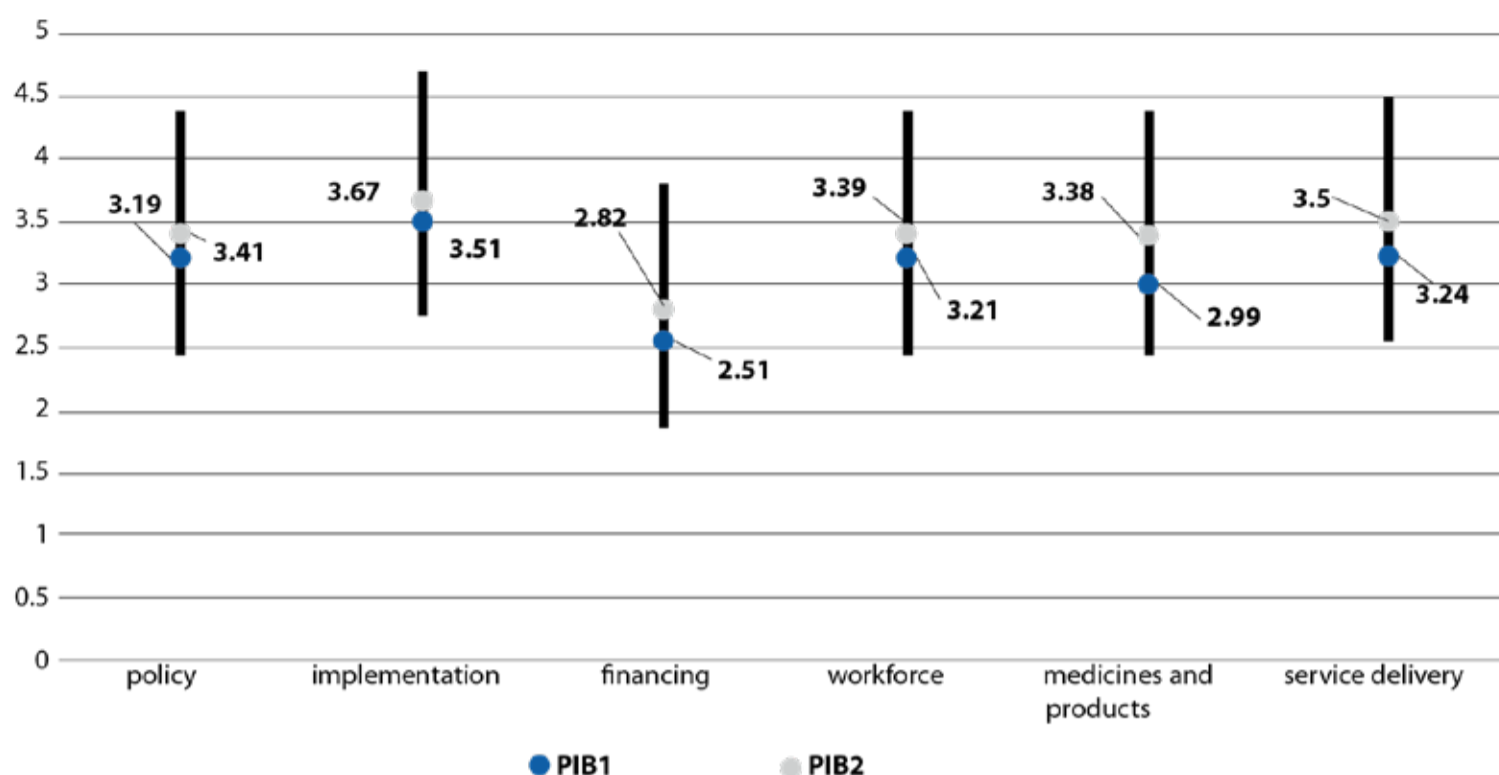


Figure 3: Overall average score for each malaria policy module, 95% confidence interval for the mean

Malaria Policy programmes establishment

There were noticeable improvements from baseline to follow- up on participants reporting:

1. LLINs programme (63% vs 72%),
2. RDT programmes (84% vs 91%),
3. ICCM programmes (58% vs 67%) reporting gained optimum coverage or fully established comparing baseline and follow-up respectively in all three instances.

There were however proportionately more people at baseline than at follow-up reporting gained optimum coverage or fully established programmes on:

1. IRS programmes (32% vs 24%) and
2. Larval source management (37% vs 29%)

Table 4: Extent of establishment of malaria policy (n=289)

Item	PIB 1			PIB 2		
	Not/ partially established	Fully established	Gained Optimum coverage	Not / partially established	Fully established	Gained Optimum coverage
Policy awareness	19(19%)	68 (69%)	11 (11%)	67(23.2%)	192 (66.4%)	23 (8%)
Mapping programme	49(49%)	41 (41%)	10 (10%)	125(43.2%)	128 (44.3%)	18 (6%)
IRS programme	68(68%)	19 (19%)	6 (6%)	220(76.2%)	52 (18.0%)	8 (2.8%)
LLINs program	37(37%)	47 (47%)	13 (13%)	80(27.7%)	180 (62.3%)	26 (9%)
Larval source management	63(63%)	26 (26%)	5 (5%)	204(70.6%)	73 (25.3%)	4 (1.4%)
Prompt case management	15(15%)	57 (58%)	23 (23%)	28(10%)	224 (77.5%)	37 (12.8%)
RDTs programme	16(16%)	54 (55%)	27 (27%)	27(9%)	223 (77.2%)	39 (13.55)
iCCM programme	42(42%)	38 (38%)	14 (14%)	94(33%)	166 (57.4%)	25 (8.6%)

Note: the data was obtained on a Likert scale (Don't know - gained optimum coverage/ results), Don't know were treated as missing

Respondents were asked to express their opinions on the implementation of the malaria policy/programmes in their institutions. The implementation of malaria policy programs was generally viewed favourably, as respondents agreed in their responses to various issues regarding the implementation of malaria policy programs. The main issue that respondents agreed to was the adequacy of the strategies to control malaria, if well implemented, with an average score of 4.2 and the presence of a clear monitoring and evaluation (M&E) strategy. However, the views of respondents about the timely contribution of other sectors or ministries to the malaria programmes were moderate. Table 5 below shows responses in relation to the implementation of malaria policy/programmes.

As indicated from the results, most respondents expressed their agreement to the status of many issues in respect of the implementation of malaria programmes. Approximately more than 60% of respondents agreed with every issue raised in relation to malaria policy implementation except for the timely contribution from other sectors, to which less than half of respondents expressed their agreement. No major changes occurred with the opinions of respondents in relation to key issues of malaria programmes between the baseline survey and follow-up, for example, there is a slight change in the views about the adequacy of the strategies from 92% in PIB1 to 88.9% in PIB2. There is also an increase in the confidence in the presence of M&E strategies from 63% in PIB 1 to 81.3% in PIB2

Table 5: Implementation of the malaria policy/programmes (n=289)

Item	PIB 1			PIB 2		
	Disagree	Moderate	Agree	Disagree	Moderate	Agree
Targets' knowledge	7 (7%)	11 (11%)	78 (78%)	11 (3.8%)	43 (14.9%)	227 (78.6%)
Strategies' satisfaction	2 (2%)	3 (3%)	92 (92%)	5 (1.7%)	26 (9.0%)	257 (88.9%)
Political support	10 (10%)	17 (17%)	71 (71%)	26 (9.0%)	51 (17.6%)	201 (69.6%)
Visibility champions	15 (15%)	16 (16%)	63 (63%)	14 (4.8%)	47 (16.3%)	222 (76.9%)
Political oversight satisfaction	21 (21%)	20 (20%)	54 (54%)	28 (9.6%)	74 (25.6%)	172 (59.9%)
Participatory process	18 (18%)	15 (15%)	57 (57%)	29 (10.0%)	53 (18.3%)	174 (60.2%)
Organisations' coordination	16(16%)	19 (19%)	52(52%)	20 (6.9%)	61 (21.1%)	193 (66.8%)
Private sector contribution	10 (10%)	20 (20%)	64 (64%)	19 (6.5%)	51 (17.6%)	212 (73.3%)
Community advocacy	12 (12%)	21 (21%)	62 (62%)	16 (5.5%)	61 (21.1%)	210 (72.6%)
Sectors' timely contribution	25 (25%)	27 (27%)	39 (39%)	43 (14.9%)	93 (32.2%)	139 (48.1%)
Clear M&E information	14 (14%)	16 (16%)	63 (63)	6 (2.1%)	40 (13.8%)	235 (81.3%)
Organisations' relationships	8 (8%)	15 (15%)	68 (68%)	9(3.1%)	37 (12.8%)	226 (78.2%)
Conducive environment	12 (12%)	22 (22%)	57 (57%)	29(10.0%)	73 (25.3%)	177 (61.2%)

Financing of Malaria policy programmes

Respondents were requested to express their opinions on financial support for the malaria policy programme (Table 6). About 62% of the respondents agreed that there was optimal value and benefits from the funds made available for malaria programme, up from the 56% at baseline. It was however evident from the results, that a large proportion of respondents disagreed with most of the issues related to financing of the malaria programme as shown by the low percentage of people agreeing to the following statements on funding:

1. funding adequacy (26% vs 36%),
2. timely availability of funding (28% vs 35%),
3. favorable allocations of funding (24% vs 37%),
4. predictable funding (33% vs 42%), v) sustainable funding (18% vs 30%) and
5. user ability to pay (18% vs 25%) comparing baseline and follow-up in all cases respectively.

Table 6: Financing for Malaria programme

Item	PIB 1			PIB 2		
	Disagree	Neutral	Agree	Disagree	Neutral	Agree
Funding adequacy	48 (48%)	26 (26%)	18 (18%)	75(30%)	74 (26%)	105(36%)
Timely availability	40 (40%)	18 (18%)	28 (28%)	81(28%)	76 (26%)	100(35%)
Favourable allocations	40 (40%)	21 (21%)	24 (24%)	66(26%)	82 (28%)	106(37%)
Government source	31 (31%)	3 (3%)	57 (57%)	89(31%)	29 (10%)	157(54%)
Activity costs affordability	34 (34%)	22 (22%)	26 (26%)			
Predictable funding	30 (30%)	16 (16%)	33 (33%)	76(26%)	53 (18%)	120(42%)
Sustainable funding	36 (36%)	22 (22%)	18 (18%)	84(29%)	58 (21%)	86(30%)
Users' ability to pay	48 (48%)	19 (19%)	18 (18%)	147(51%)	53 (18%)	73(25%)
Optimal value	13 (13%)	20(20%)	56 (56%)	33(11%)	59 (20%)	178(62%)

Workforce is another major resource that enables the success of any programme. More specifically, the type and amount of workforce is critical to achieving specific policy objectives, and the motivation of the workforce is paramount in the implementation of activities. Respondents were therefore requested to provide their opinions on various key issues regarding the workforce tasked with implementing the malaria programme (Table 7). Seventy-eight per cent (78%) of the respondents agreed that the workforce had the essential guidelines and directives necessary for performing programme activities, while 71% of the respondents agreed that government was the main employer for the workforce supporting the malaria programme. Twenty-nine per cent (29%) of respondents thought that the salaries and wages paid to malaria workforce were reasonable, a small decrease from the percentage at who felt the same at baseline (31%). Forty-seven per cent (47%) of participants at the follow-up visit felt that there was adequate deployment of malaria health workers to the programme, and only 38% of respondents felt that the workforce for the malaria programme was adequate, a slight increase from the 32% at baseline.

Table 7: Workforce for programs- Malaria

	PIB 1			PIB 2		
Item	Disagree	Neutral	Agree	Disagree	Neutral	Agree
Adequate workforce	50 (50)	16 (16)	32 (32)	95(32.8)	80 (27.7)	109(37.7)
Adequate time devotion	24 (24)	23 (23)	51 (51)	52(18.0)	75 (26.0)	158(54.7)
Adequate training and skills	13 (13)	28 (28)	57 (58)	30(10.4)	70 (24.2)	185(64.0)
Adequate deployment	37 (37)	20 (20)	37 (37)	67(23.2)	80 (27.7)	135(46.7)
Guidelines availability	7 (7)	10 (10)	78 (79)	15(5.2)	43 (14.9)	224(77.5)
Government workforce source	21 (21)	3 (3)	74 (74)	62(21.5)	21 (7.3)	205(70.9)
Affordable salaries	46 (46)	17 (17)	31 (31)	96(33.2)	95 (32.9)	83(28.7)
Sufficient tools	32 (32)	30 (30)	35 (35)	52(18.0)	85 (29.4)	148(51.2)
Optimal supervision	19 (19)	26 (26)	53 (53)	33(11.5)	87 (30.1)	167(57.8)
Community-level workers contribution				16(5.5)	70 (24.2)	197(68.2)

Medicines and key products

Availability of medicines and products in terms of timeous availability and in quantities to match the demands for malaria programme is essential for its successful implementation. Respondents were, therefore, requested to express their views on the status of medicines and products for the malaria programme (Table 8). With regard to medicines and products, 80% felt that the quality of medicines and products was optimal. There were large improvements on perceptions about medicine and products between baseline and end line on a number of issues that included:

1. Adequate stock (36% vs 61%)
2. Medicines and products were available timeously (39% vs 65%)
3. Medicines and products were reasonably costed (38% vs 45%)
4. Medicines and products were of acceptable quality and safety (53% vs 66%)
5. The supply chain for medicines and products were sustainable (44% vs 64%) and that
6. Users were able to pay for medicines and products (15% vs 28%)

Table 8- Medicines and products- Malaria

	PIB 1			PIB 2		
Item	Disagree	Neutral	Agree	Disagree	Neutral	Agree
Adequate stocks	40 (40)	17 (17)	36 (36)	47 (16.2)	60 (20.8)	176 (60.8)
Timely availability	23 (23)	31 (31)	39 (39)	45 (15.6)	54 (18.7)	187(64.7)
Government main source	17 (17)	9 (9)	52 (52)	43 (14.9)	23 (8.0)	216 (74.8)
Reasonable cost	29 (29)	22 (22)	37 (38)	53(18.4)	62 (21.4)	129 (44.6)
Acceptable quality/safety.	9 (9)	22 (22)	53 (53)	18(6.2)	46 (15.9)	190 (65.7)
Predictable flow	18 (18)	20 (20)	55 (55)	33 (11.4)	47 (16.3)	200 (69.2)
Sustainable supply chain	21 (21)	25 (25)	44 (44)	34 (11.8)	59 (20.4)	184 (63.7)
Users ability to pay	51 (51)	25 (25)	15 (15)	136 (47.1)	59 (20.4)	80 (27.6)
Optimal quality medicines and products				8 (2.7)	46 (15.9)	230 (79.6)

Service Delivery

Participants at follow-up were more likely than those at baseline to indicate that there was good service delivery for malaria as they had a higher percentage on these service delivery questions.

1. there were adequate service outputs for malaria (63% vs 74% baseline compared to follow-up respectively)
2. that there was satisfactory access to malaria services (49% vs 66%)
3. that there were adequate prevention services (45% vs 64%) and
4. that there was adequate clinical services' distribution (51% vs 65%)

Table 9: Service delivery of programs- Malaria

	PIB 1			PIB 2		
Item	Disagree	Neutral	Agree	Strongly Disagree	Neutral	Agree
Adequate service outputs	11 (11)	23 (23)	63 (63)	8 (2.7)	61 (21.1)	214 (74.0)
Identified priority groups	14 (14)	12 (12)	66 (67)	23(8.0)	58 (20.1)	202 (69.9)
Satisfactory access	23 (23)	26 (26)	48 (49)	27 (9.3)	67 (23.2)	190 (65.7)
Favourable attitudes	19 (19)	19 (19)	57 (58)	17 (5.8)	81 (28.0)	185 (64.0)
IEC wide reception	19 (19)	33 (33)	44 (44)	58 (20.0)	81 (28.0)	141 (48.8)
Adequate prevention service	26 (26)	26 (26)	45 (45)	29 (10.0)	71 (24.6)	185 (64.1)
Continuous preventive services	44 (44)	22 (22)	30 (30)	71(24.5)	97 (33.6)	117 (40.5)
Adequate clinical services' distribution	19 (19)	23 (23)	51 (51)	29 (10.0)	67 (23.2)	187 (64.7)
Community prevention responsibility	11 (11)	20 (20)	66 (67)	13 (4.5)	54 (18.7)	217 (75)
The communities are doing enough to prevent the causes of [this illness or program]				50 (17.3)	116 (40.1)	108 (37.4)

4.2 Emergency Obstetric Care (EmOC)

Two hundred and thirty-three (233) participants responded to the emergency obstetrics Care (EmOC) questionnaire, mostly from government or district facilities. Table 10 and figure 2 presents the views of each of the EmOC policy subdomains as average scores.

The average score for the EmOC policy domain ranged from 2.85 (financing) to 3.57 (implementation). There were improvements on all EmOC policy domains, compared between baseline and this round of evaluation, except for policy programmes establishment with scores 3.21 at baseline and 3.08 at follow-up. The average scores for each component of the policy programmes establishment ranged from 2.57 (Blood transfusion) and 3.52 (birth preparedness). Under this same policy domain, policy awareness (3.29), adequate EmOC service provision (3.24), birth preparedness (3.52), referral transport programme (3.08), waiting shelters (3.13) and maternal death audit (3.42) had all average scores above 3, where the range of possible scores was above 0 to 5.

Under the implementation policy domain for EmOC, the individual component scores for this domain had average scores ranging from 4.12 (strategies satisfaction) to 3.06 (Sector's timely contribution), i.e. all average scores were above 3. The following individual components had average scores above 3.50 for the implementation domain; organisation relationships (3.74), clear monitoring and evaluation (M & E) information, private sector contribution (3.89), visibility champions (3.60), political support (3.53), target knowledge (3.92) and strategies satisfaction (4.12). Generally the finance component had the lowest average domain scores on the EmOC domain. The individual component average scores for the finance sector under EmOC ranged from 2.46 (user ability to pay) to 3.36 (optimal value). The only components under finance that had average scores above 3.00 were optimal value (3.36), and government source (3.18).

