HealthPartners
Uganda Health Cooperative
Plot 2, Ibis Vale, Off Prince Charles Drive, PO
Box 27659, Kampala, Uganda
Tel: 256-41-342353 Fax: 256-41-258678

HealthPartners
Uganda Health Cooperative Child Survival
First Annual Report for 2005-2006

October 31, 2006

Program Area: Bushenyi District, Uganda
Cooperative Agreement: GHS-A-00-05-00031-00
Program Dates: September 30, 2005 – September 29, 2010

Subject: Child Survival and Health Program

Authors and Reviewers:
Scott Aebischer, HQ Backstop
Jennifer Wenborg, HQ Program Manager
Joy Batusa, Field Program Manager
Lydia Kiwanuka, Administrator
Grace Karungi, Health Services Trainer
Dorah Musiimire, Community Educator

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Abbreviations and Acronyms

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

CHGP Data Form

Child Survival and Health Grants Program Project Summary

Oct-13-2006

Health Partners (Uganda)

General Project Information:

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

Field Program Manager Information:

Name:	Rebecca Joy Batusa
Address:	Plot 2, Ibis Vale Kampala
Phone:	256-41-342353
Fax:	256-41-258678
E-mail:	rjbatusa@psiu.co.ug

Alternate Field Contact:

Name:	Grace Karungi
Address:	Rwemirokora Ward 3 Bushenyi
Phone:	256-048-543880
Fax:	
E-mail:	gracekrng@yahoo.co.uk

Funding Information:

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

Project Information:

Description:

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

Location:

Bushenyi District, Uganda.

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

General Strategies Planned:

Social Marketing
Private Sector Involvement
Strengthen Decentralized Health System

M&E Assessment Strategies:

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

Behavior Change & Communication (BCC) Strategies:

Social Marketing

Groups targeted for Capacity Building:

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

Interventions/Program Components:

Control of Diarrheal Diseases (25 %)

(IMCI Integration)

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

Malaria (50 %)

(IMCI Integration)

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

Maternal & Newborn Care (25 %)

(IMCI Integration)
(CHW Training)

- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Delay 1st preg Child Spacing
- Integr. with Iron & Folate
- Normal Delivery Care
- STI Treat. with Antenat. Visit
- Control of post-partum bleeding
- PMTCT of HIV

Target Beneficiaries:

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

Rapid Catch Indicators:

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	25	92	27.2%	9.1
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	26	40	65.0%	14.8
Percentage of children age 0-23 months whose births were attended by skilled health personnel	45	95	47.4%	10.0
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	46	70	65.7%	11.1
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	24	24	100.0%	0.0
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	12	18	66.7%	21.8
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	33	43	76.7%	12.6
Percentage of children age 12-23 months who received a measles vaccine	33	43	76.7%	12.6
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	30	95	31.6%	9.3
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	72	95	75.8%	8.6
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	5	64	7.8%	6.6
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	61	95	64.2%	9.6
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	2	95	2.1%	2.9

Comments for Rapid Catch Indicators

A. Program Accomplishments in Year One

HealthPartners goal is to link child survival interventions to prepaid health schemes, building on the existing structure to sustainably reduce morbidity and mortality for WRA and children under 5 in Bushenyi district in rural Uganda. HealthPartners Child Survival strategy is a three tiered approach addressing the Community Social Dimension, Health Service Delivery and strengthening the Local Organizational Dimension. The slogan is "Sustaining a Healthy Community through Partnership." Interventions to improve health status include mobilizing communities on behaviors that have been proven to reduce morbidity and mortality and removing barriers to these behaviors. HealthPartners is working to increase community competence through creating support systems to encourage and maintain key life saving and health improving behaviors and by increasing capacity, and empowering communities, Community Owned Resource Persons (CORPS), leaders and partners to play an active role in improving their health. HealthPartners is working closely with the District Health Service team and the Ministry of Health to provide training and behavior change strategies for improved health service delivery and supervision. The third component of HealthPartners sustainability strategy is to improve the local capacity and viability of health systems. Community participation in planning for health care needs through cooperative prepayment schemes is a key component of HealthPartners plan. Capacity building for partners, members and leaders and the elected board of directors will provide the skills and experience they need to sustain a cooperative health care environment.

In the first year HealthPartners and its NGO affiliate, Uganda Health Cooperative (UHC), greatly increased their capacities in child and maternal health, infectious disease prevention and treatment as well as improving their ability to create partnerships and to design, manage, monitor and evaluate child survival programs in Uganda. Startup activities included hiring and training new staff. The HQ Program Manager attended New Grantee Orientation, the Field Program Manager attended CORE's Qualitative Research Methods Workshop; all field staff attended mentorship training with Africare. UHC staff worked with consultants to learn LQAS methodology and to conduct baseline assessments including KPC, HFA, and ISA. Stakeholders including representatives from the District Health Service team, MOH, hospital administrators and health workers, members of the Uganda Community Based Health Finance Association, scheme leaders, members, community volunteers, local politicians, and NGO and PVO partners, met to learn the results of baseline assessments and to work together to develop the detailed implementation plan. Qualitative assessments were carried out to better understand the barriers to key behaviors in the community and health care settings and to inform the BEHAVE strategy. The HQ Program Manager and the Field Program Manager attended the Mini-University which proved to be a helpful mentorship, networking and capacity building opportunity.

UHC staff worked with partners in Bushenyi district to develop community mobilization plans and a behavior change strategy. Partnerships were established for CORP and Health Worker training, resources for distribution were ordered, and presentation materials, handouts, brochures, posters, and key messages were adapted and translated to

fit the behavior change strategy for Bushenyi district. Tracking processes and forms were developed to record attendance at mobilization and training and to gather feedback from each event in order to learn how to increase intervention impact.

The Uganda Health Information System was reformatted on a Windows platform to reduce the need for costly Oracle licensing, upgrades and support. An installation and training plan was developed to launch the database which will allow providers and scheme managers to track encounters, member history, services, diagnoses, vaccinations and income and loss by cooperatives. The installation date was moved back because the M&E Coordinator who will be primarily responsible for orchestrating use of the data left the project in July. A database administrator will be employed to enter data monthly; however the M&E Coordinator is responsible for making sure that scheme managers, leaders, providers and the board of directors utilize reports to make results based health care decisions. Travel is scheduled for a HealthPartners information services specialist to install UHIS February 2-10, 2007.

Twenty-five Community Owned Resource Persons (CORPS) attended orientation in July, Malaria mobilization training in August and Community IMCI mobilization training in September. These sessions were conducted in partnership with Population Services International, MoH and DDHS in Bushenyi. CORPS began leading mobilization sessions throughout Igara County in August. At the end of the first month of mobilization, 20 CORPS turned in 65 sign-in lists with 2084 signatures! The actual audience from the priority group for these key messages is estimated to have been over 4,000. Participants were skeptical of the repercussions of signing their names to a list so many refused. Fifty-seven feedback forms were turned in and many lessons were learned about what worked well for CORPS and what kind of support was still needed.

To launch interventions in the health services dimension, UHC worked with the Ministry of Health in August to develop a barrier analysis tool in order to establish a behavior change strategy for improving maintenance of essential stock supplies at health facilities in Igara County. Barrier analysis was a new approach for the MOH; they were intrigued by the concept and enthusiastically partnered with UHC to help fine tune and implement the tool. The MOH continues to work with UHC on the follow up of assessing results and developing the behavior change strategy.

In September UHC partnered with the three facilitators from the Ministry of Health and three from the DDHS to conduct IMCI training for health workers. The workshop was opened by the deputy DDHS and closed by the Chairman LC5. Twenty five health workers from NGO and Government facilities in Igara County attended. Daily evaluations were collected to assess retention of key points and facilitator meetings were held each evening to review and plan for the following day. Pre and post test were filled out by all attendees and showed excellent improvement. UHC is working with the DDHS to plan IMCI follow up and supervision schedules.

A manual was developed for the UHC Board of Directors to orient members and to facilitate initial activities. The manual includes the Mission, Vision, Background, Roles

and Responsibilities, Work plan for 2007, Timeline for 2007, Agenda for the First Board Meeting, Self assessment forms and proposed Bye-Laws. The first Board of Directors meeting was held in early October and Board members played a large role in the First Annual General Meeting for UHC members also held in October.

All project activities have progressed according to the Work Plan in the original DIP with the exception of UHIS database installation which has been postponed until February 2007 and stock supply training which was replaced with barrier analysis first in order to plan a targeted behavior change strategy for overcoming barriers to maintaining essential supplies.

Key Activities

Project Objectives	Key Activities for Interventions	Status of Activities
Reduce incidence of malaria in Bushenyi district for children under 5 and pregnant women	▪ Prepare CORP orientation ▪ Prepare Malaria CORP training ▪ Prepare resources, materials and partnerships for mobilization ▪ Order ITNs ▪ Develop ITN distribution Plan ▪ Conduct Malaria CORP training ▪ Develop M&E tools for mobilization ▪ IMCI training for health workers	▪ Completed preparation for training and education ▪ Conducted orientation for 25 CORPS ▪ Conducted Malaria training for 24 CORPS ▪ CORPS conducted 52 mobilization sessions with 2084 attendance signatures received ▪ Began ITN distribution according to plan. ▪ ITN distribution: -18 free to pregnant wm -32 free to CU5 -22 sold to members -17 sold to non-members ▪ Revised ITN distribution plan to overcome challenges. ▪ Completed M&E tools for Malaria ▪ Partnered with MOH and DDHS to hold IMCI training for health workers
Reduce incidence of diarrhea in Bushenyi district for children under 5	▪ Prepare Diarrhea training materials. ▪ Establish partnership for training. ▪ Conduct CORP training. ▪ Monitor/observe CORP led mobilization.	▪ C-IMCI training including diarrhea prevention, sanitation and hygiene conducted by UHC, MOH (3) and District Trainers (3). ▪ 23 CORPS attended. ▪ So far CORPS have conducted 48 sessions with 1,326 attendance signatures, 26 additional sessions/dates are scheduled ▪ Distributed C-IMCI charts to CORPS to help facilitate mobilization ▪ Observing CORP led session has been challenging due to lack of advance notice and transport. Plans for sessions have been turned in by CORPS and UHC staff is working on scheduling transport to ensure observation.

Increase % of pregnant women receiving improved ANC, delivery and post partum care	▪ Prepare training plan and materials for CORPS. ▪ Conduct CORPS training ▪ Monitor CORP sessions	▪ Prepared training plan for CORPS. ▪ Prepared ANC training plan for CORPS. ▪ On schedule to conduct education and to monitor sessions.
Build local organizational capacity to manage health schemes	▪ Disseminate baseline assessment results ▪ Conduct DIP workshop ▪ Prepare for first annual general meeting ▪ Conduct first training for BOD.	▪ Held stakeholder workshop to disseminate baseline results ▪ Conducted DIP workshop, collected feedback ▪ Disseminated final DIP ▪ First training for BOD was enthusiastically received. Members are engaged, eager to learn and understood concepts well. Plans for AGM complete-scheduled Oct. 22 ▪ Plans for 1st Annual CS Stakeholder Workshop complete-schedule Oct. 23. ▪ Scheduled travel for Backstop to attend AGM and Stakeholder workshop.
Improve health care management especially for WRA and children under 5	▪ Reduce incidents of stock outs ▪ Improve use of IMCI and SCM ▪ Improve ANC ▪ Improve postpartum care ▪ Improve delivery and use of AMTSL ▪ Improve self assessment ▪ Build relationship between DDHS, Providers and Community	▪ Completed preparation for training and education ▪ Worked with MOH to develop barrier analysis to inform behavior change strategy to maintaining essential stock—still in progress. ▪ Conducted IMCI training for 25 HWs. District officials attended. Post tests showed great improvement. ▪ Working with DDHS and MOH to schedule follow up and supervisory visits ▪ DDHS, Providers and community are increasingly working together through UHC events. ▪ On schedule to complete AMSTL, delivery and post partum training preparations in time to conduct training according to original work plan. ▪ STI/HIV AIDS training plan on schedule—in development. ▪ Self Assessment training plan on schedule—in development.

Technical Interventions

Technical Intervention	Key Activities in Technical Interventions	Status of Activities

CSHGP Orientation	Short sessions on Preparing the DIP, Role of the Backstop, Administrative and Financial Management, Program Design M&E, BEHAVE, technical tips, mentoring and networking.	Program Manager completed October 2005.
Qualitative Methods	CSTS Qualitative Research Methods Workshop in Kenya	Director completed training December 2005.
BEHAVE training	BEHAVE mentorship training with AFRICARE	UHC staff completed February 2006
Staff Capacity Building	DIP Workshop for Staff	Pretest, training and post-test Completed May 2006
Mini-University	Short technical sessions on behavior change strategy, CSSA, M&E. Networking and opportunities to learn from other programs.	Field and HQ program manager Completed June 2006
Field Guide Discussions for UHC growth assessment	UHC Growth Assessment Survey to assess health and health seeking behaviors, understanding/knowledge of health plan concept, learn barriers to joining.	Completed June 2006. Lessons learned were implemented in marketing manager training to develop more effective messages and interventions.
Qualitative study	A qualitative study was conducted to fill in gaps from baseline assessments.	Qualitative Study on the Practices and Their Behavioral Determinants among Women and Men and Health Workers in Bushenyi Completed July 2006
Barrier Analysis	Barrier Analysis Training for Staff	Completed August 2006
Staff Capacity Building	Malaria, Diarrhea, Sanitation and Hygiene, C-IMCI training for staff	Completed August 2006 September 2006
Database design	UHIS platform upgrade	Completed September 2006
Cooperative Registration	UHC applied for Registration Status with the Republic of Uganda Registrar of Cooperative Societies	UHC received a legal Certificate of Registration by the Registrar on September 15, 2006. Being recognized formally by the Government of Uganda is an important milestone for sustainability.
UHC Board of Directors Manual	Manual was developed as a tool for board capacity building.	Completed September 2006. First meeting/training held in October.
Database design	UHIS reports upgrade	3/11 Reports need additional parameter selection capabilities. To

		be completed by Nov 2006.
Database implementation	UHIS Installation and Training Plan	Installation and training postponed due to lack of M&E staff. Rescheduled for February 2007.
Improve staff communication & reporting	Increase mentorship training on reporting expectations and feedback. Implemented staff bonus for signing new scheme members and penalty for turning in late reports.	Reporting detail and accuracy improved. Marketing stages were defined to facilitate better communication and understanding of priorities and goal setting. The first month after penalty was implemented 50% of staff had reductions. Thereafter reports have been on time, thorough and show improvement in strategic planning for activities.

B. Factors that have impeded progress toward achievement of overall goals and objectives and actions being taken to overcome constraints:

Challenge: M&E Coordinator left the program in July; he had transferred from the capital city of Kampala to rural Bushenyi for the position and the move did not work for his family.
Action being taken: A search for a new M&E Coordinator is under way; it has been difficult to find someone with the skills needed for this position who resides in Bushenyi. UHIS database installation was postponed because this key position needs to be in place for training. The CE and HST have done an excellent job implementing M&E tools, collecting signatures and feedback from education and training, and writing reports detailing results of each major event. Their monthly reports also capture important monitoring information. Still, the M&E position must be filled by November in order stay on schedule for stakeholder capacity building. This role will become imperative in February as the first Phase nears its completion and LQAS, HFA, ISA and self assessments need to be carried out. A full scale search will continue in order to fill the M&E position by November.

Challenge: Lack of transportation is a problem on all program levels: Staff have difficulty traveling to the field to monitor CORP mobilization, CORPS have difficulty traveling to groups to conduct mobilization, CORPS have difficulty traveling to UHC training, and Scheme Marketers find it difficult to travel to potential groups. Transportation is expensive and options are limited.
Action being taken: The program has one vehicle and one motorcycle: staff is working to improve coordination of pick ups and drops offs by scheduling appointments and travel in advance.

