P.D. ABF-010

isn-80178

FIRST ANNUAL REPORT

1992-1993

for

CHILD SURVIVAL VII

PDC-0500-A-00-1097-00

UGANDA

Submitted to

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
Washington, D.C.

by

ADVENTIST DEVELOPMENT AND RELIEF AGENCY INTERNATIONAL
Silver Spring, MD

October 1992

TABLE OF CONTENTS

I. MAIN ACTIVITIES
- A. Baseline Survey 1
- B. Selection of TOT's 1
- C. Selection of Village Health Committee 2
- D. Training 3
- E. DIP 4
- F. Schedule of Activities 4
- G. Change in Approach to Individuals at Higher Risk 4

II. HUMAN RESOURCES AND COLLABORATION
- A. Staffing 4
- B. Continuing Education 4
- C. Technical Support 5
- D. Community Participation 5
- E. Linkages to Other Health and Development Activities 6

III. CONSTRAINTS, UNEXPECTED BENEFITS OF LESSONS LEARNED
- A. Constraints 6
- B. Unexpected Benefits 8

IV. CHANGES MADE IN PROJECT DESIGN
- A. Changes in Perceived Health Needs 8
- B. Change in Project Objectives 8
- C. Change in Planned Interventions 8
- D. Change in Potential & Priority Beneficiaries 8

V. HEALTH INFORMATION DATA COLLECTION
- A. Characteristics of the Health Information System 8
- B. Special Capacities of Health Information System 9
- C. Management of the Health Information System 9
- D. Collecting, Compiling, Analyzing and Monitoring Data 10

VI. SUSTAINABILITY
- A. Plan 10
- B. Activities to Cut Recurrent Costs 11
- C. Cost Recovery 11

VII. BUDGET CHANGES 11

VIII. WORK PLAN FOR CHILD SURVIVAL PROJECT VII 12

APPENDIX

A. Training of Trainers Workshop 14
B. Training of Village Health Committees 58
C. Job Description and Curriculum Vitaes 76
D. Pipeline Analysis 79
E. USAID Health and CS Project Questionnaire 83

GLOSSARY

ADRA ..... Adventist Development ad Relief Agency
CDD ..... Control of Diarrhea Disease
CHW ..... Community Health Workers
CS ..... Child Survival
DIP ..... Detailed Implementation Plan
DMO ..... District Medical Officer
HIS ..... Health Information System
IGA ..... Income Generation Activity
PWA ..... Patients With Aids
RC ..... Chief's Resistance
SDA ..... Seventh-day Adventists
TOT ..... Trainer of Trainers
UCBHCA ..... Uganda Community Based Health Care Association
USAID ..... United States Agency for International Development
VHC ..... Village Health Committees
VHW ..... Village Health Workers

I. MAIN ACTIVITIES - First Year

A. Baseline Survey

A Baseline Survey was conducted in February and a report is available at ADRA International.

B. Selection of Trainer of Trainers (TOT's) - Kalagala Sub-County

During the month of March, the selection of Trainer of Trainers (TOT's) (Community Health Worker Supervisors) was organized by contacting sub-county Chiefs, Resistance Council (RC) officers, RCI RCII, RCII, Parish Chiefs, and sub-parish chiefs who eventually mobilized community members.

There is usually a meeting once a month at the sub-county headquarters known as RCIII Council Meeting. This meeting gathers all of the above mentioned community leaders to discuss matters affecting their community.

ADRA staff had a chance to talk to this group for 1 1/2 hours telling them:

- What ADRA is
- What ADRA is involved in, internationally
- Why ADRA chose to work in Kalagala
- Our Child Survival Project objectives as indicated in the Project proposal
- Why it was important to have TOT's selected. This was discussed in detail emphasizing the issue of sustainability.

Qualities and Roles of these TOT's were outlined as follows:

1. Qualifications:

    - Must be a resident of that community
    - Volunteer
    - Write and read (preferably with secondary education)
    - Friendly
    - Honest
    - Willing to learn

2. Roles:

- Train Village Health Workers, Community members
- Act as Secretary to the Village Health Committees
- Co-ordinate Health Activities in his/her sub-parish
- Be responsible for passing on reports to sub-county supervisors and vice-versa.
- Community mobilizers

A schedule for the selection of TOT's was drawn with these community leaders, each of them giving us a date that best suited his/her community.

March 4, 1992 - Meeting leaders in RCIII Council Meeting.

March 16-20, 1992 - Actual selections in different areas of the sub-county.

The sub-county is divided into eight parishes and in each parish two people were selected, each caring for a sub-parish.

On average one sub-parish is made up of 3-4 RC's or Villages.

Community leaders were asked to mobilize people at the central place which would be convenient for all community members. On the days for selection, it takes between 1 to 1 1/2 hours to tell them:

- What ADRA is, its activities internationally
- Child Survival Project objectives
- The importance of selecting TOT's
- Qualities and roles of Trainers

After this, community members were asked to suggest three names from which they would select one by lining behind the candidate.

C. Selection of Village Health Committee (VHC)

During the month of July the selection of VHC's was organized throughout Kalagala sub-county. A total number of 15 VHC's were selected at the sub-parish level. The VHC's are made up of:

- Chairman
- Vice Chairman
- Secretary - CHW Supervisor

- Treasurer
- Committee Members (bringing the total number of VHC to 11)

Sixty percent of the VHC members are women. Since a sub-parish is made up of several RC's it was made in such a way that each RC gets a representative on the VHC.

The administrative structure in Uganda is made up of RC and these RC's range from 1-5. Each is made up of nine people.

Out of the nine, one serves as "Secretary for Mass Mobilization and Education". That is the person responsible for health related activities. It was found necessary to bring the Secretary for Mass Mobilization as an ex-officio to our VHC's in order to link the VHC and RC's.

D. Training

1. Orientation Seminar

   During the last week of March, a team from ADRA International headed by Dr. W. Dysinger, arrived in Uganda to run an Orientation Seminar for Child Survival staff. The seminar ran from March 26 to April 2, 1992.

   A detailed report is available at ADRA International office.

2. Trainer of Trainers (TOT's) Course

   TOT Course Phase I for CHW Supervisors for Kalagala sub-county was done during the 2nd week of June 1992. For more details see Appendix "A".

3. Training VHC's

   Dates for training of the VHC's are set during the process of their selection. A one day training seminar is held for each VHC in each parish.

   This training was not exhaustive but was made purposely to enlighten the VHC members about their roles and acquire some leadership skill. It is our plan that when the CHW

supervisors complete their training they will be in a position to give these people more training. For more information see Appendix "B".

E. DIP

This was done in April and a report is available at ADRA International.

F. Schedule of Activities:

Date	Activity
July 2, 1992	Meeting with sub-county chief and RCIII Executive members.
July 6, 1992	Meeting with CHW supervisors for briefing and organize the selection of VHC.
July 7, 1992	Meeting with RCIII Council members and briefing them about our program.
July 13-16; 20-23; 27-28, 1992	Actual selection of VHC's in different areas within Kalagala sub-county.

G. Change in Approach to Individuals at Higher Risk

Nothing has been done in this section yet.

II. HUMAN RESOURCES AND COLLABORATION

A. Staffing

- John Kiyimba, Training Officer
- Paddy Bukenya, Agriculturalist

See Appendix "C" for Job Description and Curriculum Vitaes.

B. Continuing Education

1. The Training Officer took the facilitator Course Phase I, on September 19-26, 1992. This training was necessary for him to acquire better training skills for community health workers.

2. The Director was invited and participated in a National Conference.

C. Technical Support

1. Health Information System

   The project occasionally made use of technical advice from Uganda Community Based Health Care Association (UCBHCA), regarding the organization of HIS.

2. Control of Diarrheal Disease

   The project received 20 books on the control of diarrhea diseases from the Ministry of Health. The project has received a donation of a Mitsubishi minibus from USAID Uganda.

D. Community Participation

The Village Health Committees (VHC's) in existence are those of Kalagala sub-county. They were selected and trained two months ago so they have all met at least once in the past 90 days. However, the reports we have are that all the 15 VHC's have at least met within the last 30 days, and after the training they all mobilized themselves into action groups using different approaches to health problems, depending on the VHC's.

1. VHC in Kayindu

   Raise funds from among VHC members each contributing Ush.4000 so that they could buy a cow for milk production as an Income Generating Activity (IGA) and an approach to improve nutrition standards in their community.

2. VHC in Lunyolya and Kalanamu

   Started poultry farming from their own local breed by asking each member of the VHC to donate two hens to the project.

3. Degeya, Busiika, Busoke and Kamira VHC's

They are involved in agricultural projects.

- Degeya and Busoke - have cultivated Maize and Cassava for IGA.
- Busiika and Kamira are particularly involved in vegetable gardening.

4. VHC Vvumba

First they improved their home environment hygiene, by helping their fellow members in VHC to build or repair latrines, kitchens, dish racks, bathing shelters, rubbish pits etc. They have programmed themselves to carry out these activities once a week on a rotation basis. The aim is that VHC members first organize their homes before they enter the community. There are many people in this community who have admired the system to an extent of asking how much money one has to pay in order to become a member.

E. Linkages to Other Health and Development Activities

Not much has been done in this section, however, the project has been in close contact with UCBHCA and this association has assisted us so much especially in training TOT I and TOT II. They have shared with us their facilitator.

- UCBHCA has made a big contribution in training our new training officer, Mr. John Kiyimba at almost no cost to the Child Survival Project. Also through the UCBHCA the Child Survival Project has had a chance of sharing ideas and experiences with other members projects as well as learning from them.

III. CONSTRAINTS, UNEXPECTED BENEFITS OF LESSONS LEARNED

A. Constraints

1. Transportation

The project vehicles were delivered late, therefore, this affected our work. Sometimes we use public transportation, but it is not effective because we can not be sure of reaching our

destination on time. At other times we have had to rely on hired transportation, but this has not proved to be cost efficient.

Due to the delay in the delivery of the vehicles, ADRA/Uganda approached the local USAID office for help. The latter provided us with a minibus as a grant in aid to the Uganda Government through the Child Survival VII project. The operation of the vehicle took many months to be finalized. We now have the vehicle in our possession.

Solution: The Child Survival vehicles are now in the country waiting for registration and licensing, after which we believe, the transportation problems will finally be solved.

2. Work space

Until now, Child Survival does not have a central office where the staff can focus and centralize its activities. Most of the employees are working in various places, causing general communication to slow down.

Solution: Construction of a field office building is in progress and is expected to be completed next month. Staff housing has also been finalized.

3. High expectations - Water

Water is the priority need for the people in our project area and it has come up almost in every meeting held with the local people, chiefs at the sub-county level, RC officers, and even the Minister of State in the President's office - who happens to be the Member of Parliament for this area.

Some VHC members have stated that they would show no interest in the project if the problem of water is not attended to. For the moment it appears that the budget provision for water is not satisfactory.

Plan: A proposal was prepared and submitted to the local USAID office for funding but was rejected. Now ADRA/Uganda is looking to other donors who could assist in this matter.

B. Unexpected Benefits

Not yet known.

IV. CHANGES MADE IN PROJECT DESIGN

A. Changes in Perceived Health Needs

None

B. Change in Project Objectives

None

C. Change in Planned Interventions

None

D. Change in Potential & Priority Beneficiaries

None

V. HEALTH INFORMATION DATA COLLECTION

A. Characteristics of the Health Information System

This is not in place yet as the communities are still in the process of getting organized. Technical Assistants (TA) from head office has not been made available to assist field staff in the development of the format of the Health Information System (HIS). It is hoped that HIS can be one in December 1992.

1. Set-up for Family Planning Clinic:

   Not yet complete. No refinements in clinic activity reports have been made.

2. System for reporting activities of CHW's.

   The CHW Supervisors are the Secretaries to the Village Health Committees, and each time they sit, they have been requested to send their meeting decisions to the Management.

Another system so far is holding meetings with the CHW Supervisors and ask them to report on their activities in the community.

B. Special Capacities of Health Information System

1. Community Health Volunteers.

The Community Health Volunteers have not been selected yet. However, we are taking a keen interest in monitoring the activities of CHW Supervision.

Example: We have already identified a CHW Supervisor who developed a chronic disability so she has been replaced by another person from the same community.

2. Continuing Education Training for CHW's

There is a sub-county supervisor who is a full-time worker and one of his responsibilities is to see that all activities concerning CHW's are effectively carried out.

Also the training officer is a man who is concerned with all training of CHW's, he is also a full-time employee of the Project.

3. Data Collection

We have not done extensive data collection yet.

C. Management of the Health Information System

The indicators in the Baseline Survey were reviewed February 12-24, 1992. The management is using this data as its guideline in the project.

1. People who Collected the Data

Every individual who collected the data received a copy of the compiled data.

2. Health Workers

The last time we shared data with health workers was July 6, 1992.

3. Community Members

The data has been shared with the RCIII Executive (9) and each of them received a copy. Also members of the RCIII Council were briefed on July 2 and 7, 1992.

4. Ministry of Health

We received the data and had a copy sent to the District Medical Officer, Luwero, on June 4, 1992.

D. Collecting, Compiling, Analyzing and Monitoring Data

- Community Health Workers are responsible for collecting data from the community.
- Sub-county Supervisor collects data from CHW's then passes them to the Project Co-ordinator.
- The Project Co-ordinator compiles and analyzes the data and sends it to the Health Information System Co-ordinator who computerizes the data.

We have been anxiously waiting for the group from ADRA International for an HIS seminar.

VI. SUSTAINABILITY

Not able to estimate at this point in time.

A. Plan

We have decided that the budgeted monthly pay figures for CHW Supervisors all put into a pool to create a revolving fund. These CHW Supervisors have been asked to present income generating projects of their own choice but within the limitation of money due to them. The money is given to them as a loan, depending on the type of project. It may be given in the form of materials: e.g. seeds, hoes, chicken feed, etc.

Out of this loan we are asking them to make sure that they design projects which will be successful because after a certain period they will have to pay back a percentage (15-25%).

The purpose of this is to promote self-sufficiency and reduce their dependency on salaries. If this comes true, it is likely to affect the Project's sustainability long after the funding is over.

It is planned that a percentage of the loaned money that is paid back, will be ploughed into the revolving fund of the Village Health Committees.

B. Activities to Cut Recurrent Costs

Because of slow release of funds, additional interest changes have cost the project due to an unsecured overdraft.

A misunderstanding over financial reporting caused the slow release of funds. The policy adopted by head office not to release funds until a report on previous releases has been received is now fully understood and accepted by field managers. However, if funds in the future are slow to be released all field activities will be placed on hold until funds arrive. This makes field management very difficult considering the communication difficulties in Uganda.

C. Cost Recovery

Close attention will be given to these issues during the next fiscal year. Small charges will be introduced only after full discussion with all appropriate bodies.

VII. BUDGET CHANGES

It is thought that additional funds will be needed for TOT's, Village Health Committees, Village Health Workers and Family Planners during 1993. The final changes are not worked out but it is thought that we can make some adjustments from unused line items. This will be finalized and forwarded for advice and comment from head office in November 1992.