Individual components of the workforce EmOC component ranged from 2.83 (Adequate workforce) to 3.79 (guideline availability), and the components that had the highest scores were adequate time devotion (3.30), adequate training and skills (3.61), equitable deployment (3.13), guidelines available (3.79), government workforce source (3.55), optimal supervision (3.46) and community workers contribution (3.56). Individual component average scores for the EmOC medicines and products domain ranged from 2.52 (users' ability to pay) to 3.89 (acceptable quality). The medicines and products that had average scores above 3.00 were sustainability of supply chain (3.18), predictable flow (3.62), acceptable quality (3.89), government main source (3.66) and timely availability (3.27).

EmOC service delivery average component scores ranged from 2.99 (continuous services distribution) to 3.55 (satisfactory community demand). All individual components under service delivery were above 3.00 except for continuous services distribution.

Table 10: Average score for each EmOC policy domain

Policy programmes establishment		Implementation		Financing		Workforce		Medicines and Products		Service delivery	
Question items	Av score	Question items	Av score	Question items	Av score	Question items	Av score	Question items	Av score	Question items	Av score
Policy awareness (q39)	3.29	Strategies' satisfaction (q49)	4.12	Funding adequacy (q124)	2.69	Adequate workforce (q133)	2.83	Adequate stocks (q144)	2.98	Adequate service outputs (q154)	3.57
Adequate EmOC service provision (q40)	3.24	Targets' knowledge (q50))	3.92	Timely availability (q125)	2.83	Adequate time devotion (q134)	3.30	Timely availability (q145)	3.27	Identified priority groups (q155)	3.52
Male involvement programme (q41)	2.91	Political support (q51)	3.53	Favourable allocations (q126)	2.74	Adequate training and skill (q135)	3.61	Government main source (q146)	3.66	Satisfactory access (q156)	3.22
Birth preparedness (q42)	3.52	Political oversight satisfaction (q52)	3.26	Government source (q127)	3.18	Equitable deployment (q136)	3.13	Reasonable costs (q147)	2.71	Favourable attitudes (q157)	3.41
Referral transport programme (q43)	3.08	Stakeholder engagement (q53)	3.46	Activity costs affordability (n5e)		Guidelines availability (q137)	3.79	Acceptable quality (q148)	3.89	IEC wide reception (q158)	3.19
Waiting shelters (q44)	3.13	Visibility champions (q54)	3.60	Predictable funding (q128)	2.92	Government workforce source (q138)	3.55	Predictable flow (q149)	3.62	Adequate services distribution (q159)	3.23
Blood transfusion programme (q45)	2.57	Participatory process (q55)	3.11	Sustainable funding (q129)	2.58	Affordable salaries (q139)	2.85	Sustainable supply chain (q150)	3.18	Continuous services provision (q160)	2.99
Vacuum extraction programme (q46)	2.80	Organisations' coordination (n9c)		Users' ability to pay (q130)	2.46	Sufficient tools (q140)	2.99	Users' ability to pay (q151)	2.52	Adequate clinical services' distribution (q161)	3.33
C section theatres (q47)	2.85	Private sector contribution (q56)	3.89	Optimal value (q131)	3.36	Optimal supervision (q141)	3.46	-		Satisfactory community demand (q162)	3.55
Maternal deaths audit (q48)	3.42	Community advocacy (q57)	3.47	-	-	Community workers' contribution (q142)	3.56	-	-	Community prevention responsibility (q163)	3.02
-		Sectors' timely contribution (q58)	3.06	-	-	-	-	-	-	-	-
-		Clear M&E information (q59)	3.74	-	-	-	-	-	-	-	-
-		Organisations' relationships (q60)	3.74	-	-	-	-	-	-	-	-
-		Conducive environment (q61)	3.46	-	-	-	-	-	-	-	-
Overall averages PIB 2	3.08		3.57		2.85		3.31		3.23		3.30
Overall averages PIB 1	3.21		3.22		2.49		2.96		2.99		3.06
T-test	0.35		0.62		0.92		0.09		0.32		0.01

Note: The scale for policy programme establishment domain: 1-Not yet established; 2- Initial steps taken; 3- Partially established; 4- Fully established; 5- Functioning optimally. The scale for implementation, financing, workforce, medicines and products, service delivery domains: 1- Strongly disagree; 2-disagree; 3-moderate; 4-strongly agree; 5- agree.

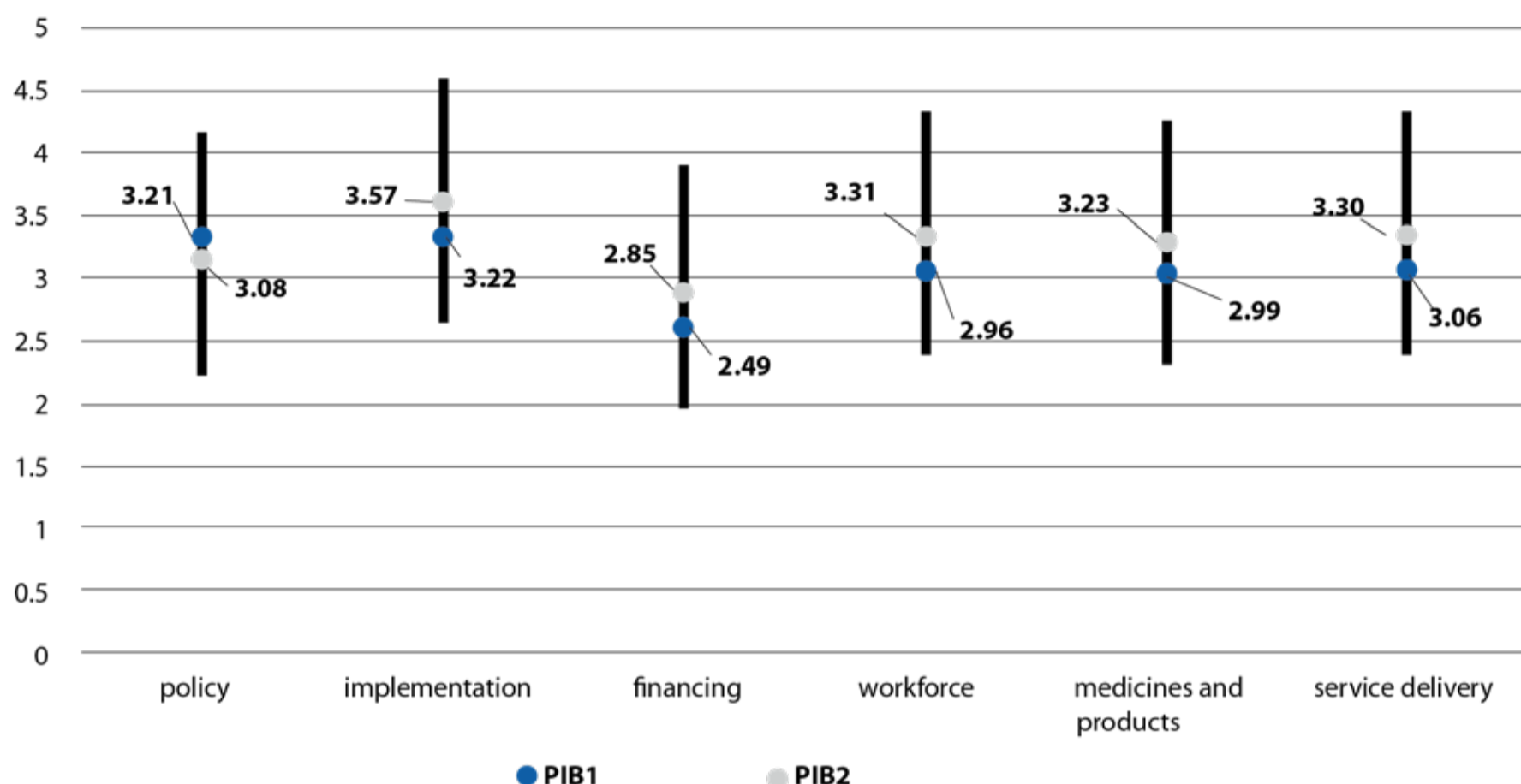


Figure 2: Overall averages for each emergency obstetric care module

The results below present the same results as above, instead using frequencies and percentages rather than average scores for each EmOC policy domain component.

Establishment of EmOC policy programmes

The respondents were requested to provide their opinions about the EmOC policy establishment in rural areas and institutions. The results are presented in table 11 below, where baseline results are compared to follow-up results. There were noticeable differences between baseline and follow-up on the percentage reporting gained optimum coverage or fully established on;

1. Fewer participants at follow-up than at baseline indicating policy awareness of EmOC (68% vs 52% for baseline and follow-up respectively)
2. Fewer participants at follow-up than at baseline reporting that gained optimum coverage and fully established on waiting shelters (57% vs 48%)
3. Similarly fewer participants at follow-up reporting optimum or fully established coverage of the vacuum extraction programme (55% vs 45%)
4. Proportionately more participants at follow-up than at baseline were more likely to say that maternal death audits had gained optimum coverage or were fully established (49% vs 69%).

Table 11: Extent of establishment of emergency obstetric care policy (n=233)

Item	PIB 1			PIB 2		
	Not / partially established	Fully established	Gained Optimum coverage	Not / partially established	Fully established	Gained Optimum coverage
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Policy awareness	25 (32)	41(52)	12 (15)	111 (47.7)	107 (45.9)	7 (3.0)
Adequate EmOC service provision	34 (53)	33 (42)	12 (15)	135 (57.9)	85(36.5)	9 (3.9)
Male Involvement programme	53 (68)	19 (24)	5 (6)	157 (67.3)	64 (27.5)	5 (2.2)
Birth preparedness	25 (32)	40 (51)	13 (16)	82 (35.2)	134 (57.5)	12 (5.1)
Referral transport programme	40 (51)	29 (37)	8 (10)	130 (55.8)	90 (38.6)	12 (5.2)
Waiting shelters	35 (43)	29 (37)	7 (9)	120 (51.5)	105 (45.1)	6 (2.6)
Blood transfusion programme	48 (61)	21 (27)	7 (9)	153 (66.3)	74 (31.8)	5 (2.1)
Vacuum extraction programme	36 (45)	26 (33)	15 (19)	129 (55.3)	95 (40.8)	5 (2.1)
C-sections theaters	44 (55)	20 (25)	12 (15)	119 (51.1)	103 (44.2)	10 (4.3)
Maternal death audits	40 (51)	22 (28)	14 (18)	71 (30.5)	152 (65.2)	6 (2.6)

Implementation of EmOC programmes

Participants were asked about their options on the implementation of the EmOC, and the results from the follow-up study survey (PIB2) are compared to results at baseline (PIB1). Opinions of participants at follow-up to the following statements compared to baseline are shown in table 12.

1. Targets' knowledge - 82% vs 73%
2. Political support – 63% vs 54%
3. Political oversight satisfaction - 60% vs 43%
4. Stakeholders engagement – 55% vs 48%
5. Community advocacy - 58% vs 50%
6. Clear M & E information – 74% vs 69% and
7. Organisations' relationships 77% vs 69%.

Table 12: Opinion about emergency obstetric care (n=233)

Item	PIB 1			PIB 2		
	Disagree	Moderate	Agree	Disagree	Moderate	Agree
Strategies' satisfaction	6 (8)	2 (3)	69 (87)	6 (2.6)	23 (9.9)	202 (86.7)
Targets' knowledge	6 (8)	9 (11)	58 (73)	7 (3.0)	31 (13.3)	191 (82.0)
Political support	14 (18)	18 (23)	43 (54)	30 (12.9)	48 (20.6)	147 (63.1)
Political oversight satisfaction	18 (23)	25 (32)	34 (43)	45 (19.3)	65 (27.9)	117 (60.2)
Stakeholders' engagement	13 (16)	25 (32)	38 (48)	20 (8.6)	82 (35.2)	127 (54.5)
Visibility champions	9 (11)	19 (24)	49 (62)	20 (8.6)	59 (25.3)	150 (64.4)
Participatory process	15 (19)	16 (20)	41 (52)	33 (14.2)	55 (23.6)	121 (51.9)
Private sector contribution	2 (2)	14 (18)	57 (72)	7 (3.0)	45 (19.3)	177 (76.0)
Community advocacy	13 (17)	22 (28)	39 (50)	29 (12.5)	66 (28.3)	135 (57.9)
Sectors' timely contribution	17 (22)	28 (35)	28 (35)	49 (21.0)	80 (34.3)	93 (39.9)
Clear M&E information	5 (6)	13 (16)	55 (69)	6 (2.6)	47 (20.2)	173 (74.2)
Organisations' relationships	5 (6)	13 (16)	47 (69)	10 (4.3)	37 (15.9)	179 (76.9)
Conducive environment	12 (16)	18 (23)	45 (57)	24 (10.3)	67 (28.8)	137 (58.8)

Financing of EmOC

When asked about the financing policy domain of the EmOC, there were improvements from baseline to follow-up on all assessed items, Table 13. Changes with at least a 10% (absolute) increment were seen on the following:

1. Funding adequacy - 19% vs 28%
2. Favorable allocation - 20% vs 34%
3. Activity cost affordability – 46% vs 27%
4. And users' ability to pay 19% vs 2%

When comparing the baseline to follow-up which included proportionately more people at both baseline and follow-up, fewer participants felt that there was adequate funding for the EmOC component; 50% of respondents agreed to the statement there was only government sourced funding (54.4%) and optimal value (59%).

Table 13: Financing- Emergency obstetric care (%)

Item	PIB 1			PIB 2		
	Disagree	Neutral	Agree	Disagree	Neutral	Agree
Funding adequacy	40 (51)	17 (22)	15 (19)	90 (38.8)	63 (27.2)	64 (27.6)
Timely availability	39 (49)	15 (19)	20 (25)	85 (36.7)	53 (22.8)	81 (34.9)
Favourable allocations	48 (61)	10 (13)	16 (20)	74 (31.8)	58 (25.0)	79 (34.0)
Government source	22 (28)	10 (13)	32 (53)	69 (29.8)	27 (11.6)	126 (54.4)
Activity costs affordability	32 (40)	12 (15)	21 (27)	49 (21.1)	52 (22.4)	106 (45.7)
Sustainable funding	32 (41)	15 (19)	20 (26)	80 (34.4)	52 (22.4)	71 (30.6)
Users' ability to pay	52 (65)	19 (24)	2 (2)	140 (60.3)	40 (17.2)	45 (19.4)
Optima value	11 (15)	15 (19)	46 (58)	33 (14.2)	54 (23.3)	136 (58.6)

Responses on the views on the status of medicines and products for the EmOC programme, and the results are presented below, Table 15. Over 70% of respondents in the follow-up survey agreed that i) government was the main source of medicines and products for EmOC (71.9% at follow-up compared to 63% at baseline), ii) that medicines and products were of acceptable quality (73.2% at follow-up vs 62% at baseline) and optimal quality medicines and products (77% at follow-up). Participants were however less likely to agree that users were able to pay for medicines and products (19% at follow-up and 11% at baseline), were less likely to say that medicines and products were reasonably priced (35% vs 31% at follow-up and baseline), neither were they likely to agree that there were adequate stocks of medicine and products (40% vs 27% at follow-up and baseline respectively).

Table 15: Medicines and products- Emergency obstetric care (%)

	PIB 1			PIB 2		
Item	Disagree	Neutral	Agree	Disagree	Neutral	Agree
Adequate stocks	36 (46)	19 (24)	21 (27)	77 (33.2)	70 (30.2)	81 (34.9)
Timely availability	23 (29)	21 (27)	32 (41)	57 (24.6)	57 (24.6)	115 (49.4)
Government main source	17 (21)	10 (13)	50 (63)	47 (20.3)	16 (6.9)	167 (71.9)
Reasonable cost	25 (32)	22 (28)	24 (31)	58 (25.0)	59 (25.4)	82 (35.4)
Acceptable quality/safety.	9 (11)	13 (16)	49 (62)	14 (6.1)	33 (14.2)	170 (73.2)
Predictable flow	18 (23)	14 (18)	45 (57)	25 (10.8)	50 (21.6)	149 (64.2)
Sustainable supply chain	20 (26)	15 (19)	39 (59)	43 (18.5)	46 (19.8)	126 (54.3)
Users ability to pay	53 (67)	12 (15)	10 (11)	125 (53.9)	55 (23.7)	44 (19.0)
Optimal quality medicines and products				7 (3.0)	44 (19.0)	178 (76.7)

EmOC level of service delivery

There were noticeable improvements on participants' perceptions about service delivery between baseline and follow-up, indicated in table 16 below. The largest improvements were seen on the perception about adequate service outputs (62.1% at follow-up compared to 51% at baseline), favourable attitudes (56% at follow-up compared to 41% at baseline), and satisfactory community demand (61% at follow-up compared to 48% at baseline). Participants' perceptions about community prevention responsibility decreased from 47% at baseline to 35% at follow-up, the only instance where such a decrease was noted. At follow-up, participants generally agreed that there was adequate service outputs (62%), there were identifiable priority groups (63%), there were favourable attitudes (56%), there were adequate clinical service distribution (54%) and that there was satisfactory community demand. However, participants at follow-up felt that there was lack of continuous service provision (33%).