Challenge: UHC utilized baseline results to develop and prioritize an eight month phase structure addressing specific interventions each month. The purpose of this approach was to provide clear messages and reliable schedules for staff, partners and the community. By focusing on one county at a time UHC is able to concentrate their efforts, gain

feedback, learn what works and what can be improved and can increase the impact of interventions in later phases. UHC worked closely with partners to develop behavior change strategies and messages for each month. In order to take advantage of existing curricula and materials and in an effort to work around community health events and other general events for scheduling, flexibility is needed in the intervention structure.
Action being taken: UHC is working with partners to adapt materials and the training schedule to fit the needs of the community. For example, instead of conducting CORP training solely on interventions for diarrhea, UHC worked with partners to provide C-IMCI training and materials to CORPS. This training included more than just diarrhea prevention and treatment and required additional training time. CORPS were given two months to conduct C-IMCI mobilization in order to allow sufficient time to work with the community on these the behavior change activities.

In November/December 2006, Uganda celebrates National Child days by scheduling immunization, deworming and other events at health centers and community locations. CORP and HW training will take place before these events and a schedule has been developed for CORPS and scheme managers to conduct mobilization at these events. By taking advantage of this opportunity and being flexible with the intervention structure both CORPS and HWs will be able to reach greater numbers of the target population with key messages.

UHC has decided to keep the eight month structure of intervention topics with the understanding that this monthly schedule can be flexible according to the resources available and the needs of the community. The seventh month will still be used for LQAS, HFA, ISA and self assessment to monitor impact and the eighth month will be reserved for training, workshops, updating materials and revising plans for full coverage of all interventions.

Challenge: Demand for ITNs in Igara County is greater than UHC can manage according to the original plan. The message that ITNS should be free to everyone has reached deep into the district. MOH policy is free ITNs for pregnant women and CU5 however MOH supplied nets are not available in Bushenyi. UHC planned to distribute free nets to all attendees at CORP-led malaria mobilization sessions however demand was greater than could be met. Confusion of masses looking for free nets was a great distraction from mobilization.
Action being taken: UHC scheme managers distribute ITNs at health centers in the district. Pregnant women and CU5 receive free nets at ANC visits or at the time of delivery. ITNs may be purchased at these locations by scheme members at a discount (10,000 USH) or by non-members for 12,000 USH. ITN distribution and sales are closely tracked with revenue from nets sold being used to purchase additional ITNs. UHC is working with the Uganda Malaria Control Program and has been able to incorporate materials generated from this group in the BCC strategy including: posters and hand outs on first line antimalarial treatment for uncomplicated malaria, fact sheets on malaria in Uganda, information on the new malaria treatment policy, information on indoor residual spraying, posters on malaria in pregnancy, ITNs, malaria danger signs and malaria treatment. Under the US President's Malaria Initiative, AFFORD is seeking proposals

for organizations with existing avenues for free ITN distribution to pregnant women and CU5. Bushenyi district in not included in the first round of distributions but partners have given UHC advance notice that Bushenyi will be included in the second round. UHC has completed application forms to be included in this opportunity to procure ITNs for free distribution.

Lessons learned from CORP education and mobilization include: More training on how to conduct effective mobilization sessions is needed for CORPS. They knew the key points that they were to convey but some were not able to or lacked confidence in conducting the sessions. CORPS also need additional training on how to administer feedback forms. Events held at churches are more widely attended and churches are happy to work with CORPS to provide this benefit to their communities. Sessions held at health centers are the second most commonly attended. Mobilization attendance improves on weekends. DDHS and political leaders have been cooperative and are eager to join sessions. Some CORPS did not schedule any meetings and some said they did but did not. CORPS have been demanding about wanting to be paid for their time and transport.
Result: Additional training and opportunities to practice mobilization were added to help CORPS build their skills and confidence in conducting sessions and gathering feedback. CORPS are encouraged to partner with churches and health centers and to plan mobilization for weekends when possible. CORPS are also encouraged to invite representatives from the DDHS, political and other leaders to join mobilization. All CORPS were recognized at the First Annual Stakeholder workshop and certificates were given to encourage their continued participation. Outstanding CORPS were given a small token of appreciation. This event was used as an opportunity to encourage volunteerism and to reinforce why partnership is the key "to sustaining a healthy community." Additional CORPS are being recruited to replace those who lose interest. Participants in the AGM and Stakeholder workshop were encouraged to become CORPS and/or to encourage their friends to help with this and other important volunteer work. Scheme managers have reported member interest and at times complaints about CORPS—in response to this they have encouraged these people to become CORPS themselves.

C. Technical Assistance is required in …

- Board of Director Capacity Building
- Additional training in Monitoring and Evaluation and Operations Research
- Independent financial analysis of UHC operations and membership to aid in setting appropriate milestones for sustainability.

Training Plan for Year 2	*Month*	*Personnel*
Annual Child Survival stakeholder workshop and **Annual UHC General Meeting**-increase capacity of all stakeholders in order to build toward sustainability. Increase understanding of how the health plan works; prepare for gradual transition of health plan activities to leaders, district	October 2006	All UHC staff, Program Backstop

health team, CORPS, other volunteers; build credibility and capacity of Board of Directors. Recognize outstanding leaders and volunteers to increase volunteerism.		
CSHGP Backstop Institute Program Design, Monitoring and Evaluation-Sustainability training to build capacity of local staff in program design, management, M&E.	December 2006	UHC Program Administrator
Budget and Financial Management- Consultant training on cooperative financial management and balancing budgets.	January 2007	UHC staff, UHC BOD
LQAS Methodology Online Course Training-Capacity building for staff to increase understanding of data collection considerations and importance and use of accurate data.	February 2007	UHC staff and Intern
Community mobilization by CORPS-implement behavior change strategies	Weekly	Community
CORPS training-behavior change, increasing community capacity to reduce morbidity and mortality	Monthly	CORPS
BOD Sustainability Training-training in scheme and budget management, understanding data and applying lessons learned to programmatic approach.	October 2006, January, April, July 2007	M&E Coordinator, BOD, Scheme Managers, Field Manager
CORE and CSTS Capacity Building-training for UHC staff as recommended by supervisors and as child survival intervention and technical courses become available.	TBD	UHC Staff
Operations Research-training to prepare project managers to develop and test subsidized prepaid health care options to cover basic health services for the most vulnerable populations of WRA and CU5	TBD	UHC Director, Backstop, M&E Coordinator

D. There are no **substantial changes** from the project description and DIP that would require modification to the Cooperative Agreement. The following minor change was made.

- Using the term DHE was confusing for the District Health Officials because they use this title for paid staff. Thus DHE's are now referred to by the local term Community Owned Resource Persons or CORPS.

E. Use the project's monitoring plan to **describe progress, gaps and the programmatic responses** proposed (i.e. how data are being used for monitoring.)

Monitoring using LQAS, HFA, ISA and self assessments will take place at the end of each implementation phase; the first time this monitoring data will be collected is February 2007 as scheduled in the DIP work plan. An intern interested in public health and international development will finance her own travel and accommodations in order to visit the program for 6 weeks to observe and assist UHC with this process.

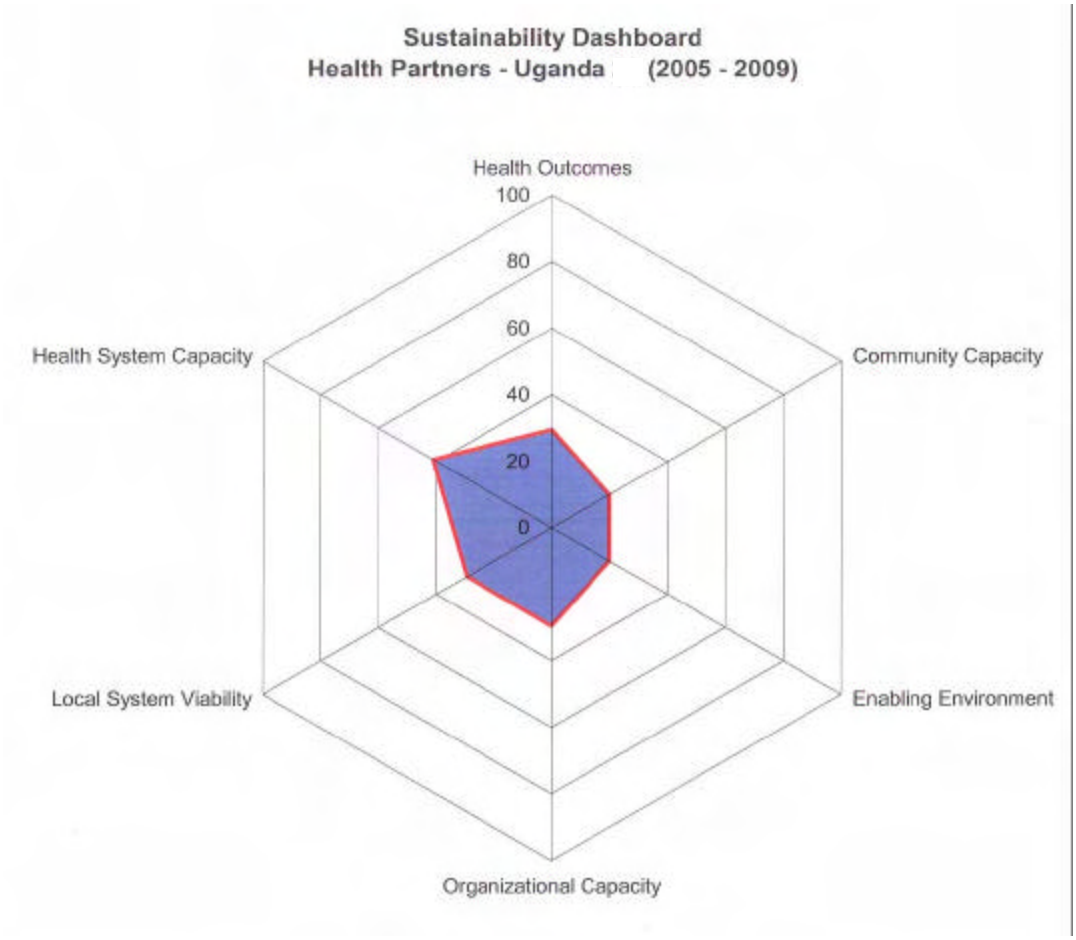
The M&E Coordinator left the project in July 2006 and a replacement has yet to be found. The HST and CE have taken responsibility for writing detailed training reports (see Annex A & B) and ensuring accurate records each month by collecting signatures and feedback forms from CORP and HW training, and collecting signatures and feedback forms from CORP led mobilization sessions. The UHC Field Manager is responsible for updating the ITN distribution log which details ITNs distributed to pregnant women, for children under 5, and those sold to members and non-members. Shillings collected from ITN sales are used to purchase additional nets. When staff have not turned in shilling amounts to match their distribution/sales, this amount has been withheld from their salary. The UHC accountant cross checks the ITN distribution log with stock supplies of ITNs and shillings received to verify accounts each month.

All staff are responsible for submitting detailed monthly reports including qualitative and quantitative data. Reports are reviewed by their direct supervisors and discussed in monthly meetings. Copies of these reports are filed in the Ishaka UHC office, and emailed to HQ and Kampala offices. Reports are used in the field to facilitate mentorship and learning opportunities, for setting goals, and for general monitoring. Reports are used by HQ and Field program managers to mentor staff who have direct reports, to plan capacity building/training opportunities and to inform programmatic and strategic changes.

To date monitoring has not been greatly hindered by the absence of the M&E coordinator however once UHIS is installed, the Board of Directors are ready for capacity building and Phase I monitoring data collection begins this role will be vital.

F. **Sustainability Plan**: steps taken, targets reached or to be reached, and constraints to date.

Since the core goal of UHC is to build a sustainable child survival program, the child survival sustainability framework was utilized in the program design from its inception. Baseline assessments were conducted in January 2006 and data was entered into SUSPRO. The baseline sustainability dashboard can be seen below.



LQAS, HFA, ISA and self assessment monitoring is scheduled every 8 months of the project beginning at the end of Phase I in February 2007. In March 2007, monitoring data will be entered in SUSPRO as midterm data to allow stakeholders to visually compare project impact from baseline and Phase I results. This will not be the official midterm data. At the end of Phase II monitoring results will replace Phase I data again giving stakeholders a snapshot of progress to date. Actual midterm data will be collected at the end of Phase III. This data will be entered and saved as midterm data in SUSPRO. At the end of Phase IV, and V, monitoring data will be entered in the Final data category. This will be helpful for stakeholders but will ultimately be replaced by the actual Final data from the project.

The transformation report from SUSPRO (below) shows indicator scales. The tools listed for indicators that do not currently have ranges will be explored as options to self assessments and field guide discussions that were planned to capture this data. The tools that are implemented in February 2007 will be used thereafter to ensure comparative data.

Transformation - Report					
Health Partners - Uganda (2005 - 2009)					
Indicator	Poor	Emerging	Interm	Promising	Strong

Absence of dependency on external financial support (HICAP)	-	-	-	-	-
Access to Improved Toilet (KPC)	0	21	41	61	81
Access to Improved Water Source (KPC)	0	21	41	61	81
Administration of financial resources (OCTAGON)	-	-	-	-	-
Antenatal care coverage (KPC-CATCH)	0	21	31	41	51
Application of a clear division of duties and responsibilities (OCTAGON)	-	-	-	-	-
Budget review (HICAP)	-	-	-	-	-
Caretaker knowledge of child management (BASICS-26)	0	21	41	61	81
Community Consciousness (HCP)	-	-	-	-	-
Counseling on continued feeding (BASICS-20)	0	21	41	61	81
Financial Management Capacity (HCP)	-	-	-	-	-
Financial sustainability A (OCAT)	-	-	-	-	-
Hand washing - 2 of 4 critical times (NEW CATCH)	0	21	31	41	51
Health facility has IMCI chart booklet and mothers' counseling cards (WHO-S18)	0	21	41	61	81
ITN use (KPC-CATCH)	0	21	41	61	81
Leaders Accountability and Decision Process (HICAP)	-	-	-	-	-
M&E data inform decision (HICAP)	-	-	-	-	-
Malaria prophylaxis in pregnancy (KPC-CATCH)	0	21	41	61	81
ORT use (KPC-CATCH)	0	21	31	41	51
Program reporting A (OCAT)	-	-	-	-	-
Safe disposal of stool (KPC)	0	21	41	61	81
Safe Storage for Drinking Water (KPC)	0	21	41	61	81
Skilled birth attendance (KPC-CATCH)	0	21	41	61	81
Stakeholder commitment/ ownership A (OCAT)	-	-	-	-	-
Stock-out of essential drugs in previous month (BASICS-28b)	51	41	31	21	0
Supervision in last 6-12 months (BASICS-24)	0	21	31	41	51
Two week period prevalence of diarrhea (KPC)	50	40	30	20	0
Two week period prevalence of fever (KPC)	50	40	30	20	0

UHC works with a wide range of partners including PVOs, NGOs, health care providers, government health teams, cooperative and health financing groups and community members. Below is the table of Project Partners from SUSPRO.

PROJECT PARTNERS				
Health Partners - Uganda (2005 - 2009)				
Partner	Health Services	Main Local Organization	Community	Other Collaborating Partner
Ministry of Health	✔	✔	✔	
PSI Uganda	✔	✔	✔	
UPHOLD		✔		
Uganda Community Based Health Finance Organization		✔		
AFRICARE		✔	✔	
Uganda Private Midwives Association	✔		✔	
Business PART Project	✔		✔	
Uganda Health Cooperative Prepaid Schemes	✔	✔	✔	
District Director of Health Services	✔	✔	✔	

G & H. The specific **information that was requested** during the DIP consultation was UHC's BEHAVE framework. All baseline data was collected in time for inclusion in the DIP. Behavior change indicators will be monitored and evaluated in accordance with the project's M&E plan as detailed in the DIP.

