



HealthPartners

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**HealthPartners
Uganda Health Cooperative Child Survival
Second Annual Report for 2006-2007**

October 31, 2007

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

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Abbreviations and Acronyms

AMTSL	Active Management of Third Stage Labor
CORP	Community Owned Resource Persons
CBHFA	Community Based Health Financing Association
BCC	Behavior Change Communication
BOD	Board of Directors
C-IMCI	Community Based Integrated Management of Childhood Illness
DDHS	District Director of Health Service
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
MNC	Maternal Newborn Care
MOH	Ministry of Health
NGO	Non-government Organization
ORS	Oral Rehydration Solution
PSI	Populations Services International
PVO	Private Voluntary Organization
VCT	Voluntary Counseling and Testing
SCM	Standard Care Management
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
UHC	Uganda Health Cooperative
UHS	Uganda Health Information System
UMPA	Uganda Private Midwives Association
WRA	Women of Reproductive Age

Child Survival and Health Grants Program Project Summary

Oct-17-2007

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

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Funding Information:

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

Project Information:**Description:**

The Uganda Health Cooperative 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 are 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.

HealthPartners promotes "Sustaining a Healthy Community through Partnership" by building capacity and linkages between community-social, health services and local organizational dimensions. HealthPartners works with the Ministry of Health to build the capacity of the District Health Team, health workers, community volunteers, leaders and partnering organizations. Interventions are linked to member owned prepaid health care schemes, and include ITN distribution, BCC on ITN use, recognition of warning signs and seeking timely treatment for illness, improved hygiene and access to clean water, increased access to and use of ORS, promotion of ANC and VCT, increased male involvement in MNC and improved birthing practices.

Location:

Bushenyi District, Uganda.

Project Partners	Partner Type	Subgrant Amount
MOH	Collaborating Partner	
PSI Uganda	Collaborating Partner	
Family Planning Association of Uganda	Collaborating Partner	
Red Cross	Collaborating Partner	
Uganda Community Based Health Finance Association	Collaborating Partner	
Bushenyi District Health Team	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 Dist. Health System Health Facility Staff	Health CBOs CHWs

Interventions/Program Components:

Control of Diarrheal Diseases (25 %)

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

Malaria (50 %)

- (IMCI Integration)
- (CHW Training)
- (HF Training)
- Training in Malaria CM
- Access to providers and drugs
- Antenatal Prevention Treatment
- ITN (Bednets)
- ITN (Curtains and Other)
- Care Seeking, Recog., Compliance
- IPT
- Community Treatment of Malaria

Maternal & Newborn Care (25 %)

- (IMCI Integration)
- (CHW Training)
- (HF Training)
- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Delay 1st preg Child Spacing
- Integr. with Iron & Folate
- Normal Delivery Care
- Birth Plans
- 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 0-23 months:	6,300
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:

	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

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A. Program Accomplishments in Year Two

HealthPartners Uganda Health Cooperative Child Survival program increases the capacity of local stakeholders and links 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. Community and health service interventions are linked through the Uganda Health Cooperative (UHC), a member-owned prepaid health care system. UHC promotes “Sustaining a Healthy Community through Partnership.” UHC 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 (CORP), leaders and partners to play an active role in improving their health. UHC collaborates with the Ministry of Health (MOH) to build the capacity of the District Health Team (DHT) who, in-turn, provide training and supervision for improved health service delivery. UHC has been strengthened this year through consultant and HQ training for the Board of Directors and providers, installation of the Uganda Health Information System (UHIS), mentorship and incremental transition of management responsibilities to community leaders.

The highlight of the program in 2006/7 was the extent to which partners collaborated with UHC; the more partners learned, the more they stepped up to participate and take ownership of interventions. The Bushenyi District Director of Health Services has been a key advocate of the program attending all Child Survival trainings, monitoring and events with his DHT. This group provides strong political support and leverage for the program in the community. They pay close attention to interventions and their impact, adopting lessons learned in their own programming. One example of this is UHC’s incentive for pregnant women to attend ANC. At their fourth ANC visit, women are given clean birth kits or mamakits which can be used to make delivery safer at the health facility or for home birthing. After noting the increase this incentive is having on ANC demand, the DDHS has added mamakits to their 2008 budget. Similarly community volunteerism is increasing as CORP see the impact they can have in the community and as they are linked to the health care network. Twenty-four CORP were trained in Phase I. Phase II began with 44 CORP, 24 from the community and 20 from health scheme groups. Fifty four CORP attended the last two training sessions for Phase II. Religious organizations have been especially supportive of interventions, inviting CORP to mobilize their congregation after services.

Collaboration and partnership support have also been strong this past year. Scott Aebischer, HealthPartners Senior Vice President and HQ Program Manager traveled to Uganda to train the director and to introduce her to partners including UPHOLD, AFRICARE, and MACIS. At the same time Jennifer Wenborg, HealthPartners Uganda Program Manager, traveled to work with the field team to assess program progress and needs and to build capacity. HealthPartners Database Technician traveled to Bushenyi to install the Uganda Health Information System and to train staff, providers and the Board of Directors how to track data and use reports to make results based decisions to improve health service planning, health scheme management and community interventions. An intern volunteered and paid her own way to learn about international development and community based prepaid health care. She helped staff conduct

Phase I end monitoring and worked with the team to incorporate lessons learned and stakeholder feedback into Phase II plans documented in the 2007 Work Plan (Annex A.) She applied for a Masters program in Public Health when she returned from this opportunity and began her graduate education this September. Land O' Lakes sponsored a cooperative development consultant to join the field team, training the Board of Directors on health scheme management and sustainability. The Board of Directors helped design a monthly training plan to increase their capacity and 24 local PVOs and NGOs came together to organize a health fair on sustaining a healthy community through partnership. The Uganda Community Based Health Financing Association (UCBHFA) collaborated with UHC increasing community and staff capacity through forums for sharing lessons learned. And finally, HealthPartners Foundation Executive Officer volunteered and paid his way to travel to Bushenyi to work with the UHC Board of Directors, the District Health Team and staff to help increase a sense of cooperative ownership in the community through participatory approaches.

Not only did community and partnership capacity increase this year, staff skills in everything from monitoring, using data to make results based decisions, management, communication, computer skills, report writing and strategic thinking improved. Staff attended professional courses, shared lessons learned with one another, and were closely partnered with supervisors who worked to develop their strengths. At the request of staff, the top down management style was changed to bottom up which proved to be an empowering growth opportunity. By developing a financial tracking tool, financial management responsibilities were able to be transferred to local Ugandan management with HQ mentorship. The program is stronger as a result of the local team's increased ability to prioritize interventions within financial parameters.

Summary of Phase I Accomplishments

Statistics	Aug	Sept	Oct	Nov	Dec	Jan	Total
CORP trainings held	2	1	0	1	1	1	6
# of CORP trained	24	23	23	23	23	23	
# of sessions led by CORP	52	18	39	43	34	27	213
# of CORP-led session attendees	2084	392	1207	5526	674	673	10,521
HW/Midwife training/supervision	0	1	1	0	1	2	5*
# of HW/ Midwives trained/supervised	0	24	16	0	17	18	66
Scheme mgmt meetings	21	21	24	22	15	12	115
Marketing meetings	29	29	31	36	37	37	199
# of provider meetings held	7	8	5	4	3	2	29
# of board meetings held	0	0	1	0	0	0	1
ITNs sold	83	6	13	1	0	7	103
ITNs given to women who deliver with skilled attendant	0	0	16	270	233	480	956
Mama Kits distributed at ANC	0	0	0	0	141	522	663
PUR sachets distributed	0	0	0	0	0	520	520
ORS distributed	0	211	0	0	0	0	211
Comboni membership	1,391	1391	1,314	1,314	1,314	1,367	
Ishaka membership	924	924	590	590	590	435	

BMC membership	477	482	1,051	1,051	1,051	1,060	
Mitooma membership	166	169	247	247	266	279	
Nyakasiro membership	819	819	819	819	819	819	
Total membership	3777	3785	4021	4021	4040	3961	

* MNC follow up training for Phase I was moved to March due to MOH scheduling conflicts.

Summary of Phase II Accomplishments

Statistics			P	H	A	S	E	II	Total	I & II Total
	Feb	Mar	April	May	June	July	Aug	Sept		
CORP trainings held	0	0	2	1	0	1	0	2	6	12
# of CORP trained	0	0	44	23	0	47	0	108		
# CORP-led sessions	30	32	12	18	40	26	10	144*	312	525
# of CORP-led session attendees	743	711	395	458	765	1322	525	4212*	9131	19,652
HW/Midwife training/supervision	0	2	2	1	1	1	1	0	8	13
# of HW/Midwives trained/supervised	0	18	42	42	24	32	38	0		
Scheme mgmt meetings	9	10	13	12	15	13	10	16	98	213
Marketing meetings	21	39	36	29	30	24	29	27	235	434
# of provider meetings	0	2	3	2	3	1	0	0	11	40
# of board meetings/training	2	1	1	1	0	1	2	0	8	9
ITNs sold	4	14	9	0	0	0	0	0	27	130
ITNs given to women who deliver with SBA	192	166	170	88	-	-	-	853*	1469	2425
ITNs given to health scheme members U5	0	0	0	0	0	527	0	0	527	527
Mama Kits distributed at ANC	206	300	142	48	-	-	-	627*	1323	1986
PUR sachets distributed	0	0	0	0	120	0	0	0	120	640
ORS distributed	0	0	0	0	75	0	0	0	75	286
Comboni membership	1367	1367	1379	1379	1680	1615	1846	1846		
Ishaka membership	436	436	0	0	0	0	0	0		
BMC membership	1060	460	469	469	494	471	471	471		
Mitooma membership	279	411	391	401	363	344	344	346		
Nyakasiro membership	819	819	819	767	767	767	767	636		
BBC membership			25	25	25	25	25	25		
Nyakashaka						244	244	244		

members										
Total membership	4081	3493	3058	3016	3304	3466	3697	3568		

* There was a delay in collecting sign-in lists, feedback forms and distribution data from health facilities so data presented is for June-September.

Status of Program Objectives

Program Objectives	Key Activities for Interventions	Status of Activities in Year II
Reduce incidence of malaria in Bushenyi district for children under 5 and pregnant women	<ul style="list-style-type: none"> ▪ ITN distribution ▪ Increase demand for ITNs and proper use ▪ Train malaria warning signs and treatment ▪ Increase demand for IPT 	<ul style="list-style-type: none"> ▪ 527 ITNS have been distributed to scheme members Under age 5 to encourage health scheme participation ▪ 2,425 ITNS have been distributed to women who delivered with a skilled health provider at health facilities ▪ 130 ITNS have been sold with profits going into to coffers to purchase more ▪ 44 CORP trained in C-IMCI ▪ 54 CORP trained in Malaria prevention ▪ 23 CORP attended C-IMCI refresher training ▪ CORP held 525 mobilization sessions turning in sign-in lists with a total of 19,652 signatures. About 50% of attendees either cannot or choose not to sign forms thus actual estimated impact is closer to 40,000. C-IMCI BCC includes when and how to use ITNs and who should be first priority for sleeping under them. These sessions also include recognizing warning signs of malaria and when to seek treatment, and BCC on ANC to increase demand for IPT.
Reduce incidence of diarrhea in Bushenyi district for children under 5	<ul style="list-style-type: none"> ▪ Train diarrhea warning signs ▪ Improve access to safe water ▪ Increase safe water practices and hand washing ▪ Improve sanitation practices ▪ Train diarrhea home care 	<ul style="list-style-type: none"> ▪ 44 CORP trained in C-IMCI ▪ 23 CORP attended C-IMCI refresher training ▪ CORP held 525 mobilization sessions turning in sign-in lists with 19,652 signatures. C-IMCI training includes diarrhea warning signs, safe water, hand washing and sanitation and diarrhea home care. ▪ ORS stations have been established and stocked with necessary supplies in 27 health centers; 15 of which report preparing ORS daily; 7 children were given ORS during the most recent monitoring visit. When ORS is given, people are trained to administer it. ▪ HWs appreciated being able to distribute ORS from the stations and demonstrated increased skills in preparation and monitoring results as they were motivated to maintain this benefit. ▪ Safe home competitions were held by 24 CORP in Igara to encourage improved sanitation, hand washing and access to safe water.
Increase % of pregnant women receiving	<ul style="list-style-type: none"> ▪ Create demand for ANC ▪ Train community on 	<ul style="list-style-type: none"> ▪ 62 CORP received MNC training ▪ 54 CORP attended HIV/AIDS training ▪ CORP held 525 mobilization sessions turning in sign-in lists with 19,652 signatures.