Table 16: Service delivery of programs- Emergency obstetric care (%)

	PIB 1			PIB 2		
Item	Disagree	Neutral	Agree	Disagree	Neutral	Agree
Adequate service outputs	12 (15)	25 (32)	40 (51)	21 (9.0)	65 (28.0)	144 (62.1)
Identified priority groups	19 (25)	12 (15)	43 (55)	17 (7.3)	62 (26.7)	146 (62.9)
Satisfactory access	25 (31)	22 (28)	28 (36)	53 (22.9)	71 (30.6)	106 (45.7)
Favourable attitudes	16 (20)	25 (32)	32 (41)	25 (10.8)	72 (31.0)	130 (56.0)
IEC wide reception	21 (26)	20 (25)	31 (40)	56 (24.2)	57 (24.6)	113 (48.7)
Adequate service' distribution	19 (24)	22 (28)	32 (40)	49 (21.1)	63 (27.2)	115 (49.5)
Continuous service provision	25 (32)	29 (37)	21 (27)	73 (31.5)	82 (35.3)	76 (32.8)
Adequate clinical service distribution	14 (18)	27 (34)	35 (44)	45 (19.5)	59 (25.4)	125 (53.8)
Satisfactory community demand	16 (20)	20 (25)	38 (48)	24 (10.3)	66 (28.4)	141 (60.8)
Community prevention responsibility	12 (15)	24 (30)	37 (47)	66 (28.5)	81 (34.9)	82 (35.4)

A look at the EmOC workforce policy domain showed that there were improvements on perceptions between from baseline to follow-up on the following aspects comparing baseline and follow-up respectively:

1. Adequate workforce 17% vs 29%
2. Adequate deployment 29% vs 43%
3. Affordable salaries 14% vs 27%
4. Optimal supervision 60% vs 39% and
5. Community-level workers contribution 52% vs 63%.

There were low percentages at follow-up of participants who felt that the workforce was adequate (29%), that salaries were adequate (27%) and that there were sufficient tools (32%). However large percentages of participants at follow-up felt that there was adequate training and skills (63%), guidelines were available (75%), that the government was the main source of the workforce in EmOC (69%) and that there was community-level worker contribution (63%).

Table 17: Workforce for programs -Emergency obstetric care (%)

Item	PIB 1			PIB 2		
	Disagree	Neutral	Agree	Disagree	Neutral	Agree
Adequate workforce	50 (64)	14 (18)	13 (17)	98 (42.2)	64 (27.6)	68 (29.3)
Adequate time devotion	22 (28)	16 (20)	39 (50)	53 (22.9)	64 (27.6)	113 (48.7)
Adequate training and skills	13 (17)	18 (23)	46 (59)	25 (10.7)	60 (25.9)	147 (63.3)
Adequate deployment	30 (40)	21 (27)	23 (29)	72 (31.0)	59 (25.4)	99 (42.7)
Guidelines availability	11 (14)	11 (14)	54 (68)	12 (5.1)	44 (19.0)	173 (74.6)
Government workforce source	17 (21)	7 (9)	52 (66)	63 (27.2)	8 (3.4)	161 (69.4)
Affordable salaries	51 (65)	15 (19)	11 (14)	77 (33.2)	88 (38.0)	62 (26.7)
Sufficient tools	40 (50)	18 (23)	18 (23)	71 (30.7)	88 (37.9)	73 (31.5)
Optimal supervision	21 (26)	25 (32)	31 (39)	32 (13.8)	58 (25.0)	139 (59.9)
Community-level workers contribution	14 (18)	19 (24)	41 (52)	23 (9.9)	62 (26.7)	144 (62.5)

4.3 Family Planning

A total sample of 208 participants responded to questions about family planning, most of whom were from the category of partners . A majority of the groups are engaged in facility level service provision. On the family planning policy domain, respondents at baseline had higher mean scores on all aspects (implementation, financing, workforce, medicines and products and service delivery) than at follow-up except for the policy programme establishment component (2.83 vs 2.89 for baseline and follow-up respectively), Table 17 and Figure 3 below. The average mean scores for various components ranged from:

1. 2.17 (private shops programme) to 3.53 (IEC programme) for the policy programmes establishment component.
2. 3.24 (sector's timely contribution) to 4.08 (strategies' satisfaction) for the financing component. All individual questions under implementation for family planning policy domain had average mean scores of 3 and above.
3. 2.32 (user's ability to pay) to 3.27 (optimal value) which was the only factor with an average score above 3 under the finance component.
4. 2.82 (affordable salaries) to 3.63 (community workers fair contribution) under the workforce component. This component had generally high scores (all above 3) except for affordable salaries (2.82) and adequate workforce (2.91).
5. 2.46 (users ability to pay) to 3.80 (quality of medicines and products adequate) under the medicines and products component. Reasonable costs (2.78) and users' ability to pay (2.46) were the only questions under this section that had mean scores below 3 under this section.
6. All questions under service delivery had mean scores above 3, ranging from 3.02 (continuous contraceptive provision) to 3.63 (adequate service outputs).

Table 18: Average score for each Family Planning policy domain

Policy programmes establishment		Implementation		Financing		Workforce		Medicines and Products		Service delivery	
Question items	Av score	Question items	Av score	Question items	Av score	Question items	Av score	Question items	Av score	Question items	Av score
Policy awareness	3.48	Strategies' satisfaction	4.08	Funding adequacy	2.66	Adequate workforce	2.91	Adequate stocks	3.04	Adequate service outputs	3.63
Adolescent program	3.20	Targets' knowledge	3.87	Timely availability	2.81	adequate time devotion	3.25	Timely availability	3.12	Identified priority groups	3.53
IEC programme	3.53	political oversight	3.25	Favourable allocations	2.77	Adequate training and skill	3.37	Government main source	3.28	Satisfactory access	3.31
House-to-house programme	2.36	Visibility champions	3.63	Government source	2.85	Adequate deployment	3.02	Reasonable costs	2.78	Favourable attitudes	3.27
Religious/ cultural programme	2.24	Participatory process	3.34	Stable funding	2.71	Guidelines availability	3.73	Acceptable quality	3.70	IEC wide reception	3.24
Private shops programme	2.17	Organisations' coordination	3.51	Sustainable funding	2.61	Government workforce source	3.40	Predictable flow	3.30	Public awareness	3.17
Schools programme	2.27	Private sector contribution	3.84	Users' ability to pay	2.32	Affordable salaries	2.82	Sustainable supply chain	3.10	Continuous contraceptive provision	3.02
FP methods programme	3.38	Community advocacy	3.46	Optimal value	3.27	sufficient tools	3.14	Users' ability to pay	2.46	Long term FP methods distribution	3.24
-	-	Sectors' timely contribution	3.24	-	-	Optimal supervision	3.40	Quality of medicines and products adequate	3.80	Satisfactory community demand	3.40
-	-	Clear M&E information	3.64	-	-	Community level workers fair contribution	3.63	-	-	Communities doing enough	3.06
-	-	Organisations' relationships	3.76	-	-	-	-	-	-	-	-
-	-	conducive environment	3.56	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-	-	-
Overall averages: PIB1	2.83		3.60		2.75		3.27		3.17		3.29
PIB2	2.89		3.40		2.34		2.98		2.82		2.83
T- test	0.36		0.79		0.75		0.1		0.08		0.02

Note:

The scale for policy programme establishment domain: 1-Not yet established; 2-Initial steps taken; 3-Partially established; 4-fully established; 5-Functioning optimally

The scale for implementation, financing, workforce, medicine and products, service delivery domains: 1-Strongly disagree; 2-Disagree; 3-Moderate; 4-Agree; 5-Strongly agree

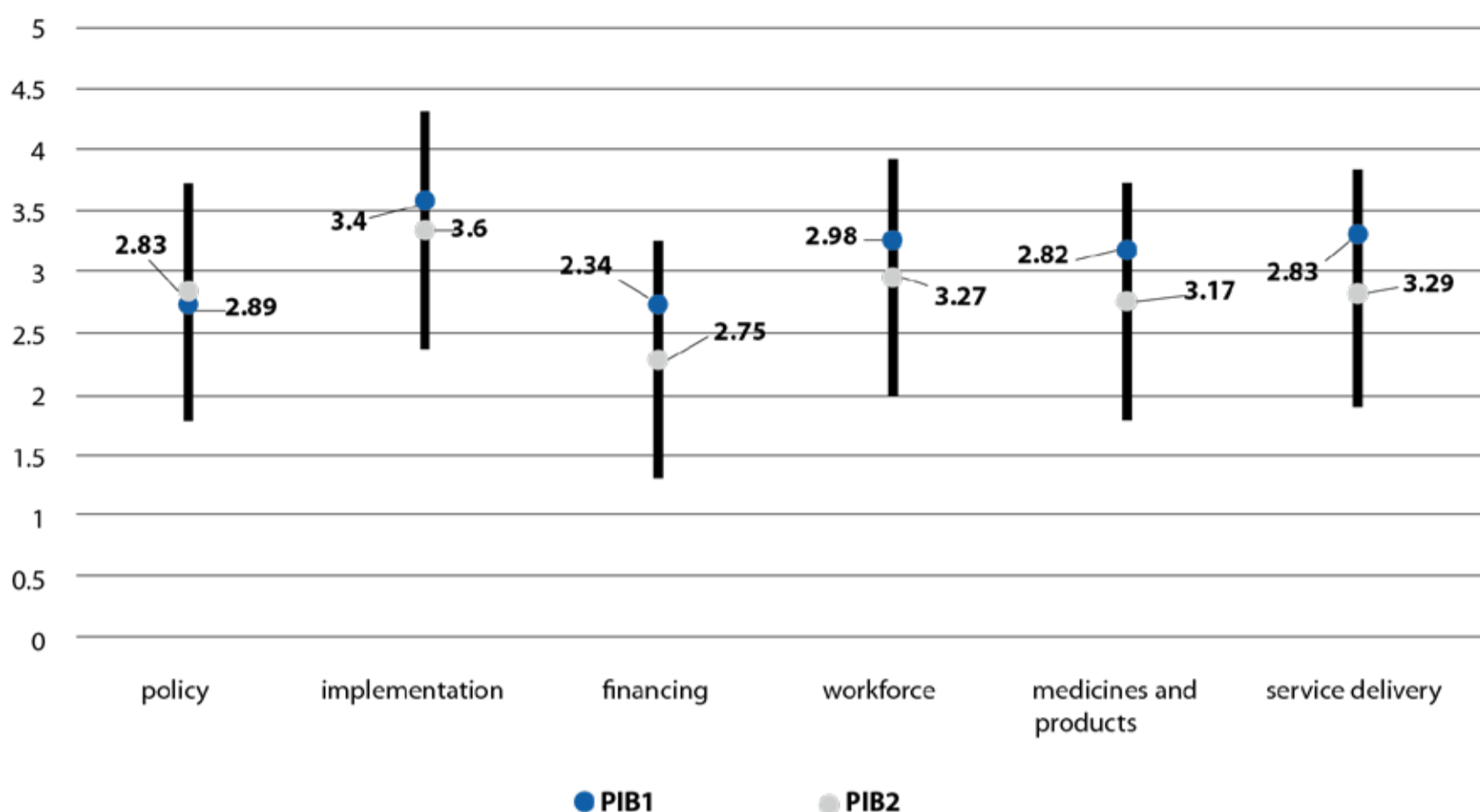


Figure 3. Overall averages for each family planning module

Establishment of FP programmes

There was little difference on the percentage of respondents between baseline and follow-up on opinions about the level of establishment of family planning policy/programmes. Difference in percentages above 5% but below 10% points (absolute) were observed on the following questions:

1. adolescent programmes (57% vs 50%) for gained optimum coverage or fully established comparing baseline and follow-up
2. IEC programmes (72% vs 64%)
3. Religious/cultural programmes (29% vs 24%)
4. Private shops programmes (33% vs 28%) and
5. Schools programmes (30% vs 24%) Comparing baseline and follow-up.

Table 19: Establishment of Family Planning policy/programme (%).

Item	PIB 1			PIB 2		
	Not/partially established	Fully established	Gained optimum coverage	Not/partially established	Fully established	Gained optimum coverage
Policy awareness	32 (37%)	41 (48%)	11 (13%)	68 (32.7%)	126 (60.6%)	11 (5.3%)
Adolescent programme	36 (43%)	40 (47%)	7 (8%)	103 (49.5%)	92 (44.2%)	10 (4.8%)
IEC programme	24 (28%)	44 (52%)	16 (19%)	75(36%)	117 (56.2%)	14 (6.7%)
House-to-house programme	55 (65%)	21 (25%)	6 (7%)	145(69.7%)	46 (22.1%)	11 (5.3%)
Religious/cultural programme	60 (71%)	22 (26%)	1 (1%)	158(76%)	39 (18.8%)	5 (2.4%)
Private shops programme	57 (67%)	21 (25%)	6 (6%)	150 (72.2%)	47 (22.6%)	5 (2.4%)
Schools programme	59 (70%)	19(22%)	6 (7%)	159 (76.4%)	37 (17.8%)	7 (3.4%)
FP methods programme	37 (44%)	33(39%)	14 (16%)	83 (39.9%)	108 (51.9%)	16 (7.7%)

Noticeable changes on opinion of the implementation of family planning were observed between baseline and follow-up on:

1. political oversight (36% vs 49%)
2. participation process (49% vs 61%) and
3. organisations' coordination (53% vs 65%).

A large percentage of participants at follow-up felt that strategies were satisfactory (86%), there was high target knowledge (78%), there was private sector contribution (77%), and that there were established organisation relationships (72%). Few participants however agreed that there was political oversight (49%) and that there was sectors' timely contribution.

Table 20: Implementation of Family planning

Item	PIB 1			PIB 2		
	Disagree	Moderate	Agree	Disagree	Moderate	Agree
Strategies' satisfaction	1(1%)	8 (9%)	74(87%)	7(3.3%)	19 (9.1%)	179(86.1%)
Targets' knowledge	12(14%)	5 (6%)	66(74%)	11(5.3%)	31 (14.9%)	162(77.9%)
political oversight	31(37%)	16 (19%)	31(36%)	38(18.2%)	60 (28.8%)	101(48.5%)
Visibility champions	9(11%)	14 (17%)	57(67%)	17(8.2%)	43 (20.7%)	141(67.7%)
Participatory process	12(14%)	18 (21%)	43(49%)	23(11.1%)	39 (18.7%)	127(61.1%)
Organisations' coordination	11(13%)	17 (20%)	47(53%)	20(9.6%)	40 (19.2%)	136(65.4%)
Private sector contribution	8(9%)	6 (7%)	66(78%)	10(4.8%)	35 (16.8%)	159(76.5%)
Community advocacy	13(15%)	24 (28%)	43(50%)	24(11.6%)	59 (28.4%)	117(56.3%)
Sectors' timely contribution	11(25%)	20 (24%)	34(40%)	41(19.7%)	60 (28.8%)	99(47.5%)
Clear M&E information	7(8%)	16 (19%)	56(67%)	8(3.4%)	46 (22.1%)	143(68.85%)
Organisations' relationships	6(7%)	8 (9%)	66(78%)	7(3.4%)	46 (22.1%)	150(72.2%)
Conducive environment	7(8%)	26 (31%)	48(56%)	20(9.6%)	53 (25.5%)	130(62.5%)

Financing for FP

Generally perceptions on financing for family planning improved between baseline and follow-up. The most changes were observed for:

1. Funding adequacy (21% vs 28%)
2. Timely availability for funding (28% vs 36%)
3. Favourable allocations (22% vs 34%) and
4. Activity costs affordable (27% vs 36%), table 20.

Perceptions about funding were generally low among follow-up participants for all questions ranging from a high of 54.8% (optimal value) to a low of 17% (users' ability to pay).

Table 21: Financing for family planning

Item	PIB 1			PIB 2		
	Disagree	Moderate	Agree	Disagree	Moderate	Agree
Funding adequacy	39(46%)	11 (13%)	18(21%)	76(36.5%)	52 (25.0%)	59(28.3%)
Timely availability	36(42%)	9 (11%)	24(28%)	67(32.2%)	49 (23.6%)	74(35.6%)
Favourable allocations	35(41%)	16 (19%)	18(22%)	58(27.9%)	57 (27.4%)	71(34.1%)
Government source	32(37%)	12 (14%)	29(34%)	91(43.7%)	22 (10.6%)	87(41.8%)
Activity costs affordability	27(31%)	13 (15%)	23(27%)	60(28.9%)	47 (22.6%)	75(36%)
Sustainable funding	32(38%)	12 (14%)	26(31%)	79(37.9%)	46 (22.1%)	61(29.3%)
Users' ability to pay	41(48%)	16 (19%)	16(18%)	121(58.2%)	40 (19.2%)	36(17.3%)
Optimal value	8(9%)	15 (18%)	47(56%)	29(14%)	52 (25.0%)	114(54.8%)

Comparing baseline and follow-up on questions on workforce for FP, the largest improvements on perceptions were observed on:

1. Adequate time devotion (37% vs 51%)
2. Guidelines available (67% vs 74%) and affordable salaries (15% vs 26%), table 21 below.

There were low percentages of participants at follow-up who felt that salaries were affordable (26%), that there was adequate workforce for FP (37%), that there was adequate deployment (38%) or that there were sufficient tools (40%). Participants at follow-up were however more likely to say that guidelines for FP were available (74%) for family planning services.

Table 22: Workforce for the FP

Item	PIB 1			PIB 2		
	Disagree	Moderate	Agree	Disagree	Moderate	Agree
Adequate workforce	43(51%)	12 (14%)	28(33%)	80(30.8%)	49 (23.6%)	77(37%)
Adequate time devotion	25(30%)	27 (32%)	31(37%)	57(27.4%)	42 (20.2%)	107(51.4%)
Adequate training and skill	22(26%)	14 (16%)	46(55%)	39(18.8%)	59 (28.4%)	109(52.4%)
Adequate deployment	34(40%)	18 (21%)	28(33%)	68(32.7%)	57 (27.4%)	80(38.4%)
Guidelines availability	12(14%)	11 (13%)	57(67%)	18(8.6%)	33 (15.9%)	154(74%)
Government workforce source	27(31%)	7 (8%)	49(58%)	65(31.2%)	14 (6.7%)	128(61.5%)
Affordable salaries	49(58%)	16 (19%)	12(15%)	65(31.2%)	81 (38.9%)	54(26%)
Sufficient tools	32(38%)	17 (20%)	33(39%)	50(24.4%)	73 (35.1%)	83(39.9%)
Optimal supervision	20(24%)	16 (19%)	46(54%)	32(15.3%)	64 (30.8%)	110(52.8%)

In terms of the medicines and products domain, proportionally fewer participants at follow-up than at baseline felt that;

1. FP medicines and products supply chain was sustainable (47% vs 44% for baseline and follow-up respectively)
2. That users' were able to pay for medicines and products (23% vs 20%).