BEHAVE FRAMEWORK

Broad Behavior Change Goal: Reduce morbidity and mortality of women of reproductive age and children under 5.

Channels of Communication

Church Meetings: CORPS have partnered with churches who have welcomed an opportunity to provide community mobilization and key messages in conjunction with weekly services.

Drama Groups: Drama is popular form of communication and learning in Uganda. UHC works with drama groups to encourage behavior change through skits on issues like who should sleep under and ITN and why and when to go for RCT and why.

CORP Education and Mobilization: Community Owned Resource Persons are selected by their peers and/or volunteer to attend monthly training on preventive health care and key behavior change messages. CORPS work with UHC staff to plan a schedule of community mobilization. They promote their meetings ahead of time and share the lessons they have learned. They follow up regularly with their community groups to answer questions and reinforce behaviors. Each month new key messages are added to the existing ones. New CORPS are encouraged to join at all times and are trained accordingly.

Radio messages: UHC works with Radio West, a local station, to promote health schemes. Health promotion talks support behavior change messages and the Local District Chairman is including promotion of UHC's activities in his regular radio hosting schedule.

Posters: are displayed at churches, community centers and health centre locations. The UHC slogan is "sustaining a healthy community through partnership." Posters are given to CORPS to fill in and post in order to promote their meetings ahead of time. Posters that convey key behavior change messages like, C-IMCI, and "Malaria during pregnancy is dangerous! Support your partner to visit a health facility for malaria preventive medicine and advice" are posted at health centre locations and are given to CORPS to help spread key messages. Some of these posters have been developed by the Ministry of Health and others by NGO partners. Most are written in the local language.

National Immunization and other health event days: UHC staff make a point to plan events around national event days at provider locations. These are great opportunities for CORP led community mobilization and a booth to promote prepaid health plans.

Brochures (see Annex D): explaining how health schemes work and providing key behavior change messages are handed out at UHC marketing events and are used by CORPS in community mobilization.

T-shirts and other promotional items: UHC had t-shirts made with the UHC and USAID logos. On the back is the slogan, "sustaining a healthy community through partnership." T-shirts were given to CORPS in appreciation for their participation and to establish a brand for UHC. HealthPartners sends promotional items like band-aids, pens and logo wristbands to be used as prizes for contests where respondents are asked to answer questions or as incentives for community sanitation and hygiene contests. A few large prizes, like 6 months or a year of cooperative membership were offered at the AGM and stakeholder workshop to encourage continued volunteerism.

BEHAVE FRAMEWORK -- Malaria

Objective: Increase number of pregnant women and children under 5 who sleep under ITN every night.
Indicator: % of children under 2 who slept under an ITN last night. % of pregnant women who slept under an ITN last night.
Summary of Strategy: Critical areas of behavior change are for CORPS and drama groups to encourage regular sleeping under long lasting treated bed nets, especially for pregnant women and infants. UHC will promote ANC and it will be a distribution point for long lasting ITNs for all pregnant women throughout pregnancy and during post-partum period. At the community level and through large targeted groups UHC will promote demand for ITNs and will distribute ITNS free at provider locations to pregnant women per national policy. ITNs will also be available for sale at a reduced price to scheme members at UHC offices. Revenue from ITNs sold through UHC will be used to purchase additional ITNs. Mobilization training will include educating target populations on how to use ITNs appropriately, such as how it should be hung, the importance of peak biting times and who should sleep under the ITNs. All ITNs distributed will be long lasting in order to reduce the need for retreatment. Free ITNs are being made available from the US President's Malaria Initiative to not-for profit organizations in specified districts of Uganda. Bushenyi is not included in the first round of these disbursements but UHC has been informed by partners that Bushenyi will be included in the second round. UHC has prepared an application for procurement of these free nets for distribution through the project.

Audience	Behaviour	Key Factors	Interventions	Key Messages
WRA and caretakers	WRA sleep under ITN with CU5 every night	-Availability, cost -Belief that wage earner or man of house should use net -Fear of suffocation or poisoning	- Increase availability of long lasting ITNs to pg women and CU5 in conjunction with BCC messages -Drama shows to demonstrate proper ITN use -Mobilization to include testimonies of people who	- Free ITNs are distributed to pg women at ANC and at the time of delivery at skilled provider locations -UHC ITNs can be easily recognized and are trustworthy -Mobilization sessions are well planned and easy to attend. They give important information and tools to reduce malaria and save lives of CU5 -Malaria can kill unborn children and CU5. Women and CU5 are 1st priority for sleeping under ITN

			safely sleep under ITNs and who do not get sick -Additional ITNs available for purchase at UHC offices -Display MOH malaria treatment and ITN posters (in local language) in community -Coordinate efforts with MCP and partner events	-ITNs are safe. -ITNs have holes that let fresh air in and keep mosquitoes out. -You save money because you do not spend on treating malaria, buying insecticide sprays and mosquito coils
Pregnant Women	Pregnant women and CU5 sleep under ITN every night	-Availability, cost -Belief that wage earner or man of house should use net -Fear of suffocation or poisoning -Lack of control over decisions	- Distribute free long lasting ITNs to pg women at ANC -CORS mobilization to include BCC messages, drama groups and demonstrations of proper ITN use -Mobilization to men and others to build support for pg women sleeping under ITN	-UHC ITNs are free for pg women at ANC visits. -ITNs are safe. -ITNs have holes that let fresh air in and keep mosquitoes out -UHC ITNs can be easily recognized and are trustworthy -Mobilization sessions are well planned and easy to attend. They give important information and tools to reduce malaria and save lives
Men. Grand-mothers	Support pg women, mothers and CU5 sleeping under ITN every night	-Belief that wage earner or man of house should use net -Lack of understanding about importance for pg women and CU5 sleeping under ITN -Scepticism about how/if they work	-Provide mobilization for men on why it is important for pg women and CU5 to sleep under ITNs -Community leaders and prominent men to be included in mobilization to reinforce msg. and address concerns	-ITNs are not just for the rich, they are for any wise person who wants to keep their wives and children healthy -Men are strong and can recover better from malaria. Pg women and CU5 may die from it; they need to be first priority for sleeping under ITNs -UHC ITNs can be easily recognized and are trustworthy -Mobilization sessions are well planned and easy to attend. Attending sessions will save the lives of women and children. -UHC ITNs are free to pg women and CU5. Additional ITNs can be purchased at UHC offices

CORPS	Promote pg. women, mothers and CU5 sleeping under ITN every night.	-Time and training tools for CORPs to promote desired behaviour. -Access to ITNs -Lack of knowledge to answer ITN questions from community	-Provide ITNs for CORPs to distribute -Partnership w DDHS to commit CORPS time to addressing MCH -CORP education sessions to train key messages to overcome barriers when working with the community	-Mobilizing communities makes a big difference. -CORPS are leaders -Lack of information is not the only reason people may not do what is best for them. Barriers to behaviors need to be addressed to allow people to do the behavior. People need support and follow up to help them change behavior. -UHC greatly respects CORPs -UHC supports CORPs. UHC welcomes questions to help CORPs.
HWs	Promote pg. women, mothers, CU5 sleeping under ITN every night.	-Lack of stock supply -Lack of treatment protocols that include ITN education	-Reduce barriers to keeping ITNs and retreatment kits in stock for free distribution to pg women and CU5. -IMCI training to include ITN education and promotion. -Post MOH malaria in pregnancy and ITN posters at health centre	-Proper ITN usage is KEY to preventing malaria. -Refer patients to the UHC office for ITNs. This will make HW job easier. -Following protocols makes treatment easier and more effective -ITN education for patients

Objective: Increase timely, appropriate malaria treatment for pg women and CU5
Indicator: % of children under 2 and pregnant women w fever in the last 2 wks who received antimalarial treatment
Summary of Strategy: Increasing proper care seeking behavior will be addressed through monthly mobilization including early recognition and care seeking for fever, compliance with prescribed treatment and knowledge of location of HWs in case of severe disease. The Uganda Malaria Control Program has a new policy on the treatment of malaria. UHC will work in collaboration with this program to support the MOH policy and to bring resources and training to the most remote areas in the district as soon as they are available. UHC will also promote appropriate malaria recognition and case management at the provider level. The approach will focus on SCM, including quality of care, access and demand. Quality of care is defined as appropriate assessment and differential diagnosis, classification, treatment (and/or referral) and counseling. UHC will participate in effective training in SCM, supervision of HWs and will assure an adequate supply of the anti-malarial drug of first choice through stock supply planning and monitoring. UHC will work with HWs to improve SCM under IMCI, including care for severely ill and anti-malaria therapy. Health facility stock supply training will include IPT and ITNs and the importance of including these items in ANC.

Audience	Behaviour	Key Factors	Interventions	Key Messages
WRA, caretakers and pg women	Appropriate early care seeking for pg women and CU5 with signs of malaria	-Inadequate knowledge of health practices -Health is not a high priority -Use of herbs and ineffective home remedies -Waiting too long for treatment -Malaria confused with other illness and wrong treatment is given	-Mobilization on early warning signs -Promote early treatment seeking behaviour -Promote health schemes to reduce barriers to seeking HW care	-Early warning signs -Malaria kills if treatment is not started early. Seek immediate treatment on realizing onset of fever in your child -Seek immediate treatment on realizing onset of fever in pregnant woman -By joining UHC members can get care whenever they need it.
Men	Support women seeking early care for malaria in pregnancy and for CU5	-Belief that it is the woman's role to care for child, no need for man to be involved. -Lack of knowledge on increased risks of malaria for pg. women and CU5 -Belief that treatment costs are too expensive	-Mobilization on dangers of not seeking timely care -Mobilization to support women seeking early treatment -Promote health schemes to reduce barriers to seeking HW care -Community leaders and prominent men to be included in mobilization to reinforce msg. and address concerns	-If not treated in time, CU5 easily die from malaria -If not treated in time, pregnant women will lose their child from malaria -By joining UHC members can get care whenever they need it. -Responsible men support their wives and children
CORPS	Mobilize community on early	-Lack of time, tools and organization to	-Update training on recognition of key warning signs	-The community needs the information that you can provide now!!! -You can help save lives by educating, motivating, and

	warning signs and SCM -Build community support for early treatment	visit communities and to follow up on key messages -MOH has developed policy but it will take a long time for roll out to reach Bushenyi	-Update training on appropriate treatment and referral -Partner w DDHS to commit CORPS time to addressing appropriate malaria treatment -Set schedules to allow time for BCC	supporting early care seeking behaviour for treatment of malaria -You can save lives by encouraging men to support women and care for them and their children -People may need repeat visits and support in order to adopt a new behaviour. They need your patience and help.
HWs	Treat women and children according to IMCI and SCM	-Stock outs -Low morale -Not enough HWs -Inadequate knowledge on disease differentiation and SCM -Lack of recent training -Lack of supervision -Lack of follow up after training	-Stock supply training -Train appropriate recognition of malaria -Partnership with MOH to include training IMCI and SCM -MOH partnership for supervision of IMCI and SCM -Develop supervision plans to ensure continued compliance with IMCI and SCM	-Severe symptoms of malaria -Malaria treatment protocol -CU5 with severe symptoms of malaria need immediate treatment and should be put first in cue
Objective: All pregnant women receive 3 doses of IPT at appropriate times during their pregnancy **Indicator:** % of pregnant women receiving IPT as verified by maternal card **Summary of Strategy:** UHC will mobilize women on the importance of ANC and receiving IPT 3 times during pregnancy. BCC will also address the need for women to retain maternal cards and will work with support systems including men, grandmothers to help maintain maternal ANC and IPT seeking behaviors. Health facility stock supply training will include IPT and the importance of including it in ANC. ANC will be covered by the health scheme.				
Audience	**Behaviour**	**Key Factors**	**Interventions**	**Key Messages**
Pregnant	Go for	-Cannot afford	-Mobilize on importance of	-Malaria in pregnancy is dangerous and can lead to

Women	ANC and get 3 doses of IPT during pregnancy	ANC -No transport for ANC -Don't know why ANC is necessary -Men don't support ANC -Negative impression of HWs	IPT -UHC is facilitating training HWs to help them give better care and be more respectful to women -Help communities plan transport for ANC -ANC is covered by the health scheme	miscarriage or reduced chances for infant survival -IPT will improve health and chances for survival -ANC is free for health scheme members -Plan ahead for transport to ANC
Men. Grand-mothers	Encourage/ support pg women going for ANC and getting 3 IPT doses during pregnancy	-Don't see need for ANC	-Mobilize on importance of ANC and IPT -Testimonies from those who have saved lives of pg women or babies through ANC	-Men can save lives of their wives and children by supporting ANC -IPT is given at ANC and will reduce chances of death from malaria -Responsible men support their family -Grandmothers can help save the lives of the children by supporting preventive health care
CORPS	Mobilize women to get 3 IPT doses during pregnancy	-Need key messages to give WRA and pg women	-Monthly mobilization sessions approved and supported by DDHS -CORPs will be trained and provided tools to mobilize and assist communities	-All women in Bushenyi need IPT during pregnancy to ensure the health of the mother and the baby -It is important for men and grandmother to support women so that they can get IPT -Women need help planning for ANC transport -Support needs to be ongoing for people to change long standing behaviours
HWs	Give 3 doses of IPT to pregnant women at	-HWs have been reported to be rude to clients. -Can't help women if they do	-Mobilize community on need for ANC and IPT -Sensitize HW on respecting patients and giving care according to protocols	-Treat patients with respect -Follow care protocols -Educate / counsel pregnant women on IPT

	appropriate times	not come for care	-Sensitize HW on importance of IPT	

BEHAVE FRAMEWORK -- Diarrhea

Objective: Improve recognition and appropriate treatment of diarrhea and dehydration for children under 5 in Bushenyi District
Indicator: % of caretakers who know at least two signs that a child under 5 needs treatment.
Summary of Strategy: UHC will promote and distribute ORS at the end of community education sessions that address recognition of warning signs for severe diarrhea and dehydration. UHC will promote proper infant feeding practices (continuation of breastfeeding - frequent small feedings – catch up feeding) in case of diarrhea. Mothers will be educated on recognition and care seeking for serious cases (dehydration, dysentery, and chronic/persistent diarrhea). When zinc becomes available, UHC will train HWs to include the importance of zinc in community education. UHC will encourage PSI and other health PVOs to provide zinc supplements as part of efforts to control diarrheal diseases. UHC will participate in effective training in SCM, supervision of HWs and will assure an adequate supply of ORS to HWs. UHC will work with HWs to improve SCM for diarrhea under IMCI.

Audience	Behaviour	Key Factors	Interventions	Key Messages
WRA, grandmothers and caretakers	Recognize and treat diarrhea and dehydration in CU5 according to C-IMCI	-Belief that reducing food/fluids will stop diarrhoea -Lack of access to ORS, -Poor knowledge why ORS is important -Lack of information about proper ORS preparation -Lack of money to seek treatment	-Community mobilization and BCC on warning signs of diarrhea and dehydration, ORS information and proper preparation, importance of continued feeding and when to seek treatment -Demonstrate ORS preparation and have audience repeat it so they gain confidence that they can do it. -Post C-IMCI posters	**If you see these signs, seek immediate care** -Skin pinch goes back very slowly -Dark urine or no urine -Overly sleepy or drowsy -Very dry mouth -Unable to drink or breastfeed -Bloody diarrhoea - Frequent watery stool -A child's teeth cannot cause diarrhoea or any other disease. Do not remove your children's teeth. -Giving more food and fluids can be lifesaving! Giving more fluids will not make diarrhea worse. -Continue breast feeding -ORS stops dehydration and can save a baby's life. -Where ORS is available. -How to prepare ORS. Demonstrate—have participants prepare it.