See Appendix "D" for Pipeline Analysis

VIII. WORK PLAN FOR CHILD SURVIVAL PROJECT VII

Month	Activity
1992	
October	• TOT II Course for Kalagala CHW supervisors • Selection of Village Health Workers
November	• Selection of VHW's continued • Training of VHW's
December	• Training of VHW's continued • TOT Course Phase III for Kalagala sub-county • Operation of Family Planning Clinic at Bugema
1993	
January	• CHW Supervisors help VHW's to do census/survey of their communities • Setting demonstration plots for kitchen gardens in Kalagala sub-county • Meet RCIII of Health Management Committees for Zirobwe, Review Baseline results • Orientation of Health Center staff • Selection of TOT for Zirobwe sub-county
February	• TOT IV for Kalagala • TOT I for Zirobwe • Train Promoters for Kalagala in special interventions (CDD)
March	• Organize selection of Village Health Committees for Zirobwe • Continue training of Promoters for Kalagala in special interventions (Immunizations)

1993 - continued

April	• Training of VHC 's for Zirobwe • Training of Promoters for Kalagala in Nutrition and Growth Monitoring • TOT Phase II for Zirobwe (CHW Supervisors)
May	• Selection of Promoters (Village Health Workers) for Zirobwe sub-county • Training Promoters in Family Planning/Aids prevention for Kalagala
June	• Help CHW's to train Village Health Workers (Promoters) for Zirobwe sub-county
July	• TOT Phase III for CHW Supervisors - Zirobwe • Zirobwe Health Promoters do Census/Survey of their communities
August	• Train promoters in Zirobwe in CDD
September	• Train promotor in Zirobwe in Immunization

APPENDIX A

Training of Trainers Workshop

CHILD SURVIVAL VII

TRAINING OF TRAINERS WORKSHOP

PHASE 1

KALAGALA SUB-COUNTY

HELD AT CARDINAL NSUBUGA MEMORIAL TRAINING CENTRE - NSEMBYA

14th JUNE - 19th JUNE 1992

Implemented by: ADRA/UGANDA

-15'

TABLE OF CONTENTS

	Page
Introduction	1
Facilitators	1
List of Participants	2
Course Objectives	3
Sharing Field Experiences	4
Health & Development	8
CBHC Concept	10
PHC Background & Essential Elements	11
CBHC/PHC Comparison	12
Scales of Health Care	13
Steps to set up a CBHC Program	15
Qualities & Roles of a CC, VHW & Trainer	17
Survey	21
Steps in carrying out a Survey	23
Field Visit & Data Collection	24
Survey Analysis	25
Planning	27
Aids	29

INTRODUCTION

Adventist Development & Relief Agency (ADRA) through the Child Survival Project (CS7) has planned to run four series of Training of Trainers (TOT's) Course for Kalagala sub county which is part of our project area in Luwero District.

The people (TOT's) have been trained in order to meet the need of Trained Community Health Workers (CHW's) and other Community Health Promoters. These TOT's are supposed to be role models, who will train CHW's/VHW's, motivate and inspire community resourceful people for a positive change. The fact that our project is on a community based approach, participants were trained in such a way that they develop the right attitude to community work and go through the process of self-discovery using the psycho-social method of teaching. eg: Throwing questions and discussions in groups, through stories etc.

The training is broken into 4 interspersed weekly phases.

This report is on Phase I of TOT Course which took place at Nsembya Cardinal Nsubuga Memorial Training Centre from 14th - 19th June 1992.

All participants arrived on the 14th evening, registered themselves and assigned different rooms to sleep.

Session 1 started on Monday 15th in the morning with one of the facilitators requesting participants to introduce themselves, by their names, designations and place of work. Facilitators also introduced themselves to participants.

One of the facilitators asked participants to contribute towards group norms, which could help them to stay together comfortably.

"Helping Hands" also was introduced to the participants for each one of them to participate.

FACILITATORS:

Sister Matilda	-	Masaka Diocese
Prisca Nakitto	-	P.O. Box 14009, Kampala
Regina Bukenya	-	P.O. Box 2886, Kampala
Israel Musoke	-	P.O. Box 6434, Kampala

LIST OF PARTICIPANTS:

Robert Mwogeza	-	URCS, P.O. Box 494, Kampala
Herbert Lubwama	-	Kalagala Sub-county
Annitah Namuyiga	-	Kireka Dispensary
Fatuma Nantege	-	Kalanamu
G. Sendagire Mugalasi	-	Vumba Kalagala Sub-county
Rehema Kaaya	-	Kalagala
Robert Lutaaya	-	Busoke Kalagala Sub-county
Mawejje Kasim	-	Ddegeya Kalagala Sub-county
Falida Kizza	-	Kayindu Kalagala Sub-county
Andrew Ssemambo	-	Ddegeya Kalagala Sub-county
George Nsubuga	-	Busoke Kalagala Sub-county
Kato Musoke	-	Lunyolya Kalagala Sub-county
Livingstone Ssekanjako	-	Busiika Kalagala Sub-county
Emmanuel Katamba	-	Busiika Kalagala Sub-county
John Katwere	-	Kamira Kalagala Sub-county
Liljan Meredith	-	P.O. Box 6529, Kampala
Beverley Chapman	-	P.O. Box 9946, Kampala
Deborah Saka	-	Bugema Adventist College
John Kityo	-	Kalagala
Juliet Namazzi	-	Kireka Dispensary

NORMS

1. Respect to one another
2. Love to all
3. Honest
4. No smoking in public
5. Cleanliness
6. Avoid drunkenness
7. Observe silence
8. Punctuality
9. In dining, observe table manners

TIMETABLE

7.30 - 8.00	Breakfast
8.00 - 8.15	Devotion
8.15 - 8.45	Reporting & Evaluation
8.45 - 10.30	1st Session
10.30 - 11.00	Morning break
11.00 - 1.00	2nd Session
1.00 - 2.15	L U N C H
2.15 - 4.30	3rd Session
4.30 - 5.00	Evening tea
5.00 - 8.00	Entertainment
8.00 - 8.30	Supper & night break

18

PARTICIPANTS EXPECTATIONS

* Child Survival
* Family Planning
* Fight ignorance and poverty
* Immunization
* Change way of living
* Learning from others
* Dosage of drugs and types of diseases
* First Aid
* Project Planning
* Project Implementation
* Community mobilization
* Inspiration
* Motherhood

COURSE OBJECTIVES

1. Health & Development
2. Concept of CBHC
3. PHC/CBHC How to start CBHC Project
4. Qualities/Roles of CHW's, VHC's and Trainers
5. Survey
6. Planning
7. Work Plans
8. Aids

PRE & POST TEST T.O.T. I 1992

1. What is HEALTH?
2. a). What is COMMUNITY BASED HEALTH CARE?
   b). What is PRIMARY HEALTH CARE?
   c). How do COMMUNITY BASED HEALTH CARE and PRIMARY HEALTH CARE fit together?
3. Why is it important to have V.H.C.?
4. a). List 5 Qualities of the TRAINER?
   b). List 5 Roles of a C.H.W.?
5. What are the 7 steps of Planning?
6. Give 3 ways you want to carry out survey?
7. Give 3 facts about A.I.D.S.
8. Give 4 ways to motivate C.H.W's.
9. List 3 things you would hear and 3 things you would see which will help you to know that you have succeeded in creating awareness in the community.
10. List 4 steps you would take when starting COMMUNITY BASED HEALTH CARE PROGRAMME.

SHARING FIELD EXPERIENCES

1. Have you ever heard of CBHC?
2. Have you ever been involved in any CBHC program?
3. If you have, what problems have you encountered? What success have you achieved?
4. If you have not been involved in any CBHC program, what health problems do you have in your area?

These 4 questions were discussed in 12 groups, as per project origin.

GROUP PRESENTATION

Lunyolya Parish CBHC Project - CBHC is not known
- No involvement in CBHC

Problems in the community:

1. Diarrhoeal diseases are common
2. Poor sanitation
3. Poor nutrition
4. Lack of safe water supply
5. Poor housing
6. Rapid spreading of Aids
7. Drunkardness
8. Smoking

Kalagala Tusitukire Wamu - Habitants for Humanity International
- CBHC is not known
- They are not involved

Problems in the community:

1. Community mobilization
2. Lack of water supply
3. Poor response to immunization
4. Malaria

Kayindu Parish - They have heard of CBHC
- They are involved in CBHC

Problems in the community:

1. Lack of good water
2. Poor sanitation
3. Poor feeding
4. Lack of latrines in most homes
5. Lack of proper information about immunization
6. Lack of information about mode of spread of Aids
7. Alcoholism
8. Malnutrition
9. Lack of Family Planning methods

20'

Achievements: Home visiting to mobilize the community in health education.

Busiika Project - No knowledge of CBHC

Problems:

1. Lack of pure water which has lead to Typhoid Fever
2. Poor sanitation resulting in diahroea
3. Malnutrition - mainly in children
4. Aids spreading rapidly

Vvumba Project - They have heard of CBHC
- They are not involved in CBHC

Problems:

1. Malnutrition
2. Ignorance with regards to immunization
3. Ignorance with regards to Family Planning
4. Lack of proper shelters
5. Lack of community mobilization

Busoke Project - They have not heard of CBHC

Problems:

1. Low immunization due to distance to medical centres
2. Family planning is unknown
3. Water system is poor
4. Poor sanitation
5. Poor housing conditions
6. No health programs in the area
7. Rapid spread of Aids

Ddegeya Project - They know CBHC program
- They are involved in CBHC program

Problems:

1. Community mobilization
2. Poor sanitation

Achievements: They have started constructing Pit Latrines
Through the RC's, community mobilization is gradually improving

UGANDA RED CROSS, KAMPALA EAST DIVISION - Has heard of CBHC
- Is partly involved

Problems:

1. Community mobilization
2. Poor sanitation
3. Wrong ideas about immunization
4. Poor community attendence to seminars
5. Lack of transport, materials and funds for seminars

Achievements: Some members of the community have shown interest in solving their problems. ie: spring protection, immunization, and a few attend seminars.
Four (4) sensitization seminars have been organized

KALANAMU PROJECT - They have heard of CBHC
- They are involved in CBHC

Problems:

1. Poor sanitation
2. Lack of information about Family Planning
3. Lack of water supply

Achievements: Most children are immunized

NABIYAGI PROJECT - They have heard of CBHC
- They are involved in CBHC

Problems:

1. Transport
2. Alcoholism
3.
4. Lack of community participation
5. Immunization rejected

Achievements: Formed and trained VHC
Home visitation

BUGEMA FAMILY PLANNING PROJECT - They have heard of CBHC
- They are involved in CBHC

Problems:

1. Lack of community participation
2. No change of behaviour
3. Men resist Family Planning
4. Rapid spread of Aids

Achievements: Community has been sensitized
Mothers are responding to Family Planning

*** 12 Communities had heard of CBHC and were involved.

*** 4 Communities had NOT heard of CBHC.

FIELD PROBLEMS:

1. Lack of community participation
2. People not willing to change their life-style
3. Family Planning methods not accepted
4. Aids/HIV spreading very rapidly
5. Poor sanitation/water
6. Poor mobilization of community
7. Lack of transportation
8. Excessive drinking
9. Lack of co-operation
10. Immunization rejected
11. High expectations of the community
12. Lack of Family Planning
13. Poor nutrition
14. Lack of health education

Achievements:
1. Community has been sensitized
2. There is a positive response to Immunization
3. Better community participation
4. Construction of shelters

77

HEALTH & DEVELOPMENT

1. What is HEALTH?

2. What would you consider as contributing factors towards health in the community.

3. Who is responsible for health in the community.

4. What is development.

5. How does health and development fit together.

THE ABOVE QUESTIONS WERE DISCUSSED IN 4 GROUPS AND THEY CAME UP WITH THE FOLLOWING PRESENTATION:

Health is well-being of the total person, mental, physical, socio-economical, political and spiritual, not merely the absence of disease or infirmities.

Q1. - Contributing factors towards health in the community
Q2. - Underlying sanitation
- Nutrition - food supply
- Curative services
- Education
- Participation of community
- Safe drinking water
- Recreation grounds/socio activities
- Co-operation of community members
- Housing
- Clothing
- Church/mosques
- Immunization
- Family planning
- Communication
- Transport system
- Security

Q3. People responsible for health in the community
- The whole community
- Members of the health committee V.H.C.
- Members of the RC's
- V.H.W.
- Medical workers
- Religious leaders
- Opinion leaders
- Elders
- Extension workers
- Traditional healers
- Traditional Birth Attendants (TBA's)
- Trading centres
- Agriculture
- Industry

Q4. Development: Defined as:

- Progressive change towards something better for the community.
- A state of man changing from any poor condition to a better one using better resources after admiration.
- Uplifting the standard of living
- Change of living from bad to good, socially, politically and economically.

Q5. How does health & development fit together?

- All efforts put in the promotion of health leads to development.
- No development where there is no health.
- Once there is development in the community, people improve their standards of living.

THE MAIN CONCLUSIONS

Everyone has a different view of what health is and they are all correct.

The most important elements of health are social factors rather than medical.

In our CBHC we have to know what the community thinks is their viewpoint of health and what they want to achieve within development for health in their community - so we must deal with many different aspects of life so as to improve health and not to just concentrate on medical issues.

Development and health are very closely joined together. We cannot have health without development, and we cannot have development without health.

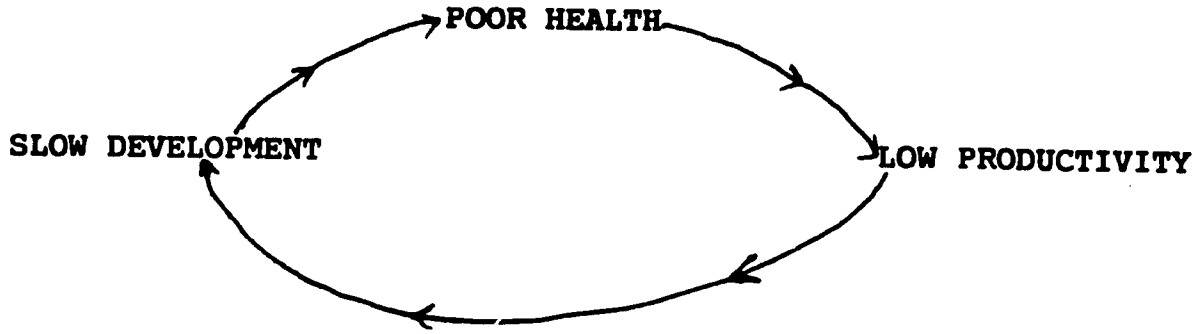
Generally where incomes are low and food supply production is not enough, both health and development will be affected.

Low income for government means limited services to the people. eg:

- medical facilities
- education - poor schools
- poor roads

Education and knowledge have a big influence on health and development. There are more than 1/2 as many infant deaths where mothers have had no education in comparison to mothers who have higher education. EDUCATED people can run business more technically and wisely than uneducated people - hence leading to national/community development.

25



CBHC CONCEPT

The topic was presented with a case study as follows:

- Koko Village in Bulemezi County has very many Health problems leading to many people falling sick.

- M.O.H. has posted Dr. Magezi who has two degrees in medicine to work in Kalagala Health Unit/Center.

Participants were asked to assemble possible patients before Dr. Magezi for attention. The health Centre was so crowded with patients so that such were to be seen the next day.

GROUP ACTIVITY

Participants were asked to discuss factors in health/medical units that frustrate patients to such an extent that discourage them from going back for medical attention.

Factors that frustrate patients from going back for medical attention.

1. Shortage of drugs.
2. So many patients.
3. Irresponsibility of the medical personnel.
4. Long distances from home to Unit, lack of transport.
5. Mishandling of patients.
6. Lack of equipment in medical units.
7. Medical staff having residential clinics.
8. High expectations by the patients.
9. Corrupt medical personnel.
10. Expensive payment of medical fee.
11. Lack of education in the patients.
12. Shortage of medical staff.
13. Wrong treatment.
14. Traditional beliefs.
15. Failure to respond to treatment given.
16. Over confidence in some medical personnel.
17. Lack of communication/instructions.
18. Language barrier.
19. Un-hygienic medical units.

PHC BACKGROUND - ALMA - ATA - DECLARATION

1. 1978 - WHO member countries met in Russia to examine the method which can be adopted in dealing with disease control.
2. The meeting discussed among other things, financing health programs.
   - Procurement of medical equipment
   - Manpower development
   - Community health, etc.
3. They made a declaration known as Alma-Ata Declaration with the famous theme "Health for all by the year 2000." The only strategy to obtain/reach this goal was through Primary Health Care.