<p>improved ANC, delivery and post partum care</p>	<p>importance of VCT and PMTCT</p> <ul style="list-style-type: none"> ▪ Train MNC ▪ Distribute mama kits and train importance of planning for safe birth 	<ul style="list-style-type: none"> ▪ CORP BCC includes the importance of ANC, VCT, PMTCT, MNC and safe birth plans. ▪ 1,986 mama kits have been distributed at the fourth ANC session to encourage women to attend all MOH recommended ANC. ▪ 2,425 ITNs have been distributed to women who delivered with a skilled health professional in a facility.
<p>Build local organizational capacity to manage health schemes</p>	<ul style="list-style-type: none"> ▪ Improve board mtgs & capacity ▪ Change health scheme benefit structure ▪ Promote health scheme membership ▪ Build Board capacity and train self assessment ▪ Update UHIS for CS and train users to manage data and make results based decisions 	<ul style="list-style-type: none"> ▪ 47 CORP attended orientation training on health plans, child survival and behavior change communication ▪ 434 marketing meetings encouraging people to join health schemes have been held. ▪ UHC posters have been posted at health facilities ▪ 40 provider meetings have been held to build the capacity of health scheme management and improved service management for women and CU5 ▪ 9 Board of directors meetings have been held to build the capacity of the UHC board to manage and sustain cooperative based health schemes ▪ A stakeholders workshop was held after the first phase to disseminate monitoring results, lessons learned and for participatory planning for Phase II ▪ A community health fair was held with partners to spread the word about health schemes and promote preventive health care strategies. Malaria and Diarrhea prevention stalls and an MNC stall were manned by a CORP and HW to promote healthy behaviors and to distribute IEC materials. Program included awards for volunteer and health service participation and drama on positive health practices. ▪ UHIS installed, training for staff, providers and BOD. ▪ UHIS reports are printed monthly and shared with leaders and the BOD to help them see how data can improve decision making to improve the health of the community and performance of health schemes. ▪ UHC tracks member premiums, co-pay, treatment costs and surplus and deficit by group and provider each month and cumulatively. This tool improves management, monitoring and decision making.
<p>Improve health care management especially for WRA and children</p>	<ul style="list-style-type: none"> ▪ Improve resource stock maintenance ▪ SCM for malaria and diarrhea 	<ul style="list-style-type: none"> ▪ In collaboration with the MOH, followed up barrier analysis on stock management with stock management training for all health facilities in Bushenyi District. ▪ 12 HWs attended Phase I MNC training and 9 attended follow up training. 24 HW attended Phase II MNC training. Phase II MNC follow up for Igara included 9 medical

<p>under 5</p>	<p>according to IMCI & MOH</p> <ul style="list-style-type: none"> ▪ SCM for MNC ▪ SCM for safe/clean delivery and AMTSL ▪ Train and follow up on self assessments 	<p>officers, 12 clinical officers, 44 nurse midwives and 5 anesthetics; follow up for Ruhinda included 8 medical officers, 10 clinical officers, 20 nurse midwives and 2 anesthetics.</p> <ul style="list-style-type: none"> ▪ 25 HW attended Phase I IMCI training, 17 participated in follow up training. 21 HW attended Phase II IMCI training, 15 HWs from Phases I and II participated in IMCI follow up. ▪ 46 HW attended drug quantification/stock management training. ▪ The Bushenyi DHT attended a series of IMCI and MNC training and supervision courses on how to train and follow up health workers and how to collect and use data to improve services. The DDHT will conduct these trainings and follow up sessions for Phases III-VII. ▪ Supplemented MOH funding to ensure coverage reached Bushenyi providers. ▪ Printed MOH protocols and guidelines for best practices and distributed to health workers to post in health facilities. ▪ Visited Health Facilities to ensure protocols and guidelines were posted and are easily accessible. ▪ Self assessment training was determined to be too much on top of already time challenged schedules for HWs. Focus instead has been shifted to building relationships between HW and DDHT and increasing supervision and support.
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Status of Technical Interventions

Technical Intervention	Key Activities in Technical Interventions	Status of Activities
<p>Staff Capacity Building</p>	<p>Staff selected continued education courses in conjunction with Director recommendations for building their skills. After the courses each person developed a presentation to share the lessons they learned with the rest of the team.</p>	<p>Participatory marketing training led by HQ PM for staff February. Computer training was held for all staff by PSI computer specialist in March. Excel training led by Director for all staff in April. One Scheme Mgr attended mgmt skills training course, one attended customer care training, and one attended a course on public relations and customer care at UMI in May. Accountant attended budgetary management and expense control course at UMI in May. Field and Scheme Mgrs and Marketers attended UCBHFA monitoring and narrative report writing course in June. Scheme Marketer attended communication and presentation skills course at UMI in June. M&E Coordinator completed AMREF M&E Training in Kenya, July. Scheme Mgr was invited by UCBHFA to a fully sponsored exchange visit to Community Health Finance organizations in Tanzania in July.</p>

Mini-University	Short technical sessions on behavior change strategy, CSSA, M&E. Networking and opportunities to learn from other programs.	Director Completed June
LQAS, HFA and ISA Monitoring	Phase I Igara County LQAS, HFA and ISA monitoring took place in February 2007, stakeholder workshop held in March. Phase II Ruhinda LQAS, HFA, ISA monitoring will begin October 2007, stakeholder workshop is planned November 6, 2007.	Phase I monitoring completed. Results were disseminated in March 2007 and included in a work plan developed by field staff and disseminated to staff and partners in April 2007. Lessons learned were applied to Phase II program planning and enhanced the impact and number of beneficiaries in this phase.
Database Implementation, Training and Use	UHS was upgraded in 2006 and installed by HealthPartners Information Services Technician in February 2007. Staff and BOD training followed installation.	Staff, providers and BOD were trained by HealthPartners IS Technician to maintain database, read reports and make results based decisions regarding management of health schemes and preventive health/BCC for targeted groups. Follow up training on using reports to determine priority interventions held by M&E Coordinator in August.
UHC Board of Directors Capacity Building	BOD met 9 times in the past year to increase their involvement and capacity to manage health schemes.	BOD fills out quarterly self assessments which show improved ratings. Cooperative consultant met with BOD in February to increase leadership skills. BOD toured health providers and met with scheme mgrs in May. Health fair planning meetings held May-June, BOD lead health fair activities. Financial mgmt training held for BOD in July. BOD met with HealthPartners Foundation Executive Director to learn participatory research and improving member services in August. Mentorship and planning mtg. took place in August for the BOD to prepare to lead the Annual General Meeting in Nov.
Improve staff communication & reporting	<p>Monthly reports due by all staff.</p> <p>Monthly meetings are held with Managers and direct reports and Director leads team meetings each month.</p> <p>Director meets with individual staff as necessary to increase targeted skills.</p>	<p>PM, Director and Field Manager mentor staff using reports to improve SMART goal setting and to help prioritize activities for the following month. Reports show improved staff ability to think strategically.</p> <p>UHC tracks member premiums, treatment costs, co-pay, surplus and deficit by group and provider each month to improve communication and understanding of scheme performance and sustainability.</p> <p>Community Educator developed report writing guidelines to help staff improve skills.</p>

Improved Financial Management	<p>Improve BOD ability to maintain health cooperative, setting appropriate premiums and leveraging surpluses to a reserve fund.</p> <p>Improve staff ability to make strategic financial decisions to improve intermediate results.</p> <p>Improve leadership ability to prioritize programmatic decisions within financial limitations.</p>	<p>Held BOD financial management training in July. Control over setting premiums and making other financial decisions has begun to be transitioned to BOD.</p> <p>Developed a monthly and annual cumulative budgeting spreadsheet in US Dollars and Uganda shillings to help leadership staff make appropriate financial decisions for the program.</p> <p>Staff manage individual budgets to prioritize their activities within the full scope of program goals.</p>
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B. Factors that have impeded progress toward achievement of overall goals and objectives and actions being taken to overcome constraints:

Challenge: Uganda has a long history with international donor organizations. There is an expectation in Bushenyi that money and resources should be provided for free to the community. HealthPartners was able to overcome this with UHC largely because it is member-owned and requires commitment from providers, members and leaders. By adding involvement of the MOH, the DHT and by increasing benefits for mothers and children under 5, the program was faced with an influx of demands and requests for resources and remuneration for participation in program activities.

The Uganda Health Sector Strategic Plan requires the district health teams to carry out support supervision of the district staff at least once every quarter. In reality national and district budgets are not adequate for this activity. UHC supports the implementation of this activity in Bushenyi district. This requires the program to cover training fees and per diem allowances for MOH trainers to train HWs in clinical IMCI and reproductive health and life saving skills as well as cover the expenses for transportation, and allowances for the district team to carry out support supervision visits.

The BOD also lobbied for payment for the time and transportation that they contribute to the program. CORP requested payment for their time, benefits, transportation refunds, and more. Even some attendees at CORP held sessions refused to sign attendance lists without payment.

Action being taken: HealthPartners goal is to build a “Sustainable Community through Partnership.” By reiterating this point and by working with those who choose to contribute their time to improve the health of their family and the community, the frequency of requests for remuneration and benefits has waned. CORP and health scheme leaders receive t-shirts when they attend their orientation and first training session. This helps them to be identifiable in the community. At the first monthly capacity building session with the BOD, a Land O’ Lakes consultant addressed reimbursement and benefits directly. He was able to explain to the BOD that their benefit is reflected by their elevated standing in the community and their ability to

shape health schemes and improve the health of their communities. Sustainability is a key issue in discussing benefits because people understand that if they own the cooperative, and if it is to continue, they must play a role.

Incentives to move the program towards its goals were agreed upon by staff and stakeholders. The BOD requested a tour to visit other prepaid health schemes which is scheduled for December of this year. Active and exceptional CORP are awarded a bicycle at a refresher training course if they attended the six month series of training sessions, and consistently turned in feedback and sign-in lists that track attendance at mobilization events that they have held. Finally, transportation refunds are allotted to make it possible for stakeholders to attend meetings and events.

The approach with the MOH trainers has been to pay their fees for training in Phases I and II. The sessions in each Phase were similar and the DHT attended both to reinforce their skills in conducting this training and follow up. The DHT will lead training for CORP and supervision for HW in Phases III-VI, increasing their direct linkages with the providers in their district and reducing expenses for the program as the coverage area increases. The MOH will continue to train HW and will participate in workshops and program events.

Challenge: MOH policy is free ITNs for pregnant women and CU5 however MOH supplied nets have not been available in Bushenyi and demand for ITNs, Mamakits and ORS is greater than UHC can financially accommodate.

Action being taken: UHC has been able to tie ITN distribution to behavior change incentives with great success. Pregnant women are given ITNS when they deliver their babies with skilled health providers at health facilities. This approach also supports increasing monitoring skills of providers as their ITN supplies are only replenished when data forms detailing distribution are turned in. To encourage the community to participate in health schemes, CU5 enrolled in the health scheme were given free ITNS. Since it is more difficult to verify pregnant women in health schemes it has taken longer to roll out this benefit but ITNS will soon be distributed to pregnant women enrolled in schemes as well. ITNS have been available for purchase at the UHC office and from scheme managers and health providers.

In August, Malaria Control Program partners expanded into Bushenyi District with free ITNS to distribute broadly. This has been excellent for the region but early reports from Phase II end monitoring suggest (draft report Annex F) that many people have yet to open or use their nets. UHC will intensify BCC malaria interventions in Phase III and refresher training for Phases I and II to capitalize on this opportunity and to increase proper hanging and use of ITNS for the most vulnerable populations.

Mamakits are given to women at their fourth ANC visit. A letter of appreciation was received from Comboni Hospital for the increased attendance they are seeing of pregnant women as a result of this distribution plan. ORS stations were established in 27 health facilities in the district so far. Having the tool necessary to provide ORS allows health workers to overcome the barriers that kept them from this service. Additionally ORS stations make it possible for HWs to have time to train how to prepare ORS. Whenever possible, caretakers are allowed to prepare the solution themselves to increase their confidence in managing and avoiding dehydration.

