HealthPartners®

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July 16, 2006

Thomas R. Carter
BHR/PVC - RR Building Room 7.6.70
U.S. Agency for International Development
1300 Pennsylvania Ave NW
Washington, DC 20523

Dear Tom,

Scott thought that you might be interested in seeing our Detailed Implementation plan for the Child Survival program. We are excited about the positive impact this will have on the Uganda Health Cooperative.

The program design is based on the child survival sustainability assessment which acknowledges the multidimensional components necessary for success. The program builds on the Uganda Health Cooperative structure and includes strengthening the health status of the population and increasing the capacity of health care providers. Our cooperative development funding is devoted to staffing and expanding the schemes. Through Child Survival we will be able to improve the health of the community while raising the profile of UHC. We will reach a much wider audience with prepaid health care messages and can increase training for the UHC board in order to build local organizational capacity and viability.

Thank you so much for your continued support!

Sincere Regards,

Jennifer

Jennifer Wenborg
HealthPartners Uganda Program Manager

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USAID
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HealthPartners
Uganda Health Cooperative Child Survival
Detailed Implementation Plan

June 30, 2006

Program Area: Bushenyi District, Uganda
Cooperative Agreement: GHS-A-00-05-00031-00
Program Dates: September 30, 2005 – September 30, 2010
Final Due Date: June 30, 2006

Subject: Child Survival and Health Program

Authors:
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Daniel Ololia, M&E Coordinator

A. EXECUTIVE SUMMARY **5**

B. CHGP DATA FORM **7**

C. DESCRIPTION OF DIP PREPARATION PROCESS **11**

D. REVISIONS **12**

E. DETAILED IMPLEMENTATION PLAN **12**

1. PROGRAM SITE INFORMATION 12
2. SUMMARY OF BASELINE AND OTHER ASSESSMENTS 18
3. PROGRAM DESCRIPTION 26
4. MONITORING AND EVALUATION PLAN 61
5. PROGRAM MANAGEMENT 81
6. ORGANIZATIONAL DEVELOPMENT 90
7. TRAINING PLAN 94
8. WORK PLAN 96

Annex 1: Response to DIP Review *107*
Annex 2: Maps of Program Area *117*
Annex 3: KPC, HFA and Rapid CATCH Assessment *123*
Annex 4: ISA Methodology Report *216*
Annex 5: Agreements *231*
Annex 6: Organizational Chart / Management Plan *250*
Annex 7: Resumes *0*
Annex 8: Training and Technical Guidelines *7*

Abbreviations and Acronyms

AMTSL	Active Management of Third Stage Labor
CBHW	Community-Based Health Worker
CDD	Control of Diarrheal Disease
BCC	Behavior Change Communication
BCI	Behavior Change Intervention
BOD	Board of Directors
CE	Community Education
C-IMCI	Community Based Integrated Management of Childhood Illness
CORE	Child Survival Collaborations and Resources Group
CSTS	Child Survival Technical Support
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
FP	Family Planning
HFA	Health Facility Assessment
HIV	Human Immunodeficiency Virus
HQ	Headquarter (Minnesota based)
HST	Health Services Training
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Preventive Treatment
IR	Intermediate Results
IMR	Infant Mortality Rate
ISA	Institutional Strengths Assessment
ITN	InsecticideTreated Nets
KPC	Knowledge, Practice and Coverage Survey
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MCH	Mother and Child Health
MCP	Malaria Control Program (by MOH)
MMR	Maternal Mortality Rate
MNC	Maternal Newborn Care
MOH	Ministry of Health
NGO	Non-government Organization
ORS	Oral Rehydration Solution
PPH	Post Partum Hemorrhage
PSI	Populations Services International
PVO	Private Voluntary Organization
RCT	Routine Counseling and Testing (Updated from VCT)
SCM	Standard Care Management
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
TRM	Technical Reference Materials
UHC	Uganda Health Cooperative
UHIS	Uganda Health Information System
UMPA	Uganda Private Midwives Association
WRA	Women of Reproductive Age

A. Executive Summary

HealthPartners and its NGO affiliate, Uganda Health Cooperative (UHC), are working to develop their capacities in child and maternal health, infectious disease prevention and treatment as well as to improve their abilities to design, manage, monitor and evaluate child survival programs in Uganda.

Program Location and Problem Statement: HealthPartners and UHC will work in Bushenyi district in South Western Uganda which has high rates of maternal, 326/100,000[i] and child mortality, 87.9/1,000[ii]. The total population of the district is 759,201 of which 394,562 are women. The under 5 population is 153,359 and under 1 year is 32,646 with 36, 821 births expected annually[iii]. In Bushenyi, malaria and diarrhea are the highest prevalence rates with caretakers reporting that 44% of 0-23 month old infants had fever and 55% of infants had diarrhea in last two weeks[iv].

Estimated number of beneficiaries: HealthPartners will directly[v] reach at least 34,500 WRA, 3,200 children 0-12 months, 3,100 children 12-23 months and 9,200 children 24-59 months old totaling a minimum of 50,000 women and infants in the Bushenyi over five years. In addition to those reached, at least 14,000 WRA and children under five will be covered under prepaid health schemes by 2010.

Program goal, objectives and major strategies: HealthPartners goal is to link child survival interventions to prepaid health schemes, building on the existing structure to sustainably reduce morbidity and mortality for WRA and children under 5.

HealthPartners achieved major behavioral changes in villages and member groups through prepaid health schemes that reduce barriers for members to seek early treatment, and engender change through preventive measures such as community education and incentive programs for improved sanitation. Given limited MOH budgets, self-financing approaches may be the only means to provide quality services to large numbers of mothers and infants.

Community Social Dimension
Objective 1: Reduce incidence of malaria in Bushenyi for children under 5 and pregnant women. ***Strategies include:*** Increase demand for and access to ITNs; Train proper use for maximum benefit to pregnant women and children under 5; Increase timely malaria treatment; Increase IPT. **Objective 2:** Reduce incidence of diarrhea in Bushenyi for children under 5. ***Strategies include:*** Improve safe water access; Increase safe water practices and hand washing; Improve sanitation practices; Increase intervention for severe diarrhea & dehydration. **Objective 3:** Increase % of pregnant women receiving improved ANC, delivery and post partum care. ***Strategies include:*** Increase demand for RCT; Improved caretaker knowledge of nutrition, child spacing, and danger signs in pregnancy; Increased access to safer birthing.

Local Organizational Dimension

Objective 4: Build local organizational capacity to manage health schemes. ***Strategies include:*** Increase capacity of BOD; Growth of health scheme; Increase ability of cooperative to financially cover service & administration.

Health Services Dimension
Objective 5: Improve health care management especially for WRA and children under 5. ***Strategies include:*** Reduced incidence of stock outs; Improve use of IMCI; Improved ANC; Improve delivery (including AMTSL); Improve self assessment.

Breakdown of level of effort: Fifty percent of interventions will address the prevention and treatment of malaria, and 25% each for diarrheal control, and MNC.

Proposed Operations research and/or anticipated documentation strategy for the project: UHC will explore the design and implementation of subsidized prepaid health care to cover basic health services, antenatal, delivery and postnatal care for the most vulnerable populations of women and children in Bushenyi District. The results will be closely monitored and compared with non-subsidized prepaid health plans in other communities. UHC will explore how alternative financing for women and children will be received by the community and whether or not it may be successfully incorporated into the current health scheme structure, adopted by the Ministry of Health or supported by other organizations.

Local partners in the district include Bushenyi Local Government Health Sector, Bushenyi Medical Centre, Ishaka Hospital, Comboni Hospital, Mitooma Central Clinic, UMPA, and TBAs for health services training, SCM, IMCI, commodity management and self assessments. The project will work with UCBHFA, the UHC BOD, leaders and members to build capacity in health scheme management. PSI, Africare, UPHOLD, MOH and Business PART Project will play an important role in mentorship, shared use of health data gathered in the district, protocols, trainers and training tools.

Category of CSHGP application: Entry
Start and end dates: September 29, 2005 - September 29, 2010
Level of Funding: UHC's budget is for $1,250,000 with cost share of $312,500.

Name and position of the local USAID Mission representative with whom the program has been thoroughly discussed: Jessica Kafuko, Health Advisor, USAID/Uganda Mission, 42 Nakasero Road, P. O. Box 7856, Kampala, Uganda, jkafuko@usaid.gov, Tel: 256-31-387204.

Primary writers of the document include: Jennifer Wenborg, HealthPartners project manager, Rebecca Joy Batusa, UHC field program manager and Daniel Ololia, M&E Coordinator.

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B. CHGP Data Form

Child Survival and Health Grants Program Project Summary

Apr-11-2006

Health Partners
(Uganda)

General Project Information:

Cooperative Agreement Number:	**GHS-A-00-05-00031**
Project Grant Cycle:	**21**
Project Dates:	**(9/30/2005 - 9/30/2010)**
Project Type:	**Entry/New Partner**
Health Partners Headquarters Technical Backstop:	**Scott Aebischer**
Field Program Manager:	**Rebecca Joy Batusa**
Midterm Evaluator:	
Final Evaluator:	
USAID Mission Contact:	

Field Program Manager Information:

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Alternate Field Contact:

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Funding Information:

USAID Funding:(US $): $1,250,000 **PVO match:(US $)** $312,500

Project Information:

Description:

Uganda Health Cooperative's Child Survival goal is to demonstrate that prepaid health plans are viable strategies to address child survival and achieve scale and community-wide impact. Child survival interventions will be implemented in order to reduce maternal and child morbidity and mortality. Fifty percent of the interventions will address the prevention and treatment of malaria, and 25% each for diarrheal control, and MNC.
A reduction of malaria rates will be achieved through aggressive marketing of ITNs, Homa Paks for household treatment and early identification of at risk patients for treatment by health providers. Major strategies to address diarrhea include early recognition by mothers of severe anemia and fevers, availability of ORS, improved hygiene practices and clean water. For MNC, HealthPartners will promote family planning, ANC, VCT and improved birthing practices for home births including training of midwives and availability of birthing kits for clean deliveries. UHC will work closely with key partners in the district for each intervention.

Location:

Bushenyi District, Uganda.

Project Partners	Partner Type	Subgrant Amount
MOH	Collaborating Partner	
PSI Uganda	Collaborating Partner	
UPHOLD	Collaborating Partner	
AFRICARE	Collaborating Partner	
Uganda Private Midwives Association	Collaborating Partner	
Business PART Project	Collaborating Partner	

General Strategies Planned:

Social Marketing
Private Sector Involvement
Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment

Health Facility Assessment
Organizational Capacity Assessment for your own PVO
Lot Quality Assurance Sampling
Community-based Monitoring Techniques

Behavior Change & Communication (BCC) Strategies:

Social Marketing

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
US HQ (General) US HQ (CS unit) Field Office HQ CS Project Team	(None Selected)	Private Providers	National MOH Health Facility Staff	Health CBOs CHWs

Interventions/Program Components:

Control of Diarrheal Diseases (25 %)

(IMCI Integration)
- Water/Sanitation
- Hand Washing
- ORS/Home Fluids
- Feeding/Breastfeeding
- Care Seeking
- POU Treatment of water
- Zinc

Malaria (50 %)

(IMCI Integration)
- Training in Malaria CM
- Adequate Supply of Malarial Drug
- Antenatal Prevention Treatment
- ITN (Bednets)
- Care Seeking, Recog., Compliance
- IPT
- Community Treatment of Malaria
- ACT

Maternal & Newborn Care (25 %)

(IMCI Integration)
(CHW Training)
- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Delay 1st preg Child Spacing
- Integr. with Iron & Folate
- Normal Delivery Care
- STI Treat. with Antenat. Visit
- Control of post-partum bleeding

Target Beneficiaries:

Infants < 12 months:	3,200
Children 12-23 months:	3,100
Children 24-59 months:	9,200
Children 0-59 Months	15,500
Women 15-49 years:	34,500
Population of Target Area:	759,201

Rapid Catch Indicators:

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	25	92	27.2%	9.1
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	26	40	65.0%	14.8
Percentage of children age 0-23 months whose births were attended by skilled health personnel	45	95	47.4%	10.0
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	46	70	65.7%	11.1
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	24	24	100.0%	0.0
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	12	18	66.7%	21.8
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	33	43	76.7%	12.6
Percentage of children age 12-23 months who received a measles vaccine	33	43	76.7%	12.6
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	30	95	31.6%	9.3
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	72	95	75.8%	8.6
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	5	64	7.8%	6.6
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	61	95	64.2%	9.6
Percentage of mothers of				

children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	2	95	2.1%	2.9

Comments for Rapid Catch Indicators

C. Description of DIP Preparation Process

Project start up activities and detailed implementation plan preparation began immediately upon inception of the Child Survival program. Joy Batusa, based in Kampala, Uganda was approved as the Field Program Manager and Scott Aebischer based in Minnesota was approved as the HQ Technical Backstop. Lydia Kiwanuka, based in Kampala is the UHC Accountant and David Tiffin is the HQ Accountant. Jennifer Wenborg, HQ Program Manager wrote the start up work plan and Joy Batusa began the recruiting process. An office was established in Bushenyi district and staff was hired.

HealthPartners HQ Program Manager attended the DIP Mini-University in Baltimore in June 2005 to learn about DIP preparation. The initial work plan covered set up, staffing, baseline assessments, intervention/procurement planning, and DIP deadlines. A library of Child Survival resources was compiled and a prioritized checklist developed for training staff.

HealthPartners HQ Program Manager attended New Grantee Orientation in October 2005 and the Field Program Manager attended CORE's Qualitative Research Methods Workshop in November 2005. Staff spent one week in mentorship training in their respective roles with Africare February 13-17.

In the earliest stages of DIP preparation, the Field Program Manager met with the following personnel from the Uganda Mission: Rhona Walusimbi, Performance Monitoring Specialist, Liz Regan Kiingiand, Director Program and Policy Development Office, Erik Janowsky and Jessica Kafuko, Health Advisor. A Technical Assistance Committee of Ugandan experts was developed to provide coordination and oversight. Working relationships were developed with MOH, GOs/PVOs, stakeholders and potential partners.

Mr. John Ssekamate Ssebuliba from Makerere University was hired to consult on the KPC, Rapid Catch, HFA and ISA. A baseline assessment coordinating team, comprised of stakeholders helped develop the results framework, provided feedback on assessment tools, discussed results and participated in DIP planning. An additional planning session was held with all UHC/CS staff, the BCC coordinator from Africare and the PSI Malaria Programs Coordinator.

KPC 2000+ and HFAs were carried out in January 2006 and the initial DIP draft sent to CSTS for review February 8. The consultant originally hired to write the baseline reports turned in a draft report one month after his contracted deadline date with incomplete and inaccurate results. Simon Kasasa, a Biostatistician at the Institute of Public Health at Makerere University was then hired to re-enter data, to analyze results and to write the final report. Focus group discussions were conducted to further explore behaviors and barriers to change for some interventions.

Two DIP Stakeholder Workshops were held in Bushenyi district; one was technical for the DDHS, HWs, CBOs and other partners and the second meeting was held for stakeholders including health schemes and village CBOs. A debriefing and follow up stakeholders meeting is scheduled for July 2006 in which copies of the final approved DIP will be disseminated and discussed.

A total of six months were spent gathering information, meeting with potential partners, planning activities and M&E, building staff capacity and carrying out baseline assessments in preparation for the final DIP.

D. Revisions

UHC reduced the number of staff per application review recommendations; instead of employing specialized staff for each intervention a health services trainer, community educator and communication and distribution coordinator were hired. Staff will work with local health educators, health assistants, District Economist/Planners and PVO/NGO partners to implement behavior change strategies and health services training.

No significant changes to the budget have been made.

E. Detailed Implementation Plan

1. Program Site Information

Location and population: Annex 3 includes maps of the program area, Bushenyi district by population and a list of health facilities broken down by county, subcounty, health unit and type. Bushenyi district is comprised of five counties with a total population of 759,201. The female population is 394,562 and the under 5 population is 153,359. The population for children 0-1 is 32,646, 12-23 months is 31,317, children 24-49 months is 93,951 and 36, 821 births expected in the next year[vi]. HealthPartners will directly[vii] reach at least 34,500 WRA, 3,200 children 0-12 months, 3,100 children 12-23 months and 9,200 children 24-59 months old totaling a minimum of 50,000 women and infants in the Bushenyi over five years. In addition to those reached, at least 14,000 WRA and children under five will be covered under prepaid health schemes by 2010.

Health status: Uganda's population is about 25.6 million people with an overall IMR of 87.9 out of every 1,000 children born, with 141.9 under five mortality rates[viii]. The MMR is 880 deaths per 100,000 live births[ix]. Children under five, expected pregnancies and

births are broken out by counties below. Sheema includes North and South regions and Igara includes East and West.

2005 Bushenyi projections according to the
Bushenyi District Health Report 2004.

County	Under 5 years	Expected pregnancies	Expected births
Sheema	37,791	9,354	9,073
Igara	43,126	10,674	10,354
Bunyaruguru	21,346	5,284	5,125
Ruhinda	33,717	8,346	8,095
Buhweju	3,699	4,302	4,173

Health status of population under 5 (maternal and mortality rates),
major causes (Bushenyi District Health Report 2004.)

Disease	Population affected number	No. deaths	Case fatality rate
Malaria	15,502	314	2.03
Diarrhea (acute)	417	17	4.08
Diarrhea (dysentery)	44	1	2.27
Pneumonia	1,512	59	3.90
Anemia	1,212	64	5.28
Respiratory infections	2,807	19	0.68
AIDS	31	1	3.23

Many factors influence the health of women and children in Bushenyi district: low incomes among households, long distances to health units, low levels of education, high rates of domestic violence, inadequate knowledge on health practices, inadequate medical facilities –beds, beddings, rooms, low morale among medical workers, and political influence at all levels (especially when there is leadership change). Health programs are often initiated without monitoring or follow up, and women are not independent in decision making about their health and that of their children. Religious beliefs in prayers for healing, no family planning for Catholics, and using traditional herbs hinder quality care and care seeking practices of women. Some women do not trust their delivery to male or young female medical workers in health facilities and many believe that all health unit deliveries end in caesarean births. In accordance with cultural

traditions, many pregnant women are denied foods like fish and chicken which are nutritious during pregnancy and nursing.

Other factors that influence health: Mothers' education is inversely associated with her child's risk of death. Additionally childhood mortality is linked to demographic factors, including the sex of the child, mother's age at birth, birth order, and previous birth interval and birth size. Studies show that a women's status influences infant mortality in which women have little say in family decisions and can not refuse sex and/or have been abused by their husbands. Focus group discussions in Bushenyi district reveal that in order of importance, men are followed by cows, then women and finally children. Education is a higher priority for children than health.

Priorities for **changes in traditional beliefs and practices** include: inappropriate uses of herbs and ineffective home remedies; reliance on traditional healers, rather than professionals; waiting too long for treatment; abortions without medical assistance; poor birthing practices such as forcing births through exerting pressure; poor hygiene (unwashed hands during birth and births in the bush); poor hygiene (lack of hand washing when dealing with food preparation and disposal of child feces); lack of knowledge dealing with maternal bleeding after birth; not keeping the baby warm after birth; small cuts in the vagina for use of herbs in healing; bad weaning practices (pepper on breasts to stop suckling); water/juices provided to baby to "ease pains to mother", lack of birth spacing and fistula. Often malaria is confused with other illnesses and the wrong drugs are given to the sick. Women lack rights and control over their sexuality, and are stigmatized if they are HIV positive (it is often assumed to be the woman's fault).

Health care services in Bushenyi are either provided by government or non-profit hospitals and clinics. Government services in theory are free, but they are overcrowded and of poor quality. Residents often prefer to utilize non-profit facilities but must either be able to pay for services at the time of treatment, or must join prepaid health plans. HealthPartners UHC works closely and is directly linked to the three major health providers as part of its prepaid health schemes: Bushenyi Medical Centre with four satellite clinics, Comboni Hospital, Mitooma Central Clinic, and Ishaka Seventh Day Adventist Hospital. All of the hospitals provide public health and clinical services in family planning, antenatal and postnatal care, child health (immunization), TB/HIV testing and counseling, antiretroviral treatment (Comboni, Ishaka and Bushenyi Medical Centre) and oral health.

The doctor to population ratio is 1:30,765; the ideal ratio is 1:5000-10,000 according to the Bushenyi Local Government Health Sector Conference Presentation, 2006/7. There are 785 approved health care worker positions, 465 of which are filled. Thus there is a 40.7% understaffing: 320 additional health care workers are needed in Bushenyi district according to the recent health sector conference.

Health centers throughout the country are categorized as Health Center II, Health Center III, and Health Center IV. Each facility category depends on the administrative zone

served (i.e., parish, sub county, and health sub-district) and the different types of services they provide.

A Health Center Grade II (HC II) serves a parish with a population of approximately 5,000 people. It provides outpatient care, antenatal care, immunization, and outreach. An HC II is supposed to be staffed by one enrolled nurse, one enrolled midwife, and two nursing assistants. All HC IIs provide community-based preventive health service.

A Health Center Grade III (HC III) serves a sub-county with a population of approximately 20,000 people. It provides all the services of an HC II plus inpatient care and environmental health. It is usually staffed by one clinical officer, one enrolled nurse, two enrolled midwives and one nursing assistant, one health assistant, one laboratory assistant, and a records officer. According to the HSSP, all HC IIIs provide the services offered in an HC II plus maternity services, inpatient health services, and laboratory services.

A Health Center Grade IV (HC IV) serves a health sub-district with a population of approximately 100,000 people. It is the headquarters unit of the health sub-district. It provides all the services of an HC III, plus surgery, supervision of the lower-level units, collection and analysis of data on health, and development of plans for the health sub-district. Each HC IV should have at least one medical officer, two clinical officers, one registered midwife, one enrolled nurse, one enrolled midwife, one registered comprehensive nurse, two nursing assistants, one laboratory technician, one laboratory assistant, one health inspector, one dispenser, one public health dental assistant, one anesthetic officer, one assistant health educator, one records assistant, one accounts assistant, and two support staff. The Health Sector Strategic Plan calls for all HC IVs to provide emergency surgery and blood transfusion services as well as all the services offered at HC IIIs.

Bushenyi district has 74 health units and 500 traditional birth attendants at parish level. Eighty TBAs were given walkie talkies by the Ministry of Health to enable them make referrals to Health Centre IV and hospital. MOH studies have shown that their efforts to roll out BCC programs for TBAs have not improved maternal health. The MOH is currently scaling back their assistance to this group and have recommended that UHC not include them in our target population of health care workers. Because there is still reliance on TBAs for birthing in the target population, and because the reason that the program did not improve maternal health is unknown, UHC has decided to include TBAs in health sector training for initial phases while closely monitoring results. A determination of whether or not to continue to include this group in training will be made by analyzing end of Phase LQAS reports and by looking at the midterm assessment results.

The Uganda Private Midwives Association (UPMA) has branches throughout Uganda. Each branch meets at least once a month and representatives from the respective branches meet at the headquarters in Kampala every month. There are 13 UPMA registered members in Bushenyi district. Each of these members operates a clinic where integrated

reproductive health services are delivered. These services include; antenatal care, deliveries, post natal care, family planning, immunizations, IPT and Infant nutrition. UPMA hopes to partner with UHC in improving antenatal care, deliveries and post natal care for the mothers in Bushenyi.

A total of 4,054 volunteers in Uganda have been trained by The MOH to manage simple malaria via the distribution of free HomaPak. Two distributors were selected by each village to carry out this volunteer work. Distributors manually track distribution and replenish supplies by visiting health centers as necessary. With the development of the Malaria Control Program (MCP-MOH, 2006) which focuses on combination drug therapy for treatment of Malaria, the HomaPak program will likely be replaced by educating these volunteers on recognition of malaria symptoms and early seeking of care. UHC is collaborating with MCP-MOH to develop a complimentary plan to support MOH policies and to ensure that the health services, organizational and community and social dimensions are all addressed to reduce malaria for women and children under 5 in Bushenyi district.

The following groups are considered disadvantaged, underserved or living in extreme poverty: disabled, orphans, widows, subsistence farmers in Kanyabwanga and young mothers who marry early to avoid poverty. Villages without local health centres include; Bihanga, Kiyanga and Kanyabwanga. Bunyaruguru has limited access to safe water sources.

Linkages and complementary activities: UHC will also coordinate malaria interventions to compliment the work of The Uganda Program for Human and Holistic Development (UPHOLD). UPHOLD interventions include Health, Education and HIV/AIDS; they are funded by USAID and managed/implemented by JSI and its Partners. UPHOLD has already begun mentoring UHC on CS intervention strategies. UPHOLD partnerships will include mentorship and collaboration on malaria control activies including ITN distribution, home based management of fever and working with providers to improve SCM through IMCI.

By the end of 2003, all 56 districts in Uganda were implementing IMCI components 1) health worker training, and 2) health system support. Around 8,000 health workers of different cadres have been trained by the MOH according to IMCI guidelines, including 40 health workers in Bushenyi district. In addition, 8,200 students throughout Uganda received IMCI pre-service training; half of these are nurse assistants trained in IMCI as part of a three month upgrading course for nursing aids organized by the MOH. It is unclear how many of these students work in Bushenyi district.

Ten districts began implementing the IMCI referral package in 2003. All districts in Uganda except one are now able to do IMCI training for their health workers. Districts use their own decentralized budgets for training and supervision. Variations in resources between districts are an important constraint.

A 3-day IMCI refresher course has been developed and the program has increasingly focused on pre-service training. At all 30 nursing and clinical officer schools IMCI has

been introduced in varying degrees into the curriculum. In 13 schools full IMCI training is given with IMCI questions present in the final qualifying examinations. At the university level, IMCI is part of medical and nursing curricula at both Makerere and Mbarara universities. In 2003, short courses in IMCI were begun for private medical practitioners, using a negotiation/discussion format.

From the beginning, IMCI trainers have visited newly trained IMCI health workers 6 weeks after completion of training. A recent development has been regular visits by the zonal technical support teams to health workers trained in IMCI to address difficulties health workers are having in implementing IMCI. According to the baseline HFA 57% of HWs received IMCI training in the past three years and 28% have been visited by an IMCI supervisor in the last three years. UHC will work with these existing channels following MOH policy and IEC materials and will utilize the BEHAVE framework to reduce barriers to monitor and evaluate the use and supervision of IMCI for HWs in Bushenyi.

UHC also is collaborating with the Uganda Community Based Health Cooperative Association and the MOH to pilot and document alternative health service financing.

In addition to working with its 17 prepaid plan groups, collaborating non-profit health providers and dozens of PVOs and NGOs, UHC works closely with and is co-located with Population Services International (PSI) in Kampala. UHC will purchase safe water products including PUR and Waterguard, Long lasting ITNs and Mamakits through established PSI channels. UHC will partner with PSI and MOH in the use of IEC and training materials. In addition, joint behavior change communication efforts may be undertaken and PSI staff will participate in training DHE teams before they go out into the community.

UHC will utilize the BEHAVE framework which recognizes the complexities of people's motivations and ability to change. Through research to determine the priority group, the behavior to focus on, the key factors and activities, communication materials and campaigns can be developed to effect the changes necessary to reduce maternal and child morbidity and mortality. Behavior change is particularly important for family planning (Uganda is the fourth highest in family fertility rates[x]), and to address the causes of HIV/AIDS. UHC has successfully used two local drama groups to promote community health education at the village level. HealthPartners will reach beyond health scheme members to include all women and children in Bushenyi district in these behavior change communication campaigns.

UHC plans to adapt lessons-learned by Africare in its child survival project. Africare's CSHGP interventions are malaria, nutrition and diarrhea control. Africare staff indicated that they had not been successful in creating sustainable village-level organizations[xi]; they are interested in collaborating with UHC to promote prepaid cooperative-based plans for sustainable child survival interventions.[xii] Africare has already proven a generous and helpful partner providing mentorship training to UCH staff, reviewing the

results framework and baseline assessments and joining UHC meetings to provide recommendations for activity and BCC planning.

HealthPartners has a history of collaboration with Commercial Market Strategies and plans continued partnership with Peter Cowley, MD, who is now managing a follow-on project with Business PART Project to address HIV/AIDS in the workplace. This partnership will consist of sharing IEC materials for HIV prevention and treatment and encouraging routine counseling and testing and PMTCT. Business PART Project staff will participate in training UHC staff, DHE teams and HWs on preventing HIV/AIDS, reducing stigma and discrimination, the need to seek testing and counseling and appropriate treatment.

UHC engaged and consulted with all of the organizations above in the preparation of the DIP. Collaborating organizations and stakeholders were consulted frequently for input on plan design. Particularly valuable input was provided by local health leaders and women who are active in health schemes on child survival practices and recommended interventions.

2. Summary of Baseline and Other Assessments

Baseline assessment tools and methodology: The KPC 2000+ and Rapid CATCH questions served as the starting point for developing tools to collect baseline data. The first UHC draft questionnaire was shared with a number of experts and stakeholders including Africare and CSTS for comments. Their recommendations were used to generate a second draft. This draft was shared with another group of stakeholders to produce a third draft ready to be tested.

The third draft of the questionnaire was translated into Runyankole, which is the language spoken in Bushenyi district. Another language expert was hired to back translate from the Runyankole questionnaire and the few discrepancies in the two versions were ironed out.

The Health Facility Assessment questionnaire was developed from the MEASURE Evaluation Integrated Health Facility Assessment. This tool was adapted to the Ugandan health service environment with assistance from the MOH. It was then adapted to the needs of the project by project staff to address those areas that are to be particularly targeted. The final tool was tested and finalized for use in the survey.

The KPC survey utilized Lot Quality Assurance Sampling (LQAS) design, in which the five counties of Bushenyi were selected as supervision areas. Rubabo county, from Rukungiri district, served as the control area and was divided in two supervision areas, Rubabo A and Rubabo B. Nineteen households were randomly selected from each supervision area leading to a sample of 133 households. From each household one mother of a 0 – 23 month old child was selected for interview.

The survey supervisors and interviewers were men and women from the Bushenyi District Local Government and Local NGOs. This team was experienced in LQAS methodology. It was consequently decided to give them abbreviated refresher training of 2 days instead of the usual four. They also participated in pre-testing and finalization of the translated questionnaire.

Using the data from the Uganda Bureau of Statistics, village lists were compiled for each of the counties. The lists also provided proper addresses for the Sub-Counties and Parishes in which a particular village is located. That way, the selected villages were not hard to find. The County lists were provided with population figures, which were used to calculate sampling intervals. Table 2.1 presents the counties in the study area with their total populations.

Population of the Study Area by County, Bushenyi KPC, 2006

County	Population
Buhweju	80,489
Bunyaruguru	102,757
Igara	207,396
Ruhinda	157,720
Sheema	172,827
Total	**721,189**

Using a table of random numbers, a starting point was selected and thereafter every i^{th} village was selected until 19 villages were selected from the county (Supervision Area). The process was repeated for every county until finally 5 different samples of 19 were selected yielding a total sample of 95 villages.

It was found that most village Local Council 1 (LC 1) leaders did not have village lists and most villages were quite large. Interviewers were instructed to always use the LC 1 person to sub-divide the village into 2 or 3 roughly equal parts so that the parts would be about 30 households each. They then randomly selected one of the sub-divided parts. Thereafter, the interviewer, with the help of the LC 1 official would develop a village list for the selected portion of the village. From this list, one household would be selected randomly.

Once the household was selected, the interviewer would inquire if there was a mother with a child aged less than two years, with both of them living there. If such a respondent existed, the interviewer would go ahead and administer the questionnaire. If there were more than one such respondent the interviewer was instructed to randomly select one respondent from them. On the other hand, if no such respondent existed in the selected household, the interviewer would go on to the nearest household and continue that way until an appropriate respondent was found as specified.

After finalization of the questionnaire, teams of one supervisor and three interviewers were dispatched per supervision area. Due to the hard terrain in most of the district, each interviewer was covering about three households in a day. Consequently, fieldwork took three days.

Quality control measures were taken at every step in the baseline surveys. Stakeholders and experts helped design the questionnaire, the most highly experience field staff were selected, and a overseer was assigned to each field team to ensure consistent data collection.

After field work the questionnaires were checked for completeness. The field staff were taken through a brief training in hand tabulation of results. They then started tabulating the results. The tabulation involved mostly UHC staff and supervisors and some interviewers who expressed interest. The purpose was to develop and strengthen the local capacity among the project's partners for them to be able to conduct small surveys in future. A dissemination meeting of the results had been scheduled to share the results with the district authorities. However, due to the tight schedule at the beginning of the year, the scheduled meeting was postponed.

The completed questionnaires were carried to the UHC office in Kampala. Data entry clerks were hired and the data entry formats were written by the Consultant in Epi info 3.3.2. After data entry, the consultant carried out data cleaning, tabulation and data analysis. He also prepared the first draft of the KPC report.

The constraints in this undertaking lay mainly in the process of executing the survey. The first constraint was virtually no village of those selected had a list of households as required by the sampling design that was employed. This meant resorting to the time consuming option of constructing village lists on the spot.

The second constraint was the terrain. This is a very hilly region and in many cases villages were inaccessible except on foot. This meant that field workers had to walk very long distances to reach the selected villages.

A third constraint was that the survey was done during millet harvest. This time was preferable because it involved mostly that single activity unlike others where multiple activities would be taking place at the same time. However, this meant that many mothers were not found at home. In some cases interviewers went to the field to find the women and in others they returned to the home at a later time.

Survey results are summarized in the following table:

Indicator	*Numerator*	*Denominator*	*Percent*	*Confidence limits*
Rapid Catch Indicators				

% of children 0-23 months who are underweight (-2SD from the median weight for age, according to the WHO/NCHS reference population)	25	92	27.17	± 9
% of children age 0-23 months who were born at least 24 months after the previous surviving child	26	40	65	± 14.8
% of children aged 0-23 months whose births were attended to by a skilled health personnel	45	95	47.4	± 10
% of mothers of children aged 0-23 months who received at least 2 tetanus toxoid injections before the birth of their youngest child	46	70	65.7	± 11.1
% of infants aged 0-5 months who were exclusively breastfed in the last 24 hours	24	24	100	± 0.0
% of infants aged 6-9 months receiving breast milk and complementary foods	12	18	66.67	± 22
% of children 12-23 months who were fully vaccinated against the five vaccine preventable diseases before their first birth day (measles was used as a proxy indicator for complete immunization)	33	43	76.7	± 12.6
% of children 12-23 months who received a measles vaccine	33	43	76.7	± 12.6
% of children 0-23 months who slept under ITN the previous night (in malaria- risk areas only)	30	95	31.6	± 12.2
% of mothers who know at least two signs of childhood illness that indicate the need for treatment	72	95	75.8	± 8.6
% of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past 2 weeks	5	64	7.8	± 6.6
% of mothers to children age 0-23 who cite at least 2 known ways of reducing the risk of HIV infection	61	95	64.2	± 9.3
% of mothers to children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation and after attending to a child who has defecated	2	95	2.1	± 2.9
Objective 1: Reduce the incidence of malaria for pregnant women and children under 5				
% of children under 2 with fever in the last 2 weeks	42	95	44.2	± 10
% of children under 2 who slept under ITN last night	30	95	31.6	± 12.3
% of pregnant women who slept under ITN last night	18	95	18.9	± 16.3
% of pregnant women with fever in the last 2	No data			

weeks who sought anti-malarial advice or treatment	gathered			
% of children under 2 with fever in the last 2 weeks who received anti-malarial treatment	30	42	71	± 14
% of pregnant women who received IPT during last pregnancy as verified by maternal card	26	95	27	± 9
Objective 2: Reduce incidence of diarrhea for children under five				
% of children under 2 with diarrhea in the last two weeks	52	95	54.7	± 10
% of care takers/mothers who know at least 2 signs that a child under 2 needs treatment	72	95	75.8	± 8.6
% of households who use improved water source	47	95	49.5	± 10
% of households with a designated hand washing facility	23	95	24.2	± 8.6
% of caretakers who usually wash hands with soap/ash before food preparation, before feeding children, after defecation and after attending to a child who has defecated	2	95	2.1	± 2.9
% of caretakers who dispose off children's feces hygienically	65	95	68.4	± 9.3
% of households with access to a covered pit latrine	18	95	18.9	± 8
% of children 0-23 months with diarrhea in the last two weeks who received ORS	0	95	0	0
% of children 0-23 months who were offered more fluids during the illness	15	95	15.8	± 7.3
% of children 0-23 months who were offered the same or more food during the illness	40	95	42.11	± 10
% of children 2-59 months with diarrhea in the last two weeks who were treated with zinc supplements	On hold	For	US	Approval
Objective 3: Increase % of pregnant women receiving improved ANC, delivery and post partum care				
% of pregnant women with 4 ANC visits	17	95	17.9	± .08
% of pregnant women seeking VCT services	32	95	33.68	± 9.5
% of caretakers that have knowledge of child spacing	90	95	94.74	± 4.5
% of caretakers that have knowledge of danger signs	72	95	75.8	± 8.6
% of pregnant women with safe birthing plans				
- plan where to deliver	66	95	69.5	± 9.3
- plan transport	43	95	45.3	± 10
- plan having a birth kit	50	95	52.6	± 10
- asked to plan all 3	36	95	37.9	± 9.7
% of pregnant women with access to a clean razor	77	95	81.1	± 7.8

to cut the cord				
% of women who delivered with a skilled birth attendant	45	95	47.4	± 10
Objective 5: Improved health care management especially for WRA and children under 5		Numerator	Denominator	Percentage
% of stock outs in the past 30 days	ORS	12	43	28%
	Cotrimoxazole	22	43	51%
	Mebendazole	8	43	18.6%
	Amoxicillin Syrup	27	43	63%
	Naladixic Acid	27	43	63%
	Ciprofloxacin	27	43	62.8%
	Doxcycline	12	43	28%
	Metronidazole	18	43	42%
	Injectable Contraceptives	14	43	32.6%
	Contraceptive Pills	14	43	32.6%
	Condoms	15	43	34.9%
	Chloroquine	5	43	11.6%
	Fansidar	1	43	2.3%
	Quinine	21	43	48.8%
	Ergometrine	4	43	9.3%
	Homapak	15	43	35%
	Oxcytocin	24	43	55.8%
	Misoprosol	26	43	60.5%
	Iron Foliate	7	43	16.35%
	Mama Kit	32	43	74.45%

	Zinc			Not in stock
	ITNs	30	43	69.8%
2. % of HWs who have received IMCI training in the last 3 years		82	144	57%
3. % of HWs who have been supervised in IMCI within the last year		12	43	28%
4. % of HWs who have MOH policy and guidelines/protocol on antenatal and obstetric care services.		19	43	44.2%
5. % of facilities who provide information on nutrition& hygiene, ITNs, breastfeeding, STI/HIV/AIDs prevention, warning signs, post natal care.	Nutrition and Hygiene	41	43	95.5%
	ITNs	41	43	95.3%
	Breastfeeding	41	43	95.3%
	STD/HIV AIDS	39	43	90.7%
	Warning signs	41	43	95.3%
	Post natal care	39	43	90.7%
6. % of HWs who received training in AMTSL in the last 3 years		57	72	79%

According to the consultant contract, KPC, HFA and Rapid Catch data and reports were due January 30. The first draft was delivered in mid February with incomplete and inconsistent data. Upon questioning, additional problems in the report were evident. Simon Kasasa from the Institute of Public Health at Makerere University was hired to review the data and write the baseline assessment report. Simon found the data questionable and requested permission to re-enter data directly from the source in order to ensure its reliability. The final KPC, Rapid Catch and HFA data still showed surprising results when compared to Bushenyi Local Government Health Sector Data.

KPC report results showed that 44% of children under 2 suffered from fever within the two weeks prior to the survey. This result closely relates to Bushenyi local district data which shows 45.5% malaria incidence rate for children 0-4 years. However the assessment was conducted in off-peak malaria season; higher rates would be expected to be reported during peak season. KPC shows that 71% of women polled sought care for their children for malaria. Thirty eight % of households reported having ITNs with 32% of children under 5 and 19% of women reporting sleeping under them the previous night.

KPC results show that 55% of children were reported to have suffered from diarrhea within the previous 2 weeks. None of these children received ORS treatments, only 16%

received increased fluids and 42% received the same or increased amounts of food during illness.

Lack of access to safe water, hygiene and sanitation are likely causes of the high rates of diarrhea throughout the district. Five percent of women used a bore hole, 22% had access to a public tap, 22% had access to a protected dug well, 15% only had access to an unprotected dug well, 2% utilize rain water and 15% utilize surface water. Only 2% of women reported washing their hands on all occasions recommended with 2% never washing hands. Sixty-six percent did wash before preparing children's food and after defecation however only 15% washed hands before feeding a child or after attending a child who had defecated. Disposal of Children's feces could be improved: 67% dropped feces into toiled but the remainder disposed of it somewhere else in the yard or outside the premises. The majority of women in the study reported that they use a simple pit latrine without a slab (75%). Health in these communities can be greatly improved by adding a slab to these pits.

Sixty five percent of women in the baseline KPC reported attending ANC however only 18% of 4 or more ANC visits could be verified by a maternal card tracking the encounters and services. IPT was reportedly received by 80% of those questioned in the baseline survey but only by 37% (2004/5) in Local Bushenyi Government reports. Tetanus immunization KPC coverage was 66% with women reporting two or more tetanus shots. Eighty three percent of women polled for the KPC reported being informed on the importance of delivery preparations, 58% reported learning about breastfeeding and 63% learned about child spacing and danger signs of pregnancy. Sixty-four percent of women were able to cite at least 2 known ways of reducing the risk of HIV infection and 34% took HIV tests during pregnancy. In VCT out of 7,422 who tested, 1,122 or 15% tested positive with a ratio of 2:1 women to men[xiii].

Forty-seven percent of women in the KPC survey reported having given birth with a skilled birth attendant (a doctor, nurse or midwife) however Bushenyi Government reports show that 25% of women in the district delivered babies under supervision in past 5 years and national statistics show 20% coverage for this indicator. Eighty percent of women in the KPC reported that a new razor was used to cut the cord.

From the initial tabulations of the baseline KPC data it was clear that the program needed to refactor results based on verifiable means whenever possible. Thus several changes were made to the wording of indicators and to the wording of the questions. Changes to the indicators are detailed on page 108. Reworded questions and instructions to interviewers for verification of answers are included in the LQAS monitoring document that begins on page 110. Maternal cards will be used for verification of ANC, IPT, and TT. Interviewers will be instructed to view ITNs for those who report sleeping under them. Interviewers are also instructed to view hand washing stations to confirm these reports. As monitoring and data analysis occurs, there may be additional changes to improve the accuracy of data. Every effort has been and will continue to be made to maintain comparable data but baseline data will be skewed slightly as a result of some indicators that relied on interviewee recall.

In the HFA, health workers were asked whether there were any stock outs of specified medicines in the last six moths. Results showed that there were high proportions of stock outs for anti-malarials. 48% of the health facilities reported a stock out on quinine, 11.6% stocked out on chloroquine and 2.3% stocked out on fansidar. Homapack (used in management of uncomplicated malaria) was out of stock in 35% of the health facilities. 69.8% of the facilities did not have ITNs in the previous six months before the survey.

Family planning products were also out of stock in facilities. Condoms were out of stock in 34.9% of facilities, Contraceptive pills in 32.2% and injectable contraceptives in 32.6%. Medicines that are used for women in labor were also out of stock at many of the facilities. Misoprosol was out of stock in 60.5%, Oxcytocin in 55.8% of the facilities and Ergometrine in 9.3 of the facilities. A large majority of the facilities (74.4%) did not have clean birth kits (mama kits) in stock.

Medicines that are used in treatment of infections like coughs, diarrhea and pneumonia were found to be out of stock. Amoxicillin (syrup) was not in stock at 63%, Ciprofloxacin was out in 62.8% of the facilities, cotrimoxazole was at 51%. Other antibiotics out of stock were Naladixic acid at 63%, Metronidazole at 42% and Doxcycline at 28% of the facilities.

Mebendazole that is commonly used for deworming children was out of stock at 18.6% of the facilities while ORS was out at 28% of the facilities. Iron foliate was not in stock at 16.3% of the facilities.

Health Facility staff that are involved in IMCI and AMTSL were asked whether they had received training in the last three years. It was found that 57% had received IMCI training and 79% were trained in AMTSL. However, only 28% of the health facilities had been supervised within the last year.

Wile it was important that health facilities had access to the most up to date guidelines / protocols on antenatal and obstetric care services, the assessment found that only 44.2% had access to the protocol, 26.1% had access to the policy and guideline for PMTCT services; while 30.4% reported having the MOH policy and guideline for HIV/AIDS.

Between 90-95% of facilities provided information on nutrition& hygiene, ITNs, breastfeeding, STI/HIV/AIDS prevention, warning signs and post natal care.

Additional information, especially regarding barriers to following IMCI and supervision of health workers, is being gathered through a qualitative study, and field guide discussions. A stock order needs assessment and barrier analysis will be carried out in the appropriate health facilities at the beginning of each phase.

3. Program Description

The program strategy and structure: UHC utilized the child survival sustainability assessment with slight variations on the three dimensions: community/ social, heath services, and local organizational (see CSSA p. 38) as the primary model for the program. The results framework includes three objectives addressing the community/social dimension, and one objective each for health services and local organizational dimensions. Each objective includes strategies, activities and indicators to monitor and evaluate progress (see Results Framework pp. 31-34.) The work plan (pp.84-93) details the timeline and phase structure for rolling out interventions for the community social and health services dimensions.

While some staff are paid through a cooperative development subgrant and others are paid through the child survival grant, all staff are referred to as UHC. This decision was made in response to staff recommendations from the ISA. Understanding HealthPartners background in developing UHC provides context from which the child survival program strategy and work plan were developed.

Background on health schemes and preventive care strategies: In 1997 HealthPartners received a USAID cooperative development sub agreement from Land O' Lakes, Inc. to develop a system for affordable prepaid health care in Uganda. Members of communities were frequently falling ill and would sell their only income generating assets to receive health care. Often these families would wait until illness was life threatening to seek care. HealthPartners formed the Uganda Health Cooperative (UHC) to organize members of groups to pay quarterly premiums to health care providers in order to reduce barriers to care when they need it. UHC began working with dairy cooperatives and in 2002 UHC expanded to offer health schemes to coffee and tea cooperatives, micro-finance groups, burial societies, teachers and students at boarding schools among others.

UHC began community health education in response to members who complained that if they did not fall sick during a premium period, they should receive a refund on their premiums. UHC mobilized communities on the principles of how cooperatives worked but also recognized that by educating members on preventive health care, members would remain healthier and treatment costs would be lowered for providers. Community health education was also a strategy to encourage communities and groups to sign up and remain current in premiums.

UHC collaborated with PVOs and the MOH to provide HomaPaks for malaria treatment at home for children, Mama Kits for home-based clean birthing practices, and training on safe water/sanitary practices (cisterns and hand washing). Particular attention was given to malaria, the number one killer of infants and pregnant women in Uganda. Among the most effective programs that UHC implemented was In Net, providing ITNs to health scheme members through a partnership with the Commercial Market Strategies project.

ITNs were expensive, were not understood and were not available in Bushenyi. In Net supplied ITNs to this area, UHC trained members on the benefits and use of ITNs and providers subsidized the nets for health scheme members because their use reduced

treatment costs. As a result, through In Net, members were able to afford and properly use ITNs. Nearly 7,000 nets were sold to health scheme members. The degree of cost savings varied from scheme to scheme; there was no underwriting in Bushenyi Medical Centre for three consecutive quarters. The membership in the schemes increased by 28.9% on average and the average ITN coverage reached 22.3%. Increased awareness of malaria prevention created a demand for ITNs. The reduction in number of illness episodes among users and increased productivity was an important lesson in the fight against malaria.[xiv] The In Net project ended in Bushenyi but the demand for ITNs continues.

Prepaid health care has represented a significant behavioral change (focus on wellness and prevention), reducing reliance on herbs and traditional healers, and improving sanitary habits. Through prevention initiatives such as safe birthing kits and subsidized ITNs[xv] to ward off mosquitoes, members receive benefits even if they are healthy thus they are motivated to remain with the plan.

The Uganda Community Based Health Financing Association (UCBHFA), a partner NGO, represents private health providers and receives about $62,000 from the MOH to partially support plan managers at four hospitals in Bushenyi – Bushenyi Medical Centre, Comboni Hospital, Mitooma Central Clinic, and Ishaka Seventh Day Adventist Hospital.[xvi] Directly and through the association, UHC has formal agreements with each of the providers, and the MOH supports prepaid health schemes as a matter of policy and in its current budget.

Many non-profit providers in Uganda are linked to rural clinics. They benefit from the plans because of the steady payments, reimbursement for services, earlier interventions and increased income since about 20-40% of walk-in clients are unable pay for services. UHC member groups may select their provider and can change hospitals or clinics if they are not satisfied with their care. As a result, improving patient services has become a priority among providers. Based on membership data, 75% to 80% are infants under five and WRA. This is because families tend to cover their most vulnerable members (four members are included in the base plan which costs 20,000 USH, or about $11 quarterly), and the impetus to join health schemes usually comes from mothers.

In cooperation with Oracle Corporation (mostly donated services and software), HealthPartners created a computer-based database to track premiums, treatment costs, co-payments, membership, frequency of patient visits, diagnoses and services. The cost recovery of most plans is 80 to 90%, 95% to 100% for older and larger plans (e.g. the tea cooperative), and over 140% for students. UHC's goal is 100% cost recovery for all plans including administrative and marketing costs, which are currently supported by HealthPartners' USAID grant and contributions, the MOH and non-profit health providers.

UHC incorporated the pre-paid health schemes within one cooperative structure (each plan has chairpersons and officers, and they have elected a UHC board of directors). The goal is to build the capacity of this governing body to manage the health scheme,

maintain a balanced budget, and to utilize the UHIS data collection system to enable the cooperative to make results based decisions to improve the health of the community. Maternal and child health will continue to be supported through this cooperative structure even after USAID funding is no longer available.

How UHC fits with child survival: The prepaid health scheme provides a solid base to build health care sustainability for child survival interventions: members are not only physically invested in the health scheme, they are also financially invested. UHC carries out monthly mobilization education that includes prepaid health scheme topics like clarifying roles and responsibilities of members, leaders and providers. This has been an effective method of educating members and leaders about benefits of the health scheme and it is beneficial for mobilizing new members. In order to increase attendance at these meetings, to add value for members and to reduce provider costs, UHC also includes a preventive health care topic each month to educate community groups and to help them improve the health of their group. By partnering prepaid schemes and child survival interventions, the community gains a financially viable option and incentive to sustain improved health.

Results Framework

UHC/CS Goal: Link child survival interventions and partnerships to prepaid health schemes, building on the existing structure to sustainably reduce morbidity and mortality for WRA and children under 5.

Each objective will be achieved through the implementation of basic strategies and will be monitored and evaluated using indicators listed.

Community and Social Dimension

Objective 1: Reduce incidence of malaria in Bushenyi district for children under 5 and pregnant women

Strategy 1: Increase demand for and access to ITNs. Train proper use for maximum benefit to pregnant women and children under 5.

Strategy 2: Increase timely, appropriate malaria treatment

Strategy 3: Increase IPT

Objective 2: Reduce incidence of diarrhea in Bushenyi district for children under 5

Strategy 1: Improve safe water access & use

Strategy 2: Increase safe water practices and hand washing

Strategy 3: Improve sanitation practices

Strategy 4: Increase intervention for severe diarrhea & dehydration

Objective 3: Increase % of pregnant women receiving improved ANC, delivery and post partum care

Strategy 1: Increase demand for RCT

Strategy 2: Improve caretaker knowledge of nutrition, child spacing, and danger signs in pregnancy

Strategy 3: Increase access to safer birthing

Local Organizational Dimension

Objective 4: Build local organizational capacity to manage health schemes

Strategy 1: Increase capacity of Board

Strategy 2: Growth of health scheme

Strategy 3: Increase ability of health scheme to financially cover service & administration

Health Services Dimension

Objective 5: Improve health care management especially for WRA and children under 5

Strategy 1: Reduce incidence of stock outs

Strategy 2: Improve use of IMCI

Strategy 3: Improve ANC

Strategy 4: Improve delivery (including the promotion of "clean" practices and AMTSL)

Strategy 5: Improve self assessment ability

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Results Framework

Goal: Link child survival interventions and partnerships to prepaid health schemes, building on the existing structure to sustainably reduce morbidity and mortality for WRA and children under 5.