4. In 1979 - Government of Uganda called a meeting in Mweya Safari Lodge attended by Ministries and NGO's in Uganda.
5. The first National TOT series started in 1982 in Bushenyi. This was followed by TOT series at district levels up to now.
6. The member programs met and formed the Uganda Community based Health Care Association in 1986 in Mukono.

THE SEQUENCE OF T.O.T.'S

T.O.T. BLOCKS		DURATION
TOT I	3 months	1 WEEK
TOT II	4 months	1 WEEK
TOT III	4 months	1 WEEK
TOT IV	Refresher course	1 WEEK

1 YEAR IMPLEMENTATION PERIOD

PRIMARY HEALTH CARE (PHC)

DEFINITION - Is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community, through their full participation and effort at a cost that the community and county can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

27

ESSENTIAL ELEMENTS OF PHC

1. Education concerning health problems and methods of preventing them.
2. Promotion of food supply and proper nutrition.
3. Maternal and child health care including Family Planning.
4. Adequate supply of safe water and basic sanitation.
5. Immunization against major infectious diseases.
6. Prevention and control of locally endemic diseases.
7. Prevention and control of common diseases and injuries.
8. Provision of essential drugs.

IN UGANDA - INCLUDED

1. Mental Health Care
2. Dental Health Care
3. Rehabilitation of disabled

COMMUNITY BASED HEALTH CARE (CBHC)

DEFINITION: Is the participation and involvement of the whole community in solving their own health related problems, with responsibility for the health of the community resting with the community.

Planning, Personnel and other resources must all come from within the community, with external assistance only (acting as a catalyst) helping to start the process and provide limited technical advice.

CBHC ACTIVITIES ARE SIMILAR TO THOSE IN PHC

In CBHC we encourage and enable the community to take care of its own health, rather than leave it all to the health care services (MOH/NGO's)

DIFFERENCE BETWEEN PHC AND CBHC

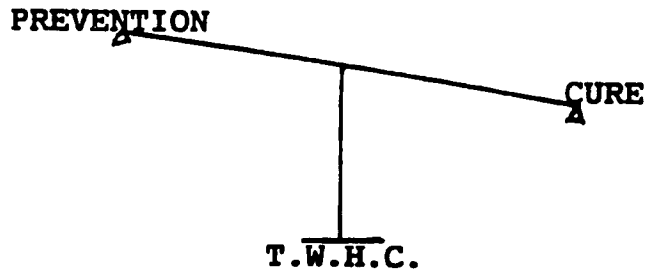
PHC

1. Is an outside Idea brought to the community.
2. Idea imposed on people.
3. Less community participants.
4. Takes time because of irregular supply.
5. Leaders/authority identify community problems.
6. Leads to over dependency.
7. Services imposed on people.
8. Mainly rely on outside resources.
9. There may be little co-operation.
10. Less chances of success.
11. Expensive.

CBHC

1. The idea comes from the community/people.
2. People realize their own problems.
3. Full participation by community.
4. Short time because the resources are within.
5. Community and its leaders identify their problems.
6. Leads to self-reliance.
7. Almost voluntary.
8. Rely mainly upon local resources - only import from outside when necessary.
9. There is high co-operation.
10. Greater chances of success.
11. Cheap.

SCALES OF HEALTH CARE
TRADITION WESTERN HOSPITAL CARE

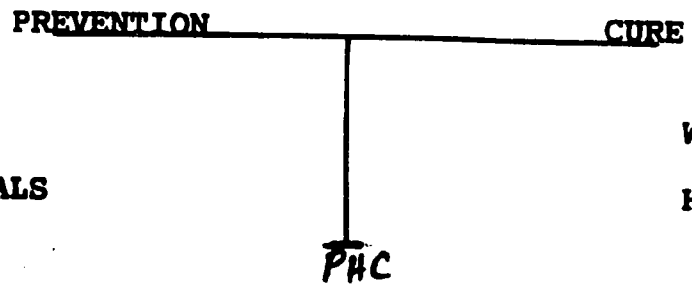


WORKERS

DOCTORS
NURSES/MIDWIVES
MEDICAL TECHNICIANS
MEDICAL ASSISTANTS
PARA MEDICALS

PLACE: HOSPITAL CURE HAS MORE WEIGHT
THE SCALE IS HEAVIER ON THE CURATIVE SIDE

PRIMARY HEALTH CARE



WORKERS

PROFESSIONALS
NON-PROFESSIONALS

ACTIVITIES
Water protection
Immunization
Health Education
Nutrition
C.D.D

PLACE

HEALTH CENTRES
DISPENSARIES
A.N. CLINICS
IMMUNIZATION CENTRES

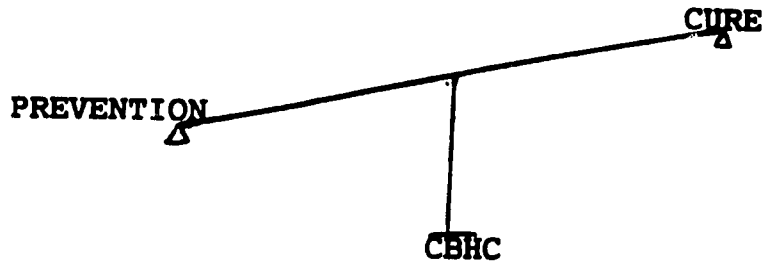
There is a balance between CURE & PREVENTION

29

COMMUNITY BASED HEALTH CARE

WORKERS

NON-PROFESSIONALS
VHCs
CHWs
TBAs
TRADITIONAL HEALERS



PLACE:

COMMUNITY

CBHC - A program of the people, for the people, by the people.

30

STEPS TO SET UP A CBHC PROGRAMME

The session was introduced by a role play where a newly trained person - forgot to follow the steps which he learnt during T.O.T. Workshop. He communicated to his friend to mobilize the community for his first meeting. There was poor communication and the community rejected the meeting because the objectives/agenda were not explained. The key people were not involved. The meeting did not take place. After the role play participants were asked these questions:

-What have you seen?
-What have you heard?
-Does it happen in our situation?
-Why does it happen? Give examples.
-What can we do about it?

Participants discovered that the role play was about community entry.

INTRODUCTION: There are five common ways in which CBHC Programs are organized:

1. From a Mission Hospital or clinic.
2. From a Diocese Headquarters or Parish Center.
3. From a project office run by a `Development Agency.'
4. From DMO's office
5. From a Government Clinic.

The way in which the programme is organized determines the way it takes the first steps in beginning its community work. Basically, the church related groups make their initial contacts with the communities through the church system.

The government sponsored programs work through the R.C. and extension worker system. Also the Mission sponsored have sometimes centered on church community groups, and these groups have worked throughout the local community. Ministry of Health and development agency sponsored programme have tried to work with the whole community right from the start. These are differences of broad structure, but the basic approach and attitudes of the programme staff and the programme as a whole is the same.

The following is the sequence of steps in development of C.B.H.C. Programme sponsored by the Ministry of Health. The steps are in order, but may not necessarily happen in this exact order. Probably some steps will have to be repeated. The local situation will determine exactly what will happen. Each step is important in itself, especially for those who are concerned with the assurance that the community has a very clear understanding of what they need to achieve.

CONCLUSION

The programme must:

-Take time to create enough awareness.
-Listen to the people and respect their ideas. Discuss those ideas before bringing something very new.
-Not organize committees and C.H.W.'s until the community is fully aware and prepared to support them.
-Not begin with only a few people who have understood quickly leaving the rest far behind.
-Not accuse the community of doing wrong (always count fingers) and think of what the programme must do to solve the problems created by the misunderstanding.

GROUP DISCUSSION

In three groups participants were given 16 paper strips of proposed steps of starting a C.B.H. Programme to be put in order. After rearranging them together they came up with the following:

1. Make a geographical survey. You should know the natural resources, population and health status of the people in that area.

2. Meet key people. Give awareness of CBHC. Meet individual leaders to introduce your ideas about CBHC.

3. Contact Extension Staff. Discuss with the Extension Staff, find out problems they meet and how they solve them. Give CBHC awareness.

4. Call key people - discuss about CBHC. Discuss with all the leaders of different groups, plan with them when and where you will meet the community.

5. Leaders mobilize the community. Meet the community. Give awareness of CBHC Programme. Find out what they want to know. Plan the day for another meeting.

6. Call more meetings - give awareness of CBHC/VHC and CHW's. Mobilize the community for meetings. This depends on the understanding of the community and how much they have accepted the programme to be their own. DO NOT RUSH.

7. Select VHC by the COMMUNITY. When the community is ready help to select the VHC. You need a chairman, a vice-chairman, a secretary, treasurer and some committee members. Make sure when these members of the committee are selected to have representatives from different groupings. e.g. Religious leaders or womens leaders. The whole committee may have members from 7 to 11. Make sure they are always an odd number.

8. Train VHC. When you are training the VHC make sure that you explain what they have to do that each person may know his responsibilities as well as the responsibilities of others.

9. VHC mobilizes the community to select CHW's. A VHC mobilizes the community to select the CHW's When they have divided the community into small groups of 5 to 10 houses for one CHW as not to neglect their family duties because we expect them to be volunteers.

10. Train CHW's and TBA's. Make sure that you teach them what is needed in their work and how they will do it. If you are not able to train TBA please do not start, but invite someone else for the training.

11. Make a survey. In making a survey, community should be aware of the information needed in the survey and why it is needed.

12. Meet the community. Prioritize problems and help the Community to solve them. After the survey the community may be invited to hear the report of the survey. You help them to prioritize their problems and plan what they want to do first.

13. Community networking. The community starts working on the chosen activity.

14. Follow-up. You do follow-up to encourage them and offer help where it is needed.

15. Make evaluation. You make evaluation to find out how successfully you have done the work.

16. Invitation to next community. If the work has been good the nearby communities will be invited you to C.B.H.C. Programme in their areas.

QUALITIES AND ROLES OF A TRAINER V.H.C. AND C.H.W.

The programme was introduced by a role play where a C.H.W. visited a family whose child had diarrhoea and malaria. He refused to sit on a chair because it was dirty. He accused them of being dirty and of refusing to do what he tells them to do. He commanded them to build a latrine as soon as possible, then he left. The family was very angry with him and said that they would not do anything he told them to do.

Questions were raised:

1. What have you seen?
2. What have you heard?
3. Does that happen? Give example.
4. Why does it happen?
5. What can we do about it?

Answers were given then participants were divided into three groups to answer the following questions:

Group 1. What are the qualities of a trainer?

1. Knowledgeable
2. Has respect for others
3. Well behaved
4. Ready to learn from others and accept his mistakes/ flexible
5. An example to others
6. Calm
7. Tolerant
8. Resourceful
9. Honest
10. Tactful
11. Able to express himself
12. Social
13. Kindly
14. Smart

What are the roles of a trainer?

1. Educate/Facilitate/Train/Create Awareness
2. Guide
3. Motivator
4. Makes follow-up evaluations
5. Planning
6. Makes a survey

What are the roles of a trainer? (continued)

7. Links the community to the supporting units
8. Co-ordinator of CHW's, VHC and Community
9. Write reports, keep records and give feedback
10. Cooperates with extension workers

34

Group 2. **What are the qualities of a VHC?**

1. Resident of the village
2. Social
3. Volunteer
4. Patient
5. Hard working
6. Good Mobilizer
7. Educated/knowledgeable
8. Creative
9. Respects public and is respected
10. Responsible - smart
11. Kind, influential
12. Honest - Good Advisor
13. Able to do the work
14. Ready to learn

What are the roles of a VHC?

1. Mobilizes residents
2. Identifies problems of village
3. Looks for ways of solving problems
4. Has to work hand in hand with the CHW's
5. Divides the village into communities
6. Plans for the community
7. Supports the CHW's
8. Evaluates
9. Makes survey
10. Makes report
11. Links the CHW's, Trainer and Community
12. Administers whole programme

Group 3 **What are the qualities of a CHW?**

1. Resident
2. Social - an example to others
3. Honest
4. Flexible
5. Co-operative - smart
6. Kind
7. Respectable
8. Tactful and educative
9. Able to express him/herself
10. Responsible
11. Approachable

What are the roles of a CHW?

1. Creates awareness in the community
2. Improves health related services with Community
3. Makes survey
4. Follow-up
5. Evaluates
6. Reports
7. Coordinates the VHW and the Trainer
8. Does home visitation
9. Mobilizes the Community
10. Works within limits
11. Promotes self-reliance

CONCLUSION

Because of their position the Trainers will be leaders. This will happen most in the early stages of the Development of CBHC in a community. The trainer will, therefore, need to know how to be a good leader so as to:

- Motivate people to start their own CBHC.
- Act as an example to the leaders who will take over full responsibility of their CBHC work.
- Does not dominate. From the start begins the process of shifting the responsibility for leadership to the community.

COMMENTS

WE NEED TO KNOW:

i) What it is like to have to follow a leader.
ii) How a leader must respect people and treat each person fairly.
iii) A leader for CBHC must represent the needs of the people with the most health problems.
iv) How a leader must be fair and honest.
v) The need for a democratic way of decision making.
vi) That a leader cannot promise anything they are not sure will happen.

SURVEY

The session was introduced with a role play. The CHW was visited by another CHW from another area. They were discussing their work, one was doing very well, while the other was having problems. CHW "A" wanted to know how CHW "B" knew how he was doing very well. CHW "B" knew he had more latrines than when he started but had no proof of it.

After the role play, the facilitator went through and showed questions to assist the participants in discovering the topic. Participants were divided into four groups to discuss the following:

GROUP 1. WHAT IS A SURVEY?

- Moving around in a given area collecting information and recording it for further development.
- Research of planned information for development or recording purposes.
- Fact finding process/exercise

WHO DOES THE SURVEY?

- Trainer
- UHW
- CHW
- RC's/Chiefs
- Extension workers
- Religious Leaders
- Elders
- Other members of community
- Government officials

GROUP 2. LIST METHODS OF SURVEY?

1. Contact RC's/influentials/Elders/Extension workers
2. Home visitation
3. Using a questionnaire
4. Attending meetings
5. Attending social gatherings
6. Participating in community activities
7. Records/statistics
8. Mass media
9. Observation
10. Interviewing
11. Maps

GROUP 3. WHY IS A SURVEY DONE?

1. To know what is happening in the Community
2. Population
   Housing
   Diseases/Immunization
   Water
   Sanitation
3. Related medical services
4. In order to arrange for further development
5. Act as a guide-line
6. Know the failures and successes/evaluation
7. Obtain information
8. Gauging magnitude of problem, eg. baseline survey

GROUP 4. HOW DO YOU PREPARE FOR A SURVEY?

1. Begin with a plan
2. Know what information is needed
3. Know where to get it
4. Know who will do it
5. Know how to get it
6. Consider cost/logistics
7. Make list of priorities
8. Know the dangers and difficulties involved
9. Assess the collected information

QUESTIONNAIRE

A questionnaire is a set of questions put together in a written form for required information. It should include the following:

1. Location/place
2. Name of the head of household
3. Number of family members
4. Age group eg. 0-5 years
5. Immunization schedule
6. Sanitation/Food/Water
7. Nutrition
8. Health status
9. Family Income
10. Community Relationship
11. Education

COMMUNITY APPROACH

Discussion on community approach was done and the following were observed.

APPROACH TO HOME VISITATION

1. Introduction
   - Be introduced by the person who is known to community, during the first visit.
   - Greetings and self introduction
   - Explain the purpose of your visit
2. Encourage co-operation.
3. Sensitivity to family and community
4. Give advise diplomatically
5. Survey - When filling forms or writing notes, do so when you have left the family or person.
6. Children - Be friendly with children, take time and help the child to accept you.
7. Questions - Ask questions diplomatically and in indirect way.
8. Avoid emotional involvement.
9. Observe confidentiality.
10. When leaving the family or community thank them for their co-operation.