There were however improvements on perceptions about

1. Adequate stocks (30% vs 38% for baseline and follow-up respectively)
2. Timely availability of medicine and products (35% vs 43%)
3. Adequately quality of medicines and products (63% vs 76%) and
4. Predictable flow of medicines and products (48% vs 54%).

Only 20% of participants at follow-up agreed that users' were able to pay for medicines and products, 36% felt that medicines and products were reasonably costed, while only 38% felt that there were adequate stocks of medicines and products. However most participants felt that medicines and products were of acceptable quality.

Table 23: Medicines and products for FP

Item	PIB 1			PIB 2		
	Disagree	Moderate	Agree	Disagree	Moderate	Agree
Adequate stocks	37(44%)	15 (18%)	26(30%)	63(30.3%)	62 (29.8%)	80(38.4%)
Timely availability	31(36%)	18 (21%)	29(35%)	53(25.5%)	62 (29.8%)	90(43.3%)
Government main source	28(33%)	10 (12%)	34(52%)	64(30.7%)	29 (13.9%)	113(54.3%)
Reasonable costs	20(24%)	20 (23%)	28(33%)	55(26.4%)	58 (27.9%)	74(35.6%)
Acceptable quality	4(5%)	14 (17%)	53(63%)	11(5.3%)	31 (14.9%)	157(75.5%)
Predictable flow	20(24%)	17 (20%)	40(48%)	41(19.7%)	48 (23.1%)	113(54.3%)
Sustainable supply chain	15(17%)	20 (24%)	40(47%)	55(26.4%)	53 (25.5%)	92(44.3%)
Users' ability to pay	39(46%)	15(18%)	19(23%)	116(55.8%)	43 (20.7%)	42(20.2%)

Noticeable changes on options between baseline and follow-up on service delivery of FP services were reported on:

1. Adequate service outputs (48% vs 69% for baseline and follow-up respectively)
2. Satisfactory access to services (27% vs 51%)
3. Favorable attitudes (33% vs 45%)
4. IEC wide reception (37% vs 48%)
5. Continuous contraceptive provision (27% vs 51%).

The largest concerns on service delivery were observed on the following aspects (agreeing to the statement) at follow-up;

1. Continuous contraceptive provision (37%)
2. Favorable attitudes (45%) and
3. IEC wide reception (48%).

Generally participants at follow-up were happy with adequate service outputs (69%) and the identification of priority groups (65%).

Table 24: Service delivery of the FP

Item	PIB 1			PIB 2		
	Disagree	Moderate	Agree	Disagree	Moderate	Agree
Adequate service outputs	20(23%)	21 (25%)	41(48%)	13(6.2%)	46 (22.1%)	144(69.2%)
Identified priority groups	17(20%)	12 (14%)	45(62%)	29(13.9%)	38 (18.3%)	136(65.4%)
Satisfactory access	24(29%)	27 (32%)	23(27%)	40(19%)	57 (27.4%)	107(51.4%)
Favourable attitudes	24(29%)	20 (24%)	28(33%)	34(16.3%)	78 (37.5%)	93(44.7%)
IEC wide reception	23(27%)	26 (31%)	31(37%)	49(23.5%)	56 (26.9%)	100(48.1%)
Public awareness	23(27%)	24 (28%)	33(39%)	43(20.6%)	61 (29.3%)	95(45.6%)
Continuous contraceptive provision	36(42%)	20 (24%)	23(27%)	62(29.8%)	63 (30.3%)	77(37%)
Long term FP methods distribution	36(42%)	17 (20%)	23(27%)	38(18.3%)	52 (25.0%)	106(51%)
Satisfactory community demand	23(27%)	22 (26%)	36(42%)	31(14.9%)	71 (34.1%)	104(49.9%)

5.0 Discussion

The discussion is organised into three main sections: Section (1) focuses on generic issues that relate to the PIB as a tool and its application; Section (2) discusses findings by selected policy domain namely, emergency obstetric care, malaria and family planning; and Section (3) focuses on traversal findings that cover the three selected policy domains.

5.1 General observations

The uptake for PIB 2 survey increased by 63% from the first PIB. This could be attributed to the fact that the tool was getting traction and there was notable interest in it, and also because of improved logistical planning for the second survey. In the second survey, other non-government partners and respondents, from district and Health Centre II that were not included in the first survey were included.

The respondents were variously involved in activities related to the three selected policies depending on their designation and job location (district, facility, community). Most of the respondents were involved in activities related to the selected policies, particularly at facility level. The foregoing was more so for emergency obstetric care given the nature of the services involved which are largely facility based.

5.2 Malaria Policy Programme

Over 71% of the respondents acknowledged involvement in the implementation of the malaria programme. This is expected given the endemic nature of malaria in Uganda. What is important though are the ratings of areas or sub-domains by respondents. To summarise these perceptions average scores were used which clearly show that most of the components of the malaria program had reached optimum coverage particularly as it relates to awareness of programme, levels of implementation of specific strategies, workforce, and service delivery. However, financing and a related input, medicine and products were perceived to be moderately available. For finance, this was due to its inadequacy and untimeliness, and for medicines and products it was because of costs involved and user's ability to co-share the costs (e.g. for RDTs programme, Score 2.55).

Overall slight improvements are observed across these domains when the results are compared between PIB1 and PIB2. We found coverage improvements in LLIN, RDT, and iCCM programmes compared to baseline. The significance of these increases needs to be interpreted in the context of programme targets and investments made in the intervening period. However, more respondents acknowledged optimum levels of implementation in PIB2.

With regards to implementation elements of the malaria programme, the majority of the respondents scored them highly suggesting that the programme targets were well understood; there was satisfaction with proposed strategies; programme champions were visible; there was political oversight; community participation and generally a conducive environment for implementing the programme. It is only the level of inter-sectoral collaboration (timely collaboration) that seemed to be a challenge (PIB2 48% vs 39% PIB 1). Therefore, this is an area that needs attention to ensure that other governmental sectors respond timeously to issues of malaria control and management in the country.

Overall, respondents acknowledged that the funding made available for the malaria programme was used appropriately and with desired effects. However, there were reservations (hence low scores) regarding funding adequacy, its timely availability, allocations across different activities, predictability, and considerations of user ability to pay. Slight improvements were observed across these financing elements between PIB1 and PIB2 but the overall view remains low.

The success of most health programmes is a function of workforce availability amongst other things. This does not only mean adequate numbers of workers but also a dedicated workforce that is willing to serve the community. What stands out from the survey findings is that only 38% of the respondents (versus 32% PIB1) agreed that the workforce was adequate for malaria control and 33%% disagreed (versus 50% PIB1). This shows that workforce challenges remain, although there are some notable changes compared to baseline results for most of the sub-domains. These include: adequacy of numbers, time devotion, training and skills and deployment) except for availability of guidelines which decreased slightly.

The barometer survey results on the quantities and availability of essential medicines and key products generally show improvements compared to the baseline. More specifically the quality of medicines and products remains high (80%). These improvements were observed across other sub-domains. For instance, adequacy of stock (improved by 22% to 61%); timeous availability (improved by 25%) and reasonability of costs (increased by 7%); sustainability of supply chain (improved by 20%) and user ability to pay only increased by 8% to 28%. The results create a general impression that medicines and related products are increasingly available, and more importantly, significant increases have occurred between the baseline and PIB 2. The challenge is now to maintain the positive results and more importantly improve them. Most low and middle income countries struggle to stock high quality medicines and products and distribute them effectively to where they are needed at reasonable cost to the user. Clearly, an increase in user ability to pay raises policy questions in the context of Ugandan broader strategy of attaining UHC by 2030 like most other countries. The introduction of National Health Insurance will hopefully address this challenge of paying of essential medicines for malaria.

Malaria service delivery improved significantly between the two PIBs as evidenced by positive scores across its dimensions. Service outputs were at 74% and access to services at 66% in PIB 2. More important to malaria control is prevention services which was considered adequate by 64% of the respondents. More needs to be done in this area given the contribution of malaria to the burden of diseases in Uganda.

5.3 Emergency Obstetric Care (EmOC)

Maternal health is a priority for the Ugandan government given the high fertility rate of 5.4 (12) and maternal mortality rate which stood at 343 per 100 000 live births in 2016 (13) which is one of the highest in the world. The barometer survey produced average scores for EmOC in terms of both specific programme activities and resources in PIB 2 which were generally high showing improvements. Birth preparedness was highly rated and so was policy awareness and knowledge about maternal death audits. The evidence shows that emergency obstetric care is generally understood and relatively better resourced and implemented (with high implementation scores). This could partly be because of the extensive training that health professionals receive as part of their medical training and more so through tailored in-service trainings often supported by external partners. Most respondents understood the policy norms and standards in terms of strategies and targets and level of political support for EmOC was high (score of 3.53). Challenges in terms of funding levels (despite the 10% improvement since baseline), workforce availability and adequacy of medicines and products remain although improvements were observed when compared to PIB 1 results.

A direct comparison of results using proportions (not average scores) per domain between PIB 1 and PIB 2 show improvements in all implementation dimensions from policy awareness to maternal audits. This can, in part, be attributed to the priority attached to this programme and the perceived improvements in resourcing of the programme as a national strategy to reduce maternal and infant deaths. As aforementioned, perceptions of funding for EmOC actually regressed except for an observed increase in users' ability to pay (19% compared to 2%). An increase in user ability to pay is not necessarily a good thing because it shows that households are expected to cost-share for such an essential service that saves lives. The proposed national health insurance will hopefully address this challenge (14) and access to essential services in general including family planning and malaria services. Although maternal mortality rate remains high, it has dropped significantly from the 2007 figure of 671 per 100 000 due to the implementation of an integrated EmOC that saw most health workers trained on how to deal with critical signs and risks that may lead to maternal deaths.

5.4 Family Planning

In 2018, contraceptive prevalence in Uganda was estimated to be 39% among married women (15) or 41.8% among women aged 15 to 49 years (16). This is relatively low compared to world standards. A high uptake of family planning is critical to reducing fertility and ultimately the need for emergency obstetric care amongst women of childbearing age. Some studies have shown that the low uptake is due to limited access to services, religious and cultural reasons (including power relations) and many others (17).

The survey results show high levels of understanding of the policy and its implementation. It is therefore not surprising that the mean scores for programme components and implementation dimensions were high. As for malaria and EmOC programmes scores for funding levels and sustainability, ability to pay and workforce availability were low which suggests general health system challenges. Whilst the policy is well understood the challenges remain that of resourcing and education, to ensure that both urban and rural areas have high contraceptive use amongst women of child bearing age. This is critical amongst 15-24 years age group in which there are relatively high levels of unwanted pregnancies, abortions, morbidity and mortality related to pregnancy.

What is surprising is that the mean scores across the family planning domains were lower than at baseline. Many factors could possibly explain this phenomenon including declining support from government and partners for family planning programme which saw a decline in funding, health workers and availability of relevant family planning commodities. The SPEED project's philosophy is to engage stakeholders with such results to discuss the root-causes, but more importantly, identify and assign corrective actions. We expected an improvement in the results of PIB2 compared to PIB1, not a decline due to stakeholder engagements in the intervening period. Such a discrepancy needs follow up work to establish the exact cause or causes.

6.0 Conclusion

An analysis of the results across the three policy domains shows that the policy norms and standards were generally well understood, meaning that communication from the centre to the periphery and within the periphery, amongst partners was good. Although there was no clear evidence of limited enforcement of policies, family planning provides an example where such might not have occurred as evidenced by the drop in implementation scores across many policy domains. Even with limited or the same resource availability, it was expected that the scores would be maintained or improve.

Availability of quality resources was indeed a cross-cutting issue particularly as it relates to levels of funding and its predictability and sustainability, and the availability of medicines and key products for malaria, family planning and EmOC. The government needs to look at additional innovative ways of mobilising resources to at least maintain, and improve, service coverage and its quality. The existence of cost-sharing for such critical services is contrary to the vision of universal health coverage. The introduction of national health insurance in Uganda provides a real opportunity to ensure that costs do not become a barrier to accessing these services.

The policy implementation barometer has inherent limitations like any other barometers because of its cross-sectional nature, and if not conducted frequently, might not establish trends and pick up relevant enablers and challenges of policy implementation. However, the two surveys have been highly illuminating particularly on policy understanding and ultimately implementation. We therefore maintain that if such surveys are frequently done and results engaged with at appropriate multi-sectoral platforms, the barometer is an effective and low cost mechanism for ensuring that corrective action is taken in time and that upstream communication also occurs in time to allow for allocation of requisite resources. We therefore recommend that such a tool be applied on a regular basis and results used in conjunction with routine monitoring statistics for effective policy implementation.

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8.0 Annexures

Annexure 1: Tools

Definition of policy:

Policy has different definitions. For this study, policy will be broadly defined as a broad statement of goals, objectives, and means that create the framework for action. Plans, standards or guiding decisions that provide a framework for government-directed health programs will all be taken as examples of policies.

Interview identifiers

District: (Gulu, Kitgum, Lira, Arua, Kibuku, Tororo, Mbale, Jinja, Kampala, Wakiso, Ibanda, Kabarole, Hoima, Kabale, Masaka, NA):

National (Type name of entity e.g. MoH, etc + NA) _____

Interviewer initials:(TR, KJ, NM, CA, SM, TM, PB, NA, EO, RN, CT, CTA, NMI, JW, RB, JM, AM, AE, RK, JK)

Date of interview: _____ (insert calendar)

Policy: EmOC, Malaria, FP _____ **GIS Coordinates:** _____

Demographics of Respondent

Question	Response		
1. What is the name of your organization? (Specify name of; district/ NGO/health facility/any other institution)	_____		
2. What job title do you hold?	_____		
3. For how long have you been working in this position/facility	[] Years [] Months		
4. To what extent is your job engaged in activities related to malaria control programs/ activities?	Low	Moderate	High
5. To what extent is your job engaged in activities related to family planning program/activities in your position?	Low	Moderate	High
6. To what extent is your job engaged in activities related to emergency obstetric care programs /activities in your position?	Low	Moderate	High
7. To what extent is your job engaged in activities related to district level health system?	Low	Moderate	High
8. To what extent is your job engaged in activities related to facility level service provision?	Low	Moderate	High
9. To what extent is your job engaged in activities related to community level health programs?	Low	Moderate	High
10. If you work at the health facility, what level is the health facility? If not which other category e.g. (MoH, CSO, etc.)	Referral hospital General hospital Health center IV Health center III Health Centre II Others (specify) _____		

Malaria Program (policy specific domain)

Look back to malaria control activities by your organization last financial year (2017/2018), choose the answer that best represent your experience.	Not yet established	Initial steps taken	Partially established	Gained Optimum coverage / results	Fully established	Don't Know
	1	2	3	4	5	0
1. To what extent do you and your team have a well-established awareness of the policy objectives and strategies for malaria control in your organization						
2. To what extent does your organization (/district/facility) have a well-established program for mapping/assessing malaria transmission intensity?						
3. To what extent does your organization (/district/facility) have a well-established program for in-door residual spray for mosquitoes?						
4. To what extent do your organization (/district/facility) have a well-established program for distribution of long-lasting insecticidal nets (LLINs)						
5. To what extent does your organization (/district/facility) have a well-established program for clearing breeding sites for mosquitoes (larva source management)						
6. To what extent does your organization (/district/facility) have a well-established program for prompt malaria case management with ACTs/coartem?						
7. To what extent does your organization (/district/facility) have a well-established program for rapid diagnostic tests (RDTs) for malaria?						
8. To what extent does your organization (/district/facility) have a well-established program for community-level use of ACTs to treat malaria after confirmation with malaria RDTs (iCCM)?						

Policy implementation

For each of these statements, use the response categories to the right to indicate your opinion regarding the implementation of the Malaria policy/programs in your organization or area.	Strongly disagree	Disagree	Moderate	Agree	Strongly agreed	Don't Know
	1	2	3	4	5	0
1. The expected targets of these strategies are well known at your district/organizational level						
2. If well implemented, the above strategies are adequate to control Malaria in your community						
3. These policy / programs enjoy support from the political leaders at your level						
4. The policy /program has effective champion(s) that mobilize visibility and support within the administration						
5. b) The political oversight for this policy implementation since it started is satisfactory						
6. The process of developing the policy/program /plans and targets were participatory enough for all major organizations/actors supporting malaria control activities.						
7. The different organizations that are involved in policy / program activities are well coordinated in their work.						
8. The private sector is providing a major contribution to the program objectives.						
9. The policy / program has effective advocacy at the community level						
10. The vital contributions from other sectors / ministries /departments are well mobilized and timely						
11. The policy/program has clear, reliable and actionable information to guide decision making						
12. The policy/program enjoys excellent relationships with external organizations that provide support and resources						
13. The external environment (beyond your control) is conducive for the success of the policy / program activities						

* Add a choice of specific policy strategies for the policy. (for malaria these can be 1) ACT medicine, 2) Community Treatment, 3) Mosquito nets and 4) Indoor Residual Spray (IRS). The details for these will also come from document review and database trends.

1.2 Emergency Obstetric Care (policy specific domain)

Look back to the last financial year and to your organization to answer the following questions	Not yet established	Initial steps taken	Partially established	Gained Optimum coverage / results	Fully established	Don't Know
	1	2	3	4	5	0
1. The awareness of the policy objectives for [EOC] among its implementers is satisfactory						
2. To what extent does your organization (/district/facility) have a well-established distribution of Midwives and doctors for adequate provision emergency obstetric care?						
3. To what extent does your organization (/district/facility) have a well-established program for Male Involvement in maternal care services?						
4. To what extent does your organization (/district/facility) have a well-established program for encouraging birth preparedness at the country / district / community?						
5. To what extent does your organization (/district/facility) have a well-established program for transport/ambulances for emergency referrals of obstetric emergencies?						
6. To what extent does your organization (/district/facility) have a well-established program for Waiting Shelters/houses to encourage delivery in the health facilities?						
7. To what extent does your organization (/district/facility) have a well-established program for Blood transfusion services to treat hemorrhage during childbirth?						
8. To what extent does your organization (/district/facility) have a well-established program for vacuum extraction for incomplete abortion?						
9. To what extent does your organization (/district/facility) have Functional theater for that can undertake C-sections						
10. To what extent does your organization (/district/facility) have a well-established program for maternal death audits?						