Community Social Dimension	***Community Social Dimension***	***Community Social Dimension***	***Local Organizational Dimension***	***Health Services Dimension***
Objective 1: Reduce incidence of malaria in Bushenyi district for children under 5 and pregnant women	**Objective 2:** Reduce incidence of diarrhea in Bushenyi district for children under 5	**Objective 3:** Increase % of pregnant women receiving improved ANC, delivery and post partum care	**Objective 4:** Build local organizational capacity to manage health schemes	**Objective 5:** Improve health care management especially for WRA and children under 5
IR 1: Increase ITN use **IR 2:** Increase timely, appropriate malaria treatment **IR3:** Increase IPT	**IR 1:** Improve recognition by caretakers of warning signs that child needs treatment **IR 2:** Improve safe water access & use **IR 3:** Increase safe water practices and hand washing **IR 4:** Improve sanitation practices **IR 5:** Increase	**IR 1:** Increase demand for ANC **IR 2:** Increase demand for RCT **IR 3:** Improve caretaker knowledge of nutrition, child spacing, and danger signs **IR 4:** Increase access to safer birthing	**IR 1:** Increase capacity of Board **IR 2:** Growth of health scheme **IR 3:** Increase ability of health scheme to financially cover service & administration	**IR 1:** Reduce incidence of stock outs **IR 2:** Improve use of IMCI and SCM **IR 3:** Improve ANC **IR 4:** Improve postpartum care **IR 5:** Improve delivery (including the promotion of "clean practices and AMTSL) **IR 6:** Improve self

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	intervention for severe diarrhea & dehydration **IR 6:** Increase zinc supplementation (On hold for US approval)			assessment ability
Activity 1: ITN distribution **Activity 2:** Train ITN retreatment and proper use **Activity 3:** Train malaria warning signs and SCM **Activity 4:** Increase IPT demand	**Activity 1:** Train diarrhea warning signs **Activity 2:** Improve access to safe water **Activity 3:** Increase safe water practices and hand washing **Activity 4:** Improve sanitation practices **Activity 5:** Train diarrhea home care, SCM **Activity 6:** Distribute and train zinc use (pending)	**Activity 1:** Create demand for ANC **Activity 2:** Train community on importance of RCT and PMTCT **Activity 3:** Train MNC **Activity 4:** Distribute mama kits and train importance of planning for safe birth	**Activity 1:** Improve Board mtgs & capacity **Activity 2:** Change health scheme benefit structure **Activity 3:** Promote health scheme membership **Activity 4:** Build Board capacity and train self assessment **Activity 5:** Update UHIS for CS and train users to manage data and make results based decisions	**Activity 1:** Improve resource stock maintenance **Activity 2:** SCM for malaria and diarrhea according to IMCI & MOH **Activity 3:** SCM for ANC **Activity 4:** SCM for post partum care **Activity 5:** SCM for safe/clean delivery and AMTSL **Activity 6:** Train and follow up on self assessments

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Indicator: Percentage of children under 2 with fever in the last 2 weeks **Indicator:** Percentage of children under 2 who slept under an ITN last night. **Indicator:** Percentage of pregnant women who slept under an ITN last night. **Indicator:** Percentage of children under 2 with fever in the last 2 weeks who received antimalarial treatment **Indicator:** Percentage of pregnant women receiving IPT during pregnancy as verified by maternal card	**Indicator:** Percentage of children under 2 with diarrhea in the last two weeks **Indicator:** % of households who use improved water source (borehole, public tap, or protected dug well.) **Indicator:** Percentage of households with a designated hand washing station with a covered container for water. **Indicator:** Percentage of caretakers who wash hands with soap/ash before food preparation; before feeding children; after defecation; after attending to a child who has defecated. **Indicator:** Percent of households who safely disposed of their child's feces the last time s/he	**Indicator:** % of women w 4 ANC visits as verified by maternal card. **Indicator:** Percentage of pregnant women seeking RCT services **Indicator:** Percentage of mothers knowledgeable in proper nutrition, child spacing and danger sign in pregnancy **Indicator:** Percentage of women who delivered with a skilled health professional as verified by a maternal card.	**Indicator:** Board meeting notes show MCH issues being addressed **Indicator:** Membership exceeds 14,000 **Indicator:** Balanced BOD budget including premiums, resources, management of MCH and provider costs	**Indicator:** Percentage of stock outs in the past 30 days **Indicator:** Percentage of HWs who have received IMCI training the last 3 years **Indicator:** Percentage of HWs who have been supervised in IMCI in the last year **Indicator:** Percentage of HWs who have MOH policy and guidelines/ protocol on ANC and obstetric care services **Indicator:** Percentage of HWs who utilize AMTSL while delivering babies **Indicator:** Percentage of HWs who filled out a self assessment in the last year.

	passed stool **Indicator:** Percentage of households with access to a covered pit latrine **Indicator:** Percentage of children under 2 with diarrhea in the last two weeks who received ORS **Indicator:** Percentage of children under 2 who were offered more fluids and food during illness			**Indicator:** Percentage of self assessments that showed higher ratings in the past year.

Key behaviors that the project will focus on include building community recognition that planning ahead for health care can reduce the incidence and duration of illness. UHC aims to: improve early recognition of signs and symptoms of serious disease and reduce waiting to seek care in such cases; improve appropriate home care of disease including ORS and increased feeding and fluids for treating diarrhea; improve access to and recognition of the importance of ITNs in preventing malaria and understanding that pregnant women and children under 5 should be the first priority in the family for sleeping under an ITN; improve male and female understanding of the importance of ANC and post partum care including receiving IPT, TT, learning about maternal nutrition and birth planning; improving birth practices and providing options to help women increase birth spacing.

Community health education and mobilization will be conducted by existing trusted sources including district health educators, health assistants, and districting nursing officers who are familiar with the household behaviors and care seeking practices in each county. For behavior change to be effective in Bushenyi district, men need to be included in training because they remain the primary decision makers. Grandmothers and others in the community also need to be included in behavior change because they provide care to children when mothers are in the field and key people are in a position to support or undermine mothers' changes in behavior. Political leaders

are frequently involved in health scheme launches and communication because they add credibility and importance to the sessions, also they like to be linked to making efforts to improve health. Marketing of education sessions will include radio announcements, announcements at health fairs and in local newspapers, invitation letters will be sent to large cooperatives, employment groups and community leaders, and notices will be posted at health centers, churches, and community centers and/or district council halls.

Intervention structure and quality improvement strategy. UHC will roll out interventions for the community social and health services dimensions in six phases according to counties in Bushenyi district: Phase I) Igara East and West, Phase II) Ruhinda, Phase III) Sheema South, Phase IV) Sheema North, Phase V) Buhweju, Phase VI) Bunyaruguru. Each phase is broken down into topics by month. In the community social dimension, the first month addresses malaria, second month diarrhea, then sanitation and hygiene, maternal newborn care, and HIV/AIDs. The Community Educator will meet with DHEs during the first week of each phase to provide training and to distribute BCC plans, resources and monitoring tools. DHEs include: Health Assistants, Nursing Officers, Community Development Officers, Health Educators and Volunteers. DHEs will then utilize the BCC plans when visiting communities throughout the county the rest of the month. After each session feedback forms will be distributed and a verbal feedback session will be held to assess lessons learned by participants and to collect recommendations for making improvements. The education session in the sixth month will include review topics tailored to that county by feedback from the initial five sessions. The seventh month is reserved for LQAS to monitor key indicators. LQAS monitoring will include the county completing the phase of mobilization as well as counties that have already completed mobilization in order to assess behavior change retention. The seventh month will also be used for updating BCC, materials, and resources to incorporate lessons learned before the next phase.

A parallel phase structure will apply to training rolled out for HWs including those located at hospitals, health centers, midwives and TBAs within the respective counties. TBAs are not considered skilled birth attendants and will have separate, targeted education and training to improve their messages, safety, skills, record keeping and referral practices. Topics for the HW monthly sessions begin with stock order planning, followed by malaria, diarrhea, ANC, Delivery and postnatal care including active management of third stage labor. Community education topics and Health services training are purposefully staggered so that a partner like PSI can participate in both aspects of intervention. After each training HWs will be asked to fill out a feedback form to determine lessons learned and areas for improvement. The sixth month for health services training will cover how and why to fill out self assessments and a review informed by responses from each previous training session in the phase. A key component of training throughout the phase will be to address and strengthen monitoring and supervision. HFAs and stock supply checklists will be filled out in the seventh month of each phase in order to inform improvements in the training process and to measure improvements toward indicators. At the

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end of each phase, self assessments and HFA monitoring will also be collected from HWs completing the current phase and from those who have been trained in earlier phases.

Below is a summary of the community education and health services intervention structure including quality improvement in the7th month and information dissemination in the 8th month. Again, the phases will be repeated five additional times in counties throughout Bushenyi district.

Intervention structure and quality improvement strategy

PHASE 1	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8
Community Social Dimension	**Malaria prevention**	**Diarrhea prevention**	**Sanitation & Hygiene education**	**MNC**	**HIV/AIDS and STI education**	**Review /coverage of points missed**	**LQAS & education improvement**	**Alternating stakeholder or staff workshop**
Topics	c-IMCI, BCC, ITN distribution and proper use, malaria warning signs, SCM	C-IMCI, BCC, Warning signs, home care/SCM, ORS	BCC, Access to safe water, hand washing, sanitation	BCC, Warning signs, nutrition, safe birth planning, Mamakits	BCC, VCT, HIV/ AIDS education	BCC, Malaria, diarrhea, MNC, sanitation & hygiene, HIV/AIDS	LQAS current phase plus sample from previous phase(s)	Results of education from previous phase(s), areas for improvement
Monitoring	Feedback after session turned in before receiving ITN & HomaPak	Feedback after session turned in before receiving ORS	Feedback after session turned in before PUR water filter	Feedback after session turned in before receiving Mamakit	Feedback forms	Feedback forms turned in before materials distributed	Education coordinator to assess feedback/ and LQAS to improve BCC for next phase	Comparison of LQAS results through phase progression. ISA for staff capacity building

Health Service Dimension	**Develop stock order plans**	**SCM malaria**	**SCM diarrhea**	**SCM ANC**	**SCM AMTSL**	**Self assessment training**	**HFA & training improvement**	**Alternating stakeholder or staff workshop**
Topics	Develop stock order plans	IMCI and SCM malaria	IMCI and SCM diarrhea	SCM ANC	SCM postnatal care and delivery	Self assessment training	HFA and training improvement	Results of training from previous phase(s), areas for improvement
Monitoring	Copy of stock order plan	Feedback at the end of training	Feedback at the end of training	Feedback at the end of training	Feedback at the end of training	Feedback at the end of training	HST to assess feedback and HFA to improve training for next phase	Comparison of HFA results through phase progression. ISA for staff capacity building

In the eighth month of DHE training, the Community Educator will share results from the LQAS monitoring to help the DHE's learn how their efforts have impacted the county. This data will be compared with baseline KPC data disaggregated by county. DHE's will be encouraged to continue to utilize this curriculum for mobilization sessions in additional, new communities.

In the eighth month of DHE mobilization, a resource person from each community will be elected and will be charged with continuing that community's monthly meetings to support one another and to share lessons learned with other mothers, sisters, friends, and neighbors. This community resource person will be the primary contact for the DHE after the phase has been completed. DHE's will continue to visit communities after the phase to provide support and resources to the resource person, to reinforce messages and behaviors and to answer questions. These visits will be guided by the requests from the resource person and her reports on the needs of the community. Additionally, UHC scheme marketers and partners will continue providing preventive health care and scheme mobilization in these communities.

In each county in Bushenyi, a district health worker is charged with supervising the health workers in that area. Midwives are assigned to supervise TBAs. Barrier analysis of these supervisory systems will be conducted during the needs assessment in preparation for health services training in each phase. Barriers will then be address through partnerships with the DDHS, MOH, TBAs, UPMA and other partners and stakeholders. Behavior change strategies will also be utilized to overcome barriers and systems

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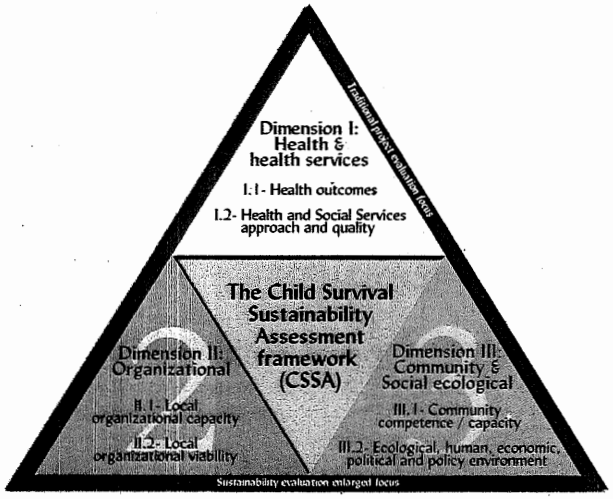
will be monitored to ensure appropriate supervision is taking place. By the end of each phase, the health workers and TBAs included training will have a plan for SCM, IMCI and monitoring appropriate health worker performance. The HST will revisit health workers who were trained in earlier phases in order to follow-up on supervision and to reinforce these activities. The HST will monitor supervisory systems throughout the course of the project and will work with the DDHS, MOH, TBAs, UPMA and other partners and stakeholders to ensure that an effective supervisory system is supporting SCM, IMCI and appropriate health worker performance.

Nearly all current UHC members reside in Igara County and will be included in Phase I. After Phase I, mobilization will focus primarily on non-members. UHC membership will be offered as an option for groups however it will not be required for preventive care education and health improvement interventions. Statistics of health improvement between members and non-members will be tracked by UHIS.

Child Survival Sustainability Assessment Framework



Dimension I: Health and Health Services

Component 1: Health Status
Component 2: Health Service Delivery

Dimension II: Local Organization

Component 3: Local Organizational Capacity
Component 4: Local Organizational Viability

Dimension III: Community and Social/Ecological

Component 5: Community Competence
Component 6: Social/Ecological Environment

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Since the core goal of UHC is to build a sustainable child survival program, the child survival sustainability framework was utilized in the program design from its inception. UHC addresses all dimensions and components of the sustainability assessment but focuses on strengthening the second dimension to support interventions in the first dimension. In an effort to simplify this structure for programmatic purposes, UHC refers to the dimensions in terms of Community Social, Health Service and Local Organizational Dimensions. The CSSA table below includes each component as defined by the CSSA framework, and the corresponding programmatic M&E tool, indicator and dimension.

For programmatic purposes UHC envisions the *Community Social Dimension* to include components 1 and 5. Interventions to improve health status include mobilizing communities on activities/behaviors that have been proven to reduce morbidity and mortality and removing barriers to these activities/behaviors. Addressing health status will also include community competence through creating support systems to encourage and maintain activities/behaviors and increasing capacity/empowering communities, DHEs, leaders, and partners to play an active role in improving their health. Component 2, *Health Service Delivery* is the equivalence of Health Services. Components 3 and 4 are combined to be referred to as the *Local Organizational Dimension*. While Component 6 will be measured and included on the CSSA dashboard, UHC interventions to not directly address this component.

Comparison of CSSA Framework and CSSA as applied to the Uganda Health Cooperative Child Survival Program

Dimensions & Components	Tools	CSSA Indicators	Programmatic Equivalence
1: Health Status	KPC, LQAS Monitoring	% of children under 2 with fever in the last 2 weeks	*Community Social Dimension*
2: Health Service Delivery	HFA, Monitoring, Self assessments	% of HWs who have been supervised in IMCI within the last year	*Health Services Dimension*
3: Local Organizational Capacity	ISA, UHC Board self assessments, Board meeting notes, Board budget	UHC annual board meeting notes address at least 1 MCH issue and include a balanced budget	*Local Organizational Dimension*
4: Local Organizational Viability	UHC reports, Membership	Number of UHC plan members	*Local Organizational Dimension*
5: Community	UHC AGM attendance list	Number of stakeholders including DDHS	*Community Social*

Competence	and meeting notes	officials, Health Facility Administrators, Health Workers, Leaders and Members at the UHC Annual General Meeting.	*Dimension*
6: Social/Ecological Environment	Human Development Index Report (United Nations Development Programme)	Human Development Index which is a composite index including life expectancy, education and GDP all weighted by 1/3 to derive HDI. (Uganda Human Development Report 2005)	*Other Influences*

The sustainability dashboard will be an important tool to monitor the program's progress toward building a sustainable infrastructure that improves maternal and child health. The dashboard will be utilized at staff and stakeholder meetings to illustrate the multidimensional picture of health conditions in Bushenyi district. Monitoring these indicators will help keep program staff and stakeholders informed of progress toward sustainability and will help guide programmatic decisions about ways to strengthen the lasting impact of the program.

Program managers have been working with SUSPRO to aid in developing, monitoring and discussing the CSSA strategy for this program. SUSPRO will be an invaluable tool in creating sustainability dashboards and in developing presentations to review and analyze results at stakeholder and staff meetings.

The following tables further define how CSSA strategy is being utilized in the program.

Vision of the local system	**UHC Child Survival Sustainability Assessment** Link child survival interventions and partnerships to prepaid health schemes to build a sustainable infrastructure. Utilize BCC to improve community knowledge of preventive health care and to improve case management by HWs including providers, TBAs and midwives in Bushenyi district. Develop a model that can be expanded and adopted in new locations.		
Dimensions	***Community and Social Dimension***	***Health Services Dimension***	***Local Organizational Dimension***
Goals	Improve the health of children under five through increased ITN use,	Build capacity of providers to offer IMCI and SCM and ensure resource stock to	Build knowledge and capacity of UHC Board to enable them to competently run

	increased ANC, safe delivery and post natal care, improved knowledge of warning signs and treatment for childhood illness in under 5s, improved hygiene and sanitation.	reduce childhood and maternal morbidity and mortality. Help providers develop a system to monitor their training, care and supplies. Demonstrate prepaid plan ability to address social health for adoption by the ministry of health to cover the poorest populations.	UHC. Strengthen trust and ties between HWs and community groups to enable best practices and continued coverage for members. Build incentive for membership, leadership and provider participation. Build capacity of UHC team, stakeholders and partners.
General Objectives of the Local System	▪ ITN use ▪ Increased early, appropriate treatment for malaria ▪ Increased knowledge of home care SCM for malaria and diarrhea ▪ Increased use of ORS ▪ Increased use of ANC and post natal care ▪ Improved water source and sanitation practices ▪ Increased number of safe birthing plans ▪ Increased health cooperative membership	▪ HW use of IMCI and SCM ▪ ANC covers IMCI and SCM ▪ Delivery and postpartum care SCM (including AMTSL, FP, training of infant illness warning and referral signs) ▪ Provider use of self assessment to monitor and improve services ▪ Reduced incidence of stock outs for SCM resources ▪ Provide model for MOH to adapt plan for coverage (or at least subsidy) of the poorest populations.	▪ Board meeting notes addressing maternal and childhood issues ▪ Fulfillment of leadership, provider and community responsibilities ▪ Growth of the health scheme ▪ Increased ability of the health scheme to financially cover services and administration ▪ Board use of self assessment to build capacity and maintain management ▪ ISA methodology for UHC staff and partners ▪ Train users to maintain UHIS data management system ▪ Train users to use UHIS data for improved decision making.
Monitoring	▪ Post training surveys ▪ Next training follow up surveys ▪ Quarterly UHIS reports will track	▪ Semi-annual self assessments ▪ Monthly site visits to observe treatment with IMCI and SCM checklists	▪ Semi-annual self assessments ▪ Ongoing training ▪ UHC representation at monthly

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	number of ANC visits, deliveries with skilled health professional, postnatal care visits, and diagnoses of malaria and diarrhea ▪ LQAS	▪ Monthly follow up training ▪ Semi-annual stock evaluation	meetings ▪ Monthly then quarterly board budget review ▪ Monthly UHIS scheme management reports
Evaluation	▪ KPC and Rapid Catch Indicators	▪ HFA	▪ ISA

Performance Criteria for Component 1: Health Status Indicators

Performance Scale	% of children under 2 with fever in the last two weeks	Timely treatment of malaria	% of children under 2 with diarrhea in the last two weeks Baseline	Increase food and fluids for child with diarrhea	% of women w 4 ANC visits as verified by maternal card	Mothers who delivered with a skilled health professional as verified by maternal card
Strong	19%	84%	20%	20%	30%	65%
Promising	25%	80%	29%	16%	27%	60%
Medium	31%	77%	38%	12%	24%	56%
Emerging	38%	74%	46%	8%	21%	52%
Minimal	44%	71%	55%	2%	18%	47%

Performance Criteria for Component 2: Health Service Delivery

Performance Scale	HW use of IMCI	ANC covers items on protocol	Delivery and postpartum care covers items on protocol	HW use of self assessment to monitor and improve services	Reduced incidence of stock outs for set list of items	Provide model for MOH to adapt plan for coverage (or at least subsidy) of the poorest populations

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Strong	80% of HWs trained in IMCI follow checklist and average 8 on self assessment forms	90% of HWs trained in ANC follow checklist and average 9 on self assessment forms	90% of HWs trained in postpartum care follow checklist and average 9 on self assessment forms	Semi annual self assessment average self rating of 9 or 10/10	No stock outs in six months. HW adds new procurement items to plan.	MOH commits to include coverage or subsidy of health services for the poor through the health scheme according to CS standards.
Promising	65% of HWs trained in IMCI follow checklist and average 7 on self assessment forms	75% of HWs trained in ANC follow checklist and average 8 on self assessment forms	75% of HWs trained in postpartum care follow checklist and average 8 on self assessment forms	Semi annual self assessment average self rating of 8/10	HW updates plan by contacting distributors for changes. No more than 1 stock out in 6 months.	MOH contributes to propagation of the health scheme and coverage for the poor.
Medium	50% of HWs trained in IMCI follow checklist and average 6 on self assessment forms	50% of HWs trained in ANC follow checklist and average 6-7 on self assessment forms	50% of HWs trained in postpartum care follow checklist and average 6-7 on self assessment forms	Semi annual self assessment average self rating of 7/10	Less than 3 stock outs from order plan in 6 months	Midterm and monitoring results are shared with MOH. Proposal for possible coverage is shared. Input incorporated.
Emerging	HWs received follow up training on IMCI and fill out self assessment forms	HWs received follow up training on ANC and fill out self assessment forms	HWs received follow up training on postpartum care and fill out self assessment forms	Semi annual self assessment average self rating of 5/10	First order is placed according to plan before stock out occurs	Baseline and monitoring results are shared with MOH. Input is incorporated.
Minimal	HWs are trained	HWs are trained	HWs are trained on	HWs implement	Item order list	UHC/CS work closely

	on IMCI	on ANC and given resources	postpartum care and given resources	bi-annual self assessment	and procurement plan is established with provider	with MOH to establish pilot program

Performance Criteria for Components 3 and 4: Local Organizational Capacity and Viability

Performance Scale	Productive board meeting notes addressing maternal and childhood issues	Fulfillment of roles and responsibilities	Growth of the health scheme (total members)	Increased ability of the health scheme to financially cover services, administration	Board use of self assessment to build capacity and maintain management
Strong	Board mtg notes show MCH action item follow up and next steps	Semi annual self assessment average 9	14,000	Board balances budget without CS support	Semi annual self assessment average 9
Promising	Board mtg notes include discussion of MCH with assigned action items	Semi annual self assessment average 8	10,000	Board balances budget with maintaining CS services w/ reduced direct CS support	Semi annual self assessment average 8
Medium	Board mtg notes include discussion of improving maternal child health	Semi annual self assessment average 7	7,000	Board balances cost structure to serve providers and members	Semi annual self assessment average 7
Emerging	Board meets regularly and notes demonstrate discussion of relevant issues	Semi annual self assessment average 5	5,000	Board demonstrates understanding of budget and cost decisions	Semi annual self assessment average 5
Minimal	Board meets regularly and keeps	Semi annual self	3,500	Board budget	Board implements bi-

	meeting notes	assessment average 3		drawn to track premiums, MNC resource costs and provider costs	annual self assessment

Child survival interventions fit strategically into HealthPartners other activities by building on prepaid health schemes. In prepaid health schemes, members are physically and financially invested in improving their health. This investment is a key goal of child survival programming in terms of sustainability. When HealthPartners began working in Bushenyi district, some of the barriers they had to overcome were: 1) lack of income, 2) human health not seen as a high priority, 3) no relationships established with health care providers, 4) lack of trust of health care providers, 5) community history of negative experiences trusting third parties to help them pool money, 6) community history of receiving donor contributions for free. It took some time to overcome these barriers to build a structure where groups were willing to financially invest in order to be a part of a system that they could maintain even after HealthPartners was no longer involved.

Implementing child survival within this structure allows both programs to reach more communities with mobilization messages. Distributing items that support key messages at mobilization further encourages people to attend and builds word of mouth for the messages and the benefits that health schemes provide.

The capacity building opportunities presented by Child Survival for the local organizational structure and for health workers is a tremendous support of UHC goals. In a health scheme, all stakeholders benefit from improved health, yet cooperative development does not support actual health care interventions. By coupling these initiatives together a much stronger system can be developed.

Involvement of relevant in country organizations
The process taken to select and involve organizations was to ensure setting up a well run and sustainable child survival program. These are district (local), national and international partners. District partner organizations include the Uganda Private Midwives Association, the District Health Office, health scheme groups and hospitals and HWs in the district and the Uganda Rain Water Association.

At the National level, the partners included MOH (the Child Health Department and Malaria Control Program), Africare, UPHOLD, PSI, Quality Chemicals Ltd, Kampala Pharmaceutical Industries, Joint Medical Store, Business Part Project and AFFORD.

The process was guided by UHC's goal and objectives. There are many health organizations in Uganda but the special interest organizations had to be those that fit the following criteria:

1. Contribute to prevention of infant mortality and maternal morbidity locally or globally
2. Have worked in Bushenyi or a comparable district. Proximity to the child survival program area was an important factor

3. Implementation experience with a community based approach.
4. Have extensive knowledge on malaria, diarrhea, maternal and newborn care or other child survival interventions
5. Policy level organization that advocates for better child and maternal health
6. Ability to share useful information and technical assistance

How the organizations were involved

- Wide consultations at the proposal writing stage. UHC had meetings / discussions with Bushenyi district health office, local hospitals and the MOH. Through these discussions, critical child health needs in the program area were identified.
- Meetings with each of the organizations on specific intervention areas. This was to determine their interest and to assess their capacity. Then meetings were held with individual organizations on possible collaboration at implementation.
- UNICEF and UPHOLD data was reviewed to provide insight on child and maternal health in Bushenyi. The data review process included discussion with these organizations on coverage levels of services for children and mothers.
- For the ones that are M&E oriented, they participated in the design of the baseline assessment
- One week long meeting was held with Africare for mentorship and training UHC in respective roles. BCC Coordinator also attended activity planning sessions with UHC staff to aid in intervention and M&E planning. Africare also provided feedback on the DIP and results framework.
- Consultative meetings were held with officials from the child health department of the MOH.
- UHC has joined the task force of Dr. Mbonye, MOH and Dr. Olinda Vicent, and Janet Kabarangara UNICEF, and others are who in the process of developing SCM for Maternal and New born care for Uganda.
- In the development of the detailed implementation plan, UHC involved partner organizations to refine the program goal, objectives and interventions.

No	Organization	Role
1	PSI Uganda	• Supply PUR • Supply Safe Birthing Kits • Train UHC staff, HWs and community on the use of PUR, Bed nets and safe birthing kits. • IEC and promotional materials
3	Quality Chemicals Uganda Limited	• Supply Retreatment Kits. • Training on the use of the retreatment kits
4	UPHOLD	• Link us to their trained Community Medicine

		Distributors and Child Growth Monitors • Avail IEC material on Child Health both to educate mothers & health workers • Provide technical support and guidance.
5	Kampala Pharmaceutical Industries.	• Supply HomaPak.
6	Africare	• Mentorship training for UHC staff
7	Business PART Project	• Training UHC staff and HWs on HIV/AIDS • Provide technical guidance and support. • Training HWs on AIDS treatment protocols. • Avail IEC and promotional materials.
8	MOH- Malaria Control program	• Partnership in Malaria Control Program. • Technical guidance and support.
9	Joint Medical Store	• Supply of ORS. • IPT • Iron / Foliate tablets
10	Uganda Rain Water Association	• Training resource persons at district and county levels, UHC staff, and Community focal persons in Rain Water Harvest. • M&E of water supply using RWH • Mobilize resources for rain water harvesting activities.
11	Bushenyi Medical Centre	• Training in IMCI, SCM, developing stock order plans, health scheme management, self assessments.
12	Ishaka Hospital	• Training in IMCI, SCM, developing stock order plans, health scheme management, self assessments.
13	Comboni Hospital	• Training in IMCI, SCM, developing stock order plans, health scheme management, self assessments.
14	Mitooma Central Clinic	• Training in IMCI, SCM, developing stock

		order plans, health scheme management, self assessments.
15	District Health Office	• BCC training for District Health Educators, District Nursing Officers, and Health Assistants
16	Uganda Private Midwives Association.	• AMTSL (Includes administration of uterotonic agents, controlled cord traction and Uterine message after delivery of the placenta, as appropriate) • Training and Community outreach FP, HIV, and IMCI • Training of trainers for HWs • Training in safe water • Avail Monthly reports of all activities

In addition to partnering with key organizations, UHC will work with key players in the community. The following table clarifies who is being referred to with the terms DHE's, HWs and UHC and Partners

Key Players for Interventions

Community Social	***Health Services Dimension***	***Local Organizational***
DHE	HW	UHC and Partners
Health Assistants Nursing Officers Health Educators Drug Distributors Volunteers Community Development Officers	Facility Health Workers Midwives TBAs will have separate, targeted education and training to improve their messages, safety, skills, record keeping and referral practices.	UHC members and leaders UHC Board Political Leaders MOH DDHS UHC Staff Partners

Who will be trained to conduct community education? UHC staff met with the DDHS to determine DHE teams comprised of Health Assistants, Nursing Officers, Health Educators, Drug Distributors, Volunteers and Community Development Officers, and with a minimum of two from each sub-county. DHE teams will meet with the Community Educator and Partners like PSI or Business Part Project at the beginning of each month to receive the BCC strategy and materials for education that month. Each DHE will then visit a minimum of 6 groups for education each the month.

Example of expected results for community education coverage:

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Phase	1	II	III	IV	V	VI	Total
County	Igara	Ruhinda	Sheema S	Sheema N	Buhweju	Bunyaruguru	**Bushenyi district**
Populations	207,396	157,720	86,414	86,414	80,489	102,757	**721,189**
District Health Educators	14	14	6	6	8	8	**56**
Months of training	6	6	6	6	6	6	**36**
Communities visited by each DHE	6	6	6	6	6	6	**36**
Average attendance per community	45	40	30	30	24	34	**34**
Total beneficiaries	**22,680**	**20,160**	**6,480**	**6,048**	**6,912**	**9,792**	**72,504***

*Note the total number of beneficiaries listed here is larger than the total target population of WRA and children under 5. This is because men, grandmothers, etc. will also be included in BCC.

Who is the target audience and how will community education be conducted? Mobilization sessions will target the most appropriate audience(s) for the intervention (mostly WRA and men since they are the decision makers) and will include reducing barriers to behavior change. DHEs will mobilize communities throughout the county based on the BEHAVE framework, C-IMCI, TRMs, and lessons learned from the field. Partner organizations will play a key role in planning and carrying out mobilization. Each mobilization session will also include an introduction to prepaid health schemes and explanation of how the schemes work.

Feedback forms for written responses and a discussion to record verbal reactions to training (for those who cannot read/write) will conclude each session. Feedback forms and discussions will help the coordinator gauge how key messages are received and if appropriate behavior will ensue as a result of training. Follow up messages, materials and meetings will be developed according to responses from initial mobilization sessions to reinforce behavior change. When preventive health care materials (like ITNs) are provided at mobilization sessions, they will be distributed after feedback forms are turned in (or after participation in verbal feedback) in order to ensure participants attend the

entire session. This will also encourage participation in feedback. Sign in lists from the beginning of training will include a check off area to track materials distributed.

The mobilization schedule will include a visit to at least 6 different groups per trained DHE each month. Members and non-members will be invited and encouraged to join these sessions. A marketing campaign to raise awareness of upcoming mobilization will be conducted in each county prior to the commencement of each Phase and reminders/teasers on topics that will be covered will be posted ahead of time each month. Distributing preventive healthcare tools like free ITNs for pregnant women and children under 5 will aid word of mouth and build incentive to attend mobilization.

Who will be included in health service training? The UHC Health Services Coordinator worked as the Assistant Health Educator to District Director Health Services in the Bushenyi District Local Administration for eight years. She has been working with these district contacts and other partners since the inception of the program to assess where partnerships for training make sense and are feasible. There are 465 health care workers at 74 provider locations including hospitals and health centers in Bushenyi district. At least one HW from each hospital and health center and all 13 midwives in the district will be encouraged to participate all six months of training. TBAs will receive separate training to specifically address their skills and role in the community.

Example of expected results for health service training coverage:

Phase	**1**	**II**	**III**	**IV**	**V**	**VI**	**Total**
County	Igara	Ruhinda	Sheema S	Sheema N	Buhweju	Bunyaruguru	**Bushenyi district**
Health Facilities	21	16	8	8	8	13	**74**
HWs	21	16	8	8	8	13	**74**
TBAs	20	15	9	10	8	15	**77**
Midwives	1	3	1	0	3	2	**10**
Total beneficiaries	**42**	**34**	**18**	**18**	**19**	**30**	**161**

How will health service training be conducted? Training will be conducted by the MOH for IMCI and SCM and by the health services trainer and partners. Each phase includes six sessions: developing and implementing stock order plans, malaria SCM, diarrhea SCM, ANC SCM, Postnatal care and delivery SCM and self assessment/review. Training will be developed based on MOH policies, IMCI, SCM, TRMs, Improving the Performance of Facility and Community Based Health Workers (developed by CSTS, CORE, USAID and Johns Hopkins, December 2003), M&E coordinator design

assistance and partner recommendations, materials and programs. Focus group discussions will be conducted to gather data to help develop stock order plans and to determine barriers to maintaining consistent stock. These discussions will also provide information on IMCI and SCM practices.

Feedback forms will be handed out at the end of each training to assess information learned and to allow HWs to make recommendations on how the training can be improved. The HW self assessment will be developed in conjunction with the M&E Coordinator with input from key partners with Child Survival experience. The self assessment will be trained in the sixth month of each phase and will be collected by the Health Services Trainer from all previous participants in training at the end of each phase—in order to reinforce the importance of the self assessment process and to encourage HWs to continue this practice. HFA monitoring will be conducted for the current and previously trained county groups in the seventh month of each phase.

Interventions by UHC will support MOH goals with its Health Sector Strategic Plan in addressing child survival to reduce maternal and infant deaths. The following are the HSSP II Key output targets by 2009/2010:

- Percentage of children less than 1 year receiving 3 doses of DPT/Pentavalent vaccine according to schedule from 89% to 95%
- Percentage of households with at least one ITN from the estimated 23.5% (in rural areas) to 70%
- Percentage of households with a covered pit latrine from 57% to 70%
- Total OPD utilization from 0.9 to 1.0
- Percentage of deliveries taking place in a health facility from 25% to 50%
- Percentage of health facilities without any stock outs of first line antimalarial drugs, Fansidar, measles vaccine, Depo Provera, ORS and contrimoxadol from 40% to 100%
- Reduce the case fatality ratio among malaria inpatients aged less than 5 years from 4% to 2%

Targets that are specifically Maternal and Child health related.

1. Increase the proportion of deliveries by skilled attendants from 38 to 50%
2. Reduce the unmet need for emergency obstetric care from 86% to 40%
3. Increase the attendance for 4 visits per pregnancy from 42 to 50%
4. Increase the contraceptive prevalence rate from 23% to 40% [xvii]

Consistency with Global Health and USAID/Uganda SOs and IRs UHC will contribute to achieving the Global Health Bureau's SOs, especially increased use of maternal health interventions, and addressing infectious diseases, especially malaria. The project strategy will also help achieve PR2 for increased sustainability of child and maternal health care initiated by PVOs and their partners. The UHC model will increase local capacity of communities and local partners to effectively address health needs and

to improve local health systems with co-financing. The project will test new approaches to achieve scale and impact.

Under its Strategic Objective for human capacity building, USAID/Uganda is helping to "mitigate infant and child mortality due to preventable infectious diseases."[xviii] USAID/Uganda is providing "technical assistance, training and software to the Ministries of Health and Education as well as the private sector to improve social service management and financing" including public-private partnerships and health of children improved through availability of ITNs and increased births attended by trained personnel.[xix] Under its UPHOLD/Services, implementers are addressing safe motherhood through improved ANC and IMCI, prevention and care for malaria and other communicable diseases.[xx] UHC collaborates closely with these programs, especially in the provision of ITNs, safe water and improved sanitary practices at the community level.

Under its Results Framework, this DIP helps achieve the mission's SO8 for improved Human Capacity and its IRs 8.1 and 8.2 for improved quality, availability, access the positive behavior changes in social sector services, and sustainable services through an increased role of private sector in service delivery.[xxi] More specifically, the proposal addresses children under five who constitute 20% of the population and have high mortality rates of 87.9 deaths per 1,000 live births per year. The results framework addresses child survival by addressing prevalence of diarrhea and chronic malnutrition, better management of childhood illnesses especially; malaria, diarrhea and reducing high risk pregnancy.

Intervention Specific Approach

Malaria

UHC interventions are based on global child survival tools including TRMs and on the Uganda National Malaria Control Policy and Initiatives. UHC will focus 50% of its efforts to prevent or treat malaria. Critical areas of behavior change are to encourage regular sleeping under long lasting treated bed nets, especially for vulnerable mothers and infants. Use of ITNs for mothers and infants can lower malaria rates and reduce the number of infants that are under weight or born prematurely by 25% or higher if they never have malaria. UHC will promote ANC and it will be a distribution point for long lasting ITNs for all pregnant women throughout pregnancy and during post-partum period. At the community level and through large targeted groups (coops, agricultural groups and villages) UHC will promote demand for ITNs, will distribute them free to WRA and children under five per national policy. Distribution of ITNs other than at ANC appointments will take place at community education sessions as incentive to attend. Long lasting ITNs will be subsidized or covered in payment plans for additional nets for family members.

The success of reducing malaria is contingent upon correct retreatment over time as well as proper and consistent use of nets by the most vulnerable members of the household.

Mobilization training will include educating target populations on how to use ITNs appropriately, such as how it should be hung, the importance of peak biting times and who should sleep under the ITNs. All ITNs distributed will be long lasting in order to reduce the need for retreatment.

Increasing proper care seeking behavior will be addressed through monthly mobilization including early recognition and care seeking for fever, compliance with prescribed treatment and knowledge of location of HWs in case of severe disease. Children and pregnant women with malarial signs and symptoms need to receive prompt, appropriate care otherwise severe malaria may develop in a few days. It is most important in counseling and community-based health education programs to recognize early warning signs such as fever, loss of appetite, fatigue, etc. and the importance of continued feeding and increased fluids during and after illness. Education on this last intervention is especially important because KPC results show that only 16% of women gave the same or more fluids to their children during illness. Women who are pregnant for the first time are at the greatest risk[xxii] for complications from malaria and will be encouraged to attend or get counseling for antenatal services. Anemia is the most important consequences of malaria during pregnancy.

Mobilization sessions will be open to all those residing in Bushenyi district but will especially target populations like men, mothers and caretakers for children under 5 and grandmothers, etc. for particular interventions. Monitoring will track coverage for mobilization and additional sessions and locations will be added to include the most vulnerable populations.

UHC will work with the MOH to ensure that HomaPaks are available throughout the district as long as this is the MOH priority. Mobilization will include creating a demand for HomaPaks as well as raising awareness of early warning signs of malaria and the increased risk for pregnant women. HomaPaks assist in at home SCM of uncomplicated malaria. The Uganda Malaria Control Program has a new policy on the treatment of malaria. UHC will work in collaboration with this program to support the MOH policy and to bring resources and training to the most remote areas in the district.

Malaria parasites in Uganda have become increasingly resistant to Chloroquine + SP combination. The Ministry of Health has decided that malaria patients should be treated with Artemether/Lumefantrine (COARTEM®). This will increase the effectiveness of malaria treatment and also help slow down the development of resistance. Sulfadoxine/Pyrimethamine remains the recommended medicine for Intermittent Preventive Treatment (IPT) during pregnancy. Quinine is recommended for the treatment of clinical malaria during the 1st trimester of the pregnancy during which period ACTS should **NOT** be given. During the advanced stages of the pregnancy, ACTs - A/L (Coartem) OR Artesunate + Amodiaquine will be used as first line treatment.

The principle impact of malaria infection during pregnancy is associated with malaria-related anemia in the mother and with the presence of parasites in the placenta. The resultant impairment of fetal nutrition contributing to low birth weight is a leading cause of poor infant survival and development. UHC will mobilize women on the importance of ANC and receiving IPT at least 2 times during pregnancy. BCC will also address the need for women to retain maternal cards and will work with support systems including men, grandmothers to help maintain maternal ANC and IPT seeking behaviors.

UHC will also promote appropriate malaria recognition and case management at the provider level. The approach will focus on SCM, including quality of care, access and demand. Quality of care is defined as appropriate assessment and differential diagnosis, classification, treatment (and/or referral) and counseling. UHC will participate in effective training in SCM, supervision of HWs and will assure an adequate supply of the anti-malarial drug of first choice through stock supply planning and monitoring. UHC will work with HWs to improve SCM under IMCI, including care for severely ill and anti-malaria therapy. Health facility stock supply training will include IPT and ITNs and the importance of including these items in ANC.

Research to establish the impact of DDT as a vector control measure was commissioned by the MOH and carried out in Kihihi Sub-county in Kanungu District, Western Uganda. Findings of the study indicate that low levels of DDT were found in plasma, urine, soils, beans and fish with no associated environmental damage or human defects of infertility, impotence, neurological abnormalities and cancers. The implication of this is that although DDT used in malaria control persists in the environment and in human tissues, it is at harmless levels. Based on the findings, the researchers recommended that Government may safely use DDT in the control of malaria using the Kihihi model.
They however cautioned Government to facilitate tracer studies to identify undeclared sources of DDT in the country. The research was carried out by Doctors – G.S. Bimenya, W. Byarugaba, M. Lugemwa, B.B. Byarugaba and L.Okwi. UHC will work with the MOH policy regarding the spraying of DDT as part of mosquito control efforts.

Control of Diarrheal Disease

To control diarrheal diseases for an estimated 25% of CSHGP efforts, UHC will emphasize safe water, appropriate and early SCM and improved hygiene and sanitation in its community education programs. UHC will promote and distribute ORS at the end of community education sessions that address recognition of warning signs for severe diarrhea and dehydration. UHC will promote proper infant feeding practices (continuation of breastfeeding - frequent small feedings – catch up feeding) in case of diarrhea. Mothers will be educated on recognition and care seeking for serious cases (dehydration, dysentery, and chronic/persistent diarrhea). When zinc becomes available, UHC will train HWs to include the importance of zinc in community education. UHC will encourage PSI and other health PVOs to provide zinc supplements as part of efforts to control diarrheal diseases.

At the community level, UHC will promote improved hygiene including hand washing with soap/ash after defecation, handling of infant feces, before preparing food and before child feeding. Community health education and assistance will be provided for sanitary disposal of human feces including use of covered pit latrines. Drying racks will be recommended to keep cooking utensils clean.

UHC will collaborate with Procter & Gamble and especially with PSI in Uganda to encourage the use of PUR water treatment systems especially for health facilities to improve access to safe water. UHC will explore partnership opportunities with the Uganda Rain Water Association for the construction of rainwater collection systems and cisterns. Building rain water tanks in each community is not economically feasible however the prepaid health plan concept could possibly be used to help communities' pool money and save for these systems. Additionally, UHC will provide covered containers for safer storage of safe water and will provide community mobilization promoting safe water sources including bore holes, public taps and protected dug wells.

UHC will participate in effective training in SCM, supervision of HWs and will assure an adequate supply of ORS to HWs. UHC will work with HWs to improve SCM for diarrhea under IMCI.

Maternal / Newborn Care

For about 25% of the level of effort, UHC will promote maternal and newborn care through creating demand for and increasing access to prenatal care including IPT, ITNs, iron/foliate supplements, planning for delivery and availability of tetanus toxoid immunization. ANC training will include RCT for HIV and a referral system will be established for PMTCT and treatment.

The national policy in Uganda on maternal and child health comprises of the following maternal and newborn health services: preconception care; ANC; post abortion care; intra-partum care; emergency obstetric care; care of the new born and post natal care. For each of these services, the MOH has set national standards, on activities and services, targets and priority groups. The target groups are pregnant women and their partners, women in labor, post-natal and breast feeding mothers, adolescents, women who are HIV positive or suffering from AIDS and are pregnant, women with disabilities and women who are aborting; new born babies who are sick, have low birth weights, have congenital abnormalities, born to HIV positive mothers and babies whose mothers die during child birth. While this much of the national policy has been discussed by the MOH and local PVOs and NGOs, SCM addressing these issues has yet to be finalized and implemented. UHC has joined the task force of Dr. Mbonye, MOH and Dr. Olinda Vincent, and Janet Kabarangara, UNICEF, and others in an effort to complete and roll out SCM for MNC.

Monthly mobilization education will cover improved awareness of men, women, families and communities about the special needs of pregnant and lactating women in terms of nutrition, rest, antenatal, delivery and postpartum rest and care. Danger signs and

symptoms of complications of pregnancy and delivery will be covered and pregnant women will be helped to develop an appropriate delivery plan, based on the woman's history and health status. The importance of early (initiation of breastfeeding during the first hour post partum, including the "utilization" of colostrum,) and exclusive breastfeeding and on demand feeding (for up to 6 months) for all infants, including a practical approach to breastfeeding in a high AIDS/HIV prevalence situation will be addressed through BCC. Through the KPC it is evident that coverage of appropriate breastfeeding practices has already been largely adopted however some information will still be included to ensure that this practice does not change as BCC on other topics becomes available for improving maternal and child health. Since the Uganda total fertility rate remains high at 6.9% (UDHS 2000/01), UHC will promote programs that integrate family planning including natural family planning for appropriate populations: delayed age of first pregnancy, reduced total number of children, and increased birth spacing.

UHC will encourage and educate pregnant women on obstetric danger signs including prolonged labor, mal presentation, excessive bleeding, retained placenta, convulsions, fever and foul smelling discharge. BCC messages will address the promotion of "clean" practices including clean hands of the birth attendant; clean cutting of the umbilical cord; clean delivery surface; safe water and soap; clean string to tie the cord; and clean cloths to wrap the baby. The importance of delivery with a skilled health professional will be stressed.

Mothers will be mobilized to retain maternal cards as verification of 4 ANC visits, IPT, and TT coverage. UHC will conduct further studies to better understand if and where weaknesses remain in maternal care for providers in Bushenyi. The Bushenyi Local Government's maternal mortality ratio 2004/05 was still high at 326/100,000 live births. HWs will be trained to improve quality of ANC including iron/foliate supplementation, early detection and management of malaria, presumptive treatment for malaria, early detection and management of (pre-)eclampsia, early detection and management of STIs, development of an appropriate delivery plan, based on the woman's history and health status, and recognition by the mother, her immediate environment and first line providers of antenatal care of danger signs (bleeding, convulsions, pallor, swollen hands or face, labored breathing, fever.)

UHC will help train HWs to discourage poor birthing practices at the village level, especially use of herbs and pressing down to stimulate contractions. Clean delivery will emphasize avoidance of unnecessary vaginal examinations, episiotomies and induced rupture of the membranes. In addition, UHC will help train HWs in clean hands, clean delivery surface and clean cloths to wrap the baby in (included in Mama Kits that UHC will promote). UHC does not need to focus a great deal of time and attention on providing clean razors to cut the cord because this is already a common practice in village settings. Eighty one percent of women in the Bushenyi district KPC reported having had a clean razor to the cut the cord. This is probably because a razor costs less

than 100 shillings and the MOH has had a nation wide campaign for expectant mothers to carry the razor with them wherever they are after they reach the 7th month of pregnancy.

Midwives who traditionally supervise TBAs will receive additional mobilization in order to address the barriers that they face in supervision and to improve the frequency and quality of supervision in addition to improving the reporting of TBA interventions in Maternal Newborn Care.

TBAs will be trained separately in order to help shift their focus from delivery and to other aspects of MNC. Their training will include components of DHE training as well as portions of the HW training. This approach has been adopted because the reality is that TBAs continue to play a large role in MNC and deliveries in Bushenyi district. Emphasis for TBA training will especially be placed on recognizing danger signs and referring cases that present any risk at ANC, delivery or postpartum visits. Referral for HIV/AIDS counseling and testing will also be covered. TBAs will be trained on the six cleans (clean hands of the birth attendant; clean cutting of the umbilical cord; clean delivery surface; clean water and soap; clean string to tie the cord; and clean cloths to wrap the baby), the importance of encouraging immediate and exclusive breastfeeding, recognizing and responding to danger signs in newborns, and the need to visit every new mother six days after delivery to assess the health of mother and child.

DHEs and TBAs will be trained on providing and keeping records of postpartum care. Training will stress the need to visit all mothers 6 days after the birth of the baby to check for danger signs, encourage immunizations, counsel on newborn care, counsel on breastfeeding, check to be sure mothers have had Vit. A, and to counsel on sleeping under ITN. DHEs and TBAs will be charged with making sure mothers and caretakers in the household can name and recognize newborn danger signs and have a plan to seek appropriate care immediately if necessary.

Cooperative based health schemes will cover basic maternity care and delivery. HWs will be trained in SCM to detect, manage and/or refer high-risk cases and complications. SCM will include clean and safe delivery practices during normal delivery, the use of clean birth kits, safe delivery of the placenta, early detection and management of hypertension, hemorrhage and sepsis, and active management of third stage labor and recognition of and referral for obstetric emergencies.

Postpartum visits will be included in health scheme benefit packages and will provide skilled support for breast-feeding, family planning, birth spacing, immunization, maternal nutrition and services to mother and partner. HWs will be trained in best practices for postpartum visits including improving knowledge of women, their families and communities about the danger signs and symptoms of complications of postpartum period.

HealthPartners will provide management and project oversight from its headquarters and through periodic visits to provide training especially to UHC in management of consumer owned systems, recording-keeping, staff retention and management of non-profit health care providers. Health care and health management professionals are available and can train UHC staff as well as assist in promotion at the village and community level. HealthPartners will work through CORE and CSTS to make sure interventions and strategies are consistent with internationally adopted standards for child survival programs.

How quality will be monitored.

ITNS

- Specifications must conform to the Uganda Standard Specifications for mosquito nets.
- Should have approval from National Drug Authority
- Ensure that specific samples are approved and signed off by both parties i.e. Health Partners and Supplier.
- Designing contracts or MOU listing clear specifications.
- Incoming good inspection of ITNs against specific checklists.
- Issuing goods received note for received and approved ITNs supplied with specification sheets
- Goods rejection note- in cases where the ITNs do not measure to standards should be issued and signed by both parties on acceptance of non conformances.
- Most importantly, ensure that suppliers/partners are given ample time to manufacture and deliver goods.
- Proper storage.

PUR and Waterguard

- Ensure that products have been approved by MOH and NDA
- Incoming good Inspection of products against specific checklists. E.g. Checking the expiry a date for timely replacements
- Issuing goods received note for received and approved products supplied with specification sheets
- Proper Storage.

Clean birthing Kits

- Should have approval from MOH and National Drug Authority
- Incoming good Inspection of kits against specific checklists. i.e. Does it contain all its components? e.g. Surgical gloves(2 pairs), Antibacterial soap (45gm), Razor blades (2), Cord ligatures (2), Plasting sheeting (2 X 1 meter), 200,000 IU Vitamin A capsules (1), 3.5g.Tetracycline Eye Ointment tube (1), Cotton wool (200grams), Child Health /immunization card, Postnatal Care Card and Pictorial and written instructions (translated to local languages)

- Goods rejection note- in cases where the kits do not measure to standards should be issued and signed by both parties on acceptance of non conformances
- Issuing goods received note for received and approved kits supplied with specification sheet.
- Proper storage.

HomaPak, IPT drugs and Iron tablets

- Ensure that products have been approved by MOH and NDA
- Strict Incoming good Inspection of products against specific checklists. E.g. Checking the expiry a dates for timely refilling
- Issuing goods received note for received and approved products supplied with specification sheets

- Designing short time lag (renewable) contracts with associated penalties.
- Ensure that the storage for the drugs is up to standards.

Services e.g. Trainings on PMTCT, AC, PC, Drug distributor and on delivery among others quality will be ensured by;

- Follow MOH guidelines and regarding the areas to be tackled e.g. MOH has a guideline for training Community Drug Distributors
- Identifying what to work on and choosing the right partners to do the work, partners in the related field e.g. do they have the experience in what we want them to do, availability of materials etc
- Analyzing what the problem is and what the root causes are (from the baseline data) and work to address this.
- By writing MOU or contracts that clearly define the scope of work e.g. Training objectives, the target audience and what the input, processes, output, effects and impacts.
- Clearly stating the deliverables to be made and timeline.
- Thorough supervision by HP staff
- M & E e.g. Pre and post test, report writing and observation.

How the program will ensure safety. (Degree of minimizing risk) e.g. safe use of insecticide for re-dipping

- Through sensitizations and training of key persons to assist with re-dipping at village level
- Organizing mass re-dipping.
- Thorough supervision by UHC to ensure that the nets have been treated.

UHC will supplement baseline assessments with focus groups and additional information gathering in order to develop a BEHAVE framework to address barriers to accessing health care. This way UHC will be sure that the appropriate target population has been selected in addition to determining barriers to behavior change in that population.

UHC will address access to quality services by including all income levels and men in community education campaigns. By working within the existing district health structure and including political and community leaders, the community investment toward improving health care and especially conditions for WRA and children under 5 will be deeply and solidly rooted. Because groups select the health care provider that they want to contract with for their prepaid scheme, providers are encouraged to improve their services to maintain patients. Providing HWs with additional support and tools to more easily manage treatment for pregnant women and children under five and by assessing reasons for current practices and reducing barriers to change, health practices and morale of medical personnel are expected to improve.

Monitoring and evaluation will provide a solid base for UHC capacity building and for improving interventions. Communication of progress will be an important aspect of the program at all levels. Partners will need regular reports on how their participation affects the district and stakeholders will be able to see how their investment in health care improves the health status of the community.

Mobilization will be provided for UHC members and relatively economically stable groups who could potentially become UHC members. Community education and scheme mobilization will be carried out in all counties regardless of prepaid health scheme membership status. A portion of the most vulnerable population of women and children under five will receive subsidized health care coverage under the scheme. This structure and statistical results in health improvement will be presented to the MOH, employers, NGO's and PVO's for potential underwriting to maintain subsidized funding.

In the past UHC tried providing matatu's or ambulances as part of the prepaid health scheme in order to transcend transportation barriers. Unfortunately the matatu's were frequently lured away from health care services by those who needed transport and could pay for it immediately. The MOH tried providing walkie talkies to villages for HomaPak distribution. This method could be applied to improve communication for health emergencies. These and other options will be researched and transportation challenges will be addressed throughout the district.

4. Monitoring and Evaluation Plan

The Current Information system in Bushenyi district is the Health Management Information System. This operates in the structure presented below:

i) MOH and other National Level Institutions
ii) National referral Hospitals
iii) Regional Referral Hospitals
iv) District Health Services
v) Health Sub-district
- Referral facility - General Hospital or Health Centre IV (District Level)
- Health Centre III (Sub-County Level)
- Health Centre II (Parish Level)
- Health Centre I (Village Health Team)

Each health facility keeps daily records that are either written or printed out from a database spreadsheet and then summarized into weekly statistics. Each health sub district has an HIMS / records officer that goes to each of the health centers in his area (every Monday) collecting this information. The records officer summarizes this into a health sub district monthly report (HMIS 105) that he presents to the District Health Management Team. HMIS 105 reports will be collected by the M&E coordinator and used to monitor changes in health statistics and improvements in essential drug stock maintenance.

Under the request from the Uganda Cooperative Based Health Finance Association, HealthPartners developed the Uganda Health Information System (UHIS) a database system designed specifically for Uganda. The system, developed in partnership with Oracle Corporation, tracks membership, patient encounters, and vaccinations and also provides reports of profit and loss, frequent diagnoses, and diagnoses by cooperative. These reports are excellent tools for UHC staff and are also valuable as the cooperative works toward sustainability because they allow the cooperative board, providers, members and leaders to make results based decisions to improve their health.

The work plan details updating and implementing UHIS to track child survival interventions and rapid catch indicators in addition to current monitoring of prepaid health schemes. Monthly UHIS reports including membership tracking, Income/Loss, YTD Top Services, YTD Top Diagnoses, and the CS Report will be generated by the three primary hospitals in Bushenyi district detailing health statistics. **The M&E coordinator will collect these reports each month and will facilitate a review and discussion on the results at the monthly team meeting and at all board meetings** in order to build the capacity of these local organizations in making results based health care decisions.