C. Technical Assistance is required in ...

- Operations Research
- BCC

<i>Training Plan for Year 2</i>	<i>Month</i>	<i>Personnel</i>
Annual Child Survival stakeholder workshop –share accomplishments and lessons learned from Phase I and Phase II monitoring and monthly and stakeholder feedback. Facilitate participatory program planning for Phase III. Increase capacity of all stakeholders in order to build toward health scheme and behavior change intervention sustainability. Recognize outstanding leaders and volunteers to increase volunteerism.	November 2007	All UHC staff, stakeholders and Program Backstop
Annual UHC General Meeting –leadership opportunity for BOD. Increase understanding of how the health scheme works; transition health scheme activities to members, leaders, providers and the BOD. Continue to build credibility and capacity of Board of Directors. Recognize outstanding leaders and volunteers to increase volunteerism.	November 2007	All UHC staff, members, leaders, providers and Program Backstop
Budget and Financial Management - Continue to build staff and BOD capacity for financial management and maintenance of health scheme and programs.	Ongoing	UHC field and HQ staff
CORP training -behavior change, increasing community capacity to reduce morbidity and mortality	Monthly	CORP
Community mobilization by CORP - behavior change strategies, C-IMCI, MNC	Weekly	Community
BOD Sustainability Training -capacity building and increased results based decision making in scheme and budget management, understanding data and applying lessons learned to programmatic approach.	Monthly	M&E Coordinator, BOD, Scheme Managers, Field Manager
Staff Capacity Building -training for UHC staff as recommended by supervisors and requested by staff	Ongoing	UHC Staff
Operations Research -training to prepare M&E Coordinator, Director, program manager and stakeholders 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, Stakeholders
Behavior Change Communication -HealthPartners is looking into additional opportunities to increase the skills and understanding of BCC for staff and stakeholders.	TBC	All staff and stakeholders
BOD Cooperative Development Training -Increase skills to prepare for full management of health schemes	3 rd quarter	Land O' Lakes, BOD, staff

D. Changes

There are no **substantial changes** from the project description and DIP that would require modification to the Cooperative Agreement. One change that was determined by the program team is to reduce the number of Phases from VI to V by combining Sheema North and South in Phase III. The six months for Phase VI will be used for follow up training for the entire district to reinforce HW and CORP skills to build on improved tools for behavior change and to bridge gaps indicated by stakeholder feedback and monitoring results.

E. Monitoring

Increasing stakeholder ability to collect and analyze data is an important component of the UHC program. CORP are trained to collect attendance sign-in lists and verbal feedback from their target audiences after their meetings. They record the name of the group, venue, number of people who attended, date, and suggestions for improvement. CORP have found this to be a helpful way to increase the impact of their time and staff use this feedback to improve CORP training and resources. Since transportation is incredibly difficult in Bushenyi, incentive in the form of a bicycle is provided for CORP to reach ever wider audiences and to turn in their lists and feedback forms. Bicycles are only awarded to active CORP at refresher training after they have a proven track record of commitment to their role in community behavior change. Feedback forms are collected from HW and CORP after each capacity building session in order to improve future sessions.

Health scheme members have photo ID cards to prove membership at the provider however since membership fluctuates, member lists are turned in by group leaders to providers each month for cross referencing. Providers track member visits, treatment costs, diagnoses, services and co-pay and turn these reports in to UHC monthly. The year to date UHC financial management report by provider showing monthly and cumulative membership and surplus vs. deficit can be seen in Annex B. A database manager enters this data into the Uganda Health Information System to generate income and loss, diagnosis and service treatment reports. Annex C shows the UHIS Top Diagnosis report for the Igara Tea group from January through July. UHIS reports are used by scheme managers to determine preventive care initiatives that would particularly benefit a group. These reports can be also helpful in determining the cause of abnormalities in scheme performance. For example, one provider had inordinately high deficits; from reviewing their top diagnosis report it was clear that they were including treatment for chronic care which is not covered by the health scheme. In addition to being used by the UHC team, providers and group leaders, UHIS reports are shared with the BOD, Director and HQ team to inform programming.

Monitoring using LQAS, HFA, and ISA tools takes place at the end of each six month Phase with the seventh month devoted to data collection and the eighth month reserved for disseminating results to stakeholders, and updating training materials and programmatic plans with lessons learned. Baseline monitoring included all counties in Bushenyi District. Interventions and refresher training continue in each Phase after Phase End monitoring but for financial and logistical reasons, phase end monitoring only includes the most recent county addressed. Midterm and final assessments will be cumulative.

End of Phase I monitoring showed that the prevalence for both fever and diarrhea in the past two weeks for children under two years was reduced from 44% to 21% for malaria and from 55% to

32% for diarrhea. ITN usage increased from 32% to 35% for children under 2, and from 19% to 22% for pregnant women. The percentage of caretakers who dispose of children's feces hygienically increased from 68% to 71% and the number of households with improved water source increased from 50% to 78%. While the number of women who attended 4 ANC visits as verified by a maternal card declined from 18% to 16%, the number of mothers who delivered by skilled health workers increased from 58% to 68%. The number of children 0-23 months who were offered more fluids and more food during illness declined from 16% to 14% and 42% to 29% respectively. These results showed areas for improvement in BCC emphasis and messages to be stressed in Phase II interventions.

Health facility assessment results show that the number of health workers who reported having received IMCI training in the last 3 years declined from 57% at baseline to 43% at the end of the phase. A decline was also noted in health workers reporting of receiving training in AMTSL in the last three years. Health workers reported an increase in IMCI supervision with in the last year from 28% to 94%. The percentage of health workers who had MOH policy and guidelines/protocol on ANC and obstetric care services increased from 44% to 57%.

Phase II monitoring took place in Ruhinda county in October. The results were not completed in time to be incorporated in this report but the draft Phase II End Report is included as an attachment, Annex F.

Monitoring results and lessons learned were shared with stakeholders in March. Training materials and program plans were updated to incorporate these lessons and stakeholder feedback. A work plan (Annex A) was developed by stakeholders and staff to document changes. Schedules for stakeholder and staff capacity building were detailed, plans for increased cross over between UHC and CS interventions were included, marketing terminology and approaches were updated, and innovative ideas to overcome transportation and other challenges were planned to improve impact for Phase II.

In response to the Institutional Strengths Assessment several changes were implemented. Staff salaries and benefit packages were reviewed and augmented and continued education opportunities were scheduled and completed by July. Improvements for resource management were detailed and carried out by May. Training to improve health scheme management and marketing skills, computer skills and report writing was also planned and implemented for staff. For several of these trainings, in-house staff expertise was leveraged to build the capacity of team members. Monthly training was planned for the Board of Directors to improve their capacity to manage and sustain the health schemes. The overall request was for a change in the top down approach to bottom up. This was an important change that began with staff development of the work plan and culminated in restructuring financial management on all levels of programming. A detailed description of financial management changes can be found on page 22.

Self assessment can be powerful tool to monitor capacity building and sustainability. Self assessment training was planned in the program design for HW and the Board of Directors. After conducting the barrier analysis for HW it was evident that adding to HW work load would not be the most beneficial way to improve these services. Focus for HW has instead been shifted

to building the capacity of the district health team to improve health services through regular IMCI monitoring, feedback and strengthening linkages between the DHT, HW and CORP.

The UHC BOD embraced the self assessment tool (quarterly results below) and it has become an important method of communication for them. Consistent higher ratings have been shown in most categories with the areas where changes are desired, clearly evident. As board capacity was increasing between April and July their desire to take on more responsibility increased and their self ratings declined. Financial training and increased information sharing and transitioning of control over health scheme management has been taking place since July in response to these ratings and their feedback.

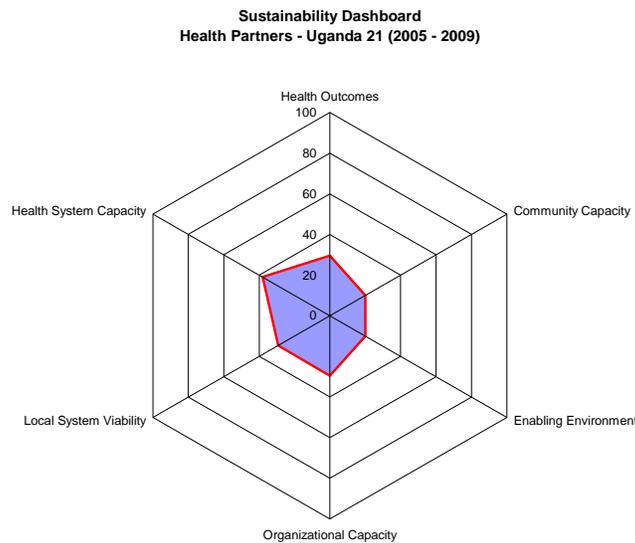
Board of Directors Average Self Rating Results Summary October 2006 to July 2007

S/ N	Considerations	Average Self Rating per Quarter			
		Oct 2006	Feb 2007	April 2007	July 2007
1	Board has full and common understanding of their roles & responsibilities	3.3	4.1	6.4	5.6
2	Board members understand the organization's mission and its products/programs	3.5	6.3	7.1	6.7
3	Structural pattern (board, officers, committees, executive and staff is clear)	4.3	4.8	6	6.4
4	Board has clear goals and actions resulting from relevant and realistic strategic planning	2.6	3.8	5.8	6.7
5	Board attends to policy related decisions which effectively guide operational activities of staff	2.1	4.6	4.8	3.9
6	Board receives regular reports on finances/budgets, products/program performance and other important matters	1	3.4	3.2	1.6
7	Board effectively represents the organization to the community	5.6	6.3	7	5.7
8	Board meetings facilitate focus and progress on important organizational matters	3.6	6.1	7.9	7.1
9	Board regularly monitors and evaluates progress toward strategic goals and product/program performance	3.1	3.6	5.4	4.1
10	Board uses self assessment to build capacity and maintain management	4.1	7	7.5	5.7
11	Each member of the board feels involved and interested in the board's work	4.8	7	8.5	6.6
12	All necessary skills, stakeholders and diversity are represented on the board	2.8	5	6.6	5.1
	Average per quarter	3.4	5.2	6.4	5.4
	Performance Scale	Minimum	Emerging	Emerging	Emerging

To date the program’s monitoring plan has proven successful in building the capacity of stakeholders and in improving the impact of the program. The team is looking forward to receiving monitoring results for Phase II in order to adjust programmatic planning, approaches and resources to be more effective in Phase III.

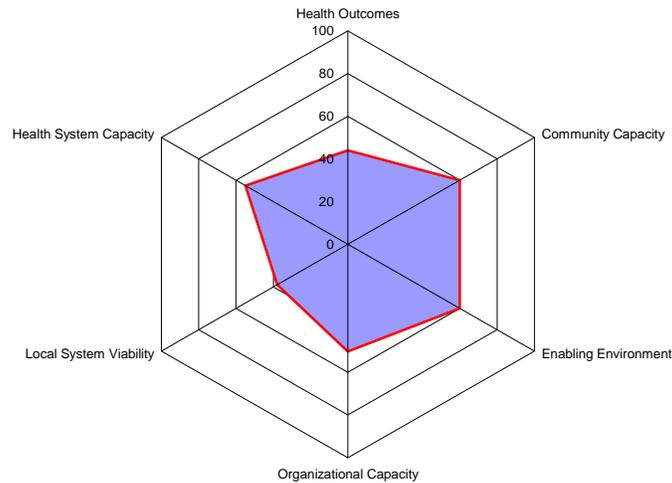
F. Sustainability

Since the 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. In March, monitoring data was entered in SUSPRO as midterm data to allow stakeholders to visually compare project impact from baseline and Phase I results. This is not 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. Since Phase I took place in the most relatively urban county of Bushenyi District, and since the baseline assessment was a collection of data from all counties, the results for Phase I monitoring are expected to be disproportionately higher for this initial comparison. Actual midterm data will be collected at the end of Phase III. This data will include Igara, Ruhinda and Sheema counties and 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.

Sustainability Dashboard
Health Partners - Uganda 21 (2005 - 2009)



The sustainability growth from the Baseline assessment to Phase I End monitoring is impressive, but it is expected that the actual change is slightly smaller since the baseline included six counties in Bushenyi district and Phase I focused only on Igara, the most relatively urban of the counties. There are more health care providers in Igara County, and terrain and transportation are relatively less problematic for volunteers in this area. The dashboard suggests that program impact has been strongest in building community, environmental and local organizational capacity. This suggests that slightly increased efforts to strengthen health facility interventions would help balance sustainability.

The Transformation Report showing indicators for sustainability is below.

Transformation - Report					
Health Partners - Uganda 21 (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 reporting A (OCAT)	-	-	-	-	-
Financial sustainability A (OCAT)	-	-	-	-	-
Handwashing - 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
Monitoring and evaluation (CORE-D4)	-	-	-	-	-
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 control 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, community members and volunteers. Below is the table of Project Partners from SUSPRO.