STEPS IN CARRYING OUT A SURVEY

1. Decide on objectives.
2. Decide on how to obtain information.
   - From whom, how, when
   - Contact the community
   - Create awareness
3. Train Manpower
   - How many
   - Who will supervise
   - Who will do what
4. Select Appropriate survey methods
   - Questionnaire
   - Interview
   - Observation
   - Measuring methods
   - Home visiting
5. Cost
   - Estimate/budget
   - Are you paying the workers?
   - Stationary and materials needed
   - Timing - how long will it take
     - distance involved
   - Transport needed
   - Local markets
   - Consider seasons

6. Approach
   - Does the community see the purpose
   - How will it effect them
7. Coding - putting special categories into groups
8. Analysis - sorting out of data
9. Setting priorities
   - Explain how the seriousness, commonness and solvability of a problem. Help to determine the priority it should receive in the project.
   - Believe that problems need to be prioritized based on the needs of the community.
10. Editing - correcting/reporting
11. Begin planning for several of the priority problems in the community.

FIELD VISIT & DATA COLLECTION

For the purposes of participants to gain experience

- See how an organized CBHC project should be

- Practically try a survey tool

A field visit was organized with Uganda Catholic Medical Bureau (UCMB) to visit one of their projects at Maganjo. It is situated about 10 kms from Kampala on Bombo Road.

Survey questionnaires were passed out to participants a day before and all necessary explanations made. Two mini busses were organized for transport. Participants were directed into 3 groups with a leader for each groups and a facilitator.

In the community we were welcomed by the members of the Village Heath Committee led by the Chairman. Members of the Village Health Committee divided themselves into 3 to head the 3 groups of our visiting team. The results of the survey are as indicated below:

Apart from data collection the following observations attracted participants:

1: Different Micro-Income generating activities organized in the community for VHC members, and groups of CHW for sustainability purposes. These include:

Poultry
Piggery
Mushroom farming

2: Great improvement on housing. Most of the people had permanent and decent houses.

40

SURVEY ANALYSIS

HOUSEHOLD	GROUP 1	GROUP 2	GROUP 3	TOTAL
Number of Houses Visited	6	4	4	14%
Number of occupants	44	30	32	106%
Number of children under 5 yrs	14	6	8	28%
Number of Women of child bearing age	9	4	8	21%
Source of Water		No Safe Source		
Distance	1/2 mile	1/2 mile	1/2 mile	

HOME ENVIRONMENT

TYPE OF HOUSING		GROUP 1	GROUP 2	GROUP 3	TOTAL	%
Temporary		-	-	-		
Semi-Permanent		-	1	1	2	14%
Permanent		6	3	3	12	86%
Ventilation	Good	6	3	3	12	86%
	Poor	-	1	1	2	14%
Compound Swept	Yes	6	2	2	10	71%
	No	-	2	2	4	28%
Dishrack	Yes	5	4	2	11	78.5%
	No	1	-	2	3	21.4%
Latrine	Yes	6	4	3	13	93%
	No	-	-	1	1	7%
Bath shelter	Yes	6	4	3	13	92.8%
	No	-	-	1	1	7%
Rubbish Pit	Yes	3	1	2	6	42.8%
	No	3	3	2	8	57.1%

Animal shelter					
Yes	2	2	2	6	42.8%
No	-	-	2	2	14%
Raised Fire Place					
Yes	2	-	1	3	21.4%
No	4	4	3	11	78.5%
Vegetable Garden					
Yes	4	3	2	9	64.2%
No	2	1	2	5	35.7%
Safe Drinking Water					
Yes	6	2	2	10	71%
No	-	2	2	4	28.5%

IMMUNIZATION COVERAGE

No. of children Imm. cards seen of under 5yrs.	11	4	4	19	67.8%
No of fully Immunized	4	3	4	11	39%
No of partially Immunized	7	1	0	8	28.6%
No of children with BCG scar					
No of women of CBA with TT cards	2	2	0	4	19%

NUTRITION

No of children 5 yrs and under					
Arm c/m red					
yellow	4	-	-	4	14%
green	2	2	5	9	39%

42

COMMON DISEASES

	GROUP 1	GROUP 2	GROUP 3	TOTAL	%
Malaria	4	1	2	7	66%
Diarrhoea	1	2	-	3	3%
Cough	9	3	-	12	11%
Skin problems	2	1	1	4	3.7%
Eye problems	-	-	2	2	1.9%
Teeth & Gums	1	1	2	4	3.7%
Any other	-	3	-	3	3%
Distance to Health Unit		1 1/2 miles			
No of Handicapped & Mentally sick	1	- -	2	3	3%
Mortality Rate of children under 5 yrs within a period of one year	-	-	1	1	
Mortality rate of women 15-49 yrs within a period of one year	-	-	-	-	

WHAT IS PLANNING?

1. Setting objectives to achieve a goal.
Considering ways and means of achieving those objectives in a given situation.

2. Why do we plan?

- For good preparation of what we want to achieve.
- Have a guideline to a set goal.

3. When do we plan?

- When we want to start a project.
- After making an evaluation.
- When need arises.

** OBJECTIVES

** Specific
** Measurable
** Achievable
** Reliable
** Time bound

43

WORK PLAN

2 latrines constructed in Kayindu RC1 from 1st July to 1st Sept, 1992.

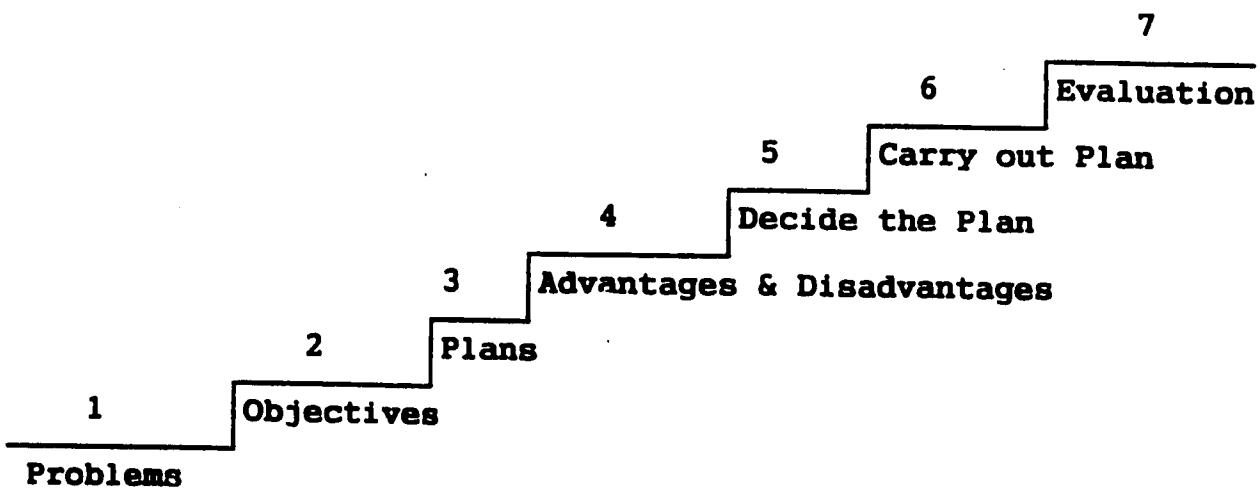
STRATEGIES

- Hiring laborers
- Doing personally

TEAMWORK

- Logs
- Concrete

7 STEPS IN PLANNING



1. **Problems:** What is the problem or need of the community.
2. **Objectives:** What do we want to achieve.
3. **Plans:** What are the possible plans to meet the objective.
4. **Advantages & disadvantages:** What are the advantages and disadvantages of each plan.
5. **Decide Plan:** Which plan to follow.
6. **Carry out Plan:** Who, what, how, where and when.
7. **Evaluation:** Who, what, how, where and when.

441

A I D S

stands for:

ACQUIRED - something you get

IMMUNE - protection against disease

DEFICIENCY - a lack of

SYNDROME - a group of different signs and symptoms

It is a combination of diseases caused by a virus which impairs the body's ability to fight infection, making the body susceptible to opportunistic infection. eg: T.B, pneumonia, cancer etc.

4 THINGS EVERYONE SHOULD KNOW ABOUT AIDS

1. Aids is a deadly disease without cure.
2. Mode of transmission.
3. Signs and symptoms.
4. Aids control/prevention

FEARS/FEELINGS ABOUT AIDS

- Dying alone
- Blame
- Shame
- Isolation
- Loss of job
- Loss of friends
- Donating blood
- Revenge
- Denial
- Lonely/abandoned
- Social limitations
- Suicide

MYTHS/FALSE BELIEFS ABOUT AIDS

- Witchcraft
- Spread by casual contact
- Spread by insect bites
- Spread through animal products (contaminated milk)
- In Africa - through immunization
- A biological warfare experiment that went wrong in America

FACTS ABOUT AIDS

- No-one knows for certain where it came from
- It is called by a virus called Immuno-Deficiency Syndrome OR Suppressive Virus - H.I.V.

MODE OF SPREAD

1. Through sexual contact with an infected person
2. Through receiving contaminated blood with H.I.V virus
3. Through use of unsterilized skin piercing instruments
4. Can be passed to unborn child of infected mother

* Aids is a chronic disease which can last for years
* All blood groups are equally affected
* Aids has no respect for body size
* Although the majority of children born with Aids die within 2 years - A few can live for up to 10 years

MAJOR SYMPTOMS	MINOR SYMPTOMS
1. Chronic fever (1month)	1. Itchy skin rash
2. Chronic weight loss	2. Chronic cough
3. Chronic diarrhoea (1month)	3. Swollen glands
	4. Herpes Zoster
	5. Chronic Herpes Simplex
	6. Thrush

STAGES OF H.I.V. INFECTION

LIFE LINE

1. Normal	Point of infection	2. (3-6 months)	3.	4. Herpes Zoster	5.	6.
		Window period	Asymptomatic sero-positive H.I.V + VE	Symptomatic sero-positive H.I.V + VE	AIDS	DEATH

<----------> HEALTH 3+2 yrs

CAN LIVE UP TO 10 YEARS

FACE TO FACE WITH AIDS

1. Community interaction - Health education on control/behavior change
2. Commitment - Pastoral care/Faith in God
3. Involvement - Emotions/feeling
4. Endurance - Talk to people about Aids
   - Team work - Get a break from stigmatization

COPING WITH H.I.V./AIDS NEWS

People adjust to the news of their infection or disease from when they are first told. Their true response may appear only when they have grown physically stronger.

Most people, on learning of the news, may experience a chain of reactions as they adjust to the reality of being HIV infected. These reactions are sometimes termed:

LOSS REACTION

- Shock: Sweating - breathing becomes difficult
- Denial: "Can't believe it". "It is a mistake"
- Anger: Blaming "Why am I unlucky?" God, why me?
- Bargaining: "Is there any way this disease can be taken away from me"
- Depression: Fear of illness and dying
- Acceptance: "The fact cannot be changed. It has come to stay"
- Coping: Positive living. I am going to live until I die.
- TASO: The Aids Support Organization - trained counsellors

WORK PLAN - BUSOKE

PROBLEM: Poor nutrition in children under 5 years.

OBJECTIVE: Improving nutrition in children under 5 years by 10% from 1st July 1992 to 15th July 1993 at Mpigi RC1

STRATEGIES: Mobilize the mothers first, fathers and RCs. Create awareness to the community. Mobilize the CHWs.

ADVANTAGES: Mothers will be co-operative.

DISADVANTAGES: It may take time.
Poor attendance of the community.

DECIDE PLAN: Mobilize mothers.

CARRY OUT PLAN:
Who - community mothers.
What - improving nutrition.
Where - Mpigi RCs
How - By growing greens.
When - From 15th July 1992 to 15th July 1993.

EVALUATION: Will be carried out at the end of the work done.

Who - Trainer
When - 15th July '92 - 15th July '93
Where - Mpigi RC1

WORK PLAN - KAYINDU SUB-PARISH

PROBLEM: Lack of kitchens in Kayindu sub-parish.

OBJECTIVE: Constructing 4 kitchens in Luteete commencing 1st July '92 - 30th May '93.

STRATEGIES:
1>. Contact RCs
2>. Opinion leaders and Elders
3>. Mobilize community
4>. Training
5>. Contact experts

ADVANTAGES:
1>. You get ideas from the community
2>. Working together

DISADVANTAGES:
1>. Improper handling of people may cause the work to be very difficult
2>. May fail to get materials needed

DECIDE PLAN: Find out who will do this work.
WHO WILL WORK: RCs, community, yourself.
HOW LONG WILL IT TAKE: At times the work may not be completed.

48

WORK PLAN - NABUZE

PROBLEM: Lack of safe drinking water

OBJECTIVES: Want to achieve a well protected spring on Nabuze Kireka RC1, Banda from 1st July - 1st December 1992.

PLAN/STRATEGIES: 1>. Contact RCs, influencial leaders, extensi workers, to create awareness in the community
2>. Get experts to do the job.
3>. Train the community, CHWs & VHCs.

ADVANTAGES OF (1): The best method
Easy mobilization/activities easier
Will make the work efficient
To get good water

DISADVANTAGES OF (1): Will take a long time
Some will not co-operate
Not easy to mobilize (poor attendance)

ADVANTAGES OF (2): Will do the work efficently
They have the technical knowledge
Will take shorter time
Not tiresome

DISADVANTAGES OF (2): Not easy to get
More expensive
Take a long time to do the job

ADVANTAGES OF (3): Get ideas from the people
Involvement of the community/participation
Raising responsibility in the community
Team work - organized

DISADVANTAGES OF (3): Rejection of the idea
Taxing and time consuming
May not participate

MATERIALS & COST: Sand, stones, pipes, hoes, slashes & spades to clear the area. Cement

ADVANTAGES OF MATERIALS: May be obtained locally
Team work

DISADVANTAGES OF MATERIALS: Expensive
Not easy to get

PLAN: Contact RCs and influencial leaders

CARRY OUT PLAN: Who - Trainer, RCs, Influencials
What - Mobilize and protect springs
Where - Nabuze
When - 1st July - 1st December 1992

EVALUATION: A well protected spring with water flowing clearly.
How - By inspecting at the end of the work.
When - At the end of the work.

49

WORK PLAN - DEGEYA PARISH

PROBLEM: Diarrhoea disease

OBJECTIVES: Construct 2 pit latrines and to rehabilitate a well in Degeya parish from 1st July '92 - early January 1993.

STRATEGY/PLAN: Contact RCs, influential leaders of the community.
Create awareness
Train the community, CHWs, VHWs
Team work

ADVANTAGE:
Contact RCs
Best method
Easy mobilization
Make the work efficient
Exchange advice

DISADVANTAGES:
Take time
Some will not co-operate
Not easy to mobilize

ADVANTAGE:
Get ideas from the community
Involvement of the community
Raising responsibility in the community
Team work

DISADVANTAGES:
Rejection of ideas
May not participate
May not turn up

PLAN TO FOLLOW: Mobilization of the community

CARRY OUT PLAN:
What - Construct 2 pit latrines and dig a well.
Where - Degeya parish
How - Using local materials
When - From 1st July '92 - early January '93

EVALUATION: Will be carried out at the end of the work done.
Who - Trainer
Where - Degeya parish

60

WORK PLAN - KAMIRA PARISH

PROBLEM: Infant mortality (due to six killer diseases)

OBJECTIVE: To reduce infant mortality rate by 5% in 1 year, starting from 1st October '92 - 30th October '93 in Kamira Parish.

PLAN/STRATEGY: Contact RCs, influential people
Create awareness in the community
Train CHWs and VHCs
Team work
Immunization of children under 5 years & Women between 15-49 years

ADVANTAGES: Contact influential leaders in order to make mobilization and activities easier.