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M&E Plan

Baseline, midterm and final evaluations using KPC 2000+, HFA and ISA tools will be conducted in addition to routine monitoring. Two consultants were hired to lead the baseline assessments. For the midterm and final evaluation, the capacity of the M&E coordinator will be reviewed and either he will conduct the assessments or a consultant will be hired to aid in the assessment and report writing process. Monitoring using LQAS, HFA and self assessments will take place at the end of each implementation phase.

Objective/ Result	Indicators	Source/ method of measurement	Frequency/ person responsible	Baseline Value	EOP target
Objective 1: Reduce incidence of Malaria in Bushenyi district for children under 2 and pregnant women Indicator: % of children under 2 with fever in the last two weeks Baseline: 44%, EOP: 19%					
IR 1: Increase ITN use	% of children under 2 who slept under an ITN last night. % of pregnant women who slept under an ITN last night.	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E	32% 19%	55% 36%
IR 2: Increase timely malaria treatment	% of children under 2 w fever in the last 2 wks who received antimalarial treatment	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E	71%	84%
IR 3: Increase IPT	% of pregnant women receiving IPT as verified by maternal card	1. KPC 2000+ 2. Post mobilization questionnaires	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E	27%	49%

		3. LQAS 4. HMIS 105	3. Semi-annual/M&E		
Objective 2: Reduce incidence of Diarrhea in Bushenyi district for children under 5 % of children under 2 with diarrhea in the last two weeks Baseline: 55%, EOP target: 20%					
IR 1: Improved recognition by caretakers of warning signs that child needs treatment	% of caretakers who know at least two signs that a child under 5 needs treatment.	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E	76%	84%
IR 2: Improve safe water access & use	% of households who use improved water source (borehole, public tap, or protected dug well.)	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E	50%	60%
IR 3: Increase safe water practices and hand washing	% of households with a designated hand washing station with a covered container for water	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E	24%	46%
	% of caretakers who usually wash hands with soap/ash before food preparation	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E	42 %	64%

	% of caretakers who usually wash hands before feeding children	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E	15%	35%
	% of caretakers who usually wash hands after defecation	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E	63%	82%
	% of caretakers who usually wash hands and after attending to a child who has defecated	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E	8%	30%
IR 4: Improve sanitation practices	% of households who safely disposed of their child's feces the last time s/he passed stool	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E	68%	82%
	% of households with access to a covered pit latrine	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-	19%	36%

			annual/M&E		
IR 5: Increase intervention for severe diarrhea & dehydration	% of children 0-23 mos with diarrhea in the last two weeks who received ORS	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E	0 %	30%
	% of children aged 0-23 mos who were offered more fluids and food during the illness?	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E	2 %	20%
IR 6: Increase zinc supplementation **(Pending US approval)**	% of children 0-23 mos w diarrhea in the last 2 weeks who were treated with zinc supplements.	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E	---	---
Objective 3: Increased % of pregnant women receiving improved ANC, delivery and post partum care.					
IR 1: Increased demand for ANC	% of women w 4 ANC visits as verified by maternal card.	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS 4. HMIS 105	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E	18%	30%
IR 2: Increased demand for	% of pregnant women seeking	1. KPC 2000+ 2. Post	1. Baseline, Mid, EOP/Consultant	34%	44%

RCT	RCT services	mobilization questionnaires 3. LQAS 4. HMIS 105	2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E		
IR 3: Improve caretaker knowledge of delivery preparations, breastfeeding, child spacing and danger signs of pregnancy?	% caretaker knowledge of breastfeeding, child spacing and danger signs of pregnancy	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E	38% 95% 76%	55% 99% 90%
IR 4: Increased access to safer birthing	% of women who delivered with a skilled health professional as verified by a maternal card.	1. KPC 2000+ 2. Post mobilization questionnaires 3. LQAS 4. HMIS 105	1. Baseline, Mid, EOP/Consultant 2. Monthly/DHEs turn in to CE and M&E 3. Semi-annual/M&E	47%	65%
Objective 4: Build local organizational capacity to manage health schemes					
IR 1: Increased capacity of Board	performance scale	Review of Board meeting notes	Quarterly/M&E	Minimal	Strong
IR 2: Growth of health scheme	performance scale	Scheme manager monthly reports	Monthly/Scheme Mgrs to M&E	Minimal	Strong
IR 3: Increased ability of scheme to	performance scale	Self assessment and UHIS reports	Monthly, semi-annual/M&E	Minimal	Strong

financially cover service & admin					
Objective 5: Improved health care mgmt especially for WRA and children under 5					
IR 1: Reduced incidence of stock outs	% of stock outs in the past 30 days	HFA and self assessment performance scale HMIS 105	1. Baseline, Mid, EOP/Consultant 2. Semi-annual per county/M&E	41%	18%
IR 2: Improved use of IMCI	% of HWs who have received IMCI training in the last 3 years	HFA and self assessment performance scale	1. Baseline, Mid, EOP/Consultant 2. Semi-annual per county/M&E	57%	70%
	% of HWs who have been supervised in IMCI within the last year	HFA and self assessment performance scale	1. Baseline, Mid, EOP/Consultant 2. Semi-annual per county/M&E	28%	40%
IR 3: Improved ANC	% of HWs who have MOH policy and guidelines/protocol on antenatal and obstetric care services.	HFA and self assessment performance scale	1. Baseline, Mid, EOP/Consultant 2. Semi-annual per county/M&E	44%	65%
IR 4: Improved post partum care	% of facilities who provide information on nutrition& hygiene, ITNs, breastfeeding, STI/HIV/AIDs prevention, warning signs, post natal care.	HFA and self assessment performance scale	1. Baseline, Mid, EOP/Consultant 2. Semi-annual per county/M&E	94%	98%
IR 5: Improved	% of HWs who received training in	HFA and self assessment	1. Baseline, Mid,	79%	90%

delivery (including AMTSL)	AMTSL in the last 3 years	performance scale	EOP/Consultant 2. Semi-annual per county/M&E		
IR 6: Improved self assessment	% of HWs who filled out a self assessment in the last year	self assessment performance scale	1. Baseline, Mid, EOP/Consultant 2. Semi-annual per county/M&E	0%	25%
	% of HW self assessments that showed higher ratings over the past year	self assessment performance scale	1. Baseline, Mid, EOP/Consultant 2. Semi-annual per county/M&E	0%	18%

*Performance scale indicators detailed in CSSA tables pp. 42-45.

Community mobilization will begin with the CE coordinator and partners training DHEs. DHEs will in turn travel throughout the county during the rest of the month sharing these presentations and materials with community groups.

Quality assurance will take place at every level of implementation. Signatures will be gathered at the beginning of training and community education to track attendance. After each community mobilization and health service training, questionnaires and feedback sessions, which cover the same material as the questionnaire for those who cannot read/write, will be conducted to assess recognition of key points and to record suggestions for improved mobilization and training. Questionnaires/feedback sessions will be developed by the M&E coordinator, partners like PSI and Business PART Project, and the CE coordinator for each community education and health service training topic. Questionnaires and feedback methods will be field tested by the M&E coordinator and will be reviewed at the end of each implementation phase to determine how they can be improved.

The M&E coordinator will visit DHE training in the beginning of the phase to explain the importance of accurate data collection and the steps necessary for them to ensure quality data in attaining signatures, feedback and records of those receiving preventive health care items like ITNs. The CE coordinator and training partners will visit and observe each DHE at least one time each month to be sure that messages are clear and consistent and data is being accurately collected. The M&E Coordinator will attend the first health services training session in each phase to monitor accurate data collection.

Monitoring using LQAS, HFA and self assessments will be conducted by the M&E coordinator in the target county in the seventh month of each phase. A slightly smaller

subset of LQAS indicators will be used for this monitoring (Annex 1.) LQAS and HFA monitoring will include the county currently being mobilized as well as countries from previous phases in order to assess how well information and behavior change is being retained. For each county disaggregated data from the baseline KPC will be compared to the results at the end of their phase. The results will indicate progress toward IRs and will inform changes that may be necessary to curriculum and/or strategies. Sharing results with DHEs and HWs will help to build their capacity and will be a motivator for them to continue program activities.

Self assessments will build the capacity of the health service sector helping them to be aware of how their care compares to standards of care set by the MOH and IMCI guidelines.

UHIS database reports including Income/Loss, YTD Top Services, YTD Top Diagnoses, and the CS Report will also be collected monthly, analyzed and used to build capacity of the UHC team, BOD and other stakeholders.

Other monitoring tools include PLA/PRA approaches such as focus group discussions which will be developed as additional information is needed. These tools will be pre-tested and implemented in order to develop BCC to overcome barriers and improve results. These tools shall be designed in a participatory manner involving program staff, partners and beneficiaries under the guidance of the M&E coordinator. The M&E Coordinator will also review the monthly HMIS 105 reports turned in to the District health office from health units. This form will be a helpful monitoring tool for malaria and diarrhea diagnoses, ANC attendance, IPT given, family planning users, RCT and essential drug stock maintenance.

Data collected through questionnaires and signatures will be turned in to the CE by DHE's at the end of each month. The HST will also collect signatures and feedback from training participants. Reports are due to the Director the first week of the following month and a copy must be turned in to the M&E coordinator and the Field Administrator for filing. Monthly review of questionnaire and feedback files will be conducted by the Administrator.

In addition to CE and HST reports, UHC scheme managers are responsible for turning a copy of their monthly reports in to the M&E coordinator. After subsidized health schemes are implemented, they will be monitored monthly with the same tools currently utilized by UHC. A review and comparison between subsidized and non-subsidized plans will be conducted by the M&E coordinator and the director and will present results at stakeholder and CS workshops. In addition to the presentation, a written copy of this review will be distributed to the MOH and the Uganda Mission.

M&E Coordinator reports will provide a statistical overview of all aspects of the program.

This data will be analyzed by the CE, HST and M&E Coordinator to monitor target audience recognition of key points. The data will be used in monthly staff meetings to determine progress toward goals and changes that can be made to improve education and training sessions.

Feedback on Reports

One of the ways to improve interventions as well as quality of reports is to establish and implement a consistent feedback system. The director will meet individually with her direct reports to review their progress toward goals and to work with each person to address issues and challenges, to implement lessons learned and to set individual goals for the following month. The HQ Program Manager will review reports and the director's comments in order to track lessons learned and any changes that may be necessary in management structure, M&E, budgeting and/or program design.

A diagram of the reporting and feedback loop is included below.

Reporting and Feedback Structure

Monthly reporting templates follow. These reports will be field tested and revised to completely and concisely provide an overview of activities and progress toward IRs each month.

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HST REPORT

Month _____ Year _____Phase_____

By HST:_____ **To:** Joy Batusa **Due:** 2nd Monday of each month
Date received by Director: _____

Health and Services Training

Topic:	Goals:
Resources:	Cost:
Source of Materials:	Partnership(s):
Total # of HWs selected for training this month:	Total # of HWs attended training:
# of CBHWs selected for training this month:	# of CBHWs attended training:
# of TBAs selected for training this month:	# of TBAs attended training:
# of midwives selected for training this month:	# of midwives attended training:
Total # of questionnaires received after training:	
Lessons learned from feedback/questionnaires:	
Other Challenges, Opportunities and Lessons Learned:	

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CE REPORT

Month _____ Year _____ Phase_____

By CE:_____ **To:** Joy Batusa **Due:** 2nd Monday of each month

Date received by Director: _____

Community and Social Mobilization

Topic:	Key Messages:
Resources:	Cost:
Source of Materials:	Partnership(s):
Date(s) of DHE training:	# of DHE attended training:
Total # of groups selected for education this month:	Total # of DHE education you attended:
Total # of sessions held this month:	Total # of groups/people you trained:
Total # of attendees at sessions this month:	
Lessons learned from feedback/questionnaires:	
Other Challenges, Opportunities and Lessons Learned:	

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M&E REPORT

Month _____ Year _____Phase_____

By M&E:_____ **To:** Joy Batusa **Due:** 2nd Monday of each month **Date received by Director:** _____

Community/Social	**Health/Service**	**Local Organizational**
# of DHE in this county:	# of HWs targeted in this county:	Health scheme Membership:
Total # of mobilization sessions conducted this month:	Total # of training sessions conducted this month:	Review of UHIS progress and reports:
Total # of attendees at mobilization this month:	Total # of attendees in training this month:	Date of last board meeting:
# of mobilization questionnaires collected:	# of feedback questionnaires collected after training sessions:	Date of last board self assessment:
# of mobilization sessions you attended:	# of HW training sessions you attended:	Review of board progress:
Challenges, Opportunities and Lessons Learned:	Challenges, Opportunities and Lessons Learned:	Challenges, Opportunities and Lessons Learned:

Attachments:

1) UHIS reports A) Income/Loss Report, B) YTD Top Services, C) YTD Top Diagnoses, D) CS Report

2) Questionnaires from community and health service trainings

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Documentation

Copies of the DIP will be distributed to all stakeholders in a dissemination meeting after the CSHGP Mini-University and USAID comments have been received and incorporated in the plan. All staff will receive their own copy of the DIP and additional copies will be stored in Bushenyi, Kampala and HQ offices.

The following documentation of monitoring results will be turned in and filed in the Bushenyi Office by the 15th day of the following month. When any changes are made a copy of the updated material will be filed in addition to, and in front of, older materials in the appropriate file. The administrator will review files on the 15th of each month to ensure appropriate materials have been filed and to follow up on missing data.

Due Dates	Community Social	Person responsible	Health Service	Person responsible	Local Organizational	Person responsible
7/15/06, 3/15/07 11/15/07, 7/15/08 3/15/09, 11/15/09	Malaria Training presentation and handouts	CE	Stock order plans by phase and provider,	HST	MTTs	M&E
7/15/06, 3/15/07 11/15/07, 7/15/08 3/15/09, 11/15/09	Malaria Questionnaire/ Feedback template	CE	Stock order plan questionnaire/feedback template	HST	UHIS reports	M&E
7/15/06, 3/15/07 11/15/07, 7/15/08 3/15/09, 11/15/09	Malaria Questionnaire/ Feedback field responses filed by phase, presenter and group.	M&E	Stock order plan Questionnaire/Feedback provider responses filed by phase HMIS 105	M&E	Board meeting notes and budget when applicable	M&E
7/15/06, 3/15/07 11/15/07, 7/15/08 3/15/09, 11/15/09	CE Monthly Report	CE	HST Monthly Report	HST	M&E Monthly Report	M&E
8/15/06, 4/15/07 12/15/07, 8/15/08 4/15/09, 12/15/09	Diarrhea Training presentation and handouts	CE	SCM Malaria presentations and handouts	HST	MTTs	M&E
8/15/06, 4/15/07 12/15/07, 8/15/08 4/15/09, 12/15/09	Diarrhea Questionnaire/Feed back template	CE	SCM Malaria questionnaire/feedback template	HST	UHIS reports	M&E
8/15/06, 4/15/07 12/15/07, 8/15/08 4/15/09, 12/15/09	Diarrhea Questionnaire/ Feedback field responses filed by phase, presenter then group.	M&E	SCM Malaria Questionnaire/Feedback provider responses filed by phase HMIS 105	M&E	Board meeting notes and budget when applicable	M&E
8/15/06, 4/15/07 12/15/07, 8/15/08 4/15/09, 12/15/09	CE Monthly Report	CE	HST Monthly Report	HST	M&E Monthly Report	M&E
9/15/06, 5/15/07 1/15/08, 9/15/08 5/15/09, 1/15/10	MNC Training presentation and handouts	CE	SCM Diarrhea presentations and handouts	HST	MTTs	M&E

9/15/06, 5/15/07 1/15/08, 9/15/08 5/15/09, 1/15/10	MNC Questionnaire/ Feedback template	CE	SCM Diarrhea questionnaire/feedback template	HST	UHIS reports	M&E
9/15/06, 5/15/07 1/15/08, 9/15/08 5/15/09, 1/15/10	MNC Questionnaire/ Feedback field responses filed by phase, presenter then group.	M&E	SCM Diarrhea Questionnaire/Feedback provider responses filed by phase HMIS 105	M&E	Board meeting notes and budget when applicable	M&E
9/15/06, 5/15/07 1/15/08, 9/15/08 5/15/09, 1/15/10	CE Monthly Report	CE	HST Monthly Report	HST	M&E Monthly Report	M&E
10/15/06, 6/15/07 2/15/08, 10/15/08 6/15/09, 2/15/10	Sanitation Training presentation and handouts	CE	SCM Antenatal Care presentations and handouts	HST	MTTs	M&E
10/15/06, 6/15/07 2/15/08, 10/15/08 6/15/09, 2/15/10	Sanitation Questionnaire/ Feedback template	CE	SCM Antenatal Care questionnaire/feedback template	HST	UHIS reports	M&E
10/15/06, 6/15/07 2/15/08, 10/15/08 6/15/09, 2/15/10	Sanitation Questionnaire/ Feedback field responses filed by phase, presenter then group.	M&E	SCM Antenatal Care Questionnaire/Feedback provider responses filed by phase HMIS 105	M&E	Board meeting notes and budget when applicable	M&E
10/15/06, 6/15/07 2/15/08, 10/15/08 6/15/09, 2/15/10	CE Monthly Report	CE	HST Monthly Report	HST	M&E Monthly Report	M&E
11/15/06, 7/15/07 3/15/08, 11/15/08 7/15/09, 3/15/10	HIV/AIDS Training presentation and handouts	CE	SCM Delivery and postnatal care presentations and handouts	HST	MTTs	M&E
11/15/06, 7/15/07 3/15/08, 11/15/08 7/15/09, 3/15/10	HIV/AIDS Questionnaire/ Feedback template	CE	SCM Delivery and postnatal care questionnaire/feedback template	HST	UHIS reports	M&E
11/15/06, 7/15/07 3/15/08, 11/15/08 7/15/09, 3/15/10	HIV/AIDS Questionnaire/ Feedback field responses filed by phase, presenter then group.	M&E	SCM Delivery and postnatal care Questionnaire/Feedback provider responses filed by phase HMIS 105	M&E	Board meeting notes and budget when applicable	M&E
11/15/06, 7/15/07 3/15/08, 11/15/08 7/15/09, 3/15/10	CE Monthly Report	CE	HST Monthly Report	HST	M&E Monthly Report	M&E
12/15/06, 8/15/07 4/15/08, 12/15/08 8/15/09, 4/15/10	Review Training presentation and handouts	CE	SCM AMTSL presentations and handouts	HST	MTTs	M&E
12/15/06, 8/15/07 4/15/08, 12/15/08 8/15/09, 4/15/10	Review Questionnaire/ Feedback template	CE	SCM AMTSL questionnaire/feedback template	HST	UHIS reports	M&E
12/15/06, 8/15/07 4/15/08, 12/15/08 8/15/09, 4/15/10	Review Questionnaire/Feed back field responses	M&E	SCM AMTSL Questionnaire/Feedback provider responses filed	M&E	Board meeting notes and budget when applicable	M&E

	filed by phase, presenter then group.		by phase HMIS 105			
12/15/06, 8/15/07 4/15/08, 12/15/08 8/15/09, 4/15/10	CE Monthly Report	CE	HST Monthly Report	HST	M&E Monthly Report	M&E
1/15/07, 9/15/07 5/15/08, 1/15/09 9/15/09, 5/15/10	Phase I LQAS Results	M&E	Phase I HFA & Self Assessments by phase, then provider HMIS 105	M&E	Phase I Self assessments and ISA	M&E
2/15/07	Annual CS Workshop presentations and notes	Administrator			ISA Report	M&E
9/15/07	Phase II LQAS Results	M&E	Phase II HFA & Self Assessments by phase, then provider	M&E	Phase II Self assessments and ISA	M&E
10/15/07	Annual Stakeholder Workshop presentations and notes	Administrator			ISA Report	M&E
5/15/08	Midterm KPC results	M&E	Midterm HFA results	M&E	Midterm ISA	M&E
6/15/08	Annual CS Workshop presentations/notes	Administrator			Subsidized Health scheme	M&E
1/15/09	Phase IV LQAS Results	M&E	Phase IV HFA & Self Assessments by phase, then provider	M&E	Phase IV Self assessments and ISA	M&E
2/15/09	Annual Stakeholder Workshop presentations/notes	Administrator			ISA Report	M&E
9/15/09	Phase V LQAS Results	M&E	Phase V HFA & Self Assessments by phase, then provider	M&E	Phase V Self assessments and ISA	M&E
10/15/09	Annual CS Workshop presentations/notes	Administrator			ISA Report	M&E
5/2/10	Final KPC results	M&E	Final HFA results	M&E	Final ISA	M&E

LQAS, HFA and Self Assessment data will be collected by the M&E coordinator and analyzed in the seventh month of each phase by the data collection team including UHC staff, partners and the M&E coordinator. Data results will be discussed and compared and changes will be applied immediately to improve interventions.

Results of LQAS, HFA and Self Assessments will be shared by the M&E coordinator at each annual stakeholder workshop and at each annual staff workshop. The goal of these workshops is to share progress toward IRs, lessons learned and to build capacity. Mission representatives will be invited to stakeholder workshops and will be given a copy of program results and updates. Data will also be used in workshops to identify

areas that need improvement, supervision areas that need prioritization and specific activities that have been implemented successfully and reasons for their success identified to be replicated in other interventions. Partners will be encouraged to access, discuss and use monitoring data with support from the M&E coordinator.

Results of LQAS, HFA and Self Assessments will also be shared at the end of each phase with DHEs and HWs who participated in the interventions. Baseline data disaggregated by county will be compared with end of phase results to help participants see the fruits of their efforts. Reviewing and analyzing this data will build capacity and will aid in motivating participants to continue using the curricula and lessons learned from this opportunity.

The M&E coordinator will attend all Board/Committee meetings and UHC Annual General Meetings throughout the program life in order to systematically build Board capacity for managing data, budgets and results based decision making for the health schemes. It is expected that by 2010 the board will have full ability to plan for and carry out CS interventions and monitoring. The final four to six months of the program are reserved for additional review and training in the counties and for preparing all levels of the system to continue improving the health of women and children in the district.

The M&E coordinator is responsible for monitoring timely reports and conducting appropriate LQAS, HFA and self assessments. The field administrator can in turn make sure that all reports are completed and kept on file. The HQ program manager is responsible for ensuring that data collection is logical and supporting objectives. The director is responsible for ensuring feedback is given according to report data and that results are moving the program toward set objectives. Because partners will play a major role in training they will have a vested interest in viewing results as the program progresses. They will also be able to share lessons learned from incorporating changes to improve results.

M&E skills of all staff will need to be strengthened throughout the life of the program. All UHC staff will receive basic M&E training as soon as it is available through CORE, CSTS or another reputable, preferably child survival organization. Partners will also be invited to attend basic M&E training. Direct supervisors will provide coaching for capacity building as they view reports each month. Supervisors will seek CSTS, CORE or other appropriate training opportunities to build staff skills. Institution Strengths Assessment Methodology will be carried about prior to annual staff workshops each year and results will be discussed during the workshop.

Sustainable data collection at program completion includes UHIS database reports which will be generated by the hospitals and collected by the secretary of the Board of Directors. UHIS data reports include membership tracking, Income/Loss, YTD Top Services, YTD Top Diagnoses, and the CS Report which will include rapid catch indicators. These reports will enable the Board to make results based health care

decisions that will impact the entire community in addition to helping them wisely manage the cooperative. Results will be shared by the Board at Annual General UHC meetings. The cooperative will be able to vote on health scheme benefit packages and the extent to which preventive health care and maternal child care is included.

Self assessments are also important monitoring tools because they may be maintained after the life of the program. Assessments act as a comprehensive guide to help HWs remember the tools that they have gained for the most appropriate standard care management and maintaining stock of essential items.

Operations research will be conducted on subsidized health scheme membership for high risk populations of women and children under 5: After mobilization phases are well established, groups have had an opportunity to join UHC, and CS staff is familiar with target populations in each county, a subsidized health scheme structure will be developed to close the gap for the most vulnerable populations mobilized to this point. A study will be carried out to determine participation parameters and premiums. UHC has experience implementing subsidized prepaid health care to vulnerable populations through the Mothers Uplifting Child Health (MUCH) program in Gulu, Northern Uganda from 2001-2003. Below is the current UHC premium structure, the structure that was used for the MUCH program and a potential CS subsidy. This structure may change according to results from the study and lessons learned from the initial phases of the program.

UHC Premium Schedule in Uganda Shillings

Current UHC Structure			**MUCH Subsidized Health scheme**			**Proposed CS Subsidy**		
Group	**Premium**	**Subsidy**	**Group**	**Premium**	**Subsidy**	**Group**	**Premium**	**Subsidy**
Women	5000	0	Women	850	400	Women	0	5000
Men	5000	0	Men	1250	0	Men	5000	0
Children	5000	0	Children	350	900	Under 5	0	5000
School Children	5000	0	School Children	900	350	School Children	5000	0
Elderly	5000	0	Elderly	0	1250	Elderly	5000	0

Results of the subsidized health plans will be closely monitored and recorded to provide insight into the efficacy of this approach in reaching the most vulnerable populations. Results will be shared at stakeholder workshops and will be detailed in a separate final analysis.

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The following table identifies how this program supports CSHGP Program Objectives.

CSHGP Program Objective:

To contribute to sustain improvements in child survival and health outcomes through U.S. PVOs/NGOs and their local partners.

PR1: Improved Health Status of Vulnerable Target Populations

PR1: KPC indicators will show improvements in health of WRA and children under 5.

PR1.2: Improved quality and availability of key health services at health facilities and within communities

PR1.2: HFA indicators will show improvements in SCM.

PR1.3: Increased capacity of communities, local governments and local partners to effectively address local health needs

PR1.3: Board meeting notes and self assessments will show increased awareness of MNC issues and a balanced UHC BOD budget will demonstrate increased capacity to manage care

PR2: Increased Scale of Health Interventions

PR2: UHC scheme manager reports will show increase of 14,000 members over the LOP.

PR2.1: Increased population reached through the use of strategic partnerships and networks

PR2.1: CE reports will record number of target population mobilized (est. 72,5000) and HST reports will record number of HWs trained (est. 160)

PR2.2: Improved health systems and policies that support effective heath programs and services in government and private sectors

PR2.3: Widespread development or adoption of innovative approaches

PR2.4: Improved collaboration with USAID Missions

PR2.2-4: Presentation will be provided to the MOH & Mission at EOP with data on correlations of health indicators and scheme membership.

PR3: Increased contribution of CSHGP to the global capacity and leadership for child survival and health

PR3.1: Increased opportunities for supporting technical excellence

PR3.2: Improved recognition and visibility of PVO work in health

PR3.3: Increased capacity of new partners of CSHGP to implement effective health programs

PR3.4: Increased capacity of PVOs to participate in scale-up of proven health interventions

PR3: UHC program final report will detail KPC and HFA indicator improvements and increased capacity from UHC and partners will be evident in ISA and UHC BOD mtg notes and self assessments.

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Uganda Mission Strategic Objective:

Improved Human Capacity

IR8.1: Effective use of social sector services	IR8.2: Increased capacity to sustain social sector services	IR8.3: Strengthened enabling environment for social sector services
UHC is working within the District Director of Health Services in Bushenyi to improve HW capacity and timely care seeking by vulnerable populations	***UHC is introducing and scaling up prepaid health schemes which benefit health care providers through consistent income, earlier interventions, healthier populations and increased income because 20-40% of walk-in clients are unable to pay for services.***	***UHC structure engages community leaders in health care, it provides a stake for health care providers in community improvement of health and it establishes ownership/leadership for health care management decisions in the hands of a BOD. A presentation correlating health indicators and scheme membership will be provided to the MOH in addition to a report analyzing data on subsidized health plans for vulnerable populations.***

The program midterm evaluation is planned for June 2008 and the final evaluation is scheduled for June 2010. The final stakeholder workshop will be held in September 2010 and the final report will be disseminated to all stakeholders.

5. *Program Management*

As a large consumer-owned, health network, HealthPartners has in place comprehensive organizational structures, human resource and financial management systems with over 45 employees in all financial disciplines alone (accountants, financial analysis, compliance, budgeting). HealthPartners successfully operates a USAID sub grant and fully complies with US government and USAID accountability and financial management requirements. As a participant in various U.S. government-funded health programs, HealthPartners has financial staff familiar with all compliance standards. However, the headquarters unit of HealthPartners will participate in capacity building opportunities as they are available through CORE and CSTS.

Scott Aebischer, HealthPartners Senior Vice President of Customer Service and Product Innovation, who has been engaged with the UHC from its inception and is responsible for its basic design is the Headquarter Backstop.

Headquarter program management will be carried out by **Jennifer Wenborg** who has been manager for the UHC project since 1999. She holds a MA from Northwestern Health Sciences University.

Joy Batusa is the CS Field Program Manager; she has been working on the UHC project from its inception. She has managed UHC's 12 person staff, knows the PVO, NGO, and MOH officials engaged in child survival programs, and provides leadership of UHC/CS field activities including community education and prepaid plan management. She has a Masters in Social Sector Planning and Management from Makerere University. Joy and the program administrator/ accountant are co-located with PSI in Kampala near MOH, Makerere University and other partners; they spend 50% of their time in Bushenyi.

Ms. Batusa has balanced the responsibilities of building partnerships in Kampala, maintaining daily email and weekly telephone communication with HealthPartners (neither mode of communication is reliable in Bushenyi) and managing field staff since she began working with HealthPartners in 1998. Program field management is closely monitored through monthly reporting to ensure that distance is not a barrier to staff accountability and program management. Location of staff will be evaluated each year and if at any time distance is determined to be a barrier, if internet and telephone connections become reliable in Bushenyi, and/or if reliance on key partnerships is reduced, then location of staff will be adjusted as appropriate.

In the attachments are CVs of key staff expected to contribute to the project including percentages of their time devoted to project activities.

The HQ Technical Backstop reports to HealthPartners CEO and USAID and is responsible for executive program management. He travels to Uganda two times each year and participates in weekly meetings with the HQ Program Manager and weekly conference calls with the HQ Program Manager and the Director.

The HQ Program Manager reports to the HQ Technical Backstop and is responsible for program planning, design, and monitoring. This position has daily email communication with the Director and in conjunction with the HQ supervisor, participates in weekly conference calls with the Director to ensure transfer of skills, information, technical assistance/updates and lessons learned. This position also communication regularly via email with the Accountant/Administrator and the M&E Coordinator. Consultants and HealthPartners personnel including the Senior Account, Physicians, Corporate Communications and Information Technology Specialists who will be assisting with the program as Match donation will report to the HQ Program Manager. These positions are located in Minnesota, USA.

The Director/Field Program Manager reports to the HQ Technical Backstop and is responsible for managing the program and staff. She is based in Kampala, Uganda for easy access to partners and reliable communication via email and telephone. She spends

over 50% of her time with field staff in Bushenyi district. The director has four direct reports, each one covering a major aspect of the program.

The Health Services Trainer is based in Bushenyi and is responsible for designing and implementing child survival health services training and coordinating efforts with partners. She will report to the Director and will supervise the Community Educator. The reason the Health Services Trainer supervises the Community Educator is that the person hired for this role had especially strong ties with the Bushenyi District Health office because she worked there for several years. She is well equipped to mentor the Community Educator and to guide the CE in connecting with appropriate people. The Community Educator will work with partners to plan, implement and help monitor mobilization. Additionally she will work closely with the scheme marketer who will be presenting scheme concepts to target populations in conjunction with BCC efforts.

The M&E Coordinator works closely with all staff and is responsible for developing and implementing M&E tools to assess and inform program activities to achieve program objectives. The M&E Coordinator is based in Bushenyi and supervises the UHIS data manager. The UHIS data manager is paid by Bushenyi Medical Centre, and is responsible for entering data and maintaining UHIS systems.

The Field Program Manager is responsible for all scheme management and marketing and sales staff. This team resides in Bushenyi and is paid through a USAID cooperative development subgrant.

The Accountant/Administrator has been with the program for many years and is highly detail oriented, organized and ready for additional responsibilities. Because the role of the Communication and Marketing Coordinator is more difficult to monitor in terms of productivity and reporting it makes sense for this person to report to the Accountant/Administrator who is well versed in all aspects of the program and who will have time to mentor him/her. The Communication & Marketing Coordinator is responsible for coordinating partnerships to ensure that partners are routinely updated on program details and to find opportunities to enhance collaboration throughout the LOP. This person is also responsible for developing and carrying out marketing plans to ensure that community education is attended by the appropriate target populations. The A/A and CMC will be based in the Kampala office but will spend at least 50% of their time in Bushenyi.

When new staff are hired, they are given a copy of the UHC Orientation packet which includes the mission, vision, the position description and corporate responsibility scorecards for their position, benefits and insurance information, holiday and vacation information, the communication plan, management calendar, partners and stakeholder background information and per diem rates for in-country travel. These packets are updated annually by the A/A, and approved by the Director and the HQ Program Manager.

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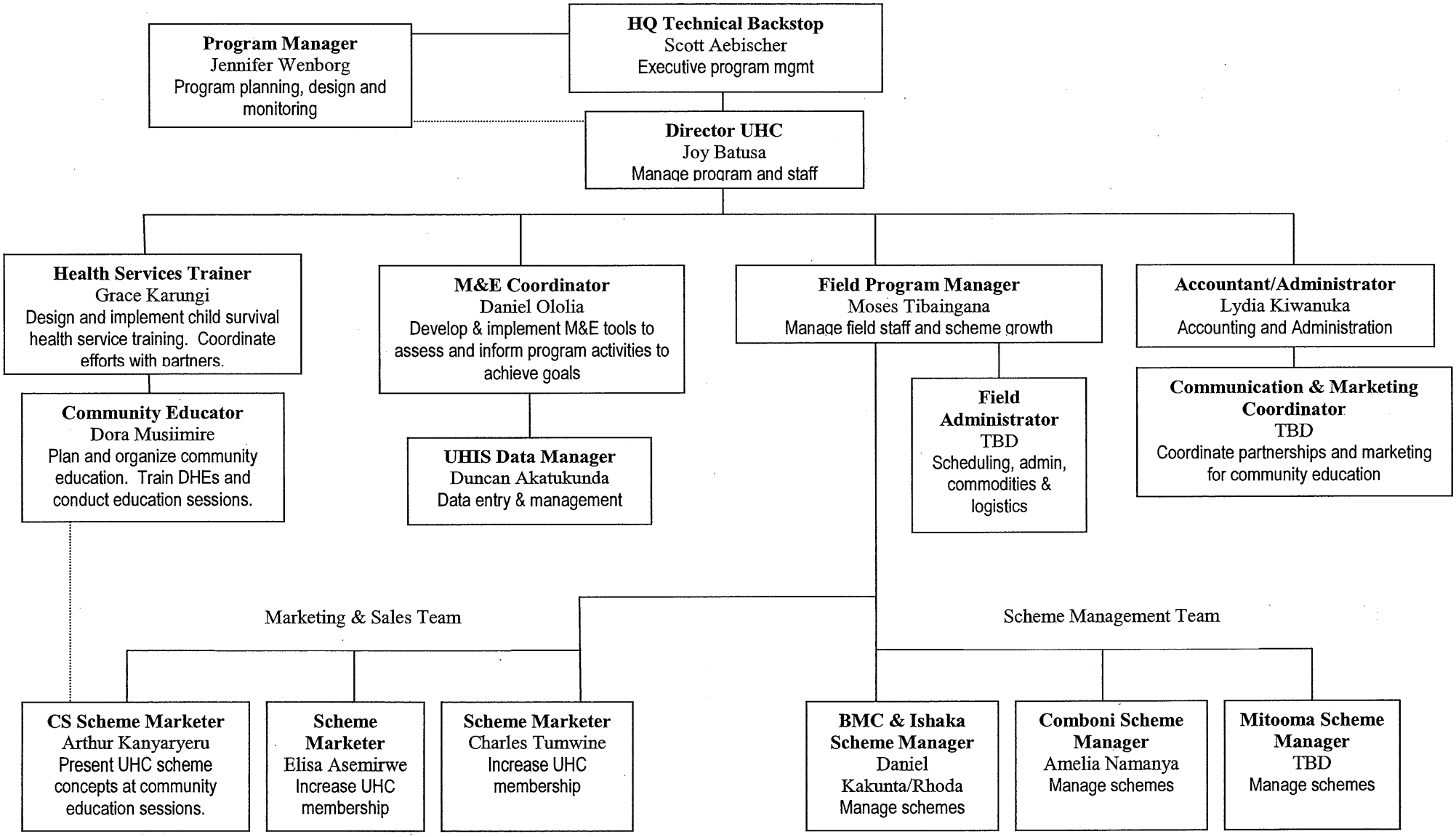

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Management Structure

Name	**Title**	**Location**	**Reports to:**	**Responsibility**	**% Effort**	**Remuneration**
Scott Aebischer	HQ Technical Backstop	MN	USAID	Executive program mgmt	50%	Match contribution
Jennifer Wenborg	HQ Program Manager	MN	HQ Backstop	Program planning, design, monitoring	50% 50%	Child Survival UHC Coop Dev.
Joy Batusa	Field Program Manager / Director	Kampala	HQ Backstop	Manage program and staff	75% 25%	Child Survival UHC Coop Dev.
Lydia Kiwanuka	Accountant/ Administrator	Kampala	Director	Accounting, Administration	50% 50%	Child Survival UHC Coop Dev.
Daniel Ololia	M&E Coordinator	Bushenyi	Director	Develop & implement M&E tools to assess and inform program activities to achieve goals	100%	Child Survival
Grace Karungi	Health Services Trainer	Bushenyi	Director	Design and implement child survival health service training. Coordinate efforts with partners.	100%	Child Survival
Moses Tibaingana	Field Program Manager	Bushenyi	Director	Manage field staff and scheme growth	100%	UHC Coop Dev.

TBD	Communication & Marketing Coordinator	Bushenyi	Accountant/Administrator	Create and coordinate community and stakeholder awareness for all mtgs, events and reports.	100%	Child Survival
Flavia	Field Administrator	Bushenyi	Field Mgr	Scheduling, admin, commodities & logistics	100%	UHC Coop Dev.
TBD	CS Scheme Marketer	Bushenyi	Field Mgr	Present UHC scheme concepts at community education sessions.	100%	Child Survival
Charles Tumwine	Scheme Marketer	Bushenyi	Field Mgr	Increase UHC membership	100%	UHC Coop Dev.
TBD	Scheme Marketer	Bushenyi	Field Mgr	Increase UHC membership	100%	UHC Coop Dev.
Daniel Kakunta & Rhoda	BMC & Ishaka Scheme Manager	Bushenyi	Field Mgr	Manage schemes	100%	Ishaka Hospital
Amelia Namanya	Comboni Scheme Manager	Bushenyi	Field Mgr	Manage schemes	100%	UHC Coop Dev.
TBD	Mitooma Scheme Manager	Bushenyi	Field Mgr	Manage schemes	100%	UHC Coop Dev.
Duncan Akatukunta	UHIS Data Manager	Bushenyi	M&E Coord.	UHIS data management	100%	BMC
TBD	Community Educator	Bushenyi	Health Services Coordinat	Design and implement child survival community education. Coordinate	100%	Child Survival

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			or	efforts with partners.		
Peter Cowley, MD	Business PART Project Director	Kampala	HQ Backstop	Consult on management and partnerships	15%	CMS
David Tiffin	Senior Accountant	MN	HQ PM	Accounting, grant back stop	10% 10%	Child Survival UHC Coop Dev.
Ted Weihe	Cooperative Advisor	VA	HQ PM	Consult on coop practices, development & fundraising	5% 5%	Child Survival UHC Coop Dev

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A Bushenyi District Office has been established in Ishaka/Bushenyi Township near the center of the district. Staffing changes were made from the original proposal as recommended in the application review. Instead of hiring several CEs, partnerships with other NGO and PVOs, existing providers, health educators, and health assistants will be utilized for mobilization and training.

All staff are responsible for turning in monthly reports detailing their activities before meeting with their supervisor. These reports are the basis of monthly meetings to assess individual goals, challenges and activities planned for the next month. When they are hired, staff are given a Corporate Responsibility Scorecard which details expectations for their position for the year. Scorecards are reviewed periodically during the year to help staff succeed and reach their goals. Performance reviews are conducted annually and raises are determined by averaging scores from performance ratings. Reviews are provided by the direct supervisor for each person on staff. All annual reviews are discussed in advance with the Director and the Director's annual reviews are discussed in advance with the HQ Backstop. The HQ backstop provides Director and HQ program manager reviews also based on Corporate Responsible Scorecards for their positions. If staff performance falls below standards two warnings will be given and without improvement termination will follow.

For details on the reporting and feedback structure including a diagram and sample reports see the M&E section of the DIP (pp. 66-74.)

The following management calendar details meetings for the 2005/6 year. These are set ahead of time so that staff can plan ahead. If staff cannot make a set meeting date, at least 1 week of advance notice and rescheduling with direct supervisor is expected. Reports are due at least 2 days before meetings. Exceptions need to be cleared with the direct supervisor.

Management CALENDAR

October 2005
Premiums Due

Su Mo Tu We Th Fr Sa
1
2 3 4 5 6 8
10 13 15
16 17 18 19 20 22
23 24 25 26 27 29
30 31

November 2005

Su Mo Tu We Th Fr Sa
1 2 3 5
6 7 10 12
13 14 15 16 17 19
20 21 22 23 24 26
27 28 29 30

December 2005

Su Mo Tu We Th Fr Sa
1 3
4 5 6 7 8 10
11 12 15 17
18 19 20 21 22 24
25 26 27 28 29 31

January 2006

February 2006

March 2006

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Premiums Due

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8 [redacted] [redacted] [redacted] 12 [redacted] 14
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22 23 24 25 [redacted] [redacted] 28
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26 27 28

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12 13 14 15 16 [redacted] [redacted]
19 20 21 22 23 [redacted] 25
26 27 28 29 30 [redacted]

April 2006
Premiums Due

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23 24 25 26 27 [redacted] 29
30

May 2006

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21 22 23 24 25 [redacted] 27
28 29 30 31

June 2006

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11 12 13 14 15 [redacted] 17
18 19 20 21 22 [redacted] 24
25 26 27 28 29 [redacted]

July 2006 Premiums Due

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23 24 25 26 27 [redacted] 29
30 31

August 2006

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20 21 22 23 24 [redacted] 26
27 28 29 30 31

September 2006

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10 11 12 13 14 [redacted] 16
17 18 19 20 21 [redacted] 23
24 25 26 27 28 [redacted] 30

KEY		[redacted]		[redacted]
Director/Field Mgr Mtg		[redacted]		Field Manager and Scheme Manager Mtg
[redacted]		Annual CS Workshop		Stakeholder Workshop

Staff	Direct Report	Meeting Date	Meeting Report

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[redacted]		[redacted]	[redacted]
Director	Field Manager	2nd Thursday of the month @ 10 AM	Discuss Sustainability & Field Mgmt Report & MTTs
Field Mgr	Scheme Mgrs	2nd Monday of the month@ 9 AM and 10 AM	MTT (FM uses Sustainability & Field Mgmt & MTT to direct goals)
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
Director	ALL STAFF	2nd Friday of the month	Director gives all staff review of progress, goals and way forward. Opportunity for staff to break off and work together as appropriate to reach goals.
ALL STAFF	CS Workshop	March 2007	Workshop agenda and concluding report.
ALL STAFF	ALL STAKEHOLDERS	November 2007	Presentations on program by all staff. Educate stakeholders and relay lessons learned.

6. Organizational Development

HealthPartners principal organizational development needs are in the management of USAID cooperative development programs, meeting accountability and compliance under the FAA Act and consistency with Child Survival policy and mandates. HealthPartners will seek capacity building opportunities for staff, partners and stakeholders through CSTS and CORE CSSA, BCC and other workshops; partnering PVOs and NGOs; consultants; and online tools and resources. HealthPartners will engage its professional staff to participate in the program as appropriate and will share experiences and lessons-learned through online publications, internet and intranet sites, regular updates to the Board of Directors and press releases. HealthPartners' organizational objective under CSHGP is to develop its capacities as a PVO to engage in child survival programs, more effectively in Uganda and potentially other African countries.

UHC carried out a baseline Institutional Strengthening Assessment (ISA) and has incorporated the lessons learned in the DIP. The recommendations, listed below, were particularly astute and helpful.

- The PVO should initiate annual opportunities for health unit field staff from different projects/ countries to meet and interact and share experiences.
- The health unit staff should be offered more opportunities for professional development. In addition staff should access regular refreshment training.
- In order to improve organizational learning, staff should have an opportunity to access lessons learned from other health projects.
- Funding sources for the health unit need to be diversified
- The roles and responsibilities of staff need to be regularly discussed, reviewed and updated.
- The health unit should explore closely collaborating and working with the district and ministry of health.
- UHC should be given support in retention of members and in handling providers in cases of changes in management of providers.
- Employees need training on budget management and other financial management issues.
- There should be a closer relationship between UHC and Child Survival in the field.
- Backstop staff should visit with the field projects time and again to provide technical support in the field and be able to meet together as a team.
- Efforts should be made to increase opportunities for CS and UHC staff to work together and to share lessons learned in a routine and regular manner.
- Monthly meetings need to include sharing up to date budget information to build staff capacity and to garner their feedback as the budget relates to their role in implementation.

ISA's will be distributed prior to each annual staff workshop, results we be discussed at the workshop and changes will be implemented in the program design and workplan.

Africare has already been a helpful partner in UHC capacity building. Staff attended one week of mentorship training February 13-17 where they learned about Africare's Uganda Integrated Community Health model. The mini-BEHAVE training provided to the team by the BCC coordinator was especially helpful. The Africare BCC coordinator also attended Action Planning sessions with staff to aid in this process. UHC will continue to work closely with Africare both on interventions and on capacity building opportunities learning from their experience on management, designing interventions, HST and monitoring and evaluation.

UHC will partner with UPHOLD, the Uganda Program for Human and Holistic development, for capacity building and mentorship opportunities in addition to collaboring on data collection and in utilizing materals they have developed to educate mothers and health workers on child health. UPHOLD is funded by USAID and managed/implemented by JSI and its Partners. They are active in Mbarara near Bushenyi district.

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In preparation for the DIP UHC met with Dr. Olinda Vicent- Senior Project Officer, Health, Nutrition and Water Environment & Sanitation and Jeremy England, Regional Manager, Eastern Uganda, UNICEF. UNICEF does not enter into partnerships with organizations in implementing activities however they have offered to give Advisory support. UHC will also work with UNICEF and MOH in their efforts to establish SCM policy for MNC in Uganda.

UHC will be assisted by Ted Weihe, currently executive director of the Overseas Cooperative Development Council, who is an expert in micro-insurance programs including author of the pioneering documents on the role of insurance in development, micro-insurance methodologies in reaching the rural poor, and experienced having undertaken the evaluations of micro-insurance impacts and the design of micro-insurance programs. He currently serves on the Advisory Committee on Foreign Aid, and completed a case study of UHC and concluded a field evaluation. He will assist in design and execution of incorporating objectives within the existing cooperative structure. Mr. Weihe is scheduled to visit UHC staff, cooperative members, leaders and officials from the board of directors April 20-21, 2006. He will act as a consultant on building the capacity of the UHC Board and steering committees and will also mentor the HQ Program Manager and Field Program Manager on writing grants, developing linkages and fund raising principles.

Dr. Peter Cowley, Business PART Project has advised UHC since its inception including ways to use prepaid health schemes to change social behavior especially in addressing malaria. Before working with Business PART Project, he was Country Director for the Commercial Market Strategies Project in Uganda that promoted the NGO health sector and carried out social marketing of condoms, ITNs, contraceptive and sexually transmitted disease treatment kits. Dr. Cowley has a long career in development assistance health projects including training in the delivery of better health services (DISH Project), senior scientist for Abt Associates for World Bank health sector reviews, consultancies for WHO and PAHO in evaluating health interventions, HIV/AIDS, and prenatal and delivery care. He holds a M.P.H. from Johns Hopkins and a M.D. from Baylor College of Medicine in addition to completing residency at Johns Hopkins.

HealthPartners has traditionally participated in the International Health Summit in Miami, Florida, where the UHC model has been presented to worldwide audiences concerned about health care in developing countries. HealthPartners will share lessons learned from the child survival health grants program at the International Health Summit in 2007. HealthPartners developed a manual on the UHC approach and shares its methodologies widely to PVOs and the development communities through its web site, and participates in several outside evaluations and assessments. Finally, workshops will be held annually in Uganda for all stakeholders including providers, leaders, members, partners, NGOs and PVOs.

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HealthPartners intends to measure and document organizational change through its Monitoring and Evaluation Systems (M&E) including: (1) tracking the involvement and amount of time spent by UHC staff in mentorship training (2) annual implementation of ISA (3) incorporating lessons learned from the ISA and (4) documenting capacity building over the LOP.

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The following training plan will be updated annually with actual training and planned training for the following year.

7. Training Plan

Topic	Training	Location and date	Participants	Measure Results
Grant Writing, Fund Raising and Developing Formal Linkages	Mentorship on USAID grant writing process. 1) USAID expectations 2) How to access resources 3) Developing support network	Telephone and internet interactive process. Travel to Uganda to assess and advise UHC Director. Fall 2004	Ted Weihe, Executive Director, OCDC and HQ PM, Director	Completed CSHGP RFA. At least one additional source of funding by year 3. At least 4 new Uganda linkages.
USAID Office of Acquisition and Assistance, Cost, Audit and Support Division	USAID processes & procedures for financial reporting--timely accurate invoices, SF reporting, and indirect/direct accounting.	HealthPartners Minneapolis, MN August 22-26, 2005	David Tiffin, HW PM, Kevin Brandt, Eleanor Jefferson	CAM audit report approval. Accurate reporting.
CSTS Mini-University	DIP review, mini courses on CSHGP strategies, networking	Baltimore, MD June 5-9	HQ PM, Director, M&E Coordinator	Course completion, DIP approval
Monitoring & Evaluation	M&E Workshop	Africa	UHC Staff	Successful course completion, follow up survey to ensure comprehensive understanding.
Prevention of Post Partum	Access Preventing Postpartum Hemorrhage Conference	Kampala, Uganda April 4-7, 2006	HST, CE, HWs	Successful course completion

Hemorrhage				
Child Survival Sustainability Assessment	Sustainability Planning & Evaluation using CSSA Workshop	Washington, DC TBD	HQ PM, Director	Successful course completion
Behavior Change Strategy	BEHAVE mentorship. Gain better understanding and show proficiency implementing behavioral change	Africare February 2006	All UHC staff	CORE behavioral determinants
KPC TOST Training	This two-week training course is geared toward personnel who will be involved in training of KPC survey teams.	Kampala, Uganda August 8-19, 2005	CORE A/A	Leadership in KPC process Dec-Feb 2005-2006
Qualitative Research Methods Workshop	This training is geared toward PVO program managers and field based personnel that will be involved in conducting qualitative assessments as part of their programs.	Nairobi, Kenya Nov 30-Dec 8, 2005 TBD	CORE Director M&E Coordinator	Successful KPC and M&E Plan approval for DIP June 2006 Successful completion of course
LQAS Methodology	Online course option will be utilized if training is not soon available in or near Uganda	TBD	All UHC staff	Successful course completion
Annual workshops	As needed determined from challenges in semi-annual reports	Kampala, Uganda	UHC Staff and either HQ technical backstop or HQ PM	Survey at the end of the workshop

Annual Stakeholder Workshop	Results and lessons learned.	Kampala, Uganda	UHC Staff, HQ Technical backstop + stakeholders	Survey at the end of workshop
Monthly Community Mobilization	Regular monthly forum for behavior change communication	Monthly, Bushenyi District	Members, Leaders, Non-Members, UHC Staff	Post training questionnaire / feedback
BOD Sustainability Training	Quarterly updates and training at meetings to build board capacity to make informed decisions and to lead the health scheme	Monthly, Bushenyi District	UHC Board of Directors, UHC staff, Consultant	Bi-annual self assessments
Budget and financial management	Consultant training on cooperative financial management and balancing budgets	Bushenyi district, TBD	UHC staff UHC BOD	Improved budget management Improved ability to monitor and manage cooperative budget
Health Services IMCI, SCM training	IMCI and SCM training and follow up. Participatory self assessment training, and BEHAVE	Monthly by Phase, Bushenyi District	Bushenyi District HWs	Self assessments follow up training questionnaires and observation tools, Integrated health facility assessment.
CORE and CSTS Capacity Building	Training for UHC staff as recommended by supervisors and as courses become available	Africa, US	UHC Field and HQ staff	Semi-annual ISA to learn areas for capacity building. Lessons learned will be actively incorporated into training and implementation plans.