PROJECT PARTNERS				
Health Partners - Uganda 21 (2005 - 2009)				
Partner	Health Services	Main Local Organization	Community	Other Collaborating Partner
Ministry of Health	✓	✓	✓	

PSI Uganda	✓	✓	✓	
Bushenyi District Health Team	✓	✓		
Uganda Community Based Health Financing Organization	✓	✓		
Health Care Providers	✓	✓		
Family Planning Association of Uganda		✓	✓	
Red Cross		✓	✓	
Uganda Health Cooperative Prepaid Schemes	✓	✓	✓	

L. Program Management Systems

Financial Management Systems

UHC employs an accountant who organizes expense reports from staff in Uganda. Receipts, bank statements and reconciliation sheets are sent monthly to HealthPartners HQ 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.

In an effort to support bottom up management a new tracking tool was developed and implemented to build financial management capacity and facilitate increased decision making by field staff. An excel spreadsheet includes monthly budgets, expenditures and line item variations in shillings and US dollars. Monthly spending automatically calculates into annual cumulative totals allowing the program director and accountant to make changes as necessary to maintain balanced budgets. To support this change on all levels, field staff were given individual budgets to maintain. Developing the tool increased communication and capacity of HQ and field staff and empowered field staff to make decisions with immediate feedback and mentorship support. This change is a helpful learning tool, reduced spending after the first month of implementation and is empowering staff to make the decisions they feel are most appropriate for the program.

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 with country specific benefits and holidays having been established through consultation with PSI and other partners.

Communication System and Team Development

The communication system detailed in the DIP has worked well. Staff submit detailed monthly reports including qualitative and quantitative data. Reports are reviewed by their direct supervisors and are the basis of discussion for monthly meetings. Copies of 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 SMART goals, and for general monitoring. Reports are used by HQ and Field program managers to mentor staff who have others reporting to them, to plan capacity building/training opportunities and to inform programmatic and strategic changes. Increased reporting expectations and mentorship directly

improved staff accountability this past year. A bonus incentive program was put in place from March to June to encourage marketers to overcome challenges to increasing scheme membership. The bonus program was not extended because it did not impact the rate of membership growth.

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.

Capacity building is a large component of the program. After Phase I staff skills were reviewed and training plans were developed with their input. For details on the continued education courses taken by staff see Technical Interventions, staff capacity building on page 14 of this report.

Local Partner Relationships

HealthPartners works closely with community and government organizations and volunteers in all three dimensions of programming. UHC works with the Ministry of Health to increase the capacity of the District Health Team to train and supervise health workers on IMCI and MNC best practices and stock supply management. UHC contracts with hospitals and health centers and meets with them regularly to develop their capacity in managing prepaid health schemes. In Phase II UHC facilitated district-wide improved stock supply management training and supervision for HW by the MOH. MOH policy on TBA training was completed and released in September. As soon as MOH supported curriculum and resources are completed, district-wide training and supervision will be scheduled for TBAs in Bushenyi.

UHC has introduced employer, school and community based groups like the Child Development Center to the benefits of prepaid health care. Volunteers from these groups, and community volunteers who have worked with the district health team in the past are trained monthly as community owned resources persons or CORP. CORP training includes developing monitoring skills and CORP assistance with developing monthly schedules to reach the community. The most successful avenue CORP have found in reaching the community regularly, is to plan mobilization sessions immediately following church services.

PVO coordination/collaboration in country

UHC continues to be co-located with Population Services International and PSI is the primary partner for procurement of long lasting ITNs, PUR, ORS and Mamakits. PSI has been a generous partner helping UHC overcome transportation challenges. PSI provides UHC with access to vehicles and drivers for a reasonable fee and when one of their projects ended, PSI donated a vehicle to the Child Survival program.

Partners who participated in programming include Land O' Lakes, ICOBI, Family Planning Association of Uganda (FPAU), Red Cross, Mbarara Regional Blood Bank, AIDS Information Center, the Uganda Community Based Health Financing Association (UCBHFA), Community Health Financing Association for Eastern Africa (CHeFA –EA) and AMREF. FPAU

participates with the MOH and DDHS in regular training and assessment to build health worker skills and the Land O' Lakes, Red Cross, Mbarara Regional Blood Bank, AIDS Information Center, FPAU and other partners participated in the planning and implementation of a health fair held in June to promote sustaining a healthy community through partnership. The Health Fair report can be found in Annex D.

Several partners and volunteers helped to build staff capacity this year. HealthPartners Information Services Technician traveled to Uganda to train staff on the importance of monitoring and using data when she installed the Uganda Health Information System. Land O' Lakes sent a consultant who worked with the UHC Board of Directors to reduce their expectations for reimbursement and to help shift their focus on planning for sustainability. The PSI computer technician provided continued training for staff on managing software. UCBHFA sponsored training for all UHC staff in reporting writing and data collection and the elected one person to travel with a team on an exchange health scheme visit to Tanzania. And finally HealthPartners Executive Officer for the Research Department volunteered his time and paid to travel to Uganda to work with staff and the BOD on improving member relations and increasing their sense of ownership of the cooperative.

M. Mission Collaboration

Collaboration with the Uganda Mission has been challenging. Requests for meetings with the Mission director were not able to be granted. A copy of the Annual Child Survival Report was sent to the Mission director and she was invited with a letter and a telephone call to the monitoring results dissemination workshop, the Health Fair and the Annual Stakeholders workshop. The UHC Director attended the Mission sponsored American Independence day event at the Ambassador's residence and met briefly with the Dr. Kafuko at the recent UDHS dissemination event however she has yet to meet the newly appointed director. UHC will continue to pursue efforts to increase communication and improve collaboration with the Uganda Mission.

UHC did collaborate regularly with the Uganda MOH. The Malaria Control Program provided soft copies of IEC materials and guidelines which were printed and distributed and UHC provides a regularly summarized report of the number of ITNS distributed for inclusion in their national report. UHC participated in MCP meetings to determine joint monitoring and evaluation indicators and discussed the possibility of using program CORP to distribute Coartem.

The HIV/AIDS Control Program of the MOH provided IEC materials in PMTCT and guidelines which were reprinted and distributed HW during training. The MOH Reproductive and Child Health Division provided trainers for HW and CORP in IMCI and trained HW in reproductive health and life saving skills. They provide IEC materials and guidelines to HW. UHC was asked to review and provide recommendations for the Draft Uganda National Health Insurance Policy by the Planning Division of the MOH. UHC also attends stakeholders meetings, the annual health assembly and joint review mission to discuss sector performance and to identify priorities for 2008 with the MOH Planning Division.

N. Timeline of activities for 2007-8

Major Activities	Month	Personnel
Phase II End Monitoring LQAS, HFA and ISA.	October	All staff and partners
Annual General Meeting for UHC membership led by Board of Directors. Empower membership and stakeholders, membership vote on key scheme management issues.	November	All staff, BOD, HQ backstop, members, leaders & providers
Annual Child Survival Stakeholders workshop to share Phase II monitoring results, lessons learned and for participatory program planning for Year III.	November	All staff, HQ backstop, MOH, DDHS, stakeholders
BOD study tour	December	Director, M&E, BOD
Phase III monthly CORP training topics include Orientation, C-IMCI, MNC, HIV/AIDS, Malaria, Review, Health schemes	December-May	HST, CE, Director, M&E
Phase III monthly HW IMCI and MNC training and supervision	December-May	HST, CE, Director, M&E, DDHS
Monthly health scheme sustainability training for BOD, Providers, Leaders and members.	December-May	M&E, Field Mgr, BOD, UHC stakeholders
Phase I and II CORP Refresher training	January	HST, CE, Director, M&E
Staff corporate responsibility scorecard based reviews. Develop staff capacity building priorities and schedule	January	Director, HST, CE, AA, PM
Assess UHIS role in stakeholder decisions making. Adjust training and development according to results	February	M&E, Director, PM, US consultants
Phase I and II HW Follow up and Supervision	April and May	HST, CE, Director, M&E, DDHS
Review monitoring results and prepare Operations Research	April-May	M&E
Financial assessments and capacity building of stakeholders on issues of health scheme subsidy	June-July	M&E, Field Mgr, Director, SM, BOD
Mobilize subsidy/Operations Research participants and beneficiaries	August	M&E, Field Mgr, Director, SM
Implement OR subsidy	September	M&E, Field Mgr, Director, SM, BOD
Midterm Evaluation, LQAS, HFA and ISA.	June	All staff and stakeholders
CS work shop to disseminate results of Midterm evaluation and for participatory program planning	July	All staff and stakeholders
Update Phase IV materials and schedules to includes lessons learned from feedback and monitoring	August	Director, HST, CE, CC, M&E
Begin Phase IV training for CORP and HW and follow for Phase I-III CORP and HW	September-February	Director, HST, CE, CC, M&E

O. Results Highlight

HealthPartners **innovation** has been to link child survival interventions to prepaid health schemes, building on the existing structure to sustainably reduce morbidity and mortality for WRA and CU5. **The problem** being addressed is that in Southwestern Uganda, like many other sites for international aid, programs have a tendency to provide benefits to the community that disappear when international funding is no longer available. The Uganda Health Cooperative (UHC) is a community-owned prepaid health care program. Employer, school and community groups pool money together quarterly, select benefit packages and contract with providers in order to access the care they need when they need it. A member elected board of directors makes results based decisions to manage and maintain UHC. Building on this indigenous and financial based structure, HealthPartners expanded the network to include direct involvement from the national government, the MOH, local government, the District Health Team, Health Care providers, the Uganda Community Based Health Financing Association, NGOs and community volunteers. HealthPartners uses a training of trainers strategy enabling the Ministry of Health to build the training and supervision capacity of the District health team who in turn train and supervise health workers. In a similar manner HealthPartners facilitates C-IMCI, MNC, HIV-AIDS and other behavior change intervention training for community owned resource persons (CORP) who after a series of capacity building sessions, share their messages with churches, schools and community groups.

Local ownership and quality improvement are key strategies to HealthPartners approach. Programming is rolled out in phases by counties to incorporate lessons learned from monitoring and participatory programming to improve and expand interventions and strengthen partnerships. Incentives encourage participation on many levels. Mamakits are provided to women at their fourth ANC visit and ITNs are provided to women when they deliver their babies with a skilled health professional. ITNs are given free to health scheme members who are pregnant and members under age 5. Appropriate ITN use is trained to CORP who share this message and other malaria prevention and C-IMCI messages with their communities. Active CORP who consistently turn in feedback forms and sign in lists from attendees at their community mobilization sessions receive a bicycle to help them continue to reach wider target audiences.

HealthPartners has linked together a network of 20,000 direct beneficiaries and over 40,000 indirect beneficiaries from government, NGO, employer groups, schools and communities. HealthPartners facilitated: capacity building for the board of directors, members, leaders and providers and cooperative health care coverage for 3,500 members; IMCI and MNC training and supervision of District Health Team Staff and Health Workers; C-IMCI, MNC and preventive health care training of trainers for 98 CORP who collected 19,652 signatures from attendees at sessions that they have led. In a culture of low literacy and skepticism of how signatures may be used, less than half of attendees sign forms. Monitoring results show improved indicators for maternal and child health and Board of Director self assessments show improved capacity to manage the cooperative. Perhaps the most exciting demonstration of sustainability is the Annual General Meeting attendance and meeting notes demonstrating the increased governance capacity of this local institution.

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

Dr. Grace Namaganda, Director Uganda Health Cooperative, was a guest speaker at the Social Health Insurance workshop, Sponsored by HEPNET, the Health Economics and Policy Network in Africa, in Cape Town, South Africa May 28 – May 30, 2007. Dr. Grace Namaganda shared lessons learned from UHC with her presentation on “Community Financing for Health Services.”

George Halvorson, past President and CEO of HealthPartners has written a book about developing the Uganda Health Cooperative. The goal of this book is to help those interested in similar ventures learn from this program. The book launch was sponsored by Kaiser Permanente, held at the World Bank in Washington, DC and was attended by Scott Aebischer, HealthPartners Uganda Team Lead and Joy Batusa, Director, Uganda Health Cooperative. National Public Radio covered this event with a follow up piece from their 2002 coverage both of which can be found at the following link: <http://www.npr.org/templates/story/story.php?storyId=6915566>. A website was developed, <http://xnet.kp.org/permanentejournal/ugandabook/micro.html>, to link HealthPartners to those who are interested in learning more about the program. Through this resource, UHC has been able to connect with over forty-five organizations developing similar programs.

A book event sponsored by HealthPartners was held at the corporate office to celebrate the publication of George Halvorson’s book and to share program updates with U.S. partners, members and the community on June 8, 2007 in Bloomington, MN. Mary Brainerd, President and CEO of HealthPartners was the master of ceremonies and Mr. Halvorson delivered a presentation and signed books.

Dr. Namaganda presented “How Qualitative Research Can Successfully Inform Program Design and Implementation” as a part of a panel discussion June 8, 2007 at the Child Survival and Health Grants Mini-University held at Johns Hopkins Bloomberg School of Public Health in Baltimore, MD.