DISADVANTAGES: Some may not co-operate
It will take time
Not easy to mobilize/poor attendance

ADVANTAGES OF CREATING AWARENESS: Mobilization and activities are made easier.
More people will attend the meetings.

ADVANTAGES OF TRAINING CHWs & VHCs:
Create more awareness/mobilize
They will educate the community
They will assist with immunization program

DISADVANTAGES: They will not be willing to work voluntarily
They will be time comsuming/retired (????)

ADVANTAGES OF IMMUNIZATIONS: Will reduce infant mortality rate

DISADVANTAGES: May not get sufficient supply of vaccines
Lack of man power

PLAN/STRATEGY:
Who - CHWs & VHCs
What - Immunizations
Where - Kamira parish
When - 1st October 1992 - 30th October 1993
How - Team work hand in hand with community

EVALUATION: Do a survey after 30th October 1993
Who - CHWs & VHCs
What - Progress of the program
Where - Kamira parish
How - Visiting homes, looking at cards of children under 5 yrs and women between 15-49 yrs
When - After 30th October 1993

WORK PLAN - KAYINDU PARISH, NABITEETE RC1B

PROBLEM: Poor sanitation

OBJECTIVE: To smear all the temporary residential houses found in Nabiteete RC1B between 1st July '92 and 31st Dec '93

PLAN/STRATEGY: Contact RCs, influencials, leaders of community
Creat awareness
Organize the community
Select a VHC
Team work

ADVANTAGES OF CONTACTING RCs: Is the best method
Easy mobilization/activities easier
Will make the work efficient
Will give good advice

DISADVANTAGES OF CONTACTING RCs: Will take time
Some will not co-operate
May not be easy to mobilize
Poor attendance

ADVANTAGE OF MOBILIZING THE COMMUNITY:
To get ideas from the community
To create awareness
To enable the community to participate fully

DISADVANTAGES: The idea may be rejected
Time consuming
The community may not participate
They may not turn up

ADVANTAGES OF TEAMWORK: The work is easy
It takes a short time
It is efficient

DISADVANTAGES OF TEAMWORK: Others may not respond

PLAN/STRATEGY: To get the mobilized community to do the work

CARRY OUT PLAN:
Who - The mobilized community
What - Smearing all temporary residential houses
Where - Nabiteete RC1B - Kayindu A Sub-parish
How - Using dust mixed with cow-dung
When - From 1st July - 31st December 1993

EVALUATION: To be done by the trainer
At the end of the given period
At Nabiteete RC1B
By visiting each home

WORK PLAN - KAMPALA EAST DIVISION

PROBLEM: Poor sanitation and lack of health education in community

OBJECTIVE: To educate and contract 5 VIPS at Nsasa from July '92 - December 1993

PLAN/STRATEGY: Contact key leaders
Mobilization of community
Train VHWs & VHC
Involve extension workers

ADVANTAGES: Get advice
Team work/involvement of community
Makes the work easy
provide skills

DISADVANTAGES: Taxing/time consuming
May reject it
Takes long time to train

DECIDED PLAN: Mobilize the key people (RCs, elders etc)
Create awareness
Train
Involve community/extension workers

CARRY OUT PLAN:
- Who - RCs, trainers, VHC, CHWs, extension workers, elders, opinion leaders
- What - Mobilize, educate, construct, dig pits, carry out survey, training.
- Where - Nsasa RC Village Council
- How - Through team work, involving community, extension workers, VHC, VHWs
  Using constructing, digging and educational materials

EVALUATION:
- Who - Trainer, VHC, VHW, extension workers, RCs
- What - The impact of health education/awareness, Construction of 5 VIP, latrines and 5 rubbish pits between July '92 -Dec '93
- How - Home & site visiting, organize questionaire
- When - December 1993
- Where - Nsasa RC1 community

WORK PLAN - BUSIIKA PARISH

PROBLEM: Poor nutrition of children

OBJECTIVES: To set up a horticultural garden in order to supply green vegetables so as to fight (resist) anaemia in children by 3%. The expected garden should be of 1/8th of an acre near a source of water. From 6th July '92 - 20th November '92

STRATEGIES: 1>. Hiring labourers
2>. Team work through residents

ADVANTAGES OF HIRED LABOURERS:

1>. Speed up the project
2>. Work not tiresome

DISADVANTAGES OF HIRED LABOURERS:

1>. Expensive work
2>. Not efficient
3>. Dishonest

ADVANTAGES OF TEAMWORK:

1>. Speed up the project
2>. Efficient work
3>. Not tiresome
4>. Availability of seeds and land
5>. Money for insecticides easily obtained from team mates
6>. Exchange of ideas (two heads are better than one)

DISADVANTAGES OF TEAMWORK:

1>. Creation of awareness to the community
2>. Lack time
3>. Poor attendance
4>. No co-operation

DECIDE PLAN: Team work together with hired labourers

CARRY OUT PLAN: By members of the community and hired labourers to clear the bush, ploughing, planting, weeding and harvesting. The project will take place at Wabikokoma "Kayiwa River" using irrigation methods when necessary. Starting from 6th July '92 to 20th November '92.

EVALUATION: The evaluation will be taken by the two trainers of Busiika parish together with the RCs and community on the horticultural garden at Wabikokoma "Kayiwa River". By harvesting and supply the yields to the children of the community at the end of the season.

WORK PLAN - BUSIIKA PARISH

PROBLEM: Poor nutrition of children

OBJECTIVES: To set up a horticultural garden in order to supply green vegetables so as to fight (resist) anaemia in children by 3%. The expected garden should be of 1/8th of an acre near a source of water. From 6th July '92 - 20th November '92

STRATEGIES:
1>. Hiring labourers
2>. Team work through residents

ADVANTAGES OF HIRED LABOURERS:

1>. Speed up the project
2>. Work not tiresome

DISADVANTAGES OF HIRED LABOURERS:

1>. Expensive work
2>. Not efficient
3>. Dishonest

ADVANTAGES OF TEAMWORK:

1>. Speed up the project
2>. Efficient work
3>. Not tiresome
4>. Availability of seeds and land
5>. Money for insecticides easily obtained from team mates
6>. Exchange of ideas (two heads are better than one)

DISADVANTAGES OF TEAMWORK:

1>. Creation of awareness to the community
2>. Lack time
3>. Poor attendance
4>. No co-operation

DECIDE PLAN: Team work together with hired labourers

CARRY OUT PLAN: By members of the community and hired labourers to clear the bush, ploughing, planting, weeding and harvesting. The project will take place at Wabikokoma "Kayiwa River" using irrigation methods when necessary. Starting from 6th July '92 to 20th November '92.

EVALUATION: The evaluation will be taken by the two trainers of Busiika parish together with the RCs and community on the horticultural garden at Wabikokoma "Kayiwa River". By harvesting and supply the yields to the children of the community at the end of the season.

WORK PLAN - KIREKA RC1 B

PROBLEM: Malnutrition 87% in children 5 years and under.

OBJECTIVE: To reduce the percentage by 20% within a period of 2 years starting 1st September '92 - 1st September 1994.

PLAN:
- Mobilize RCs, Influencials, elders, VHC and extension workers.
- Mobilize community, especially mothers.
- Create awareness.
- Train CHWs
- Home visiting

ADVANTAGES:
- Creating awareness will be easy.
- Task force available
- Community participation

DISADVANTAGES: People may not co-operate.
- May take a long time to train CHWs.
- Poverty may become a barrier.

PLAN:
- Mobilize RCs, VHC, experts.
- Mobilize community.
- Create awareness.
- Train CHWs

CARRY OUT PLAN:

Who - RCs, trainers, VHC, CHWs, Extension workers, Influencials, Elders.
What - Mobilize, educate, demonstrate, train.
Where - Kireka RC1 B
How - Team work
When - 1st September '92 - 1st September '94

EVALUATION:
Who - VHC, CHWs, RCs, Trainer
What - Whether I have achieved the 20% reduction of malnutrition.
Where - In Kireka RC1 B
How - By doing home visiting
When - At the end of the 2 years.

54

WORK PLAN - LUNYOLYA PARISH

PROBLEM: Poor sanitation

OBJECTIVE: - To improve sanitation by constructing 25 dish racks from 1st July - 30th July 1992.

PLAN:
1>. Team work
2>. Hiring labourers
3>. Constructing personally

ADVANTAGES OF TEAMWORK: The work is speedy
Not costly
Not tiresome

DISADVANTAGES OF TEAMWORK: Creation of awareness may take time. People may not co-operate. People may reject it. At times the goal may not be reached within allotted time.

ADVANTAGES OF HIRING LABOURERS: Takes shorter time.

DISADVANTAGES OF HIRING LABOURERS:
Expensive
Not efficient
Sometimes the work may not be finished

ADVANTAGES OF CONSTRUCTING PERSONALLY:
Efficient
Low cost
Do not need to create awareness

DISADVANTAGES OF CONSTRUCTING PERSONALLY:
Very slow
Tiresome

PLAN: Construct personally

CARRY OUT PLAN:
Who - The community
What - Constructing dish racks
Where - Nankaaba RC1 (Kato Musoke)
Lunyolya (Dennis Musisi)
When - 1st July 1992 - 30th January 1993
How - Using local materials
eg: reeds, fibres, sticks

EVALUATION: Will be carried out at the end of the work.

TO BE DONE BY:
Who - Trainer
Where - Lunyolya parish
When - From 1st July 1992 - 30th January 1993

APPENDIX B

Training of Village Health Committees

ADVENTIST DEVELOPMENT AND RELIEF AGENCY

CHILD SURVIVAL VII PROJECT

TRAINING OF VILLAGE HEALTH COMMITTEES

KALAGALA SUB COUNTY
IN
LUWERO - DISTRICT

FROM AUGUST 3 TO 13, 1992

59

INTRODUCTION

The training of (VHC) Village Health Committees commenced on the 3rd of August and ended on the 13th of the same month. Each parish comprised of 2 or 3 RCs and the workshops were organised to last a day.

The turn up was very encouraging through out the training period.
Workshop proceedings were started by asking the participants to write down their expectations. The workshop objectives were discussed and agreed up on with all participants.

Commencement time was between 9 and 10 AM while closing time was between 5 and 6 PM.

The Facilitators:

Mr. Israel Musoke, Director Child Survival Project.

Mr. John M. Kiyimba, Assistant Training Officer.

Displayed the time table as shown below:

Assisted by Mrs. Liljan Meredith, Child Survival Project Co-ordinator.

Mrs. Deborah Saka, Responsible for Nutrition and Family Planning.

Miss. Anita Namuyiga, In charge of Immunization and growth monitoring.

Mr. Andrew Ssemmambo, Supervisor - Kalagala-Sub county.

TIME - TABLE

9:00 AM - 12:30 PM	Learning Session
12:30 PM - 1:30 PM	Lunch
1:30 PM - 2:00 PM	Rest
2:00 PM - 5:00 PM	Learning Session

The same time table was followed during all the eight workshops for the sixteen sub parishes in Kalagala sub county.

For the names of the participants see the next page.

Training of VHC Lunyolya Parish A & B

List of Participants

	NAME	ADDRESS
1	Mr. Kasule John	RCI Gaaza
2	Mr. Kayinda Edirisa	Lunyolya
3	Mr. Musisi Daniel	Lunyolya
4	Mr. Robert Lutaaya	Busoke
5	Mr. Nkaaku Amisi	Lunyolya
6	Mr. Yiga Samuel	Nakwaaba
7	Mr.Bbosa F.	Katikandegeya
8	M/s. J. Nabukera	Lunyolya
9	Mrs. Nnalongo Ssentongo	Kisubi
10	Mr. Ssekamere W.	Kisubi
11	Mr. Ssebaale Henry	Lunyolya
12	M/s. Namusoke Lovisa	Kkonko
13	Mrs. Cissy Mivule	Kkonko
14	Mrs. Jane Nsubuga	Kkonko
15	Mrs. Hadjati Mpuga	Gaaza
16	Mrs. Kevin Kavondo	Kkonko
17	Mrs. Mable Lubega	Lunyolya
18	Mrs. R. Musenze	Lunyolya
19	Mr. Basigala Emmanuel	Kkonko
20	Mr. Kunonya Benedicto	Lunyolya
21	Mr. Musoke Kato	Kkonko
22	Mrs. Margret Bannadda	Katikandegeya
23	Mrs. Dina Kawumuza	Lunyolya
24	Mr. Kalyango	Nankaaba
25	M/s. Matha Awor	Lunyolya
26	M/s Juiliet Nakintu	Lunyolya

August 1, 1992

Training of VHC Busoke Parish
List of Participants

		NAME	ADDRESS
1	Mr.	Nsubuga George	Vvumba
2	Mrs.	Aidha Ssekitto	Sseeta
3	Mr.	Nkalu Etulaimu	Sseeta
4	Mr.	Kiyingi Wilberforce	Mpigi
5	Mrs.	Nakagulire Esther	Busoke
6	Mr.	Lutaaya Robert	Busoke
7	Mr.	Mayanja E.	Busoke
8	Mr.	Ssempa Matia	Vvumba
9	Mr.	Kamya Alipe	Kiwangala
10	Mr.	Zerono Robert	Sseeta
11	Mrs.	Rachiel Wabbi	Busoke
12	Mrs.	Harriet Nakalembe	Mpigi
13	Mrs.	Jenipher Kiwanuka	Kiwangala
14	Mrs.	Aidha Ssekayiri	Vvumba
15	Mrs.	Cissy Batte	Kiwangala
16	Mrs.	Everlyn Nankumba	Mpigi
17	Mrs.	Grace Kanyiga	Busoke
18	Mr.	Kyaate Nathias	Vvumba
19	Mrs.	Jesca Kitonsa	Sseeta
20	Mrs.	Jenifer Kyobe	Busoke
21	Mrs.	Edward Mukasa	Busoke

August 5, 1992

Training of VHC Vvumba Parish A & B

List of Participants

	NAME	ADDRESS
1	Mr. Christopher Katamba	Kyetume
2	Mrs. Beatrice Sebakigye	Vvumba
3	Mr. Seniwagi	Ndeeba
4	M/s. Namuyanja Violet	Kyetume
5	Mr. Omar Kintu	Kakoni
6	Mr. Mawanda Joseph	Ndeeba
7	Mr. Zedi Sembagye	Kibanga
8	Mr. Moses Kitaka	Kyetume
9	Mr. Matovu John	Kabembe
10	Mrs. Sarah Kayondo	Kibanga
11	Mrs. Masittula	Kibanga
12	Mr. Sekaboga Ibrahim	Kabembe
13	Mr. Salomgo Francis	Kakoni
14	Mrs. Kisitu Saul	Ndeeba
15	Mrs. Moreen Sebbalu	Vvumba
16	Mr. Kayira Fred	Kyetume
17	Mrs. B. Kirabira	Kabembe
18	Mrs. Regina Sewava	Kibanga
19	M/s. D. Namukasa	Ndeeba
20	M/s. Specioza Nalwanga	Ndeeba
21	Mrs. Topista Bayego	Ndeeba
22	Mrs. Rehema Kiwanuka	Ndeeba
23	M/s. Kiyimba Joyce	Ndeeba
24	Mr. Haruna Kiwanuka	Vvumba
25	Mr. David R.Salongo	Vvumba
26	Mr. Sendagire Magalaasi	Ndeeba
27	Mr. Kasirye Mike	Vvumba