Men	Recognize warning signs of diarrhea and dehydration in CU5 and support treatment	-Belief that caring for children is the woman's role -Lack of support for seeking treatment -Lack of understanding why/how continued food/fluids, ORS and other treatment can save life of child	-Mobilization on warning signs and importance of seeking appropriate treatment -Promotion of health scheme to reduce cost barriers to seeking treatment -Community leaders and prominent men to be included in mobilization to reinforce msg. and address concerns	These signs in a CU5 require immediate CARE or death could result -Skin pinch goes back very slowly -Dark urine or no urine -Overly sleepy or drowsy -Very dry mouth -Unable to drink or breastfeed -Bloody diarrhoea -Dehydration is life threatening! ORS is easy, and treats dehydration. -Where ORS is available. -A child with diarrhea needs more food and fluids than usual. -A child's teeth cannot cause diarrhoea or any other disease. Do not remove your children's teeth.
CORPS	Train recognition and proper treatment for diarrhea and dehydration in CU5 Train communities on preventing diarrhea	-Lack of recent training on recognition and treatment of diarrhea in CU5 -No resources to treat cases that are not severe -Lack of time to visit communities with BCC messages	-Give free ORS packets with demonstrations and opportunities for community to prepare ORS to build confidence in ability. -Train CORPs, provide curriculum and resources to help them educate the community and reduce barriers to recognizing and appropriately treating diarrhoea and dehydration in CU5	These signs in a CU5 require immediate CARE or death could result -Skin pinch goes back very slowly -Dark urine or no urine -Overly sleepy or drowsy -Very dry mouth -Unable to drink or breastfeed -Bloody diarrhoea -ORS is easy to give and stops dehydration. -Have audience demonstrate and practice ORS preparation to increase their confidence that they can do it. -Tell them 3 places near them where ORS is available. -Continued fluids and food during sickness will give child strength to fight it.
HWs	Treat diarrhea in CU5	-Lack of IMCI training -Lack of IMCI	-IMCI training in partnership with MOH -IMCI supervision in	-Signs of dehydration -HWs need to know Diarrhoea IMCI chart by memory. -Need to cover a list of what they should explain to

	according to IMCI and SCM.	supervision -Lack of time to educate how/why treatment works	partnership with MOH -Training on importance of taking time to explain how ORS works and letting the person practice preparing it.	caretakers including danger signs and when to bring child for care, how to recognize dehydration, ORS is for Dehydration, how to prepare ORS, and how to avoid diarrhoea in the future—hand washing, disposal of faeces from all infants and children in a pit latrine. -Supervision plans to ensure compliance with IMCI and SCM
Objective: Increase access to safe water and safe water usage **Indicator:** % of households who use improved water source (borehole, public tap, or protected dug well.) **Summary of Strategy:** UHC will provide community mobilization on safe water sources including bore holes, public taps and protected dug wells, safe water use and storage. Drying racks will be recommended to keep cooking utensils clean. UHC will provide and/or help communities obtain covered containers for safer storage of safe water.				
Audience	**Behaviour**	**Key Factors**	**Interventions**	**Key Messages**
WRA, grandmothers and caretakers	Use safe water for drinking, cooking and washing hands	-Availability of safe water -Lack of knowledge of importance of behaviour -Lack of support for behaviour -Distance and cost	-Improve access to covered container to store safe water -Improve knowledge of how to find safe water -Assistance determining safe water source -Mobilization on connection between bacteria and illness -Mobilization for community support of healthy activity	-Safe water saves lives. -Boil water, treat water or get it from a safe source. Discuss with community until you are sure they have a safe option. Talk about barriers like time, distance and cost of safe water. Compare them to time, distance and cost of having a baby with diarrhea or work time lost if mother/father is sick from dirty water. -If taste of water is a barrier, have a taste test and discuss what safe water tastes like. -Keep containers with safe water covered. -Chemicals used to treat water have been studied and tested and will not harm their health. -Water sources can get dirty over time when people bathe or animals are in it. Sources that may have been safe for your parents are no longer okay to use without boiling or treating the water.
Men	Support women	-Belief that water was used by	-Mobilization on connection between bacteria and illness	-Safe water saves lives. -Travel and work now to have safe water and you won't have

	seeking safe water	parents before them and it was safe then -Lack of knowledge of importance of behaviour -Distance and cost	-Assistance determining safe water source	to travel and spend money later to cure the sickness. -Chemicals used to treat water have been studied and tested and will not harm health. -Women need support for the time it will take to make sure water is safe. -Smart families use safe water.
CORPS	Reduce barriers to safe water	-Lack of information about safe water	-Train what makes water dirty and how to find or make safe water -Provide education materials for CORPs to use during BCC -Help communities find the safest water option possible for them	-Dispel myths and fears that people have about safe water—tastes different, has chemicals… -Safe water is worth the time and money to get it because it can save your child's and your life.
HWs	Use and encourage use of safe water	-Lack of safe water -Lack of covered containers to store water	-Ensure safe water at provider sites -Provide easy messages for HWs to give to patients about the importance of safe water	-Safe water saves lives. -Encourage them to reinforce safe water messages to patients.
Objective: Increase hand washing practices at appropriate times especially for mothers and caretakers of CU5 **Indicator:** % of households with a designated hand washing station with a covered container for water **Summary of Strategy:** At the community level, UHC will promote improved hygiene including hand washing with soap/ash after defecation, handling of infant feces, before preparing food and before child feeding.				
Audience	**Behaviour**	**Key Factors**	**Interventions**	**Key Messages**
WRA, grandmothers and caretakers	Wash hands with soap/ash before food preparation	-Availability of soap/ash -Availability of safe water -Lack of	-Explore options with partners to improve access to soap/ash -Improve access to covered container to store safe water -Mobilization on connection	-Dirty water and dirty hands spread disease. -Washing hands reduces sickness. -Keep containers with safe water covered. -It is okay to share pit latrines but must wash hands with soap/ash.

	and feeding children, after defecation and tending to a child who has defecated	knowledge of importance of behaviour -Lack of support for behaviour	between bacteria and illness -Mobilization for community support of healthy activity -Competitions to reward those who wash hands appropriately	-Even if toilet paper is used, must wash hands with soap/ash.
Men	Support mothers/caretakers who want to wash hands at appropriate times	-Belief that washing hands is not necessary or is wasteful	-Mobilization on connection between bacteria and illness -Community leaders and prominent men to promote support of appropriate hand washing	-Dirty water and dirty hands spread disease -Washing hands reduces sickness! -It is okay to share pit latrines but must wash hands with soap/ash. -Even if toilet paper is used, must wash hands with soap/ash.
CORPS	Reduce barriers to hand washing at appropriate times	-No soap/ash, safe water, covered containers to hold safe water -Lack of education materials -Lack of time for BCC	-Provide resources for hand washing to CORPs to hand out during BCC -Provide education materials for hand washing for CORPs to use during BCC -Enlist support of DDHS to allow time and resources to be spent in hand washing BCC -Competitions to reward those who wash hands at appropriate times	-Educate on when to wash hands. -Dispel myths and fears that people have about safe water—tastes different, has chemicals… -Safe water is worth the time and money to get it because it can save your child's and your life.
HWs	Wash hands at appropriate	-Lack of covered containers to store	-Improve access to resources needed for hand washing at health facilities	-Reinforce hand washing messages -Encourage HWs to reinforce these messages to patients, especially those who come with diarrhoea.

	times in treatment of patients	water -Lack of soap/ash		
Objective: All faeces disposed in pit latrines. **Indicator:** % of households who safely disposed of their child's feces the last time s/he passed stool. **Summary of Strategy:** Community health education and assistance will be provided for sanitary disposal of human feces including use of covered pit latrines. BCC will be utilized to address cultural beliefs/practices that do not encourage safe fecal disposal.				
Audience	**Behaviour**	**Key Factors**	**Interventions**	**Key Messages**
WRA, grandmothers caretakers and men	Dispose of all faeces including that of children in pit latrine.	-Belief that faeces from children under 2 is not harmful -Lack of pit latrines -Routine and bad habits for places to throw this faeces -Fear that disposal of faeces will harm teeth	-Raise awareness of danger of all faeces -Stress importance of using pit latrines	-Disposing of child's faeces in pit latrine will not harm the child's teeth -All faeces, whether from animal, adult, or child under 2, is dangerous and has disease causing bacteria in it. -Pit latrines should be kept clean and covered -Children need to be kept away from faeces -Flies can land on faeces and can carry disease to people -No harm will come from disposing of child and adult faeces in the same place -Keep pit latrine key always in same place and easily accessible -Okay to share pit latrines
CORPS	Educate community on proper disposal of faeces to improve health	-Belief that faeces from children under 2 is not harmful -Lack of pit latrines -Routine and bad habits for places to throw this faeces	-Raise awareness of danger of all faeces -Stress importance of using pit latrines -Dispel myths and incorrect beliefs about faeces not being dangerous or about it affecting a child's teeth	-Disposing of child's faeces in pit latrine will not harm the child's teeth -All faeces, whether from animal, adult, or child under 2, is dangerous and has disease causing bacteria in it. -Pit latrines should be kept clean -Children need to be kept away from faeces -Flies can land on faeces and can carry disease to people -No harm will come from disposing of child and adult faeces in the same place

		-Fear that disposal of faeces will harm teeth		
HWs	Proper disposal of all faeces	-Lack of facilities and time to dispose of faeces appropriately	-Train proper disposal -Ensure time, facility and system appropriate for disposal	-All faeces is dangerous to health and must be disposed of in a covered pit latrine as soon as possible.
Objective: Increase use of slabs to cover pit latrines **Indicator:** % of households with access to a covered pit latrine **Summary of Strategy:** UHC will promote the use of covered pit latrine and will explore options for making this available to communities.				
Audience	**Behaviour**	**Key Factors**	**Interventions**	**Key Messages**
WRA, Men	Cover pit latrines	-Lack of understanding how slabs help -Cost -Not sure where to get them -People think they are for the rich	-Slabs are available in Mbarara for 5000/= -Cost is 10,000/= to transport them -Explore options with communities to determine how we can make these available -Discuss options with DDHS - Can we work with MOH or DDHS to get a break on transporting them so they would be available to people?	If we can figure out affordable procurement -Covered pit latrine is long lasting and easier to clean -Covered pit latrine reduces smell and improves health. -Where slabs are available

NOTE ON SLABS: The slabs talked about in the study are the ones that have been constructed and ready for use. Otherwise, there are cheaper alternatives for construction "on site". Materials used are cement, sand and stone plus metal bars.

BEHAVE FRAMEWORK – Maternal Newborn Care

Objective: Increased demand for ANC (including IPT) and post partum visits **Indicator:** % of women w 4 ANC visits as verified by maternal card. **Summary of Strategy:** UHC will promote maternal and newborn care through creating demand for and increasing access to prenatal care including IPT, ITNs, iron/foliate supplements, planning for delivery and availability of tetanus toxoid immunization. ANC training will

include RCT for HIV and a referral system will be established for PMTCT and treatment. ANC will be covered by health schemes. Mothers will be mobilized to retain maternal cards as verification of 4 ANC visits, IPT, and TT coverage. HWs will be trained to improve quality of ANC including iron/foliate supplementation, early detection and management of malaria, presumptive treatment for malaria, early detection and management of (pre-) eclampsia, early detection and management of STIs, development of an appropriate delivery plan, based on the woman's history and health status, and recognition by the mother, her immediate environment and first line providers of antenatal care of danger signs (bleeding, convulsions, pallor, swollen hands or face, labored breathing, fever.)				
Audience	**Behaviour**	**Key Factors**	**Interventions**	**Key Messages**
WRA, grandmothers and caretakers	Pregnant women go for 4 ANC visits during pregnancy Women, newborns receive postpartum visits/care	-Belief that govt services are overcrowded and poor quality -Lack of money to seek care -Distance to health centres -Do not know benefits of ANC -lack of men's support -Lack of privacy -Tradition of giving birth at home -Not having a maternal card -Fear that HWs will be young, inexperienced or rude to them -Do not have materials the are required for birthing at health centre -Fear to test for HIV -Position of giving birth -Belief that pregnancy is a "normal" state -Women do not acknowledge pregnancy until when visible (six –seven months) -Negative cultural beliefs e.g restricted women movement during and after delivery	-Mobilization on the importance of ANC and post partum visits -Health scheme coverage of ANC including IPT and TT -Provide posters to health centres on importance of IPT - Teach mothers to self monitor for complications especially the first 24 hours and seek services if needed. - Encourage women to be receptive to a CORP visit especially within the first 24 hours after delivery	-At ANC mother is checked for any conditions which may harm her pregnancy. -At ANC mother gets information that will help her have a healthy pregnancy and a healthy baby -At ANC mother gets 2 tetanus immunisations to protect the baby from getting tetanus. -TT vaccine is tested safe and free -At postpartum visits, mother and baby checked for any complications that may be harmful

Men	Support women going for ANC	-Do not understand why ANC is beneficial -Too expensive -Tradition of home birthing -Fear that HWs will be interns or students -Negative cultural beliefs -Socio-cultural expectations of woman -Belief that reproductive health issues is the responsibility of the woman	-Mobilization on importance of ANC and supporting women -Display "Malaria during pregnancy is dangerous!" posters that show man and woman and say "support your partner to visit a health facility for malaria preventive medicine and advice" in local language. -Educate men to help women reduce workload during pregnancy and after delivery	-Good "husbands" support and take care of their partners during pregnancy
CORPS	Encourage women to go for ANC. Educate them on benefits	-Lack of knowledge of key educational messages -Lack of tools to promote ANC and post partum visits	-Conduct CORPS training and provide tools for community mobilization	-Community awareness of benefits of ANC and danger signs helps to improve the health of the community -Community participation in MNC helps save mothers and babies
HWs	Treat pregnant women with sensitivity to their needs and fears	-Not enough time to care for women with compassion -Not aware of women's concerns and fears -Fear of contracting HIV from treating women who refuse to test.	-Train Health workers to provide skilled ANC without risk of HIV transmission. -Improve supervisory systems -Provide posters to health centres on importance of ANC and IPT - Dialogue with HWs to address their biases and attitudes about methods and clients - Train health workers to deliver	-Every pregnant woman has a right to proper care and information during ANC and postpartum visits -Every pregnant woman should be treated with dignity

			services in a culturally acceptable manner	and sensitivity
Objective: Increased demand for RCT **Indicator:** % of pregnant women seeking RCT services **Summary of Strategy:** UHC will work with Business PART Project to train CORPS to conduct HIV/AIDS awareness mobilization and to promote RCT. Brochures, posters and other materials will be given to CORPS for BCC in prevention of HIV/AIDS, reducing stigma and discrimination of HIV/AIDs and for Living positively with HIV/AIDS. ANC training will include RCT for HIV and a referral system will be established for PMTCT and treatment. Referral for HIV/AIDS counseling and testing will also be covered.				
Audience	**Behaviour**	**Key Factors**	**Interventions**	**Key Messages**
WRA, grandmothers and caretakers	Seek testing and counselling for HIV/AIDS during pregnancy	-Women lack rights and control over their sexuality -Fear to know status -Fear of blame, abuse and abandonment by husbands -Fear of social stigma -Counsellor is not available -Requirement to test w husbands	-Mobilize on importance of RCT -Make brochures in local language on reducing HIV/AIDS Stigma & Discrimination, Prevention of HIV/AIDS Infection, and Living Positively with HIV/AIDS available	-Knowing a mother's HIV status helps to save the unborn baby -Routine counselling and testing is a key to better family life
Men	Support woman seeking RCT during pregnancy	-Fear of social stigma	-Mobilize on importance of RCT -Make brochures in local language on reducing HIV/AIDS Stigma & Discrimination, Prevention of HIV/AIDS Infection, and Living Positively with HIV/AIDS available	- Knowing a mother's HIV status helps to save the unborn baby -Routine counselling and testing is a key to better family life
CORPS	Create community support for RCT	-Lack of trained counsellors nearer where pregnant women live (CORPS as counsellors) - Distance to testing centres	-Mobilize on importance of RCT -Make brochures in local language on reducing HIV/AIDS Stigma & Discrimination, Prevention of HIV/AIDS Infection, and Living Positively with HIV/AIDS available	-Health workers are a trusted source of information on HIV/AIDS -Knowing a mother's HIV

				status helps to save the unborn baby
HWs	Sensitively handle RCT	-Not enough trained health workers to do routine counselling -Not enough time spent with pregnant women during routine counselling	-Provide HW training on RCT -Provide brochures in local language to educate community on HIV/AIDS -Provide posters for health facility on RCT importance and HIV/AIDS -Train feeding options for HIV positive mothers	-Health workers are a trusted source of information on HIV/AIDS

Objective: Improved caretaker knowledge of nutrition, child spacing, and danger signs in pregnancy
Indicator: % caretaker knowledge of breastfeeding, child spacing and danger signs of pregnancy
Summary of Strategy: Monthly mobilization education will cover improved awareness of men, women, families and communities about the special needs of pregnant and lactating women in terms of nutrition, rest, antenatal, delivery and postpartum rest and care. Danger signs and symptoms of complications of pregnancy and delivery will be covered and pregnant women will be helped to develop an appropriate delivery plan, based on the woman's history and health status. The importance of early (initiation of breastfeeding during the first hour post partum, including the "utilization" of colostrum,) and exclusive breastfeeding and on demand feeding (for up to 6 months) for all infants, including a practical approach to breastfeeding in a high AIDS/HIV prevalence situation will be addressed through BCC. Since the Uganda total fertility rate remains high at 6.9% (UDHS 2000/01), UHC will promote programs that integrate family planning including natural family planning for appropriate populations: delayed age of first pregnancy, reduced total number of children, and increased birth spacing.