8. Work Plan

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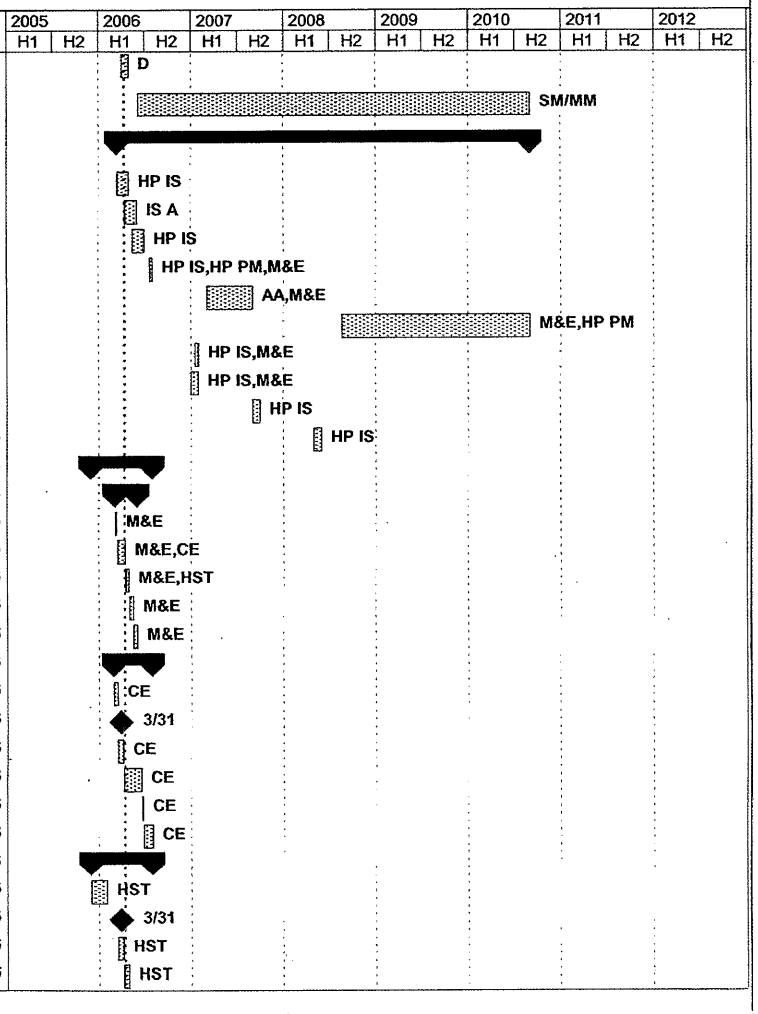
UHC CSHGP Work Plan
2005-2010

ID	Task Name		Start	Finish
1	Change Health Plan Benefit Scheme: Organizational Dimension	Local	Tue 4/4/06	Sun 4/30/06
2	Promote Health Plan Membership: Organizational Dimension	Local	Tue 6/6/06	Wed 9/1/10
3	**UHIS: Organizational Dimension**	**Local**	**Thu 3/16/06**	**Wed 9/1/10**
4	Change Platform		Thu 3/16/06	Sun 4/30/06
5	Develop Specs for updates		Sat 4/15/06	Wed 5/31/06
6	Update and test system		Mon 5/15/06	Fri 6/30/06
7	Installer/trainer to Uganda		Fri 7/21/06	Mon 7/31/06
8	Contract service		Mon 3/5/07	Sat 9/1/07
9	Collect and analyse monthly reports		Thu 8/21/08	Wed 9/1/10
10	Follow up training to close gaps		Tue 1/16/07	Wed 1/31/07
11	Board/committee training on reports		Mon 1/1/07	Tue 1/30/07
12	Follow up		Sat 9/1/07	Sun 9/30/07
13	Follow up		Thu 5/1/08	Sat 5/31/08
14	**Intervention Planning**		**Thu 12/1/05**	**Mon 7/31/06**
15	**Develop M&E tools**		**Mon 3/6/06**	**Wed 5/31/06**
16	Prepare registration forms for Trainings		Mon 3/6/06	Fri 3/10/06
17	Develop questionnaires for HST		Thu 3/16/06	Fri 4/14/06
18	Develop questionnaires for CE		Mon 4/17/06	Fri 4/28/06
19	Develop Health Services self assessment		Mon 5/1/06	Wed 5/17/06
20	Develop Board of Directors self assessment		Thu 5/18/06	Wed 5/31/06
21	**Develop BCC/Community Education**		**Wed 3/1/06**	**Mon 7/31/06**
22	Assemble resources and partners		Wed 3/1/06	Wed 3/15/06
23	Secure signed MOUs		Fri 3/31/06	Fri 3/31/06
24	Order necessary resources		Thu 3/16/06	Fri 4/7/06
25	Develop handouts & presentations		Mon 4/10/06	Fri 6/16/06
26	DDHS mtg to review BCC/CE plans		Mon 6/19/06	Fri 6/23/06
27	Incorporate changes, finalize education		Mon 6/26/06	Mon 7/31/06
28	**Develop Health ServicesTraining**		**Thu 12/1/05**	**Mon 7/31/06**
29	Assemble MOH, IMCI and SCM guidelines		Thu 12/1/05	Tue 1/31/06
30	Secure signed MOUs		Fri 3/31/06	Fri 3/31/06
31	Order necessary resources		Thu 3/16/06	Fri 4/7/06
32	Prepare Stock Order Training		Mon 4/10/06	Fri 4/28/06



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UHC CSHGP Work Plan
2005-2010

ID	Task Name	Start	Finish	2005 H1	2005 H2	2006 H1	2006 H2	2007 H1	2007 H2	2008 H1	2008 H2	2009 H1	2009 H2	2010 H1	2010 H2	2011 H1	2011 H2	2012 H1	2012 H2
33	Develop district wide PMTCT referral plan	Mon 5/1/06	Fri 5/12/06				HST												
34	Develop training handouts and presentations	Mon 5/15/06	Fri 6/30/06				HST												
35	DDHS mtg to review training plans	Mon 7/3/06	Fri 7/7/06				HST												
36	Incorporate changes, finalize education	Mon 7/10/06	Mon 7/31/06				HST												
37	**Health Plan Mobilization**	**Mon 3/20/06**	**Mon 7/31/06**																
38	Hire scheme mobilizer	Mon 3/20/06	Fri 4/7/06				D												
39	Train scheme mobilizer	Mon 4/24/06	Fri 5/12/06				D,FM,SM/MM												
40	Develop mobilization education for each sessi	Mon 5/15/06	Fri 6/30/06				SM,FM,D												
41	Develop handout & follow up materials	Sat 7/1/06	Mon 7/31/06				SM/MM,FM,D												
42	**Phase I: Igara County East and West**	**Tue 8/1/06**	**Wed 2/28/07**																
43	**Community Mobilisation Training: Community and Social Dimension**	**Tue 8/1/06**	**Wed 2/28/07**																
44	**Malaria:**	**Tue 8/1/06**	**Wed 8/30/06**																
45	ITN Distribution & training	Tue 8/1/06	Wed 8/30/06				CE												
46	Malaria Warning Signs	Tue 8/1/06	Wed 8/30/06				CE												
47	Questionnaire/feedback/handout	Tue 8/1/06	Wed 8/30/06				M&E												
48	**Reduce Incidence of Diarrhea**	**Fri 9/1/06**	**Sat 9/30/06**																
49	Diarrhea Warning Signs	Fri 9/1/06	Sat 9/30/06				CE												
50	Diarrhea Home Care	Fri 9/1/06	Sat 9/30/06				CE												
51	Zinc (pending)	Fri 9/1/06	Sat 9/30/06				CE												
52	Questionnaire/feedback/handout	Fri 9/1/06	Sat 9/30/06				M&E												
53	**Maternal Newborn Care**	**Sun 10/1/06**	**Tue 10/31/06**																
54	HomaPak	Sun 10/1/06	Tue 10/31/06				CE												
55	Warning Signs	Sun 10/1/06	Tue 10/31/06				CE												
56	Nutrition	Sun 10/1/06	Tue 10/31/06				CE												
57	Safe Birthing Plans	Sun 10/1/06	Tue 10/31/06				CE												
58	Questionnaire/feedback/handout	Sun 10/1/06	Tue 10/31/06				M&E												
59	**Sanitation**	**Wed 11/1/06**	**Thu 11/30/06**																
60	Access to Clean Water	Wed 11/1/06	Thu 11/30/06				CE												
61	Hand Washing	Wed 11/1/06	Thu 11/30/06				CE												
62	Sanitation	Wed 11/1/06	Thu 11/30/06				CE												
63	Questionnaire/feedback/handout	Wed 11/1/06	Thu 11/30/06				M&E												
64	**HIV/AIDS and STIs**	**Fri 12/1/06**	**Sun 12/31/06**																
65	RCT-HIV/AIDS	Fri 12/1/06	Sun 12/31/06				CE												

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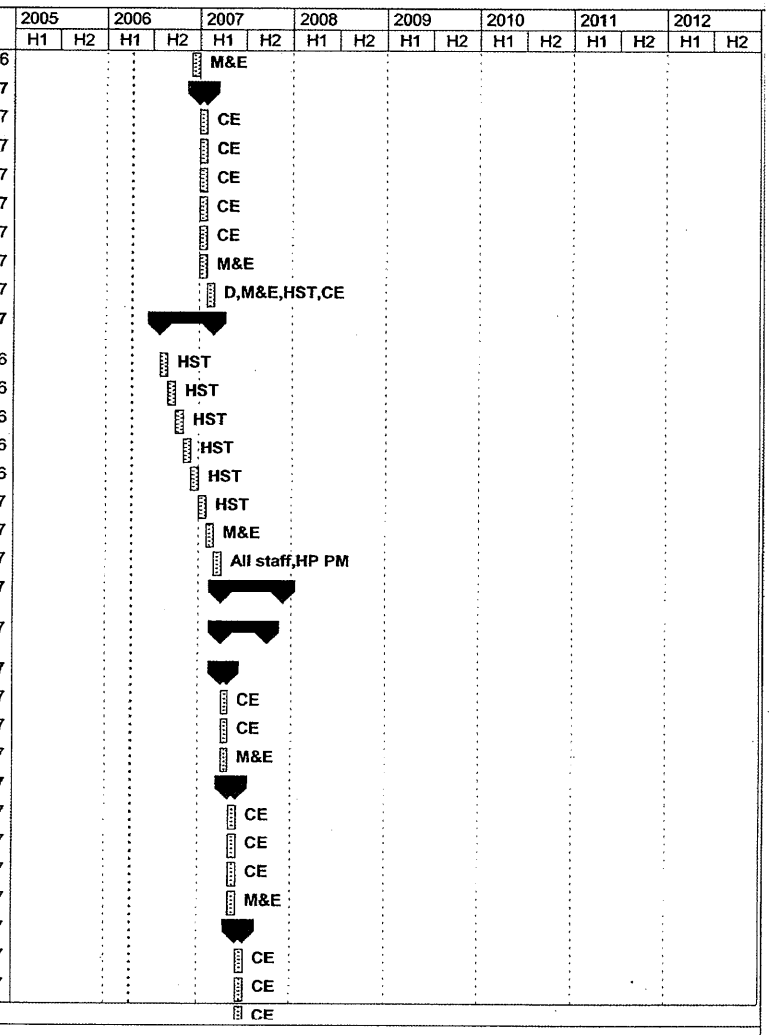
UHC CSHGP Work Plan
2005-2010

ID	Task Name	Start	Finish
66	Questionnaire/feedback/handout	Fri 12/1/06	Sun 12/31/06
67	**Review**	**Mon 1/1/07**	**Tue 1/30/07**
68	Malaria	Mon 1/1/07	Tue 1/30/07
69	Diarrhea	Mon 1/1/07	Tue 1/30/07
70	MNC	Mon 1/1/07	Tue 1/30/07
71	Sanitation	Mon 1/1/07	Tue 1/30/07
72	RCT-HIV/AIDS	Mon 1/1/07	Tue 1/30/07
73	Questionnaire/feedback/handout	Mon 1/1/07	Tue 1/30/07
74	LQAS and update Mobilisation	Thu 2/1/07	Wed 2/28/07
75	**Provider Training: Health Service Dimension**	**Tue 8/1/06**	**Wed 2/28/07**
76	Stock order plans	Tue 8/1/06	Wed 8/30/06
77	SCM Malaria	Fri 9/1/06	Sat 9/30/06
78	SCM Diarrhea	Sun 10/1/06	Tue 10/31/06
79	SCM ANC	Wed 11/1/06	Thu 11/30/06
80	SCM Postnatal & delivery (AMTSL)	Fri 12/1/06	Sun 12/31/06
81	Self Assessment Training (& Review)	Mon 1/1/07	Tue 1/30/07
82	HFA and update provider training	Thu 2/1/07	Wed 2/28/07
83	Annual CS Workshop/ISA/Training	Thu 3/1/07	Sat 3/31/07
84	**Phase II: Ruhinda County**	**Sun 4/1/07**	**Fri 11/30/07**
85	**Community Mobilisation Training: Community Social Dimension**	**Sun 4/1/07**	**Sun 9/30/07**
86	**Malaria:**	**Sun 4/1/07**	**Thu 4/26/07**
87	ITN Distribution & training	Sun 4/1/07	Thu 4/26/07
88	Malaria Warning Signs	Sun 4/1/07	Thu 4/26/07
89	Questionnaire/feedback/handout	Sun 4/1/07	Thu 4/26/07
90	**Reduce Incidence of Diarrhea**	**Tue 5/1/07**	**Thu 5/31/07**
91	Diarrhea Warning Signs	Tue 5/1/07	Thu 5/31/07
92	Diarrhea Home Care	Tue 5/1/07	Thu 5/31/07
93	Zinc (pending)	Tue 5/1/07	Thu 5/31/07
94	Questionnaire/feedback/handout	Tue 5/1/07	Thu 5/31/07
95	**Maternal Newborn Care**	**Fri 6/1/07**	**Sat 6/30/07**
96	HomaPak	Fri 6/1/07	Sat 6/30/07
97	Warning Signs	Fri 6/1/07	Sat 6/30/07



Page 3

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UHC CSHGP Work Plan
2005-2010

ID	Task Name	Start	Finish	2005 H1	2005 H2	2006 H1	2006 H2	2007 H1	2007 H2	2008 H1	2008 H2	2009 H1	2009 H2	2010 H1	2010 H2	2011 H1	2011 H2	2012 H1	2012 H2
99	Safe Birthing Plans	Fri 6/1/07	Sat 6/30/07						CE										
100	Questionnaire/feedback/handout	Fri 6/1/07	Sat 6/30/07						M&E										
101	**Sanitation**	**Sun 7/1/07**	**Tue 7/31/07**																
102	Access to Clean Water	Sun 7/1/07	Tue 7/31/07						CE										
103	Hand Washing	Sun 7/1/07	Tue 7/31/07						CE										
104	Sanitation	Sun 7/1/07	Tue 7/31/07						CE										
105	Questionnaire/feedback/handout	Sun 7/1/07	Tue 7/31/07						M&E										
106	**HIV/AIDS and STIs**	**Wed 8/1/07**	**Thu 8/30/07**																
107	RCT-HIV/AIDS	Wed 8/1/07	Thu 8/30/07						CE										
108	Questionnaire/feedback/handout	Wed 8/1/07	Thu 8/30/07						M&E										
109	**Review**	**Sat 9/1/07**	**Sun 9/30/07**																
110	Malaria	Sat 9/1/07	Sun 9/30/07						CE										
111	Diarrhea	Sat 9/1/07	Sun 9/30/07						CE										
112	MNC	Sat 9/1/07	Sun 9/30/07						CE										
113	Sanitation	Sat 9/1/07	Sun 9/30/07						CE										
114	RCT-HIV/AIDS	Sat 9/1/07	Sun 9/30/07						CE										
115	Questionnaire/feedback/handout	Sat 9/1/07	Sun 9/30/07						M&E										
116	LQAS and update Mobilisation	Mon 10/1/07	Wed 10/31/07						M&E,D,HST,CE										
117	**Provider Training: Health Services Dimension**	**Sun 4/1/07**	**Sun 9/30/07**																
118	Stock order plans	Sun 4/1/07	Thu 4/26/07						HST										
119	SCM Malaria	Tue 5/1/07	Thu 5/31/07						HST										
120	SCM Diarrhea	Fri 6/1/07	Sat 6/30/07						HST										
121	SCM ANC	Sun 7/1/07	Tue 7/31/07						HST										
122	SCM Postnatal & delivery (AMTSL)	Wed 8/1/07	Thu 8/30/07						HST										
123	Self Assessment Training (& Review)	Sat 9/1/07	Sun 9/30/07						HST										
124	HFA and update provider training	Mon 10/1/07	Wed 10/31/07						M&E										
125	Annual Stakeholder Workshop/ISA/Training	Thu 11/1/07	Fri 11/30/07						All staff,HP staff,Stakeholders,Partners										
126	**Phase III: Sheema County South**	**Sat 12/1/07**	**Thu 7/31/08**																
127	**Community Mobilisation Training: Community and Social Dimension**	**Sat 12/1/07**	**Fri 5/30/08**																
128	**Malaria:**	**Sat 12/1/07**	**Mon 12/31/07**																
129	ITN Distribution & training	Sat 12/1/07	Mon 12/31/07						CE										
130	Malaria Warning Signs	Sat 12/1/07	Mon 12/31/07						CE										
									M&E										

Page 4

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UHC CSHGP Work Plan
2005-2010

ID	Task Name	Start	Finish	2005 H1	2005 H2	2006 H1	2006 H2	2007 H1	2007 H2	2008 H1	2008 H2	2009 H1	2009 H2	2010 H1	2010 H2	2011 H1	2011 H2	2012 H1	2012 H2
132	**Reduce Incidence of Diarrhea**	**Tue 1/1/08**	**Wed 1/30/08**																
133	Diarrhea Warning Signs	Tue 1/1/08	Wed 1/30/08							CE									
134	Diarrhea Home Care	Tue 1/1/08	Wed 1/30/08							CE									
135	Zinc (pending)	Tue 1/1/08	Wed 1/30/08							CE									
136	Questionnaire/feedback/handout	Tue 1/1/08	Wed 1/30/08							M&E									
137	**Maternal Newborn Care**	**Fri 2/1/08**	**Fri 2/29/08**																
138	HomaPak	Fri 2/1/08	Fri 2/29/08							CE									
139	Warning Signs	Fri 2/1/08	Fri 2/29/08							CE									
140	Nutrition	Fri 2/1/08	Fri 2/29/08							CE									
141	Safe Birthing Plans	Fri 2/1/08	Fri 2/29/08							CE									
142	Questionnaire/feedback/handout	Fri 2/1/08	Fri 2/29/08							M&E									
143	**Sanitation**	**Sat 3/1/08**	**Mon 3/31/08**																
144	Access to Clean Water	Sat 3/1/08	Mon 3/31/08							CE									
145	Hand Washing	Sat 3/1/08	Mon 3/31/08							CE									
146	Sanitation	Sat 3/1/08	Mon 3/31/08							CE									
147	Questionnaire/feedback/handout	Sat 3/1/08	Mon 3/31/08							M&E									
148	**HIV/AIDS and STIs**	**Tue 4/1/08**	**Wed 4/30/08**																
149	RCT-HIV/AIDS	Tue 4/1/08	Wed 4/30/08							CE									
150	Questionnaire/feedback/handout	Tue 4/1/08	Wed 4/30/08							M&E									
151	**Review**	**Thu 5/1/08**	**Fri 5/30/08**																
152	Malaria	Thu 5/1/08	Fri 5/30/08							CE									
153	Diarrhea	Thu 5/1/08	Fri 5/30/08							CE									
154	MNC	Thu 5/1/08	Fri 5/30/08							CE									
155	Sanitation	Thu 5/1/08	Fri 5/30/08							CE									
156	RCT-HIV/AIDS	Thu 5/1/08	Fri 5/30/08							CE									
157	Questionnaire/feedback/handout	Thu 5/1/08	Fri 5/30/08							M&E									
158	Midterm Evaluation	Sun 6/1/08	Mon 6/30/08							All staff,Stakeholders,Partners									
159	**Provider Training: Health Services Dimension**	**Sat 12/1/07**	**Fri 5/30/08**																
160	Stock order plans	Sat 12/1/07	Mon 12/31/07							HST									
161	SCM Malaria	Tue 1/1/08	Thu 1/31/08							HST									
162	SCM Diarrhea	Fri 2/1/08	Fri 2/29/08							HST									
163	SCM ANC	Sat 3/1/08	Mon 3/31/08							HST									
164	SCM Postnatal & delivery (AMTSL)	Tue 4/1/08	Wed 4/30/08							HST									

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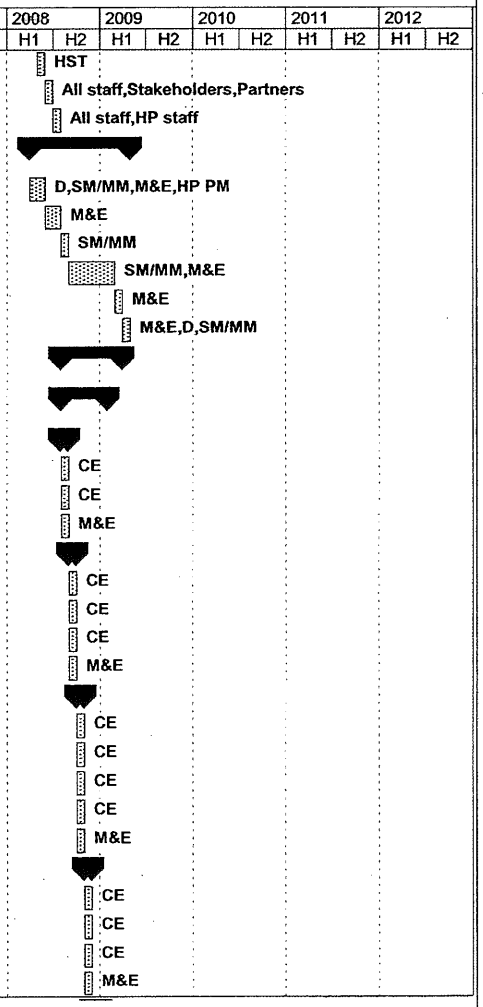
UHC CSHGP Work Plan
2005-2010

ID	Task Name	Start	Finish
165	Self Assessment Training (& Review)	Thu 5/1/08	Fri 5/30/08
166	Midterm Evaluation	Sun 6/1/08	Mon 6/30/08
167	Complete Eval/Annual CS Workshop	Tue 7/1/08	Thu 7/31/08
168	**Subsidized Health Plan: Local Organizational Dimension, Activity 2**	**Tue 4/1/08**	**Thu 4/30/09**
169	Review Phase 1-3 Assessments	Tue 4/1/08	Sat 5/31/08
170	Financial assessment to determine target	Sun 6/1/08	Thu 7/31/08
171	Mobilize subsidy beneficiaries	Fri 8/1/08	Sun 8/31/08
172	Implement subsidy structure for Phase 1-III	Mon 9/1/08	Sat 2/28/09
173	Assess subsidy	Sun 3/1/09	Tue 3/31/09
174	Revise system and adjust/expand	Wed 4/1/09	Thu 4/30/09
175	**Phase IV: Sheema County North**	**Fri 8/1/08**	**Tue 3/31/09**
176	**Community Mobilisation Training: Community Social Dimension**	**Fri 8/1/08**	**Sat 1/31/09**
177	**Malaria:**	**Fri 8/1/08**	**Sun 8/31/08**
178	ITN Distribution & training	Fri 8/1/08	Sun 8/31/08
179	Malaria Warning Signs	Fri 8/1/08	Sun 8/31/08
180	Questionnaire/feedback/handout	Fri 8/1/08	Sun 8/31/08
181	**Reduce Incidence of Diarrhea**	**Mon 9/1/08**	**Tue 9/30/08**
182	Diarrhea Warning Signs	Mon 9/1/08	Tue 9/30/08
183	Diarrhea Home Care	Mon 9/1/08	Tue 9/30/08
184	Zinc (pending)	Mon 9/1/08	Tue 9/30/08
185	Questionnaire/feedback/handout	Mon 9/1/08	Tue 9/30/08
186	**Maternal Newborn Care**	**Wed 10/1/08**	**Fri 10/31/08**
187	HomaPak	Wed 10/1/08	Fri 10/31/08
188	Warning Signs	Wed 10/1/08	Fri 10/31/08
189	Nutrition	Wed 10/1/08	Fri 10/31/08
190	Safe Birthing Plans	Wed 10/1/08	Fri 10/31/08
191	Questionnaire/feedback/handout	Wed 10/1/08	Fri 10/31/08
192	**Sanitation**	**Sat 11/1/08**	**Sun 11/30/08**
193	Access to Clean Water	Sat 11/1/08	Sun 11/30/08
194	Hand Washing	Sat 11/1/08	Sun 11/30/08
195	Sanitation	Sat 11/1/08	Sun 11/30/08
196	Questionnaire/feedback/handout	Sat 11/1/08	Sun 11/30/08



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2005-2010

ID	Task Name	Start	Finish	2005 H1	2005 H2	2006 H1	2006 H2	2007 H1	2007 H2	2008 H1	2008 H2	2009 H1	2009 H2	2010 H1	2010 H2	2011 H1	2011 H2	2012 H1	2012 H2
198	RCT-HIV/AIDS	Mon 12/1/08	Wed 12/31/08									CE							
199	Questionnaire/feedback/handout	Mon 12/1/08	Wed 12/31/08									M&E							
200	**Review**	**Thu 1/1/09**	**Sat 1/31/09**																
201	Diarrhea	Thu 1/1/09	Sat 1/31/09									CE							
202	Malaria	Thu 1/1/09	Sat 1/31/09									CE							
203	MNC	Thu 1/1/09	Sat 1/31/09									CE							
204	Sanitation	Thu 1/1/09	Sat 1/31/09									CE							
205	RCT-HIV/AIDS	Thu 1/1/09	Sat 1/31/09									CE							
206	Questionnaire/feedback/handout	Thu 1/1/09	Sat 1/31/09									M&E							
207	LQAS and update Mobilisation	Sun 2/1/09	Sat 2/28/09									BCC,M&E,D,PP							
208	**Provider Training: Health Services Dimension**	**Fri 8/1/08**	**Sat 1/31/09**																
209	Stock order plans	Fri 8/1/08	Sun 8/31/08								HST								
210	SCM Malaria	Mon 9/1/08	Tue 9/30/08								HST								
211	SCM Diarrhea	Wed 10/1/08	Fri 10/31/08								HST								
212	SCM ANC	Sat 11/1/08	Sun 11/30/08								HST								
213	SCM Postnatal & delivery (AMTSL)	Mon 12/1/08	Wed 12/31/08								HST								
214	Self Assessment Training (& Review)	Thu 1/1/09	Sat 1/31/09								HST								
215	HFA and update provider training	Sun 2/1/09	Sat 2/28/09								M&E								
216	Annual Stakeholder Workshop/ISA	Sun 3/1/09	Tue 3/31/09								All staff,HP staff,Stakeholders,Partners								
217	**Phase V: Buhweju County**	**Wed 4/1/09**	**Thu 9/30/10**																
218	**Community Mobilisation Training: Community Social Dimension**	**Wed 4/1/09**	**Wed 9/30/09**																
219	**Malaria:**	**Wed 4/1/09**	**Thu 4/30/09**																
220	ITN Distribution & training	Wed 4/1/09	Thu 4/30/09									CE							
221	Malaria Warning Signs	Wed 4/1/09	Thu 4/30/09									CE							
222	Questionnaire/feedback/handout	Wed 4/1/09	Thu 4/30/09									M&E							
223	**Reduce Incidence of Diarrhea**	**Fri 5/1/09**	**Sun 5/31/09**																
224	Diarrhea Warning Signs	Fri 5/1/09	Sun 5/31/09									CE							
225	Diarrhea Home Care	Fri 5/1/09	Sun 5/31/09									CE							
226	Zinc (pending)	Fri 5/1/09	Sun 5/31/09									CE							
227	Questionnaire/feedback/handout	Fri 5/1/09	Sun 5/31/09									M&E							
228	**Maternal Newborn Care**	**Mon 6/1/09**	**Tue 6/30/09**																
229	Warning Signs	Mon 6/1/09	Tue 6/30/09									CE							

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ID	Task Name	Start	Finish	2005 H1	2005 H2	2006 H1	2006 H2	2007 H1	2007 H2	2008 H1	2008 H2	2009 H1	2009 H2	2010 H1	2010 H2	2011 H1	2011 H2	2012 H1	2012 H2
231	Nutrition	Mon 6/1/09	Tue 6/30/09										CE						
232	Safe Birthing Plans	Mon 6/1/09	Tue 6/30/09										CE						
233	Questionnaire/feedback/handout	Mon 6/1/09	Tue 6/30/09										M&E						
234	**Sanitation**	**Wed 7/1/09**	**Fri 7/31/09**																
235	Access to Clean Water	Wed 7/1/09	Fri 7/31/09										CE						
236	Hand Washing	Wed 7/1/09	Fri 7/31/09										CE						
237	Sanitation	Wed 7/1/09	Fri 7/31/09										CE						
238	Questionnaire/feedback/handout	Wed 7/1/09	Fri 7/31/09										M&E						
239	**HIV/AIDS and STIs**	**Sat 8/1/09**	**Mon 8/31/09**																
240	RCT-HIV/AIDS	Sat 8/1/09	Mon 8/31/09										CE						
241	Questionnaire/feedback/handout	Sat 8/1/09	Mon 8/31/09										M&E						
242	**Review**	**Tue 9/1/09**	**Wed 9/30/09**																
243	Malaria	Tue 9/1/09	Wed 9/30/09										CE						
244	Diarrhea	Tue 9/1/09	Wed 9/30/09										CE						
245	MNC	Tue 9/1/09	Wed 9/30/09										CE						
246	Sanitation	Tue 9/1/09	Wed 9/30/09										CE						
247	RCT-HIV/AIDS	Tue 9/1/09	Wed 9/30/09										CE						
248	Questionnaire/feedback/handout	Tue 9/1/09	Wed 9/30/09										M&E						
249	LQAS and update Mobilisation	Thu 10/1/09	Sat 10/31/09										BCC,M&E,D,PP						
250	**Provider Training: Health and Service Dimension**	**Wed 4/1/09**	**Wed 9/30/09**																
251	Stock order plans	Wed 4/1/09	Thu 4/30/09										HST						
252	SCM Malaria	Fri 5/1/09	Sun 5/31/09										HST						
253	SCM Diarrhea	Mon 6/1/09	Tue 6/30/09										HST						
254	SCM Antenatal care	Wed 7/1/09	Fri 7/31/09										HST						
255	SCM Postnatal & delivery (AMTSL)	Sat 8/1/09	Mon 8/31/09										HST						
256	Self Assessment Training (& Review)	Tue 9/1/09	Wed 9/30/09										HST						
257	HFA and update provider training	Thu 10/1/09	Sat 10/31/09										M&E						
258	Annual CS Workshop/ISA/Training	Sun 11/1/09	Mon 11/30/09										All staff,HP staff						
259	**Phase VI: Bunyaruguru County**	**Tue 12/1/09**	**Thu 9/30/10**																
260	**Community Mobilisation Training: Community Social Dimension**	**Tue 12/1/09**	**Mon 5/31/10**																
261	**Malaria:**	**Tue 12/1/09**	**Thu 12/31/09**																
262	ITN Distribution & training	Tue 12/1/09	Thu 12/31/09										CE						

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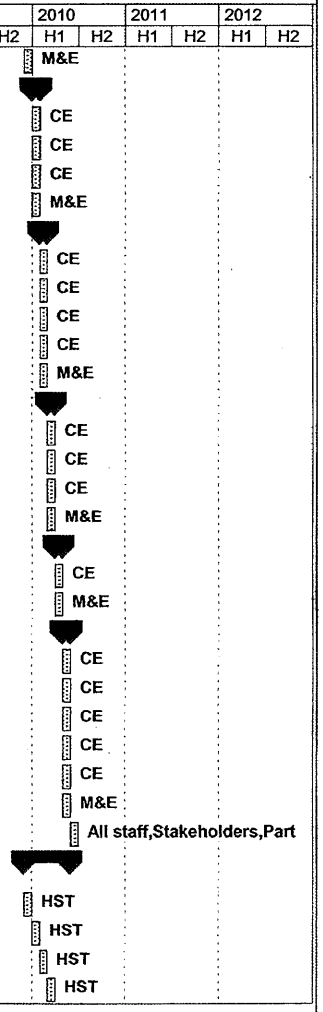
2005-2010

ID	Task Name	Start	Finish
264	Questionnaire/feedback/handout	Tue 12/1/09	Thu 12/31/09
265	**Reduce Incidence of Diarrhea**	**Fri 1/1/10**	**Sun 1/31/10**
266	Diarrhea Warning Signs	Fri 1/1/10	Sun 1/31/10
267	Diarrhea Home Care	Fri 1/1/10	Sun 1/31/10
268	Zinc (pending)	Fri 1/1/10	Sun 1/31/10
269	Questionnaire/feedback/handout	Fri 1/1/10	Sun 1/31/10
270	**Maternal Newborn Care**	**Mon 2/1/10**	**Sun 2/28/10**
271	HomaPak	Mon 2/1/10	Sun 2/28/10
272	Warning Signs	Mon 2/1/10	Sun 2/28/10
273	Nutrition	Mon 2/1/10	Sun 2/28/10
274	Safe Birthing Plans	Mon 2/1/10	Sun 2/28/10
275	Questionnaire/feedback/handout	Mon 2/1/10	Sun 2/28/10
276	**Sanitation**	**Mon 3/1/10**	**Wed 3/31/10**
277	Access to Clean Water	Mon 3/1/10	Wed 3/31/10
278	Hand Washing	Mon 3/1/10	Wed 3/31/10
279	Sanitation	Mon 3/1/10	Wed 3/31/10
280	Questionnaire/feedback/handout	Mon 3/1/10	Wed 3/31/10
281	**HIV/AIDS and STIs**	**Thu 4/1/10**	**Fri 4/30/10**
282	RCT-HIV/AIDS	Thu 4/1/10	Fri 4/30/10
283	Questionnaire/feedback/handout	Thu 4/1/10	Fri 4/30/10
284	**Review**	**Sat 5/1/10**	**Mon 5/31/10**
285	Malaria	Sat 5/1/10	Mon 5/31/10
286	Diarrhea	Sat 5/1/10	Mon 5/31/10
287	MNC	Sat 5/1/10	Mon 5/31/10
288	Sanitation	Sat 5/1/10	Mon 5/31/10
289	RCT-HIV/AIDS	Sat 5/1/10	Mon 5/31/10
290	Questionnaire/feedback/handout	Sat 5/1/10	Mon 5/31/10
291	Final Assessment	Tue 6/1/10	Wed 6/30/10
292	**Provider Training: Health and Service Dimension**	**Tue 12/1/09**	**Mon 5/31/10**
293	Stock order plans	Tue 12/1/09	Thu 12/31/09
294	SCM Malaria	Fri 1/1/10	Sun 1/31/10
295	SCM Diarrhea	Mon 2/1/10	Sun 2/28/10
296	SCM ANC	Mon 3/1/10	Wed 3/31/10



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UHC CSHGP Work Plan
2005-2010

ID	Task Name	Start	Finish	2005		2006		2007		2008		2009		2010		2011		2012	
				H1	H2	H1	H2	H1	H2	H1	H2	H1	H2	H1	H2	H1	H2	H1	H2
297	SCM Postnatal & delivery (AMTSL)	Thu 4/1/10	Fri 4/30/10											HST					
298	Self Assessment Training (& Review)	Sat 5/1/10	Mon 5/31/10											HST					
299	Final Assessment	Tue 6/1/10	Sat 7/31/10											All staff,Stakeholders,Part					
300	Coordinate Transition Plans for program	Sun 8/1/10	Tue 8/31/10											D,M&E,CE,HST					
301	Final Stakeholder Workshp	Wed 9/1/10	Thu 9/30/10											All staff,Stakeholders,P					

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Annex 1: Response to DIP Review

Changes to HealthPartners Uganda Health Cooperative
Detailed Implementation Plan
Per USAID, CSTS and Peer Reviews

I. The following Rapid Catch indicators were analyzed to include only those who did both or all of the activities listed.

1. % of sick children age 0-23 months that received increased fluids and continued feeding during an illness in the past two weeks. Baseline: 6/64 or 7.8%
2. % of mother of children 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation and after attending to a child who has defecated. Baseline: 2/69 or 2.1%

II. The following indicators were reworded and the baseline results were hand tabulated.

1. Objective 1, IR 3: *Changed from* "% of pregnant women receiving IPT", *to* "% of pregnant women receiving IPT as verified by maternal card."
2. *Added* Objective 2, IR 2: (which was not included in the April 14 DIP but which was originally included in the report) "% of households who use improved water source (borehole, public tap, or protected dug well.)"
3. Objective 2, IR 3: *Changed from* "% of households with a designated hand washing facility", *to* "% of households with a designated hand washing station with a covered container for water."
4. Objective 2, IR 4: *Changed from* "% of child feces disposed of hygienically", *to* "% of households who safely disposed of their child's feces the last time s/he passed stool."
5. Objective 3, IR 1: *Changed from* "% of women w 4 ANC visits", *to* "% of women w 4 ANC visits as verified by maternal card."
6. Objective 3, IR 4: *Changed from* "% of women who delivered with a doctor, midwife or TBA", *to* "% of women who delivered with a skilled health professional as verified by a maternal card."
7. Objective 3, IR 4: *Removed* "% of pg women with access to clean razor to cut the cord."
8. Objective 5, IR 6: *added indicator*: "% of self assessments that show higher ratings in the past year."

III. Additional detail explaining postpartum and newborn care interventions is included in the Maternal/Newborn Care section that begins on page 56.

IV. Added detail on the role of TBAs (page 58.)

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V. **Follow up plans for education and training are included in more detail on page 37.**

VI. **Detail was also added to how LQAS and HFA monitoring results will be disseminated and discussed with DHEs and HWs at the end of each phase in addition to being addressed at stakeholder meetings.** These additions can be found on pages 69-70.

VII. **Operations research was not accurately defined in the DIP.** Changes were made to include the following description of plans for OR: UHC will explore the design and implementation of subsidized prepaid health schemes to cover basic health services, antenatal, delivery and postnatal care for the most vulnerable populations of women and children in Bushenyi District. The results will be closely monitored and compared with non-subsidized prepaid health plans in other communities. UHC will explore how alternative financing for women and children will be received by the community and whether or not it may be successfully incorporated into the current health scheme structure, adopted by the Ministry of Health or supported by other organizations. OR training will be sought for headquarter and UHC field staff prior to the initiation of these activities.

VIII. **A table defining key partners/trainers in each dimension was added on page 49.** These roles are also clarified in more detail in the narrative on page 35.

IX. **Additional explanation of how the CSSA framework will be utilized in the program was added on pages 38-40.** Frequency of monitoring was added to activities the CSSA chart.

X. **Community mobilization scheduling was changed so that the topic of sanitation and hygiene follows diarrhea and is before MNC.** This change was made in the work plan and throughout the document.

XI. **The subset of indicators and the LQAS monitoring tool are included below.**

Objective/ Result	Indicators	* LQAS Question #	Baseline Value	Phase I	EOP target
Objective 1: Reduce incidence of Malaria in Bushenyi district for children under 2 and pregnant women	% of children under 2 with fever in the last two weeks	10 (1)/total	44%		19%
IR 1: Increase ITN use	% of children under 2 who slept under a properly hung ITN last night	14(1) **and** 15 (1) **and** 16(1)/total	32%		55%

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IR 2: Increase timely malaria treatment	% of children under 2 w fever in the last 2 wks who received antimalarial treatment within 24 hours of onset.	13(1)/10(1)	71%		84%
IR 3: Increase IPT	% of women who received 2 doses of IPT during their last pregnancy as verified by their maternal card.	39(2)/total	80%		90%
Objective 2: Reduce incidence of Diarrhea in Bushenyi district for children under 5	% of children under 2 with diarrhea in the last two weeks.	17 (1)/total	55%		20%
IR 2: Improve safe water access & use	% of households who use improved water source (borehole, public tap, or protected dug well.)	22(1, 2, or 3)/total	50%		60%
IR 3: Increase safe water practices and hand washing	% of households with a designated hand washing station with a covered container for water.	27(1)/total	24%		46%
	% of caretakers who washed hands with soap/ash before preparing their last meal, before the last time they fed their child, after their last defecation, after the last time they attended to a child who has defecated	28 (2, 3, 4, **and** 5)/total	2%		%
IR 4: Improve sanitation practices	% of households who safely disposed of their child's feces the last time s/he passed stool	25(1)/total	68%		82%
	% of households with access to a covered pit latrine (flush toilet or VIP pit latrine)	26(1 **or** 2 **or** 3)/total	19%		36%
IR 5: Increase intervention for severe diarrhea & dehydration	% of children 0-23 mos with diarrhea in the last two weeks who received properly prepared ORS	18(2) **and** 21(1)/17(1)	0 %		30%
	% of children aged 0-23 mos who were offered more fluids and food during the illness? …	19(3) **and** 20(2 or 3) /17(1)	2%		20%
IR 1: Increased demand for ANC	% of women w 4 ANC visits as verified by Maternal card.	38(4)/total	65%		85%

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IR 2: Increased demand for RCT	% of women who received HIV counseling services during their last pregnancy	34(1)/total	34%		44%
IR 3: Improve mother's knowledge of delivery preparations, breastfeeding, child spacing and danger signs of pregnancy?	% caretaker of 0-23 mos old children had knowledge of breastfeeding, child spacing and danger signs of pregnancy?	32(four 1's)/total	38% 95% 76%		55% 99% 90%
IR 4: Increased access to safer birthing	% of women who delivered with a skilled birth attendant?	29(1 **or** 2 **or** 3)/total	58%		74%
	% of population who are UHC plan members	7(yes)/total	2%		
Health Plan Membership	% of mothers who know at least two signs of childhood illness that indicate the need for treatment	9(any two of answers B-H)/total	76%		
Rapid Catch—Childhood illness	% of mothers of children 0-23 months old who cite at lest 2 known ways of reducing the risk of HIV infection	36(any two of 2-11 and 15)/total	64%		

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LQAS Monitoring Tool

INFORMED CONSENT

Hello. My name is _____, and I am working with (NAME OF ORGANIZATION). We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of **your youngest child under the age of two.** This information will help HealthPartners to plan health services and assess whether it is meeting its goals to improve children's health. The survey usually takes 15 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey?

Signature of interviewer: _____
Date: _____

RESPONDENT AGREES TO BE INTERVIEWED 1
RESPONDENT DOES NOT AGREE TO BE INTERVIEWED . . . . . 2 END

Cluster Number.....
Household Number.....
Record Number.....

1. RECORD INTERVIEW DATE

Day		Month		Year	

2. How old are you?
RECORD AGE OF RESPONDENT IN YEARS: _____

3. How many children living in this household are under 24 months? _____

4. READ ONE OF THE FOLLOWING QUESTIONS BASED UPON MOTHER'S RESPONSE TO Q.3:

ONLY 1 CHILD UNDER FIVE: "What is the name, sex, and date of birth of that child?"

MORE THAN 1 CHILD UNDER FIVE: "What are the names, sexes, and dates of birth of your children?"

	NAME	SEX	DATE OF BIRTH
5		1. MALE 2. FEMALE	__ __/__ __/__ __ DD MM YY
6		1. MALE 2. FEMALE	__ __/__ __/__ __ DD MM YY

7. Are you member of the Uganda Health Cooperative?
IF NO, SKIP TO Q.9,

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8. IF YES, how long have you been a member? ____ years ___months

THE FOLLOWING QUESTIONS PERTAIN ONLY TO THE YOUNGEST CHILD UNDER THE AGE OF 2

Integrated Management of Childhood Illnesses (IMCI)

9. Sometimes children get sick and need to receive care or treatment for illnesses. What are the signs of illness that would indicate your child needs treatment? *DO NOT PROMPT. CIRCLE ALL MENTIONED.*

A. DON'T KNOW
B. LOOKS UNWELL OR NOT PLAYING NORMALLY
C. NOT EATING OR DRINKING
D. LETHARGIC OR DIFFICULT TO WAKE
E. HIGH FEVER
F. FAST OR DIFFICULT BREATHING
G. VOMITS EVERYTHING
H. CONVULSIONS
I. OTHER _____
(SPECIFY)

J. OTHER _____
(SPECIFY)

K. OTHER _____
(SPECIFY)

Malaria Prevention

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
10	Did (NAME) experience a fever in the past two weeks?	YES . . . . . 1 NO 2	14
11	Did you seek advice or treatment for (NAME'S) fever?	YES . . . . . 1 NO 2	14
12	Where did you first go for advice or treatment? IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE (NAME OF PLACE)	HOSPITAL . . . . . 1 HEALTH CENTER . . . . . 2 FIELD/COMMUNITY HEALTHWORKER. . . . 3 OTHER HEALTH FACILITY_____4 (SPECIFY) OTHER SOURCE TRADITIONAL PRACTITIONER. . . . . 5 PHARMACY . . . . . 6 COMMUNITY DISTRIBUTORS . . . . . 7 FRIEND/RELATIVE . . . . . 8 OTHER_____88 (SPECIFY)	
13	How long after you noticed (NAME'S) fever did you seek treatment from that person/place?	WITHIN 24 HOURS . . . . . 1 BETWEEN 24-48 HOURS . . . . . 2 AFTER 48 HOURS 3	
14	Do you have any insecticide treated bednets in your house?	YES . . . . . 1 NO 2	17

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15	Who slept under an insecticide treated bednet last night? RECORD ALL MENTIONED.	CHILD (NAME). . . . . 1 HUSBAND/PARTNER . . . . . 2 MYSELF . . . . . 3 OTHER CHILDREN OR PEOPLE _____ 88 (SPECIFY)	
16	ASK TO SEE ITN. IS IT HUNG PROPERLY OVER A SLEEPING AREA SO AS TO PROVIDE EFFECTIVE PROTECTION?	YES . . . . . 1 NO 2	

Now we would like to talk about Diarrhea...

Diarrhea, sanitation and hygiene

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
17	Did (NAME) experience diarrhea in the past two weeks?	YES.....1 NO.....2	**22**
18	What was given to treat the diarrhea? Anything else? RECORD ALL MENTIONED	NOTHING ..... 1 FLUID FROM ORS PACKET. . . . . 2 HOME-MADE FLUID. . . . .3 PILL OR SYRUP . . . .4 INJECTION.....5 (IV) INTRAVENOUS.....6 HOME REMEDIES/HERBAL MEDICINES.....7 OTHER _____ 88 (SPECIFY)	
19	"When (NAME) was sick, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?"	LESS .....1 SAME.....2 MORE..... 3	
20	When (NAME) was sick, was he/she offered less than usual to eat, about the same amount, or more than usual to eat?	LESS .....1 SAME.....2 MORE..... 3	
21	Have you heard of ORS? IF YES, ASK CARETAKER TO DESCRIBE ORS PREPARATION FOR YOU. IF NO, CIRCLE 3 (NEVER HEAD OF ORS.) ONCE CARETAKER HAS PROVIDED DESCRIPTION, CIRCLE 1 IF THE CARETAKER MENTIONED THE FOLLOWING: • USE 1 LITER OF CLEAN DRINKING WATER (1	DESCRIBED CORRECTLY.....1 DESCRIBED INCORRECTLY.....2 NEVER HEARD OF ORS.....3	

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	LITER=3 SODA BOTTLES) • USE THE ENTIRE PACKET • DISSOLVE THE POWDER COMPLETELY IF ALL STEPS WERE NOT MENTIONED, CIRCLE 2.		
22	What is the main source of drinking water for members in this household?	Borehole.....1 Public tap.....2 Protected dug well.....3 Unprotected dug well.....4 Rain water collection.....5 Surface water (river/pond/lake/dam/stream)....6 Other_____88 (specify)	
23	Do you treat your water in any way to make it safe to drink?	YES.....1 NO.....2	
24	How is the water treated	PUR.....1 Waterguard.....2 Boiling.....3 Other_____7 SPECIFY	
25	The last time (name) passed stool, where were the feces disposed? (IF "WASHED AWAY", PROBE WHERE THE WASTE WATER WAS DISPOSED. IF "DISPOSED" PROBE WHERE IT WAS DISPOSED SPECIFICALLY.	Dropped into toiled facility.....1 Disposed Into solid waste/ trash.....2 Somewhere in Yard.....3 Outside premises.....4 Buried.....5 Did nothing.....6 Other_____ (Specify)	
26	What kind of toilet facility does this household use? ASK TO SEE FOR VERIFICATION.	Flush toilet.....1 Ventilated Improved Pit latrine.....2 Covered pit latrine.....3 Simple pit latrine without slab.....4 Bucket latrine.....5 No facility OR NOT VERIFIED 88	
27	ASK TO SEE WHERE THEY WASH HANDS. IS THERE A DESIGNATED HAND WASHING STATION WITH COVERED CONTAINER FOR WATER THAT CAN BE REACHED IN LESS THAN A MINUTE?	YES.....1 NO.....2	
28	When do you usually wash your hands with soap/ash? RECORD ALL MENTIONED	NEVER.....1 BEFORE FOOD PREPARATION.....2 BEFORE FEEDING CHILDREN.....3 AFTER DEFECTION.....4 AFTER ATTENDING TO A CHILD WHO HAS DEFECTATED.....5 OTHER_____88	

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		(Specify)	

We would now like to talk about maternal and newborn care.

Maternal and Newborn Care

29. I would like to ask you about the time when you gave birth to (NAME). Who assisted you with (NAME'S) delivery?
    1. DOCTOR
    2. NURSE/MIDWIFE IN HEALTH FACILITY
    3. OTHER MIDWIFE
    4. TRADITIONAL BIRTH ATTENDANT _____ (NAME)
    5. COMMUNITY HEALTH WORKER
    6. FAMILY MEMBER _____ (SPECIFY RELATIONSHIP TO RESPONDENT)
    88. OTHER _____ (SPECIFY)
    99. NO ONE

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
30	Did you see anyone for prenatal care while you were pregnant with (NAME)?	YES.....1 NO.....2	 **32**
31	IF YES: Whom did you see?	HEALTH PROFESSIONAL DOCTOR ... 1 NURSE/MIDWIFE ..... 2 NO ONE 99	
	Anyone else? PROBE FOR THE TYPE OF PERSON AND RECORD ALL PERSONS MENTIONED BY THE MOTHER.	OTHER PERSON TRADITIONAL BIRTH ATTENDANT....3 COMMUNITY HEALTH WORKER ..... 4 OTHER _____ 88 (SPECIFY)	
32	During your pregnancy were you counseled on the following: Delivery preparations? Breastfeeding? Child spacing? Danger signs of pregnancy?	YES NO 1 2 1 2 1 2 1 2	
33	For your last pregnancy did you have a plan for **all three** of the following before you went into labor: 1. Where to deliver 2. transport to place of delivery 3. Having a birth kit	YES.....1 NO.....2	
34	For your last pregnancy were you given counseling on HIV/AIDS?	YES.....1 NO.....2	
35	During your last pregnancy, did you voluntarily test for HIV?	YES.....1 NO.....2	
36	What can a person do to avoid getting AIDS or the virus that causes AIDS? *CIRCLE ALL MENTIONED.*	1. NOTHING 2. ABSTAIN FROM SEX 3. USE CONDOMS	**Are these the answers that would**

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		4. LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PARTNER 5. LIMIT NUMBER OF SEXUAL PARTNERS 6. AVOID SEX WITH PROSTITUTES 7. AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS 8. AVOID INTERCOURSE WITH PERSONS OF THE SAME SEX 9. AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY 10. AVOID BLOOD TRANSFUSIONS 11. AVOID SHARING RAZORS, BLADES 12. AVOID INJECTIONS 13. AVOID KISSING 14. AVOID MOSQUITO BITES 15. SEEK PROTECTION FROM TRADITIONAL HEALER 88. OTHER_____ (SPECIFY) 88. OTHER_____ (SPECIFY)	**be considered correct?**
37	Do you have a maternal health card for your pregnancy with (NAME)?	YES, SEEN . . . . . 1 NOT AVAILABLE . . . . . 2 NEVER HAD A CARD 3	**END**
38	LOOK AT CARD AND RECORD THE NUMBER OF PRENATAL VISITS WHILE MOTHER WAS PREGNANT WITH (NAME).	1 VISIT.....1 2 VISITS.....2 3 VISITS.....3 4 VISITS.....4	
39	LOOK AT CARD AND RECORD THE NUMBER OF IPT WHILE MOTHER WAS PREGNANT WITH (NAME).	1 DOSE IPT.....1 2 DOSES IPT.....2 NO IPT.....3	

Thank You.