August 6, 1992

Training of VHCs Kalanamu Parish

List of Participants

	NAME	ADDRESS
1	Mr. Fred Bongore	Kalanamu
2	Mr. Wilson Sserunjogi	Kyaasampaawo
3	M/s. Sarah Nakimweero	Gangama
4	Mr. Muyomba Mark	Kalanamu
5	M/s. Nakasuja Josephine	Kalanamu
6	Mr. Nkaaku Eriasi	Kalungu
7	Mr. Stephen Ntume	Gangama
8	Mr. Fredrick Kyeyune	Nakibanga
9	Mr. Balimwogerako	Nakibanga
10	M/s. Nakityo Ruth	Nakibanga
11	Mrs. Sarah Kikomeko	Kalanamu
12	Mrs. Jenifer Ssemakula	Kalungu
13	M/s. Fatuma	
14	Mrs. Gladys Semusu	Kalagala
15	Mrs. Nuru Mulambuzi	Kalagala
16	Mrs. Rehema K. Kaaya	Kalagala
17	Mrs. Florence Kyeyune	Kyaasampaawo
18	Mrs. Deborah Kijjambu	Kyaasampaawo
19	Mr. Jack Kijjambu	Nakibengo
20	M/s. Tansi Nankya	Kalagala
21	Mrs. Ruth Kamunvi	Kalagala
22	Mrs. Ruth Zediimye	Kalagala
23	Mr. Iga Sam	Kalagala

August 10, 1992

Training of VHCs Kamira Parish A & B

List of Participants

	NAME	ADDRESS
1	Mr. Oduma	Lukyamu
2	Namwandu Kakumba	Bunsule
3	Mr. Yowana Mutebi	Gangama
4	Mr. Elias Owori	Bunsule
5	Mr. Gerald Ddungu	Bunsule
6	Mrs. A. Kayongo	Bunsule
7	M/s. Annet Namuli	Kamira
8	Mrs. Edith Mirembe	Lukyamu
9	Mr. M.K. Musoke	Bunsule
10	Mr. Katwere John	Bugema
11	Mrs. Namazzi Sarah	Kamira
12	Mrs Lubwama	Lukyamu

August 11, 199

Training of VHCs Busiika Parish

List of Participants

	NAME	ADDRESS
1	Mr. Ssekanjako Living	Busiika
2	Hadija Katugga	Busiika
3	Mrs. Namyaalo Ssengabi	Busiika
4	Mr. Joseph Kikomeko	Lubanyi
5	Mr. Zeedi Kalumba	Wabikokooma
6	Mr. Abdu Kayongo	Busiika
7	Mr. Hakimu Kato	Senero
8	Mr.Budala Bukade	Senero
9	M/s. Hanida Namusisi	Senero
10	M/s. S. Margret	Senero
11	Mrs. Robina Ssekanjako	Busiika
12	Mr. Fred Kinene	Nakafumu
13	Mr. Samuel Ssentamu	Nakafumu

August 12, 199

Training of VHCs Kayindu Parish

List of Participants

	NAME	ADDRESS
1	Mrs. Nanyonga Aisa	Busaakwa
2	Mr. Kalulu Robert	Kayindu
3	Mr. Elusaana Ntege	Busaakwa
4	Mr. Saadi Mugalu	Kyampisi
5	Mr. Ahamed Gamusambwa	Busaakwa
6	Mr. Christopher Kato	Kalagala
7	Mr. Sserunjogi David	Kayindu
8	M/s. Alice Namukasa	Kalagala
9	Mr. V. Baweyamba	kalagala
10	Mrs. Sarah Waliggo	Nabiteete
11	M/s. Layiya Nalume	Lutete
12	M/s. Rebecca Nakazzi	Lutete
13	M/s. Nnalongo Medina	Kyampisi
14	Mrs. Kiwanuka Nnabaggala	Lutete
15	Mr. John Kityo	Nabiteete
16	Mr. David Simwogerere	Kyampisi
17	Hadija Kalidi Kasule	Kalagala
18	M/s. Aisa Nakisitu	Kayindu B
19	Mrs. Fanda Kizza	Luteete
20	mrs. L. Nsereko	Kayindu
21	M/s. N. Nabbowa	Bugondo
22	Mrs.Nulu Kiriisa	Kyoga
23	Mr. Emmanuel Nsubuga	Wampeewo
24	M/s. Margret Nalukwago	Wampeewo

August 13, 1992

Training of VHCs Ddegeya Parish

List of Participants

	NAME	ADDRESS
1	M/s. Efulansi Namusisi	Luteete
2	Mr. A. Kimuli Wamala	Bulemezi
3	M/s. Madina Nakato	Bugabo
4	Mr. Fred Mukasa	Ddegeya
5	Mrs. Nulu Mawejje	Ddegeya
6	Mrs. Margret Busulwa	Ddegeya
7	Mr. Mesach Katongole	Bugabo
8	Mr. S. Lubwama	Bugabo
9	Mr. H. W. Golooba	Bulemezi
10	Mr. Musa Ssemakula	Namwatulire
11	Mr. Abdu Ssendagire	Ddegeya
12	Mr. M. Mayombwe	Namwatulire
13	Mr. Herbert Lubwama	Ddegeya
14	Mrs. Damali Nasali	Ddegeya
15	M/s. Nantale Annet	Ddegeya
16	Mr. Philip Mukasa	Ddegeya
17	Mr. Kigongo George	Kireka
18	M/s. Specioza Nakalule	Ddegeya
19	Mr. Kasimu Mawejje	Ddegeya
20	M/s. Janida Namirembe	Kibajjwe
21	M/s. Nakazi	Kalagi
22	M/s. Sefoloza Nantume	Namwatulire
23	Mr. John Kiwanuka	Kalagi
24	Mr. Eriazali Nsobya	Ddegeya

Climate Setting

Always th workshops started by a short prayer led by a lady or gentleman chosen by the participants.

Introduction

It was suggested and agreed that we were to introduce ourselves clock-wise as we sat in a circle.

Workshop Objectives

At the juncture the facilitators presented the workshop objectives as follows:
At the end of the workshop, participants will be able to:

1. Describe how development and health fit together.
2. Know the role and responsibility of a VHC.
3. Be helped to Change from negative to positive attitude.
4. Help people identify and solve problems in their communities.

Participants' Expectations and Workshop Objectives

Participants Expectations

Participants were asked to write on small pieces of paper what they expected to learn from the workshop. They presented their lists of expectations which were analysed as follows:

- To understand the roles and functions of members of VHC
- To Learn Good Leadership
- Meaning of ADRA
- Health Care
- Agriculture
- Making Dish Racks
- First Aid Skills
- Immunization
- Development
- Protection of Springs
- ADRA Objectives
- How to Mobilise and Sensitize the Community
- Child Survival Objectives

Child Survival Project (Intervetions)

The facilitators described ADRA as the Seveth-Day Adventist world services agency, responsible for responsible for relief and development activities regardless of race or denomination.

It is ADRA's deliberation to run the Child Surviva project in Kalagala and Zirobwe respectively as a measur of bringing about development and self reliance.
It was explained further that Child Survival intervetion were:

- Immunization of children of 5 yrs and below against th six killer diseases which are:
  * Diphtheria
  * Polio
  * Tetenus
  * Tuberculosis
  * Whooping Cough
  * Measles

  This also applies to women of the child bearing age o of 15 to 49 years. They are immunized against tetenus

- Family Planning

- Nutrition and Child Growth Monitoring

- Control of Diarreal Diseases

The method used in all the workshops was psycho social Role plays were used and group discussion which made th work shop a comfortable one for the participants.

Management of Diarrea Using Home-made ORS

Participants always were divided into group to list sign of dehydration and how they could prepare home-made ORS

Signs of Dehydration

Below is the list of statements they came up with:-

- Body Weakness
- Paleness
- Dry Lips
- Thirst
- Lack of Blood etc. etc.

<u>Conclusion</u>

The following were included:

- Sunken eyes
- Depressed Fontanelle
- Elasticity of the Skin
- Less or Dark Yellow Urine

Home made ORS

Below are the statements they came up with:

- 4 spoons of sugar and 2 of salt in 1/2 Litre of water.
- 6 spoons of sugar and 1 of salt in 1 Litre of drinking water.
- 8 spoons of sugar and 1 of salt in 1 Litre of drinking water.
- 2 spoons of sugar and 1 of salt in 2 Litres of Clean water.

A summary was made by mentioning the following:-

One litre of drinking water, add 8 levelled spoons of sugar, then add 1 levelled spoon of salt mix well to dissolve and add fruit juice for better taste.

Other methods of home made ORS were listed as below:

- Diluted porridge
- Soup from boiled rice
- Soup from boiled Irish or Sweet potatoes, Matooke and Cassava add just a pinch of salt.

<u>Introductory Role Play</u>

A meeting of five members including:
Chairman RC 1
Chairman VHC
CHW
Trainer
Complainant

During the presentation the complainant says she lost two children and a brother is admitted because of measles. It seems nobody is doing anything about it.
The chairman RC 1 asks the chairman VHC what he has done about it. The chairman VHC feels it is the duty of the trainer to have done something about it. The trainer feels it should have been the CHW to do something about it.

The community health worker says members of the community did not tell her about it.

"How do they expect me to know?"

The meeting ended with every body not knowing who would have done something about the incidence of measles.

This was followed with questions "SHOWED" and at the end of it all, it was realized that there is need for the named personnel to know their roles and responsibilities.

They were sent to groups to discuss their roles of:-
RC 1 Chairman, VHC Chairman, CHW, Trainer.

GRP Presentations

Roles of VHC:

- It is an administrative body in community projects.
- It links community with other authorities.
- It conducts meetings in community.
- It identifies problems related to health in the community.
- It is a mobilizing body in the community.
- It is a planning body.
- Responsible for evaluation.
- It is responsible for starting IGAS.
- It is answerable to the community.

ROLES OF CHW

GRP PRESENTATIONS

- Home Visiting
- Involvement in health programmes eg. Immunization of create awareness
- Advise and solve problems
- Co - ordinate
- Motivate and encourage change
- Keep records and make reports
- Treat and refer
- Mobilize
- Promoting activities for development and prevention on disease.

ROLES OF TRAINER

- Responsible for training CHWs and VHCs
- Provision of Training facilities
- Supervision of Trainers
- Sending reports to higher authorities
- Advisor, Co - ordinator, initiator, educator, evaluator, mobilizer, supervisor, helps VHC and CHW

MAIN POINTS

Being a member of the health committee is a very important position. One must be:-

- A volunteer
- A leader for all community development programme
- Able to work together with community members
- An example and make habits and changes in his own home
- A regular attendant to meetings.

WHAT IS HEALTH?

Health was defined as follows below:

> The state of well being of a person physically, mentally, socially, politically, economically, and spiritualllly not merely the absence of disease.

WHAT IS DEVELOPMENT?

The statments were analyzed:-

DEVELOPMENT

Enabling people to serve their own problem and each fulfillment, physically, mentally, socially, spiritually, it includes areas of life such as agriculture water, passable roads, good health conditions, enough good food production and IGAs are important factors for development. "Health is health". Participants were asked to write down the people responsible for development. The list below was analyzed:-

- Community Members
- Local Leaders
- RCs
- Youth
- Religious Leaders
- Traditional Healers
- Agricultural Officers
- Extension Workers
- Women Groups
- Teachers
- Health workers etc. etc.

Participants were asked to write down signs indicating develoment and the list below was analyzed.

- Good housing
- Passable roads
- Protected springs
- Churches
- Mosques
- Schools
- Health Units and Hospitals
- Shops
- Markets
- Modern farming
- IGAs

PRIORITIZATION

The participants were asked to write on small pieces of papers health problems in their communities. Each had to write down one problem.
Below is the analyzed list from all participants.

- Water
- Bad roads
- Poor nutrition
- Lack of enough schools
- Lack of good housing
- Monkies (Crop Destroyers)
- Poverty
- Transport
- Lack of health services

Majority Mentioned water as their main health problem. Some communities go long distances to fetch water and most of their springs are seasonal.

Day's Evaluation

Always the day ended with its evaluaton by the partiicipants in a happy thankful state for the facilitators by promising to change from negative to positive attitudes and help their communities.

Closing

Participants chose one person to close with a word of prayer.

APPENDIX C

Job Description and Curriculum Vitaes

Job Description/Curriculum Vitae

Training Officer

In charge of all training for Child Survival VII Project, Uganda. Responsible for Community Mobilization Program. Also in charge of Aids Prevention awareness in the Community).

Name: John M. Kiyimba

Date of Birth: Born 1948.

Marital Status: Married with 4 children.

Experience/ Education:

1970-71: Completed two year course in Theater Technique and Nursing Ethics at Mulago Hospital, Kampala. Worked with Ministry of Health, Mulago Hospital. Later took a course in Laboratory Training Technology and qualified as Laboratory Medical Assistant at Mulago. Continued to work with MOH. Joined Bweyogerere SDA Dispensary as Administrator and Program Leader in CBHC in 1987.

1988: Took TOT Training in CBHC Programs. After that had been involved in training CHW's and mobilizing people for community programs, counselling PWA's (Patients with Aids), training their relatives to care for the Aids patients. Has conducted educational health programs and carried out research on Aids, working with Christian Medical Mission and Uganda Protestant Medical Bureau.

Job Description/Curriculum Vitae

Training Officer

In charge of all training for Child Survival VII Project, Uganda. Responsible for Community Mobilization Program. Also in charge of Aids Prevention awareness in the Community).

Name:	Paddy Bukenya
Marital Status:	Single
Education:	Has a Certificate in Tropical and General Agriculture, Crop and Poultry.
Work Experience:	Worked for the Ministry of Agriculture as a tractor operator. Has worked for a Coffee Factory as a mechanic. Also has had experience in being a Farm Manager. Was an Agricultural Trainer for the Education Association of Uganda, and Agricultural Technician for Bugema College and the Grassroots Training Program.

APPENDIX D

Pipeline Analysis

HEADQUARTERS

1992 COUNTRY PROJECT PIPELINE ANALYSIS – REPORT FORM A

PVO/COUNTRY PROJECT Child Survival VII

COST ELEMENTS	Actual Expenditures to Date (09/01/91 to 09/30/92)			Projected Expenditures Against Remaining Obligated Funds (10/01/92 to 08/31/94)			Total Agreement Budget (Columns 1 & 2) (09/01/91 to 08/31/94)		
	A.I.D.	PVO	TOTAL	A.I.D.	PVO	TOTAL	A.I.D.	PVO	TOTAL
I. PROCUREMENT									
A. Supplies									
B. Equipment									
*C. Services/Consultants									
1. Local									
2. Expatriate									
SUB-TOTAL I	0	0	0	0	0	0	0	0	0
II. EVALUATION	298.08	99.36	397.44	2,861.00	(99.36)	2,761.64	3,159.00	0	3,159.00
SUB-TOTAL II									
III. INDIRECT COSTS									
HQ/HO Overhead 17 (%)	77,362.03	27,967.05	105329.08	176,911.97	68,568.95	245,480.92	254274.00	96,536.00	350,810.00
SUB-TOTAL III									
IV. OTHER PROGRAM COSTS									
A. Personnel (list each position & total person months separately)									
1) Technical	6,824.71	2,451.14	9,275.85	19,042.29	7,066.86	26,109.15	25,867.00	9,518.00	35,385.00
2) Administrative	5,971.62	2,144.75	8,116.37	16,661.38	6,184.25	22,845.63	22,633.00	8,329.00	30,962.00
3) Support	4,265.45	1,531.96	5,797.41	11,901.55	4,417.04	16,318.59	16,167.00	5,949.00	22,116.00
B. Travel/Per Diem									
1) In country									
2) International	21,840.00	12,161.20	34,001.20	35,160.00	(1,751.20)	33,408.80	57,000.00	10,410.00	67,410.00
C. Other Direct Costs (utilities, printing rent, maintanance, etc)	5,117.37	9,205.77	14,323.14	4,882.63	10,794.23	15,676.86	10,000.00	20,000.00	30,000.00
SUB-TOTAL IV									
TOTAL HEADQUARTERS	121,679.26	55,561.23	177240.49	267,420.82	95,180.77	362601.59	389100.00	150,742.00	539842.00