Audience	Behaviour	Key Factors	Interventions	Key Messages
WRA, grandmothers and caretakers	Eat properly during pregnancy, exclusively breastfeed infant for 6 mos, supplement thereafter, plan child spacing,	-Pregnant women are denied certain foods which are nutritious to newly born babies e.g. fish, chicken and fish. -Belief in traditional herbs -Poor weaning practices (pepper on breasts to stop suckling -Water/juice provided to baby to "ease pains to mother" -Religious beliefs e.g. prayers can heal , no family planning for Catholics	-Mobilization on special needs of pg and lactating women -Mobilization on danger signs in pregnancy -Assistance with developing birth plans -Mobilization addressing barriers to family planning and natural family planning options	-Exclusively breastfeed for the first 6 months -Start complementary feeding at 6 months -Give children foods rich in micro nutrients (vitamin A, Iodine and iron) -Danger signs that require seeking health professional care -Breast milk is the best food made especially for a child -Breast milk is an adequate diet for the

	recognise danger signs in pregnancy and newborn and seek care	-Lack of or delayed recognition of danger signs - Lack of knowledge on where to seek help in case of danger signs - Belief that colostrums is not good for the baby	- Educate women on how to safely plan pregnancies after delivery	child during the first 6 months. -Exclusive breastfeeding will give the child's body all the water it needs. -Breastfeeding helps promote child spacing as it delays pregnancy
Men	Support proper nutrition, recognize danger signs in pregnancy and support seeking treatment	-Belief that pregnant women do not need more food -Belief that women should be responsible for children	-Community mobilization for fathers and men	-Responsible husbands take care of their pregnant partners and children - Men should secure adequate nutrition for their pregnant partners
CORPS	Train proper nutrition, child spacing and recognition of danger signs in pregnancy.	-Lack of knowledge of nutrition, child spacing and danger signs in pregnancy \ -Lack of tools to mobilize the community -Lack of confidence in mobilization skills	-Train nutrition, child spacing and danger signs in pregnancy -Train mobilization skills -Provide partnerships and mobilization support	
HWs	Educate women on proper nutrition, infant feeding, child spacing and dangers signs	-Lack of time to spend with women on education -Lack of knowledge of key points to cover -Women do not come to the health worker for ANC	-Train HWs on nutrition, child spacing and danger signs in pregnancy -Post care protocols to help HWs cover all key points with patients -Work with DDHS to provide additional staff	-Every pregnant woman has a right to information on nutrition, infant feeding, child spacing and danger signs in pregnancy and newborns

	during pregnancy		and more time for HWs to spend with women on key points -Promote ANC for pregnant women to increase education opportunities and support for behaviours	

Objective: Increase access to safer birthing
Indicator: % of women who delivered with a skilled health professional as verified by a maternal card.
Summary of Strategy: UHC will conduct BCC to educate pregnant women on obstetric danger signs including prolonged labor, mal presentation, excessive bleeding, retained placenta, convulsions, fever and foul smelling discharge. BCC messages will address the promotion of "clean" practices including clean hands of the birth attendant; clean cutting of the umbilical cord; clean delivery surface; safe water and soap; clean string to tie the cord; and clean cloths to wrap the baby. The importance of delivery with a skilled health professional will be stressed. UHC will conduct further studies to better understand where weaknesses remain in maternal care for providers in Bushenyi. UHC will help train CORPS to discourage poor birthing practices at the village level, especially use of herbs and pressing down to stimulate contractions. Clean delivery will emphasize avoidance of unnecessary vaginal examinations, episiotomies and induced rupture of the membranes. UHC will provide free mama kits to all women attending at least 3 ANC visits. In addition, UHC will help train HWs on the six cleans. Midwives who traditionally supervise TBAs will receive additional mobilization in order to address the barriers that they face in supervision and to improve the frequency and quality of supervision in addition to improving the reporting of TBA interventions in Maternal Newborn Care.

TBAs will be trained separately in order to help shift their focus from delivery and to other aspects of MNC. Their training will include components of CORPS training as well as portions of the HW training. Emphasis for TBA training will especially be placed on recognizing danger signs and referring cases that present any risk at ANC, delivery or postpartum visits. Referral for HIV/AIDS counseling and testing will also be covered. TBAs will be trained on the six cleans, the importance of encouraging immediate and exclusive breastfeeding, recognizing and responding to danger signs in newborns, and the need to visit every new mother six days after delivery to assess health of mother and child.

CORPs and TBAs will be trained on providing and keeping records of postpartum care. Training will stress need to visit mothers 6 days after birth of the baby to check for danger signs, encourage immunizations, counsel on newborn care, counsel on breastfeeding, check to be sure mothers have had Vitamin A, and to counsel on sleeping under ITN. CORPs and TBAs will be charged with making sure mothers and

caretakers in the household can name and recognize newborn danger signs and have a plan to seek appropriate care immediately if necessary.

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

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

Audience	Behaviour	Key Factors	Interventions	Key Messages
WRA, grandmothers and caretakers	Deliver baby with a skilled health professional	-Some women don't like to be delivered by men or young girls -Belief that all health unit deliveries end in caesarean births -Belief in using herbs and pressing down to start contractions -Lack of access to safe birthing tools -Too expensive -HWs will not help if woman has not had HIV test -Tradition of home birth -Position of birthing is too vulgar/revealing -Lack of transportation -Not enough HWs at health centre - Poor perception of the health facilities	-Health schemes will cover ANC, delivery and post partum care -Women provided safe birthing kits - Promote importance of a skilled attended birth through BCC -Educate on 6 cleans - Assist with birth planning -Provide free mama kits to women who attend at ANC at least 3 times.	-Skilled health workers are the best care givers for pregnant women -Delivery with a skilled health worker will ensure you get vitamin A capsules and information needed to keep the baby healthy -Birth planning saves lives of mothers and babies
Men	Encourage/support women through pregnancy	-Lack of male involvement in maternal health - Poor social cultural influences	-BCC on male role in reducing maternal mortality -Encourage men to participate in birth planning	-Male active and positive participation in planning and

	and to deliver baby with a skilled health professional. Participation in child care.		-Male leaders will speak to men to encourage their support	having a safe birth saves lives of mothers and babies
CORPS and TBAs	Train the importance of delivering a baby with a skilled health professional	-Lack of knowledge of reasons women should deliver with skilled birth attendant -Lack of tools and skills to educate community on key safe birthing messages	-Train 6 cleans -Provide education materials for CORPS to use in the community to support key messages -BCC on post partum warning signs for referral and care	-Birth planning will save the life of mother and baby -Skilled health workers are trained and have tools to give the best care to mother and baby at the time of and right after delivery
HWs and midwives	Sensitive treatment for women and safe delivery of babies. Active management of third stage labor.	-Fear of contracting HIV from a woman with unknown status can lead to poor treatment of these women -Fear to be seen referring to guidelines -Guidelines may not match prescriptions and tools available -Lack of time to refer to guidelines	-Training on SCM for delivery and post partum care -Follow up training on SCM for delivery and post partum care -Increase access to MOH policy and guidelines so that everyone in the health centre can use this resource. -Increased supervision for SCM for delivery and post partum care -Train AMTSL -Post AMTSL to prevent post-partum haemorrhage guides in local language in all health facilities that provide delivery services. (resource from Preventing Postpartum Hemorrhage: A Toolkit for	-Every pregnant woman should be treated with dignity and sensitivity -Encourage HWs to refer in case of complications

			Providers, E-3) -Train 6 cleans -Train HWs to deliver mothers in a culturally appropriate manner -BCC on postpartum care	

Monitoring and Evaluation

Baseline, midterm and final evaluations using KPC 200+, HFA, ISA and Self assessments will be conducted in addition to routine monitoring which will use slightly condensed versions of these tools (a sample of which was included in the DIP) in the 8th month of each Phase of the project. Reports are written to detail the results and lessons learned from each event. Signatures and feedback are gathered at all training and mobilization events. Results of monitoring will be used by the project team and partners to determine changes to strategies and/or curriculum. Results are shared with stakeholders at workshops as a learning tool and as motivation for continued program activities. UHIS database reports include Income/Loss, Year to Date top Services, Year to Date top Diagnoses and others will be collected monthly, analyzed and used to build capacity of the UHC team, BOD and other stakeholders. The M&E Coordinator will also review the monthly HMIS 105 report turned in to the District Health Office from health units. This form will be a helpful monitoring tool for malaria and diarrhea diagnoses, ANC attendance, IPT, family planning users, RCT and essential drug stock maintenance.

I, J & K. Not applicable

L. Program Management Systems

Financial Management Systems
The Uganda Health Cooperative employs an accountant who organizes monthly expenses and reports from staff in Uganda. Receipts, bank statements and reconciliation sheets are sent monthly to HealthPartners headquarters where they are reviewed by the program backstop and passed on to the accounting department. Headquarter expenses are tracked through HealthPartners by the cost center number assigned to the program. A senior accountant sends invoices and quarterly reports to USAID according to the terms of the agreement. Payments received are reconciled by the senior accountant at HealthPartners. This system is supported and audited according to HealthPartners policies and procedures.

Human Resources
Policies for Human Resource management in Uganda are documented in the Employee Orientation Packet that is distributed to new staff and updated annually. Human Resources for HealthPartners staff are governed by HealthPartners policy.

Communication System and Team Development
The communication system detailed in the DIP has worked well. The director spends a well over 50% of her time in the field and staff are required to submit monthly reports detailing their activities: these are helpful tools for monitoring and mentorship. Direct supervisors meet with staff each month to discuss challenges, resolutions and the way forward using reports as the basis for these conversations. Together they develop goals for the coming month. UHC implemented a percentage salary reduction for late reports. Twenty-five percent of staff salaries were reduced the first month after this policy went into effect however, since then all reports have been turned in on time. Increased reporting expectations and mentorship has directly improved staff accountability. A bonus incentive program was put in place to encourage marketers to overcome challenges to increasing scheme membership.

Corporate responsibility scorecards detail the expectations for each position. Staff have an opportunity to turn in self-reviews which are combined with direct supervisor assessments to determine whether staff are meeting expectations, exceeding expectations or needing improvement. Raises are determined by these ratings. The scorecards have proven to be a detailed and fair method of assessing staff performance and helping staff understand what they are doing well and what they need to work on.

Need for technical interventions and staff capacity building are derived from monthly reports, corporate responsibility scorecards and institutional strength assessments (every 8 months beginning at the end of Phase I.)

Local Partner Relationships (how is the PVO doing as assessed by the local partner?)
An institutional strengths assessment that includes feedback from local partners will be conducted in February 2007. UHC will have a better sense of how partners view program management and progress at that time. Informally partners have expressed satisfaction

working with UHC and all partners thus far have been interested in continuing partnerships throughout the LOP.

PVO coordination/collaboration in country
A communication and marketing coordinator was hired to help coordinate partnerships and marketing for community education and events.

An increased focus on developing partnerships has been a great enhancement to UHC. Partners are playing key roles by bringing their expertise and the materials they have developed to UHC members and the Bushenyi community. Working with the DDHS has been an especially exciting partnership because UHC has been able to bridge a gap by providing education and training resources to them while they have had the manpower and health center ties which in turn strengthen UHC. Most importantly the DDHS is a key player for sustainability because their increased capacity will continue to benefit the community for years to come.

The Uganda Community Based Health Finance Association is another important partner because this group is made up of local leaders who are making long-term investments in the community. The UHC director is the board chair of UCBHFA. She shares UHC lessons learned with this group of leaders working to establish health financing throughout the region. In response to questions raised about plan management in September, the UHC director brought monthly reports to show statistics of cost recovery and scheme performance. By using this data it became clear that one of the scheme managers was taking payment for his salary and housing from premiums before evaluating cost recovery. The situation was immediately remedied and a powerful lesson was learned by the Association about how maintaining accurate, detailed reports is vital to managing health schemes. The UHC director travels at least two times a year to regional health financing conferences in order to learn best practices from others and to share experiences from UHC. She is well respected throughout the Region and regularly asked to speak at conferences.

Other Relevant Management Systems

If an organizational capacity assessment of any kind has been conducted during the LOP, including a financial or management audit, describe how the PVO program has responded to the findings. HFA, ISA, and LQAS monitoring will be conducted in February 2007 as scheduled in the DIP. A subset of indicators for LQAS monitoring can be found on page 108 of the Dip and the LQAS monitoring tool is included on page 111. Monitoring will continue to take place at the end of each Phase in order to gauge how effective the interventions have been and to improve the behavior change strategy for the coming Phase. A consultant will be hired to conduct an actuarial analysis of the health scheme in January 2007. The findings of these reports and changes that are made to the program accordingly will be recorded in the Year II, Annual Report.

M. Mission Collaboration

UHC has maintained regular contact with Uganda Mission representative, Jessica Kafuko. Unfortunately Ms. Kafuko was unable to attend the first annual stakeholder workshop however she was a sent a copy of the handouts and presentation that was used at that time.

N. Timeline of activities for 2006-7 (Note-there are no major changes to the work plan timeline for Year II which was included in the DIP.)