Annex A: HealthPartners Uganda Health Cooperative Child Survival 2007 Work Plan
(Including Phase I End Monitoring Report and tools)

HealthPartners Uganda Health Cooperative Child Survival 2007 Work Plan

March 31, 2007

Authors:
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Executive Summary

The Uganda Health Cooperative Child Survival program was designed in Phases in order to capitalize on opportunities to improve implementation of the program with the maximum amount of feedback from staff, stakeholders, partners, consultants and the management team. The following work plan details results of monitoring from Phase I and input for an improved way forward for Phase II activities.

Several changes are being incorporated into the work plan for 2007. The six month intervention, one month review and one month monitoring structure will remain for both the Community Social and Health Services Dimensions of the program. However, the distribution of IEC materials and the scheduling of topics for each month has been adjusted slightly to incorporate lessons learned.

In the Local Organizational Dimension, marketing terminology has been updated to help the marketing team better discuss progress with potential members groups and to help them improve strategizing on how to increase membership. The marketing commission bonus policy was increased and extended. The team worked together to come up with a list of the most commonly asked questions and answers about UHC. The 60% minimum group membership rule will be relaxed in 2-3 test cases to see if this increases membership without compromising cost recovery. Cost recovery is consistently higher for schools yet they have challenges with covering the costs of the onsite nurse who provides care until the child can be sent to the provider. Thus, beginning in Phase II, UHC will leave 20% of school premiums at the school to cover these costs. School nurses will be invited to join health worker training provided by UHC and the MoH to increase their skills.

In an effort to promote greater cross over between prepaid health financing and CS interventions, several activities have been planned. Community Owned Resource Persons are currently selected by the District Director of Health Services. CORP from Igara County will receive follow up training and materials and new CORP from Ruhinda County will begin training. In addition, Scheme CORP will be elected from each member group. These members will be charged with attending training and bringing preventive care and treatment messages back to their member group. Member groups will also have an opportunity to visit other groups in order to increase communication and learning between groups. All CORP will receive training on prepaid health care principles and they will be asked to share these messages at each of their sessions. In June 2007 HealthPartners will have been in Bushenyi District for 10 years! A celebration is planned in conjunction with the MOH and DDHS. Preventive health care and prepaid health care information will be available in addition to a program; this event will be open to everyone in the community.

To encourage active CORP from Phase I to continue spreading key health messages, bicycles will be given to those who have consistently turned in sign-in lists from their sessions. The bicycles will be distributed at the follow up training event when a lead CORP will be elected to be the primary contact for ongoing liaison with the Community Educator.

A schedule of monthly training sessions has been developed in conjunction with the Board of Directors. These capacity building sessions will help prepare the Board to make key decisions to maintain the health scheme beginning in May 2009.

Finally, the Uganda Health Information System has been installed and data on member groups is being entered each month. Reports on health trends and statistics should help UHC staff and stakeholders better understand the benefits of the health plan. Staff salary issues have been addressed, improvements have been made for resource management at the Ishaka office and computer training and some replacement computers will aid the team in their monitoring and evaluation capabilities.

Summary of Phase I Accomplishments

Statistics	Aug	Sept	Oct	Nov	Dec	Jan	Total
CORP trainings held	2	1	0	1	1	1	6
# of CORP trained	24	23	23	23	23	23	139
CORP sessions held	52	18	39	43	34	27	213
# of session attendees	2049	392	1207	5526	674	672	10,520
HW / Midwife training	0	1	1	0	1	1	4
# of HW/ Midwives trained	0	24	16	0	17	9	66
Scheme mgmt meetings	21	21	24	22	15	12	115
Marketing mtgs	29	29	31	36	37	37	199
# of provider meetings held	7	8	5	4	3	2	29
# of board meetings held	0	0	1	0	0	0	1
ITNs sold	83	6	13	1	0	0	103
ITNs given to women who deliver with skilled attendant	0	0	16	270	233	437	956
Mama Kits distributed at 3 rd ANC visit	0	0	0	0	141	522	663
PUR sachets distributed	0	0	0	0	0	520	520
ORS distributed	0	211	0	0	0	0	211
Scheme members- Comboni	1,391	1391	1,314	1,314	1,314	1,367	
Scheme members- Ishaka	924	924	590	590	590	435	
Scheme members-BMC,	477	482	1,051	1,051	1,051	1,060	
Scheme members- Mitooma,	166	169	247	247	266	279	
Scheme members- Nyakasiro	819	819	819	819	819	819	
Total membership	3777	3785	4021	4021	4040	3985	

Summary of Phase I Monitoring Assessments

From the KPC and HFA end of Phase I monitoring survey the prevalence for both fever and diarrhea in the past two weeks for children under two years has been reduced. Use of preventive methods including IPT and ITNs has increased significantly. Although improved latrine usage is still low, improvement has been shown. A higher percentage of mothers attended the recommended number of ANC visits and an improvement was seen in the number of women who gave birth with the help of a skilled health care practitioner. More health workers received IMCI follow up guidance and an increased number of respondents reported having access to MOH policies and guidelines on Antenatal and Obstetric care services. The Health Services Trainer, Community Educator, Director and M&E Coordinator are looking closely at monitoring

results that showed declines in order to enhance Phase II interventions to close existing gaps. For more information on monitoring results see Annex 2: KPC and HFA End of Phase I Monitoring Results.

Scheme membership increased overall but challenges were encountered with one provider which resulted in many members leaving the scheme. Challenges with this scheme have been evident for some time however appropriate resolution requires collaboration and support from the Ministry of Health, Provider management and the Uganda Based Health Finance Association. The UHC Director and staff are working with these stakeholders to agree to terms and conditions on the way forward, the implementation of which is scheduled for May.

PHASE II

Programmatic Changes

The following programmatic changes were recommended by UHC staff and stakeholders. Their feedback is invaluable for determining the best way forward to link child survival interventions to prepaid health schemes, building on the existing structure to sustainably reduce morbidity and mortality for women of reproductive age and children under 5.

1. Changes in CS Intervention Structure

Community Social Dimension

Lessons learned from Phase I have been incorporated in the plan for Phase II. Follow up activities for Phase I are included in the Phase II plan.

At the beginning of the CORP six month's training sessions in Phase I CORP received a MoH CORP training manual with materials on preventive education and behavior change communication. During Phase I it was observed that CORP tended to give presentations on Malaria and/or their favorite topics leaving other topics uncovered. To reduce this tendency malaria training has been scheduled as the fourth instead of the first behavior change training and the importance of sticking to assigned pages of the manual for each designated month will be emphasized. Hopefully this will make it easier for CORP to follow key messages and will encourage them to give the scheduled messages during designated months.

Phase II CORP will be joined by elected health scheme CORP and school nurses who will attend training and will share messages with their group.

April	Orientation and Community-IMCI
May	C-IMCI (Will be attending Immunization activities) Phase I refresher training (include distribution of new materials, election of lead CORP and distribution of bicycles to active CORP.)
June	MNC (distribute bicycles to Phase II CORP)
July	HIV/AIDS
Aug	Malaria
Sept	Review
Oct	LQAS monitoring
Nov	Workshops/Updating training plans and materials

Health Services Dimension

UHC was very pleased with the enthusiasm and dedication shown by all partners but especially the District health team and the Ministry of Health in conducting training and assessments. Requests for continued partnership have been sent to these and other organizations in an effort to aid advance planning and availability.

IEC training and reference materials developed by the MOH were distributed to Health Workers during Phase I training sessions. Health Workers were asked to post the reference guides at their respective health centres. For Phase II additional resources will be reproduced and they will be taken to the health facilities by the HST and with permission hang in appropriate areas. Reference materials include those on malaria, ANC and PMTCT flow charts and information on ART and HIV counseling.

April	Clinical IMCI
May	IMCI follow up
Jun	MNC
July	Phase I IMCI follow up
Aug	Phase II IMCI follow up
Sept	Self Assessment Training (Phase I and II Health Workers)
Oct	HFA monitoring
Nov	Workshops/Updating training plans and materials

Other: to be scheduled as partners & materials are available

TBA training
Stock Order planning or intervention

2. Distribution Plans

The following preventive health care items will be distributed by UHC: Mama Kits, ORS, PUR and ITNs. Additionally materials for demonstrating how to purify water and prepare ORS will be provided to CORP. ORS and PUR will be distributed at group meetings and at the health plan office in conjunction with the appropriate key behavior change messages. Mama Kits will be distributed by Health Workers to pregnant women at their fourth ANC visit in order to encourage women to attend all recommended ANC.

The Phase II ITN distribution plan incorporates lessons learned from Phase I. UHC is in the process of collaborating with the Ministry of Health Malaria Control Programme. Variations in the ITN distribution plan may be adopted in accordance with this collaboration.

PHASE II ITN DISTRIBUTION PLAN

TRACKING: Name, age, gender, group affiliation and location of residence must be written down for each ITN distributed. When signing form, people are agreeing to use the ITN as instructed.

MONITORING: UHC staff will do random checks to be sure that those who collected ITNs have them hanging properly in the home with a pregnant woman and infants. If the net is not on the

premise, or if it is learned that there are no pregnant women or children under 5 in the household, the person named for distribution will be held accountable to pay for the net. They will not receive any other promotional item until net cost is repaid.

BRANDING: All ITNs will be removed from packaging before distribution. A mark that cannot be reproduced by the community will be placed on the nets to identify them as UHC nets.

DISTRIBUTION: ITNs will be stored at the Ishaka UHC office by the Communication and Logistics Coordinator. ITNs shall be sold at 12,000 USH for non UHC members and 10,000 USH for UHC members. ITNs shall be free to women at the time of delivery in a health facility in order to increase delivery with a skilled health professional.

Scheme managers shall distribute free ITNs to pregnant women and children under five, closely tracking distribution to reduce opportunity for abuse or resale.

PROFIT: Shillings collected from ITN sales shall be used to buy additional ITNs for distribution according to this plan.

I. ITN DISTRIBUTION AT PROVIDERS/HEALTH CENTRES and SCHEME OFFICES.

A. Pregnant woman coming for Delivery-- Free ITN

1. Verification: Pregnant women delivers baby
2. Tracking: See above
3. Rule: Only 1 net

B. Scheme member – Available for discounted purchase @ =/10,000

1. Verification: Scheme member must show ID card for verification. Name to be cross checked on current scheme membership lists.
2. Tracking: See above
3. Rule: Maximum of 4 nets sold per member.

C. Pregnant scheme member or parent to child under 5

1. Verification: Scheme members must show ID card for verification. Child's name to be cross checked on current scheme membership lists. Parent does not have to be a member but child must be covered by the scheme.
2. Tracking: See above
3. Rule: One net per child under 5 (as long as the child is covered by the scheme.)

D. Other, non-scheme members – Available for purchase @ =/12,000

1. Verification: None
2. Tracking: See above
3. Rule: When they sign their name they are promising that this net is for them. They are giving their word that they will not resell it.

II. ITN DISTRIBUTION AT MOBILIZATION SESSIONS—The original plan was to distribute free ITNs at mobilization sessions however this caused chaos, was extremely difficult to track and

monitor and reduced attention to key messages being conveyed by CORPS. As a result the plan was amended.

III. UHC DISTRIBUTION BY HEALTH WORKERS— Health workers will continue to distribute ITNs to babies born at health facilities. Pregnant women and children under five who are members of the health schemes will receive free ITNs from the scheme managers during group meetings.

3. Marketing Changes

A. Marketing Terminology

1. Type of Group

- a. Bi-annual This group meets only twice a year, meetings will be scheduled ahead of time and will not likely change
- b. Quarterly This group meets quarterly, meetings will be scheduled ahead of time and will not likely change
- c. Self Motivated This group is interested in the health plan and capable of spreading the word. Mobilisation is expected to move along quickly and this group should be a high priority for the marketer to focus on until the scheme launches.
- d. Care Groups This group has many questions and needs a lot of attention. This is not a high priority group but should receive regular attention as needed to see it through to joining the health plan.