*Excludes Evaluation Costs

FIELD

1992 COUNTRY PROJECT PIPELINE ANALYSIS - REPORT FORM A
PVO/COUNTRY PROJECT CS VII - Uganda

COST ELEMENTS	Actual Expenditures to Date (09/01/91 to 08/31/92)			Projected Expenditures Against Remaining Obligated Funds (09/01/92 to 08/31/94)			Total Agreement Budget (Columns 1 & 2) (09/01/91 to 08/31/94)		
	A.I.D.	PVO	TOTAL	A.I.D.	PVO	TOTAL	A.I.D.	PVO	TOTAL
I. PROCUREMENT									
A. Supplies	910.52		910.52	26,480.48	16,999.00	43,479.48	27,391.00	16,999.00	44,390.00
B. Equipment	2,748.27	5,563.47	8,311.74	19,301.73	51,136.53	70,438.26	22,050.00	56,700.00	78,750.00
* C Services/Consultants									
1. Local	3,239.85		3,239.85	25,460.15	4,950.00	30,410.15	28,700.00	4,950.00	33,650.00
2. Expatriate	4,053.1[illegible]		4,053.13	12,646.87		12,646.87	16,700.00		16,700.00
SUB-TOTAL I	10,951.77	5,563.47	16,515.24	83,889.23	73,085.53	156,974.76	94,841.00	78,649.00	173,490.00
II. EVALUATION									
A. Consultant/Contract				8,250.00		8,250.00	8,250.00		8,250.00
B. Staff Support				2,000.00		2,000.00	2,000.00		2,000.00
C. Other				1,500.00		1,500.00	1,500.00		1,500.00
SUB-TOTAL II	0	0	0	11,750.00	0	11,750.00	11,750.00	0	11,750.00
III. INDIRECT COSTS									
HQ/HO Overhead ____ (%)									
SUB-TOTAL III	0	0	0	0		0	0	0	0
IV. OTHER PROGRAM COSTS									
A. Personnel (list each position & total person months separately)									
1) Technical	800.00	113.91	913.91	69,650.00	(113.91)	69,536.09	70,450.00		70,450.00
2) Administrative	5,882.71		5,882.71	2,567.29		2,567.29	8,450.00		8,450.00
3) Support	52.17		52.17	36,607.83	2,345.00	38,952.83	36,660.00	2,345.00	39,005.00
B. Travel (Short Term)									
1) In country	1,971.26		1,971.26	25,778.74		25,778.74	27,750.00		27,750.00
2) International				99,344.00	8,252.00	107,596.00	99,344.00	8,252.00	107,596.00
C. Other Direct Costs (utilities, printing rent, maintanance, etc)	22,994.90	4,244.43	27,239.33	88,636.10	62,[illegible]50.57	151,286.67	111,631.00	66,895.00	178,526.00
SUB-TOTAL III	31,701.04	4,358.34	36,059.38	322,583.96	73,133.66	395,717.62	354,285.00	77,492.00	431,777.00
TOTAL FIELD	42,652.81	9,921.81	52,574.62	418,223.19	146,219.19	564,442.38	460,876.00	156,141.00	617,017.00

* Excludes Evaluation Costs

TOTAL

1992 COUNTRY PROJECT PIPELINE ANALYSIS – REPORT FORM A
PVO/COUNTRY PROJECT Child Survival VII

	Actual Expenditures to Date (09/01/91 to 09/30/92)			Projected Expenditures Against Remaining Obligated Funds (10/01/92 to 08/31/94)			Total Agreement Budget (Columns 1 & 2) (09/01/91 to 08/31/94)		
	A.I.D.	PVO	TOTAL	A.I.D.	PVO	TOTAL	A.I.D.	PVO	TOTAL
TOTAL HEADUARTERS	121679.26	55561.23	177240.49	267420.82	95180.77	362601.59	389100.00	150742.00	539842.00
TOTAL FIELD	283488.81	26168.81	309657.62	1061514.19	472922.19	1534436.38	1357753.00	499091.00	1856844.00
TOTAL	405168.07	81730.04	486898.11	1328935.01	568102.96	1897037.97	1746853.00	649833.00	2396686.00

20

APPENDIX E

USAID Health and CS Project Questionnaire

1992
USAID Health and Child Survival Project Questionnaire

with AIDS/HIV Activities Reporting Schedule

•• **PVOs** ••

Pages

Main Schedule 1
Schedule 1 - Demographic 7
Schedule 2 - Diarrheal Disease Control 8
Schedule 3 - Immunization 9
Schedule 4 - Nutrition 10
Schedule 5 - High Risk Births 12
Schedule 6 - AIDS/HIV Activities 13
Schedule 7 - Other Health and Child Survival 14

Country UGANDA

Project Title Child Survival VII Project

Project Number _____

Name(s) of person(s) responding to questionnaire: Barry Chapman/Israel Musoke

Title(s): ADRA Director / Project Director Date: Oct. 15, 1992

USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY92

Where available, information for questions 1 through 7 has been supplied. Please carefully check the supplied information for accuracy and make any corrections necessary. Where questions are left blank, please supply the requested information. If the Project Number is incorrect, or if the project is new, please write the correct number here and in the spaces provided at the bottom of each page of the questionnaire.

CIHI USE ONLY
I.D.:
Number:
Region:
Emphas:

PROJECT IDENTIFICATION

1. Project Number: _____ 2. Subproject Number: _____
3. Country: Uganda
4. a. Project Title: Child Survival VII Project
   b. Subproject Title: _____

5. a. Beginning FY: 1992 (Fiscal Year) b. Beginning FY of Subproject (if appropriate): _____ (Fiscal Year)
6. a. Project Assistance Completion Date (PACD): 1994 (MM DD YY)
   b. Termination Date of Subproject (if appropriate): _____ (MM DD YY)
7. Current Status (CIRCLE ONE ANSWER)
   1 - New, no activity yet 2 - Ongoing 3 - Discontinued 4 - Completed

PARTICIPATING AGENCIES

8. For each contract or grant, please provide the complete name of the contractor or grantee, the subcontractors working on the project, the host country counterpart(s) and the organization(s) responsible for implementation. Assign a type to each agency named as per the codes indicated below. Use additional sheets if necessary.

		Organization Type
a. Prime Contractor/Grantee or Partner in Cooperative Agreement	ADRA International	PVO
b. Subcontractors	ADRA Uganda	NGO
c. Host Country Counterpart(s)	ADRA Uganda	NGO
d. Organization(s) with major implementing responsibility	ADRA Uganda	NGO

Codes for Organization Type (PLACE THE NUMBER CORRESPONDING TO THE CODE IN THE SPACES ABOVE)

1 - Private Voluntary Organizations (U.S.)
2 - Private Voluntary Organizations (Local)
3 - Universities (all countries)
5 - Government (Host Country)
6 - Other Non-profit Organization (U.S.)
7 - Other Non-profit Organization (host and other countries)
8 - Multilateral Agencies
9 - For-profit Firms (all countries)
10 - Other _____ (Please Specify)

e. Provide the name and mailing address of the person or office that should receive relevant technical information from USAID. (PLEASE PRINT CLEARLY)

Name: Barry Chapman (ADRA Director)
Mailing Address: Israel Musoke (CS Director
P.O. Box 9946
Kampala, Uganda
A F R I C A

9. Percentage Attributions to Program Functions

This question should be answered in two steps. First complete Column A, and then complete Column B.

Step 1 - In **Column A**, write the percent of the Life-of-Project budget (USAID funding) that is attributable to each of the program functions listed. For further explanation, and definitions for each category, please refer to the instruction guide. The percentages in Column A should sum to 100%.

Step 2 - In **Column B**, write the percent of the entry in Column A devoted to Child Survival. In general, diarrheal disease/ORT, immunization, breastfeeding, growth monitoring and weaning foods, and Vitamin A are considered to be 100% Child Survival. In special cases, this may not be true and a percentage other than 100% may be entered in Column B.

PLEASE REVIEW THE EXAMPLE BELOW BEFORE COMPLETING THE TABLE

EXAMPLE

	Column A Total Percent Attribution	Column B Percent for Child Survival	Complete Schedule 1 and...
a. Diarrheal Disease/Oral Rehydration..(HEDD)	40%	100%	► Schedule 2
-	-	-	-
-	-	-	-
j. Water and Sanitation for Health ..... (HEWH)	60%	20%	► Schedule 7
-	-		-
-	-		-
TOTAL, All Functions	**100%**		

This means that 20% of the water and sanitation component of the project is attributed to child survival.

USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY92

9. Percentage Attributions of Life-of-Project Funds to Program Functions - Continued (See instruction guide for definitions)

	Column A Total Percent Attribution	Column B Percent for Child Survival	Complete Schedule 1 and...
a. Diarrheal Disease/Oral Rehydration..(HEDD)	Implementation	1993	► Schedule 2
b. Immunization/Vaccination ..... (HEIM)	"		► Schedule 3
c. Breastfeeding ..... (NUBF)	"		► Schedule 4
d. Growth Monitoring/Weaning Foods (NUGM)	"		► Schedule 4
e. Vitamin A ..... (NUVA)	"		► Schedule 4
f. Women's Health ..... (HEMH)	"		► Schedule 7
g. Women's Nutrition (including iron) (NUWO)	"		► Schedule 4
h. Child Spacing/High Risk Births ..... (HECS)	"		► Schedule 5
i. HIV/AIDS ..... (HEHA)	"		► Schedule 6
j. Water and Sanitation for Health ..... (HEWH)	"		► Schedule 7
k. Acute Respiratory Infections ..... (HERI)			► Schedule 7
l. Malaria ..... (HEMA)			► Schedule 7
m. Health Care Finance ..... (HEFI)			► Schedule 7
n. Prosthetics/Medical Rehabilitation .... (HEPR)			► Schedule 7
o. Orphans/Displaced Children ..... (ORDC)			► Schedule 7
TOTAL, All Functions	**100%**		

FUNDING INFORMATION US$ 724,922

10. What is the total USAID authorized **LIFE-OF-PROJECT** funding for this project (authorized dollar funds from ALL USAID funding accounts)? $ 539,224

11. Commodities

During FY92, were project funds committed to the purchase of any of the following? (PLEASE CIRCLE ALL THAT APPLY.)

a. ORS packets
b. vaccines
c. iron supplements
d. vitamin A
e. essential drugs
f. food supplements
g. weighing scales/growth charts
h. contraceptives
i. cold chain equipment
j. laboratory equipment
k. medical equipment
l. educational materials
m. audio-visual equipment
n. construction materials for water/sanitation and other activities
o. prosthetics
p. other (please specify) _____

For Implementation during 1993

12. What type(s) of initiatives to stimulate or support the local private sector are a part of this project? (CIRCLE ALL THAT APPLY.)

1 - Assistance to privatize public health programs or services
2 - Training of private sector health care providers
3 - Involvement of for-profit businesses in project activities
4 - Other (please specify) _____

13. Training Activities

a. Please indicate which of the following groups participated in a course, workshop or training program under the project during FY92: (CIRCLE ALL THAT APPLY.) If available, also provide the number of persons trained.

	Numbers Trained
1 - Physicians	
2 - Nurses	
3 - Community Health Workers	30
4 - Traditional Healers	
5 - School Teachers	
6 - Community Leaders/Health Comm	450
7 - Mothers	
8 - Others (please specify) _____	

b. If training was a significant component of project activities during FY92, please include a brief description of training activities and accomplishments in the space below.

14. Research Activity

Estimate the percent of **Life-of-Project** funds available to this project for research activities related to health and child survival → 0 % IF 0% SKIP TO ITEM 15

For projects with research percentages > 0%, please provide the following information:

a. **Which program functions** does this research address? (PLEASE CIRCLE ALL THAT APPLY)

1 - ORT/Diarrheal Disease
2 - Immunization/Vaccination
3 - Breastfeeding
4 - Growth Monitoring
5 - Targeted Feeding and Weaning Foods
6 - Vitamin A
7 - Women's Health/Nutrition
8 - Other Nutrition
9 - Child Spacing/High Risk Births
10 - HIV/AIDS
11 - Water and Sanitation
12 - Acute Respiratory Infection
13 - Malaria
14 - Other Vector Borne Disease Control
15 - Health Care Financing
16 - Health Systems Development
17 - Other (please specify)_____

b. **What types of research** are being funded? (CIRCLE ALL THAT APPLY)

1 - Biomedical
2 - Vaccine Development
3 - Epidemiologic
4 - Behavior/Communications
5 - Policy/Economic/Development
6 - Demographic Data Collection
7 - Operational Research

c. If this project has previously reported research titles, a summary list will be attached on the next page. Please review and update this list with current information.

d. If this is a new project or if there is additional research to report, please provide descriptive titles, years of the research, and the name, affiliation and address of the primary researcher. Also, please specify the program function to which the research is related, and the type of research. Program function codes 1-17 are listed in question 14a and research type codes 1-7 in 14b. (Use additional sheets if necessary.)

Title:_____

_____

Year: BEG:_____ END:_____

Program Function Codes ____ ____ ____ Type Code ____

Name_____

Institution_____

Address_____

USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY92

HIGHLIGHTS

15. **Given the diligent reporting efforts of PVOs in the past, information to describe project activities is readily available. The USAID Health and Child Survival Project Questionnaires, PVO Annual Reports and other routine reporting provide valuable descriptive information which is regularly used in Congressional reporting and other USAID documents. Please take a moment here to provide us lessons learned, success stories, or other highlights of your project's activities during the reporting year.**

Findings of Baseline Survey reveal that the following interventions should be addressed.

1. Scarcity of potable water
2. Lack of awareness in the transmission of Aids
3. Negative attitude of the men towards contraceptives
4. Availability of modern family planning devices

1. Expectations of the financial remunerations for the Village Health Committee members was too high.
   (ADRA Uganda is going to implement a Revolving Loan). It is our recommendation that for future CS Projects this method of (remuneration) be considered for sustainability.
   (support)

16. **Because photographs can often communicate important concepts to busy decision makers much more quickly than words, can you include photographs to supplement the above text? (If yes, please include credit/caption information, including the location and year of the photo on a separate sheet and place picture, slide, or negative in an envelope.) Do not write on photos.**

Photographs included? **1 - Yes** **2 - No**

Schedule 1 DEMOGRAPHIC CHARACTERISTICS

1 - 1 What is the **geographic area** in which this project is delivering and/or promoting health or child survival services? (CIRCLE ONE ANSWER)

1 - The entire country
(2) A geographic area smaller than the entire country
} COMPLETE ITEMS 1-2 THROUGH 1-5

3 - None. The project does not deliver or promote services.
9 - Don't know
} CONTINUE DIRECTLY TO NEXT SCHEDULE

1 - 2 In this space, state the **geographic location** of the project so that areas with project activities may be located on a national map.

Kalagala sub-county)
Zirobwe sub-county) Luwero District

1 - 3 What is the **total population** of the area in which the project is operating? 55,000

1 - 4 Potential Beneficiary Population

Provide the **number of potential beneficiaries** in each age group:

a. 0 - 11 months →	
b. 23 - 59 months 0--59 Months →	10,000 +
c. Women 15 - 44 years →	12,263
d. Other (please specify) _____ →	

Definition: Potential beneficiaries refers to the number eligible to receive services for a given age group. This includes only potential recipients of direct services (i.e., immunizations or family planning).

e. In this space, briefly describe any other target groups on which project services/activities are focused. →

1 - 5 Is the population served living primarily in an **urban** or **rural** area? (CIRCLE ONE)

1 - Primarily urban
(2) Primarily rural
3 - Mixed
4 - Don't know

Schedule 2 DIARRHEAL DISEASE CONTROL

FOCUS AND ACTIVITIES

2 - 1 For the Diarrheal Disease Control component of this project, please indicate if the project sponsored, promoted or participated in each activity during fiscal year 1992.