Major Activities	**Month**	**Personnel**
CORPS conduct C-IMCI, Barrier Analysis of Essential Stock Maintenance conducted by UHC & MOH, IMCI training and supervision begins for health workers. Scott Aebischer to travel to Uganda for Stakeholder Workshop, UHC Annual General Meeting, Acknowledge CORPS and outstanding partners. Board Meeting & Capacity Building.	October	HST, CE, Director, PM, Backstop, M&E, CC, BOD, SM Consultant
CORP MNC training, CORPS conduct MNC Mobilization, HW training ANC	November	HST, CE, Director, PM, M&E, CC
CORP STI/HIV/AIDS training, CORPS community mobilization, HW training Post Natal Care and Delivery	December	HST, CE, Director, PM, M&E, CC
CORP KEY POINTS/REVIEW training, CORPS conduct key points mobilization, HW training on self assessments. Board meeting and capacity building training. ***** Consultant to begin independent financial analysis of UHC operations and membership parameters for sustainability.	January	HST, CE, Director, PM, M&E, CC, BOD, SM Consultant
Install UHIS database system. LQAS, HFA and ISA monitoring of interventions/activities to date, revise and update curricula, materials and processes accordingly, ***** Intern to assist this process.	February	HST, CE, Director, PM, M&E, CC, SM, Intern
Annual staff workshop and training. Revise training materials according to assessment results. Enroll new UHC scheme members. ***** Intern to complete report.	March	HST, CE, Director, PM, M&E, CC, SM, Intern
Board Meeting and training. Launch Phase II in Ruhinda County. CORP malaria training, CORPS conduct malaria mobilization, HW stock order training. Enroll new UHC scheme members.	April	HST, CE, Director, PM, M&E, CC, BOD, SM
Conduct C-IMCI CORP and IMCI health worker training. CORP mobilization. Enroll new UHC scheme members.	May	HST, CE, Director, PM, M&E, CC, SM
Conduct C-IMCI CORP and IMCI health worker training. CORP mobilization. Enroll new UHC scheme members.	June	HST, CE, Director, PM, M&E, CC, SM
Board meeting and capacity building. Conduct MNC CORP	July	HST, CE,

and ANC HW training. CORP mobilization. Enroll new UHC scheme members.		Director, PM, M&E, CC, SM, BOD
Conduct CORP STI/HIV preventive care training and HW postnatal and delivery training. CORP mobilization. Enroll new UHC scheme members.	August	HST, CE, Director, PM, M&E, CC, SM
Review applications for BOD. CORP key points training and review, HW Self assessment training. CORP mobilization. Enroll new UHC scheme members.	September	HST, CE, Director, PM, M&E, CC, BOD, SM

*** Indicates activity not in the original DIP.**

O. Results Highlight

HealthPartners Child Survival program is based on the Innovative idea that utilizing community health financing as a platform for implementing child survival interventions will increase sustainability. The Uganda Health Cooperative is comprised of 3,800 members who pay quarterly premiums which allow them to seek health care when they need it. A few basic rules guide membership: 60% of a group must join the scheme to prevent adverse selection. Leaders of groups select the benefit package for their group. In order to make membership available in this poor region, chronic illness like diabetes and HIV/AIDs can not be covered by the scheme.

UHC's slogan is "sustaining a healthy community through partnership." Scheme managers manage groups, scheme marketers increase membership (the goal prepaid health coverage for at least 14,000 WRA and CU5 by 2010). The health services trainer works with the MOH and DDHS implementing training, supervision and support for health workers (25 trained to date). The community educator works with volunteer CORPS to provide the training tools, skills and confidence they need to spread key behavior change messages throughout the community (23-25 CORPS have been trained on three separate occasions and 2,443 signatures of mobilization attendees have been collected to date. Estimated target population reached is over 6,000.) Program goals are to directly reach 34,500 WRA, 3,200 children under 12 months, 3,100 children 12-23 months and 9,200 children 24-59 months by 2010. The M&E Coordinator increases capacity for stakeholders by training methods of data collection and how data can be used to make results based decisions to maintain the scheme.

The Board of Directors and Scheme leaders have learned that premiums need to be affordable for members but they must also be enough to cover the cost of care. Larger groups increase cost recovery and can bargain for lower premiums. Leaders negotiate with providers to maintain care and to include benefits that improve health. Preventive medicine and improved health save time and money. For example, if members have access to ITNs and learn how to use them properly, malaria treatment is reduced, members are healthier and providers save money. Providers have incentive to subsidize and sell ITNs.

In the scheme all stakeholders benefit from improved health and cooperation in health care management. Everyone has a stake in making sure the scheme continues.

In August UHC received official registration status with the government of Uganda. UHC is the first *health* cooperative ever to be registered. This will help the community understand that UHC is their cooperative and it will remain their own health care financing scheme long after HealthPartners has helped them to build it.

A database system has been developed to allow stakeholders to make results based decisions to maintain the schemes. As the capacity of the Board is increased they will determine the percentage of premiums set aside for administration and board activities which may include offering a subsidy to the poorest populations and/or covering maternal/child care for the community. UHC is entering the second year of their Child Survival program with great expectations for its advancement toward sustainability.

P. Information not yet obtained.

Q. Other relevant aspects.

R. Papers that highlight project results **or presentations on the project** at any major conferences or events since the last annual report.

UHC Director presented "The Challenge of CHF in poor communities" at the 6th Regional Conference on Community Health Financing sponsored by the Community Health Financing Association for Eastern African Mombasa, Kenya February 19-24, 2006.

UHC Director provided a presentation on "Community Financing for Health Services" at the Child Survival and Health Grants Mini-University in Baltimore, June 6, 2006. Joy Batusa explained how community financing is a strategy to capture more resources for the formal health system, thus improving quality of service provision and financial sustainability. The presentations described the structure of HealthPartners Uganda Health Cooperative scheme, and its effect on quality, sustainability, and utilization of services.

Annex A: IMCI Training Report

HealthPartners
Uganda Health Cooperative
Plot 2, Ibis Vale, Off Prince Charles Drive
PO Box 27659, Kampala, Uganda
Tel: 256-41-342353 Fax: 256-41-258678

REPORT ON THE INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES (IMCI) TRAINING WORKSHOP FOR IGARA COUNTY HEALTH WORKERS

FROM 4TH TO 9TH SEPTEMBER 2006

AT KATUNGU MOTHERS UNION CENTER
BUSHENYI DISTRICT

Compiled by Grace Karungi, Health Services Trainer &
Musiimire Dorah, Community Education Coordinator.

Group photo of Health workers, facilitators, and coordinators at Katungu Mothers' Union Centre Bushenyi.

ACKNOWLEDGEMENT:

Appreciation goes to: United States Agency for International Development-USAID for having funded the training, the director and the administrator HealthPartners-Uganda Health Cooperative for their input; the Ministry Of Health facilitators and the district trainers for conducting the training successfully; the District Director of Health Services, Bushenyi, for participating in selection of participants, guidance and officiating at the opening, and closure of the training as well as the chairman LC5 Bushenyi local government, for political support and involvement in the success of the training.

In addition, appreciation goes to the participants for attending the training and the management of Katungu Mothers Union for hosting the training.

REPORT SUMMARY:

The report comprises of : introduction, participants' expectations, workshop objectives, expected outcomes, workshop norms, workshop group leaders, course content, methods used, evaluation results, lessons learnt during training, achievements during training, constraints met during training , recommendations and suggestions for next trainings and way forward.

In the appendix are; names of facilitators, logistics used and evaluation forms and time table.

INTRODUCTION:

The integrated management of childhood illness training was conducted for health workers of Igara County from 4th to 9th September 2006 at Katungu Mothers Union.

The health workers trained were; clinical officers, nursing officers, enrolled nurses and midwives. These health workers were selected by the District director of health services from both government health units and Non-government organization health units within Igara County.

The workshop was opened by the deputy DDHS, Dr. Barigye Celestine and closed by the Chairman LC5, Mr. Ndyanabo Ishanga Longino. A total of six facilitators carried out the training; three were from the ministry of Health, and three from the district. This workshop was organized by HealthPartners- Uganda Health Cooperative as part of the implementation of Child Survival activities in Bushenyi District.

Below is the table showing the detailed description of health workers trained.

No	Name	Cadre	Sex	Health unit	NGO	Government
1	Nayiga Irene	E/N	F	Comboni Hospital	✓	
2	Chirchin Elkana	C/O	M	Comboni Hospital	✓	
3	Kinyamasyo Festus	C/O	M	Ishaka Hospital	✓	
4	Tiboona Hope	N/O	F	Ishaka Hospital	✓	
5	Nagaba Sarah	E/N	F	Swazi HC II		✓
6	Atukwase Edidah	E/M	F	Kyamuhunga HC III		✓
7	Mucunguzi Fidelis	N/O	F	Kyamuhunga HC II		✓
8	Kabigumira Maurice	E/N	F	Kyeizooba HC III		✓
9	Mutonyi Alice	E/M	F	Kyeizooba HC III		✓
10	Komugisha Donata	E/N	F	Nyabubare HC III		✓
11	Kobucunguzi Jean	E/M	F	Nyabubare HC III		✓
12	Musondolya John	E/N	M	Keinamo HC II		✓
13	Kanatweta Mary	E/N	F	Kabushaho HC III		✓
14	Birungi Angella	E/M	F	Kabushaho HC III		✓
15	Apollo Banyu	C/O	M	Kakanju HC III		✓
16	Mibazi Peace	E/N	F	Numba HC II		✓
17	Nakahima Mary	E/N	F	Bitooma HC III	✓	
18	Ithungu Bernadette	N/O	F	Bushenyi HC III		✓
19	Maguru Jane	E/M	F	Bushenyi HC III		✓
20	Kemitarizo Teopista	N/O	F	Kyabugimbi HC IV		✓

21	Kemirembe Eustance	E/M	F	Kyabugimbi HC IV		✓
22	Kamugisha Cornelius	E/N	M	Burungira HC II	✓	
23	Nzoghu Amon	E/N	M	Nyarugote HC II		✓
24	Nkwenge Beatrice	E/N	F	Bwera HC II		✓
25	Keneza Rose	E/N	F	Bushenyi Medical Centre	✓	
Total 25		E/N=12 E/M=6 C/O=3 N/O=4	F=19 M=6	Hospital= 2 HC IV= 1 HC III = 7 HC II= 6	Total= 7	Total=18

Key
EN= Enrolled Nurse
EM= Enrolled Midwife
CO= Clinical Officer
NO= Nursing Officer
HC= Health Centre

PARTICIPANTS EXPECTATIONS

Participants had several expectations. These included;
- Getting new skills
- To learn more about children and their illnesses
- To get more information on IMCI
- To learn about improved management of childhood illnesses
- To get allowances.
- To get certificates of attendance
- To be given hand outs
- To have good meals
- To get more knowledge about matters of childhood illnesses in relation to HIV/AIDS

WORKSHOP GOAL
The ultimate goal is improve health services providers practices in the management of common childhood illnesses (fever/ malaria, diarrhea, ARI), ability to identify and refer children with severe illnesses for appropriate management.

SPECIFIC OBJECTIVES
1. To improve health workers' case management skills for children below five years.
2. To reduce significantly, mortality and morbidity associated with the major causes of disease in children.
3. To contribute to the healthy growth and development of children.

EXPECTED OUTCOMES
- Correct assessment, classification and treatment of common childhood illnesses by health service providers.
- Early and appropriate referral of severe cases resulting in reduced complications and death due to severe childhood illnesses.

WORKSHOPNORMS.
Participants came up with the following norms.
-Active participation.
-Punctuality.
-Respecting each other.
-Co-operation.

-Phone on low tones.
- To be orderly in sessions

COURSE CONTENT

- Assess and classify the sick child of age 2 months to 5 years (diarrhea).
- Video on general danger signs, cough or difficult breathing
- Assess and classify the sick child (fever).
- Video: Diarrhea
- Classify the sick child (ear problem).
- Assess and classify the sick child and video on ear problem, malnutrition and anaemia.
- Identification of treatment
- Treating the child, treat the chills,
    - Plan A: treat diarrhea at home
    - Plan B: treat some dehydration with ORS-Oral Re-hydration Salts.
    - Plan C: treat severe dehydration quickly.
- Counsel and follow up by counseling the mother about feeding problems, individual assessment of participant case management.
- Video on assessing & and classifying young infant for bacterial infection and management,
- Assess breast feeding at maternity ward.

METHODOLOGY

Different methods were used during training and these were:

- Three field visits for clinical practice were conducted at Ishaka and Comboni hospitals. This was aimed at identifying and treating a physical sick child and assessing breast feeding at out patients', in- patients' ward and maternity ward respectively.

Assessment at in-Patient ward Comboni Hospital

Assessing a child at Out Patient Department-Ishaka hospital

- Video demonstrations and exercises were conducted in class sessions on assessing and classifying general danger signs, cough or difficult breathing, diarrhea, ear problem, malnutrition, and anemia, assess and classify young infant for bacterial infection.
- Photographs were used in finding out malnutrition, anemia, and breast feeding.
- Support supervision was used during field visits on clinical sessions.
- Demonstrations for preparation and administering ORS.
- Role plays were conducted for counseling mothers on feeding.
- Individual written exercises and feedback
- Drills and brainstorming.

– Reading charts and manuals for assessment and classification.

Participants reading an IMCI chart

– Daily evaluation was done to assess the day's work.
– Facilitators meetings were held every evening to review the days' work and plan for the next day's sessions.
– Checklist forms were used to guide facilitators during clinical practicals.
– Pre and post tests were also administered to the participants.
– Energizers were used to keep participants awake and active.

DAILY IMCI EVALUATION.

A simple questionnaire was administered to the participants daily, to find out what was most useful to them, what was difficult and the suggestions to overcome such difficulties, and suggestions for the next day.

Most useful:
- Video exercises helped participants to understand topics more clearly.
- Learning how to assess and classify the main symptoms of childhood illnesses
- To identify and classify dehydration
- To identify lethargy and unconsciousness
- Completion of modules
- Assessing, classifying and treating the sick child during clinical practice.

Most difficult

Assessing children for malnutrition and anemia.
- Fever
- Full time class attendance
- Interpreting photographs in the book let
- Overtime.

Suggestions to overcome difficulties
- Recap topics before the next session
- Discussions with fellow trainees
- Facilitators should do their best to make us understand.
- Come early for sessions
- Keep time so that we finish in time
- There should be short breaks to help us boost concentration
- Break off in time
- Prepare good meals.
- To get more photos which are of different symptoms to help us to understand better.
- To have lunch break in time

General comments
- The course has been of great importance and facilitators to continue with the same spirit.
- The course needs a period of more than one week.
- Lessons end late and we can't prepare well for the next lessons

LESSONS LEARNT

Malnutrition causes 54% of mortality among children under five years as all illnesses/ diseases contribute to it.
- Use of one guideline booklet for IMCI was found to be convenient for the health workers.
- IMCI is applied in OPD only not in-patient ward.
- IMCI is not for community workers
- IMCI is for comprehensive nurses, enrolled nurses, nursing offices and clinical officers.
- Uganda is one of the 44 countries practicing IMCI.
- Participants were interested and active during training.
- Clinical practice helps much in IMCI training.
- UHC realized that adequate preparation is important for the smooth running of the workshop.
- It was also observed that residential trainings help participants to arrive early and to regularly attend sessions as well as availing them time to discuss assignments they are given every day.
- Facilitation using different methods helps participants to understand more clearly.

- Partnerships and political will are very important in organizing and training programmes.

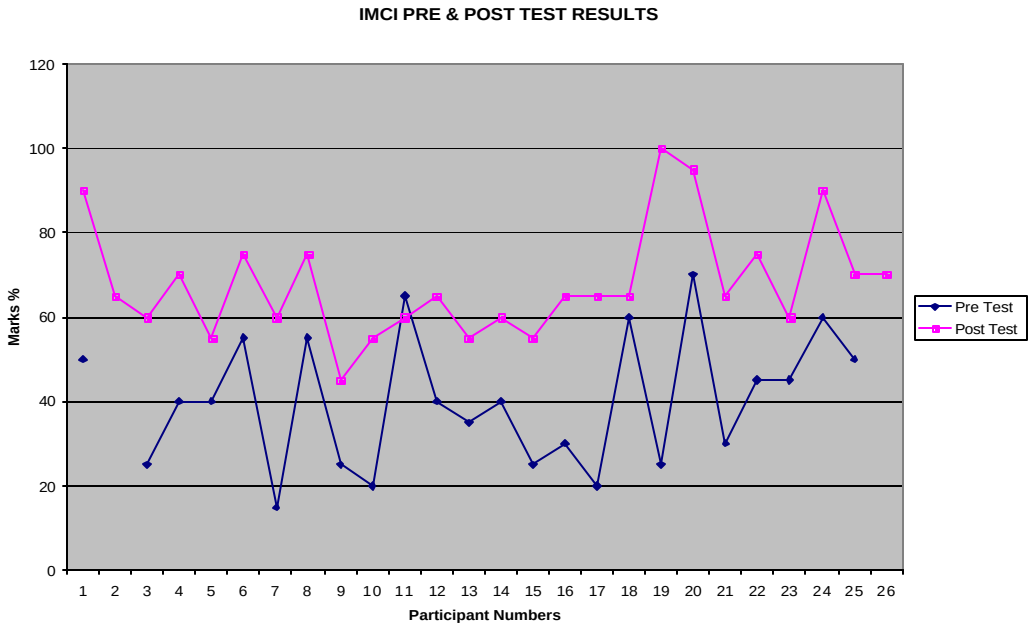
Bushenyi LC5 Chairman addressing the participants

ACHIEVEMENTS:

- All 25 health workers invited turned up and completed the training.
- All topics planned were covered successfully and training closed in time.
- Most of the activities done during workshop were captured on camera.
- District officials turned up to officiate at the training.