END OF SURVEY

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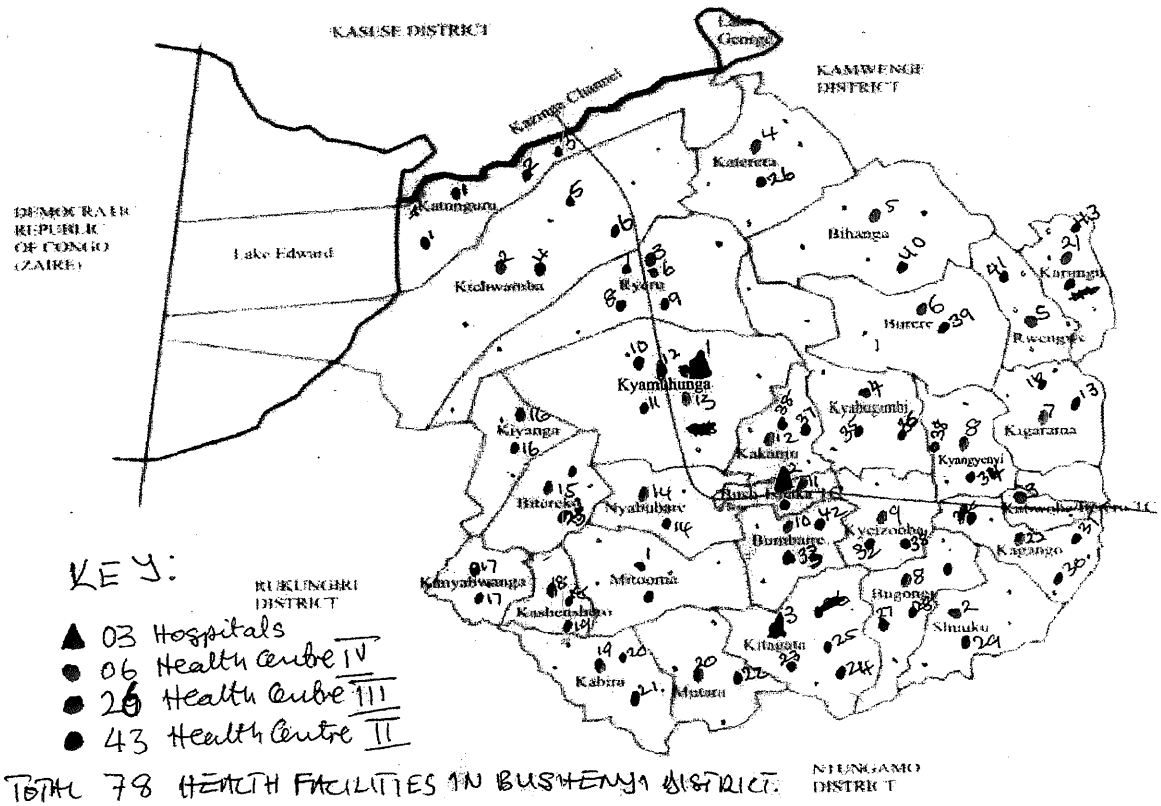
Annex 2: Maps of Program Area

MAP OF BUSHENYI DISTRICT SHOWING SUB-COUNTIES - 2004



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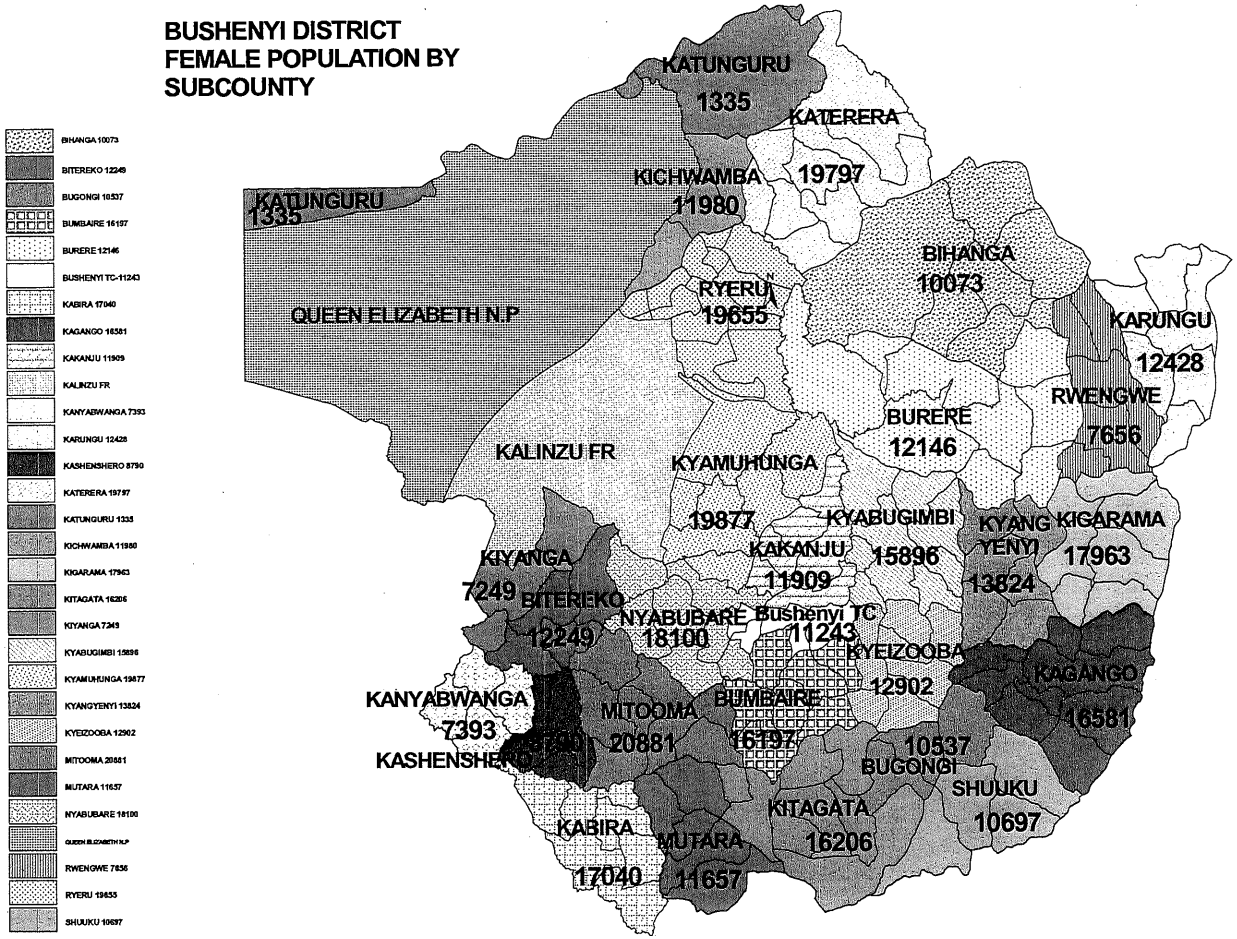
BUSHENYI DISTRICT FEMALE POPULATION BY SUBCOUNTY



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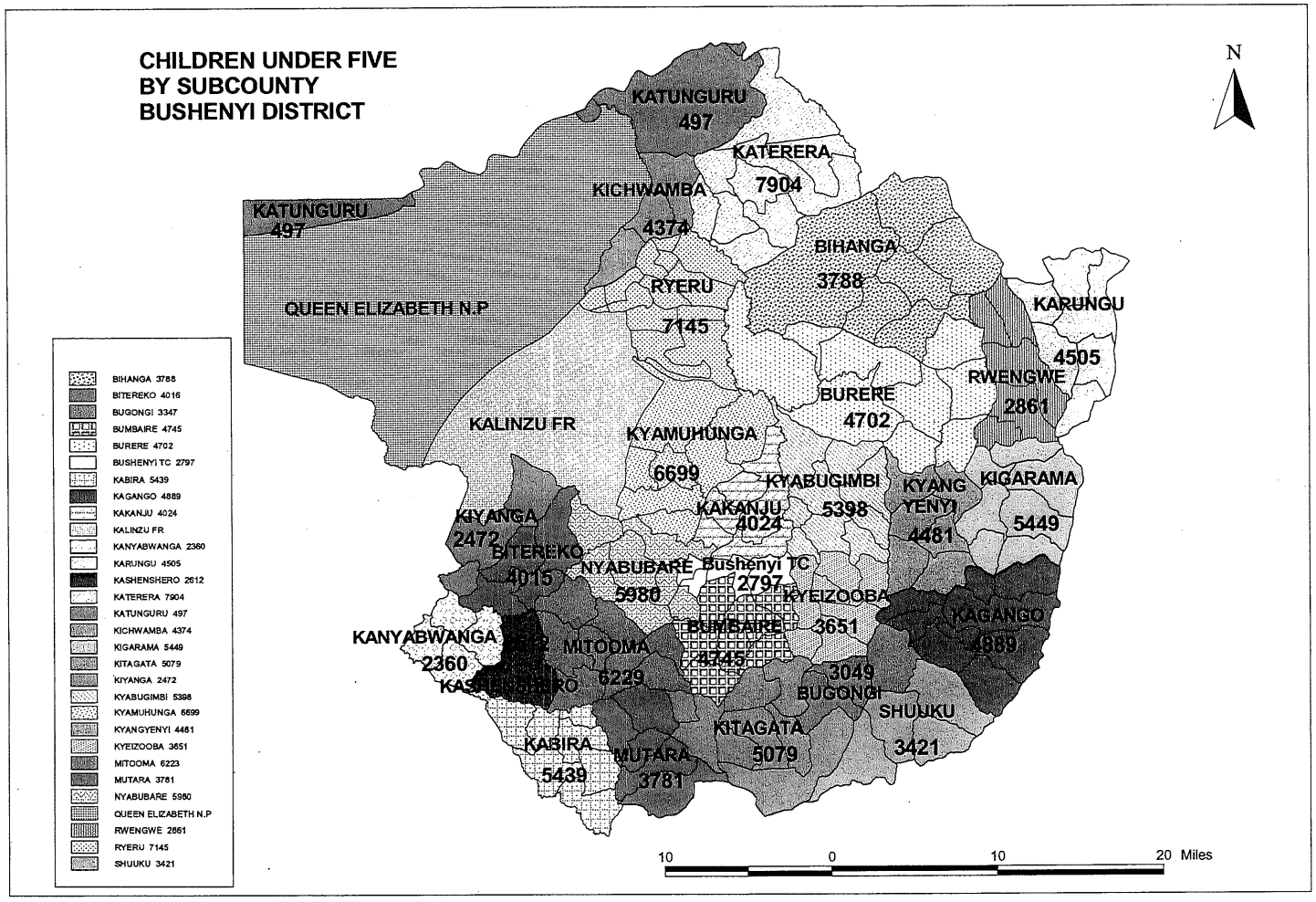

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Health Facilities in Bushenyi District

County	Sub county	Health Units	Type
Buhweju	Bihanga	Bihanga Health Centre III	Government
		Engaju health Centre II	Government
	Burere	Nyakashaka Health Centre III	Government
		Nyakashaka BMC Health Centre II	NGO
	Karungu	Karungu Health Centre III	Government
		Mushasha health Centre II	Government
	Rwengwe	Nsiika Health Centre IV	Government
		Butare Health Centre II	NGO
Bunyaruguru	Katerera	Katerera Health Centre III	Government
	Katunguru	Katunguru Health centre III	Government
		Kashaka Health Centre II	Government
		Kazinga Health Centre II	Government
		Kisenyi Health Centre II	Government
	Kichwamba	Kichwamba Health Centre III	Government
		Kyezaza Health Centre II	Government
		Rumuri Health Centre II	Government
		Nyakiyanja Health Centre II	Government
	Ryeru	Rutoto Health Centre II,Adventist	NGO
		Rugazi Health Centre II	NGO
		Rugazi Health Centre IV	Government
		Butoha Health Centre II	Government
Igara- East	Bubaire	Kabushaho Health Centre III	Government
		Numba Health Centre II	Government
		Keinamo Health Centre II	Government
	Kyabugimbi	Kyabugimbi Health Centre IV	Government
		Burugira Health Centre IV	NGO
		Rwenjeru Health Centre II	NGO
	Kyeizooba	Buyanja Health Centre II	Government

		Kyeizooba Health Centre III	Government
		Rutooma Health Centre II	Government
Igara- West	Kyamuhunga	Kyamuhanga Health Centre III	Government
		Comboni Hospital	NGO
		Bitooma Health Centre II	NGO
		Butare Health Centre II	NGO
		Mashonga Health Centre II	NGO
	Kakanju	Kakanju Health Centre III	Government
		Kakanju Moslem Health Centre II	NGO
	Nyabubaare	Nyabubaare Health Centre III	Government
		Nyarugote Health Centre II	Government
Igara West/ East	Town council	Ishaka Hospital	NGO
		Bushenyi Health Centre III	Government
		Bushenyi BMC	NGO
Ruhinda	Bitereko	Bitereko Health Centre III	Government
		Nyakasiro Health Centre II	NGO
		Karimbiro Health Centre II	NGO
	Kabira	Kabira Health Centre III	Government
		Mayanga Health Centre II	Government
		Ryenjerero Health Centre II	Government
	Kanyabwaga	Kanyabwaga Health Centre III	Government
		Kashogerero Health Centre II	Government
	Kasheshero	Kasheshero Health Centre II	Government
		Bubagizi Health Centre III	NGO
	Mitooma	Mitoma Health Centre IV	Government
		Rukararwe Health Centre II	Government
	Mutara	Mutara Health Centre III	Government
		Nyakiziga Health Centre II	Government
	Kiyanga	Rwoburuga Health Centre II	Government
		Rurama Health Centre II	NGO
Sheema	Bugongi	Bugongi Health Centre III	Government

		Karera Health Centre II	NGO
	Shuuku	Shuuku Health Centre IV	Government
		Nyakashoga Health Centre II	NGO
	Kitagata	Kitagata Hospital	Government
		Kyeihara Health Centre II	Government
		Kasaana Health Centre II	NGO
		Kashekuru Health Centre II	Government
	Kagango	Kyabadara Health Centre II	Government
		Kihunda Health Centre II	NGO
		Mushaga Health Centre III	NGO
		Kiziba Health Centre II	Government
	Kigarama	Kigarama Health Centre III	Government
		Mabare Health Centre II	Government
		Tuwerane Health Centre II	NGO
	Kyangyenyi	KyangyenyiHealth Centre III	Government
		Muzira Health Centre II	Government
		Masyoro Health Centre II	Government
	Kabwohe Itendero Town Council	Kabwohe Health Centre IV	Government

Uganda Private Midwives Association
13 Registered Midwives in Bushenyi District.

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Annex 3: KPC, HFA and Rapid CATCH Assessment

Report On The Baseline Knowledge, Practice And Coverage Survey Also Including Health Facility Assessment And Rapid Catch Indicators

HealthPartners Uganda Health Cooperative Child Survival Project In Bushenyi District, Uganda

JANUARY 2006

Uganda Health Cooperative In Partnership With PSI Uganda,Usaid Country Office, MEMS, Uganda Bureau Of Statistics, Bushenyi District Local Government, MOH, Africare Uganda, UPHOLD

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

HealthPartners - Uganda Health Cooperative (UHC) has a goal of making health care accessible and affordable through Community Health Financing schemes. Under a child survival grant from USAID the project aims at fighting malaria and diarrheal diseases among children, and improving maternal and newborn health. The project is targeting at least 50,000 women and infants in Bushenyi District, which is in Western Uganda.

UHC's Child Survival goal is to demonstrate that prepaid health schemes are viable strategies to address child survival and achieve scale and community-wide impact.

To achieve that goal, the Project has the following specific objectives:

i. Link child survival interventions and partnerships to prepaid health schemes;
ii. Improve health facility management of antenatal and postnatal care, delivery, and childhood illness;
iii. Improve community practices for seeking maternal care, increase knowledge of childhood illness warning signs and proper treatment, increase demand for and availability of services, improve hygiene and sanitation practices;
iv. Improve board of directors capacity to manage health scheme, present a successful model with options for a subsidized premium structure to cover the most vulnerable populations.

Prior to commencement of these interventions, UHC decided to set up a framework within which the project's can be evaluated. That framework starts with knowledge, practice and coverage (KPC) baseline survey.

Objectives of the KPC survey
The objectives of the KPC survey were as follows:

i) Provide baseline data on the situation of all target indicators as they stand before the introduction of any interventions;
ii) Enable Project staff to set targets and prioritize among the different indicators;
iii) Provide the benchmark against which a performance monitoring plan will be developed;
iv) Provide a base on which an evaluation framework for the entire project will be designed.
v) Strengthen partnership among MOH, PVO's, District Officials, and other Stakeholders.

Methods

The KPC survey questionnaire was developed and finalized through a number of stages. Initially, the KPC 2000+ and *Rapid CATCH* questionnaire was adopted as a starting point. Members of the Survey Team adapted this questionnaire to the project needs. Thereafter it was shared with stakeholders for review and comments. The final version was translated into Runyankole, the language spoken in Bushenyi district.

The survey was designed using the Lot Quality Assurance Sampling (LQAS) design, in which the five counties of Bushenyi were selected as supervision areas. Since the project decided to use an experimental evaluation design, two supervision areas were selected from a neighboring district, Rukungiri, to serve as a control area. Nineteen households were randomly selected from each supervision area leading to a sample of 133 households. From each household one mother of a 0 – 23 months child was selected for interview.

The survey field staff supervisors and interviewers were recruited from Bushenyi district. These were from the District Local Government, and Local NGOs. The field staff were both male and female. They were all experienced in LQAS surveys. It was consequently decided to give them an abbreviated refresher training of 2 days instead of the usual four. They also participated in pre-testing and finalization of the translated questionnaire.

Key Findings

Some of the key findings for Bushenyi district by intervention area are given below:

1. Malaria

- Fourty four percent of children under 2 had fever in the last week
- Thirty eight percent of households report possession of ITNs.
- Thirty two percent of children under 2 were reported to have slept under ITN last night
- Eighty percent of mothers report received IPT during last pregnancy

2. Diarrhea

- Fifty five percent of children under 2 had diarrhea in the last two weeks
- Twenty four percent of households had a designated hand washing facility
- Only 8% of mothers reported washing their hands after attending a child who had defecated.
- Access to VIPs or covered pit latrines was at 19%.
- Sixteen percent of mothers offered more fluids to children during the illness.
- Fourty nine percent of households have safe water sources

3. Maternal and Newborn Care

- Sixty five percent of mothers reported attendance of 4 ANC visits, 18% of these visits were verified by Maternal cards
- Thirty four percent of pregnant women sought VCT services

- Thirty eight percent of mothers had a safe birth plan

Implications

From the findings, diarrhea needs the most and urgent attention. The diarrhea prevalence rates 55%, could be due to the inaccessibility of safe water sources. Following in priority is malaria, with a similarly high prevalence rate of 44% among children. It should be noted, that the assessment was not taken during the peak malaria season, so in reality, rates are likely higher than 44%.

BACKGROUND

A. Project Location and background of the area

UHC has been working in Uganda since 1997. It is located in Bushenyi District in the western part of Uganda, with its head office in Kampala. Bushenyi district has five counties; Buhweju, Ruhinda, Sheema, Bunyaruguru and Igara. These are further divided into several sub-counties and parishes and LC 1 villages. The population of the district according to counties is summed up in the table 1 below.

Table 1: District Population According to Counties

County	Population
Buhweju	80,489
Bunyaruguru	102,757
Igara	207,396
Ruhinda	157,720
Sheema	172,827
Rubabo A	71,685
Rubabo B	69,637
Total	862,511

2002 Uganda Population and housing census

B. Characteristics of the Target Beneficiary Population

According to the 2002 population and housing census, the population of Bushenyi district is 731,392 persons. Females make up 51% of the population in the district. This population grew from 579,137 in 1991, representing an inter-censal growth rate of 2% per annum. Bushenyi's population is overwhelmingly rural with only 5% of the district total population classified as urban.

Bushenyi district has a very young population. Children below 5 years constitute about a fifth of the total district population. This situation is no doubt a result of high fertility experienced in the district. It is estimated that, at prevailing fertility rates, a woman in Bushenyi district will bear 7 children throughout her lifetime.

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Under the Child Survival and Health Grant Program, UHC is planning to directly reach at least 50,000 women and infants in Bushenyi District - Western Uganda which has some of the highest rates of maternal and child mortality (176 out of 1,000), as well as the highest prevalence rates of diarrhea and malaria with 16% of infants having diarrhea in the last two weeks, and use of ITNs at a dismally low 9%[xxiii].

C. Socio-economic and Health Conditions

According to the Uganda Human Development Report 2005, western Uganda has a literacy rate of 75%. The higher literacy rate is due to improvements in enrolments and the functional adult literacy program. The Universal Primary Education program also had its impact on the literacy rates country wide.

The Human Development Indices for Uganda show that Bushenyi has up to 0.5 Human Development Indices by the year 2005 according to the Uganda Human Development Report.

The main economic activity in the district is agriculture, accounting for over 90% of all economic activity in the district. The district draws most of its income from agricultural produce which is sold outside the district, particularly the capital city Kampala. Much this agricultural production is by small scale farmers who generally do not have access to credit. Consequently, it has proved difficult for them to break out of the vicious cycle of poverty.

According to the UDHS 2000/2001, the infant mortality rate is 88 deaths per 1000 live births. This means that one in every 11 babies born in Uganda do not survive to the first birth day. Of those who do survive to their first birth day, 69 out of 1000 die before reaching their fifth birthday. The overall under 5 mortality is estimated at 152 deaths per 1000 live births, which means that one in every seven Ugandan babies does not survive to their first birthday. The maternal mortality ratio is estimated to be 880 maternal deaths per 100,000 live births (WHO/Hill 2004). These high rates are as a result of severe malaria, pneumonia, anemia, diarrhea and poor handling of mothers before and after delivery and poor feeding/ sanitation practices for the new born.

Whereas the MOH has ensured that there are health facilities up to parish level (HC II), the Health Facility Assessment revealed that most of these health facilities were not adequately staffed. Besides, the terrain of the area also acts as an impediment to easy access to these health facilities. The district also has trained traditional birth attendants, who are considered skilled to carry out deliveries at the village level. These however require additional training on danger signs of labor such that they can make timely referrals to the health centers.

D. National Standards/Policies Regarding Maternal and Child Health

The national policy on maternal and child health comprises of the following maternal and newborn health services: preconception care; ANC; post abortion care; intra-partum care; emergency obstetric care; care of the new born and post natal care.

For each of the services above, the MOH has set national standards, on activities and services, targets and priority groups. The target groups are pregnant women and their partners, women in labor, post-natal and breast feeding mothers, adolescents, women who are HIV positive or suffering from AIDS and are pregnant, women with disabilities and women who are aborting; new born babies who are sick, have low birth weights, have congenital abnormalities, born to HIV positive mothers and babies whose mothers die during child birth.

E. Overview of the Child Survival Project: Goals, Objectives and Interventions
Under USAID's Cooperative Development Program (DCHA/PVC) with a sub-grant from Land O'Lakes, HealthPartners has been implementing an innovative prepaid health scheme program in Uganda since 1997. It is located in Bushenyi District in the western part of Uganda, with its head office in Kampala.The number one treatment sought through the health scheme was discovered to be malaria. Diarrheal diseases and maternal/newborn are also areas where interventions will make a large impact on health improvement and health scheme sustainability. HealthPartners was interested in demonstrating that prepaid health schemes are viable strategies to address child survival interventions and can achieve large scale and community-wide impact.

Project Goals
Community and Social Dimension
Improve the health of children under five through increased ITN use, increased antenatal and post natal care, improved knowledge of warning signs and treatment for childhood illness in under 5s, improved hygiene and sanitation.

Health and Services Dimension
Build capacity of providers to offer IMCI and SCM and ensure resource stock to reduce childhood and maternal morbidity and mortality. Help providers develop a system to monitor their training, care and supplies. Demonstrate prepaid plan ability to address social health for adoption by the ministry of health to cover the poorest populations.

Local Organizational Dimension
Build knowledge and capacity of UHC board to enable them to competently run UHC. Strengthen trust and ties between providers and community groups to enable best practices and continued coverage for members. Build incentive for membership, leadership and provider participation. Build capacity of UHC team, stakeholders and partners.

Intervention Activities

The program shall implement activities on three intervention areas of Malaria, Diarrhea and Maternal and Newborn Care. Under Malaria, activities shall include promotion of ITN use, Homapak treatment, IPT among pregnant women, timely and proper case management of fever.

Diarrhea activities will include; promotion sanitation and hygiene, identification of signs showing that child is sick, proper case management of diarrhea by use of ORS and increased food and water for children suffering from diarrhea.

Maternal and Newborn Care activities will involve promotion of attendance of ANC services, promotion of VCT services, and proper nutrition for children under 5, child spacing danger signs, and safe birthing practices.

Table 2: Project Objectives

Objectives		Indicators
1.0	Objective 1 Reduce incidence of malaria for pregnant women and children under 5	% of children under 2 with fever in the last 2 weeks % of children under 2 who slept under an ITN last night. % of women with fever in the last 2 weeks who sought Anti-malarial advice or treatment Percentage of women who slept under an ITN last night % of children under 2 who received antimalarial treatment. % of pregnant women who received IPT during pregnancy.
2.0	Objective 2 Reduce the incidence of diarrhea in Bushenyi district for children under 5	% of children under 2 with diarrhea in the last two weeks % of caretakers/mothers who know at least two signs that a child under 2 needs treatment. % of children under 2 who with diarrhea in the last 2 weeks % households using improved water source. % of households with a designated hand-washing facility % of caretakers who usually wash hands with soap/ash before food preparation

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		% of caretakers who usually wash hands with soap/ash before feeding children % of caretakers who usually wash hands with soap/ash after defecation % of caretakers who usually wash hands with soap/ash after attending to a child who has defecated % of caretakers who dispose of children's feces hygienically. % of households with access to a covered pit latrine % of children 0-23 months with diarrhea in the last two weeks who received ORS % of children 0-23 months with diarrhea in the last two weeks who were treated with Zinc Supplements % of children aged 0-23 months who were offered more fluids during the illness % of children 0-23 months who were offered the same or more food during the illness
3.0	Objective 3 Increase the percentage of pregnant women receiving improved antenatal, delivery and post partum care	Percentage of pregnant women receiving improved antenatal, delivery and post partum care. % of women with 4 ANC visits. % pg women seeking VCT services percentage of care takers that have knowledge of breastfeeding. Percentage of care takers that have knowledge of child spacing. Percentage of caretakers that have knowledge of sanitation. Percentage of caretakers that have knowledge of danger signs Percentage of pregnant women with safe birthing plans Percentage of pregnant women with access to clean razor to cut the cord Percentage of women who delivered with a skilled birth attendant

Main Strategies and Activities
General Strategies
Private sector involvement, strengthen decentralized health system, information systems technology.

M&E Assessment Strategies
KPC Survey, Rapid Catch Survey, Institutional Strength Assessment Methodology, Integrated Health Facility Assessment, Participatory Program Evaluation, Lot Quality Sampling, Community Based Monitoring Techniques, Participatory Evaluation Techniques and Child Survival Sustainability Assessment.

Social Behavioral and Communication Strategies
BCC, BEHAVE, improving performance of facility and community based health workers, peer communication

F. Objectives of the KPC Survey

The KPC Survey was designed as a tool for providing information that will be used in the design and implementation of the Project. In particular, the KPC survey is intended to:

vi) Provide baseline data on the situation of all target indicators as they stand before the introduction of any interventions;
vii) Enable Project staff to set targets and prioritize among the different indicators;
viii) Provide the benchmark against which a performance monitoring plan will be developed;
ix) Provide a base on which an evaluation framework for the entire project will be designed.
x) Strengthen partnership among MOH, PVO's, District Officials, and other Stakeholders.

PROCESS AND PARTNERSHIP BUILDING

A. Methods of engaging Local Partners/ Stakeholders in the KPC survey

In order to identify and engage local partners, HealthPartners began with the identification of all local organizations working in Bushenyi District and in interventions related to malaria, diarrhea and maternal and newborn care. Other organizations such as UPHOLD were consulted on partners that they worked with in the district.

B. Specific roles of local partners/ stakeholders in the KPC survey

The KPC was carried out in a participatory manner, involving as many stakeholders as was possible. Through the process from questionnaire design to data collection and

planning, stakeholders were involved. Among the stakeholders that were involved were the local partners, the MOH, USAID mission office and the district of Bushenyi where the intervention is to take place. During questionnaire design, partners participated in review of drafts and local partners particularly participated in questionnaire translation and proof reading to ensure consistency. Partners also participated in the process of data collection. District official in the population and health departments; and community development officers, participated as supervisors and data collectors respectively.

Local political leaders (LC1s) were also engaged in the process of sampling of households since there were village lists available. In this case, the program got a good introduction in all the villages from which the samples were picked. This was a voluntary exercise, aimed at initiating the spirit of voluntarism and participation in the program work during the implementation phase.

C. Constraints

The constraints in this undertaking lay mainly in the process of executing the survey. The first constraint was virtually no village of those selected had a list of households as required by the sampling design that was employed. This meant resorting to the tedious and time consuming option of constructing village lists on the spot.

The second constraint consisted of the terrain. This is a very hilly region and in many cases villages were inaccessible except on foot. This meant that field workers had to cover very long distances on foot to reach the selected villages and the selected respondents.

A third constraint was that the survey was done during millet harvest. This time was preferable because it involved mostly that single activity unlike others where a multiplicity of activities would be taking place at the same time. However, this meant that most mothers were not found at home. Either interviewers had to follow them to the fields, or special arrangements had to be made to catch them at "odd" hours. Besides, another constraint arose from the mistake made by some of the data collectors to collect information on children older than 24 months although younger than five years. This mistake could not be ignored and it necessitated us making call backs to the field to collect proper information. This therefore caused a delay and cancellation of other assignments that had been scheduled such as the dissemination workshop which has been planned to take place immediately after the data collection.

METHODS

A. Questionnaire Development

The questionnaire was adopted from the KPC 2000+ guide together with the *Rapid CATCH* questionnaire as a starting point. The following modules from the KPC 2000+

were used: Module 1a and 1b, Module 2, Module 3, Module 4a, 4b, 4c, 4e, Module 5a and 5b and Module 6.

The KPC survey questionnaire was developed and finalized through a number of stages. In the first stage, members of the Survey Team and stakeholders at various levels examined the questionnaire for completeness of Project focus. These proposed the different questions that should be included in the questionnaire to be used. Different groups were then selected to review different sections of the questionnaire and make adjustments to suit the local situation and meet project objectives. The first draft of the questionnaire therefore had the following topics outlining the scope of the survey:

i. Respondent's Background (including membership to Uganda Health scheme)
ii. Anthropometry
iii. Child Immunization
iv. HIV/AIDS
v. Hand-washing practices
vi. Integrated Management of Childhood Illnesses (IMCI)
vii. Malaria Prevention
viii. Maternal and Newborn Care
ix. Breastfeeding and Nutrition
x. Diarrhea, Sanitation and Hygiene

The first draft questionnaire was shared with the CSTS and backstop staff, locally with the MOH staff, the Uganda mission office and local partners and stakeholder for review and comments. Their comments and reactions were used to generate a second draft. This draft was also shared with another group of stakeholders to produce a third draft ready to be pre-tested.

The third draft of the questionnaire was translated into Runyankole, which is the language spoken in Bushenyi district. The questionnaire was later back translated from the Runyankole version and the few discrepancies in the two versions were ironed out. The members of the data collection team also participated in cross checking and correcting the questionnaire.

The Health Facility Assessment questionnaire was developed from a generic tool developed by UPHOLD in conjunction with the MOH. It was then adapted to the needs of the project by Project Staff to address those areas that are to be particularly targeted by the Project. The final tool was then pre-tested and finalized for use in the survey.

B. KPC Indicators

The indicators for the project to be measured in this KPC and their definitions are provided in the table below:

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Table 3: Indicators and their definitions

Indicator	**Indicator Definition**
Reduce the incidence of malaria for pregnant women and children under 5	% of children under 2 with fever in the last 2 weeks= No of children with response Q21= 1
Increase ITN use	% of children under 2 who slept under ITN last night No. of children with response Q31= A Total Number of survey children
	% of pregnant women who slept under ITN last night responses to Q31= C
Increase timely malaria treatment	% of children with fever in the last 2 weeks who sought anti-malarial advice or treatment= responses to Q 22= 1
	% of children under 2 with fever who received anti-malarial treatment = responses to Q 26= 1
Increase IPT	% of pregnant women who had maternal card =
Reduce incidence of diarrhea for children under five	
	% of children under 2 with diarrhea in the last two weeks responses to Q18= A
Improved recognition by caretakers of warning signs that child needs treatment	% of care takers/mothers who know at least 2 signs that a child under 2 needs treatment
Improve safe water access & use	% of households who use improved water source = responses to Q69= borehole, public tap, and protected dug well
Increase safe water practices and hand washing	% of households with a designated hand washing facility = responses to Q74=1
	% of caretakers who usually wash hands with soap/ash before food preparation, before feeding children, after defecation and after attending to a child who has defecated= responses to Q16 for each criteria (before food preparation; feeding; defecating; etc)
Improve sanitation practices	% of caretakers who dispose off children's feces hygienically = responses to Q72= 1
	% of households with access to a covered pit latrine = responses to Q73=1,2,3,4
Increase intervention for severe diarrhea & dehydration	% of children 0-23 months with diarrhea in the last two weeks who received ORS =

	responses to Q61=B
	% of children 0-23 months who were offered more fluids during the illness = responses to Q19=3
	% of children 0-23 months who were offered the same or more food during the illness= responses to Q20=2,3
	% of children 2-59 months with diarrhea in the last two weeks who were treated with zinc supplements
Increase % of pregnant women receiving improved antenatal, delivery and post partum care	
Increased demand for ANC	% of pregnant women with maternal card showing 4 or more ANC visits = responses to Q42= at least 4
Increased demand for VCT	% of pregnant women seeking VCT services = responses to Q45= 1
Improve sanitation practices	% of caretakers that have knowledge of sanitation= responses to Q
Improve caretaker knowledge of delivery preparations, breastfeeding, child spacing and danger signs of pregnancy	% of care takers that have knowledge of breastfeeding = responses to Q44
	% of caretakers that have knowledge of child spacing = responses to Q39=C
	% of caretakers that have knowledge of danger signs = responses to Q49 at least 2 symptoms
Increased access to safe birthing kits	% of pregnant women with safe birthing plans - plan where to deliver - plan transport - plan having a birth kit asked to plan all 3= responses to Q44=1 in each occasion
	% of pregnant women with access to a clean razor to cut the cord % responses to Q54
	% of women who delivered with a skilled birth attendant = responses to Q38
Rapid Catch Indicators	
% of children 0-23 months who are underweight (-2SD from the median weight for age, according to the WHO/NCHS	Numerator = 8; Denominator= 40

reference population)	
% of children aged 0-23 months whose births were attended to by a skilled health personnel	% responses to Q52= 2&3; Q38A, Q38B,Q38D
% of mothers of children aged 0-23 months who received at least 2 tetanus toxoid injections before the birth of their youngest child	% responses to Q37=2&3
% of infants aged 0-5 months who were exclusively breastfed in the last 24 hours	Denominator= 7 Numerator= 7
% of infants aged 6-9 months receiving breast milk and complementary foods	% responses to Q59A
% of children 12-23 months who were fully vaccinated against the five vaccine preventable diseases before their first birth day	% responses to Q59 all
% of children 12-23 months who received a measles vaccine	% responses to Q13=1
% of children 0-23 months who slept under ITN the previous night (in malaria- risk areas only)	Denominator= 11; Numerator= 13
% of mothers who know at least two signs of childhood illness that indicate the need for treatment	% responses to Q17=1
% of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past 2 weeks	% responses to Q19=2&3 &Q20= 2&3
% of mothers to children age 0-23 who cite at least 2 known ways of reducing the risk of HIV infection	% responses to Q15 (any two of correct options)
% of mothers to children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation and after attending to a child who has defecated	% responses to Q16=1 for each case

C. Sampling Design

The beneficiaries in this program are women of reproductive age and children under 5. With consultations with the consultant and back stop staff, the project adopted the Lot Quality Assurance Sampling Design. The Project obtained population figures about Bushenyi district by various administrative units from the Uganda Bureau of Statistics.

These were based on the returns from the 2002 population and housing census. The consultant, who is a statistician, selected the villages where first house holds were to be selected. With the aid of the LC 1 leaders for each village where the survey took place, starting households were identified.

The survey was designed using the Lot Quality Assurance Sampling (LQAS) design. Bushenyi district is made up of five counties, which were adopted as the supervision areas to suit the LQAS design. This decision was made because the county closely approximates the Health Sub-District at which most health service delivery decisions are taken.

Since the project decided to adopt an experimental design for the evaluation of their interventions, it was decided to select a control group to match the intervention area. For this purpose, Rukungiri district was selected. However, due to financial and time constraints, five supervision areas could not be selected in Rukungiri. Consequently, Rubabo County was divided into two to form two supervision areas which would constitute the control group. The rationale here was that although Rukungiri and Bushenyi districts were similar on a number of different characteristics, no interventions along the ones planned for Bushenyi were to be introduced in Rukungiri in the near future.

In the adjusted design, therefore, we have a study area of seven supervision areas. In a part of this area, i.e., five supervision areas, interventions will be introduced (the target area), while in the remaining two supervision areas, no intervention will be introduced (control area). Despite this little adjustment, it is felt that this strategy will still yield a proper impact evaluation design for the project. The total sample for the study area was then 133 villages, yielding a total of 133 respondents.

The data collectors and supervisors were trained on how to select the first households.

Using the data from the Uganda Bureau of Statistics, village lists were compiled for each of the counties. The lists also provided proper addresses for these villages, that is, the Sub-County and Parish in which a particular village is located. That way, the selected villages were not hard to find. The County lists were provided with population figures, which were used to calculate sampling intervals. (For the sampled villages, refer to Annex C)

A table of random numbers, a starting point was selected and thereafter the interval was followed until the 19 villages were selected from the county (Supervision Area). The process was repeated for every county until finally 5 different samples of 19 were selected yielding a total sample of 95 villages.

It was found that most village LC 1 leaders did not have village lists and most villages were quite large. Interviewers were instructed to always use the LC 1 person to sub-

divide the village into 2 or 3 roughly equal parts so that the parts would be about 30 households each. They then randomly selected one of the sub-divided parts. Thereafter, the interviewer, with the help of the LC 1 official would develop a village list for the selected portion of the village. From this list, one household would be selected randomly.

Once the household was selected, the interviewer would inquire if there was a mother with a child aged less than two years, with both of them living there. If such a respondent existed, the interviewer would go ahead and administer the questionnaire. If there were more than one such respondent the interviewer was instructed to randomly select one respondent from them. On the other hand, if no such respondent existed in the selected household, the interviewer would go on to the nearest household and continue that way until an appropriate respondent was found as specified.

D. KPC Training

The survey field staff, that is, supervisors and interviewers were recruited from Bushenyi district. These were from the local partner organizations, namely, the District Local Government, Local NGOs, etc. The field staff were both male and female. It was found that the topics under investigation were neutral enough that the sex of the interviewer did not matter. Supervisors were selected competitively on the basis of qualifications and experience in survey work.

All the field staff that were selected were already experienced with LQAS surveys and they had carried them out in Bushenyi district. Together with the M&E Coordinator, the consultant designed the training curriculum following the KPC 2000+ and KPC field guide. Consequently, although LQAS training commonly takes four days, it was possible to train these fieldworkers for two days.

The training content was as follows:

Refresher of LQAS: Objectives; Random sampling; using samples of 19;
More LQAS refresher: Selecting villages, households, respondents; interview techniques;
Discussion of English Questionnaire and role plays
Discussion of translated questionnaire and role plays
Pre-test of translated questionnaire
De-briefing from the field

After the training, the field staff participated in pre-testing the questionnaire. After the pretest, the field staff also participated in the final revision of the translated questionnaire that was used in the actual survey. Among the changes made after the pre-test was the use of commonly understood language/ words as opposed to the correct but rather hard to understand words.

The training was conducted by an LQAS expert hired from Institute of Statistics and Applied Economics, Makerere University, who is a TOST trainer, together with the Project Monitoring and Evaluation Officer. The training sessions started with a full day of orientation and review of the LQAS survey design as well as the English version of the questionnaire. The second day was devoted to reviewing and practicing (role plays) on the vernacular questionnaire. In the afternoon, trainees went for the pre-testing of the vernacular questionnaires.

E. Data Collection and Quality Control Procedures

Data collection took place between 16th and 20th January 2006 in Bushenyi District; and 24th and 25th January 2006 in Rukungiri; the control area.

Immediately after finalization of the questionnaire, teams were dispatched to the field. Each team consisted of one supervisor and three interviewers. A team was deployed per Supervision Area. Whereas it took approximately 45 minutes to complete the questionnaire, in cases where the respondent was not available, the supervisor made a decision on whether to follow the respondent in the garden or call on the nearest household. Due to the hard terrain in most of the district, each interviewer was covering about three households in a day. Consequently, fieldwork took three days. None of the mothers refused to be interviewed.

The questionnaire had a skip command which was illogical in the section of diarrhea. For this, supervisors advised the data collectors in consultation with the consultant and the M&E Coordinator. Besides this, there were no other interviewing problems.

Quality control measures were paramount considerations from the very beginning. At the questionnaire design stage, the Project decided to involve a number of experts and stakeholders. In the selection of field staff, care was taken to select only the highly experienced ones. However, in addition to that, every field team was overseen by UHC staff. The UHC staff member helped the Field Supervisor ensure that the selection procedures were properly executed and also to edit the questionnaires in the field and make corrections as needed.

F. Data Management and Analysis

After field work the questionnaires were checked for completeness. The field staff were taken through a brief training in hand tabulation of results. They then started tabulating results. Tabulation involved mostly Project staff and supervisors and some interviewers who expressed interest. During the process of hand tabulation, an error in age of children was noted. This was addressed by making a call back to the villages from which the errors were realized.

After data collection, a data management expert from Makerere University, Institute of Public Health was hired to handle data management. The M&E Coordinator developed

the data entry Screen in EPI 6 (QES, CHK, PGM files), which was used by data entrants. The data manager and the M&E Coordinator supervised data entry by guiding the data entrants in entry of 5 beginning entries and then observing subsequent entries to ensure quality and accuracy.

After data entry, an analysis program was developed and pre-tested. Other indicators such as anthropometry were analyzed using EPI 2000. For convenience, analysis was also done in SPSS.

The cleaning process involved generation of variables such as age of the children in the survey, age brackets and such other important variables that needed to be derived from the data. One error that was found was the formula used for calculating the age of the children, which had previously given false figures and affected consequent pre analysis.

To help concretize the KPC findings, operations research ideas have been identified and will be carried out. These will address the qualitative aspect embedded in the indicators, helping to answer the how, why and recommendations for easy implementation.

RESULTS

A. Background Characteristics

The KPC survey was conducted among mothers of children aged 0 – 23 months. Age is usually a proxy indicator for many other factors such as experience and openness to change. It is important therefore to present the age distribution of the respondents. The results presented in Table 4 show that 2.1% of respondents were young mothers, compared to 97.9 % who were older mothers.

Table 4: Categorization of Mothers by Age, Bushenyi KPC, 2006

Age Category	Percent
under 18	2.1
19-30	66.3
above 30	31.6
Total	100.0

The results also show that there were more children between the age bracket 10- 24 months (55.8%) as compared to 25.3% aged 0 – 5 months, and 18.9% aged 6 – 9 months.

Table 5: Age Distribution of Children

Age brackets of children	Percent

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0-5	25.3
6-9	18.9
10-24	55.8
Total	100.0

B. Table of Results and Graphics for Principal Findings Bushenyi district.

Table: 6: A Summary Table of Indicators

Indicator	*Numerator*	*Denominator*	*Percent*	*Confidence limits*
Objective 1: Reduce the incidence of malaria for pregnant women and children under 5				
% of children under 2 with fever in the last 2 weeks	42	95	44.2	± 0.100
% of children under 2 who slept under ITN last night	30	95	31.6	± 0.008
% of pregnant women who slept under ITN last night	18	95	18.9	± 0.080
% of pregnant women with fever in the last 2 weeks who sought anti-malarial advice or treatment	No data gathered			
% of children under 2 with fever in the last 2 weeks who received anti-malarial treatment	30	42	71	± 0.140
% of pregnant women who received IPT during last pregnancy	26	95	27	± 9
Objective 2: Reduce incidence of diarrhea for children under five				
% of children under 2 with diarrhea in the last two weeks	52	95	54.7	± 0.100
% of care takers/mothers who know at least 2 signs that a child under 2 needs treatment	72	95	75.8	± 0.860
% of households who use improved water source	47	95	49.5	± 1.000
% of households with a designated hand washing facility	23	95	24.2	± 0.086
% of caretakers who usually wash hands with soap/ash before food preparation, before feeding children, after defecation and after attending to a child who has defecated	2	95	2.1	± 2.9
% of caretakers who dispose off children's feces hygienically	65	95	68.4	± 0.098
% of households with access to a covered pit latrine	18	95	18.9	± 0.080
% of children 0-23 months with diarrhea in the last	0	95	0	0

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two weeks who received ORS				
% of children 0-23 months who were offered more fluids during the illness	15	95	15.8	± 0.090
% of children 0-23 months who were offered the same or more food during the illness	40	95	42.11	± 0.100
% of children 2-59 months with diarrhea in the last two weeks who were treated with zinc supplements	On hold	For	US	Approval
Objective 3: Increase % of pregnant women receiving improved ANC, delivery and post partum care				
% of pregnant women with 4 ANC visits	17	95	17.9	± .08
% of pregnant women seeking VCT services	32	95	33.68	± 0.095
% of care takers that have knowledge of breastfeeding				
% of caretakers that have knowledge of child spacing	90	95	94.74	± 0.045
% of caretakers that have knowledge of danger signs	72	95	75.8	± 0.086
% of pregnant women with safe birthing plans - plan where to deliver - plan transport - plan having a birth kit - asked to plan all 3	 66 43 50 36	 95 95 95 95	 69.5 45.3 52.6 37.9	 ± 0.093 ± 0.100 ± 0.100 ± 0.970
% of pregnant women with access to a clean razor to cut the cord	77	95	81.1	± 0.078
% of women who delivered with a skilled birth attendant	45	95	47.4	± 0.098
Rapid Catch Indicators				
% of children 0-23 months who are underweight (-2SD from the median weight for age, according to the WHO/NCHS reference population)	25	92	27.17	± 0.090
% of children aged 0-23 months whose births were attended to by a skilled health personnel	55	95	57.96	± 0.100
% of mothers of children aged 0-23 months who received at least 2 tetanus toxoid injections before the birth of their youngest child	46	70	65.7	± 0.111
% of infants aged 0-5 months who were exclusively breastfed in the last 24 hours	24	24	100	100
% of infants aged 6-9 months receiving breast milk and complementary foods	12	18	66.67	± 0.220
% of children 12-23 months who were fully vaccinated against the five vaccine preventable diseases before their first birth day **(measles was**	33	43	76.7	± 0.126

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used as a proxy indicator for complete immunization)				
% of children 12-23 months who received a measles vaccine	33	43	76.7	± 0.126
% of children 0-23 months who slept under ITN the previous night (in malaria- risk areas only)	30	95	31.6	± 0.008
% of mothers who know at least two signs of childhood illness that indicate the need for treatment	72	95	75.8	± 0.086
% of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past 2 weeks	5	64	47.8	± 6.6
% of mothers to children age 0-23 who cite at least 2 known ways of reducing the risk of HIV infection	61	95	64.2	± 0.093
% of mothers to children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation and after attending to a child who has defecated	2	95	2.1	± 2.9

B.I. Malaria Prevention

One of the intervention areas that the Project is targeting is malaria. The baseline assessment took place in Off-peak Malaria season so rates would likely be quite a bit higher at other times of the year. From the survey, it was found that 44.2% of all the children had suffered from malaria 2 weeks before the survey. Of those with fever within 2 weeks, 71.4% of the caretakers sought anti-malarial treatment. Whereas this is a fair performance for the district, the reporting of cases of malaria within the first 24 hours is still lagging behind. In this connection, the Project tries to promote timely and correct treatment of malaria. The table below gives the cross tabulation of children suffering from malaria in the last 2 weeks, and children who received treatment.

Table 7: Prevalence of Malaria and Treatment Patterns among Children 0 – 23 Months, Bushenyi KPC, 2006

Children sick	Caretakers who sought treatment for the child		Total
	Yes (%)	No(%)	
42	71.4%	28.6%	100%

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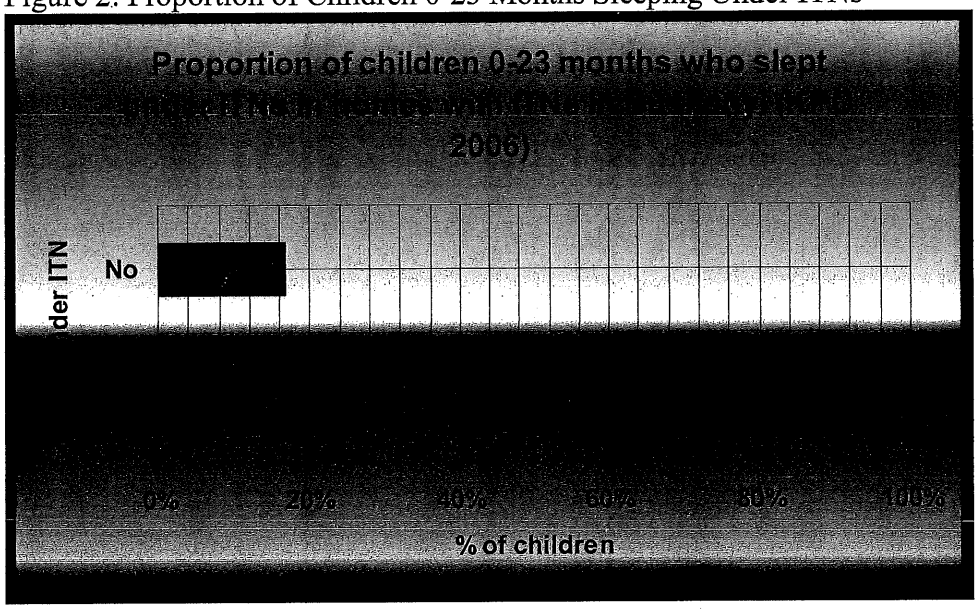
Women are encouraged to take prophylactic doses of anti-malarial drugs, particularly Fansidar, during pregnancy. The survey revealed that a significant percentage of mothers (79.8%) did receive IPT during pregnancy.

Another intervention in the fight against malaria is the promotion of ITNs. The Project plans to ensure that both pregnant women and children under 5 years of age sleep under ITNs. For this indicator, it was reported that 38% of the households in the survey reported possession of ITNs. Thirty two percent of children were reported to have slept under an ITN the previous night. Nineteen percent of women slept under ITNs the previous night. The project will need to improve the number of children and pregnant women sleeping under ITNs. The graph below illustrates the proportion of children sleeping under ITNs to those who are not.

Figure 2: Proportion of Children 0-23 Months Sleeping Under ITNs



B.II. Diarrhea, Sanitation and Hygiene

The Project also has as one of its objectives the control of diarrheal diseases particularly among children below two years. To get an idea about the magnitude of the diarrhea problem, the survey started by asking respondents whether the index child had suffered diarrhea in the two weeks preceding the survey. Figure: 3 shows that 54.7% of the target children in the survey had suffered from diarrhea, which is a very high incidence rate.

One important method to treat diarrhea and dehydration of the sick child is through the use of ORS. Despite the high incidence rates, the health seeking behavior is very poor. It can be seen from the same figure that none of the respondents whose child suffered from diarrhea reported giving the child ORS, which is the best first line treatment for diarrhea among children. It remains the challenge of the project to ensure a change in this trend.

Given this situation, it was important to find out whether the problem stemmed from a lack of knowledge of this type of therapy. The mothers were therefore asked whether they had heard of ORS, and if they had, how it was prepared. It can be seen from the table below that 25.3% of mothers could correctly describe ORS and its preparation, 51.6% described it incorrectly, while 23.2% had never heard of ORS.

Table 8: Knowledge of ORS among Caretakers

Knowledge of ORS	N= 95 Percent
Correct	25.3
Incorrect	51.6
Never heard	23.2
Total	100.0

It has further been established that zinc treatment is good for diarrhea among children. The Project will promote this intervention once the appropriate channels have been approved through USAID. The survey sought to find out how many mothers currently knew about zinc treatment. It was revealed that only 2.1% of mothers correctly described zinc treatment. The rest of them admitted they never heard of it. This was however an expected situation since zinc treatment has not yet been introduced in Uganda.

The Project intends to promote a number of healthy practices that are designed to drastically reduce the likelihood of children getting diarrhea. One of these practices is washing hands in various situations. Respondents were asked to mention the instances in which they wash their hands with soap. Current hand washing trends are presented in Table 9.

Table 9:% of Mothers Reporting Washing Hands with Soap by Occasions
Bushenyi KPC, 2006

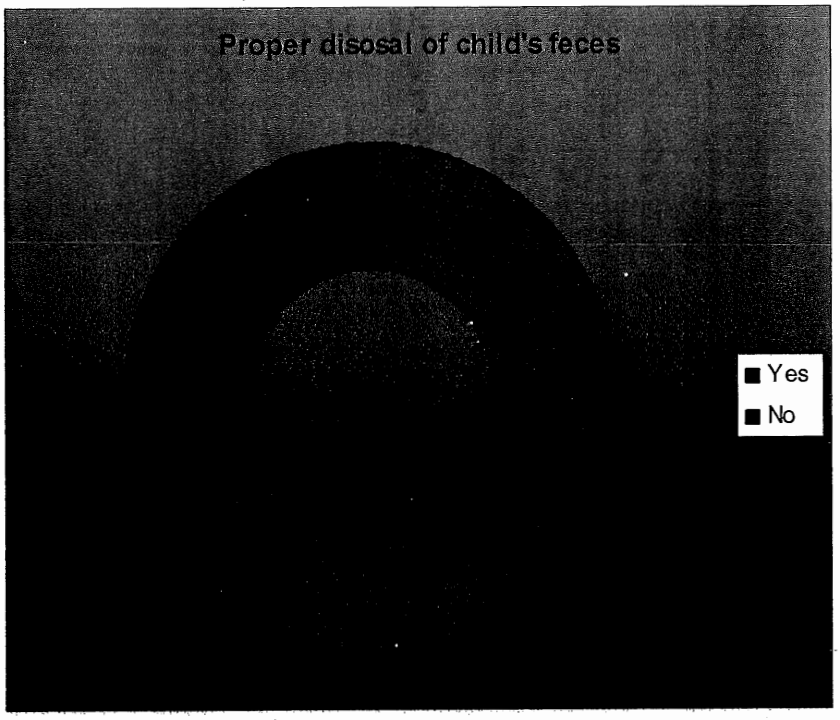
Occasion	N= 95 Percent
Before food preparation	18.9
Before feeding children	45.3
After defecation	26.3
Attending to child who has defecated	7.4
Never wash hands	2.1
Total	100.0

Forty five percent of mothers report washing their hands with soap before feeding children. However, 81.1% of mothers admitted that they do not wash hands with soap/ash before preparing food and 92.6% do not wash after attending to child who has

defecated. Such a trend of behavior needs immediate attention. It is further striking that an overwhelming majority of mothers (73.7%) do not wash hands with soap/ash after defecation and 2.1% of mothers reported that they do not wash their hands on any of these occasions.

The Project will also promote proper disposal of children's feces. The current situation as established by the survey is given in Figure: 4 below. It shows that in 68.4% of the cases, children's feces are right away dropped into the toilet facility.

Figure 4: Feces Disposal



A related practice that the Project intends to pursue is the construction of proper toilet facilities in homes. Ideally these should be either flush toilets or ventilated improved pit (VIP) latrine or covered pit latrine. As found in the survey, no single household in the sample had flush toilet facility; 2% were using VIP toilets and 16.8% had covered pit latrines. The largest portion of respondents had a simple pit latrine without slab, raising the pit latrine coverage to 76.8%. It should however be quickly noted that this type of facility is not protected from flies. The general picture thus remains that only 18.9% of the households in the survey had access to a covered pit latrine.

The practices of construction of toilet facilities with slab need to be pursued in order to secure both the environment from flies and the water sources from contamination. This is important since water is one of the avenues through which diarrhea is transmitted. Consequently, the households were asked for their main source of drinking water. The water sources that can be considered safe are borehole, public tap, and protected dug

well. The challenge then would be on the proper storage of the water. The data presented in Figure 5 shows that half of the households in the sample were getting their drinking water from safe sources while the other half were getting their water from unsafe sources.

Figure 5: Sources of Drinking Water

Child Feeding Practices

In the case of the 0 – 5 months age group, the project is interested in promoting exclusive breastfeeding. The survey therefore set out to establish how many babies in that age group had received exclusive breastfeeding. All the children in this age group were exclusively breastfed. On the other hand, in the case of the 6 – 9 moths age group, the project promotes breastfeeding coupled with complementary feeding. Results in Figure 7 show that 66.6% of these babies were being given complementary feeding, i.e. in addition to breast milk.

Figure 6: Proportion of Children 0-5 Months Who Are Exclusively Breastfed

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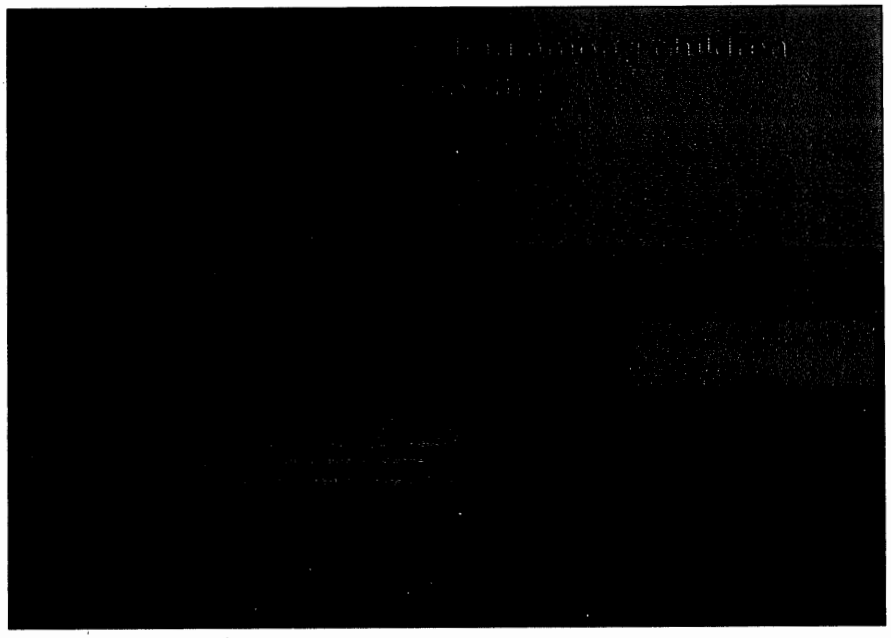

Furthermore, children's feeding becomes an issue when they experience illness. For example, when they get diarrhea, they are re hydrated through increased intake of fluids. Similarly, whatever the illness, children would be greatly assisted in re-gaining their strength if they continued being given food. The survey therefore sought to establish the proportion of mothers who were giving more fluids to their children and continuing to give at least the same amount of food when the children were sick.