Policy implementation

For each of these statements, use the response categories to the right to indicate your opinion regarding the implementation of the EmOC policy/programs in your organization or area.	Strongly disagree	Disagree	Moderate	Agree	Strongly agreed	Don't Know
	1	2	3	4	5	0
1. If well implemented, the above strategies are adequate for emergency obstetric care in your community /district /country						
2. The outcome targets of these strategies are well known at your district/organizational level						
3. The policy / program enjoys support from the political leaders at your level						
4. The political oversight for this policy implementation since it started is satisfactory						
5. The Level of key stakeholders' engagement is satisfactory						
6. The policy /program has effective champion(s) that mobilize visibility and support within the administration						
7. The process of developing the policy/program plans and targets were participatory enough for all major organizations supporting program activities.						
8. The different organizations that are involved in policy / program activities are well coordinated in their work.						
9. The private sector is providing a major contribution to the program objectives.						
10. The policy / program has effective advocacy at the community level						
11. The vital contributions from other sectors / ministries /departments are well mobilized and timely						
12. The policy/program has clear, reliable and actionable performance information to guide decision making						
13. The policy/program enjoys excellent relationships with external organizations that provide support and resources						
14. The external environment is conducive for the success of the policy / program activities						

*** Add a choice of specific policy strategies for the policy. For Emergency obstetric care - XXX**

2.0 Implementation Networks that support the policy/program activities

Look back to the last financial year (2017/2018) and to your organization and LIST all external organizations that contributed to [xxxx] policy/ program activities of your Dept./District (or facility)	Main type of contribution to policy/program [see list below] <i>list all applicable.</i>	How important is this organization to the success of the policy/program activities in your organization [Circle one]					To what extent is this organization effective in contributing to policy/program activities in your area/facility? [circle one]				
Example: Uganda.....Red Cross	5 , 7	Very Low	Low	Mod	High	Very High	Very Low	Low	Mod	High	Very High
_____		Very Low	Low	Mod	High	Very High	Very Low	Low	Mod	High	Very High
_____		Very Low	Low	Mod	High	Very High	Very Low	Low	Mod	High	Very High
_____		Very Low	Low	Mod	High	Very High	Very Low	Low	Mod	High	Very High
_____		Very Low	Low	Mod	High	Very High	Very Low	Low	Mod	High	Very High
_____		Very Low	Low	Mod	High	Very High	Very Low	Low	Mod	High	Very High
_____		Very Low	Low	Mod	High	Very High	Very Low	Low	Mod	High	Very High
_____		Very Low	Low	Mod	High	Very High	Very Low	Low	Mod	High	Very High
_____		Very Low	Low	Mod	High	Very High	Very Low	Low	Mod	High	Very High
_____		Very Low	Low	Mod	High	Very High	Very Low	Low	Mod	High	Very High
_____		Very Low	Low	Mod	High	Very High	Very Low	Low	Mod	High	Very High

Type of contribution:

1 = Funding /financing	5 = Medicines and products
2 = Administrative/Supervision	6 = Direct Service Provision
3 = Workforce/staffing support	7 = Community Mobilization
4 = Information System support	8 = Other support

3.0 Financing for Program (this will be asked alongside each policy module)

Look back to the last financial year (2017/2018), and to your organization to answer the following questions	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
1. The funds for this policy/program is adequate for the essential activities						
2. The funds for activities are made available in a timely manner						
3. The allocation of funds for prevention activities for this program is favorable						
4. The Government budget is the main source funding for this program in your district/facility						
5. The cost/price of activities and inputs for this program are affordable/reasonable for your annual budgets						
6. The amount of funds expected for program activities is predictable for the planning period						
7. The financing of program activities is sustainable in near future						
8. Most users of the program are able to pay for the services/benefits						
9. There is optimal value and benefits from the funds made available for this program activities (no inefficiencies)						

What are the main actions to improve the shortcomings in the issues assessed in this module?

4.0 Workforce for Programs (this will be asked alongside each policy module)

Look back to the last financial year (2017/2018) and to your district/organization/facility to answer the following questions	Strongly Disagree	Disagree	Moderate	Agree	Strongly Agree	Don't know
1. The size of the workforce supporting this program is adequate for the needs in the community						
2. The time devoted to this program by the availed workforce is adequate						
3. The level of training and skills for the workforce is adequate to support vital activities of this program						
4. The workforce is deployed equitably to cover communities with the higher service needs for this program activities						
5. The workforce have the essential guidelines and directives necessary for performing program activities						
6. The Government is the main source employment for the workforce supporting this program for your district/facility						
7. The salaries and wages for this program are affordable / reasonable						
8. The tools needed by the workforce are sufficiently available for optimal performance						
9. The supervision for the program activities is optimal						
10. Community-level workers are making a fair contribution to this program activities						

What are the main actions to improve the shortcomings in the issues assessed in this module?

5.0 Medicines and Products (this will be asked alongside each policy module)

Look back to the last financial year (2017/2018) and to your district/organization/facility to answer the following questions	Strongly Disagree	Disagree	Moderate	Agree	Strongly Agree	Don't know
1. The medicines stocks for this program are adequate for the needs of the community served						
2. The medicines and products for this policy/program activities are made available in a timely manner						
3. The Govt is the main source of medicines products for this program for your district/facility/clients						
4. The cost/price of medicines and products for this program are affordable/reasonable						
5. The private sources of medicines and products for this program activities is of acceptable quality/safety.						
6. The flow of medicines and products expected for program activities is predictable						
7. The supply chain of medicines and products for this program activities is sustainable						
8. Most users of the program are able to pay for the medicines and products for this program						
9. The quality of medicines and products for this program is optimal						

What are the main actions to improve the shortcomings in the issues assessed in this module?

6.0 Service Delivery of Program (this will be asked alongside each policy module)

Look back to the last financial year (2017/2018) and to your district/organization/facility to answer the following questions	Strongly Disagree	Disagree	Moderate	Agree	Strongly Agree	Don't know
1. The service outputs or benefit of the policy/program are adequate						
2. Priority communities and groups for program services have been identified (or clearly known) for effective targeting						
3. The access to program benefit by the most affected communities is satisfactory						
4. Priority communities and groups have favorable attitude towards program services						
5. IEC and promotion activities for this program are widely received by communities in your district / organization						
6. Preventive services are adequately distributed to communities with the higher needs for prevention						
7. The prevention services are continuously provided with no major gaps or delays						
8. Curative/clinical services are adequately distributed to those with the higher burden of illness in the community						
9. The demand for program services in the community is satisfactory						
10. The communities are doing enough to prevent the causes of [this illness or program]						

What are the main actions to improve the shortcomings in the issues assessed in this module?

HMIS data extraction tool

Organisational units: Health Facilities: CHs; II, III, IV, Hospital, Regional Referral Hospital, National referral Hospital;

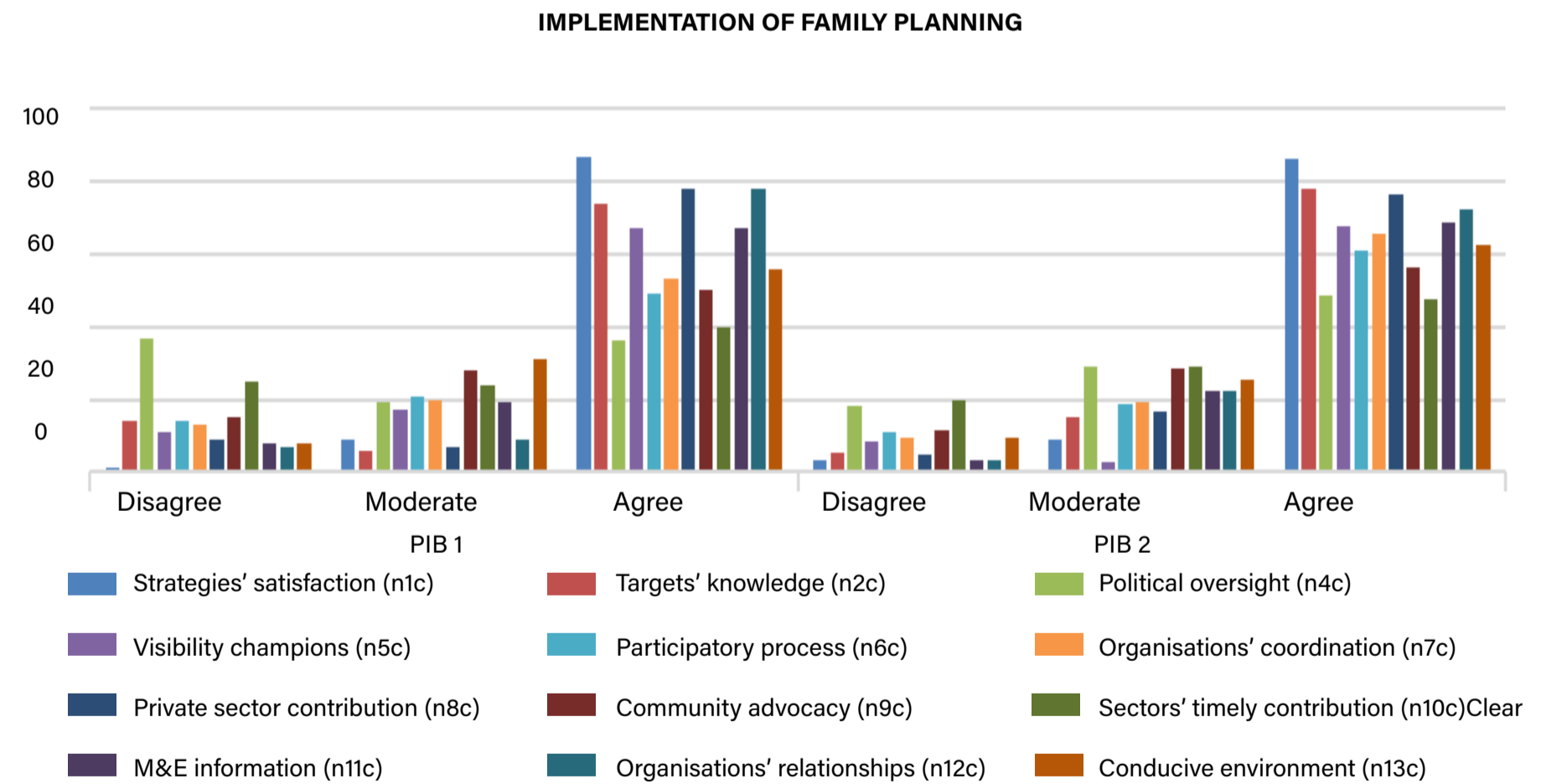
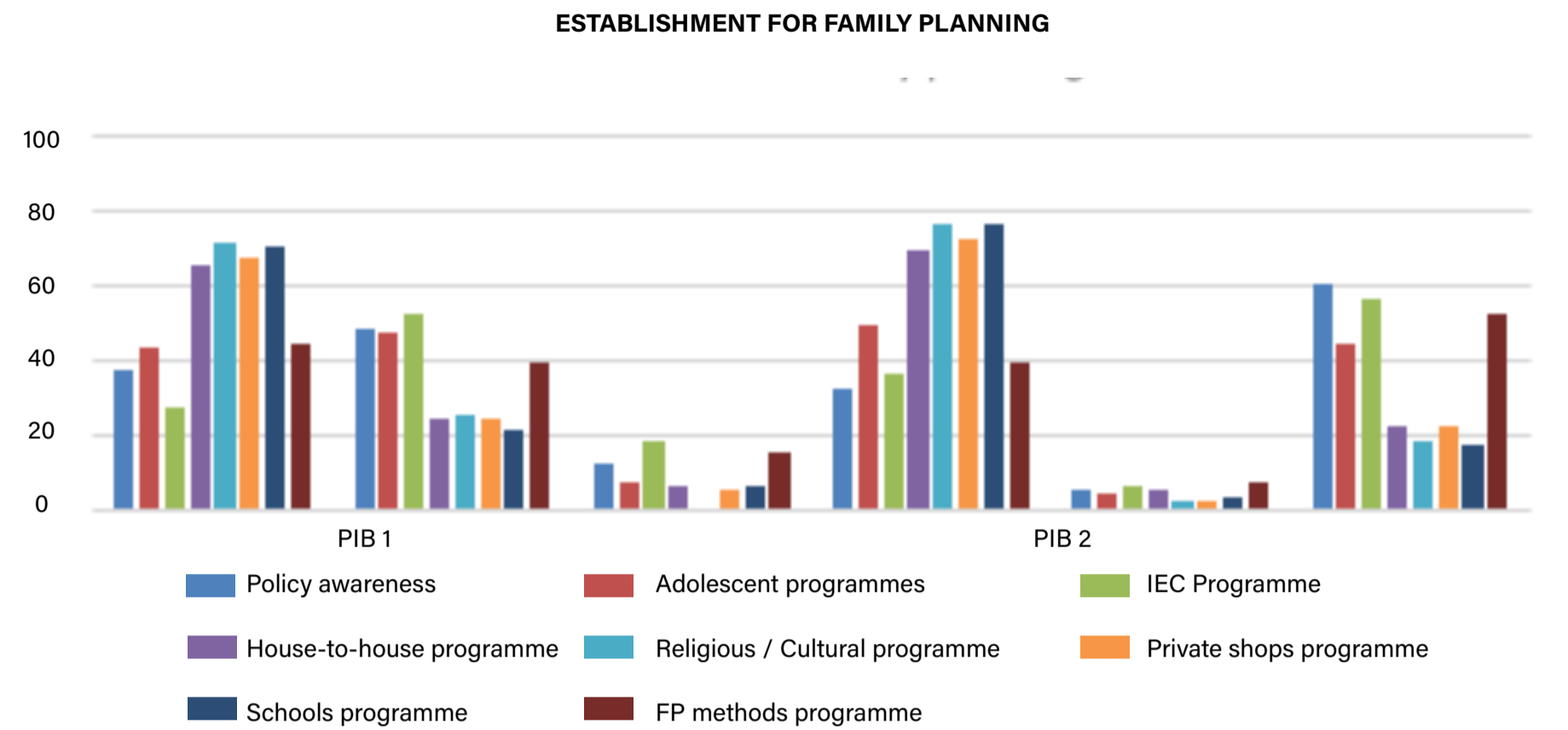
Geographical units: Districts, regions, national,

Name of Organisational Unit (from the above categories):

Program	Key indicators (more to be added based on advice from the key informants)	Period in years						
Malaria (mortality and incidence)	Inpatient Malaria deaths (/100000 persons per year							
	Proportion of malaria death of total deaths							
	Malaria cases (/1000 persons per year)							
Family Planning	New users							
	Total user							
	CPR							
Emergence obstetric care	Maternal deaths							
	Deliveries in health units							
	Functionality of EMoC services							
	4 th ANC coverage							
	1 st ANC coverage							