Deputy DDHS Bushenyi District, addressing participants

- Every participant had assessed, classified and treated a sick child during training.
- 24 out of 25 participants were above 50% in post test.



- In clinical practice, each participant managed to see an average of 6 cases in total and the following clinical signs were observed:
    - Not able to drink or breast feed

- Vomits everything
- Lethargic or unconscious
- Fast breathing
- Chest in drawing
- Sunken eyes
- Stiff neck
- Drinking poorly
- A measles rash
- Red eyes
- Pus draining from the ears
- Severe palmer pallor and some palmer pallor

– Each participant received a chart booklet as a case management guide line.

CONSTRAINTS:

– One participant was below 50% in post test.
– Failure to have preparatory meetings of facilitators and organizers before training brought delays to start on the first day.
– Starting late due to changing from non-resident to residential.
– It was not easy to get out patients because of the low patient turn up at the hospitals.

RECOMMENDATION/ SUGGESTIONS

– Facilitators and organizers to have meeting a day before training to enable prior arrangement or preparations.
– Contact facilitators before planning training.
– Need to train the remaining health workers involved in managing sick children.
– Timely follow up of IMCI trained health workers
– Regular IMCI support supervision.
– District support to IMCI activities by equipping the health units with equipment and supplies

WAY FORWARD

– Health workers to aim at reducing mortality rates among under fives by practicing IMCI immediately in order not to forget the standard IMCI procedures.
– DDHS in conjunction with MOH facilitators should conduct follow ups of health workers trained in IMCI at least with in 2 weeks after training for effectiveness of the practice.
– Health workers trained in IMCI to conduct on-job trainings to fellow junior staff
– Chart booklet to be put on prescription table for every one's access at the health unit.
– To organize and train more health workers in other counties.
– Participants to be given certificates

APPENDIX

In the appendix are; names of facilitators, logistics used, evaluation form and time table.

Ministry Of Health facilitators:

1. Ibanda Samuel
2. Kakaire Godfrey
3. Mudhasi Kayuza Aggrey

District facilitators:

1. Sr Wagama Theresa
2. Dr. Barigye Celestine
3. Mr. Wandera James

Workshop Coordinators

1. Batusa Joy
2. Kiwanuka Lydia
3. Musiimire Dorah
4. Karungi Grace.

Participants Group leaders

1. Chairperson: Ithungu Bernadette
2. Timekeeper: Musondolya John.
3. Welfare: Keneza Rose
4. Religious leader: Kamugisha Cornelius.

Logistics used

- Flip charts
- Markers
- Masking tapes
- File
- Pens and pencils
- ORS sachets
- Note books
- Cups
- Video tapes
- Charts
- Stapler
- Manuals
- Screen and deck
- Vehicles
- Paper
- Generator.

TIME TABLE

Day	Course Content	Duration
Day 1	Registration Pre-Test	1 hour
	Opening Presentation	
	Module: Assess and clarify the sick child age 2 months upto 5 years through 4.1 Assess diarrhea	3 hours
	Video: General danger signs , cough or difficult breathing	1 hour
	Module: Continue assess and clarify the sick child through 5.1 Assess fever Video: Diarrhea	2 hour 1 hour
Day 2	Recap and feedback Continue assess and clarify the sick child through 6.2 classify ear problem	 2 hours

	Out Patient session: Assess and clarify through ear problem In-patient session: Assess and clarify through ear problem	2 hours
	Module : Finish Assess and clarify the sick child Video: Ear problem , Malnutrition and Anemia Module: Introduce identify treatment	2 hours 2 hours
Day 3	Recap and feedback Module: Continue Identify treatment	 3 hours
	Out-patient session: identify treatment In-patient session: Through identify treatment Module: Finish Identify treatment Module: Introduce treat the child	2 hours 2 hours 1 hour
Day 4	Recap and feedback Module: Continue treat the child	3 hours
	Out-patient session: Treat the child Plan A: Treat diarrhea at home Plan B: Treat some dehydration with ORS In-patient session: Plan B: Treat some dehydration with ORS Plan C: Treat severe dehydration quickly	 2 hours
	Module: Finish Treat	2 hours
	Module: Introduce counsel and follow up	1 hour
Day 5	Recap and feedback Module: Finish counsel and follow up	 1 hour
	Out-patient session: Counsel the mother about feeding problems (Individual assessment of participant case management) Counsel the mother	4 hours
	Module: Introduce sick young infant Video: Assess and clarify young infant for bacterial infection	3 hours
Day 6	Recap and feedback Video: Assess and clarify young infant for bacterial infection	 1 hour
	Out-patient session: Management of the sick young infant Assess breastfeeding POST-TEST	2 hours 45 Minutes

	CLOSURE	

Daily evaluation form

1. What was the most useful for you today?

2. What was the most difficult for you today?

    a) What suggestions do you have to overcome this difficulty?

3. What suggestions do you have for tomorrow?

END

Annex B: C-IMCI Training Report

HealthPartners
Uganda Health Cooperative
Plot 2, Ibis Vale, Off Prince Charles Drive
PO Box 27659, Kampala, Uganda
Tel: 256-41-342353 Fax: 256-41-258678

COMMUNITY INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES TRAINING FOR CORPS IGARA COUNTY

CONDUCTED AT KATUNGU MOTHERS UNION

FROM 11th SEPT - 13th SEPT 2006.

REPORT BY

CHILD SURVIVAL TEAM
UGANDA HEALTH COOPERATIVE

0.2. ACKNOWLEDGEMENT

HealthPartners Uganda Health Cooperative acknowledges USAID for fully funding this three days training. Also gratitude goes the Director and the Administrator for all the necessary preparations to have this training take place.

The MOH Facilitators and District Trainers are thanked for conducting this training, while the participants are highly appreciated for their active participation and attendance in this training. The Management team Mothers' Union Katungu for providing the facilities

Lastly, many thanks go to the District Local Government leaders, namely; the Chair Man LC V and the District Director of Health Cervices (DDHS) for accepting to officiate the opening and closing of the training.

0.3. SUMMARY

This report comprises of Participants' expectations, ground rules, workshop objectives, content, methodology, lessons learnt, achievements, constraints, recommendations suggestions and way forward. In the appendix are the timetable, Evaluation form, photographs as well as the list of facilitators and participants.

0.4. INTRODUCTION

Community Integrated Management of Childhood Illnesses (IMCI) training was conducted for 23 CORPS of Igara County from 11th Sept –13th Sept.2006 at Katungu Mothers' Union Bushenyi.

This training was organized by Uganda Health Cooperative and funded by USAID. The facilitators were 3 from MOH and 3 from the district. The Deputy DDHS Mr. Barigye opened the training while the Chairman LC V M r. Longino Ndyanabo Isanga closed it.

The trained Community Owned Recourse Persons (CORPS) are the Community Educators supposed to assist the mothers and care takers to identify sick children for treatment and mobilization for prevention activities like use of Insecticide treated nets, immunization, and growth monitoring and sanitation improvement. This is mainly done through community education sessions in villages.

1.1. PAPRTICIPANTS EXPECTATIONS

Participants had the following expectations:

- To learn how to prevent diseases in children.
- To learn more about immunization against measles in children
- To get information on treatment of illnesses in children
- To learn how to care for children and prevent ion of diseases.
- To acquire skills in educating the community.

1.2. TRAINING OBJECTIVES

The following were the training objectives of the course:

- To build the district capacity to co-ordinate the implementation of House Hold/community IMCI implementation.
- To strengthen links between facility- based IMCI and individual families and communities as a whole.
- To accelerate and strengthen interventions of HH/C-IMCI level for the prevention of common childhood illnesses, improvement of home care for sick children and care seeking.

1.3 AIM: To promote key household and community practices that will ensure improved childcare for survival, growth and development among the under 5 years.

1.4 GROUND RULES / NORMS

Participants came up with the following rules:

(a) To respect each other
(b) To keep time
(c) To be orderly
(d) To provide a helping hand/ volunteering
(e) Keep all mobile phones off or in silent mode

After setting ground rules the participants went ahead to select their own leaders for smooth running of the workshop. They were as follows;

- Chair Person Salongo Mwesigye
- Time keeper Mutegaya Archangel
- Welfare Nabaasa Rita.

1.5 METHODOLOGY

The following methods were employed during the training:

- Brain storming: Used to find out what participants knew about IMCI
- Charts were also used to help participants grasp the C-IMCI concept better.
- Mock presentations/ rehearsals: these were done through out the training and each CORP was given a chance to present what he/she would have presented at a community education session. This was the framework of the training to equip CORPS with skills, to build their confidence in educating communities.

CORP practicing in education skills.

A checklist was developed to critique each participant as they presented their mock session. This list included following:

a) Proper introduction
b) Systematic presentation
c) Observation
d) Time consciousness
e) Involvement of participants
f) Wrap up of session
g) Confidence and steadiness

- Daily and end of training evaluation to review the results of the training and record lesson learnt.
- Daily meeting of facilitators and organizers to review the day's work and plan for the next day.
- Energizers were regularly done to keep participants awake and alert

CORPS going through an energizer exercise

2.1 COURSE CONTENT

Following the objectives of the training as has already been stated above, it's against that background that this content was developed.

- Exclusive breast-feeding for the first six months.
- Introducing the child to complimentary feeding at 6 months of age.
- Giving children foods rich in micronutrients (Vitamin A, iodine and iron)
- To promote the child's mental and social development
- To dispose off children's feaces in the latrine
- To seek protection from malaria
- To seek appropriate advice regarding HIV/AIDS
- To continue feeding the child during illness
- Give children appropriate home management for illness
- Prevent home accidents
- Complete a full course of immunization
- Recognize the danger signs when a sick child needs treatment at the health facility
- Seeking Ante natal care during pregnancy
- Encourage male participation in child care and reproductive health
- Roles at different levels in implementing house old and community IMCI.

2.2 DAILY EVALUATION RESULTS

These are the results from the daily evaluation done by all participants.
This was what was most useful to the participants.

- Learning that childhood immunisable diseases in Uganda are not six any more but have been increased to eight.
- Getting knowledge about the appropriate time of immunizing children. Hence better informed to educate our communities,
- The topic about home management of fever, diarrhea and cough.
- It was very important to learn about avoiding accidents at home.
- Giving a chance to participants to practice what they will teach in the communities.
- All topics were useful to us
- Having good facilitators
- Having enough drinking water is also important.
- The prevention of diseases caused by poor sanitation
- Learning about exclusive breastfeeding up to six months
- Learning key house hold practices
- Learning how to feed our babies
- The provision of learning aids such as charts, notebooks, and pens.

Participants encountered some difficulties while in this training, and according to them, these were the most difficult hurdles in their way.

- Chart 11 was so big and therefore it was not easily understood.
- There was a language problem where some participants were not familiar with certain words in luganda (native language that facilitators used).
- Again, some CORPS were not comforting because they wanted to be given an allowance as motivation.

In addition, participants suggested ways how these difficulties could be overcome.

- They thought that if facilitators used simpler language then it would be much easier for them to understand.
- Participants also thought recapping chart 11 would help them understand it better.
- They also suggested that they be given a monetary allowance for day and night.

Again, participants had general comments, which they thought could improve the training sessions.

- They thought that the teaching methods that were being used were good and should be continually used.
- That praying before breaking off for meals and after sessions was a good practice for them.
- Participants suggested that it would be good for them to have private discussions amongst themselves concerning their day's work.
- CORPs also argued that they needed out of pocket allowance to meet their personal needs.
- Participants shared the idea that they needed facilitation in form of gumboots, umbrellas and t-shirts while in the field.
- They also expressed the need to be given enough transport refund.
- CORPs also suggested that they would like to be given bicycles to facilitate the to mobilize communities.

2.3 LESSONS LEARNT:

Participants through out the training session learned a number of lessons. These were:

- That exclusive breast-feeding up to 6 months builds a child's immunity.
- Male participation is key in taking care of families.
- Poor feeding leads to malnutrition.
- Untidiness and poor storage of harmful or sharp items in a home leads to accidents at home.
- Good hand washing practices prevents many diseases.
- Late seeking of treatment is dangerous for children
- It is very important to give more food and fluids to a sick child because it rejuvenates its energy.
- False teeth-"ebyiino" and "oburo"- "millet" are none existent diseases. Therefore CORPs are to be examples in their communities, of people who do not believe and practice these two false extractions.

2.4 ACHIEVEMENTS

- 23 CORPs attended the training successfully.
- CORPs were given skills and knowledge for community education
- Course content planned for was full and well covered in time.
- CORPs were given charts to help them in conducting education Sessions.

A CORP practicing in using a chart

- There was commitment for both Ministry of Health and district facilitators
- There was district local government political support where the LC5 chairman officiated at the closure of the training.

LC5 Chairman officiating at closure

2.5 CONSTRAINTS

- CORPs had many demands as already detailed in the daily evaluation, which UHC could not afford to meet.
- 25 participants were invited but only 23 turned up for the training.
- The spirit of voluntarism is still low among the CORPs; hence they still have high expectations of being paid.

2.6 RECOMMENDATIONS/ SUGGESTIONS

- CORPS to be consistently reminded that they are volunteers and accountable to their communities, families and themselves, which is important for the development of their communities
- CORPs who did not turn up for training should be replaced so that community education in those areas is continuous.
- Health workers should also be educated about Community IMCI so that they can ably coordinate with CORPS and monitor their activities.
- CORPs who demonstrate distinguished effort in doing community education to be acknowledged with a form of motivation.
- CORPS should get review meetings with UHC at every end of month to discuss the progress of community education and plan for the next month.

2.7 WAY FORWARD

- Participants to develop work plans within 2 weeks after the training, and there after to proceed to doing community education so that they practice what they have acquired from the training.
- CORPs to work together with local councils to develop their education programs.
- UHC to follow up CORPS- to collect work plans at designated areas.