The results presented in Figure 8 show that only 16% of the children who experienced illness in the 2 weeks preceding the survey got increased fluids during an illness.

Figure 8: Proportion of Children Given Same or More Fluids during Sickness

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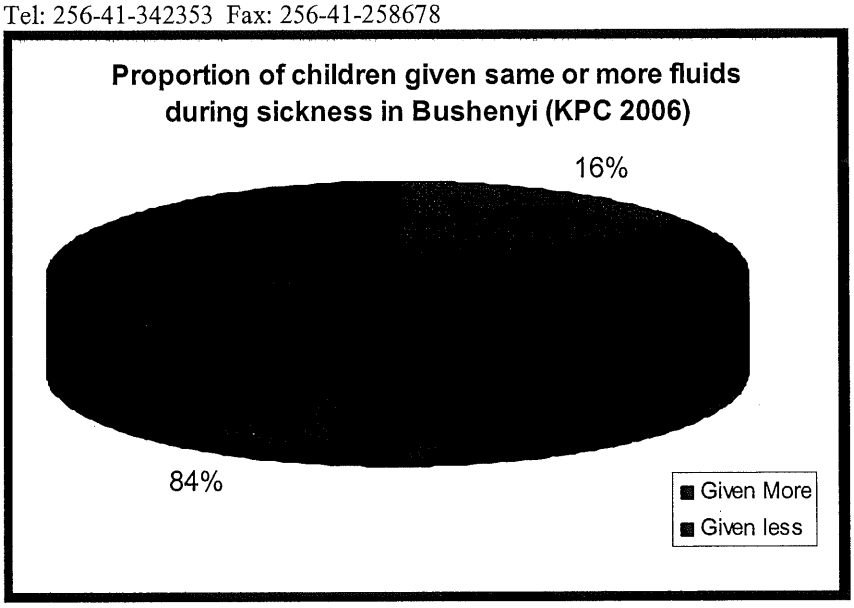

In the face of these unfavorable feeding patterns, it would be of interest to establish the nutritional status of these children. The nutritional status indicator that the survey used is the weight-for-age index. These weights were then compared to the standard population of well fed babies found in Epi info.

Figure 9: Nutrition Status of Children in Bushenyi

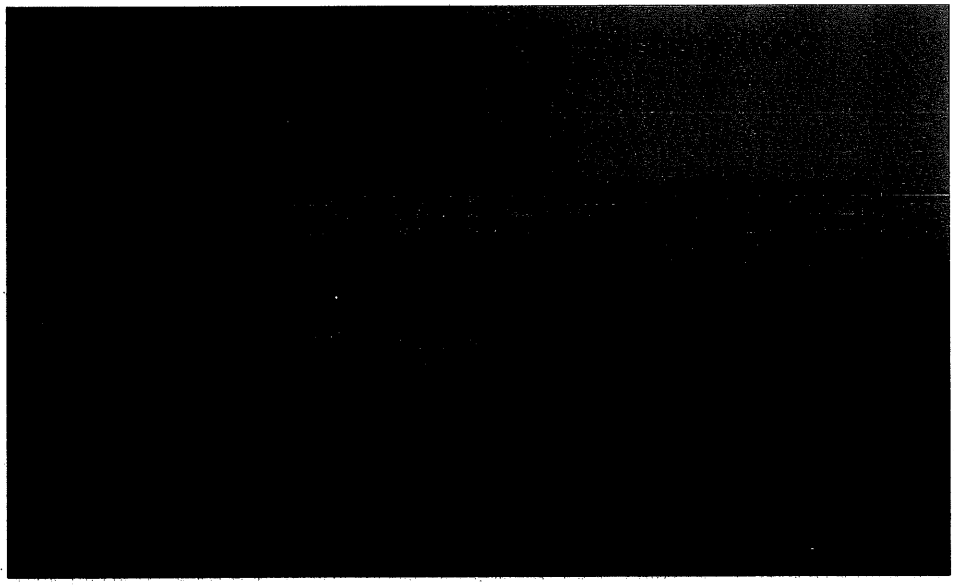

Figure 9 shows that 27% of the children in the sample were malnourished. They were found to be below -2 standard deviations from the mean. This means that they were much lighter than the weight expected for their ages.

B.III. Maternal and New Born Care

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The Project intends to give a firm foundation to child health by ensuring proper maternal and new born care. In this connection, the Project focuses on the areas of ANC; VCT during pregnancy; safe birth plans, and knowledge of pregnancy danger signs as well as nutrition; child spacing; and sanitation.

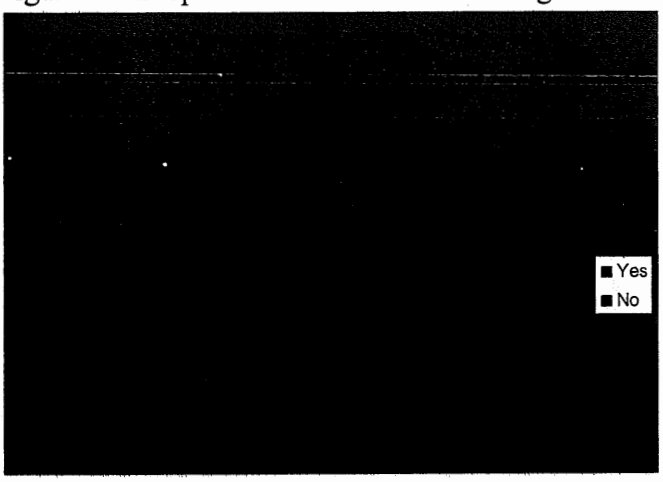
B.IV. ANC Attendance

The Project sets to promote ANC attendance among pregnant women. According to the MOH guidelines, in order to facilitate introduction of prevention of mother to child transmission (PMTCT) of HIV, women should attend ANC at least 4 times. The survey set out to establish the prevailing situation regarding ANC in the district against this guideline. From the study it was found that 18% of mothers had attended 4 or more ANC visits.

Another problem that was found in the households studied was that of card retention. Sixty five percent of mothers reported having gone for antenatal visits for a given number of times, however, they were unable to show their ANC cards. It will be the challenge of the project to raise awareness on importance of card retention.

One of the benefits accruing from ANC attendance is that mothers get immunized against tetanus. The survey asked mothers whether they got this immunization, and, if so, how many times. For a mother to be fully protected with her baby, she should receive the dose at least twice. The figure below shows the proportion of mothers receiving Tetanus toxoid during pregnancy with the index child.

Figure 11: Proportion of Mothers Receiving TT



It can be seen from Figure 11 that 66% of mothers are protected against tetanus. This means that they received two or more doses of tetanus toxoid when they were pregnant. The project should endeavor to increase levels of ANC attendance in order to protect the newly born from preventable death.

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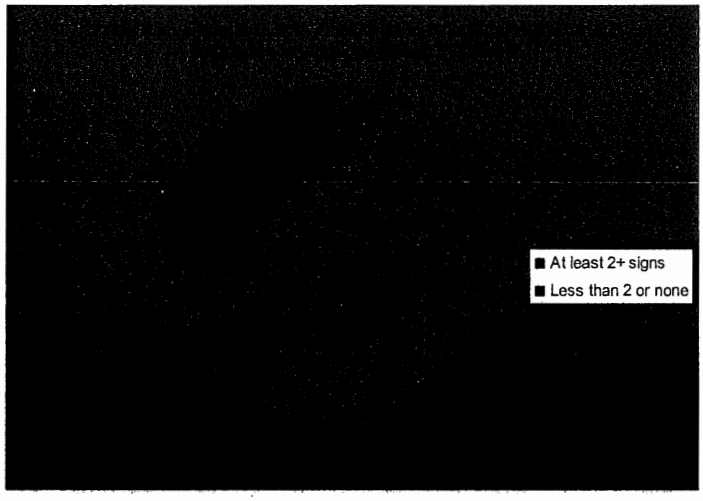
B.V. Caretaker Knowledge

The Project also intends to promote knowledge among caretakers of young children about certain key elements of early child health as another strategy of promoting maternal and child health in general. Mothers were asked to mention at least 3 danger signs during pregnancy indicating the need for health care. Seventy six percent of mothers were able to identify at least two danger signs during pregnancy. This is represented in the graph below.

Figure 12: Proportion of Mothers With Knowledge About Danger Signs During Pregnancy



Looking at the relationship between knowledge of mothers about danger signs and ages, the t- test revealed that there was no significant difference in average age between mothers who know one or no dangerous signs (27.0 years) and mothers who know at least two dangerous signs (28.0 years) (t-test = 0.689 p-value= 0.492).

B.VI. Safe Birth Practices

It is also of interest to the Project that mothers adopt safe practices around and during the birth process. In particular, the survey asked about plans on where to deliver, on transport arrangements, and birth kit. From Figure 13, it is clear that the greatest emphasis is placed on women preparing where to deliver, with 69% of them reporting that they were asked to prepare. Overall, it is evident that education to mothers on all the aspects to plan is low at 38%. Other areas such as transport to the place of delivery and the need to have a birth kit, need more attention.

Figure 13: Proportion of Mothers Advised On Birth Plans

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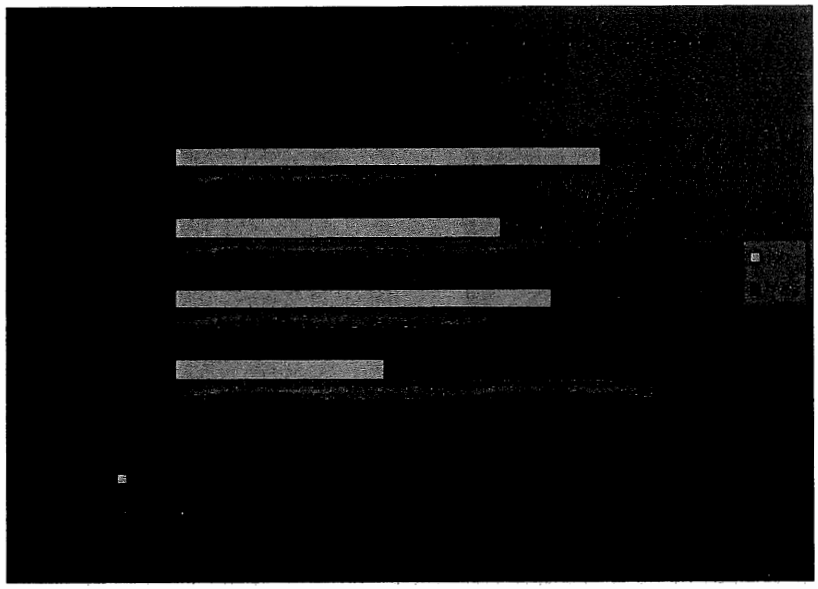
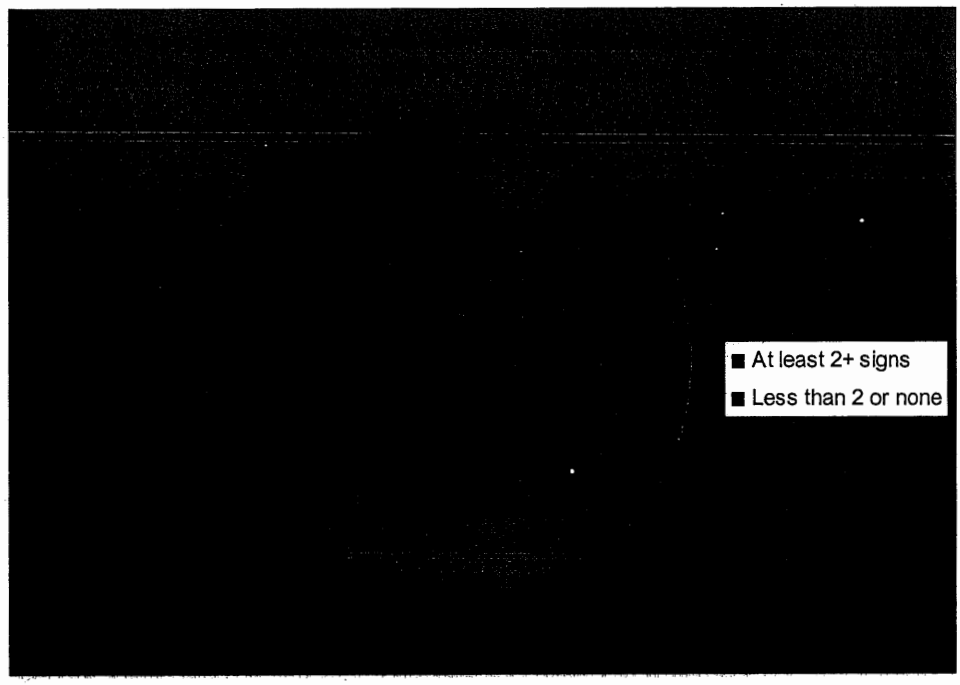


Another knowledge factor regards signs of illness which should indicate that the child needs medical attention. Mothers were asked which signs would indicate to them that their child should be taken for medical attention. Figure 14 presents what their responses indicated.

Figure 14: Proportion of Mothers with Knowledge about Danger Signs That Indicate That the Child Needs Treatment



In the area of recognizing signs of childhood illnesses, mothers seemed to be doing quite well. Seventy-six percent of the mothers could mention two or more signs that indicate a

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child is ill.

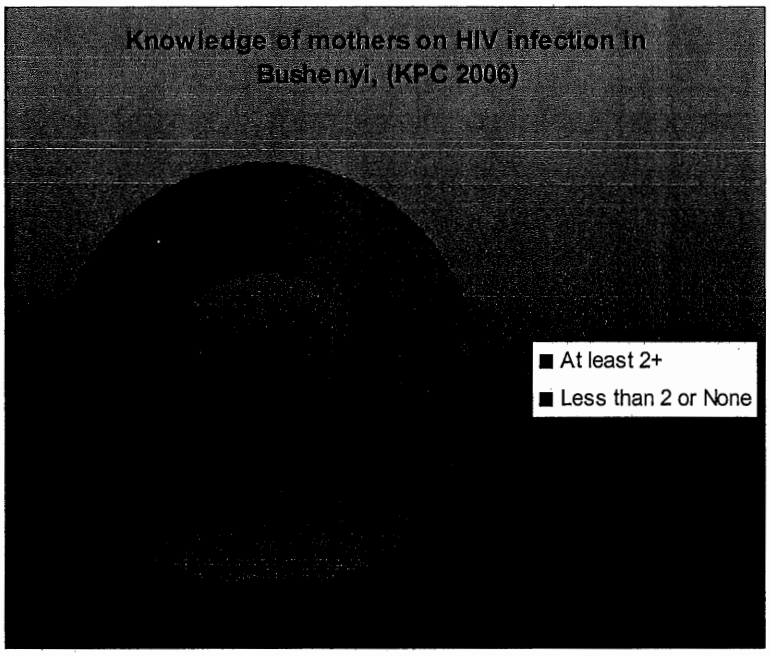
In addition, the Project has a vested interest to ensure that the tools used during the birth process are appropriate. The survey therefore asked mothers whether a clean birth kit was used during birth. It can again be seen that 52.6% of mothers reported having used a clean birth kit. Eighty one percent of mothers also reported that a new razor blade was used to cut the umbilical cord.

It is desirable that mothers should give birth attended to by skilled health personnel. When asked about the person attending their births, 58% reported having delivered with the attendance of a skilled health personnel. Skilled health personnel here included Medical health workers and TBAs.

B.VII. HIV/AIDS

Uganda in general is a high HIV risk country. Any health-related project must factor this in its operations. Since HIV/AIDS infection has no cure, the only known protection against it is through prevention. The project therefore wished to find out how many mothers knew about HIV prevention strategies. Mothers of children 0-23 months were asked to name at least 2 ways of reducing the risk of HIV infection. Figure: 15 shows that only 64.2% of mothers could mention two or more correct ways of preventing HIV infection. This means that the remaining mothers are not knowledgeable in the subject.

Figure 15: Proportion of Mothers Knowledgeable About Preventing HIV Infection



Another strategy that the Project intends to adopt to ensure proper and appropriate maternal and new born care is the promotion of VCT among pregnant women. The survey was set to find out the situation in the district regarding voluntary counseling and testing (VCT) of HIV. The mothers were first asked whether they had been counseled on VCT during their pregnancy with the index child. As presented in Table: 9 33.7% of the mothers sought VCT while still a big portion of 66.3% did not. Among those who did not get both counseling and testing, only 31.6% got either, while 34.8% got none of the services.

Table 9: VCT by Mothers

	N= 95 Percent
None	34.8
Either counseling or testing alone	31.6
Both C&T	33.7
Total	100.0

B.VIII. Immunization of Children

To establish the immunization status of the children, their mothers were asked whether they had immunization cards for their children. However, the reality showed that the practice of card retention was low. Taking this as a measure for full immunization would generate data that is inconsistent with reality. The MOH proxy indicator for full immunization is measles injection, which is given last before the child's first birth day. Mothers were asked whether the child had received a measles vaccination. Results showed that for the children aged 12 – 23 months, 76.7% were fully immunized. This is presented in Figure 16. This age bracket is used because these are the children who are expected to be fully immunized, without censoring from the survey.

Figure 16: Immunization for Children 12- 23 Months

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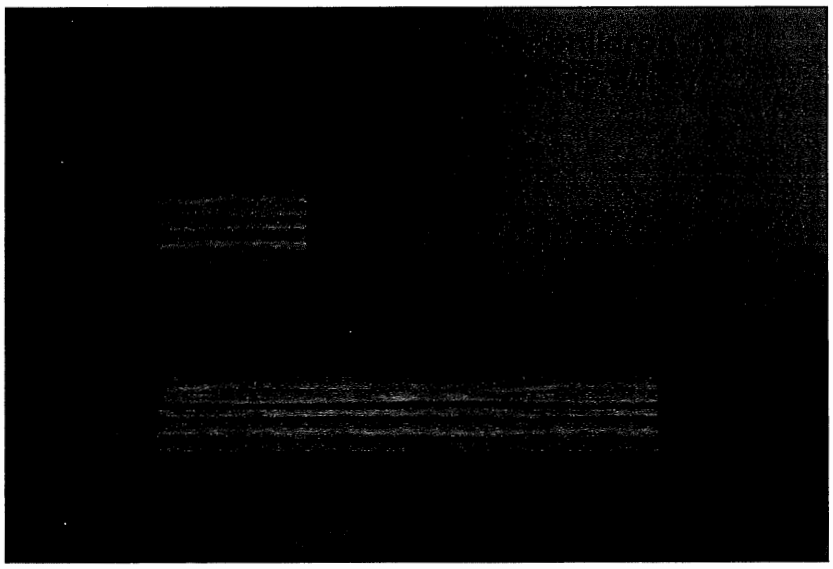

DISCUSSION

A. Discussion

The results presented in this report confirm the need for this project. The project seeks to improve the welfare of mothers and their children. This is envisaged through interventions to combat malaria, diarrhea and to improve maternal and newborn care. It is also important to note at this stage that most of the reliable and available data that can be referred to in comparison to the KPC data is from the UDHS 2000-2001, the HSSP and the National Housing and Population Census 2002. This data is presented in regions and therefore comparisons are drawn from the western region.

A.I. Malaria

It is evident in this report that there is low use of mosquito nets in the district. Whereas the UDHS report puts ITN coverage in western region at 6%, it was found from this survey that 38% of households had ITNs. This braces the project with the challenge of educating households on the importance of ITN especially among under 2s and expectant mothers. This may go a long way to include marketing and ensuring accessibility of long lasting ITNs in the district.

The results also show that only 19% of the pregnant women slept under ITN the previous night. This compares with the UDHS 4% for the region in 2000/2001. To protect both the expectant mother and the baby from cases of miscarriage and death due to malaria, the project shall have to ensure promotion of positive behaviors towards use of ITNs by expectant mothers. Adoption of the BEHAVE framework to design the implementation strategy on this will be helpful.

On malaria prevention during pregnancy, the survey found that 80% of the mothers had IPT during their pregnancy. This marks an increase from 23% in the region according to

the UDHS report in 2000/2001. Such a rate needs to be maintained and even improved to ensure effective protection of both mother and child.

A.II. Diarrhea, Sanitation and Hygiene

From the survey results, 55% of the children in the sample suffered from diarrhea two weeks preceding the survey. By 2000/2001, the UDHS put the western region, which Bushenyi district is part of at 16%. This shows an increase in prevalence of diarrhea in the district.

The treatment of diarrhea must have a strong home-based component. It has been found that ORS is very effective in counteracting the effects of diarrhea on children. These solutions can be easily prepared at home. Despite this fact, the mothers' health seeking behaviors were found to be lacking. None of the mothers gave ORS to their children while they were sick with diarrhea. The biggest reason for this seems to be the mothers' lack of knowledge. Only 25% of the mothers gave a correct description of ORS. The rest either described it incorrectly or had never even heard of it. There is therefore an urgent need to bring to the attention of these mothers the existence of this simple but effective treatment.

The WHO has found that zinc supplementation among children with diarrhea is very effective in preventing deaths. The KPC survey reveals that mothers in this area have not heard of zinc and none of them could describe it correctly. The reason for this is because zinc is not currently in use in the country and the national policy is yet to be made in order for zinc treatment to be introduced in the country. It shall therefore remain the duty of the project to negotiate immediate introduction of this treatment in the country.

It is also important to note that the best strategy in promoting child survival is through preventive measures. While some preventive measures in this district are quite satisfactory, others are extremely low. The preventive strategy for diarrhea is good hygiene and sanitation around the home. Some of the key behaviors in this strategy are hand washing with soap after contact with contaminating situations, and proper waste disposal. The survey results have shown that hand washing in these communities is still poor. This compares well with the UDHS findings that only 3.3% of care takers report washing their hands with soap or ash in the region. Besides, although the majority of households reported disposal of children's feces into toilet facilities (68.4%), a substantial minority (31.6%) still did not report proper waste disposal. This is a serious situation because improper human waste disposal will not affect just the household where it happens, but rather the whole neighborhood.

The project will be challenged with raising awareness among the communities on sanitation and hygiene practices. Practices that need to be boosted range from introduction of hand washing facilities in households, proper feces disposal, hand

washing among others. This could be done through community mobilization and drama among others.

A related issue to sanitation and hygiene is the type of toilet facility that homes have. Proper disposal in this case should mean disposal in covered pit latrines. The results here show that a majority of homes have simple pit latrines without slabs. These pits have very little protection against flies. The project will help increase the number of covered pit latrines. Further inquiry into this is necessary for the project to establish the best strategy to address this problem.

Another problem is contamination through drinking water. The results show that half of the households did not have access to safe drinking water. Diarrhea and related diseases cannot be effectively combated unless the homes have safe water sources. This compares to the 33% safe water sources in the western region as in the UDHS report in 2000/2001.

A.III. Maternal and Newborn Health

In the area of maternal and newborn health, the results have shown that 18% of motherse could verify attending the recommended four ANC visits. This is supposed to give health workers detect some life-threatening conditions during the pregnancy. The MOH recommends ANC attendance of at least four times. The biggest problem found in connection with ANC attendance is card retention. Mothers need to be sensitized about the importance of keeping maternal cards.

Mothers need to be immunized against tetanus during pregnancy. It has been shown in the results that tetanus immunization coverage in this region is 66%.

Another area of maternal health concern is HIV/AIDS. Although Uganda is a high HIV prevalence country, and by far the biggest mode of transmission is heterosexual intercourse, it is worrying to note that up to 36% of the mothers could not mention two correct ways of preventing sexual transmission of HIV. This cites an urgent attention to education on HIV/AIDS among WRA in the district to reduce rates of mother to child transmission.

The project will also have to seriously and urgently tackle counseling – testing gap. Mothers cannot be given proper HIV care, and children cannot be protected from maternal transmission of HIV unless pregnant women are convinced to routinely test for HIV. The results have shown that only 34% of them got counseled and tested for HIV.

The results have also shown that only 38% of mothers are counseled about birth preparations in totality. Specific areas of maternal and child health like breastfeeding, child spacing and pregnancy danger signs got little attention.

Many women deliver their babies at home. Closer investigation needs to done to find how why despite all this knowledge that is imparted to women, they still choose to deliver away from health facilities and skilled birth attendants.

Exclusive breastfeeding among the 0-5 months is high in Bushenyi. Child feeding also extends to, and is particularly more crucial during periods of illness. With morbidity so rampant in Bushenyi, it is worrying that mothers gave only 16% more fluids and 42% more food to their children during their illness. There is a common belief that when children are given fluids and food, diarrhea and vomiting are made worse. Such beliefs have to be dispelled if child health is to be improved.

Given the above feeding scenarios, it is probably little wonder that on the weight-for-age index, 27.17% of the children in this area are malnourished. The UDHS had this at 23.7%. This is a situation that has to be urgently addressed. Bushenyi is Uganda's breadbasket. Most of the food stuffs that are sold in Kampala and other urban areas come from Bushenyi district. It is therefore incomprehensible that it should have such a high level of malnutrition.

Finally, another child survival strategy that is in place at national level is immunization. Children are expected to be fully immunized by the time they are one year old. From the survey, full immunization was ranked at 77%.

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B. DISSEMINATION PLAN

Indicated below is the dissemination plan

Dissemination Scheduled Date: April 21, 2006

Venue / Location : Bushenyi District Council Hall

Participants : Bushenyi District Health Team
District Planning Department
Bushenyi Chief Administrative Officer
Political Leaders
Partner Organizations (PVO's , NGO's, Providers)
Community Representatives
The Press

Method of Dissemination : Introduction to the Program
Recap of the KPC baseline Survey methodology
Presentation of findings
Open discussion on findings
Recommendations on the way forward on the Program's interventions
Conclusions

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ANNEXES

Annex A: Logistical Preparations And Schedule

a) Logistics and Management Planning form

Scheduling issues to consider	**Months of the year**											
	J	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**
Holidays (Christmas , Ramadan, Easter)												
Bad Weather (Cold, Hot weather										Cold Period		
Times when respondents are less available (Harvesting , Weeding, Planting)									Planting / Weeding	Weeding		
Other Project												

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activities or scheduling conflicts for key persons												
Disease Prevalence Patterns												
Food Security and eating patterns (Hungry Season)									Drought Season			
Other Issues												

Survey Dates : The survey will be conducted approximately 10 days beginning January 16, 2006 to January 27' 2006.

b) Schedule

January 2006

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	**2**	**3** Translate questionnaire to Runyankole-	**4** Select sample area- (John)	**5** Design questionnaire with stake	**6**	**7** Selection of interviewersand supervisors- (

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		(Lydia/ Daniel) Travel to Bushenyi- Assy, Daniel & Moses) V		holders- (Jen, Joy, John & Daniel) **CT**		Daniel & Joy) V Prepare training materials- (John & Daniel)
8 Travel to Bushenyi.(John, Lydia and Joy)V	**9** Orientation of Interviewers and Supervisors (Joy, John, Daniel and Lydia)	**10** Conduct pretest with Supervisors and interviewers, modify questionnairefor	**11** Modify and reproduce questionnaire for the survey- (Core Team, S & I & Assy to handle photocopying) Identify starting household- CT, S, I & V (Study teams) Health Facility Assessment- Grace, Daniel and District person.)(V)	**12** Health Facility Assessment (V)	**13** Health Facility Assessment(V)	**14**

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		the survey.(Core team with Interviewers and supervisors) (V)				
15 Institutional Assessment- (Daniel & Joy) **22** **29**	**16** Data collection- (Study Team , John & Daniel) (V) **23** **30**	**17** Data collection(V) **24** **31**	**18** Data Collection (V) **25**	**19** Finalise hand tabulation- (Core team) (V) **26**	**20** Dissermination workshop- (CS Team/ Daniel)(V) **27**	**21** Draft survey Report- (Daniel, John & Joy) **28**

February 2006

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	**2**	**3** Finalisation of report- (Daniel, Joy & Jen)	**4**
5	**6** Stakeholders workshop	**7** Stakeholders workshop- (	**8**	**9**	**10**	**11**

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		Daniel, Joy, Assy & Partners)				
12	**13**	**14**	**15** 1st Draft of the DIP DUE	**16**	**17**	**18**
19	**20**	**21**	**22**	**23**	**24**	**25**
26	**27**	**28**				

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c) Personnel Recruitment plan (Drivers, Data entry Personnel and other Support people

Personnel recruitment plan (drivers, data entry personnel and other support people will be included in other sections)			
Task	Survey Trainer Consultant	Supervisors	Interviewers
How Many	1	2	14
Who will recruit them	Joy	Joy& Daniel	Joy & Daniel
When will they be needed	During training, data collection, tabulation and report writing, dissemination	Training, data collection, tabulation, dissemination	Training, data collection, tabulation, dissemination
From where will you recruit them?	University	PVO/Partners	Community, Partners
Lodging arrangements	Private	Resident in Bushenyi	Resident in Bushenyi
Food Arrangements	Provision of food during training and pre-test	Provision of food during training and pre-test	Provision of food during training and pre-test

d) Transportation Plan

Transportation Plan			
Task	Vehicles (drivers' charges inclusive)	Drivers	Fuel and Maintenance (drivers will maintain vehicles at their own cost)
What Kinds/ how many/ how much?	Private/ 6 cars/ 60,000 shs per car per day	6	Total cost 500,000 shs
When will you need them	Pre-test, data collection	Pre-test, data collection	Pre-test, data collection
Who will get these	Lydia, Daniel and Assy	Lydia, Daniel and Assy	Lydia & Assy
From where will you obtain them?	Private hire	Private hire	Gas stations
Other comments	One vehicle and driver will be obtained from PSI Uganda. The driver will be paid perdiem and lodging during the survey according to the PSI rates. The car will be refueled by the PVO		

e) Editing/printing/ copying survey forms and other materials

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Estimation Matrix for document copying needs			
Document	A: Number of (1 sided) pages per document	B: Number of copies of each document needed	Total Number of Copies to be made (A*B)
Surveys (for training and field use)	27	183	4,941
Other training materials (Table of random numbers)	1	50	50
Field Documents (maps/ Quick reference sheets)(village lists)	2	20	40
Tabulation Tables	5	5	25
Charts/ graphs for presentations	5	50	250
KPC Quality Checklist	-	-	-
KPC survey report	100	50	5,000
Other materials to disseminate results to the community and others (DIP document)	100	50	5,000
		Total Copies to be made	15,306

f) Planning for editing printing and copying documents

Plan for editing printing and copying document				
Task	**Who is responsible for this**	**How many/how much**	**When**	**where**
Use computer software to edit the QES file	Daniel& Data management Consultant	3 computers	After data collection	Kampala health office
Locate a good quality printer	Lydia	1 printer	Before data collection	Kampala
Identify a quality person to do the editing	Daniel& Joy	1	After data collection	Kampala

Contact a professional photocopy facility and a back up facility	(plan to purchase own photocopier)	1@UShs 3,592,017	Before data collection	Kampala
Make copies of the questionnaire for the pretest and training	Daniel	50	Before training and pretest	Bushenyi
Make copies of the other materials for the pretest and training	Daniel	50	Before training and pretest	Bushenyi
Translate the questionnaire	Lydia	1	Before training and pretest	Kampala
Make copies of the modified questionnaire shortly before the survey	Daniel& Consultant	150	After pretest	Bushenyi
Other comments- Nil				

g) Tabulation and analysis of data

Plan for computerized tabulation of the survey				
Task	**Who is responsible for this**	**How many/how much**	**When**	**where**
Obtain computers, printers, paper, ink and data base soft ware	Daniel& Data management Consultant	3 computers	After data collection	Kampala health office
Identify trained computer personnel for data entry	Daniel& Data management Consultant	2	After data collection	Kampala
Identify personnel for supervising data entry/cleaning, and	Daniel& Data management Consultant	1	During and after data entry	Kampala

maintenance of computers				
Ensure alternative power sources if power is not reliable	Lydia	(buy generator)	Before data collection	Kampala
Other comments- Nil				

h) Personnel Budget

Personnel Budget						
Type	Number of persons	Number of days	Daily salary	Daily food/ per diem cost	Daily lodging costs	Total costs
Supervisors	2	3	65,000	Nil	Nil	390,000
Interviewers	14	3	45,000	Nil	Nil	1,890,000
Core team members (staff)	5	14	Nil			1,552,000
KPC trainer consultant	1	14	250 dollars ER= Ush 1,800	Nil	Nil	6,300,000
Guides	12	1	5,000	Nil	Nil	60,000
Data entry personnel						
Sub total for personnel						10,192,000

Total Cost= (Number of persons * Number of days * daily salary) + daily perdiem + daily lodging.

i) Transportation budget

Item				
Type of vehicle	Number of Vehicles	Quantity	Cost per Unit	Total Cost
Hired	6	3 days	60,000 Ushs per day	1,080,000.
Diesel/petrol			1,900/2,300	620,000
Sub total				1,700,000
Budget for various services and equipment				

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Service/item	Quantity	Cost per unit	Total cost
Translation	11 pages	60,000 per page	660,000
Document Copying (stationery)	Nil	Nil	Nil
Rental of office and meeting space	Nil	Nil	Nil
Food costs during workshops	Nil	Nil	Nil
Sub total			660,000

j) Summary of estimated budget

Summary of estimated budget	
Budget Category	Sub total
Personnel	10,192,000
Transportation	1,700,000
Various service equipment	660,000
Estimated grand total	12,552,000

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HealthPartners Child Survival
Baseline KPC and Rapid Catch Assessment Tool

Final Copy
December 21, 2006

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INFORMED CONSENT

Hello. My name is _____, and I am working with (NAME OF ORGANIZATION). We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of your youngest child under the age of two. This information will help (NAME OF ORGANIZATION) to plan health services and assess whether it is meeting its goals to improve children's health. The survey usually takes _____ minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.
At this time, do you want to ask me anything about the survey?

Signature of interviewer: _____
Date: _____

RESPONDENT AGREES TO BE INTERVIEWED . . . . . 1?
RESPONDENT DOES NOT AGREE TO BE INTERVIEWED . . . . . 2 END

Cluster Number.....
Household Number.....
Record Number.....

1. RECORD INTERVIEW DATE

DAY		MONTH		YEAR	

2. How old are you?
RECORD AGE OF RESPONDENT IN YEARS: _____

3. How many children living in this household are under age five? _____

4. How many children living in this household are under 24 months? _____

5. How many of those children are your biological children? _____

6. READ ONE OF THE FOLLOWING QUESTIONS BASED UPON MOTHER'S RESPONSE TO Q.4:

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ONLY 1 CHILD UNDER FIVE: "What is the name, sex, and date of birth of that child?"

MORE THAN 1 CHILD UNDER FIVE: "What are the names, sexes, and dates of birth of your children?"

	NAME	SEX	DATE OF BIRTH
1		3. MALE 4. FEMALE	__ __/__ __/__ __ DD MM YY
2		3. MALE 4. FEMALE	__ __/__ __/__ __ DD MM YY

7. Are you member of the Uganda Health Cooperative?

8. IF NO, SKIP TO Q.9, IF YES, how long have you been a member? ____ years ___months

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THE FOLLOWING QUESTIONS PERTAIN ONLY TO THE ONE CHILD SELECTED FOR THIS INTERVIEW

Anthropometry

9. May I weigh (NAME)?
   1. YES
   2. NO → **SKIP TO Q.11**

10. IF MOTHER AGREES, WEIGH THE CHILD AND RECORD WEIGHT BELOW. *RECORD TO THE NEAREST TENTH.*

___ ___ . ___ KILOGRAMS

Child Immunization

11. Do you have a card where (NAME'S) vaccinations are written down?
IF 'YES'ASK 'May I see it please?'

   1. YES, SEEN BY INTERVIEWER
   2. NOT AVAILABLE (lost/misplaced, not in home) → **SKIP TO Q.13**
   3. NEVER HAD A CARD → **SKIP TO Q.13**

12. RECORD INFORMATION EXACTLY AS IT APPEARS ON (NAME'S) VACCINATION CARD.

	DAY	MONTH	YEAR
BCG			
POLIO 0			
POLIO 1			
POLIO 2			
POLIO 3			
DPT 1			
DPT 2			
DPT 3			
MEASLES			
VITAMIN A			

13. Did (NAME) ever receive an injection to prevent measles?
   1. YES

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2. NO
8. DON'T KNOW

HIV/AIDS

14. Have you ever heard of an illness called AIDS?
1. YES
2. NO → **SKIP TO Q.16**

15. What can a person do to avoid getting AIDS or the virus that causes AIDS?
CIRCLE ALL MENTIONED.
A. NOTHING
B. ABSTAIN FROM SEX
C. USE CONDOMS
D. LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PARTNER
E. LIMIT NUMBER OF SEXUAL PARTNERS
F. AVOID SEX WITH PROSTITUTES
G. AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS
H. AVOID INTERCOURSE WITH PERSONS OF THE SAME SEX
I. AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY
J. AVOID BLOOD TRANSFUSIONS
K. AVOID INJECTIONS
L. AVOID KISSING
M. AVOID MOSQUITO BITES
N. SEEK PROTECTION FROM TRADITIONAL HEALER
O. AVOID SHARING RAZORS, BLADES
W. OTHER_____
(SPECIFY)
X. OTHER_____
(SPECIFY)
Z. DON'T KNOW

Hand-washing Practices

16. When do you wash your hands with soap/ash?

DO NOT PROMPT. CIRCLE ALL MENTIONED.
A. NEVER
B. BEFORE FOOD PREPARATION
C. BEFORE FEEDING CHILDREN
D. AFTER DEFECATION
E. AFTER ATTENDING TO A CHILD WHO HAS DEFECATED
X. OTHER _____
(SPECIFY)

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Integrated Management of Childhood Illnesses (IMCI)

17. Sometimes children get sick and need to receive care or treatment for illnesses. What are the signs of illness that would indicate your child needs treatment? *DO NOT PROMPT. CIRCLE ALL MENTIONED.*

A. DON'T KNOW
B. LOOKS UNWELL OR NOT PLAYING NORMALLY
C. NOT EATING OR DRINKING
D. LETHARGIC OR DIFFICULT TO WAKE
E. HIGH FEVER
F. FAST OR DIFFICULT BREATHING
G. VOMITS EVERYTHING
H. CONVULSIONS
I. OTHER _____
(SPECIFY)

J. OTHER _____
(SPECIFY)

K. OTHER _____
(SPECIFY)

18. Did (NAME) experience any of the following in the past two weeks?
READ CHOICES ALOUD AND CIRCLE ALL MENTIONED BY RESPONDENT.

A. DIARRHEA
B. BLOOD IN STOOL
C. COUGH
D. DIFFICULT BREATHING
E. FAST BREATHING/SHORT, QUICK BREATHS
F. FEVER
G. MALARIA
H. CONVULSIONS
I. OTHER _____
(SPECIFY)
J. OTHER _____
(SPECIFY)
K. NONE OF THE ABOVE → **SKIP TO Q.28**

19. "When (NAME) was sick, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?"

1. LESS THAN USUAL
2. SAME AMOUNT

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3. MORE THAN USUAL

20. When (NAME) was sick, was he/she offered less than usual to eat, about the same amount, or more than usual to eat?
    1. LESS THAN USUAL
    2. SAME AMOUNT
    3. MORE THAN USUAL

Malaria Prevention

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
21	Did (NAME) experience a fever in the past two weeks?	YES . . . . . 1 NO 2	 **27**
22	Did you seek advice or treatment for (NAME'S) fever?	YES . . . . . 1 NO 2	 **27**
23	Where did you first go for advice or treatment? IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE (NAME OF PLACE)	HEALTH FACILITY HOSPITAL . . . . . 1 HEALTH CENTER . . . . . 2 HEALTH POST . . . . . 3 PVO CENTER . . . . . 4 CLINIC . . . . . 5 FIELD/COMMUNITY HEALTHWORKER. 6 OTHER HEALTH FACILITY_____7 (SPECIFY) OTHER SOURCE TRADITIONAL PRACTITIONER. . . . . 8 SHOP . . . . . 9 PHARMACY . . . . . 10 COMMUNITY DISTRIBUTORS . . . . . 11 FRIEND/RELATIVE . . . . . 12 OTHER_____88 (SPECIFY)	
24	How long after you noticed (NAME'S) fever did you seek treatment from that person/place?	SAME DAY . . . . . 0 NEXT DAY . . . . . 1 TWO DAYS . . . . . 2 THREE OR MORE DAYS. 3	
25	Which medicines were given to (NAME) for his/her fever? CIRCLE ALL MEDICINES THAT WERE GIVEN. IF MOTHER IS UNABLE TO RECALL DRUG NAME(S), ASK HER	ANTI-MALARIAL DRUGS – WHY USE THESE CODES A. CHLOROQUINE . . . . . 1 B. FANSIDAR . . . . . 2 C. AMODIAQUINE . . . . . 3 D. QUININE 4	

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	TO SHOW THE DRUG(S) TO YOU. IF SHE IS UNABLE TO SHOW YOU THEM, SHOW HER TYPICAL ANTI-MALARIALS AND HAVE HER IDENTIFY WHICH WERE GIVEN.	E. ARTUNUM.....5 F. METAKELFIN.....6 G. HOMAPAK.....7 OTHER DRUGS E. ASPIRIN.....8 F. PANADOL.....9 G. CO-TRIMOXAZOLE.....10 X. OTHER_____11 (SPECIFY)	
26	FOR EACH ANTI-MALARIAL MEDICINE ASK: How long after the fever started did (NAME) start taking the medicine? CIRCLE THE APPROPRIATE CODE. CODES	SAME DAY.....0 NEXT DAY AFTER THE FEVER.....1 TWO DAYS AFTER THE FEVER..... 2 THREE OR MORE DAYS AFTER THE FEVER ..... 3 DON'T KNOW.....8	
27	What causes malaria? RECORD ALL MENTIONED Anything else?	MOSQUITO BITES . . . . . A WITCHCRAFT . . . . . B SHARING RAZORS/BLADES . . . . . F BLOOD TRANSFUSIONS . . . . . D INJECTIONS . . . . . E KISSING . . . . . G OTHER _____ W (SPECIFY) OTHER _____ X (SPECIFY)	
28	When you were pregnant with (NAME), did you take any drugs to prevent you from getting malaria?	YES . . . . . 1 NO 2	**30**
29	Which drug did you take? RECORD ALL MENTIONED	FANSIDAR . . . . . A CHLOROQUINE . . . . . B OTHER.....X	
30	Do you have any bednets in your house?	1 YES . . . . . 1 NO 2	**36**
31	Who slept under a bednet last night? RECORD ALL MENTIONED.	CHILD (NAME). . . . . A HUSBAND/PARTNER . . . . . C MYSELF . . . . . B OTHER CHILDREN OR PEOPLE _____ X (SPECIFY)	
32	How long ago was the bednet bought or obtained?	MONTHS . . . . . _____ DON'T KNOW 98	
33	Was the bednet ever soaked or dipped in a	YES 1	

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	liquid to repel mosquitoes or bugs?	NO . . . . . 2 DON'T KNOW 8	35 35
34	How long ago was the bednet last soaked or dipped? RECORD ANSWER IN MONTHS (LESS THAN 1 MONTH = 00)	MONTHS. . . . . _____ DON'T KNOW 98	
35	ASK TO SEE THE BEDNET AND INSPECT IT FOR HOLES OR TEARS. NO HOLES/TEARS= GOOD CONDITION. VISIBLE HOLES AND/OR TEARS=DAMAGED.	GOOD CONDITION . . . . . 1 DAMAGED 2	

We would now like to talk about maternal and newborn care.

Maternal and Newborn Care

36. Before you gave birth to (NAME) did you receive an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth?
    1. YES
    2. NO → **SKIP TO Q.38**
    3. DON'T KNOW → **SKIP TO Q.38**

37. How many times did you receive such an injection?
    1. ONCE
    2. TWICE
    3. MORE THAN TWO TIMES
    4. DON'T KNOW

38. Now I would like to ask you about the time when you gave birth to (NAME). Who assisted you with (NAME'S) delivery?
    A. DOCTOR
    B. NURSE/MIDWIFE
    C. AUXILIARY MIDWIFE
    D. TRADITIONAL BIRTH ATTENDANT _____
    (NAME)
    E. COMMUNITY HEALTH WORKER
    F. FAMILY MEMBER _____
    (SPECIFY RELATIONSHIP TO RESPONDENT)
    G. OTHER _____
    (SPECIFY)
    Y. NO ONE

39. For how long should a mother spend after delivery to get pregnant?
    A. Less than 1 Year
    B. One and a half Year

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C. At least 2 Years

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
40	Did you see anyone for prenatal care while you were pregnant with (NAME)?	YES.....01 NO.....02	 **48**
41	IF YES: Whom did you see?	HEALTH PROFESSIONAL DOCTOR ..... A NURSE/MIDWIFE ..... B NO ONE ..... Z	
	Anyone else? PROBE FOR THE TYPE OF PERSON AND RECORD ALL PERSONS MENTIONED BY THE MOTHER.	OTHER PERSON TRADITIONAL BIRTH ATTENDANT.....D COMMUNITY HEALTH WORKER ..... E OTHER _____ X (SPECIFY)	
42	How many times did you see someone for care during the pregnancy?	NUMBER OF TIMES ..... _____	
43	During your prenatal check, were you counseled on the following: Delivery preparations? Breastfeeding? Child spacing? Danger signs of pregnancy?	YES / NO 2 / 2 2 / 2 2 / 2 1 / 2	
44	Did the Health Care Giver ask you to plan the following in advance? 4. Where to deliver 5. transport to place of delivery 6. Having a birth kit	YES.....1 NO.....2	
45	During your prenatal check, were you given any counseling on HIV/AIDS?	YES.....1 NO.....2	
46	Did you voluntarily test for HIV?	YES.....1 NO.....2	
47	Do you have a maternal health card for your pregnancy with (NAME)?	YES, SEEN ..... 1 NOT AVAILABLE ..... 2 NEVER HAD A CARD 3	 **50** **50**
48	LOOK AT CARD AND RECORD THE NUMBER OF PRENATAL VISITS WHILE MOTHER WAS PREGNANT WITH (NAME).	NUMBER OF VISITS ..... _____	
49	What are the symptoms during pregnancy indicating the need to seek health care? RECORD ALL MENTIONED.	FEVER.....A SHORTNESS OF BREATH ..... B BLEEDING ..... C SWELLING OF THE BODY/HANDS/FACE... D OTHER_____ X (SPECIFY)	
50	When you were pregnant with (NAME), did you receive or buy any iron tablets or iron syrup?	YES ..... 1 NO 2	 **53**

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	SHOW TABLET/SYRUP		
51	How many days did you take the tablets or syrup? IF ANSWER IS NOT NUMERIC, PROBE FOR APPROXIMATE NUMBER OF DAYS.	NUMBER OF DAYS . . . . . _____	
52	Where did you give birth? IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE _____	HOME (DO WE NEED NUMBERS HERE?) HEALTH FACILITY HOSPITAL . . . . . 21 CLINIC . . . . . 22 OTHER _____ (SPECIFY)	
53	Was a clean birth kit used?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
54	What instrument was used to cut the cord?	NEW RAZOR BLADE . . . . . 1 OTHER INSTRUMENT . . . . . 2 (SPECIFY NAME) _____	
55	Where was (NAME) put immediately after birth?	WITH MOTHER . . . . . 1 IN COT . . . . . 2 ON FLOOR . . . . . 3 BATHED . . . . . 4 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	
56	What did you do with (NAME) immediately after birth?	BREASTFED . . . . . 1 BATHED . . . . . 2 LET SLEEP . . . . . 3 OTHER _____ 6 DON'T KNOW 8	

Breastfeeding and Nutrition

57. Did you ever breastfeed (NAME)?
    1. YES
    2. NO → **SKIP TO Q.60**

58. How long after birth did you first put (NAME) to the breast?
    1. IMMEDIATELY/WITHIN FIRST HOUR AFTER DELIVERY
    2. AFTER THE FIRST HOUR

59. I would like to ask you about the types of liquids and foods that (NAME) consumed yesterday during the day or at night. Did (NAME) have. . .

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READ EACH OF THE FOLLOWING AND PLACE A CHECK MARK IN THE BOX NEXT TO EACH ITEM CONSUMED.

	LIQUID/FOOD	CONSUMED IN LAST 24 HOURS?
A	Breast milk?	
B	Plain water?	
C	Other liquids?	
D	Mashed, powdered, solid, or semisolid foods?	
E	Anything else SPECIFY: _____ _____ _____	

Now we would like to talk about Diarrhea…

Diarrhea, sanitation and hygiene

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
60	Does (NAME) have diarrhea now?	YES.....1 NO.....2	
61	What was given to treat the diarrhea? Anything else? RECORD ALL MENTIONED	NOTHING ..... A FLUID FROM ORS PACKET. . . . . B HOME-MADE FLUID. . . . . C PILL OR SYRUP . . . . D INJECTION.....E (IV) INTRAVENOUS.....F HOME REMEDIES/HERBAL MEDICINES.....G OTHER _____ X (SPECIFY)	
62	When (NAME) had diarrhea, did you breastfeed him/her less than usual, about the same amount, or more than usual?	LESS .....1 SAME.....2 MORE..... . . . . 3 CHILD NOT BREASTFED.....4	
63	Did you seek advice or treatment from someone outside of the home for (NAME'S) diarrhea?	YES.....1 NO.....2	 68
64	Where did you first go for advice or treatment?	HEALTH FACILITY HOSPITAL 01	

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	IF SOURCE IS HOSPITAL, HEALTH CENTRE, OR CLINIC, WRITE THE NAME OF THE PLACE _____	HEALTH CENTRE.....02 PVO CENTRE..... .03 CLINIC . . . . 04 FIELD/COMMUNITY HEALTH WORKER.....05 OTHER HEALTH FACILITY_____ (SPECIFY) OTHER SOURCE TRADITIONAL PRACTITIONER...08 SHOP.....09 PHARMACY.....10 COMMUNITY DISTRIBUTORS.....11 FRIEND/RELATIVE.....12 OTHER _____ X (SPECIFY)	
65	Who decided that you should go there for (NAME'S) illness? RECORD ALL MENTIONED	RESPONDENT.....A HUSBAND/PARTNER.....B RESPONDENT'S MOTHER.....C MOTHER-IN-LAW.....D FRIENDS/NEIGHBOURS.....E OTHER _____ X (SPECIFY)	
66	Where did you go next for advice or treatment? IF SOURCE IS HOSPITAL, HEALTH CENTRE, OR CLINIC, WRITE THE NAME OF THE PLACE _____	HEALTH FACILITY HOSPITAL . . . . . 01 HEALTH CENTRE.....02 PVO CENTRE..... .03 CLINIC . . . . . 04 FIELD/COMMUNITY HEALTH WORKER.....05 OTHER HEALTH FACILITY_____ (SPECIFY) OTHER SOURCE TRADITIONAL PRACTITIONER...08 SHOP.....09 PHARMACY.....10 COMMUNITY DISTRIBUTORS.....11 FRIEND/RELATIVE.....12 OTHER _____ X (SPECIFY)	

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67	Have you heard of ORS? IF YES, ASK CARETAKER TO DESCRIBE ORS PREPARATION FOR YOU. IF NO, CIRCLE 3 (NEVER HEAD OF ORS.) ONCE CARETAKER HAS PROVIDED A DESCRIPTION, RECORD WHETHER SHE/HE DESCRIBED ORS PREPARATION CORRECTLY OR INCORRECTLY. CIRCLE 1 [CORRECTLY] IF THE CARETAKER MENTIONED THE FOLLOWING: • USE 1 LITER OF CLEAN DRINKING WATER (1 LITER=3 SODA BOTTLES) • USE THE ENTIRE PACKET • DISSOLVE THE POWDER FULL	DESCRIBED CORRECTLY.....1 DESCRIBED INCORRECTLY.....2 NEVER HEARD OF ORS.....3	
68	Have you heard of Zinc? IF YES, ASK CARETAKER TO DESCRIBE ZINC TREATMENT FOR YOU. IF NO, CIRCLE 3 (NEVER HEAD OF ZINC.) ONCE CARETAKER HAS PROVIDED A DESCRIPTION, RECORD WHETHER SHE/HE DESCRIBED ZINC TREATMENT CORRECTLY OR INCORRECTLY. CIRCLE 1 [CORRECTLY] IF THE CARETAKER MENTIONED THE FOLLOWING: • GIVE ZINC DAILY • FOR 10-14 DAYS	DESCRIBED CORRECTLY.....1 DESCRIBED INCORRECTLY.....2 NEVER HEARD OF ZINC.....3	
69	What is the main source of drinking water for members in this household?	Borehole Public tap Protected dug well Unprotected dug well Rain water collection Surface water (river/pond/lake/dam/stream) Other_____	

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		(specify)	
70	Do you treat your water in any way to make it safe to drink?	YES.....1 NO.....2	
71	How is the water treated	PUR.....1 Waterguard.....2 Boiling.....3 Other_____7 SPECIFY	
72	The last time (name) passed stool, where were the feces disposed of? (IF "WASHED AWAY", PROBE WHERE THE WASTE WATER WAS DISPOSED OF. IF "DISPOSED"PROBE WHERE IT WAS DISPOSED OF SPECIFICALLY.	Dropped into toiled facility.....1 Rinsed away Water discarded into toilet facility....21 Water discarded into sink or tub connected to drainage system.....22 Disposed Into solid waste/ trash.....31 Somewhere in Yard.....32 Outside premises.....33 Buried.....41 Did nothing.....42 Other_____ (Specify)	
73	What kind of toilet facility does this household use?	Flush toilet.....1 Ventilated Improved Pit latrine.....2 Covered pit latrine.....3 Simple pit latrine without slab.....4 Bucket latrine.....5 No facility(field/bush/plastic bag) etc..6	
74	Observation only. Is there a hand washing device such as a tap, basin, bucket, or sink? This item should be within view or brought by the interviewee within one minute. If item is not present within one minute, check no even if brought later.	YES.....1 NO.....2	

Thank You.