Annexure 2: PIB 2 Results-Graphics

Annexure A: Graphs for Family planning



FINANCING FOR FAMILY PLANNING

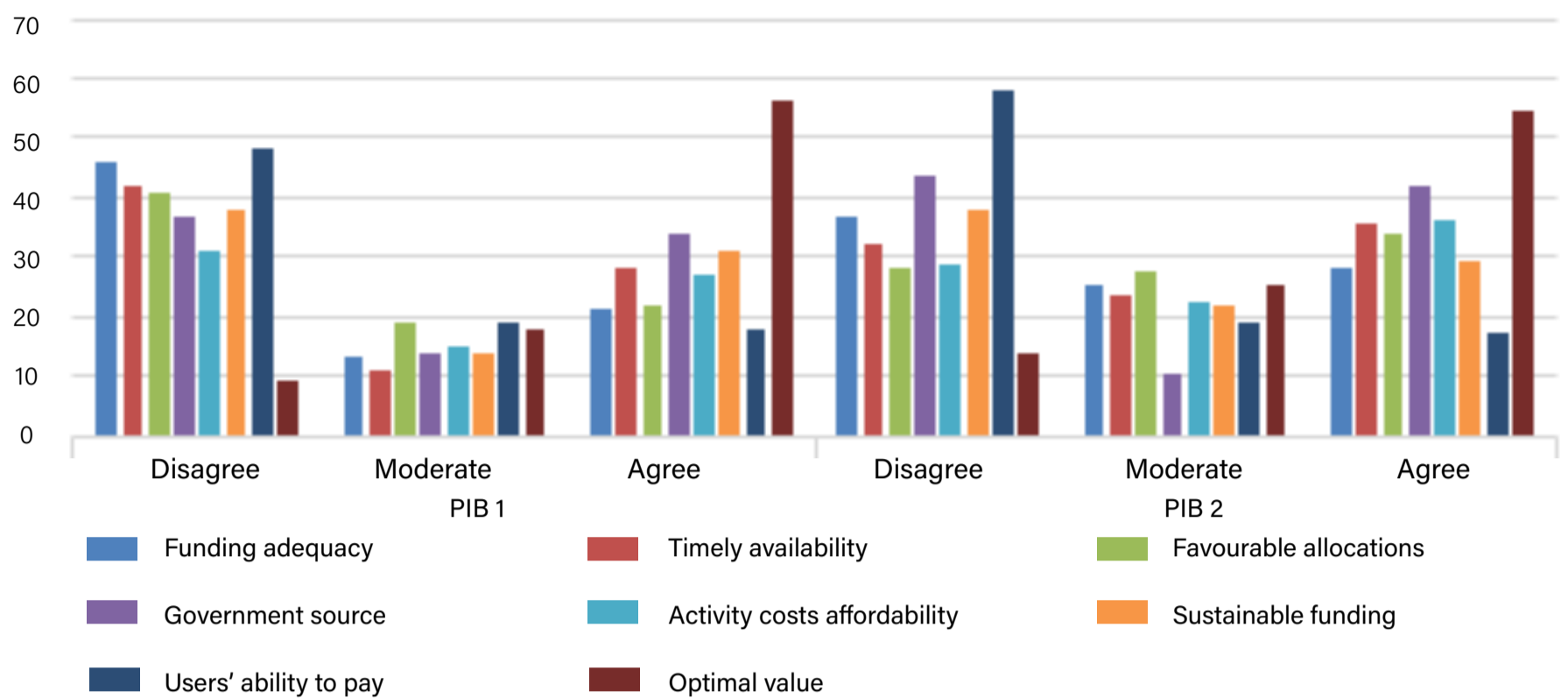


Figure 3: Financing for Family Planning

WORKFORCE FOR FAMILY PLANNING

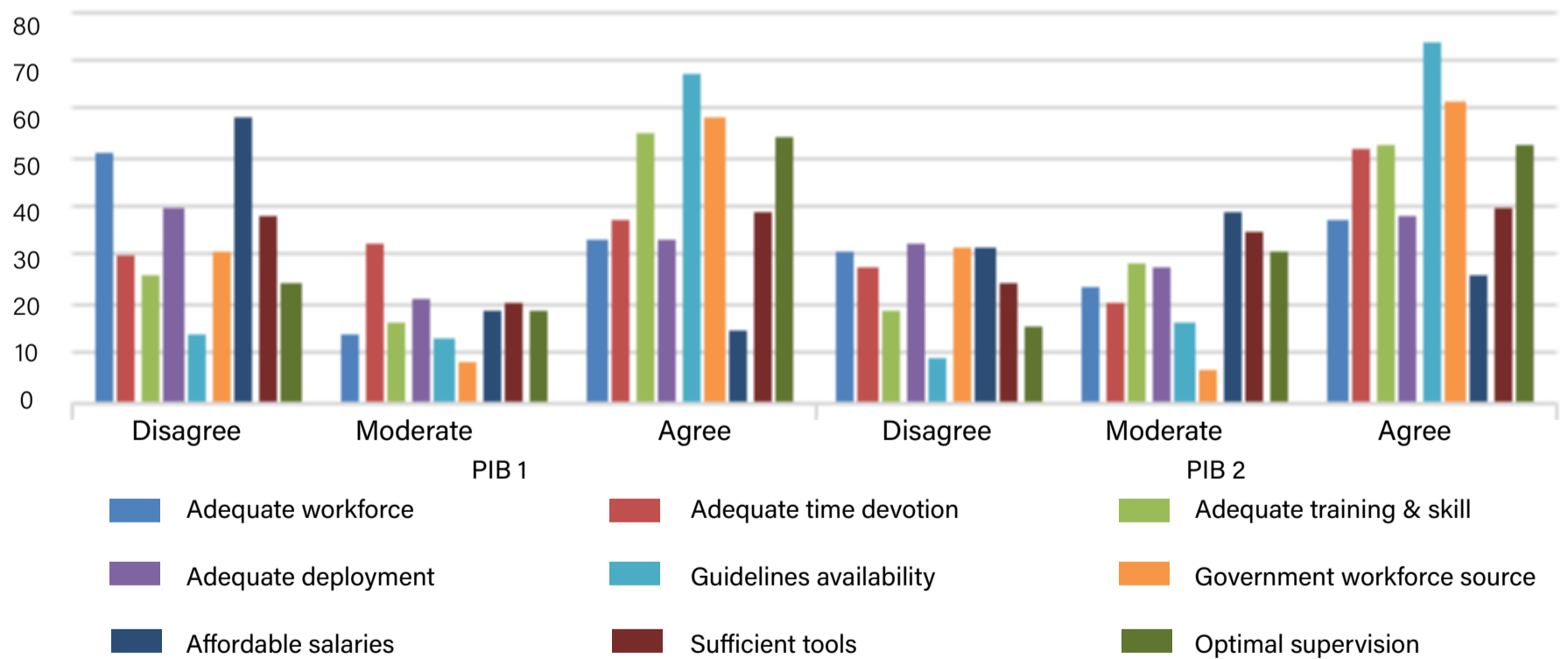


Figure 4: Workforce for Family Planning

MEDICINES AND PRODUCTS FOR FAMILY PLANNING

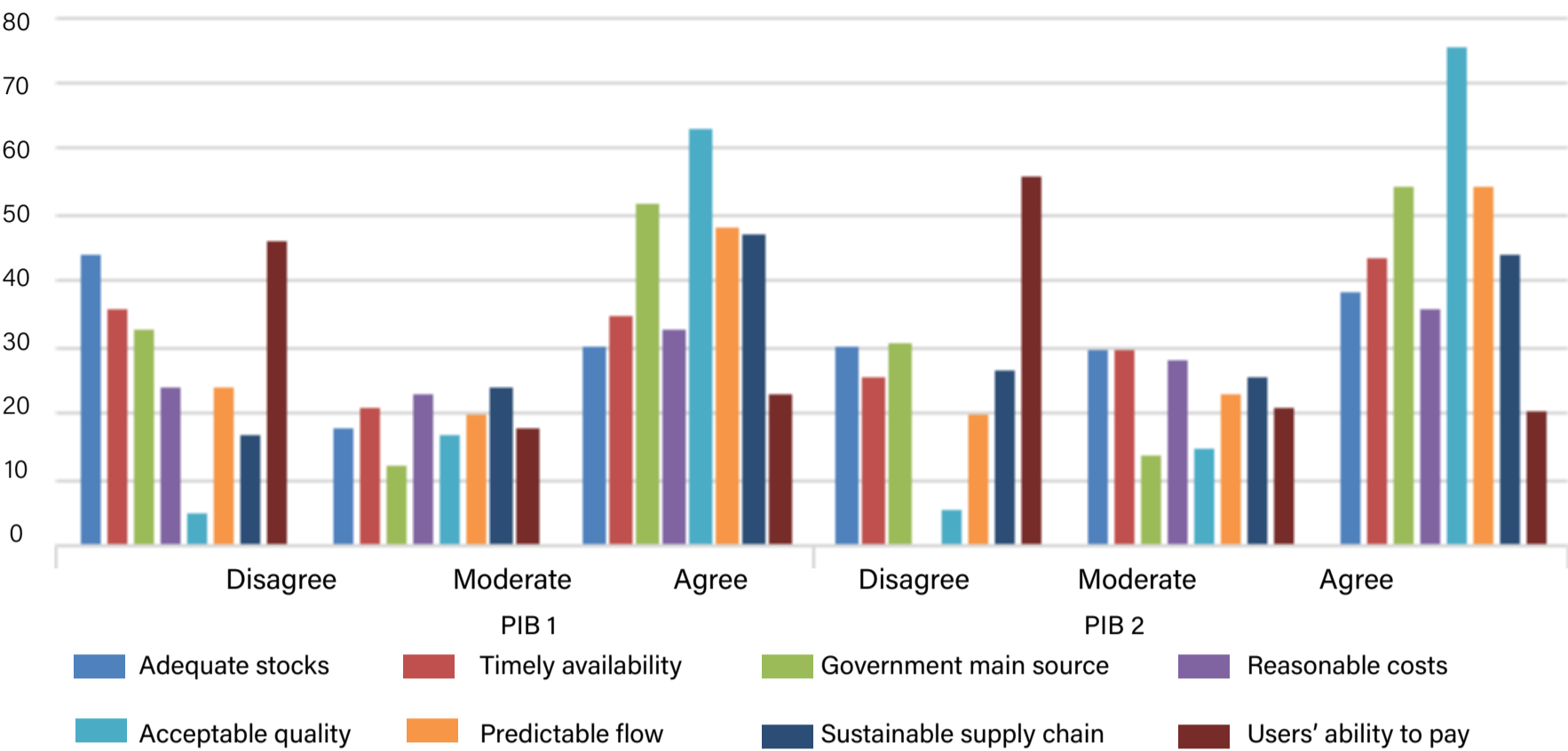


Figure 5: Medicines and Products for Family Planning

SERVICE DELIVERY FOR FAMILY PLANNING

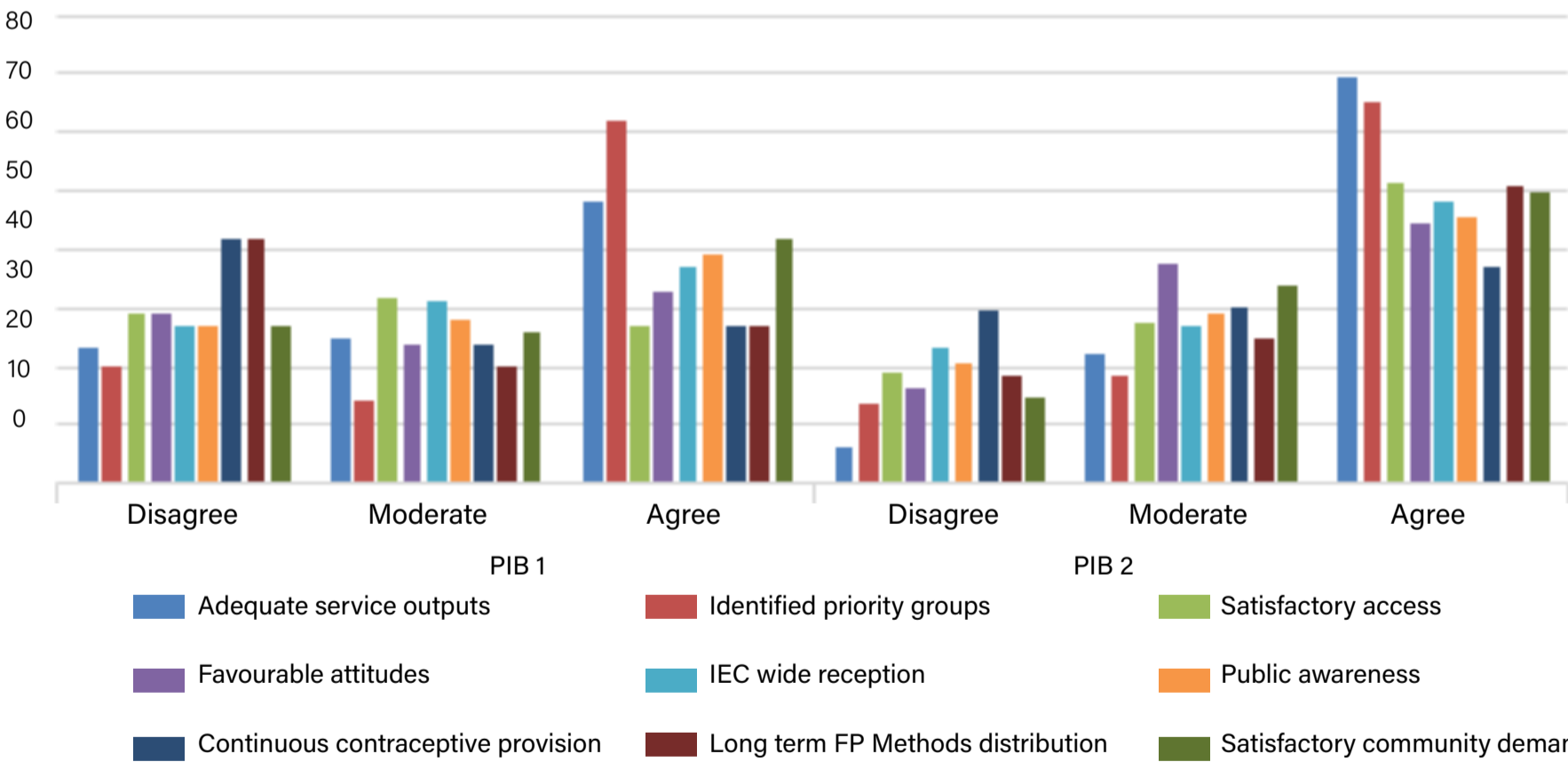


Figure 6: Service delivery for family planning

Annexure B: Graphs for the Malaria Policy

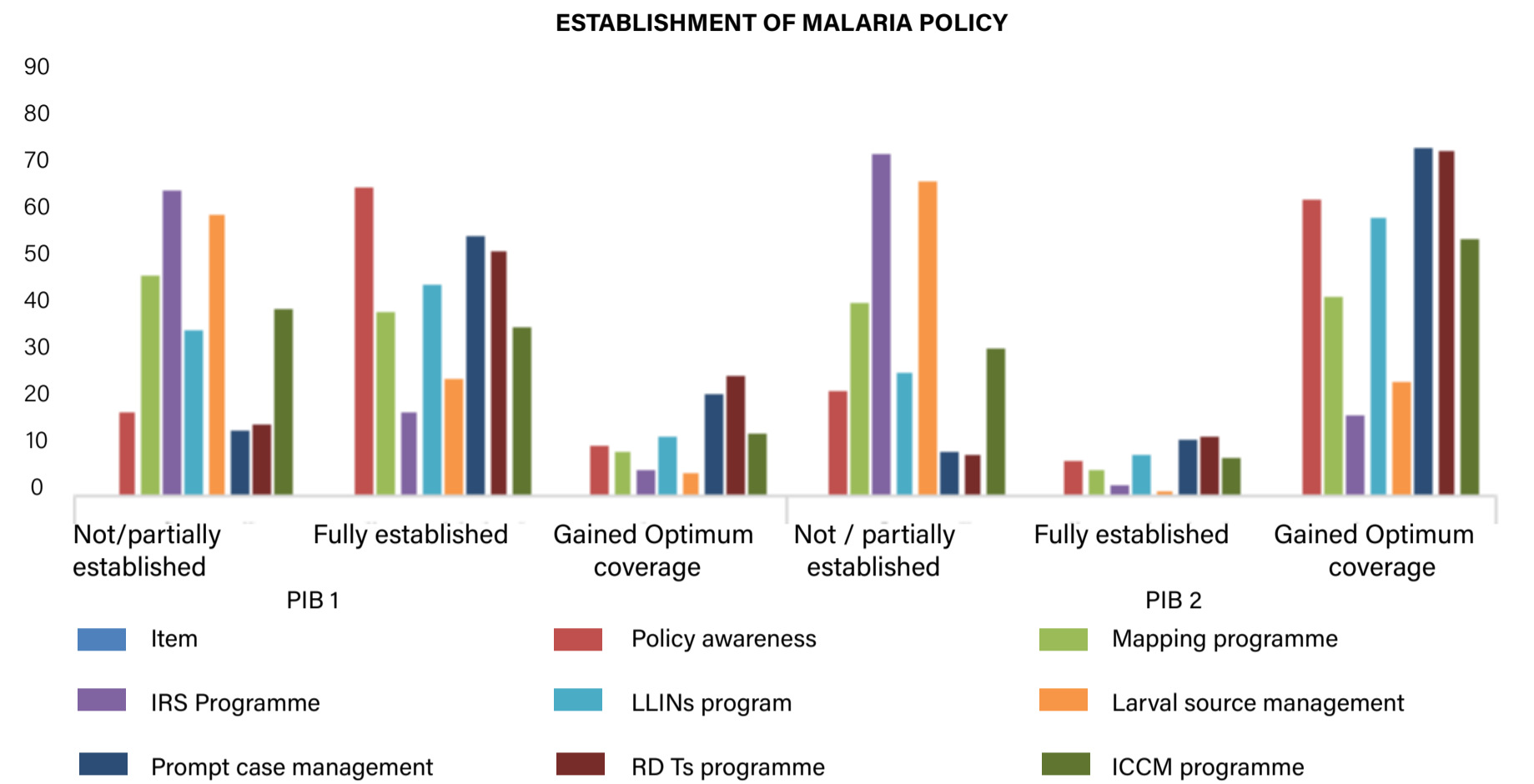