2. Marketing Stage

- a. Stage 1 Introduction
- b. Stage 2 Elect leader and provider and determine benefits
- c. Stage 3 Collect premiums, sign MOU with Provider
- d. Stage 4 Launch and transfer to scheme manager

- B. The Marketing Commission policy was increased to 50,000 USH earned per 100 new members and extended through June 2007. This opportunity is available to the Field Manager, Marketers and to Scheme Managers.
- C. Efforts are being made in Phase II to increase cross over between health schemes and CS interventions. For more information on these changes and how they will affect marketing messages see changes below.
- D. In the ISA, staff recommended additional target community involvement pointing out that “if programs are to be self sustaining after donor withdrawal it is an area that cannot be overlooked.” During program assessment and training in Bushenyi District January 31 – February 6, staff requested detailed presentations for all key audiences and stakeholders. In response to these requests presentations have been developed for Marketers to use with potential member groups; both long and short

versions are now available for marketers. Separate presentations have been developed for school groups where questions and considerations tend to be different from income earning groups. Presentations are also being developed for new providers and refresher training is being developed for existing providers. Improved resource management has been included in this work plan in order to ensure that these presentations are available to staff in both hard and soft copy formats at all times. As additional presentations are needed, staff are encouraged to use existing templates to generate new presentations. Assistance and support from management will be available to review, finalize and make all presentations available to all staff.

- E. Additional marketing material including brochures specifically targeting schools and posters that include health plan benefit information have been approved and are being developed. Marketers will be able to carry several school brochures and stock will be maintained in the UHC office in case other staff or community members would like access to this information. UHC posters will be distributed to CORP for them to give out during their talks which will now include a description of UHC health plans. Posters will also be posted at popular locations throughout the target area. All marketing material will be developed using HealthPartners branding standards with appropriately sized logos. Additional T-shirts will be made available to staff and volunteers working for UHC as the budget allows.
- F. Marketing strategies were discussed and marketers were encouraged to place a priority on mobilizing large groups. One approach is to research potential providers and talk to them about working with UHC. After a suitable provider partnership has been established, it may be easier to seek organizations with 250 employees or more for mobilization. Alternatively, marketers could begin by mobilizing the leader(s) of large employee groups to determine their current health care options and to introduce the benefits of scheme membership. These strategies are preferable to approaching individuals in event or community settings who may not have an established source of income or an understanding of how group cooperation and bargaining can benefit everyone.
- G. Marketing Commonly Asked Questions and Answers: this resource was developed by UHC staff in a brainstorming session. Staff shared the questions about the program that they receive most frequently, discussed their usual answers and together agreed upon the most concise, accurate, and effective answers to encourage new members to join the scheme. UHC staff are encouraged to refer to this resource frequently so that these brief answers are readily available to them.

Common Questions and Recommended Answers

1. Why is HealthPartners/USAID concerned about us?

These people have money and they see they can help so they want to help.

Second Question? Then why don't they pay for our premiums?

They have a common saying, “If you give a person a fish, they can eat today. If you teach a person how to fish, then they will eat for a lifetime.”

- 2. Can one get service elsewhere other than where I paid my premium?**
You can choose your provider and the services covered. Of course it would be very expensive to make a contract and distribute membership lists, and keep them updated with all providers.
- 3. Does the Scheme cover referrals?**
You can choose your provider and the services covered. Of course it would be very expensive to make a contract and distribute membership lists, and keep them updated with all providers.
- 4. Apart from treatment what other benefits are involved after joining the scheme?**
The health plan is there to help improve your health. The goal of the health plan is to improve the health of our members, our partners and the community.
- 5. How do we know that our money will be safe with the provider?**
The provider is of our choice and the leaders are elected by the people. Each money paid is issued a receipt. The idea is brought by HealthPartners but the health plan is owned by the people.
- 6. What if I don't fall sick for a long time and yet I have been contributing?**
The health plan is not just for the sick—you may not fall sick tomorrow or even for five years. But when you do fall sick, you can rest assured that you will be able to receive the care you need.
- 7. If the cost of treatment exceeds the total premium who meets the difference?**
During epidemic season cost recovery will be lower and at other times it will be higher, overall it will balance out. Providers benefit from increased attendance, reduced bad debt and regular advanced payment which allows them to plan, order drugs and pay staff.
- 8. Why is it that chronic illnesses are not covered?**
The cost of drugs for chronic illness like Hypertension, Diabetes and HIV/AIDS, etc. are so high but we cover consultations and opportunistic infections. The scheme covers the most common treatments like malaria, diarrhoea, and delivering babies.
- 9. How do we merge the school sickbay services with the scheme services?**
That is a very good idea. We are looking into this option and will get back to you in 3-6 months.
- 10. Can I join as an individual?**
Yes, but the equivalent of a family is 20,000 so this is what needs to be paid.
- 11. Am I allowed to pay for only two people in my family?**
Yes, but the equivalent of a family is 20,000 so this is what needs to be paid.

- 12. How does your health scheme handle outreaches and students being treated from schools?**
That is a very good idea. We are looking into this option and will get back to you.
- 13. Why do we pay co-payment?**
To reduce service abuse.
- 14. Can one pay in instalments?**
Yes you can pay instalments in advance.
- 15. Suppose we pay our money and we are not satisfied with the services of the selected provider?**
You have 2 choices; you can talk to your scheme manager and they will talk to the provider or you can agree as a group to change providers.
- 16. How are premiums determined?**
A study was conducted and from experience it was determined that this amount would be the lowest affordable amount that could still cover the cost of treatment when money is pooled. 1,660/= per month would not even cover the cost of one treatment!
- 17. What if a member dies before the end of the period?**
Sorry for the loss of the member of your family. Unfortunately because we turned in the lists and the money has been paid to the provider we cannot refund it.
- 18. How are new-borns handled?**
The newborn is covered with the mother until the next premium period.
- 19. What is the future of the health plan?**
That is why we have the Board of Directors. We are building the skills of the Board, the leaders, providers and members such that the plan will be sustainable and will continue for a long time.
- 20. Are you a member of this health scheme?**
Yes our staff forms a group and we contract with a provider but we have some members even in Kampala so our situation is a bit different.
- 21. What if we pool our money and keep it ourselves to clear our members' bills?**
How would that work?
- 22. Who is responsible for paying for the photos?**
Members are in charge of giving photos and we laminate the photos for them.
- 23. Who is responsible for the scheme management?**
We are analysing cost recovery and membership numbers to determine at what point should financial responsibility be turned over to the provider.

24. How do you relate with the other schemes i.e. school health made easy and Ishaka health plan?

They are similar programs but they manage their own affairs.

25. How are you different from Save for Health (SHU) IAA and the others?

They are similar programs but they manage their own affairs.

4. 60% Rule

Marketers requested a relaxation of the 60% required registration rule for signing new groups. According to this rule, groups can only join once 60% of the total membership has paid their premiums. The purpose of this rule is to reduce adverse selection—which can happen when only the sickest members of a group join a health plan. The team agreed to try removal of the 60% rule for 2 or 3 test cases. Scheme managers or marketers will submit requests for a select group that they believe would benefit from waiving this rule. Requests will be reviewed by the field manager, director and program manager and 2 or 3 groups will be approved for waiving the rule.

These test case scenarios are intended to be a learning opportunity for the UHC team and program as a whole. Fewer than 60% of the group will be allowed to enroll in the test cases while their cost recovery and membership are closely tracked. If more members join these groups and if their cost recovery averages at or above 95% for six months, exceptions to the 60% rule or possibly even removing the 60% rule will be considered.

5. Scheme CORP

UHC team members recognized that existing health plan member groups are not benefiting from CORP led preventive health care mobilization as much as was anticipated. The suggestion was made for member groups to have an opportunity to elect a Scheme Community Owned Resource Person or Scheme CORP. This person would be invited to attend CORP training in order to learn about preventive health care and to receive resources that they can take back and share with their group. The Scheme CORP program will be a benefit for scheme members/groups and will *be offered as a test case in Phase II. Scheme CORP will receive transportation refunds to make it possible for them to attend CORP training during Phase II.*

6. Group Visits

Another benefit for health plan members will be to schedule scheme visits. Member groups will be invited to participate in an exchange with another group to provide an opportunity to share lessons learned and to increase scheme member satisfaction. Scheme managers will announce this opportunity to their groups noting which ones are eager to participate. Scheme managers will bring their requests to the next group meeting where groups will be paired with one another with logistics being planned by the UHC team together. Visits will be scheduled between April and June and transportation will be provided by UHC.

7. CORP training on Health Scheme Principles

All CORP will receive training on prepaid health care principles and they will be charged with presenting a brief UHC presentation at each session. CORP will be able to distribute UHC brochures that explain the details and benefits of health plan membership. Whenever possible UHC marketers will accompany CORP to deliver their health care management and health improvement messages together.

8. Changes in School Premium Structure

Cost recovery for schools is consistently higher than cost recovery for other groups. Additionally scheme managers have learned that by presenting 100% of health care payments to the provider, schools are left without resources to manage care until the provider can be reached. Thus beginning in April 2007, 20% of school premiums will be given to the school sick bay to defray the cost of the school nurse, transportation for nurse training and for drugs for care until the child can be sent to the hospital/clinic. Nurses from schools groups who are members of UHC will be invited to attend CORP training in April 2007. The cost of training will be covered by the Uganda Health Cooperative while transport shall be provided for each school nurse from the sick bay portion of premiums.

9. 10 Year Celebration

A health fair has been planned for June 2007 for all members, leaders, providers, partners, and the community. The purpose of this event is to celebrate the 10th year the Uganda Health Cooperative has been in operation. Gratitude will be shown to all stakeholders many of whom will participate in the program and activities. The program will be designed to spread preventive health care messages on Malaria, C-IMCI, MNC and HIV/AIDS. Attendees will be able to stop by stalls to see demonstrations like how to prepare ORS and how to best make use of an ITN. One health worker from the community and at least 1 CORP will be available to answer questions at each stall. Partnering organizations may also plan to host stalls at this event. Transportation refunds for this event will be given to the Board of Directors, CORP who will be providing community education or who are in some other way working at this event and to health plan leaders in appreciation for their contributions to the health plan. Vehicles will be provided at locations set ahead of time in order to help transport health plan members to this event. Event announcements will be made via flyer beginning May 1 and via radio 2 weeks before the celebration.

10. CORP Bicycles

After months of requests and much dedication to passing key preventive health messages on to the community, Phase I CORP will be shown appreciation and helped to continue spreading their messages by being awarded bicycles. One bicycle will be given to each CORP who has turned in sign-in lists from mobilization sessions held throughout each of the six months of the Phase I cycle. CORP who did not fully participate in all six months will not be given bicycles. Donated bicycles will be branded with HealthPartners Uganda Health Cooperative and USAID logos. It is understood by the program that not all CORP know how to ride bicycles however since their children, spouses or friends can transport them on the bicycle they will still be given one. CORP will be asked to sign a promise that they will use the transportation to continue spreading key

preventive health care messages. These notes of promise will be kept on file at the UHC Ishaka office. The bicycle donation **should not be announced ahead of time.**

The Community Educator will invite Phase I CORP to refresher training. At this time a lead CORP for the county will be elected and updated training materials will be given out. Any questions that the CORP have will be answered and then the bicycles will be awarded. CORP will be encouraged to continue to meet with one another and to keep contact with the CE. During each phase refresher training like this will be held and all CORP will be invited to attend. The goal is to provide a community that encourages continued sharing of key messages. If a CORP is no longer able to continue this work, he/she is requested to find a replacement to attend training and to continue holding meetings.

11. Board of Directors

Gilbert Kansiiime was hired as the Monitoring & Evaluation Coordinator and has been assigned to be the primary contact responsible for managing board relations and training. At the Board meeting in February 2007 the Board helped to develop the following plan for training.

Activities for 2007:

- a) Roles and responsibilities of BOD
- b) Review of by-laws
- c) Marketing skills
- d) Financial Management

The training needs identified were integrated with the other activities on the schedule for the annual work plan for 2007 as shown on the table below:

UHC BOD ANNUAL WORK PLAN FOR 2007					
#	Activity	Date	Responsible Person	Venue	Time
1	-Training BOD on roles and responsibilities -Review of Bylaws	21/3/07	M & E Coordinator	UHC Boardroom, Ishaka	9:00 AM
2	BOD meeting to prepare for Health Fair; UHIS demonstration and sharing self assessment results	11/4/07	M & E Coordinator	UHC Boardroom, Ishaka	9:00 AM
3	Marketing Training for BOD	9/5/07	M & E Coordinator	UHC Boardroom	9:00 AM
4	Health Fair	June 07	M & E Coordinator	UHC Boardroom	9:00 AM
5	BOD meeting and Assessment Results; Evaluation of Health Fair	11/7/07	M & E Coordinator	UHC Boardroom	9:00 AM
6	Financial Management Training for BOD	8/8/07	M & E Coordinator	UHC Boardroom	9:00 AM
7	BOD meeting for preparing AGM; self assessment results	10/10/07	M & E Coordinator	UHC Boardroom	9:00 AM

8	Annual General Meeting (AGM)	10/11/07	M & E Coordinator		2:00 PM
9	Study Tour for BOD	Early Dec. 07	M & E Coordinator		

12. UHIS

The Uganda Health Information System (UHIS) a database designed specifically for the Uganda Health Cooperative was updated in 2006 to a Windows platform. The system was installed and training for UHC staff took place in January/February 2007. A database administrator was hired to enter data from five UHC contracted providers in one central location. A system for data collection has been established in all locations with one exception—a provider that does not currently track drugs and drug costs.