END OF SURVEY

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KPC Survey in Runyankole

OKWIKIRIZA OMANYISIIBWE

Nigaahi. Nibayeta_____ kandi ninkora n'ekitongore (eizina ryaakyo) . Twiine ebiturikorondereza kandi nitukisiima wakwatanisiza hamwe naitwe. Ninyenda nkubuuze aha bikwatiraine n'amagara gaawe hamwe nag'omwaana waawe omuto okiri ahansi y'emyaaka ebiri(2). Amakuru aga nigaija kuhweera ekitongore ekya HealthPartners kutebekanisiza obuhereza omubya amagara, kandi n'okushwijuma yaaba nikihikiriza ebigyendererwa byaakyo eby'okuta amagara g'omwaana ahamutindo .Okurondereza oku butoosha nikutwaara edakiika _____ tukaba nitumaririza. Amakuru goona agorahereze nigaija kukuumwa omukihama kandi tigarikwiija kworekwa ahabandi bantu boona.

Okukwatanisa naitwe omukurondereza oku nokwa nyekundaire, kandi nobaasa kusharamu obutagarukamu ekibuuzo kyoona ekirikukukwataho nk'omuntu nari obutagarukamu ekibuuzzo kyoona. Baitu kandi nituteekateka ngu nooza kutukwaasa omukubuririza oku ahabw'okuba eby'orikuza kutugambira nibikuru munonga.

Hariho ekiwakubaire nohurira n'oyenda kubuuza kyoona ahitwahitsya ahakubuuriza oku?

Omukono gw'orikubuririza _____

Ebiro_____ by'okweezi

ORIKUBUUZIBWA YAYIKIRIZA OKUGARUKAMU 1

ORIKUBUUZIBWA YAYANGA OKUGARUKAMU.....2

Murugyeho.

Orikubuuza naija okukuhweera okwijuzamu ebibuuzo ebi omukihama.

Webare kwikiriza okukwatanisa naitwe omumurimo ogu.

Enamba y'ekicweeka eki.....

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Enamba y'enju.....

Enamba y'ebyatahibwa.....

1. HANDIIKA EBIRO BY'OKWEZI EBIWABURIZAHO

EIZOOBA OKWEEZI OMWAAKA					

2. Oine emyaaka engahi ey'obukuru?
   HANDIIKA EMYAAKA Y'OBUKURU EY'ORIKUGARUKAMU:_____
3. N'abaana bangahi abarikutuura omunju omu abari ahansi y'emyaaka etaano(5)_____
4. N'abaana bangahi abarikutuura omunju egi abari ahansi y'emyeezi 24?_____
5. Omu baana aba boona nibagahi aboyezarire?_____
6. SHOMA KIMWE AHABIBUUZO EBYAKURATAHO KURUGIRIRA AHA MUNTU ORIKUREEBERERA OMWAANA OKUHITSYA AHARI Q 4

   OMWAANA OMWE (1) WENKA OWA AHANSI Y'EMYAAKA ETAANO: "Omwaana ogu nibamweeta oha, nimwaanaki, kandi akazaarwa ebiro bingahi by'okweezi, mumwaaka ki?

No.	**EIZIINA**	**NIMWAANA KI**	**OBUYAZAARWA**
1		1.Omwoojo 2.Omwishiki	_____/_____/_____ EBIRO OKWEEZI OMWAAKA
2		1.Omwoojo 2.Omwishiki	_____/_____/_____ EBIRO OKWEEZI OMWAAKA
3		1.Omwoojo 2.Omwishiki	_____/_____/_____ EBIRO OKWEEZI OMWAAKA

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4		1.Omwoojo 2.Omwishiki	_____/_____/_____ EBIRO OKWEEZI OMWAAKA
5		1.Omwoojo 2.Omwishiki	_____/_____/_____ EBIRO OKWEEZI OMWAAKA

7. Ori menba w'e Uganda Health Cooperative? Yes.....1
   No.....2
8. KYAABA KIRI NGU, EBINDI BIGURUKYE OKUHITSYA AHARI Q 9 KANDI YAABA ARI MEMBA, amazire obwiire burikwingana ki ari memba?_____ Emyaaka_____ Emyeezi

EBIBUUZO EBYAKURATIRAHO NIBIKWAATA AHA MWAANA OMUTO MUNONGA OWAHANSI Y'EMYEEZI 24

Abarikurondereza bapime omwaana

9. Nimbaasa okupiima (EIZIINA)
   1. Eego
   2. Ngaaha ---------- **GYENDA AHARI Q11**

10. ORIKUREEBERERA OMWAANA KWARAIKIRIZE, PIMA OBUREMEEZI BW'OMWAANA, OTATSYE EBYARUGAMU AHANSI BARIRA AHARI HAIHI N'OMWAANYA OGWA 10_____ ._____(Kgs)

Okusirika omwaana

11. onie ekipande eki (eiziina) arikusirikirwaho?
    KWARAABE AKIINE "SHABA OKURIREEBAHO"
    1. Eego, orikubuuza yakireeba

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2. TIKIRIHO (kikabura/ tinareeba ahunkikwasize/ tikiri munju) → **GENDA AHARI Q 13**
3. EKIPANDE TAKAKIGIRAHOGA → **GYENDA AHARI Q 13**

12. TATSYA BYOONA EBIRI AHA KIPANDE KYA (EIZIINA) NK'OKU BIHANDIIKIRWE

	EIZOOBA	**OKWEEZI**	**OMWAAKA**
BCG			
POLIO 0			
POLIO 1			
POLIO 2			
POLIO 3			
DPT 1			
DPT 2			
DPT 3			
OBUSHERU			
VITAMINI A			

13. (Eiziina) aratungireho ekikatu eky'okumusirika obusheru?
    1. Eego
    2. Ngaaha
    3. Tindikukimanya

AKAKOOKO KA SIRIIMU N'OBURWAIRE BWA AIDS (HIV/AIDS)

14. Orarwaireho oburwaire oburikweetwa AIDS (siriimu)
    1. Eego
    2. Ngaaha → **GYENDA HARI Q.16**

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15. Omuntu nabaasa kukoraki okwerinda AIDS nari akakooko akarikureeta AIDS?

EBIRAGAMBWE BITE OMUKAGO (SAAKO)

A. TIKIRIHO
B. ARUGYE AHABY'OKUTERANA
C. AKORESE AKAPIIRA (KONDOMU)
D. TERANA N'OMUNTU OMWE / BA OMWESIGWA AHA MUNTU OMWE
E. BARIRIRA ABANTU ABORIKUTERANA NABO
F. YETANTARE OKUTERANA NA BAMARAAYA
G. YETANTARE OKUTERANA N'ABANTU ABAINE ABANDI BAINGI (OMUMUBONANO)
H. YETANTARE OKUTERANA N'OMUSHAIJA NARI OMUKAZI MUGYENZI WAAWE
I. YETANTARE OKUTERANA N'ABANTU ABARIKURORESA EBIBAZI
J. YETANTARE OKUHEEBWA OKUTEEBWAAMU ESHAGAMA
K. YETANTARE EBIKATU
L. YETANTARE OKUNYWEGYERANA
M. YETANTARE OKURUMWA ENSIRI
N. YEBUUZE AHA MUSHAHO OW'EKIRAGUJU
O. YETANTARE AMAKWATANE G'OBUGIRITA N'EBINDI EBIRIKUSHARA
P. EBINDI (BIGAMBEHO)_____
Q. Tindikumanya

Eminabire y'omungaro/Omucwe gw'okunaaba omungaro.

16. Engaro zaawe nozinaaba ryaari n'esabuuni/ n'eiju?

OTAGIRA EKIWAGYEZAHO KUHABURA. EBYAGAMBWA BITE OMUKAGO

A. TIBURIHO
B. NTAKATEBEKANISE EBY'OKURYA
C. NTAKAGABURIRE ABAANA
D. NARUGA OMUKIHORONYO/ OMUKIYIGO
E. NAHEZA KUBONEZA OMWAANA OWAYEYAMBA (Okunia)

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F. EBINDI (BIGAMBEHO)

Emiringo y'okuraguriza endwaara z'abaana (IMCI)

17. obumwe n'obumwe abaana nibarwara kandi beteenga okureeebererwa nari okuragurizibwa. Nibubonero, ki? Obw'endwaara oburikworeka ngu omwaana nayetenga okuragurirwa? OTAHABURA NAKAKYE. EBIRAGAMBWE BYOONA BITE OMUKAGO.
    A. TINDIKUMANYA
    B. NAREEBUKA ATAINE AMAANI NARI ATARIKUZAANA NKA BUTOOSHA
    C. TARIKURYA N'OBUKWAKUBA OKUNYWA
    D. OKUBURWA AMAANI G'OKUKORA EKINTU KYOONA NARI OKWEYIMUSTYA
    E. OKUPIIPA KW'AMAANI
    F. OKWITSYA AHONAHO NARI OKUREMWA OKWITSYA
    G. OKUTANAKA BURI KAMWE AKUYARYA
    H. OKUSHAMBAGUZA
    I. EBINDI _____
    (BIGAMBE)
    J. EBINDI_____
    (BIGAMBE)
    K. EBINDI_____
    (BIGAMBE)
18. (Eiziina)abaire yagizireho bimwe ahabyagambwaho omusabiiti ibiri (2) ez'enyima? SHOMA EBYAYOREKWA BYOONA EBIRAGAMBWE ORIKUGARUKAMU BITE OMUKAGO
    A. EKIRUKANO
    B. ESHAGAMA OMUBYASHOHOZIBWA (OKUGYEREKYERA)
    C. ORUKORORO
    D. OBUREMEEZI OMUKWIITSYA
    E. OKWITSYA AHONAHO/HAKYE/OKUHAHAGIRA
    F. OKUPIIPA
    G. OMUSHWAIJA

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H. OKUSHAMBAGUZA

I. EBINDI (BIGAMBE)

J. EBY'AHARUGURU TIHARIMU NAKIMWE

K. **GYENDA AHARI Q 27**

19. (Eiziina)ahererukire ryaari okurwaara, okunywa kakye, akatari k'obutoosha , okunywa nk'obutoosha, nari okunywa bingi ebitari by'obutoosha?
    1. BIKYE BITARI BY'OBUTOOSHA
    2. EBY'OBUTOOSHA
    3. BINGI EBITARI BY'OBUTOOSHA

20. Eiziina)ahererukire ryaari okurwaara, okurya kakye akatari nk'obutoosha , okurya nkabutoosha, nari okurya bingi ebitari byabutoosha?
    1. BIKYE BITARI BY'OBUTOOSHA
    2. EBY'OBUTOOSHA
    3. BINGI EBITARI BY'OBUTOOSHA

Okwerinda omushwaija

No	EBIBUUZO NEBY'OKWIHAMU	EMIRINGO ERATAHIBWE	BIREKYE
21	(Eiziina)aine orupiipo obwahati?	Eego.....1 Ngaaha.....2	27
22	(Eiziina) kuyakwasirwe okupiipa okebuuza nari okamuraguriza?	Eego.....1 Ngaaha.....2	27
23	Ninkahi ahuwabandize kwebuuza nari kuraguza? EIRWARIRO / KIRINIKA, YOREKA EIZIINA RY'OMWAANYA	**Ahakarwariro** OMWIRWARIRO ERIKURU.....1 OMWIRWARIRO ERYA SENTA.....2 AHAMWAANYI GW'OKURAGURIRAHO.....3	

	_____ _____ (EIZIINA RY'OMWAANYA)	PVO SENTA.....4 AHAKIRINIKA .....5 AHAMUSHAWO WAITU ORIKUTUTAYAYI.....6 ENDIJO EMYAANYA EY'OKURA GURIZAMU..7 **(GIGAMBE)** ENDIJO EMYAANYA OMUSHAHO OW'EKIRAGUJU .....8 AHADUUKA .....9 AHA FAMASE.....10 AHABARIKUTURETERA EMIBAZI AHAKYAARO.....11 OWAMUNYWANI WANGYE/ OMUNYABUZAARE.....12 EBINDI/ AHANDI.....13 **(HAGAMBE)**	
24	Kuwareebire (eiziina) ya piipa okamara bwiire ki otakeburize nari kumuraguriza?	NKAMUTWARIRAHO .....O NKAMUTWAARA EIZOOBA ERYAKURATIHERO.....1 BWANYIMA Y'EBIRO(2).....2 BWANYIMA Y'EBIRO BISHATU N'OKURENGAMU.....3	
25	(Eiziina) bakamuha mubazi ki ahabw'okupiipa kwe? EMIBAZI YOONA EYAHAIRWE GITE OMUKAGO. OMUZAIRE YAABA ATARIKWIJUKA EMIBAZI YOONA MUSHABE AGIKWOREKYE, YAABA ATARIKUBAASA	EMIBAZI Y'OKUTAMBA OMUSHWAIJA A.KURORO KWIINI.....1 B. FANSIDA.....2 C.AMODIYA KWIINI.....3 D. KWIININI .....4 E. ATINAMU.....5 F. METAKEREFINI.....6 G. HOMAPAK.....7	

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	KUGIKWOREKA, MWOREKE EMIBAZI YENYINI EYOKUTAMBA OMUSHWAIJA REERU AKWOREKE EYIBAMUHAIRE.	***EMIBAZI ENDIJO*** G. ASIPURINI.....8 F. PANADOL.....9 I COTRIMOXAZOLE.....10 J. ENDIJO _____11 (GOREKE)	
26	AHARI BURIMUBAZI OGW'OKUTAMBA OMUSHWAIJA BUUZA EBI: (Eiziina) kuyatandikire okupiipa hakahwaho bwiireki atakamizire omubazi? (TASTYA EMIRINGO EHIRIKE OGITE OMUKAGO)(SAAKO)	AKATANDIKIRAHO.....0 EIZOOBA RIMWE BWANYIMA Y'OKUPIIPA....1 EBIRO BIBIRI (2) BWANYIMA Y'OKUKWATW.2 EBIRO BISHATU (3) N'OKURENGAMU AKWATSIRWE.....3 TINDIKUMANYA 8	
27	N'enki ekirikureeta omushwaija ? Handiika ebyagambwa byoona HARIHO EKINDI KYOONA?	ENSIRI Y'AKURUMA .....A OBUROGO.....B AMAKWATANE G'OBUGIRITA.....C OKUKUTAMU ESHAGAMA .....D OKUNYWEGYERANA.....E EBIKATU.....G EBINDI_____W (BIGAMBE) EBINDI_____X (BIGAMBE)	
28	Obuwabaire oine enda ya (eiziina) haine omubazi gwoona oguwamizire ahabw'okwerinda omushwaija ?	Eego.....1 NGAAHA.....2	**30**
29	Okamira mubazi ki? HANDIIKA YOONA EYARAGAMBE	FANSIDA.....A KUROROKWIINI.....B ENDIJO.....X	

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30	Oine obutimba bw'ensiri aha bitanda?	Eego.....1 NGAAHA.....2	 **36**
31	Nooha obyamire omukatimba k'ensiri ny'ekiro? Handiika byona ebyagambwa	OMWAANA (EIZIINA RYE).....A OMWAAMI/ MUHYENZI WANGYE.....B NIINYE.....C ABANDI_____X (BAGAMBE)	
32	Hahwireho bwiire ki oherize kugura nari kutunga akatimba aka?	EMYEEZI....._____ TINDIKUMANYA.....98	
33	Akatimba warakogizeho nari kukatumbika omumubazi ogurikubinga ensiri n'obushuzi (enkukuni)?	Eego.....1 NGAAHA.....2 TINDIKUMANYA.....3	**35** **35**
34	Hahwiireho bwireki oherize kwoozya akatimba kawe n'omubazi? HANDIIKA EBYAGARUKWAMU OMUMYEEZI (AHANSI Y'OKWEEZI KUMWE =80)	EMYEEZI NKA ......_____ TINDIKUMANYA.....98	
35	SHABA KUREEBA AHA KATIMBA K'ENSIRI OCEBERE YABA KAINE EMIHEGYERE NARI EBITAGUUKA. (KAABA KATEINE EBIHENGYE / EBITAGUUKA = TIKAINE NSHONGA WAREEBAMU EBIHENGYERE NARI EBITAGUUKA= KASISIKAIRE	TIKAINE NSHONGA .....1 KASISIKAIRE.....2	

Obwahati nigyenda tugambe ahabya okucebeza enda n'okureeberera omwereere

Okucebeza enda n'okureeberera omwereere

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36. Obwobaire oine enda ya (eiziina) otungire ekikatu ahamukono eky'okutangiza omwereere obutashambaguza (tetenasi) yaheza ati okuzaarwaq?
    1) Eego
    2) NGAAHA..... → **GYENDA AHARI Q. 38**
    3) TINDIKUMANYA..... → **GYENDA AHARI Q. 38**
37. Ekikatu eki okakitunga emirundi engahi?
    1) GUMWE (1)
    2) EBIRI (2)
    3) ERENGIRE AHARI EBIRI
    4) TINDIKUMANYA
38. Kare hati ninyenda nkubuuze obuwazaara (eiziina) Nooha owakuhweraire kukuzarisa (eiziina)
    A. DOKITA
    B. OMUZARISA KAZI
    C. OMUZARISA OWA AHAHAKYAARO_____
    (EIZIINA)
    D. OMUHEREZA WEBY'AMAGARA AHA KYAARO
    E. OMUNTU OWAHAKA_____
    (TUGAMBIRE OBUZAARE OBWOINE NAWE)
    F. ABANDI_____
    (BAGAMBE)
    G. TIHAINE OWAMPWERAIRE
39. Omukyaara ashemereire kugira ryaari enda endiijo bwanyima y'okuzaara?
    A. Omumwaka gumwe gutakahwaireho
    B. Omwaaka gumwe n'ekicweeka
    C. Hakiri emyaaka ebiri(2)
    D.

No	EBIBUUZO NEBY'OKWIHAMU	EMIRINGO ERATAHIBWE	BIREKYE
40	Haine owuwareebire weena ngu	Eego.....1	**48**

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	akucebere enda atakazaire? (EIZIINA)	NGAAHA.....2	
41	Waaba noikiriza . Okareeba oha? Hariho ondiijo weena? MUBURIRIZE OREEBE NIMUNTUKI KANDI OHANDIIKE BOONA NAB'EKYAARO ABOMUZAIRE ARAKUGAMBIRE	DOKITA OTENDEKIRWE.....A OMUZARISA KAZI .....B TARIHO.....C ABANDI BANTU ABAZARISA ABEKYAARO.....D OW'EBYAMAGARA AHAKYAARO.....E ABANDI_____X (BAGAMBE)	
42	Omuntu owu wareebire kukufaho oine enda okamutayaira emirundi engahi?	EMIRUNDI EYARAGAMBE.....	
43	Obuwabaire n'ocebeza enda, okaatunga obuhabuuzi ahari ebi o Okwetebekanisiza Okuzaara o Okwontsya o Obutazaara obutweera o Obubonero obwakabi waaba oine nda?	EEGO NGAAHA 1 2 1 2 1 2 1 2	
44	Omuhabuzi omuby'amagara akakugambira okwetebekanisiza ebi otakazaire? 1.Ahorazaire 2.eby'engyenda erakutwaare ahorazarire 3.okugira ekikwaato ekirimu	Eego.....1 NGAAHA.....2	

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	eby'okwetebekanisiza okuzaara		
45	Obuwabaire n'okyebeza okiine enda, okatunga okuhumurizibwa ahabya akakooko ka siriimu n'oburwaire bwa AIDS?	Eego.....1 NGAAHA.....2	
46	Okacebeza akakooko ka siriimu oyekundaire?	EEGO.....1 NGAAHA.....2	
47	Oine ekipande ky'okuceberezaho enda ya (EIZIINA)?	EEGO , NAKIREEBA.....1 TIKIRIHO.....2 TINDATUNGIRE EKIPANDE.....3	50 50
48	REEBA AHA KIPANDE REERU OTATSYE EMIRUNDI EYI NYINA W'OMWAANA YATAYAYIRE EIRWARIRO OBWO AINE ENDA YA (EIZIINA)	_____ EMIRUNDI EYIYAGIIRE OMWIRWARIRO	
49	Nibumanyisoki oburikworeka ngu oine kureeba omushaho waba oine enda? HANDIIKA BYOONA EBIBARAKUGAMBIRE	ORUSHWAIJA /OKUPIIPA.....A OKWITSYA HAKYE HAKYE.....B OKUJWA/ OKUREETA ESHAGAMA .....C OKUHAGA OMUBIRI / ENGARO/AHAMAISHO.....D OBUNDI_____X (BWOREKYE)	
50	Obuwabaire oine enda ya (eiziina) okatungaho obujuma nari omubazi gw'okunywa ogwa ayani (iron)	Eego.....1 NGAAHA.....2	
51	Okamara ebiro bingahi orikumira/orikunywa omubazi	ENAKU / AMAZOOBA AGU YAMAZIRE NAMIRA OMUBAZI OGU	

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	gwa Ayani (iron)? EMIRUNDI YAABA ETARIKUBAASA KUBARWA, BURIRIZA EBIRO HAKIRI EBIYAMAZIRE	_____	
52	Okazarira nkahi? RYAABA RIRI EIRWARIRO / KIRINIKA, HANDIIKA EIZINA RY'OMWAANYA	OMUKA.....1 AHAKARWARIRO OMWIRWARIRO ERIKURU.....2 AHA KIRINIKA.....3 AHANDI_____ 4 (HAGAMBE)	
53	Akaterekye akarimu eby'okuzarisa kakabu kari akayonjo?	Eego.....1 NGAAHA.....2 TINDIKUMANYA.....8	
54	Omuzarisa akakoresaki okusharira omwaana?	Akagirita katsya.....1 Ebindi ebirikushara.....2 (Bigambe)_____	
55	Omwereere (eiziina) bakamuta nkahi bwanyima y'okuheza kumuzaara?	Bakamuha nyiina.....1 Omukatanda kye.....2 Ahansi.....3 Bakamunabisa.....4 EBINDI...((BYOREKE)_____6 TINDIKUMANYA.....8	
56	Okakoraki bwanyima y'okuzaara(eiziina)	NKAMWONTSYA.....1 NKAMUNABISA.....2 NKAMUREKYERAYO YAGWEJEGYERE.....3	

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		EBINDI.....6 TINDIKUMANYA.....8	

Okwontsya hamwe N'okugaburira / okuriisa omwaana

57. Oronkizeho (eiziina)
    1. Eego
    2. Ngaaha → **GYENDA AHARI Q. 60**
58. Kuwaherize oti okuzaara (eiziina) okamuta ahaibere obwiire burikwinganaki omurundi ogw'okubanza?
    1. Ahonaho / omushaaha emwe naheza kuzaara
    2. Bwanyima y'eshaaha emwe
59. Ningyenda ngu nkubuuze aha by'okunywa n'eby'okurya ebi (eiziina) omuhaire nyomwebazyo omwihangwe hamwe na nyekiro (Eiziina) ariire...ki?.....

SHOOMA BURIKIMWE EBYAHAIFO REERU OCEBERE OMUKABOKISI AKARIMU EKY'OMWAANA BAMUGABURIRE

	EBY'OKUNYWA NEBY'OKURYA	**EBYARIIRE OMUSHAAHA 24 EZ'ENYIMA**
A	Amashereka (okwonka)	
B	Amaizi g'onka	
C	Ebindi eby'okunywa	
D	Eby'okurya ebicucumire, eby'esaano, ebirimu, amaizi, nari ebigumiremu?	
E	Ebindi eby'okurya byoona BYOREKE: _____	

Hati ninyenda tugambe aha kirukano.....

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Ekirukano hamwe neby'obuyonjo.

No	EBIBUUZO NEBY'OKWIHAMU	EMIRINGO ERATAHIBWE	BIREKYE
60	(Eiziina) aine ekirukano obwahati?	Eego.....1 NGAAHA.....2	68
61	Okamuhaki okumutambira ekirukano? EKINDI KYOONA? HANDIIKA BYOONA EBYARAKUGAMBIRE	TIKIRIHO.....A EBY'OKUNYWA EBYA DAROZI.....B EBY'OKUNYWA EBINAYEKOREIRE AHAKA.....C AKAJUMA / OMUBAZI OGW'OKUNYWA.....D EKIKATU.....E EKIKATU EKY'OMUMUTSYI.....F EBISHUGI EBY'EKIRAGUJU.....G EBINDI_____ X (BIGAMBE)	
62.	(EIZIINA) Kuyatandire okwirukana, okagumizamu n'okumwontsya / okacendeeza, nk'obutoosha, okarenzya?	NKACENDEEZA.....1 NK'OBUTOOSHA.....2 NKARENZYA.....3 OMWEREERE AKANGA OKWONKA....4	
63	Omwereere kuyatandikire okwirukana haine owuwaye burizeho aheeru y'eka?	Eego.....1 NGAAHA.....2	68
64	Okabandiza nkahi kuraguza nari kwebuuza	AHAIRWARIRO ERIHANGO.....1 AHAKARWARIRO.....2	

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	Ryaaba riri eirwariro yoreka eiziina ry'omwaanya _____ _____	PVO SENTA.....3 AHAKIRINIKA.....4 AHAMUHABUZI WEBY'AMAGARA AHAKYANGA KYAITU.....5 OGUNDI OMWAANYA_____6 (GWOREKE) ENDIIJO EMYAANYA OW'OMUSHAHO OW'EKIRAGUJU.....8 AHAMADUUKA.....9 AHA FAMASE.....10 ORIKUREETA AHAKYAARO.....11 MUNYWAANI WANGYE / OMUNYABUZAARE.....12 AHANDI _____X (HOREKE)	
6 5	Nooha owakuhabwiire ngu otwareyo (eiziina) kumuraguriza HANDIIKA BYOONA EBYARAKUGAMBIRE	ORIKUGARUKAMU.....A IBANYI / MUGYENZI WANGYE.....B NYIINA W'ORIKUGARUKAMU.....C MAZAARA.....D BANYWAANI / BARIRANWA.....E ABANDI _____ X (BAGAMBE)	

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66	Ahandi okaza nkahi ahabw'okuraguza nari obuhabuzi?	EIRWARIRO EIRWARIRO ERIKURU.....1 AHAKARWARIRO.....2 PVO SENTA.....3 KIRINKA.....4 OW'OMUSHAHO WAITU OW'EKYAARO.....5 ENDIJO MYAANYA Y'OKURAGURIZAMU... (GYOREKE)_____ 6 AHANDI OW'OMUSHAHO OW'EKIRAGUJU.....8 AHAMADUUKA.....9 AHA FAMASE.....10 AHA MUNTU ORIKURETA EMIBAZI AHA KYAARO.....11 MUNYWAANI / OMUNYABUZAARE....12 AHANDI_____13 (HOREKE)	
67	Orahurireho ORS? YABA NGU Eego, BUUZA ORIKUREEBERERA OMWEREERE AKUSHOBORORERE OKWERIKUKORWA. KYABA KIRI NGU NGAAHA 3 ZIITE	YAGISHOBORORA GYE.....1 TIYAGISHOBORORA GYE.....2 TINKAHURIRAHOGA ORS.....3	

	OMUKAGO (TINKAHURIRAHOGA ORS) EMWE GIITE OMUGAGO (BYAABA BIHIKIRE) NARI YAABA YAGAMBA EBI: • KORESA LITA EMWE Y'AMAIZI AMAYONJO AG'OKUNYWA (LITA EMWE(1) = ECUPA ZA SODA 3) • KORESA AKAPAKITI KOONA • TABURA AKASAANO		
68	Orihaireho zinc (Zinka) YABA NGU Eego, BUUZA ORIKUREEBERERA OMWAANA AKUSHOBORORERE ZINKI OKWERIKUTAMBA. OBA KIRI NGU NGAAHA 3 ZIITE OMUKAGO (TINKAHURIRAHOGA ZINKI) BWANYIMA Y'OMUZAIRE KUKUSHOBORORERA ZINKI OKWERIKUTAMBA, HANDIIKA YABA YAGISHOBORORA GYE NARI TIYAGISHOBORORAGYE	YAGISHOBORORA GYE.....1 TIYAGISHOBORORA GYE.....2 TINKAHURIRAHOGA ZINKI.....3	

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	EMWE GIITE OMUGAGO (BYAABA BIHIKIRE) NARI YAABA YAGAMBA EBI: • ZINKI GIGABURIRE BURIZOOBA • OKUHITSYA EBIRO 10 – 14		
69	Amaizi g'okunywa agumurikoresa omunju omu nimugataha nkahi?	Naikondo.....1 Aha taapu y'ekyaanga.....2 Ahaiziba eritimbirwe.....3 Ahakiziba ekitatimbirwe.....4 Nag'enjura.....5 Nag'enyanja / omugyera/ ekipondi/ aga daamu/ ahakagyera .....6 Ahandi (HAGAMBE)_____ 7	
70	Amaizi gaanyu haine okumuri kugashemeza gakaba amayonjo ag'okunywa?	Eego.....1 Ngaaha.....2	
71	Kukyabe kiri ego, amiizi gawe nogasemeza ota?	PUR.....1 Waterguard.....2 Okuteeka.....3 Ahandi_____ 4 (HAGAMBE)	
72	(eiziina) obwahererukire okweshemeza obubi (amazi) okaganaga nkahi? KUBIRAABE "BYATWAIRWE AMAIZI"	Nkabitwaara omukihoronyo.....1 Bikagyenda bityo.....2 Amaizi gakabitwaara omukihoronyo.....3 Amaizi gakabitwaara omukifuregye.....4 Bikagyendera omukisasiro.....5	

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	BUUZA AHU AMAIZI AGA GARIKUKOMA KWARAABE " "YAGANAGIRE" BUUZI NKAHI YOONA?	Nkabitambika aharubungo.....6 Nkabinaga ahare n'enju.....7 Nkabitabika omwitaka.....8 Tihaine ekinakozire .....9 EBINDI ..(BYOREKE)_____ __ ____ 10	
7 3.	Nikihoronyo kyamuringo ki ekimurikukoresa omunju omu?	Ekya amaizi.....1 Ekihoronyo eky'omutindo.....2 Ekihoronyo kwonka ekiine akasiminti ahamutwe (sirabu).....3 Ekihoronyo ekyabutoosha ekitaineho ka sirabu.....4 Nitukoresa akabaketi .....5 Titwiine ekihoronyo nituza omukishaka/omuntabire/ omu kaveere n'ebindi.....6	
7 4	**Rebesa amaisho kwonka:** Hariho ekintu kyoona eky'okunabiramu engaro nka taapu, ebaafu, ebaketi, nari sinka? Oshemereire kuba oine eky'orikureeba nari kyaretwa orikubuuza, omudakiika emwe yonka .waaba otakiretsiire omudakiika emwe, gyezaho n'obuwakukireeta bwanyima	Eego.....1 Ngaaha.....2	

WEBARE

OKUHENDERA KW'OKUBURIRIZA

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HealthPartners Child Survival Integrated Health Facility Assessment

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INTEGRATED HEALTH FACILITY ASSESSMENT:

IDENTIFICATION PARTICULARS	Official use only
1. LQAS No. _____ OUT OF TOTAL SAMPLE_____	
2. DISTRICT:	
3. COUNTY:	
4. HEALTH SUB-DISTRICT:	
5. FACILITY:	
6. FACILITY CODE:	
7. FACILITY TYPE: *Please circle appropriate category* 8. 1=Regional hospital; 2=District hospital; 3=Health center IV; 4=Health center III	
9. OPERATING AUTHORITY: *Please circle appropriate category* 10. 1=Government; 2=Non-government Organization; 3=Private Sector; 4=CBO, 5=FBO	
11. FACILITY LOCATION: *Please circle appropriate category* 12. 1=urban; 2=rural	
13. NAME OF HEAD OF FACILITY:	
14. TITLE OF HEAD OF FACILITY:	
15. DATE OF INTERVIEW:	
16. NAME OF INTERVIEWER:	

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ASSESSMENT OF SERVICES OFFERED FROM HEAD OF INSTITUTION

First I want to ask some general questions about specific services that are provided and the organization of service delivery at this facility. Then, I would like to speak with the person or people responsible for providing each service your facility offers to ask for some more detailed questions for each service.

Does this facility offer the following services? ENTER YES OR NO IN BOX FOR RESPONSE
Note: If service not offered, do not ask for in-charge staff for that service, and skip that service's section

Who is responsible for providing this service that I may talk to today?

SECTION	SERVICE	Yes/No	NAME & TITLE OF PRESENT, IN-CHARGE STAFF TO BE INTERVIEWED TODAY
1	HIV Voluntary Counseling & Testing and PMTCT	Yes.....1 No.....2	
2	Antenatal & Emergency Obstetric Care Services	Yes.....1 No.....2	
3*	Integrated Management of Childhood Illness (IMCI)	Yes.....1 No.....2	
4*	Diagnosis & Treatment of Malaria	Yes.....1 No.....2	
5	Commodity Management (Drug store or Pharmacy)	Yes.....1 No.....2	
6	Health Plan	Yes.....1 No.....2	

** NOTE: IMCI and malaria services may not be provided through a single department. If this is the case, ask Head of institution to direct you to the person she or he feels is most likely to have knowledge about the facility's services in these areas.*

SECTION 1: HIV: Voluntary Counseling & Testing (VCT) and PMTCT SERVICES

NAME OF RESPONDENT: _____ TITLE OF RESPONDENT: _____

	QUESTION	CODING CATEGORIES
101	How many staff are directly involved with client counseling, diagnosis or management for this service? INCLUDE ALL STAFF WHO HAVE RESPONSIBILITY FOR ANY OF THESE ACTIVITIES, EXCLUDING THE LAB TECHNICIAN.	☐☐☐
102	Among these staff, how many have received any in-service training related to VCT within the last 3 years?	☐☐☐

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103	Among these staff, how many have received any in-service training related to PMTCT within the last 3 years?	[ ][ ][ ]
104	Observe if the posters are displayed openly, translated in the local language and at least 5 posters	Adequate.....1 Inadequate.....2
105	Does the facility have any visual aids to use when providing VCT or PMTCT services?	YES.....1 NO..... 2
106	Is HIV counseling and testing for pregnant women upon request, required or recommended?	Upon request..... 1 Required.....2 Recommended.... 3
107	For pregnant women who test positive, do you offer ARVs (antiretrovirals) for the prevention of HIV transmission from the woman to her child?	YES.....1 NO..... 2
108	Does the facility offer post-test infant feeding counseling to pregnant women who test positive for HIV?	YES.....1 NO..... 2
109	Do you have a private space for delivering VCT and PMTCT services?	YES.....1 NO..... 2
110	Ask: Can I see it? If seen, is it pacious; private; and clean? (meets the criteria= adequate; doesn't meet the criteria= inadequate)	Adequate .....1 Inadequate.....2
111	Does the facility have a register or other record where you record information on clients who receive this service?	YES.....1 NO..... 2
112	Of those tested in the last six months, how many tested positive for HIV? Total: [ ][ ][ ]	Males: [ ][ ][ ] Females: [ ][ ][ ]
113	How many of the overall clients tested for HIV were pregnant women?	Total: [ ][ ][ ]
114	How many of the clients who tested positive for HIV were pregnant women?	Total: [ ][ ][ ]
115	Does this facility have the MOH policy and guidelines/protocols on HIV/AIDS VCT services? Ask to see.	Yes, seen by Interviewer.....1 No, Not seen by interviewer.....2
116	Does this facility have the MOH policy and guidelines/protocols on PMTCT? Ask to see.	Yes, seen by Interviewer.....1 No, Not seen by interviewer.....2

SECTION 2: LABORATORY SERVICES

NAME OF RESPONDENT: _____ TITLE OF RESPONDENT: _____

	QUESTION	CODING CATEGORIES
201	What is the qualification of the person who is in charge of the quality of the laboratory work?	Lab assistant certificate.....1 Lab technician diploma .....2 Lab technologist diploma or higher.....3

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		None.....4 Other_____6
202	Does the facility have guidelines or protocols for how the laboratory is to conduct diagnostic testing for HIV?	YES.....1 NO 2
203	Ask to see.	Yes seen.....1 No not seen.....2
204	Does this facility have the laboratory capacity to conduct HIV tests?	YES.....1 NO 2
205	Does the laboratory have a seperate register where laboratory test results for HIV tests are recorded?	YES.....1 NO 2
206	Does the facility have all equipment and reagents required to conduct a malaria test today?	YES.....1 NO 2
207	Is there a separate register where laboratory test results for malaria are recorded?	YES.....1 NO 2

SECTION 3: Antenatal, PRENATAL and mergency obstetric care Services
NAME OF RESPONDENT: _____ TITLE OF RESPONDENT: _____

	QUESTION	CODING CATEGORIES
301	How many staff are directly involved with management of antenatal and/or third stage of labor/ emergency obstetric care services? **INCLUDE ALL STAFF WHO HAVE RESPONSIBILITY FOR ANY OF THESE ACTIVITIES, EXCLUDING THE LAB TECHNICIAN.**	[ ][ ][ ]
302	Among these staff, how many have received training in active management of the third stage of labor in the last 3 years?	[ ][ ][ ]
303	Among these staff, how many have received in-service training in reproductive health life saving skills within the last 3 years?	[ ][ ][ ]
	Does this facility provide the following services:	
304	Administration of antibiotics by injection or by intravenous infusion?	YES.....1 NO 2
305	Administration of anticonvulsants by injection or by intravenous infusion?	YES.....1 NO 2
306	Administration of anticonvulsants for pre-eclampsia and eclampsia by injection or by intravenous infusion?	YES.....1 NO 2
307	Manual removal of placenta?	YES.....1 NO 2
308	Removal of retained products of conception (e.g., manual vacuum aspiration)?	YES.....1 NO 2
309	Assisted vaginal delivery?	YES.....1 NO 2
310	Intravenous fluids?	YES.....1 NO 2
311	Provision of iron and folic acid supplements	YES.....1 NO 2
312	Examination of the mother to evaluate the pregnancy (fetal growth and maternal health)	YES.....1 NO 2

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313	Surgery or caesarian section?	YES.....1 NO 2
314	Blood transfusion?	YES.....1 NO 2
315	Does this facility provide the following products to expectant mothers? A. Mama Kits B. Making a Birth Plan prior to delivery	 YES.....1 NO.....2 YES.....1 NO.....2
	Does this facility provide the following Information:	
316	Proper nutrition and hygiene for baby and mother	YES.....1 NO.....2
317	Malaria prevention/ Insecticide Treated Nets use	YES.....1 NO.....2
318	Importance of continued breastfeeding and child welfare	YES.....1 NO.....2
319	Prevention of STI/HIV/AIDS	YES.....1 NO.....2
320	Warning signs of pregnancy and complications	YES.....1 NO.....2
321	Post natal care and family planning	YES.....1 NO.....2
322	Dangers of self medication and use of traditional medicines during labor	YES.....1 NO.....2
323	Does this facility have the MOH policy and guidelines/protocols on antenatal, prenatal and obstetric care services? Ask to see.	Yes, seen by Interviewer.....1 No, Not seen by interviewer.....2

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SECTION 4: INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI)
NAME OF RESPONDENT: _____ TITLE OF RESPONDENT: _____

	QUESTION	CODING CATEGORIES
401	How many staff are directly involved with management of IMCI services? **INCLUDE ALL STAFF WHO HAVE RESPONSIBILITY FOR ANY OF THESE ACTIVITIES, EXCLUDING THE LAB TECHNICIAN.**	☐☐☐
402	Among these staff, how many have received any in-service training related to IMCI within the last 3 years?	☐☐☐
403	Does this facility receive regular supervision for IMCI?	YES.....1 NO 2
404	When was your last IMCI supervision?	This month .....1 This quarter .....2 In the last 6 months .....3 In the last year 4
405	What are the danger signs that indicate that a child needs urgent medical care? CIRCLE ALL THAT IS MENTIONED – DO NOT PROMPT	Convulsions .....1 Loss of consciousness .....2 Severe anemia or "lack of blood" shown by pale lips or palms .....3 Difficulty in breathing .....4 Extreme weakness (unable to sit or stand) .....5 Vomiting everything/severe vomiting .....6 Child not able to drink or breastfeed 7

SECTION 5: Diagnosis & Treatment of Malaria
NAME OF RESPONDENT: _____ TITLE OF RESPONDENT: _____

	QUESTION	CODING CATEGORIES
501	How many staff are directly involved with management of malaria? **INCLUDE ALL STAFF WHO HAVE RESPONSIBILITY FOR ANY OF THESE ACTIVITIES, EXCLUDING THE LAB TECHNICIAN.**	☐☐☐
502	Among these staff, how many have received any in-service training in management of **severe and complicated malaria**	☐☐☐

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	within the last 3 years?	
503	During their antenatal checks, are pregnant mothers provided with Antimalarial tablets like Fansidar?	YES.....1 NO.....2
504	Does the facility provide ITNs for pregnant mothers to protect them and the baby from getting malaria?	YES.....1 NO.....2

SECTION 6: COMMODITY MANAGEMENT (DRUG STORE OR PHARMACY)

NAME OF RESPONDENT: _____ TITLE OF RESPONDENT: _____

	QUESTION	CODING CATEGORIES
601	In the **last 6 months**, were there any stock outs for:	
	1. ORS	YES.....1 NO.....2
	2. Cotrimoxazole	YES.....1 NO.....2
	3. Mebendazole	YES.....1 NO.....2
	4. Amoxicillin oral	YES.....1 NO.....2
	5. Naladixic acid	YES.....1 NO.....2
	6. Ciprofloxacin	YES.....1 NO.....2
	7. Doxycycline	YES.....1 NO.....2
	8. Metronidazole	YES.....1 NO.....2
	9. Injectable contraceptives	YES.....1 NO.....2
	10. Contraceptive Pills	YES.....1 NO.....2
	11. Condoms	YES.....1 NO.....2
	12. Chloroquine	YES.....1 NO.....2
	13. Fansidar	YES.....1 NO.....2
	14. Quinine	YES.....1 NO.....2

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	15. Injectable diazepam (valium)	YES.....1 NO.....2
	16. Ergometrine	YES.....1 NO.....2
	17. Anesthesia	YES.....1 NO.....2
	18. Homa Pak	YES.....1 NO.....2
	19. Oxytocin	YES.....1 NO.....2
	20. Misoprostol	YES.....1 NO.....2
	21. Zinc	YES.....1 NO.....2
	22. Iron/Foliate	YES.....1 NO.....2
	23. ITN	YES.....1 NO.....2
	24. Mama Kits	YES.....1 NO.....2

Drug	Proper storage— FOR INTERVIEWER INFORMATION ONLY	*OBSERVE STORAGE—IS THE DRUG STORED PROPERLY?*	
		YES	*NO*
12. Oxytocin 10 units	Is it stored in 15-30 degrees C and protected from freezing?		
13. Ergometrine .2 mg	Is it protected from light and from freezing?		
14. Misoprostol 400-600 mcg	Is it at room temperature, in a closed container?		

Thank you!

END OF CHECKLIST

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Annex 4: ISA Methodology Report

HealthPartners
Uganda Health Cooperative Child Survival
Institutional Strength Assessment Report

Third Draft
February 20, 2006

Written By: Daniel Ololia, M&E Coordinator
Joy Batusa, Uganda Health Cooperative Field Program Manager
Jennifer Wenborg, Uganda Health Cooperative HQ Program Manager

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EXECUTIVE SUMMARY

Where as several organizations carry out the baseline on the community in which the intervention will be carried, the health facilities with which the organization will partner, the assessment of the institution, which is carrying out the intervention, is often left out. It is important to note that the capacity of the organization that will carry out the implementation is as important as the intervention area itself. It has been discovered by HealthPartners Uganda Health Cooperative (UHC) team that the Institutional Strength Assessment (ISA) is a very important component of program success.

UHC conducted an ISA in order to learn their strengths, weakness and opportunities for improvement in the following areas:

- Management Practices and Governance
- Administrative Infrastructure and Procedures
- Organizational Learning
- Financial Resource Management
- Human Resource Management
- Technical Knowledge of Health Unit Staff
- Use of Technical Knowledge and Skills; and
- Recommendations

On management practices and government, 78 percent of staff rated the management practices and systems as those that strongly impact the successful implementation of the program. The assessment revealed that 80 percent of the respondents assessed the organization to be having administrative procedures that impact the health unit's capacity to efficiently implement and support programs. In the section of organizational learning, 80% of staff reported that they strongly agree that the organization has a learning capacity. 20% either did not know (12%) or disagree that the organization has a learning capacity (8%).

On Financial Resource Management, only 11% of staff disagreed with issues in this section whereas 89% of staff agreed with questions in this section. Most of the staff (63%) were however unaware if backstop staff have easy access to up-to-date information on the budgets for each of their projects. On the human resources policies and practices, 10% of staff disagreed that the organization's HRM policies support staff development, deployment, and recruitment and performance appraisal.

Overall on the section of technical knowledge and skills of staff, 45% of staff believed they offered technical support in the intervention areas of the program; while 55% felt they did not offer technical support in the various technical areas. It is important to note that for five staff members Child Survival is a new program and thus these categories of technical skills were not previously applicable to their positions. Training plans for these staff should be included in the detailed implementation plan.

In the section on use of technical knowledge and skills, 88% of staff agreed that the health unit receives appropriate level of support from the PVO on the various technical areas.

Most staff recommended that staff should be receiving training and opportunities to share lessons learned with other CS programs. Results from this assessment shall be used to help management identify gaps in management, monitoring and evaluation and staff environment in order to build a strong CS program. Provision of training to staff in case they are lacking in important skills; and These results will also help management address the expectations of staff in order to ensure successful implementation of the program. It is recommended that this self assessment tool be implemented annually for the first five years for UHC in order to build their institutional strengths.

METHODOLOGY

The ISA was implemented following the adoption of an ISA tool developed by the Child Survival Technical Team in 2000. This self assessment questionnaire was completed independently by each staff after a brainstorming session on each section. Results from the questionnaires were hand tabulated to generate data representative of all members of the health unit.

An ISA was carried out among all the staff of UHC on 13th January 2006. These were 8 in number. The staff members included the following The Country Director, program Administrator/ Accountant, 2 Scheme Managers; who have been employees of HealthPartners Uganda Health Cooperative for a period of more than 3 years; the Monitoring and Evaluation Coordinator, Partnership and Procurement Coordinator, the HST and the Field manager; who have been with the program for only three months.

MANAGEMENT PRACTICES AND GOVERNANCE

To provide effective support to field projects, backstop staff balance the technical knowledge and skills necessary with effective project management skills. At the same time, backstop and field staff function within a management and governance structure that may either facilitate or impede the successful accomplishment of project goals and objectives. From the survey it was noted that the management practices and systems of the health unit strongly impact the success of the health unit. For this, 78 percent of staff rated the management practices and systems as those that strongly impact the successful implementation of the program. The health unit was rated having management practices and systems, which do not promote the successful implementation of the program by 8%.

ADMINISTRATIVE INFRUSTRUCTURE AND PROCEDURES

There are a range of administrative procedures that impact the Health Unit's capacity to efficiently implement and support its programs, ranging from the ability to procure supplies and equipment, to the administrative support necessary for producing reports and other key correspondence, to the capacity to contract with consultants for specific tasks.

At the same time, administrative and communications infrastructure such as computer hardware and software can also facilitate the Health Unit's ability to manage its work. The assessment revealed that 80 percent of the respondents assessed the organization to be having administrative

procedures that impact the health unit's capacity to efficiently implement and support programs. The other 20% of staff either did not know (10%) or were not convinced that the organization had administrative procedures that impact the capacity of the health unit to efficiently implement its programs (10%).

On reports, all staff (100%) reported that regular progress reports were received from the field. Seven out of eight reported that they strongly agreed (10) with this assertion. 38% of the staff reported that project key documents such as detailed implementation plans, evaluation guidelines and others were not routinely translated into local languages for field staff. It should however be noted that all field staff fluently share English as the common language other than the local language rendering the translation of such documents into the local language non effective.

ORGANIZATIONAL LEARNING

The assessment in this section pertained to the evolution of the learning capacity of the health unit itself. Learning organizations are ones which make adjustments to their program based on data collected from the field, and which document their learning and the new and innovative strategies that have emerged from those adjustments. These groups routinely recognize the interdependence of different divisions and units of the larger PVO. They see the value of teamwork vs. individual action, and promote an environment in which staff at all levels are comfortable contributing ideas which might improve the overall performance of the organization.

In this section, 80% of staff reported that they strongly agree that the organization has a learning capacity. 20% either did not know (12%) or disagree that the organization has a learning capacity (8%). More specifically, all the members of staff (100%) agreed that lessons learned are regularly converted into tangible actions to benefit the overall portfolio of the child survival project.

Seven out of eight (88%) of staff also reported that M&E data is regularly used to inform management and for planning purposes. It was also reported by all staff except one (88%) that health unit staff are regularly informed of the latest developments and lessons learned from projects outside the health unit.

FINANCIAL RESOURCE MANAGEMENT

Staff were also asked to examine how the health unit manages its finances, including the availability of funds for planned activities, the ability of management staff in the unit to have access to up-to-date budget information, the status of financial management and accounting systems, the accuracy of financial data, budgeting, and other relevant financial issues.

On this, only 11% of staff disagreed with issues in this section whereas 89% of staff agreed with questions in this section. Most of the staff (63%) were however unaware if backstop staff have easy access to up-to-date information on the budgets for each of their projects. Apart from 2 members of staff who reported that they did not know, all the others strongly agreed that the organization conducts regular financial audits of its health projects. On whether financial resources are transferred from HQ to the field in a timely manner, seven (88%) of staff agreed to this while only one (12%) strongly disagreed.

HUMAN RESOURCE MANAGEMENT

In this section, staff assessed the human resource management of the organization. Questions on staff development, deployment, recruitment; performance appraisal; professional growth; supervision; and other areas related to the management of an organization's human resources were asked to staff.

In general on the human resources policies and practices, 10% of staff disagreed that the organization's HRM policies support staff development, deployment, and recruitment and performance appraisal. Specifically, they disagreed that a performance review system is used to motivate employee performance (12%); that there are clearly documented policies for handling employee grievances (12%); that roles and responsibilities for health unit staff are regularly reviewed and updated; and that the organization regularly offers opportunities for professional development for staff in the health unit.

A majority of staff however strongly agreed that the organization's HRM policies support staff development, deployment, and recruitment and performance appraisal. 90% agreed with this section in general. In detail, all staff (100%) strongly agreed that there are clearly documented procedures for orientation; 75% strongly agree that a performance review system is used to motivate employee performance; 88% strongly agree that there are clearly documented policies for handling employee grievances; 100% agree that new staff are recruited in a timely manner; 100% strongly agree that the organization consistently recruit quality staff to support its health portfolio; 100% agree that the workplace environment is supportive to all staff at all levels in the organization.

TECHNICAL AFLUENCE OF HEALTH UNIT STAFF

Whereas there are several factors that impact on the success of an intervention/ a program, one among them is the technical knowledge of staff in areas which the intervention will be embedded. It is therefore very important to assess the technical knowledge and skills of staff in the various intervention areas.

A table was drawn for staff to rank the areas of intervention from 1, where they had the strongest technical support to field projects (through training, guidelines, reference, accepted standards), to 10 where they provide the least technical support. Overall, 45% of staff believed they offered technical support in the intervention areas of the program; while 55% felt they did not offer technical support in the various technical areas. Put more specifically, 25% felt they offered technical support in the area of pneumonia case management; 38% in immunization; 38% in breast feeding; 50% in control of diarrheal disease; 63% in malaria; with 38% in maternal and newborn care. As can be seen from above, staff exhibited the highest technical capacity in the areas of malaria (63%) and control of diarrheal disease (50%) in that order.

USE OF TECHNICAL KNOWLEDGE AND SKILLS

Further questions were asked to staff that address their knowledge and skills related to specific technical interventions that are featured in the organization's health portfolio. It is a reality that in

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today's environment of increasingly scarce resources, technical knowledge and skills related to monitoring and evaluation, capacity building, and sustainability are also critical areas of technical expertise.

In the overall section, 88% of staff agreed that the health unit receives appropriate level of support from the PVO on the various technical areas. Areas such as program design, conducting the health facility assessment, the KPC, and monitoring and evaluation received 100% agreement from staff as those areas where technical support is provided.

Only 4% of staff did not agree that the health unit receives appropriate support in the various areas such as in conducting organizational capacity assessment.