Figure 1: Establishment of malaria policy

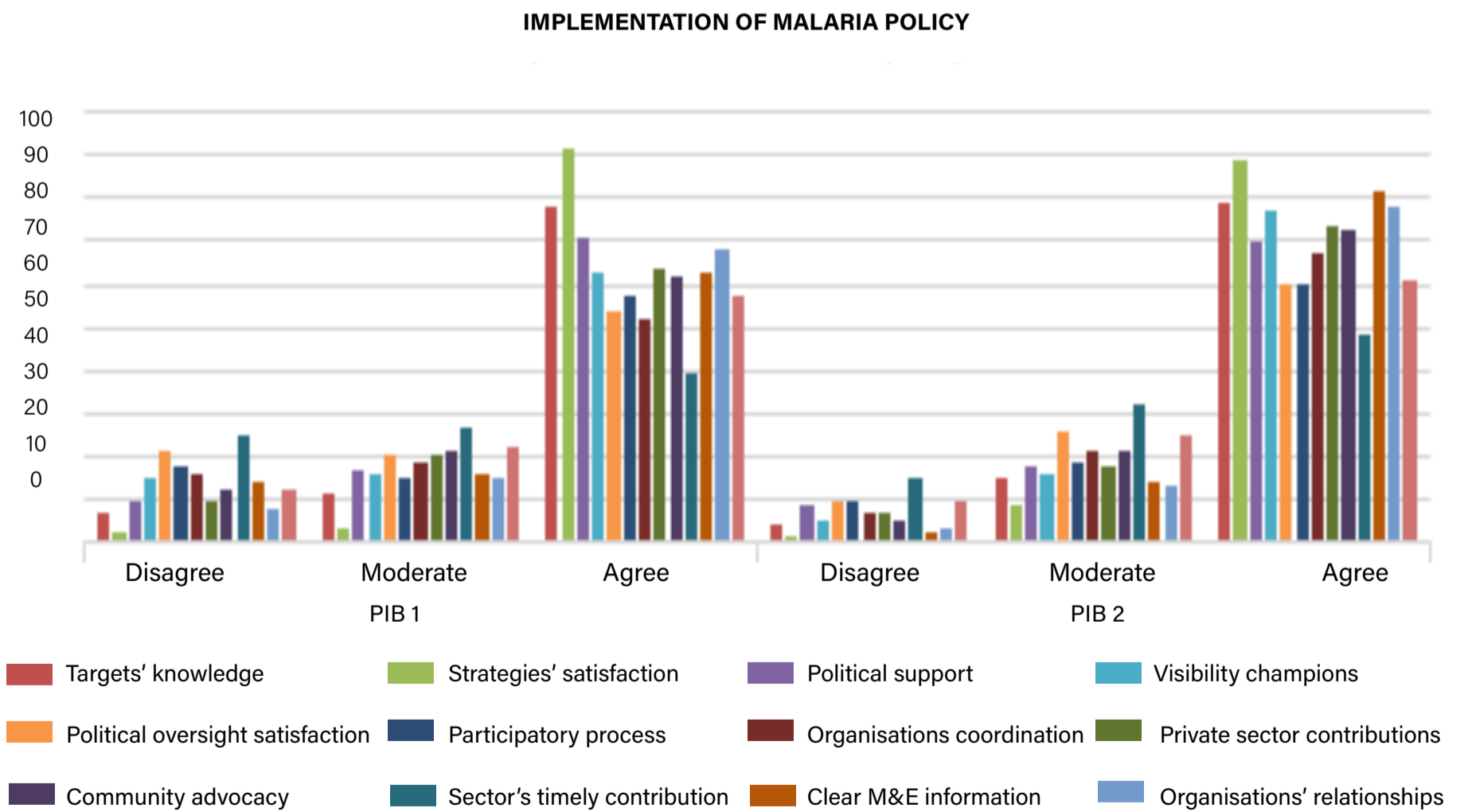


Figure 2: Implementation of malaria policy

FINANCING FOR MALARIA POLICY

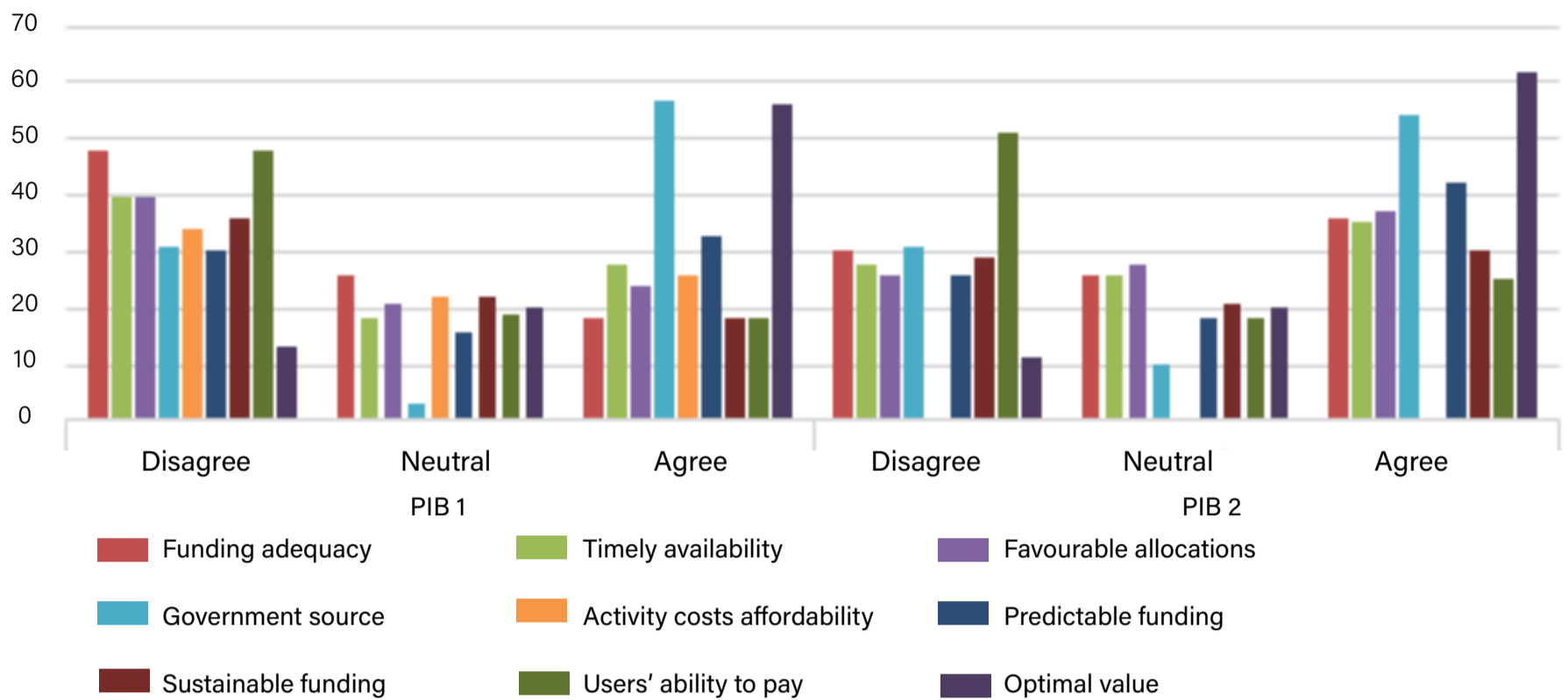


Figure 3: Financing for malaria policy

WORKFORCE FOR MALARIA POLICY

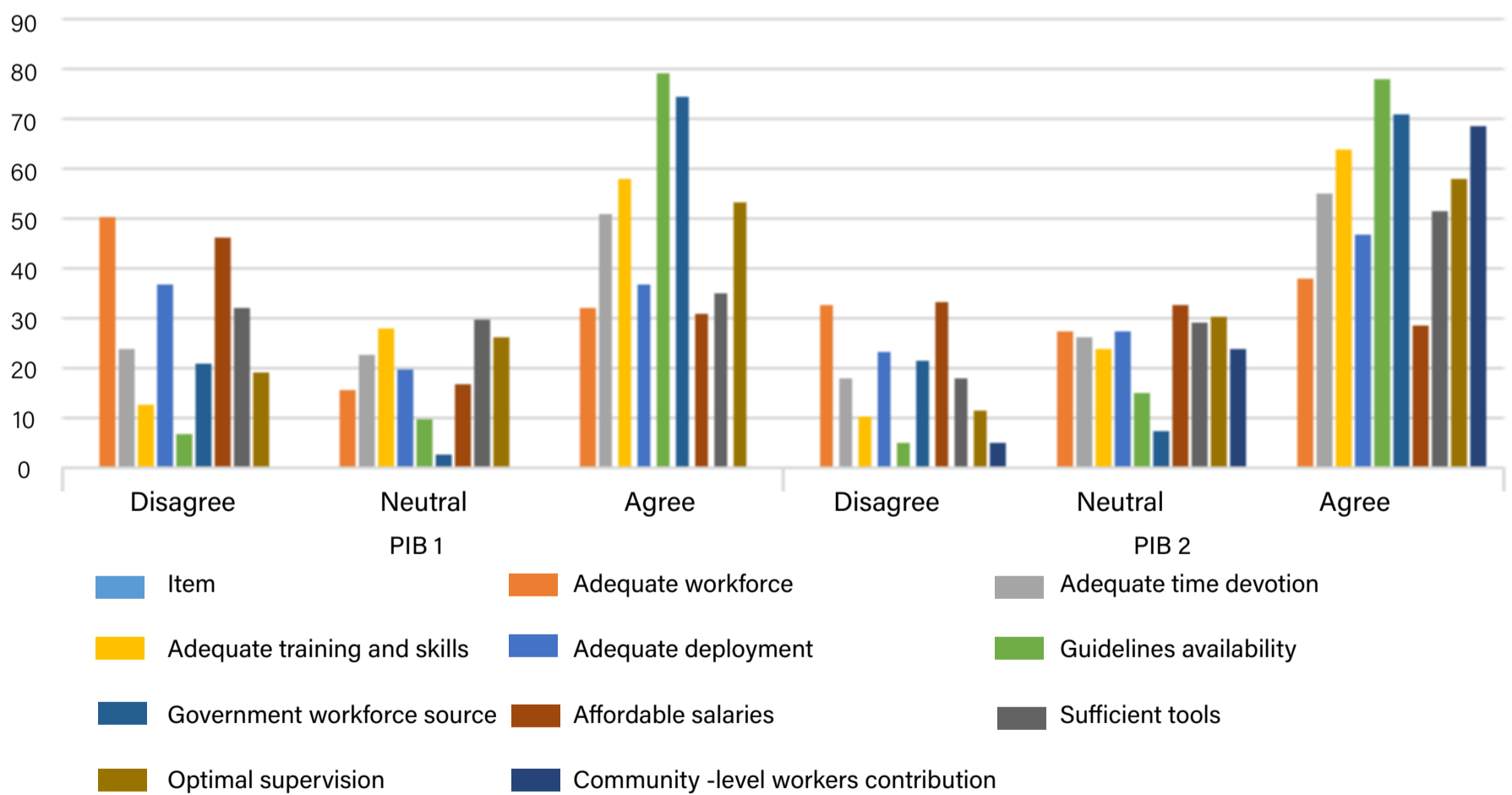


Figure 4: Workforce for malaria policy

MEDICINES AND PRODUCTS FOR MALARIA POLICY

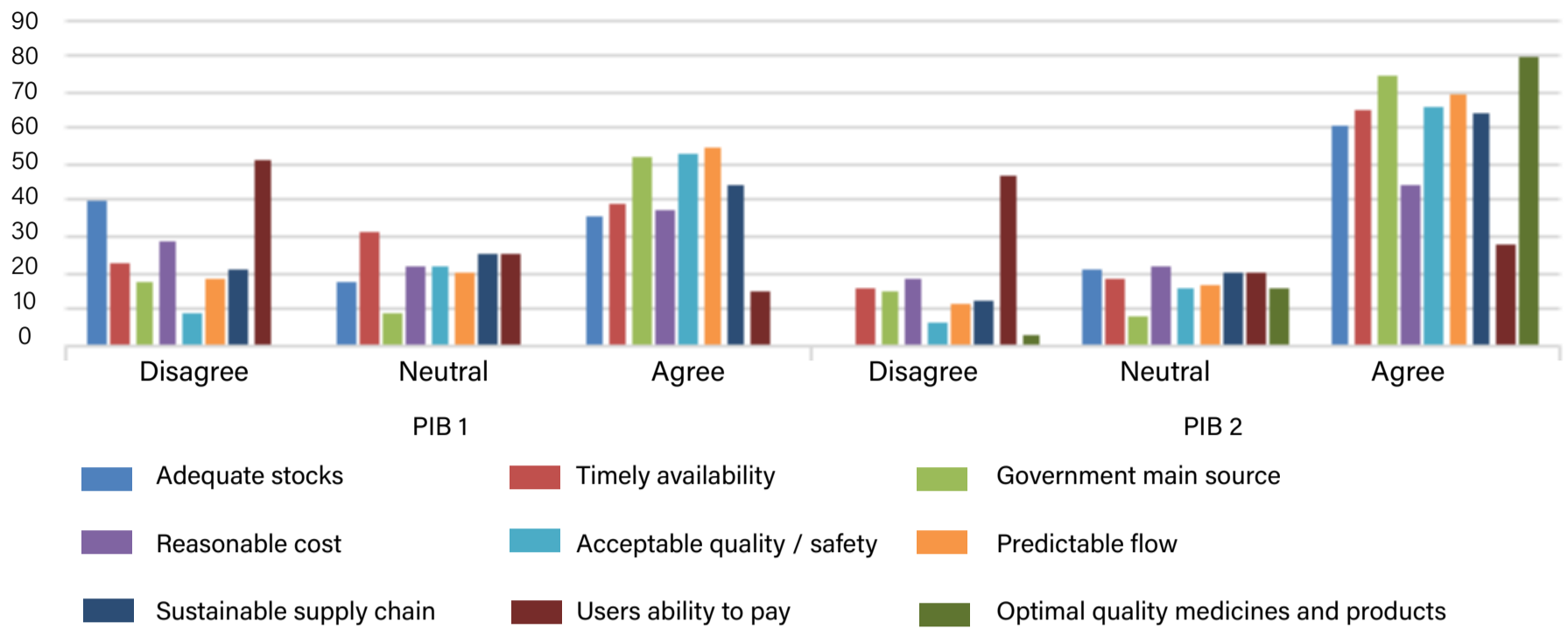


Figure 5: Medicines and products for malaria policy

SERVICE DELIVERY FOR MALARIA POLICY

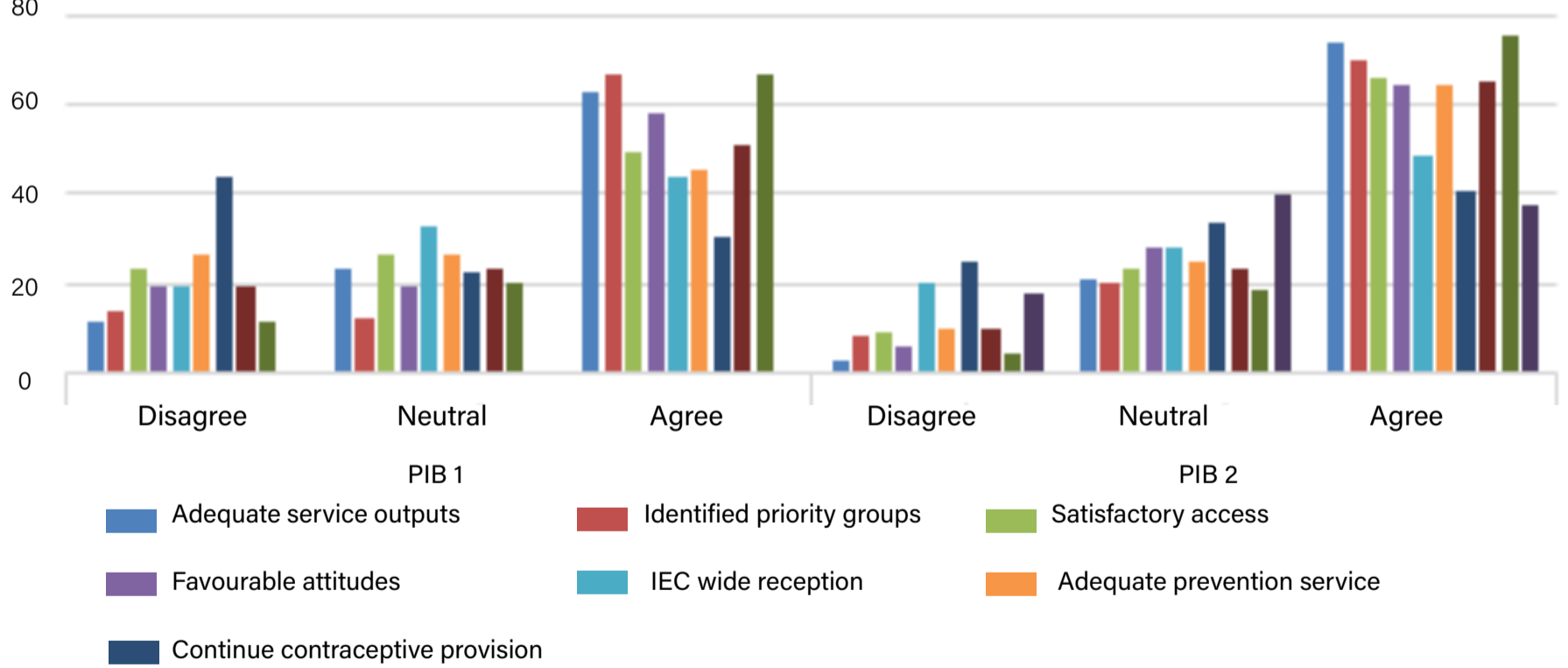


Figure 6: Service delivery for malaria policy