Data will continue to be collected and reports will be printed each month to help UHC staff better understand and share information on the benefits and challenges of scheme management. The UHC Board of Directors and participation providers will receive demonstrations and training on UHIS in April. Special attention will be given to training Nyakasiro and Mitooma to encourage the designation of one data entry person to be sure that all encounter information is accurately recorded.

Depending upon how the database program is received and utilized, making enhancements to the system as requested by users and expansion of the database capability may be pursued in late 2007/2008.

13. UHC Staff Salaries, Insurance and Loan Opportunities

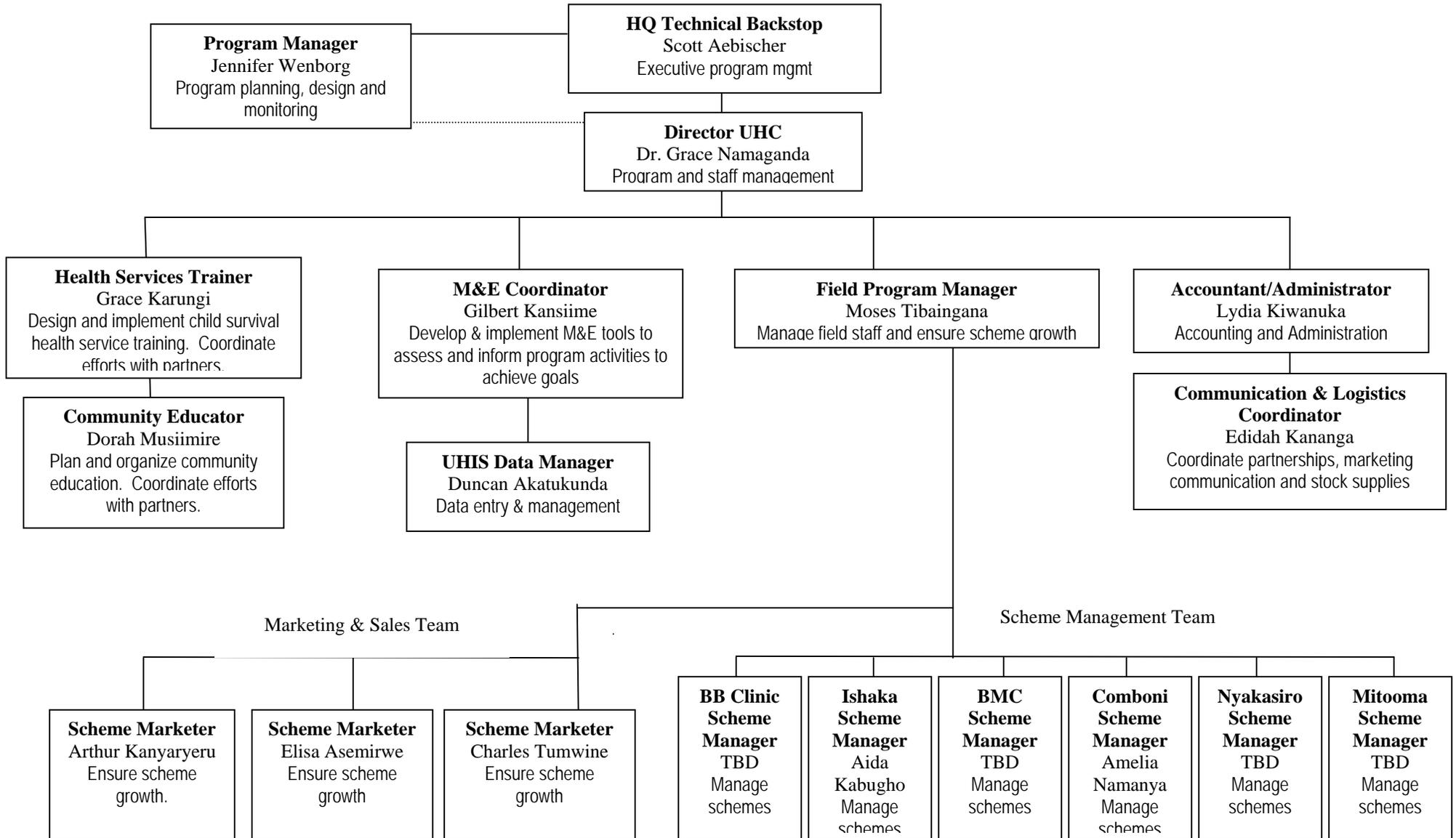
The staff salary scale for annual reviews was increased from 1% to 5% for Needs Improvement, from 3% to 7.5% for Solid Performance and from 5% to 10% for Exceptional Performance. Corporate responsibility scorecards were reviewed, consultations held and salary increases were implemented in March 2007. Insurance coverage changes were also implemented and a policy to aid staff in procuring bank loans was established. While external capacity building has always been available for staff few realized this potential benefit. The Director and M&E Coordinator took the initiative to be sure that all staff could review capacity building opportunities and with their feedback a training plan has been developed and included in this work plan for 2007.

14. Improved Resource Management at Ishaka Office

Hard copies and soft copies of the following items must be available to all staff at all times. The Communication and Logistics Coordinator is responsible for maintaining and updating these resources monthly. The Accountant/Administrator is responsible for this activity in the absence of the CLC.

1. Child Survival Agreement
2. Land O' Lakes Subcontract Agreement
3. UHC policies and procedures
4. Expense report sheets
5. Orientation packet
6. Locked drawer of all Corporate Responsibility Scorecards, past and current
7. DIP Final Version with attachments (June 2006)
8. Semi-Annual Cooperative Development Reports
9. Annual Child Survival Report
10. Annual General Meeting Reports
11. Stakeholder workshop Reports
12. Baseline Reports
13. Monitoring Reports
14. TRMs Technical Resource Materials (Updated Annually)
 - a. Malaria
 - b. Diarrheal Disease Prevention and Control
 - c. Maternal and Newborn Care
 - d. Integrated Management of Childhood Illness
 - e. Monitoring and Evaluation
 - f. Management and Logistics
15. M&E Resource shelf with the following items
 - a. KPC 2000+
 - b. Integrated Health Facility Assessment
 - c. LQAS Trainers Guide
 - d. Applying the BEHAVE Framework
 - e. Child Survival Sustainability Assessment
 - f. Sustaining Child Survival (Background document to CSSA)
16. BOD By-Laws (October 2006)
17. BOD meeting notes folder (Updated immediately following every meeting with copies of agenda & resources used)
18. Copy of all training materials and presentations given to the BOD
19. Copy of Marketing Growth Strategy 2005.
20. Marketing Commission Policy
21. Copy of Marketing presentations (2005 to date)
 - a. Marketing presentation for schools
 - b. Marketing presentation for providers
 - c. Marketing presentation short version
22. Copy of all other presentations
23. Master copy of information about all groups that have received some form of UHC marketing (updated monthly)
24. Monthly reports for all staff (each person is responsible for inserting new reports monthly)
25. Copy of monthly UHIS reports (1 of each) (including most current membership lists)
26. Other training materials or records of activities

Other Management Updates
 2007 Organizational Chart



Management Structure				
Name	Title	Location	Reports to:	Responsibility
Scott Aebischer	HQ Technical Backstop	MN	USAID	Executive program mgmt
Jennifer Wenborg	HQ Program Manager	MN	HQ Backstop	Program planning, design, monitoring
Dr. Grace Namaganda	Field Program Manager / Director	Kampala	HQ Backstop	Manage program and staff
Lydia Kiwanuka	Accountant/ Administrator	Kampala	Director	Accounting, Administration
Gilbert Kansiime	M&E Coordinator	Bushenyi	Director	Develop & implement M&E tools to assess and inform program activities
Grace Karungi	Health Services Coordinator	Bushenyi	Director	Design and implement child survival health service training. Coordinate efforts with partners.
Moses Tibaingana	Field Program Manager	Bushenyi	Director	Manage field staff and scheme growth
Edidah Kananga	Communication & Logistics Coordinator	Bushenyi	Accountant/Administrator	Coordinate partnerships, marketing communication and stock supplies
Arthur Kanyaryeru	Scheme Marketer	Bushenyi	Field Mgr	Present UHC scheme concepts at community education sessions. And increase UHC membership
Charles Tumwine	Scheme Marketer	Bushenyi	Field Mgr	Present UHC scheme concepts at community education sessions. And increase UHC membership
Amelia Namanya	Comboni Scheme Manager	Bushenyi	Field Mgr	Manage schemes
TBD	Mitooma Scheme Manager	Bushenyi	Field Mgr	Manage schemes
Duncan Akatukunta	UHS Data Manager	Bushenyi	M&E Coord.	UHS data management
Dorah Musiimire	Community Educator	Bushenyi	Health Services Coordinator	Design and implement child survival community education. Coordinate efforts with partners.

Management Meeting Calendar

January 2007						
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October 2007						
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November 2007						
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December 2007						
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Staff	Direct Report	Approximate Meeting Date	Meeting Report
Director	Field Manager	2nd Tuesday of the month	discuss sustainability and field management report and MTTS
Field Mgr	Scheme Mgrs	2nd Monday of the month	MTT (FM uses Sustainability & Field Mgmt & MTT to direct goals)
Field Mgr	Marketing Mgrs	2nd Thursday of the month	discuss sustainability and field management report and MTTS
Director	M&E, CE, HST	2nd Wednesday of the month	M&E Report CE Report, HST Report
Administrator	C&L	2nd Wednesday of the month	C&L Report
Director	HQ and PM	Conference calls Wednesday at 4:PM	Agenda to be discussed sent before hand
Director	ALL STAFF	2nd Friday of the month	Director communicates any new information to staff, gives staff review of progress, goals and review staff's plans for the next month
ALL STAFF	CS Workshop	Mar-07	Staff share lessons learnt and suggest strategies for improvement
ALL STAFF	Stakeholders	Nov-07	Presentations on program by staff. Share lessons learned.

* If you cannot make a set meeting date, at least 1 week of advance notice and rescheduling with your direct supervisor is expected.

** Reports are due at least 2 days before meetings. Exceptions need to be cleared with your direct supervisor.

Staff Annual Leave

Moses Tibaingana	Mar/Apr
Amelia Namanya	August/September
Charles Tumwine	July
Dorah Musiire	Aug/Sept
Elisa Nshemerirwe	Early September
Arthur Kanyalyeru	December
Grace Karungi	November
Lydia Kiwanuka	Late December/Early January
Gilbert Kansiime	After 1 year of service
Dr. Grace Namaganda	After 1 year of service

<i>Training Plan</i>				
Topic	Training	Location and date	Participants	Measure Results
CSTS Mini-University	DIP review, mini courses on CSHGP strategies, networking	4-8 June, Baltimore, MD, USA	Director, Dr. Grace Namaganda	Course completion, * share lessons learned with other staff
Communication and Presentation Skills	Training requested by staff and recommended by Director	21-25 May, UMI	Marketer, Nshemereirwe Elisa	*Participant to give brief overview of lessons learned to the rest of staff.
Management Skills Improvement	Training requested by staff and recommended by Director	21 May-1June, UMI	Scheme Manager, Namanya Amelia	*Participant to give brief overview of lessons learned to the rest of staff.
Strategic Marketing Management	Training requested by staff and recommended by Director	7-11 May, UMI	Marketer, Kanyaryeru Arthur	*Participant to give brief overview of lessons learned to the rest of staff.
Customer Care Training	Training requested by staff and recommended by Director	23-27 April, UMI	Marketer, Charles Tumwine	*Participant to give brief overview of lessons learned to the rest of staff.
Community Health	Training requested by staff and recommended by Director	Online, African Medical and Research Foundation. Start in May	Community Educator, Musimire Dorah	*Participant to give brief overview of lessons learned to the rest of staff.
Monitoring & Evaluation	Regional Workshop On Monitoring And Evaluation Of PHN	Addis Ababa, Ethiopia July 16 - August 3, 2007	M&E Coordinator	Successful course completion. *Participant to give brief overview of lessons learned to the rest of staff.
Business and Financial	Training requested by staff and recommended by Director	16-20 April, UMI	Accountant/Administrator, Lydia	*Participant to give brief overview of lessons learned to the rest of

Management			Kiwanuka	staff.
Social Marketing Strategies	Training requested by staff and recommended by Director	PSIU, 3 September	UHC staff	Successful course completion
Health Insurance and CBHIS	Health Insurance and CBHIS principles	By Director, Bushenyi Office, 7 May	UHC staff	Successful course completion
Computer skills training	Conducted by Raymond Twinko	31 March, Bushenyi	UHC staff	Successful course completion, reduction in computer costs due to improper shutdown and viruses
Monitoring & Evaluation Interactive mini-course on M&E Fundamentals	Monitoring and Evaluation Training Online Covers EPI and Data analysis. https://www.cpc.unc.edu/measure/training/MENTOR .	Online M&E Coordinator to schedule time expressly for this training.	M&E Coordinator, Gilbert Kansiime	Certificate of successful course completion
Dissemination Workshop	Disseminate results from monitoring assessments	March 5, 2007 Bushenyi, Uganda	UHC staff, Stakeholders, Partners	Workshop report, including details of discussions, attendance list and copies of presentations
LQAS Methodology	Provided by Simon Kasasa Institute Of Public Health, Po Box 7072, Kampala, Uganda	February 2007, Bushenyi, Uganda	UHC staff	Successful course completion
Annual General Meeting	Training on health plan concepts, leadership of BOD, implementing changes	3 November, Bushenyi, Uganda	UHC staff, stakeholders, partners	Meeting report including details of discussions, attendance list and copies of presentations
Annual Stakeholder Workshop	Share results, lessons learned and plan for the way forward	1-2, November, Bushenyi, Uganda	UHC staff, stakeholders, partners	Meeting report including details of discussions, attendance list, copies of presentations, feedback forms.