	Project activity during FY92? Yes	No
a. Community-level education to:		
1. Raise awareness of the dangers of dehydration	Y	N
2. Enable mothers to recognize when prompt medical treatment is necessary	Y	N
3. Encourage proper personal hygiene/food handling practices	Y	N
b. Case management of diarrhea through:		
1. Promotion of home-based practices:		
- recommended home fluids	Y	N
- sugar/salt solutions	Y	N
- continued breastfeeding during diarrhea	Y	N
- other appropriate feeding during and after diarrhea	Y	N
2. Promotion/Distribution of ORS packets	Y	N
3. Strengthening referral mechanisms for severe cases	Y	N
c. Upgrading of clinical services including the rational use of drugs	Y	N
d. Training		
1. Training of health care professionals	Y	N
2. Training of outreach workers (TBAs, traditional healers, community health workers)	Y	N
e. Other activities		
1. Improved disease surveillance systems	Y	N
2. Improved water or sanitation	Y	N
3. Other (specify) _____	Y	N

ADDITIONAL BACKGROUND INFORMATION

2 - 2 Please provide any other background information which would enable us to better understand the unique nature of the project's diarrheal disease component including any activities not identified above, specific lessons learned, special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary).

CHILD SURVIVAL INDICATORS

2 - 3 What is the ORT use rate in the project area?

a. ORT use rate ——→ [ ]

b. Date(mo/yr) data was collected ——→ [ ]

c. Source of the data used to make the estimate [*DC BG DK]

The definition of ORT use rate is "the proportion of episodes of diarrhea in children under five treated with ORT (oral rehydration recommended by MOH)." In many countries it is generally estimated as the proportion of diarrhea episodes occurring in the last two weeks treated with ORT."

d. If a data collection system was used, please describe it. Please give the name of the agency responsible for the system (MOH, WHO, UNICEF), its scope (national or project area specific), its permanence (special study or ongoing monitoring system), the methodology used (sample survey, clinic-based statistics, village-based statistics, and the computational procedure (weighting in a sample, weighting of data from clinics or villages, etc.).

* Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

Schedule 3 IMMUNIZATION

FOCUS AND ACTIVITIES

3 - 1 For the Immunization component of this project, please indicate if the project sponsored, promoted or participated in each activity during fiscal year 1992.

	Project activity during FY92? Yes	No
a. EPI promotion and services		
1. Activities directed to promote use of services	Y	N
2. Delivery of vaccination services through:		
- Mass campaigns	Y	N
- Fixed centers	Y	N
- Mobile vaccination teams	Y	N
- Outreach and follow-up services	Y	N
3. Vaccination of women with tetanus toxoid	Y	N
4. Vaccination against measles	Y	N
b. Training		
1. Training of health care professionals	Y	N
2. Training of outreach workers (TBAs, traditional healers, community health workers)	(Y)	N
c. Other activities (village health committees)		
1. Improved surveillance for vaccine preventable diseases	Y	N
2. Equipment and training for improved cold chain	Y	N
3. Other (specify) _____	Y	N

ADDITIONAL BACKGROUND INFORMATION

3 - 2 Please provide any other background information which would enable us to better understand the unique nature of the project's immunization component, including any activities not identified above, specific lessons learned, special steps taken to promote long-term sustainability, etc. Due to the newly announced measles initiative, we are particularly interested in hearing about any measles activity undertaken through this project. (Attach additional sheets if necessary).

CHILD SURVIVAL INDICATORS

3 - 3 What is the vaccination coverage rate (see instruction guide for information on definitions) in the project area?

	BCG	DPT3	Polio3	Measles	Tetanus for Women
Percent vaccinated (children by 12 months, or women)					
Date (month/year) data was collected					
Source of information (CIRCLE ONE)	*DC BG DK	*DC BG DK	*DC BG DK	*DC BG DK	*DC BG DK

d. If a data collection system was used, please describe it. Please give the name of the agency responsible for the system (MOH, WHO, UNICEF), its scope (national or project area specific), its permanence (special study or ongoing monitoring system), the methodology used (sample survey, clinic-based statistics, village-based statistic), and the computational procedure (weighting in a sample, weighting of data from clinics or villages, etc.).

* Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

Schedule 4 NUTRITION

FOCUS AND ACTIVITIES

4 - 1 For the Nutrition component of this project, please indicate if the project sponsored, promoted or participated in each activity during fiscal year 1992.

Demonstration Kitchen Gardens being established in strategic centers.

	Project activity during FY92? Yes	No
a. Breastfeeding		
1. Exclusive breastfeeding for first 4 - 6 months	Y	N
2. Initiation of breastfeeding within 1 hour after birth	Y	N
3. Increased duration of breastfeeding	Y	N
4. Continued breastfeeding during diarrhea	Y	N
5. Development of support groups or mechanisms for home visitation to counsel and assist mothers	Y	N
6. Revised policy for hospitals and maternity centers	Y	N
7. Policy dialogue in support of a favorable environment for breastfeeding	Y	N
b. Weaning and child feeding		
1. Community education for proper child feeding practices	Y	N
2. Emphasis on correct feeding during and after diarrhea and other infections	Y	N
3. Development and promotion of locally acceptable weaning foods	Y	N
c. Growth monitoring		
1. Use of growth monitoring as a tool for counseling mothers	Y	N
2. Use of growth monitoring as a means of nutritional status surveillance	Y	N
3. Strengthening of health worker skills in growth monitoring and counseling	Y	N
d. Vitamin A and other micronutrient deficiencies		
1. Assessment of levels of vitamin A deficiency	Y	N
2. Case detection and treatment of vitamin A deficiency	Y	N
3. Vitamin A supplements for children and/or post partum women	Y	N
4. Inclusion of vitamin A in treatment of measles	Y	N
5. Communication activities to promote increased dietary intakes	Y	N
6. Food fortification	Y	N
7. Home and community gardens	Y	N
8. Iron and folate supplements for women of reproductive age	Y	N
e. Training		
1. Training of health care professionals	Y	N
2. Training of outreach workers (TBAs, traditional healers, community health workers)	Y	N
f. Other _____	Y	N

SUPPLEMENTAL FEEDING TARGET GROUPS

4 - 2 If the project sponsored supplementary feeding during FY92, which groups were targeted? (CIRCLE ALL THAT APPLY)

1 - All ages
2 - Children under 12 months
3 - Children 12 - 23 months
4 - Children 24 - 35 months
5 - Children 36 - 60 months
6 - Pregnant or lactating women
7 - Other women
8 - Other _____
9 - None
10 - Don't know

ADDITIONAL BACKGROUND INFORMATION

4 - 3 Please provide any other background information which would enable us to better understand the unique nature of the project's nutrition component including any activities not identified above, specific lessons learned, special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary).

CHILD SURVIVAL INDICATORS

4 - 4 a. What is the **rate of malnutrition** in the target group served by the project?

Definition: Rate of malnutrition is "the proportion of children whose weight-for-age is below two standard deviations of the norm established by the National Center for Health Statistics (the norm endorsed by the World Health Organization)."

	Group 1	Group 2	Group 3	Group 4
Target group →	Children 0-11 months	Children 12-23 months	Other Specify_____	Other Specify_____
Estimate rate of malnutrition →				
Date (month/year) of estimate →				
Source of information (CIRCLE ONE)	*DC BG DK	*DC BG DK	*DC BG DK	*DC BG DK

*Source Codes: DC: Data Collection Systems; BG: Best Guess; DK: Don't Know

b. If a data collection system was used, please describe it. Please give the name of the **agency** responsible for the system (MOH, WHO, UNICEF), its scope (national or project **area** specific), its **permanence** (special study or ongoing monitoring system), the **methodology** used (sample survey, clinic-based statistics, village-based statistic), and the **computational procedure** (weighting in a sample, weighting of data from clinics or villages, etc.).

Schedule 5 HIGH RISK BIRTHS

FOCUS AND ACTIVITIES

5 - 1 For the High Risk Birth component of this project, please indicate if the project sponsored, promoted or participated in each activity during fiscal year 1992.

	Project activity during FY92? Yes	No
a. Community education to:		
1. Raise awareness of the importance of preventing high risk births	Y	N
2. Promote modern contraceptive methods for child spacing	Y	N
3. Promote breastfeeding as a method for child spacing	Y	N
4. Promote other natural family planning methods	Y	N
b. Strengthening of service delivery by:		
1. Developing a system to identify and refer high risk women for family planning services	Y	N
2. Training medical staff in clinical and counseling skills for child spacing methods	Y	N
c. Activities specifically directed at one or more of the following high risk groups:		
1. Women under age 18	Y	N
2. Women age 35 or older	Y	N
3. Women who have given birth within the previous 24 months	Y	N
4. Women with 4 or more children	Y	N
d. Training		
1. Training of health care professionals	Y	N
2. Training of outreach workers (TBAs, traditional healers, community health workers)	Y	N
e. Other _____ (please specify)	Y	N

ADDITIONAL BACKGROUND INFORMATION

5 - 2 Please provide any other background information which would enable us to better understand the unique nature of the project's high risk birth component including any activities not identified above, specific lessons learned, special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary).

CONTRACEPTIVE PREVALENCE RATE

5 - 3 What is the Contraceptive Prevalence Rate in the project area?

a. Contraceptive prevalence rate in area	
b. Date(mo/yr) data was collected	
c. Source of the data used to make the estimate	*DC BG DK

The definition of Contraceptive Prevalence Rate is: "the proportion of women aged 15 - 44 years, or in some countries, 15 - 49 years, in union or married, currently using a modern method of contraception."

* Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

d. If a data collection system was used, please describe it. Please give the name of the agency responsible for the system (MOH, WHO, UNICEF), its scope (national or project area specific), its permanence (special study or ongoing monitoring system), the methodology used (sample survey, clinic-based statistics, village-based statistic), and the computational procedure (weighting in a sample, weighting of data from clinics or villages, etc.).

Schedule 6 HIV/AIDS ACTIVITIES

6 - 1 Does this project provide funding or otherwise support activities in HIV/AIDS prevention? ____ YES _X_ NO

If your answer is YES, please use the table below to define the scope of the HIV/AIDS activities supported under this project. Provide your data in columns B through G on the basis of the Activity Categories identified in Column A.

Column B Attribute to each specific Activity Category the corresponding percent from the total FY92 obligations to HIV/AIDs programs as listed in Question 9j of the main schedule. Column B should add to 100%.

Column C Estimate the percent of resources supporting research for each activity reported in Column A.

Column D From page 1, please list the organizations which were involved in HIV/AIDS activities supported under this project. Abbreviate if necessary.

Column E Use the numbers corresponding to Target Population descriptions as appropriate for each activity.

Column F Indicate by Y or N (Yes or No) whether activities listed in Column A are community-based with target community involvement in the design, implementation, and/or evaluation of the activities.

Column G Please cite the number of individuals reached by prevention efforts in each activity area. Use your best guess if no data has been collected for this variable.

A Activity Category	B % of AIDS Attribution	C % Research	D Organizations Supported	E Target Population	F Community-based	G Nos. Reached FY92
BER						
CSP						
CPD						
PNR						
STD						
PDM						
OA1						
	100%					

ACTIVITY CATEGORY CODES:

BER - Behavioral Research
CSP - Condom Supply
CPD - Condom Protection and Distribution
PNR - Partner Number Reduction
STD - STD Management and Control
PDM - Policy Dialogue/Modeling
OA1 - Other (please specify)_____

TARGET POPULATION CODES:

1 - General Public
2 - Community Leaders
3 - Children (0-8 years)
4 - Youth (9-14 years)
5 - Female Sex Workers
6 - Male Sex Workers
7 - Other Women at Risk
8 - Other Men at Risk
9 - IV Drug Users
10 - Health Service Providers
11 - STD Patients
12 - Other (please specify)_____

6 - 2 The AIDS Division of R&D/Health needs descriptive information on all Mission sponsored HIV/AIDS programs for the Agency's Report to Congress. We would encourage you to attach to this questionnaire a brief but comprehensive description on the HIV/AIDS programs your Mission sponsors. Providing this information now would eliminate the need for further requests for such summaries.

Schedule 7 OTHER HEALTH AND CHILD SURVIVAL ACTIVITIES

This schedule is designed to record information about health and child survival interventions other than those identified in schedules 2 through 6

IDENTIFICATION OF OTHER HEALTH AND CHILD SURVIVAL ACTIVITIES

7 - 1 What type(s) of "other" health and child survival interventions received funding or other support through this project? (CIRCLE ALL THAT APPLY)

1 - Acute Respiratory Infection (**answer 7 - 3**)
2 - Maternal Health (**answer 7 - 4**)
3 - Health Care Financing (**answer 7 - 5**)
4 - Malaria (**answer 7 - 6**)
5 - Water and Sanitation
6 - Elderly/Adult Health
7 - Prosthetics
8 - Tuberculosis
9 - Other (please specify)_____

7 - 2 Please provide any other background information which would enable us to better understand the unique nature of the project's other health and child survival activities, including those not identified above, any specific lessons learned, any special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary).

FOCUS AND ACTIVITIES

For the interventions specified, please indicate which of the following activities are major elements of the **life-of-project** implementation strategy (in terms of project funds and human resources committed for this intervention); and 2) whether or not the project sponsored, promoted or participated in each activity during **fiscal year 1992.**

PLEASE ANSWER 7 - 3 ONLY IF YOU CIRCLED "1 - Acute Respiratory Infection" IN RESPONSE TO 7 - 1.

7 - 3 **Acute Respiratory Infection Strategies**	Project activity during FY92? Yes	No
a. Community-level education to:		
1. Raise awareness of the dangers of acute respiratory infection	Y	N
2. Enable mothers to recognize when prompt medical treatment is necessary	Y	N
b. Case management of respiratory infection:		
1. Training of clinical staff in case management and treatment	Y	N
2. Training of community workers in case management and referral	Y	N
3. Provision of equipment and timers for diagnosis	Y	N
4. Provision of appropriate drugs for pneumonia treatment _____ (specify drugs)	Y	N
5. Education of health staff and pharmacists to encourage rational use of antibiotics	Y	N
c. Other _____ (please specify)	Y	N

ANSWER ONLY IF YOU CIRCLED "2 - Maternal Health" IN RESPONSE TO 7 - 1.

7 - 4 Maternal Health Strategies	Project activity during FY92? Yes	No
1. Communication activities to increase women's healthy practices during pregnancy, and use of prenatal care and maternity services	Y	N
2. Training and equipment for traditional birth attendants (TBAs), midwives, and other health workers:		
- training in screening and referral of high-risk pregnancies	Y	N
- training in life-saving delivery skills	Y	N
- provision of safe delivery kits	Y	N
3. Strengthening referral systems between TBAs, health centers, and hospitals	Y	N
4. Integration of maternity care with family planning	Y	N
5. Treatment of infections, especially sexually-transmitted diseases	Y	N

ANSWER ONLY IF YOU CIRCLED "3 - Health Care Financing" IN RESPONSE TO 7 - 1.

7 - 5 Health Care Financing Strategies	Project activity during FY92? Yes	No
1. Fees for health services	Y	N
2. Income generation to support project activities _____ (please specify)	Y	N
3. Other _____ (please specify)	Y	N

ANSWER ONLY IF YOU CIRCLED "4 - Malaria" IN RESPONSE TO 7 - 1.

7 - 6 Malaria Strategies	Project activity during FY92? Yes	No
a. Prevention		
1. Public education to:		
- increase awareness of malaria and methods of prevention	Y	N
- enable mothers to recognize when and where to seek treatment	Y	N
2. Prevention of disease transmission through:		
- personal protection methods (impregnated bednets, etc.)	Y	N
- vector control (against adult mosquitos, against larvae, etc.)	Y	N
- environmental management	Y	N
b. Case management of malaria		
1. Standardization of protocols for case management	Y	N
2. Training of community workers in case management and referral	Y	N
3. Training of clinical staff in case management and treatment	Y	N
4. Provision of antimalarial drugs	Y	N
c. Other _____ (please specify)	Y	N