Annexure C: Graphs for the Emergency Obstetric Care Policy

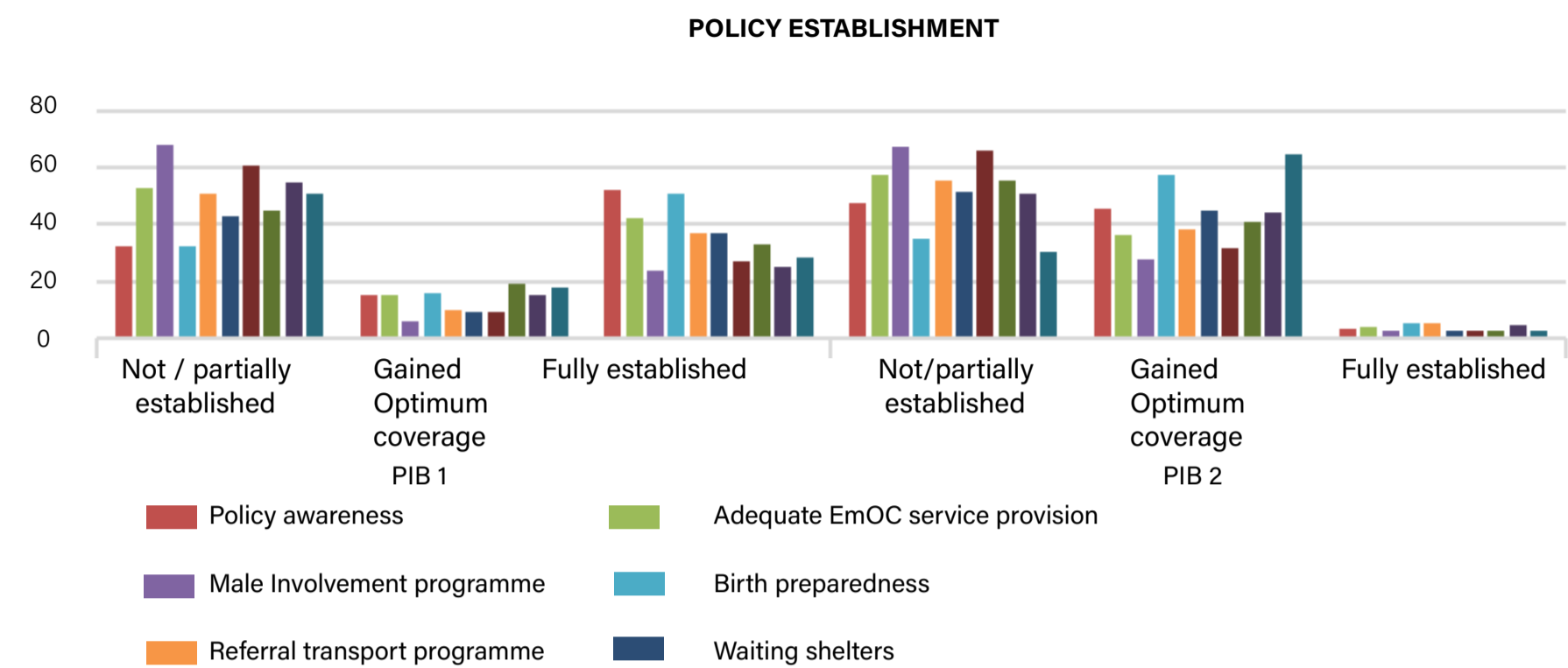


Figure 1: Establishment of EmOC policy

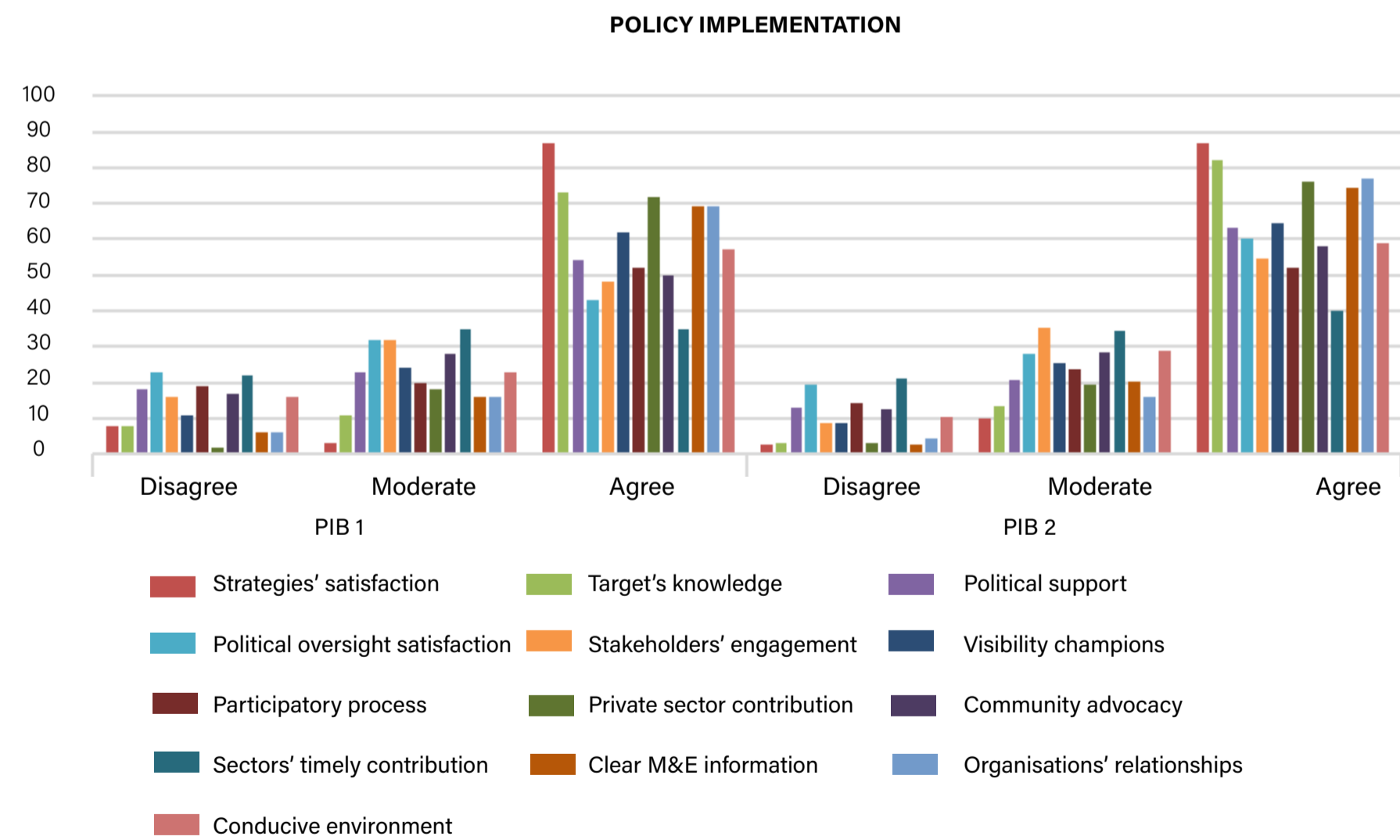


Figure 2: Implementation for EmOC policy

FINANCING

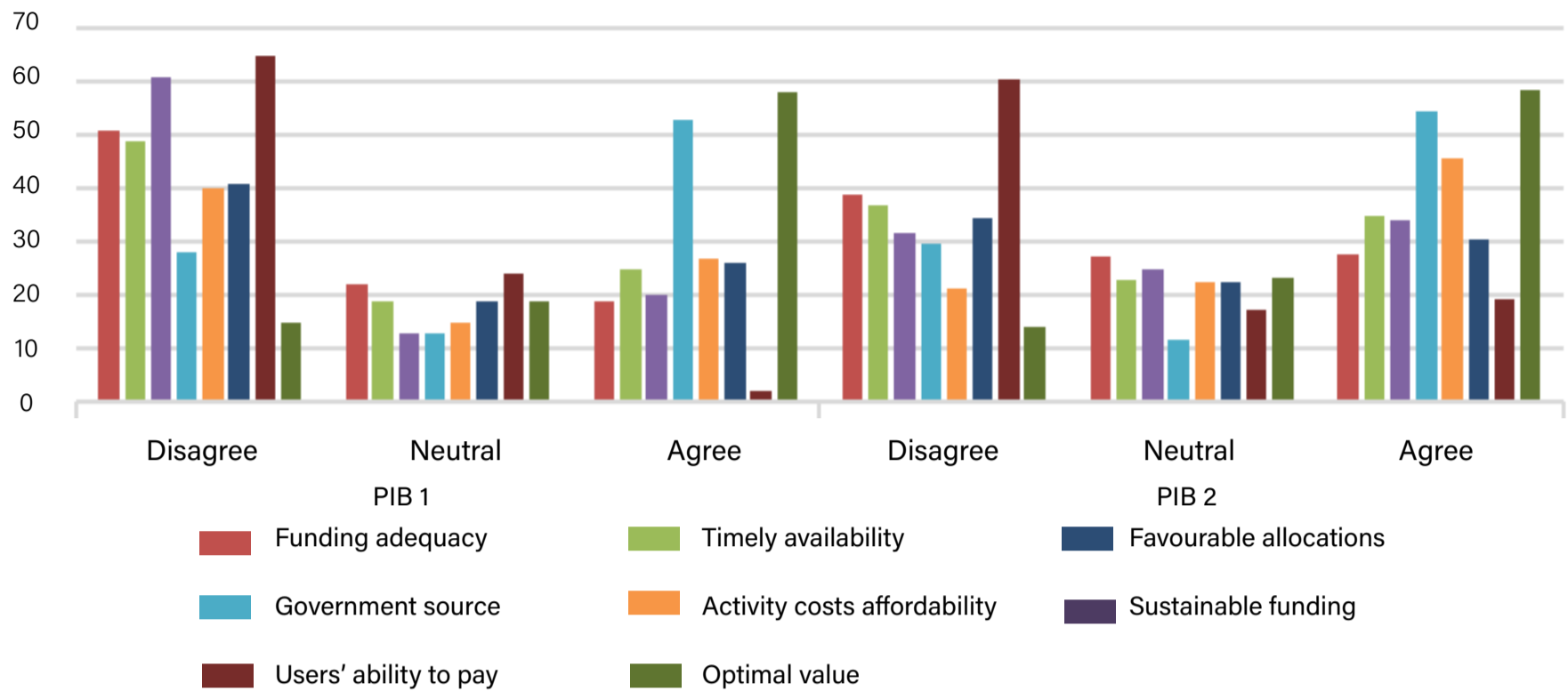


Figure 3: Financing of EmOC policy

WORKFORCE

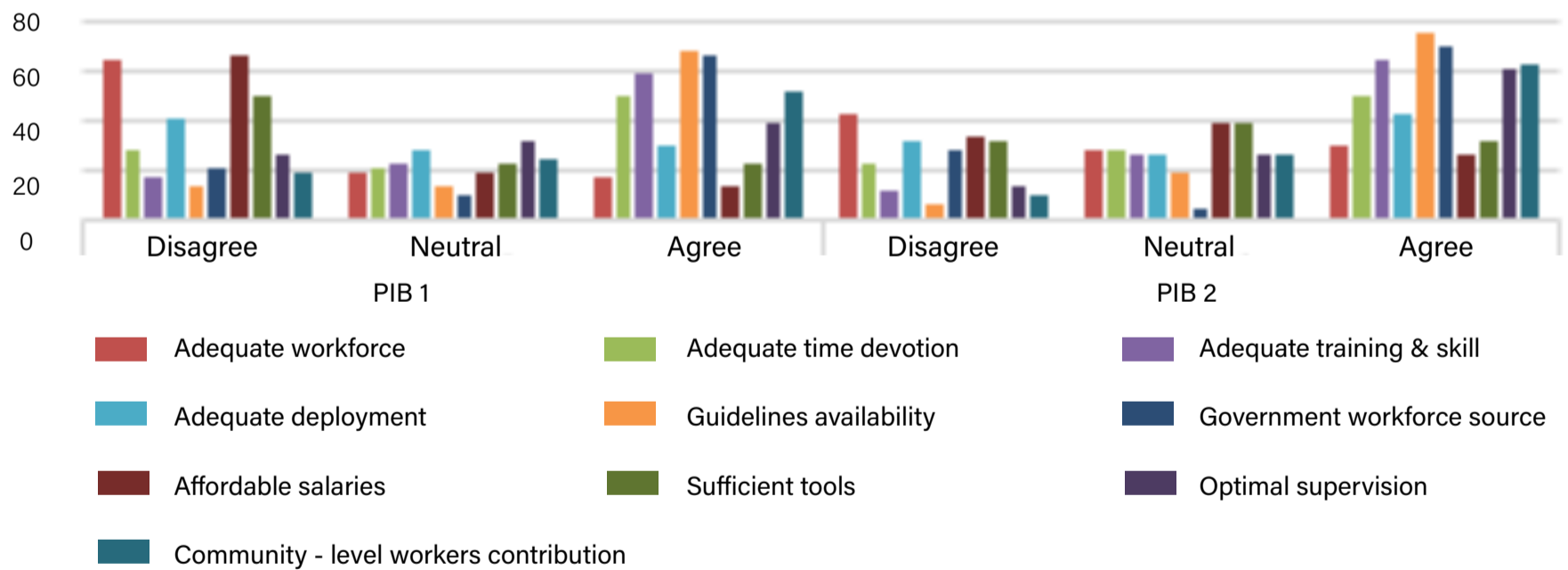


Figure 4: Workforce for EmOC policy

MEDICINES AND PRODUCTS

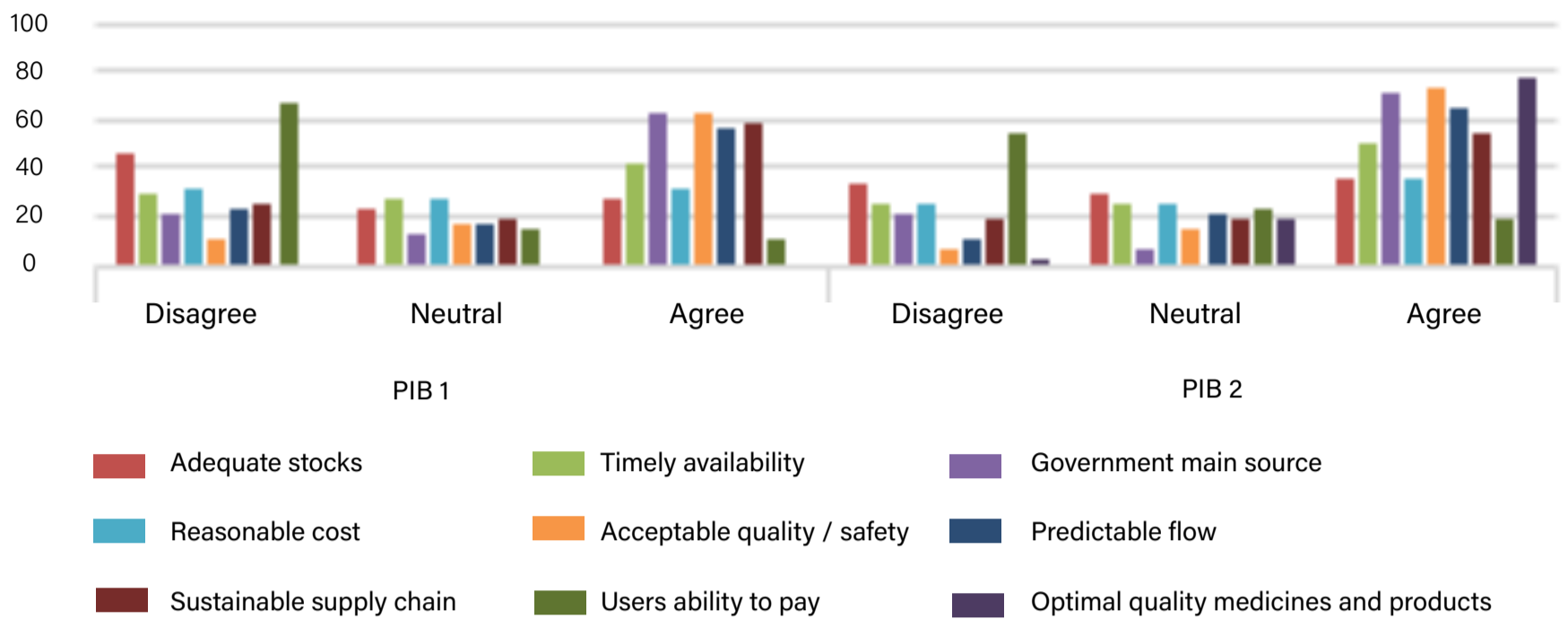


Figure 5: Medicines and products EmOC policy

SERVICE DELIVERY

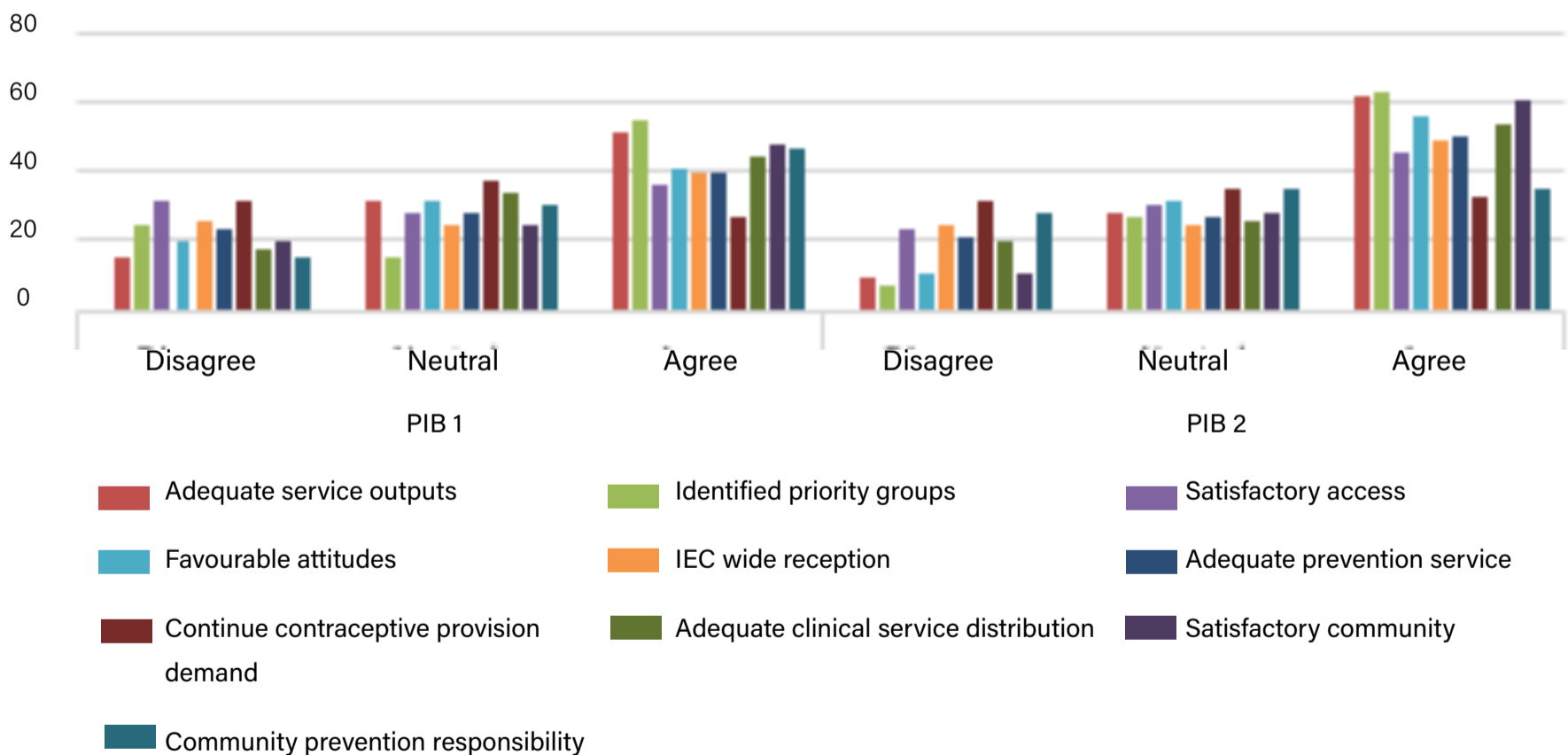


Figure 6: Service delivery of EmOC policy



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