RESULTS

I Management Practices and Governance

Scored Questions		Disagree	Agree	Don't Know
1	The management structure of thehealth unit facilitates the successful implementation of projects in the field.	0 %	100 %	0 %
2	Health backstop staff regularly receive training in project/program management.	0 %	63 %	37 %
3	There is a clearly designated point of contact for backstop support for each field-based project manager.	13 %	87 %	0 %
4	Designated backstop personnel respond to field requests in a timely manner.	13 %	87 %	0 %
5	There is regular communication between field-based project managers and their designated backstop person.	0 %	87 %	13 %
6	Backstop staff provide adequate support to field-based managers regarding interpretation and compliance with donor regulations.	0 %	100 %	0 %
7	The PVO's mission/vision statements support the promotion of the CS/Health Portfolio.	0 %	100 %	0 %
8	Representatives from our partner organizations are regularly included on the design teams for our programs at the field level.	13 %	62 %	25 %

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9	Representatives from our field projects' local partner organizations are regularly included in monitoring and evaluating those projects.	25 %	62 %	13 %
10	Representatives from our target communities are regularly included on the design teams for our programs at the field level.	13 %	87 %	0 %
11	Representatives from our target communities are regularly included in monitoring and evaluating the projects which serve their communities.	37 %	50 %	13 %
12	At least one representative from our health unit is a member of the PVO's Sr. Management Team (or equivalent).	13 %	37 %	50 %
13	The health unit has a clearly outlined strategy/protocol for starting up new projects upon confirmation of funding.	0 %	75 %	25 %
14	Primary healthcare is formally included in the PVO's strategic plan for the next year.	0 %	75 %	25 %
15	The PVO's upper management supports the health unit in its efforts to backstop field projects.	0 %	87 %	13 %
16	The Health Unit provides appropriate support if/when issues of conflict or disaster disrupt program operations.	0 %	62 %	38 %
17	Overall, we provide appropriate management-related support to our field projects.	13 %	87 %	0 %

II Administrative Infrastructure and Procedures

Scored Questions		Disagree	Agree	Don't Know
18	The Health Unit's administrative procedures are regularly reviewed and updated	0 %	62 %	38 %
19	We routinely translate project key project documents (e.g., Detailed Implementation Plans, Evaluation Guidelines, Grant Application) into local languages for field staff	38 %	62 %	0 %
20	Our computer systems are regularly upgraded to reflect industry standards.	25 %	75 %	0 %
21	Health Unit staff receive training and technical support in	25 %	62 %	13 %

	use of computer Software/hardware as needed.			
22	Health unit staff regularly access the internet for technical health information	13 %	75 %	12 %
23	Field staff have access to an internet connection	0 %	75 %	25 %
24	Field-based project managers receive training and technical support in the use of computer software/hardware as needed.	25 %	62 %	13 %
25	We receive regular progress reports from our field projects.	0 %	100 %	0 %
26	Quality consultants are routinely identified for assignments that cannot be undertaken by Health Unit or field staff.	0 %	100 %	0 %
27	There are staff in the organization designated to provide administrative support to health backstop staff.	0 %	87 %	13 %
28	Supplies and equipment are procured and delivered to field projects in a timely manner.	0 %	87 %	13 %
29	Overall, the health unit provides appropriate administrative support to its field projects.	13 %	87 %	0 %

III Organizational Learning

Scored Questions		Disagree	Agree	Don't Know
30	Lessons learned are regularly converted into tangible actions that benefit the overall portfolio of our CS and other health projects.	0 %	100 %	0 %
31	Health Unit staff are regularly informed of the latest developments and lessons learned from projects outside the health unit.	0 %	87 %	13 %
32	We regularly use M&E data to inform our management and planning for existing projects.	13 %	87 %	0 %
33	There are annual opportunities for field staff from different projects/countries to meet to exchange information and experiences.	13 %	62 %	25 %

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34	We regularly disseminate relevant state of the art information to our field projects.	13 %	87 %	0 %
35	We have documented examples of how lessons learned from our experience with health programs have been applied to other parts of the PVO.	25 %	38 %	37 %
36	Field staff are periodically asked for feedback on performance of our designated health backstop staff.	25 %	62 %	13 %
37	We regularly re-examine our strategies for managing and backstopping health programs in this organization.	13 %	75 %	12 %
38	We routinely involve multiple units, departments, or divisions in addressing challenges faced by the health unit.	0 %	100 %	0 %
39	We regularly re-examine strategies for designing and implementing health programs in this organization.	0 %	75 %	25 %
40	Field staff are regularly informed of the latest developments and lessons learned from other projects in the PVO's health portfolio.	0 %	100 %	0 %
41	Field visits from health backstop staff are used as opportunities to motivate and encourage field-based project teams.	0 %	75 %	25 %

IV Financial Resource Management

Scored Questions		Disagree	Agree	Don't Know
42	We have a sufficiently diverse array of funding sources to sustain and build upon our present health portfolio.	13 %	75 %	12 %
43	Backstop staff receive regular training on budget management, costing, and other financial management issues.	0 %	63 %	37 %
44	Field-based managers receive regular training on budget management, costing, and other financial management issues.	25 %	75 %	0 %
45	Field-based managers have access to up-to-date budget information on their projects.	50 %	50 %	0 %

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46	Backstop staff have easy access to up to- date information on the budgets for each of their projects.	0 %	38 %	62 %
47	Budget information provided to field staff is in a format that is easy to use for the purposes of project management.	0 %	75 %	25 %
48	Budget information provided to backstop staff is in a format that is easy to use for the purposes of project management.	0 %	63 %	37 %
49	The organization conducts regular financial audits of its health projects.	0 %	75 %	25 %
50	Our financial contingency measures prevent operational disruptions.	0 %	87 %	13 %
51	The Health Unit encourages and supports the identification of new/emerging funding sources for programs/projects.	0 %	75 %	25 %
52	Financial resources are transferred from HQ to the field in a timely manner.	13 %	87 %	0 %

V Human Resource Management

Scored Questions		Disagree	Agree	Don't Know
53	We routinely staff up new projects without incurring delays in project start up.	0 %	87 %	13 %
54	A performance review system is used to motivate employee performance.	13 %	62 %	13 %
55	There are clearly documented policies for handling employee grievances.	13 %	87 %	0 %
56	There are clearly documented procedures for orienting new staff to the organization.	0 %	100 %	0 %
57	We have clearly documented policies on hiring staff.	0 %	75 %	25 %
58	Roles and responsibilities of health unit staff are regularly reviewed and updated.	13 %	87 %	0 %
59	New field staff are recruited in a timely manner	0 %	100 %	0 %

60	The organization consistently recruits quality staff to support its health portfolio.	0 %	87 %	13 %
61	The organization consistently retains quality staff to support its health portfolio.	0 %	100 %	0 %
62	The organization regularly offers opportunities for professional development for staff in the Health Unit.	13 %	62 %	13 %
63	The organization has a clear policy that supports the retention of staff during bridge periods.	0 %	87 %	13 %
64	The workplace environment is supportive of staff at all levels in the health unit.	0 %	100 %	0 %
65	The support received from the Health Unit has increased the capacity of field staff to implement quality programs.	0 %	100 %	0 %
66	Backstop staff understand the local cultural dynamics that impact implementation of the projects they are assigned to support.	0 %	75 %	25 %
67	Field staff and health unit staff assigned to backstop their projects share fluency in at least one common language	0 %	100 %	0 %

VI Use of Technical Knowledge and Skills

68. Ranking of staff according to their level of technical support to the different intervention areas of the program

	Strong technical support	weak tech support	Don't Know
Pneumonia Case Management	25 %	63 %	13 %
Immunization	38 %	62 %	0 %
Breastfeeding	38 %	62 %	0 %
Control of Diahhreal Disease	50 %	50 %	0 %
Malaria Case Management	63 %	37 %	0 %
Nutrition and Micro-nutrients	38 %	50 %	12 %

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Maternal and Newborn Care	38 %	62 %	0 %
Reproductive Health / Child Spacing	38 %	50 %	12 %
STI/HIV/AIDS Prevention	63 %	37 %	0 %
Integrated Management of Childhood Illness	63 %	37 %	0 %

Scored Questions		Disagree	Agree	Don't Know
69	In responding to technical requests from the field, health backstop staff routinely access state of the art resources/information.	0 %	100 %	0 %
70	Our health interventions follow a set of nationally or internationally accepted technical standards or protocols.	0 %	100 %	0 %
71	Our PVO organization presently participates in health policy dialogue at the district level in the countries where our project(s) / program(s) operate.	25 %	62 %	13 %
72	Our PVO organization presently participates in health policy dialogue at the national level in the countries where our project(s) / program(s) operate.	25 %	38 %	37 %
73	Our health unit has the appropriate technical staff with the requisite skills to provide support to address technical challenges that arise at the project site	0 %	100 %	0 %
74	Overall, our Health Unit provides project(s)/program(s) with the appropriate level of support on technical health questions.	13 %	87 %	0 %
75	Our Health Unit provides the appropriate level of support to our project(s)/program(s) in program design.	0 %	100 %	0 %
76	Our Health Unit provides the appropriate level of support to our project(s)/program(s) in conducting population-level surveys, such as the Knowledge, Practices, and Coverage (KPC) survey.	0 %	87 %	13 %
77	Our Health Unit provides the appropriate level of support to our project(s)/program(s) in conducting Health Facility	0 %	100 %	0 %

	Assessments.			
78	Our Health Unit provides the appropriate level of support to our project(s)/program(s) in conducting organizational capacity assessment (for example of local partners).	13 %	63 %	25 %
79	Our Health Unit provides the appropriate level of support to our project(s)/program(s) in the design and implementation of behavior change communication interventions.	0 %	87 %	13 %
80	Our Health Unit provides the appropriate level of support to our project(s)/program(s) in monitoring and evaluation.	0 %	100 %	0 %
81	Our Health Unit provides the appropriate level of support to our project(s)/program(s) in improving sustainability in our interventions.	0 %	100 %	0 %
82	Our Health Unit provides the appropriate level of support to our project(s)/program(s) in conducting operations research during our interventions.	0 %	87 %	13 %
83	Our Health Unit provides the appropriate level of support to our project(s)/program(s) in the use of qualitative research.	0 %	87 %	13 %
84	Our Health Unit provides the appropriate level of support to our project(s)/program(s) in the design and implementation of activities with active community involvement.	0 %	100 %	0 %
85	Overall, our Health Unit provides the appropriate level of guidance and support to our project(s)/program(s) in order to continuously improve the quality of our health interventions.	0 %	100 %	0 %

RECOMMENDATIONS

Members of staff were requested to make suggestions for strengthening the health unit in the various areas and in relation to their submissions in the assessment. Their suggestions were as follows:

- The PVO should initiate annual opportunities for health unit field staff from different projects/ countries to meet and interact and share and share experiences.
- The health unit staff should be offered more opportunities for professional development. In addition staff should access regular refreshment training.

- In order to improve organizational learning, staff should have an opportunity to access lessons learned from other health projects.
- Funding sources for the health unit need to be diversified
- The roles and responsibilities of staff need to be regularly discussed, reviewed and updated.
- The health unit should explore closely collaborating and working with the district and ministry of health.
- There should be regular meetings with stakeholders
- There should be regular updates on programs, policies and regulations.
- UHC should be given support in retention of members and in handling providers in cases of changes in management of providers.
- Providers should be encouraged to sustain the scheme by refunding half of loses of the past years.
- There should be consistency in human resources policies. They should be made adoptive to suit the employees.
- Employees need training on budget management and other financial management issues.
- Staff should be aided in diversification of knowledge and skills through additional training in other technical areas other that their current professions such as training skills, computer skills.
- There should be a closer relationship between UHC and Child Survival in the field.
- Backstop staff should visit with the field projects time and again to provide technical support in the field and be able to meet together as a team.

COMMENTS

Despite the fact that three of eight UHC staff are new to the project, this baseline self assessment includes valuable information that will help guide management to developing an effective environment for implementing CS interventions. It would be expected that the relatively high number of "don't know" responses would be reduced over time as all staff have more experience with UHC structure, administration, organizational learning, financial resource management and human resources.

It is important for UHC to regularly include target communities and local partners in monitoring and evaluating the projects which serve their communities. Details for addressing this should be included in the M&E section of the DIP.

While the fact that the majority of the target population speaks English may suggest that translation of documents is not necessary, this issue should be explored further through community based information gathering. It is important for messages to be communicated to the target population in their primary language.

Efforts should be made to increase opportunities for CS and UHC staff to work together and to share lessons learned in a routine and regular manner. In conjunction with these sharing opportunities, staff should be encouraged to provide feedback on designated backstop staff. The method for sharing this information needs to be included in the M&E plan.

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The results in the technical support portion of this assessment are misleading due to the fact that Child Survival is new to five long-term staff and new staff have only been present for three months. This section provides baseline information but does not clearly paint a picture of programmatic success or needs in this area. Training plans for staff should include financial and budget management as well as technical skills training in their respective areas of focus for field staff.

Monthly meetings need to include sharing up to date budget information to build staff capacity and to garner their feedback as the budget relates to their role in implementation.

Additional efforts should be made to participate in health policy dialogue at district and national levels in Bushenyi District.

In conclusion, UHC staff self were primarily positive in their review of UHC program management however some important areas for improvement were indicated. It is recommended that UHC incorporate this information into their plans for building the capacity of management, staff, financial management and most importantly monitoring and evaluation. Staff should be encouraged to provide feedback through program implementation and formal institutional strengths assessments should be carried out annually to ensure the greatest improvement possible in the first five years of UHC's child survival interventions.

COPY OF THE TOOL USED
Http://www.childsurvival.com/tools/isa_self.pdf

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Annex 5: Agreements

April 19, 2006

Ms. Joy Batusa
Plot 2, Ibis Vale, Off Prince Charles Drive
P.O. Box 27659
Kampala

Re: Letter of Support to HealthPartners and Uganda Health Cooperative:

I am writing to offer our thanks to HealthPartners and its Non Government Organization affiliate, Uganda Health Cooperative for keeping the Mission informed of the work done by these two organizations in Bushenyi district. The Mission commends the efforts put into developing interventions to promote the wellbeing of the mother and the child which ultimately contributes to the attainment of the Mission goal of improving the quality of life of Ugandans.

Thank you again for the opportunity to share with us and discuss the implementation plan and the results frame work on March 16, 2006. Through such a robust plan, we believe that HealthPartners and UHC, in partnership with CBOs, will be able to realize the intended results in the control and management of malaria and diarrhea as well as promote prepaid health plans as an innovative strategy to develop a sustainable structures for maternal and child interventions.

The Mission is pleased with the progress of work so far and looks forward to getting such similar updates on a quarterly basis.

Sincerely,

Jessica Kafuko
Project Management Specialist

cc: Agravat, Namita (GH/HIDN/NUT)

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MEMORANDUM OF UNDERSTANDING
between
HEALTHPARTNERS UGANDA HEALTH COOPERATIVE
and
POPULATION SERVICES INTERNATIONAL

1. Parties

The parties to this Memorandum of Understanding ["MOU"] are Health Partners- Uganda Health Cooperative ["hereinafter referred to as "UHC"] and Population Services International ["hereinafter referred to as PSIU"] for the implementation of a Child Survival Program in Bushenyi District.

2. Program Description

UHC will work with key partners over a 5 year period to implement a Child Survival Program in Bushenyi district. The primary target of the program will be children under five years and women of reproductive age, approximately 50,000 persons.

Goal:

Link child survival interventions and partnerships to prepaid health schemes, building on the existing structure to sustainably reduce morbidity and mortality for WRA and children under 5.

Objectives:

1. Reduce incidence of malaria in Bushenyi district for children under 2 and pregnant women
2. Reduce incidence of diarrhea in Bushenyi district for children under 2
3. Increased % of pregnant women receiving improved ANC, delivery and post partum care
4. Build local organizational capacity to manage health schemes
5. Improved health care management especially for WRA and children under 5

3. Responsibilities of the Parties

PSI shall;

i. Provide Advisory support to UHC
ii. Supply agreed upon quantities of Safe water products (PUR and Waterguard) , Long lasting Insecticide Treated Bed nets (Smartnet) and Clean birthing kits(Mama kit)
iii. Provide training to UHC staff, community Health Workers, Health plan members and providers in safe water treatment, use of Insecticide Treated Nets and Clean Birthing Kits.
iv. Share IEC materials and training materials. In addition, joint behavior change communication efforts may be undertaken as considered appropriate by both parties.
v. Avail or share promotional materials on safe water products, Insecticide Treated bed nets and Birthing Kits.

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UHC shall;

i. Pay PSIU agreed upon amount of money limited to purchased products and services.
ii. Mobilize and sensitize UHC staff, community Health Workers, Health plan members and providers to participate in the trainings
iii. Coordinate training activities.
iv. Share information and collaborate with PSIU

4. Protection of Confidential/Privileged Information

Each party shall take appropriate measures to protect proprietary, privileged or otherwise confidential information obtained as a result of its activities under this MOU

5. Independence

The parties to this MOU agree that either party shall be independent organization and shall neither claim to be an agent of nor have authority to make any commitments on behalf of the other, except to the extent that such authority shall be expressly agreed under this MOU.

6. Effective Date/Term/Termination

This MOU shall be effective on the date first written below and shall remain in force until ..... 2010 or terminated unilaterally by either party upon 30days notice to the other party.

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Box 27659, Kampala, Uganda
Tel: 256-41-342353 Fax: 256-41-258678

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IN WITNESS WHEREOF UHC and PSI Uganda have each caused this MOU to be executed on their behalf, as of the date first written below.

Signed.....

Rebecca Joy Batusa
Director
Health Partners- Uganda Health Cooperative.

Date. 5/4/06

Signed.....

Susan Mpanga Mukasa (MD)
Country Representative
PSI Uganda

Date. 5/4/06.

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Uganda Health Cooperative
Plot 2, Ibis Vale, Off Prince Charles Drive, PO Box 27659, Kampala, Uganda
Tel: 256-41-342353 Fax: 256-41-258678

MEMORANDUM OF UNDERSTANDING
between
HEALTHPARTNERS UGANDA HEALTH COOPERATIVE
and

THE BUSINESS PART PROJECT

1. Parties

The parties to this Memorandum of Understanding ["MOU"] are Health Partners- Uganda Health Cooperative ["hereinafter referred to as UHC"] and The Business PART Project ["hereinafter referred to as PART"] for the implementation of a Child Survival Program in Bushenyi District.

3. Program Description

UHC will work with key partners over a 5- year period to design and implement a Child Survival Program. The CS activities will be based in the District of Bushenyi in western Uganda in the counties of Igara, Sheema, Bunyaruguru, Buhweju and Ruhinda. The primary target of the program will be children under five years and women of reproductive age, approximately 50,000 persons.

Goal:

Link child survival interventions and partnerships to prepaid health schemes, building on the existing structure to sustainably reduce morbidity and mortality for Women of Reproductive Age and children under 5.

Objectives:

6. Reduce incidence of malaria in Bushenyi district for children under 2 and pregnant women
7. Reduce incidence of diarrhea in Bushenyi district for children under 2
8. Increased % of pregnant women receiving improved ANC, delivery and post partum care
9. Build local organizational capacity to manage health schemes
10. Improved health care management especially for WRA and children under 5

3. Responsibilities of the Parties

PART agrees to:

i. Offer advisory support to program activities more so in the area of HIV/AIDS.

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Tel: 256-41-342353 Fax: 256-41-258678

ii. Provide training to HP-UHC staff, community Health Workers, Health plan members and Traditional Birth attendants on HIV/AIDS, Voluntary Counseling and Testing and PMTCT

iii. Provide IEC materials related to HIV prevention and treatment, Voluntary Counseling and Testing and PMTCT.

HP-UHC shall:

i. Mobilize and sensitize staff, community Health Workers, Health plan members, Traditional Birth attendants and providers to participate in the trainings.

ii. Coordinate training activities.

iii. Pay for training and IEC materials

4. Protection of Confidential/Privileged Information

Each party shall take appropriate measures to protect proprietary, privileged or otherwise confidential information obtained as a result of its activities under this MOU

5. Independence

The parties to this MOU agree that either party shall be independent organization and shall neither claim to be an agent of nor have authority to make any commitments on behalf of the other, except to the extent that such authority shall be expressly agreed under this MOU.

6. Effective Date/Term/Termination

This MOU shall be effective on the date first written below and shall remain in force until ..... 2010 or terminated unilaterally by either party upon 30days notice to the other party

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IN WITNESS WHEREOF UHC and Business PART have each caused this MOU to be executed on their behalf, as of the date first written below.

Signed.....

Rebecca Joy Batusa
Director
HealthPartners- Uganda Health Cooperative.

Date April 7, 2006

Signed.....

Dr. Peter Cowley
Chief of Party
Business PART Project

Date April 7, 2006

HealthPartners
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HealthPartners
Uganda Health Cooperative

UPHOLD
UGANDA PROGRAM FOR HUMAN AND HOLISTIC DEVELOPMENT

MEMORANDUM OF UNDERSTANDING
between
HEALTHPARTNERS UGANDA HEALTH COOPERATIVE
and
UGANDA PROGRAM FOR HUMAN AND HOLISTIC DEVELOPMENT (UPHOLD)

1. Parties

The parties to this Memorandum of Understanding ["MoU"] are Health Partners- Uganda Health Cooperative ["hereinafter referred to as UHC"] and Uganda Program for Human and Holistic Development ["hereinafter referred to as UPHOLD"] for the implementation of a Child Survival Program in Bushenyi District.

2. Program Description

UHC will work with key partners over a five year period to design and implement a Child Survival Program. The CS activities will be based in the District of Bushenyi in western Uganda in the counties of Igara, Sheema, Bunyaruguru, Buhweju and Ruhinda. The primary target of the program will be children under five years and women of reproductive age, approximately 50,000 persons.

Goal

Link child survival interventions and partnerships to prepaid health schemes, building on the existing structure to sustainably reduce morbidity and mortality for Women of reproductive age and children under five.

Objectives

1. Reduce incidence of malaria in Bushenyi district for children under 2 years of age and pregnant women
2. Reduce incidence of diarrhea in Bushenyi district for children under 2 years of age
3. Increased % of pregnant women receiving improved ANC, delivery and post partum care
4. Build local organizational capacity to manage health schemes
5. Improved health care management especially for Women of Reproductive Age and children under 5

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3. Responsibilities of the Parties

UPHOLD shall;

i. Provide technical support to HP-UHC in the following areas:

- Increasing involvement of families and communities in healthcare
- Community Integrated management of childhood illnesses
- Integrated reproductive health (for maternal and newborn care)

ii. Share data collected through research, IEC materials and training materials developed on child health to educate both mothers and Health workers.

(a) HP-UHC shall:

i. Share Information and Collaborate fully with UPHOLD:
   - Inform UPHOLD in advance of dates and times of different activities.
   - Inform UPHOLD about changes in plans or participation in the Child Survival Program

4. Protection of Confidential/Privileged Information

Each party shall take appropriate measures to protect proprietary, privileged or otherwise confidential information obtained as a result of its activities under this MOU

5. Independence

The parties to this MoU agree that either party shall be independent organization and shall neither claim to be an agent of nor have authority to make any commitments on behalf of the other, except to the extent that such authority shall be expressly agreed under this MOU.

6. Effective Date/Term/Termination

This MOU shall be effective on the date first written below and shall remain in force until September 2007, or terminated unilaterally by either party upon giving 30 days notice to the other party .

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IN WITNESS WHEREOF UHC and UPHOLD have each caused this MoU to be executed on their behalf, as of the date first written below.

Signed.....

Rebecca Joy Batusa
Director
HealthPartners- Uganda Health Cooperative.

Date. April 26, 2006

Signed.....
SAMSON KIRONDE

Nosa Orobaton
Ag. Chief of Party
UPHOLD Uganda

Date. 26/04/06

HealthPartners
Uganda Health Cooperative
Plot 2, Ibis Vale, Off Prince Charles Drive, PO Box 27659, Kampala, Uganda
Tel: 256-41-342353 Fax: 256-41-258678

MEMORANDUM OF UNDERSTANDING
Between
HEALTHPARTNERS UGANDA HEALTH COOPERATIVE
And
COMBONI HOSPITAL - KYAMUHUNGA

1. Parties
The parties to this Memorandum of Understanding ["MOU"] are Health Partners- Uganda Health Cooperative ["hereinafter referred to as UHC"] and Comboni Hospital ["hereinafter referred to as Provider"] for the implementation of a Child Survival Program in Bushenyi District.

2. Program Description

UHC will work with key partners over a 5- year period to design and implement a Child Survival Program. The CS activities will be based in the District of Bushenyi in western Uganda in the counties of Igara, Sheema, Bunyaruguru, Buhweju and Ruhinda. The primary target of the program will be children under five years and women of reproductive age, approximately 50,000 persons.

Goal:
Link child survival interventions and partnerships to prepaid health schemes, building on the existing structure to sustainably reduce morbidity and mortality for Women of Reproductive Age and children under 5.

Objectives:
1. Reduce incidence of malaria in Bushenyi district for children under 2 and pregnant women
2. Reduce incidence of diarrhea in Bushenyi district for children under 2
3. Increased % of pregnant women receiving improved ANC, delivery and post partum care
4. Build local organizational capacity to manage health schemes
5. Improved health care management especially for WRA and children under 5

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3. Responsibilities of the Parties

Comboni Hospital shall:

i. Engage in Community outreach activities for Maternal and New born Care, Family Planning, HIV, and Child Survival/ IMCI and management of third stage labor.
ii. Participate in training of each of the three key interventions
iii. Engage selected midwives in, monitoring, supervision and self assessments.

UHC shall:

i. Train Comboni Hospital members on each of the three key interventions and the intended outcome.
ii. Reduce incidence of stock outs
iii. Improve use of IMCI
iv. Improve ANC
v. Improve postpartum care
vi. Improve delivery (including AMTSL)
vii. Improve self assessment ability

4. Protection of Confidential/Privileged Information

Each party shall take appropriate measures to protect proprietary, privileged or otherwise confidential information obtained as a result of its activities under this MOU

5. Independence

The parties to this MOU agree that either party shall be independent organization and shall neither claim to be an agent of nor have authority to make any commitments on behalf of the other, except to the extent that such authority shall be expressly agreed under this MOU.

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HealthPartners
Uganda Health Cooperative

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6. Effective Date/Term/Termination

This MOU shall be effective on the date first written below and shall remain in force until ..... 2010 or terminated unilaterally by either party upon 30days notice to the other party

IN WITNESS WHEREOF UHC and PSI Uganda have each caused this MOU to be executed on their behalf, as of the date first written below.

Signed.....

Rebecca Joy Batusa
Director
HealthPartners- Uganda Health Cooperative.

Date.....

Signed.....

Dr. James Mukankusi
Medical Superintendent
Comboni Hospital - Kyamuhunga

Date.....11/04/2016.....

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MEMORANDUM OF UNDERSTANDING
Between
HEALTHPARTNERS UGANDA HEALTH COOPERATIVE
And
ISHAKA ADVENYIST HOSPITAL

1. Parties

The parties to this Memorandum of Understanding ["MOU"] are Health Partners- Uganda Health Cooperative ["hereinafter referred to as UHC"] and Ishaka Adventist Hospital ["hereinafter referred to as Provider"] for the implementation of a Child Survival Program in Bushenyi District.

2. Program Description

UHC will work with key partners over a 5- year period to design and implement a Child Survival Program. The CS activities will be based in the District of Bushenyi in western Uganda in the counties of Igara, Sheema, Bunyaruguru, Buhweju and Ruhinda. The primary target of the program will be children under five years and women of reproductive age, approximately 50,000 persons.

Goal:

Link child survival interventions and partnerships to prepaid health schemes, building on the existing structure to sustainably reduce morbidity and mortality for Women of Reproductive Age and children under 5.

Objectives:

1. Reduce incidence of malaria in Bushenyi district for children under 2 and pregnant women
2. Reduce incidence of diarrhea in Bushenyi district for children under 2
3. Increased % of pregnant women receiving improved ANC, delivery and post partum care
4. Build local organizational capacity to manage health schemes
5. Improved health care management especially for WRA and children under 5

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Tel: 256-41-342353 Fax: 256-41-258678

3. Responsibilities of the Parties

Ishaka Adventist Hospital ~~shall~~: May

i. Engage in Community outreach activities for Maternal and New born Care, Family Planning, HIV, and Child Survival/ IMCI and management of third stage labor.
ii. Participate in training of each of the three key interventions
iii. Engage selected midwives in, monitoring, supervision and self assessments.

UHC shall:

i. Train Ishaka Adventist Hospital members on each of the three key interventions and the intended outcome.
ii. Reduce incidence of stock outs
iii. Improve use of IMCI
iv. Improve ANC
v. Improve postpartum care
vi. Improve delivery (including AMTSL)
vii. Improve self assessment ability

4. Protection of Confidential/Privileged Information

Each party shall take appropriate measures to protect proprietary, privileged or otherwise confidential information obtained as a result of its activities under this MOU

5. Independence

The parties to this MOU agree that either party shall be independent organization and shall neither claim to be an agent of nor have authority to make any commitments on behalf of the other, except to the extent that such authority shall be expressly agreed under this MOU.

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6. Effective Date/Term/Termination

This MOU shall be effective on the date first written below and shall remain in force until October.... 2010 or terminated unilaterally by either party upon 30days notice to the other party

IN WITNESS WHEREOF UHC and the Provider have each caused this MOU to be executed on their behalf, as of the date first written below.

Signed.....
13/04/06

Rebecca Joy Batusa
Director
HealthPartners- Uganda Health Cooperative.

Date...13th/04/06.....

Signed.....

Dr. Isaqani L. Manuel
~~Dr. Isaqanil Maneul~~
Medical Director
Ishaka Adventist Hospital

Date...13-4-06.....

ISHAKA ADVENTIST HOSPITAL
P. O. Box 111, Bushenyi
SEVENTH-DAY ADVENTIST CHURCH
MEDICAL DIRECTOR'S OFFICE

HealthPartners
Uganda Health Cooperative
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P.O Box 27659, Kampala, Uganda
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MEMORANDUM OF UNDERSTANDING
Between
HEALTHPARTNERS UGANDA HEALTH COOPERATIVE
And
MITOOMA CENTRAL CLINIC

1. Parties

The parties to this Memorandum of Understanding ["MOU"] are Health Partners- Uganda Health Cooperative ["hereinafter referred to as UHC"] and Mitooma Central Clinic ["hereinafter referred to as Provider"] for the implementation of a Child Survival Program in Bushenyi District.

2. Program Description

UHC will work with key partners over a 5- year period to design and implement a Child Survival Program. The CS activities will be based in the District of Bushenyi in western Uganda in the counties of Igara, Sheema, Bunyaruguru, Buhweju and Ruhinda. The primary target of the program will be children under five years and women of reproductive age, approximately 50,000 persons.

Goal:

Link child survival interventions and partnerships to prepaid health schemes, building on the existing structure to sustainably reduce morbidity and mortality for Women of Reproductive Age and children under 5.

Objectives:

1. Reduce incidence of malaria in Bushenyi district for children under 2 and pregnant women
2. Reduce incidence of diarrhea in Bushenyi district for children under 2
3. Increased % of pregnant women receiving improved ANC, delivery and post partum care
4. Build local organizational capacity to manage health schemes
5. Improved health care management especially for WRA and children under 5

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3. Responsibilities of the Parties

Mitooma Central Clinic shall:

i. Engage in Community outreach activities for Maternal and New born Care, Family Planning, HIV, and Child Survival/ IMCI and management of third stage labor.
ii. Participate in training of each of the three key interventions
iii. Engage selected midwives in, monitoring, supervision and self assessments.

UHC shall:

i. Train Mitooma Central Clinic members on each of the three key interventions and the intended outcome.
ii. Reduce incidence of stock outs
iii. Improve use of IMCI
iv. Improve ANC
v. Improve postpartum care
vi. Improve delivery (including AMTSL)
vii. Improve self assessment ability

4. Protection of Confidential/Privileged Information

Each party shall take appropriate measures to protect proprietary, privileged or otherwise confidential information obtained as a result of its activities under this MOU

5. Independence

The parties to this MOU agree that either party shall be independent organization and shall neither claim to be an agent of nor have authority to make any commitments on behalf of the other, except to the extent that such authority shall be expressly agreed under this MOU.

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6. Effective Date/Term/Termination

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IN WITNESS WHEREOF UHC and PSI Uganda have each caused this MOU to be executed on their behalf, as of the date first written below.

Signed.....

Rebecca Joy Batusa
Director
HealthPartners- Uganda Health Cooperative.

Date 13th/04/06

Signed.....

Dr. Ben Twetegire
Mitooma Central Clinic

Dr. Twetegire Ben
MITOOMA CENTRAL CLINIC
BUSHENYI DISTRICT

Date 13th April 2006

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Uganda Health Cooperative
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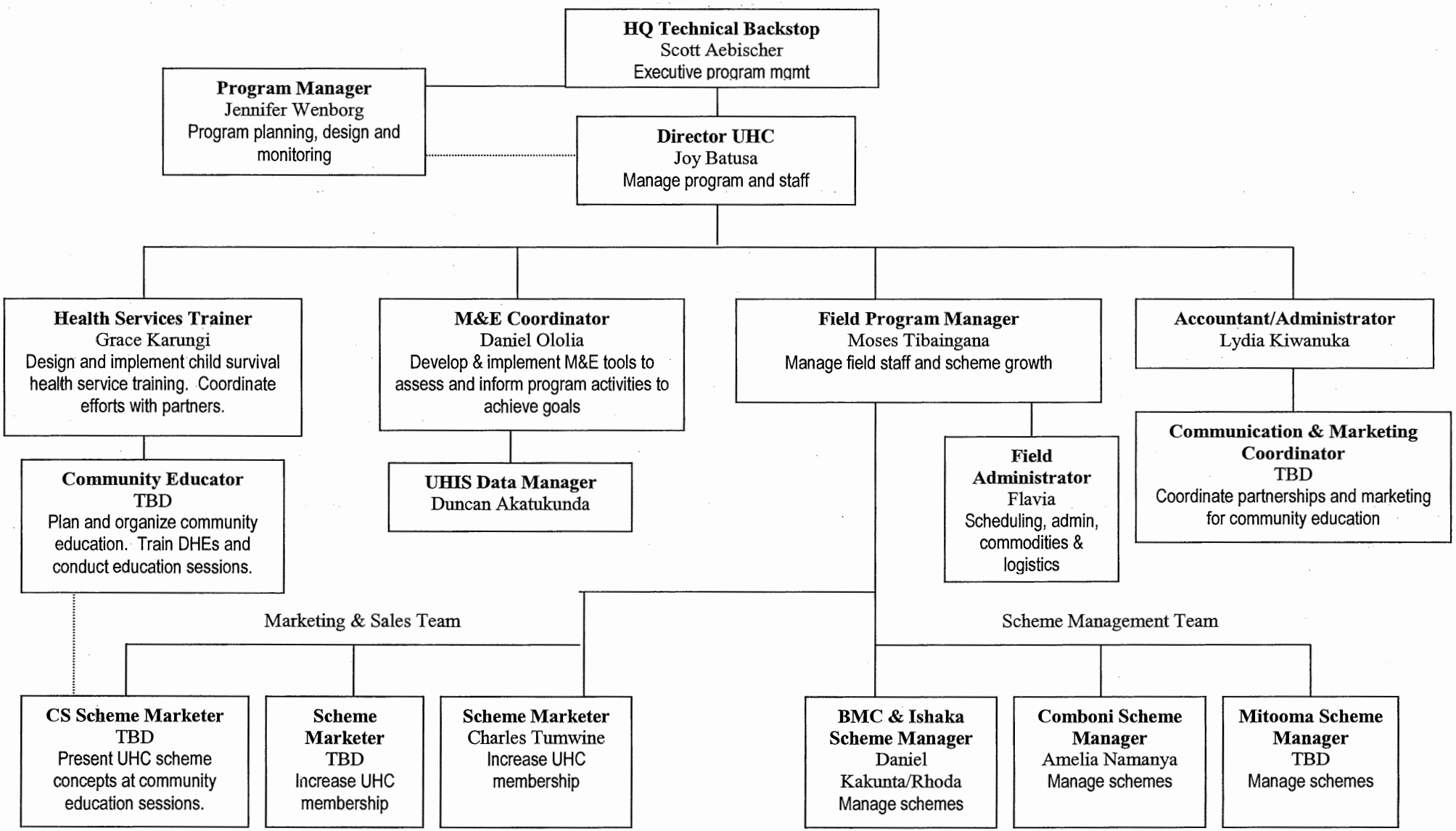
Annex 6: Organizational Chart / Management Plan



Management Structure

Name	Title	Location	Reports to:	Responsibility	% Effort	Remuneration
Scott Aebischer	HQ Technical Backstop	MN	USAID	Executive program mgmt	50%	Match contribution
Jennifer Wenborg	HQ Program Manager	MN	HQ Backstop	Program planning, design, monitoring	50% 50%	Child Survival UHC Coop Dev.
Joy Batusa	Field Program Manager / Director	Kampala	HQ Backstop	Manage program and staff	75% 25%	Child Survival UHC Coop Dev.
Lydia Kiwanuka	Accountant/ Administrator	Kampala	Director	Accounting, Administration	50% 50%	Child Survival UHC Coop Dev.
Daniel Ololia	M&E Coordinator	Bushenyi	Director	Develop & implement M&E tools to assess and inform program activities to achieve goals	100%	Child Survival
Grace Karungi	Health Services Trainer	Bushenyi	Director	Design and implement child survival health service training. Coordinate efforts with partners.	100%	Child Survival
Moses Tibaingana	Field Program Manager	Bushenyi	Director	Manage field staff and scheme growth	100%	UHC Coop Dev.

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TBD	Communication & Marketing Coordinator	Bushenyi	Accountant/Administrator	Create and coordinate community and stakeholder awareness for all mtgs, events and reports.	100%	Child Survival
Flavia	Field Administrator	Bushenyi	Field Mgr	Scheduling, admin, commodities & logistics	100%	UHC Coop Dev.
TBD	CS Scheme Marketer	Bushenyi	Field Mgr	Present UHC scheme concepts at community education sessions.	100%	Child Survival
Charles Tumwine	Scheme Marketer	Bushenyi	Field Mgr	Increase UHC membership	100%	UHC Coop Dev.
TBD	Scheme Marketer	Bushenyi	Field Mgr	Increase UHC membership	100%	UHC Coop Dev.
Daniel Kakunta & Rhoda	BMC & Ishaka Scheme Manager	Bushenyi	Field Mgr	Manage schemes	100%	Ishaka Hospital
Amelia Namanya	Comboni Scheme Manager	Bushenyi	Field Mgr	Manage schemes	100%	UHC Coop Dev.
TBD	Mitooma Scheme Manager	Bushenyi	Field Mgr	Manage schemes	100%	UHC Coop Dev.
Duncan Akatukunta	UHIS Data Manager	Bushenyi	M&E Coordinator	UHIS data management	100%	BMC
TBD	Community Educator	Bushenyi	Health Services	Design and implement child survival community	100%	Child Survival

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			Coordinator	education. Coordinate efforts with partners.		
Peter Cowley, MD	Business PART Project Director	Kampala	HQ Backstop	Consult on management and partnerships	15%	CMS
David Tiffin	Senior Accountant	MN	HQ PM	Accounting, grant back stop	10% 10%	Child Survival UHC Coop Dev.
Ted Weihe	Cooperative Advisor	VA	HQ PM	Consult on coop practices, development & fundraising	5% 5%	Child Survival UHC Coop Dev

Annex 7: Resumes

SCOTT AEBISCHER, M.P.H.
HQ Technical Backstop

Scott Aebischer currently serves as the Senior Vice President of Customer Service and Product Innovation for HealthPartners. He possesses a senior officer-level experience in the health care industry with expertise in customer service, product innovation and design, market research and communications, community relations, international health care and plan development, provider network development, contract negotiations, operations and strategic planning. With his extensive knowledge of health care delivery, he is responsible for serving approximately 660,000 members through a service center of 140 staff utilizing electronic commerce, face to face and state of the art telecommunications systems.

PROFESSIONAL EXPERIENCE
1991 - Present HealthPartners, Bloomington, MN, USA

2002 – Present, Senior Vice President, Customer Service and Product Innovation

- Responsible for health scheme product design and development.
- Provide leadership for all health scheme market communication materials.
- Provider leadership for organization-wide market research efforts.
- Oversee Regulatory relationships with the Department of Health and the Department of Commerce.
- Responsible for the recent grant extension of the Uganda program.

2000 - 2002, Vice President, Customer and Member Services

- Provide direct customer service support to employer groups, providers and members.
- Responsible for leading the Community Relations department.
- Senior Executive of International Affairs for HealthPartners. Provides leadership for the Uganda program and expansion efforts.

1995 - 2000, Vice President, Network Management

- Responsible for strategic development and contract negotiations for HealthPartners provider network. Expanded network outside metropolitan area, serving commercial and government products. Established value-based product, introducing competition between health care systems for Consumer Choice.
- Responsible for reimbursement models and contract development.
- Selected as the leader for international development of health scheme services in Uganda, Africa.
- Established consulting and service bureau model for independent medical groups.

1992-1995, Sr. Director, Network Management

- Responsible for provider relations and contracting efforts for all product lines offered by HealthPartners.

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1991-1992, Director of Affiliate Operations

- Responsible for Group Health affiliate clinic relationships.

EDUCATION

- Masters of Public Health, Mental Health Administrator, University of Minnesota, Minneapolis, MN, 1982
- Bachelor of Arts degree, Park and Recreation Administration, University of Minnesota, Minneapolis, MN, 1978

REBECCA JOY BATUSA, M.A.
Field Program Manager

Seven years experience with development of prepaid health care management, project design and monitoring. Launched UHC utilizing long distance relationship as the key source of information. Orchestrated relationships necessary for project success and negotiated buy in from local cooperatives starting the plan.

PROFESSIONAL EXPERIENCE
2001 – Present, HealthPartners Uganda Health Cooperative, Kampala, Uganda
Director

- Provide management direction the HealthPartners – Uganda Health Co-operative Project.
- Coordinate the design of project material for mobilization and capacity building
- Establish partnership relationships and identify technical resources
- Guide timely preparation of country reports (technical, substantive and financial)
- With donors and local stakeholders, establish a monitoring and evaluation system for the project and advise on implementation results of evaluations with the aim of improving project design.
- Review annual implementation plans and budgets
- Document good practices and ensure exchange of experience and lessons learnt

1998 – 2001, HealthPartners **Uganda Health Cooperative, Kampala, Uganda**
Healthcare Co-operative Senior Consultant

- Provide management support to HealthPartners
- Provide technical assistance in training and capacity development for HealthPartners Uganda Health co-operative staff and participating CBOs and private sector.
- Manage marketing of UHC plan
- Coordinated tools for hospital-based efforts creating prepayment plans.
- Coordinated appropriate database structure for outcomes measurement.

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1996 – 1998, **Church of Uganda, Namirembe Diocese HIV prevention and AIDS care Project**
Program Coordinator

EDUCATION

- Post graduate Diploma, Development Studies, (Universalizing Socio-Economic Security for the poor) Institute of Social Studies, The Hague Netherlands. 2004
- Master of Arts, Social Sector Planning and Management, Makerere University, Kampala Uganda 2003
- Certificate in Management, Carlson School of Management -University of Minnesota 2003
- Certificate in Gender studies, Makerere University, Kampala, Uganda 1997
- Certificate in Adolescent counseling 1996
- Certificate in Peer Educators Course in HIV/AIDS 1996
- Certificate in Project planning and Management, IYECA- Kampala, Uganda 1995
- Bachelor of Arts degree, Education, Makerere University, Kampala, Uganda 1994
- Certificate in Community Worker's course in HIV/AIDS 1994

JENNIFER WENBORG, M.A.
HQ Program Manager

PROFESSIONAL EXPERIENCE
1999 – Present, HealthPartners, Uganda Health Cooperative, Bloomington, MN USA
Program Manager

- Define the project scope, coordinate activities of the project team, identify resources, develop a schedule to ensure deadlines are met and provide status updates to executive management
- Develop project budgets and operate within them in order to ensure on time and under budget delivery. Prepare, track, evaluate, and reconcile capital and expense budgets for international projects.
- Lead grant writing process including defining interventions, objectives, planned activities, outcomes, measurement, organizational design, and budgetary/resource allocations.
- Communicate functional and design specifications to project staff and follow up with evaluation and change management as necessary.
- Research and provide tools for measurement, evaluation and training.
- Work with project director to develop goals and evaluation tools for team performance. Proactively addresses performance issues within the team and escalate as necessary.

- For Uganda Database technology projects, act as a liaison between users, Information Technology specialists, and Health Care Management Executives for implementing hardware and software solutions.
- Develop and maintain database budget including decision making on hardware and software procurement.

2003 – 2005, Northwestern Health Sciences University, Bloomington, MN USA
Staff Clinician

1998 –1999, the Screen Actors Guild, Los Angeles, CA USA
Los Angeles BooksPALS Coordinator/ National Administrator

- Coordinated programs and events
- Developed and implemented database tracking system
- Wrote monthly newsletters, marketing and fund raising material.

1996 –1998, Barnes & Noble Bookstores, Minneapolis, MN and Los Angeles, CA USA
Community Relations Manager

- Began as Coordinator promoted to Manager. Scheduled and promoted events.
- Opened new store, creating marketing strategy plan, launch events to build community awareness.
- Developed diverse series event structure to increase sales. Implemented measures of event success.

EDUCATION

- Master of Arts, Northwestern Health Sciences University, Bloomington, MN, 2003
- Bachelor of Arts, English and Psychology, St. Olaf College, Northfield, MN, 1994

LYDIA KIWANUKA
Accountant/Administrator

PROFESSIONAL EXPERIENCE
2003 – Present, HealthPartners, Uganda Health Cooperative, Kampala, Uganda
Accountant/Administrative Assistant

- Designed Project's forms relevant in accounting ie Payment vouchers, Travel Advance, Travel Accountability and provided accounting Support to UHC and MUCH Projects.
- Successfully processed the registration of the Project with the NGO Board.
- Manage Office Petty cash in accordance with Organizational Procedures.
- Maintain an Updated fixed assets and Office Inventory.
- Assist(ed) in Coordinating Procurement activities for UHC and MUCH.

- Maintain Office filing system.
- Coordinate staff travel plans by liaising with PSI's Office and fleet Managers.
- Prepare (d) projected monthly Expenditure Budgets for UHC and MUCH Projects.
- Audit upcountry staff expenditures in relation to amounts advanced for monthly Project activities.
- Trained staff on the basic accounting concepts ie the Use of Payment Voucher Books, preparation of end of month expenditure reports, reconciliation of advanced amounts and general proper accountability of funds.
- Liaised with the Projects' Bankers and reconciliation of the Project's accounts i.e. UHC and MUCH
- Performed general administrative and all other duties as directed by Field and HQ Program Managers.

2002 – 2003 Century Bottling Company, Coca-Cola, Kampala, Uganda
Cashier
Received cash from daily route sales deposited by sales representatives

- received all cash made from other various sales
- Prepared daily Sales Input summaries for reconciliation with the Accounts Department.
- Liaised with the Settlement Department to reconcile cash deposits made by sales representatives.
- Reconciled all daily receipts, Century Bottling Company Cheques (CBC's) paid out and actual cash at hand to be Banked.
- Performed all other duties as directed by Company's Accountant.

2000 –2001, Nsambya Hospital Healthcare Plan, Kampala, Uganda
Accounts Assistant

- Provided accounting Support
- Managed Office Petty cash in accordance with Organizational Procedures.
- Maintained an Update fixed assets and Office Inventory.
- Maintained Office filing system.
- Reconciled Project's bank accounts.
- Prepared projected monthly expenditure reports to be submitted to the donors (DFID)
- Performed all other duties as directed by Project Director.

1996 –1998, Jasper-Semu & Associates, Certified Accountants/Auditors and Multitech Accountancy Programme (MAP), Kampala, Uganda

HealthPartners
Uganda Health Cooperative
Plot 2, Ibis Vale, Off Prince Charles Drive, PO Box 27659, Kampala, Uganda
Tel: 256-41-342353 Fax: 256-41-258678
Administrative/Accounts Assistant

- Provided accounting support to the organization and was responsible for:-
  - Preparing Payroll and paid of staff salaries.
  - Preparation of payment schedules and Vouchers
  - Maintaining a proper filing system in the accounts department.
  - Maintaining Office Petty cash and it's recordings in the relevant books.
  - Computation and remittance of employee's NSSF and PAYE to the relevant tax authorities.
  - Writing up cashbooks for the three organization's ie Jasper-Semu and Associates, Multitech Accountancy Programme and Multitech management Consultants.
  - Liased with the Bank and prepared of monthly reconciliation statements for the three organizations above.
  - Processed staff loans and reconciled their repayments on a monthly basis.
- Performed general administrative as directed by the Administrative Director

EDUCATION

- Uganda Diploma in Business Studies, National College of Business Studies/Makerere University Business School, Kampala, Uganda, 1991-1993
- Uganda Advanced Certificate of Education, St. James Senior Secondary School, Jinja, Uganda, 1988-1990

DANIEL OLOLIA
Monitoring and Evaluation Coordinator

PROFESSIONAL EXPERIENCE
2005, Best Consultancy Firm, Kampala, Uganda
Monitoring and Evaluation Officer/Data Manager

- Management of qualitative and quantitative data
- Report writing and editing
- Conducted research
- Designed tools/instruments for studies
- Provided M&E technical support on various consultancy assignments

2000 – 2005,African Youth Alliance, Kampala, Uganda
Monitoring and Evaluation Assistant

- Participated in monitoring of AYA IPs
- Participated in training AYA Implementing partners on EE and HST amount young people
- Trained implementing partners in data management

2002, Uganda Bureau of Statistics (during the 2002 census), Kampala, Uganda
Sub county Supervisor

- Trained field officers.
- Monitoring of field performance.
- Receiving, compiling and submission of field data

1999 –2000, African Children's Mission (ACM), Kampala, Uganda
Field Coordinator

- Conducted EE and BCC activities among orphaned and disadvantaged children
- Sorted and edited field data for report writing
- Facilitated field activities of staff and visitors

EDUCATION

- Bachelor of Arts, Public Administration and Philosophy, Makerere University, Kampala, 2004
- Certificate in Monitoring and Evaluation by UNFPA Education Center.

GRACE KARUNGI
Health Services Coordinator

PROFESSIONAL EXPERIENCE
1982 – 1985, West Anokole Diocese, West Ankole, Uganda
Nurse

- Nursing
- Trained Community Health Workers

1985 – 1993, Kigarama Health Unit, Bushenyi, Uganda
Nurse

- Curative services
- Trained Community Health Workers
- Immunization

1994 – 2002, Bushenyi District Local Administration, Bushenyi, Uganda
Assistant Health Educator to District Director Health Services

- Coordination of CBHC and CCB activities
- Support Supervision in Health Units
- Introduced Health Information Management System

EDUCATION

- Bweranyangi Girls S.S.S., O' Level Certificate, Uganda 1978

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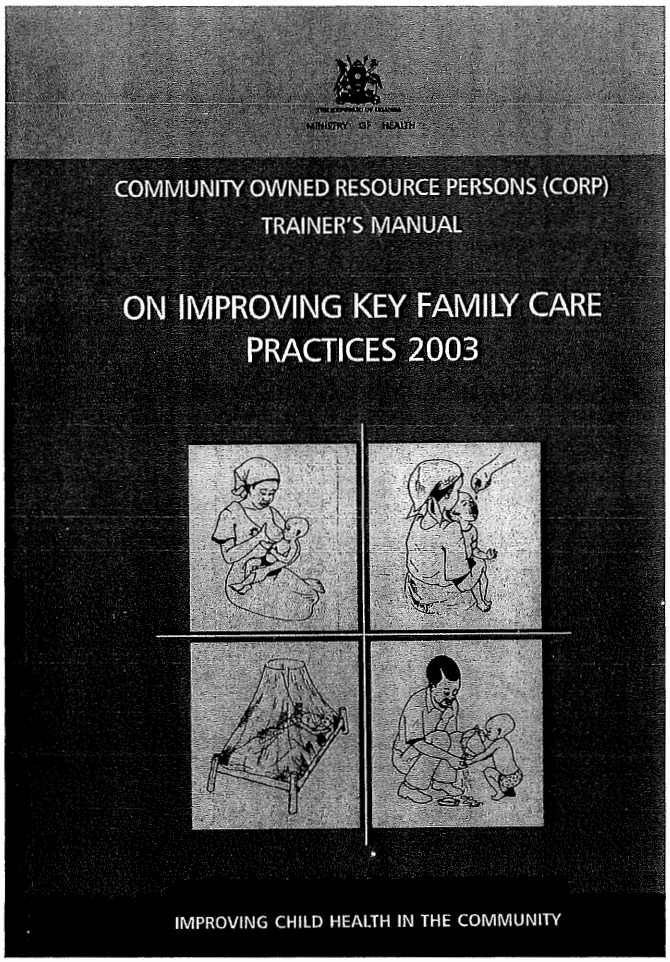
- Virika Nursing School, Nurse Certificate, Uganda, 1981
- Jinja IDA, Assistant Health Educator Certificate, Uganda, 1993
- 13 Training of Trainers courses in various programs ranging from Community Based Health Care, BCC, health management, communication approaches, participatory learning, Lot Quality Assurance Sampling, Uganda 1982-2004
- Attended 9 month course on community capacity building conducted by the Uganda Ministry of Health, Certificate, 1997

Annex 8: Training and Technical Guidelines

UHC will utilize training and program development and M&E materials from USAID, CSTS, CORE, MOH, IMCI, SCM and guidelines provided by partner organization who have child survival experience. Some sample cover pages of the latter are attached.



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Africare - Uganda
Integrated Community Health Model

SOFTWARE Components:	HARDWARE Components:

Key Partnerships: USAID

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STANDARD GUIDELINES

HOUSEHOLD AND COMMUNITY HH/C IMCI

IMPLEMENTATION STEPS

1.0 District entry/Introductory Phase

1.1 Pre-visit District.
1.2 Orientation of District Core Team.
1.3 Sensitisation of District Local Council (Civic & Political Leadership).
1.4 Identify & Orient Other Stake Holders.

2.0 Training/orienting district resource team on HH/C IMCI

3.0 Preparation for Implementation

3.1 District Baseline Survey.
3.2 Dissemination of Baseline Findings.
3.3 District Level Planning and Budgeting for HH/C IMCI Activities (communication etc).

4.0 Introducing HH/C IMCI at Sub-county Level

4.1 Pre-visit to Sub-counties.
4.2 Sensitisation of Civic & Political Leaders.
4.3. Sensitisation of Health Workers, Sub-county Health Committee & Health Unit Management Committees (HUMC).
4.4 Sensitisation of Other Stakeholders & Extension Workers.

5.0 Training Sub-county resource person

5.1 Orientation on HH/C IMCI.
5.2 IMCI tailored Participatory Rural Appraisal (PRA).
5.3 Communication Skills etc.

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[i] Bushenyi Local Government Health Sector Budget Conference for FY 2006/2007
[ii] BUCEN-IDB-2002
[iii] Bushenyi Local Government Health Sector Budget Conference for FY 2006/2007
[iv] Uganda Health Cooperative Baseline KPC Survey, Bushenyi District, January, 2006.
[v] Indirectly through child survival education, drama shows, radio and other media, UHC expects to reach 100,000 or more.
[vi] Bushenyi Local Government Health Sector Budget Conference for FY 2006/2007
[vii] Indirectly through child survival education, drama shows, radio and other media, UHC expects to reach 100,000 or more.
[viii] BUCEN-IDB-2002
[ix] WHO/Hill-2004.
[x] According to Chastain Fitzgerald, Country Representative, PSI.
[xi] Often, referred to as clubs or "Engozi".
[xii] Based on discussions at the meeting on November 12, 2004.
[xiii] Bushenyi Local Government Health Sector Budget Conference for FY 2006/2007
[xiv] In Net Project Evaluation Report, (draft, September 2003)
[xv] Three nets are provided per family, selling for 8,000 Shs ($4.50), with health providers contributing to their costs.
[xvi] *Draft Estimates of Revenue and Expenditure* 2004/2005, Ministry of Finance, Planning and Economic Development for fiscal year ending on June 30, 2005
[xvii] The Republic of Uganda, Ministry of Health. Health Sector Strategic Plan II (2005/06 – 2009/2010) Volume 1.
[xviii] Congressional Budget Justification, FY 2005.
[xix] Data sheet for Human Capacity and Global Health FY2002-2007.
[xx] UPHOLD/SERVICES, USAID/Uganda website, contact is Nosa Orobaton.
[xxi] USAID/Uganda Mission Strategic Plan.
[xxii] Source: TRM on malaria.
[xxiii] Data varies on the percentage of ITNs and more recent figure is 9% in the *Uganda National Household Survey, 2002/2003*the Western region including Bushenyi.