APPENDIX

BELOW IS THE TABLE SHOWING THE NAMES OF PARTICIPANTS AND THEIR SUBCOUNTIES OF OPERATION

NO	NAME	SEX	SUB COUNTY
1	Nabaasa Rita	F	Nyabubare
2	Muroosi Naboth	M	Nyabubare
3	Kishunju Mary	F	Nyabubare
4	Bagyenda Prutazio	M	Nyabubare
5	Nuwamanya Dinah	F	Kyamuhunga
6	Mujuni Justine	F	Kyamuhunga
7	Muteguya Archangel	M	Kyamuhunga
8	Rubahuriza Asaph	M	Kyamuhunga
9	Rutazaana Lazaro	M	Bumbaire
10	Muhumuza Laban	M	Bumbaire
11	Bahande Prisca	F	Bumbaire
12	Mucunguzi Anna	F	Bumbaire
13	Nahikiriza Loy	F	Kakanju
14	Mwesigye Ezra	M	Kakanju
15	Bayambana Saidi	M	Kakanju
16	Kategaya Obed	M	Kyabugimbi
17	Tumuhairwe Loyce	F	Kyabugimbi
18	Muramuzi Pastori	M	Kyabugimbi
19	Nuwagaba Elibayari	M	Kyabugimbi
20	Barimunsi Prossie	F	Kyeizooba
21	Ganjoojo Muhamood	M	Kyeizooba
22	Kenani Muhangi	M	Kyeizooba
23	Mugabe Henry	M	Town council

TIME TABLE

TIME & DATE	TOPIC	RESPONSIBLE PERSON
DAY 1 11/09/06		
8:30 –9:30 am	Arrival & Registration	UHC
9:30 – 10:30am	Welcome remarks. Introduction, participants' expectations, workshop objectives	UHC
10:30- 11:00am	Break tea	All
10:30 - 1:30 pm	-Exclusive breastfeeding for the first six months -Starting complementary feeding at six months.	MOH & District officials.
1:30 – 2pm	Lunch Break	All
2pm – 5:30pm	- Give children foods rich in micro-nutrients (Vitamin A) iodine and iron. -Promote child's mental and social development. Disposal of children's feaces in a latrine.	MOH & District
5:30 – 5:30pm	Daily Evaluation	All
5:30 - 5:45pm	Evening tea	All
5:45- 6:30pm	Facilitators meeting.	UHC, Facilitators.
DAY 2 12/09/06		
8:00-8:30am	-Seek protection from malaria -Prevention of child abuse	MOH & District team
10:30am- 11:00am	Break Tea	All
11:00am- 1:30pm	-Seek appropriate advice regarding HIV & AIDS. -Continue feeding during illness -give sick children appropriate home management for illness.	MOH District team
1:30pm – 2pm	Lunch Break	All
2pm –5pm	-Prevent home accidents -Complete a full course of immunization	MOH, District
5pm- 5: 15pm	Evaluation	All
	Evening tea	All

5:15pm- 5:50pm		
5:50pm- 6:30pm	Facilitators meeting	Facilitators, UHC
DAY 3 13/09/06		
8:00- 8:30am	Evaluation feedback	All
8:30-10:30am	-Recognize the danger signs when a sick child needs treatment at health facility. -Seeking ANC during pregnancy.	All
10:30-11:00am	Break tea	All
11:00-1:30pm	-Encourage male participation in child care and reproductive health -Roles at different levels in implementing house hold & community IMCI.	MOH, District facilitators.
1:30-2pm	Closure and lunch	-Chairman LC5 Bushenyi district. All

LIST OF FACILITATORS

Godfrey Kakaire	***Ministry of health***
Aggrey Mudhasi	Ministry of health
Samuel Ibanda	Ministry of health
Charles Babikunyamu	Bushenyi district
Thereza Sr Wagama	Bushenyi district
Dr Celestine Barigye	Bushenyi district

DAILY EVALUATION FORM

4. What was the most useful for you today?

5. What was the most difficult for you today?

    a) What suggestions do you have to overcome this difficulty?

6. What suggestions do you have for tomorrow?

END

Annex C: Certificate of Registration

THE REPUBLIC OF UGANDA

THE CO-OPERATIVE SOCIETIES ACT, CAP 112.

Certificate of Registration

OF

UGANDA HEALTH CO-OPERATIVE LIMITED

P.O. BOX 33871 KAMPALA

I hereby certify that I have this day registered the above-named Society and its by-laws under the provisions of section 6(2) of the Co-operative Societies Act,Cap 112.

Given under my hand this FIFTEENTH day of SEPTEMBER TWO THOUSAND AND SIX.

Certificate No. 7816/RCS.

FREDERICK EDWARD MWESIGYE

Registrar of Co-operative Societies

Annex D: Brochure for Health Scheme Promotion

HealthPartners®

Uganda Health Cooperative

Community Financing for Health Services

"Sustaining a healthy community through partnership"

Goal

HealthPartners Uganda Health Cooperative's goal is to create affordable community health schemes in Uganda. Through a working relationship with your local hospital, health care provider or clinic, we create a system for you to access care whenever you need it.

Eligibility

Health schemes are open to established and organized groups. These include formal sector employees and their families, informal sector workers associations, schools, colleges and institutions, social and community groups.

How It Works

- The scheme provides coverage for designated health services for members.
- Uganda Health Cooperative works with leaders of organized groups to sensitize members.
- Care packages are determined by group leaders and agreed upon by providers.
- At registration, members receive ID cards to show the provider when they go for care.
- Premiums are collected from members 4 times each year.
- Membership is effective after an agreement has been signed between the group and the provider.
- Members are provided regular accounts of services utilized by the entire group. This total transparency facilitates the appropriate review of premiums and coverage.
- Scheme members are invited to health education sessions to help them keep their families healthy.

What Is Covered

Coverage depends on member ability to pay, services available and amount of premium contributed. Coverage usually includes out patient, inpatient and preventive care including health education and products.

Benefits To Members

- Timely access to quality health care.
- Financial security in case of illness.
- Health care costs are predictable.
- No selling of property and borrowing of money.
- Better security and less worry if you or your family members have a catastrophic illness as less money is spent on the illness.
- Long-term relationship between you and the provider is established.
- Health education.
- Provision of preventive health products at an affordable cost.

Benefits To Provider

- Increased revenue and increased attendance.
- Predictable revenue inflow.
- Reduction of bad debts.
- Healthier clients.

What Members Say About The Health Scheme

"We do not have to worry about paying for medical bills when our family members fall sick because we have already prepaid a premium."

"Our *productivity and wealth has greatly increased because of our improved health."*

"We no longer sell our property i.e. cow, goat, etc. in order to seek medical treatment."

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or

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Enkozesa ya Sente Omu Kyanga Ahabikwatirine N'ebyamagara

"Okwemerezaho n'okuretaho amagara marungi omu kyanga obwo turikukwatanisiza hamwe"

Ekigyendererwa

Ekigyendererwa kya Health Partners Uganda Health Cooperatives, n'okutandikaho ebibiina by'ebyamagara omu byaaro ebi abantu barikubasa kushashura. Omukeretaho okukoragana na eirwariro, omuhereza w'ebyamagara hamwe n'oburwariro obukye, nitutandikaho enkora y'okureba ngu mwabasa kutunga obujanjabi buri kubwetenga.

Abu Bishemereire

Ebiina by'ebyamagara bishemereire kwetabwamu ebitongore ebihandikiisibwe. Nibyo ebi, abakozi b'ebitongore by gavumenti n'amaka gaabo, abakozi b'ebitongore ebitaribya gavumenti, amashomero, namatendekyero, hamwe n'ebibiina ebindi eby'omu byaaro.

Okukirikutwazibwa:

- Ekibiina nikihereeza be memba okurebererwa aha by'a magara okubetoraneire.
- Uganda Health Cooperative neekorara hamwe n'abebembezi b'ebitongore kushomesa abantu abari ba memba.
- Obujanjabi oburikuherezibwa nibutekateekwa ababembezi b'ebitongore, kandi bwikirizibwanaho abari kubuhereza.
- Omukuhandikwa kwa ba memba, nibaherezibwa endanga muntu (Identity cards) kwenda kworeka abahereza b'obujanjabi ahu bari kunjanjabirwa.
- Omutemo gw'esent (omusimbo) niguguma nigushorezebwa omubantu abari bamemba emirundi ena, buli mwaka.
- Obwa memba nibutandikiraho bwanyima y'okuhandika endagaano ahagati y'ekitongore, nabahereza b'obujanjabi.
- Ba memba burijo nibaguma nibaherezibwa embariira y'ebirikukozesibwa ekibiina kyoona. Amazima n'oburinganiza nibyija kuyamba okereberera gye omusimbo ogurundwainwe, n'okuhika omuri ba memba boona.
- Ba memba be ekibiina nibaguma nibeetwa omu mishomo y'ebyamagara kwenda kubayamba n'amaka gaabo kuguma baine amagara marungi.

Ebirikuherezibwa

Obuherezza nibwija kurugirira ahakubaasa kushashura kwa memba, ebyokukozesa ebiriho hamwe n'omusimbo ogurundainwe. Obuhereza burijjo nibutwariramu abarwaire, eby'okwerinda endwara, emishomo y'ebyamagara n'ebirikurugamu.

Amagoba Ahari ba Memba

- Okugira obujanjabi bw'ebyamagara oburungi kandi oburi haihi.
- Okushohoza (sente) ahabw'okujanjabwa nikuguma kuhami.
- Emihendo y'okushashurira obujanjabi nebaasa kuteberezibwa.
- Okwerinda omu bya sente nikirungi kandi n'okwerarikirira aha b'omuka yaawe nkabagwibwamu endwara mbi nikukye, ahabw'okuba sente ezirikushashurwa omukujanjabwa ninkye.
- Enkoragana y'obwaire buraingwa neija kutandikaho ahagati yaawe nabaheereeza.
- Okushomesibwa aha by'amagara.
- Okuherezibwa ebirikukozesibwa omu kwerinda endwara aha mihendo yahansi.

Amagoba Aha Barikuhereza Obujanjabi

- Okweyengyora kwentasya, n'obwingi bwa abari kwetaba omunkora egyi.
- Entesya nebasa kuteberezibwa.
- Okukyendeeza aha mabanja.
- Okugira abantu abaine amagara marungi.

Ebi Ba Memba Barikugamba Ahari Ekibiina Ky'ebyamagara (Health Scheme)

"Titwiine kwerarikiriira aha kushashurira okujanjabwa omu irwariro ab'omumaka gaitu baheza kurwara, ahabw'okuba tukashashura kare omumakwatane"

"Entunguuka n'obugaiga bwaitu bweyongyeire munonga ahabw'okugira amagara marungi"

"Titwakitunda bintu byaitu nka ente, embuzi, e'ebindi kwenda kuza kujanjabibwa".

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nari

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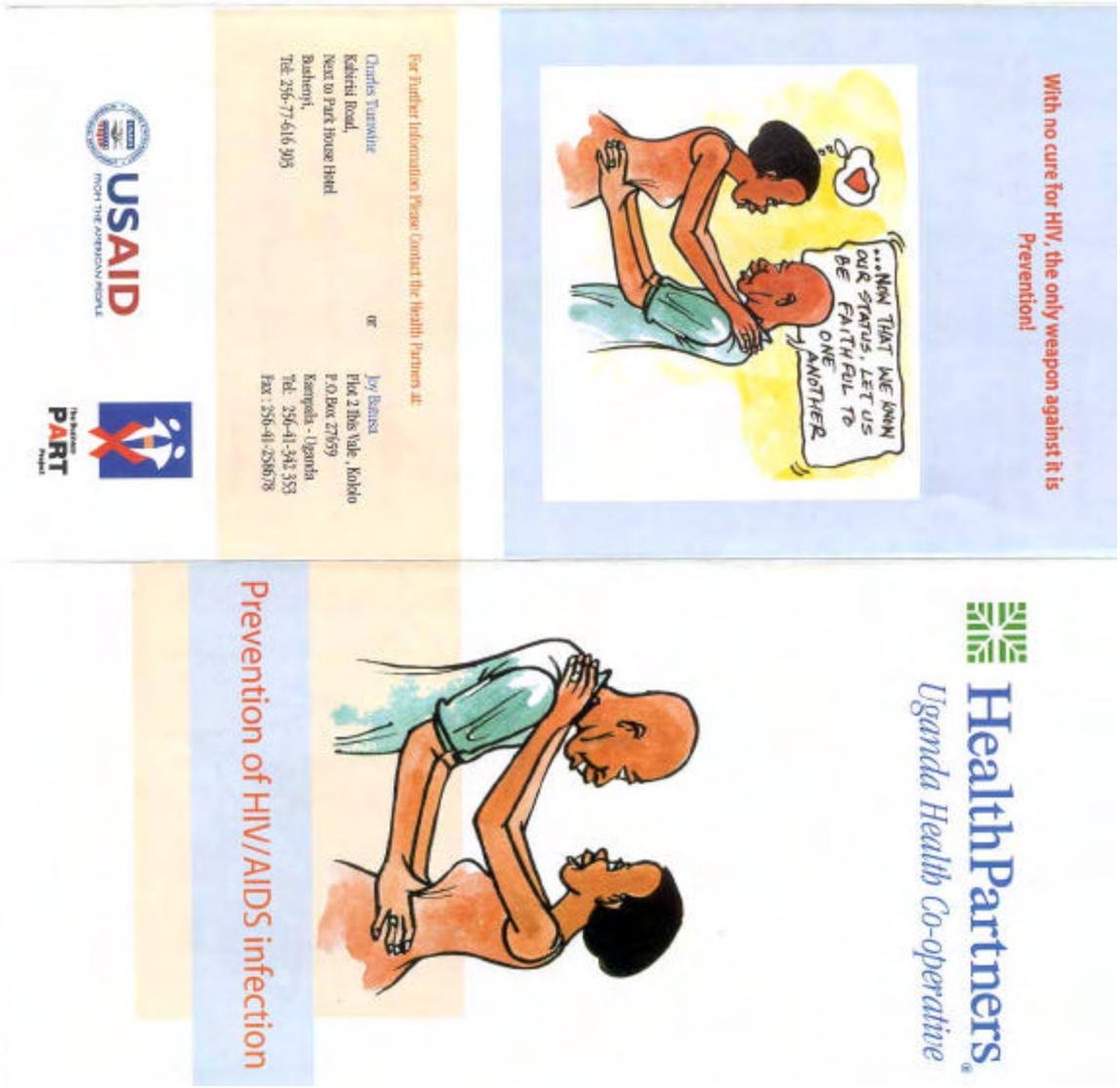
Annex E: HIV Prevention Partnership Training Brochure

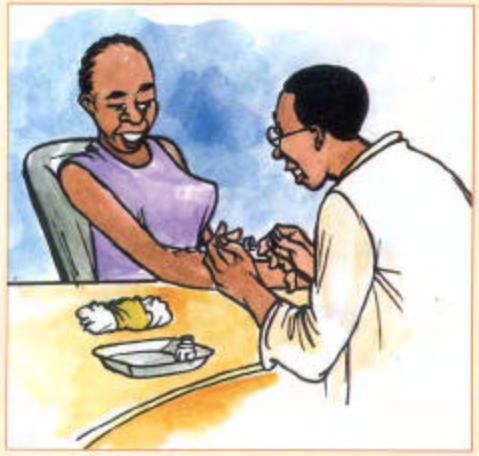


HIV/AIDS is a reality that many of us have encountered. Many people can say that they know someone who is living with HIV/AIDS.

Although this is a disturbing fact, it is important to remember that HIV is preventable. Everyone has the ability to protect themselves and each of us can help one another to stay healthy and stop HIV from spreading.

How do I know I have HIV?

The only way to determine whether you are infected is to be tested for HIV infection. You cannot base on symptoms to know whether or not you are infected with HIV. Many people who are infected with HIV don't have any symptoms at all for many years.



How is HIV transmitted?

HIV can be transmitted from an infected person to another through:

- Blood (including menstrual blood)
- Semen
- Vaginal fluids
- Breast milk

Activities that allow HIV Transmission

- Unprotected sex (without use of a condom) with an infected person
- Direct blood contact through blood transfusions, accidents.
- Through sharing sharp instruments like razor blades, injection needles, safety pins, toothbrushes.
- Mother can infect baby before and during birth as well as through breast milk.

How do I protect myself from infection?

Here are some of the things you could do:

- Abstain from sex if you are not married
- Use a condom correctly and consistently every time you have sex
- Be faithful to one uninfected partner who should also be faithful to you.
- Talk to your partner about testing for HIV if he/she hasn't tested yet.
- Do not share razors or toothbrushes with anyone
- Avoid touching anyone's blood. In cases of accidents at work, use gloves. Talk to your supervisor about providing gloves at the workplace.
- If you are pregnant or intend to get pregnant and you are HIV positive, visit an Antenatal clinic near you and know how you can protect your baby against HIV infection.