BOD Sustainability Training	Quarterly updates and training at meetings to build board capacity to make informed decisions and to lead the health scheme	Monthly Bushenyi District	UHC Board of Directors, UHC staff, Consultant, partners	Self assessments, training results and reports
Budget and financial management	Cooperative financial management: sustaining the scheme through appropriate budgetary management	Bushenyi District, TBD	UHC staff UHC BOD	Improved budget management Improved ability to monitor and manage cooperative budget
Health Services IMCI, SCM training	IMCI and SCM training and follow up. Participatory self assessment training, and BEHAVE	Monthly by Phase, Bushenyi District	Bushenyi District HWs	Self assessments follow up training questionnaires and observation tools, Integrated health facility assessment.

*** External capacity building opportunities are provided for staff with the understanding that after training each person will write a review of the lessons s/he learned from the course and that s/he will share these lessons with the rest of the team by giving a brief presentation no more than two weeks after training has been completed.**

Work Plan

Activity	Duration	Resp.	Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Distribute Mama Kits		HST									On going				
Mobilize communities to have safe water, safe disposal of feces; prevent diarrhea	On going	CE	on going							On going					
Mobilizing communities on PMTCT, RCT, prevention of HIV/AIDS transmission	On going	CE	on going							On going					
Mobilizing communities against malaria	On going	CE	on going							On going					
Distribution of ITNs	On going	HST	on going							On going					
Marketing and Group Meetings	On going	SM,MM,FM	on going							On going					
Scheme Mgr ORS and PUR Distribution/Training	On going	SM	on going							On going					
CORP HIV/AIDS Training		CE	Jan												
MNC Health Worker Training		HST	Jan												
End of Phase I Monitoring	1 month	All staff	Feb												
Marketing Commission Bonus	4 months	FM, SM, M	Feb				Feb-31Jun								
LQAS & HFA	1 month	M&E	Feb		28										
ISA	1 month	Director	Feb		28										
Lindquist Assessment/Report	1 week	Consultant	Feb		31 Jan-8 Feb										
Program Assessment & Training		PM	Feb		1-28 Feb										
Staff Review Tools/Update Materials		All staff	March				1-31 Mar								
Send cont'd partnership requests & tm dates for Phase II-VI to MOH & DDHT		CE	March				15-Mar								
Print new CORP Training Guides		AA	March				1-23 Mar								
Work Plan 2007		D, PM	March				1-31 Mar								
Intern Report		Intern	March				15-Mar								
Hold Scheme CORP elections		SM	March				19-25 Mar								
Invite School Nurses to attend CORPIMCI Trn		SM	March				By 5 Apr								
PHASE II RUHINDA COUNTY			March												
Visiting the HSD, county & sub county Hqtrs.	1 day	CE	March				12-18 Mar								
Dissemination workshop	1 day	M&E	March				5-Mar								
Training BOD on the roles and responsibilities. Review By-laws.	1 day	M&E	March				21-Mar								
Recruiting	3 day	CE					19-25Mar								
Orienting CORPS	1 day	CE	March				26-31Mar								
Follow up of trained HWs		HST	March				28-31Mar								
Disseminate work plan to staff	1 day	Director	March				26th Mar								
Interview CLC	1day	Director	March				27th Mar								
Work plan training for staff	2days	All staff	March				28-29th								
Staff training in computer maintenance and standard procedures			March				31-Mar								
Implement Programmatic Changes		All staff	April				Apr-Oct								
60% Rule test cases		FM, SM, M	April							Apr - Oct					
Member group visits		SM	April				April-Jun								
Change School Premium Structure		FM, SM, M	April							Apr - Oct					
Improved Ishaka Office Resource Mgmt		AA	April				Apr-31 May								
Training of HWs in IMCI		HST	April				6-Apr								
Training CORPs in Community- IMCI	4 days	CE	April				13-Sep								
Questionnaire / feedback / handout		M&E	April				11-Apr								
BOD meeting and self assessment. Prepare for the Health Fair.	1 day	M&E	April				11-Apr								
Present Work Plan to BOD for feedback		M&E	April				11-Apr								
Develop and Review M&E Tools		M&E					27-Feb								
Lydia Kwanuka Training	5 days	AA	April				16-20 Apr								
Charles Tumwine Training	4 days	MM	April				23-27 Apr								
Kanyaryeru Arthur Training		MM	May				7-11 May								
Nshemerirwe Elisha Training	5 days	MM	May				21-25 May								

Annex 1: CS Intervention Specific Detailed Work Plan

Objective	Activity	Target	Venue	Time Frame								Resources	Personnel Responsible	Indicator	
				Mar	Apr	May	Jun	Jul	Aug	Sep	Oct				Nov
Creating awareness of the project in Ruhinda county	Visiting the HSD, county & sub county Hqtrs.	Ruhinda county health units, sub county officials	HSD, H/Us, county and sub county offices	3rd week									Fuel, vehicle, lunch, notebooks, posters, brochures, leaflets	CS Staff	No. of officers visited, level of collaboration
	Recruiting & orienting CORP	Communities of Ruhinda county	Orientation at Ruhinda county hall	4th week											Targeted CORP turned up and oriented
Reducing incidence of malaria among U5s in Bushenyi district	Distribution of ITNs	Igara and Ruhinda newborns and mothers	Igara and Ruhinda H/Units with maternity services	Ongoing								Vehicles, ITNs, issue vouchers, tracking forms	CS/UHC staff, midwives at health units	No. of newborns that receive ITNs, reduced cases and deaths due to malaria among U5s	
Improving the quality of health care management of childhood illnesses	Training of HWs in IMCI	Nurses, midwives, clinical officers of Ruhina	Venue to be identified		1st week Ruhinda training								Hiring venue, accommodation, stationery, manuals, meals, trainers' fee, fuel	MOH and district IMCI trainers, CS staff	No. of HWs completed training
	Follow-up of HWs trained in IMCI	Ruhinda and Igara HWs	At health units where HWs are stationed			Ruhinda follow-up		2nd wk Igara follow up	Ruhinda follow-up						No. of HWs supervised and implementing IMCI guidelines

Objective	Activity	Target	Venue	Time Frame									Resources	Personnel Responsible	Indicator
				Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov			
Reducing incidence of childhood illnesses among U5s in Bushenyi district	Training CORP in community - IMCI	CORP of Ruhinda	Venue TBD		2nd week Ruhinda training								Hiring venue, accommodation, stationery, manuals, meals, trainers' fee, fuel	US/UHC staff, CORP, trainers	Targeted no. of CORP turned up and trained,
	Refresher training for Igara CORP	CORP of Igara	Venue TBD			Refresher for Igara CORP and bicycle distribution									Number of CORP that attend refresher training
	Mobilizing communities to have safe water, safe disposal of feces; prevent diarrhea	Communities of Ruhinda and Igara	In communities of Igara and Ruhinda	Mobilization ongoing											No. of communities mobilized, reduced cases of morbidity and mortality due to diarrheal diseases in targeted areas

Improving the quality of health care services so as to reduce maternal (pre & post natal) morbidity and mortality	Training HWs in lifesaving skills including active mgmt of third stage labor	Midwives and clinical officers of Ruhinda	Venue to be identified				1st week Ruhinda training						Hiring venue, accommodation, stationery, manuals, meals, trainers' fee, fuel	MOH and district LSS trainers, CS staff	No. of HWs completed training
	Follow up of trained HWs	Midwives and clinical officers of Igara	At health units of Igara	5th week Igara follow up				4th week Ruhinda follow up							No. of HWs supervised and implementing LSS, AMTSL guidelines
Increase percentage or pregnant mothers receiving improved ANC, delivery, and postnatal care	Training CORP in MNC	Ruhinda CORP	TBD				2nd week						Hiring venue, accommodation, stationery, manuals, meals, trainers' fees, fuel	CS/UHC staff, CORP, trainers	Targeted no. of CORP completed training; increased % of mothers receiving improved ANC, deliver, and post natal care
Increase no. of clean birth kits	Distribution of mama kits	Igara and Ruhinda pregnant women who have had IPT2	At Health Units with ANC clinics	Ongoing								Vehicle, mama kits, issue vouchers, tracking forms	CS/UHC staff, midwives	No. of mothers who received mama kits, no. of clean births	

Objective	Activity	Target	Venue	Time Frame									Resources	Personnel Responsible	Indicator	
				Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov				
Improve d quality of health care through improved resource stock	Training HWs in stock order plans	Ruhinda and Igara HWs esp. pharmacists, in-charges, dispensers, store managers	Venue to be determined	Date s TBD												
Creating awareness in Bushenyi of UHC activities ;promoting the goals and objectives of Health Plans and CS programs	Health Fair	UHC staff and partners, eg Health Plan members, BOD, CORP	Venue TBD				Date TBD						Hiring venue, meals, fuel, posters, transport, scheduling, banners, brochures, demonstration kits ie. for PUR water purifier, ORS, erecting booths	UHC staff, partners	Targeted partners, communities turned up, key messages passed on	
Reducing mortality and morbidity due to HIV/AIDS related illnesses esp.	Training of CORP in the prevention of HIV/AIDS including PMCT, RCT, and VCT	CORP of Ruhinda	Venue TBD					1st week Ruhinda training					Hiring venue, accommodation, stationery, manuals, meals, trainers' fee, fuel	US/UHC staff, CORP, trainers	Targeted no. of CORP turned up and trained,	

among WRA and U5s in Bushinyi	Mobilizing communities towards PMTCT, VCT, and prevention of HIV/AIDS transmission	Communities of Ruhinda and Igara	Communities of Igara and Ruhinda	Mobilization ongoing										No. of communities mobilized, reduced cases of morbidity and mortality due to HIV/AIDS in targeted areas		
Reducing incidence of malaria among U5s in Bushenyi district	Training CORP in malaria prevention	CORP of Ruhinda	Venue TBD							2nd week				Hiring venue, accommodation, stationery, manuals, meals, trainers' fee, fuel	US/UHC staff, CORP, trainers	Targeted no. of CORP turned up and trained
	Mobilizing communities against malaria	Communities of Ruhinda and Igara	Communities of Igara and Ruhinda	Mobilization ongoing									No. of communities mobilized, reduced cases of morbidity and mortality due to malaria in targeted areas			

NOTES:

* Review in September

* LQAS monitoring in October

* Workshops, updating training plans and materials

**End of Phase 1
Knowledge, Practice and Coverage and Health Facility Assessment**

**HealthPartners Uganda Health Cooperative
Child Survival Project
in
Bushenyi District, Uganda**

MARCH 2007

Uganda Health Cooperative in Partnership with, Bushenyi District Local Government.

Authors

1. Simon Kasasa Institute of Public Health Makerere University Kampala
2. Jennifer Wenborg, Program Manager, HealthPartners Uganda Health Cooperative
3. Grace Namagenda, Director, Uganda Health Cooperative
4. Gilbert Kansiime Monitoring And Evaluation Coordinator, Uganda Health Cooperative
5. Lydia Gladys Kiwanuka, Administrator/Accountant, Uganda Health Cooperative

Acknowledgements

The authors of this report would like to thank all individuals for their time and effort in the KPC process. Special thanks go to Bushenyi District Local Government especially Chairman LC V, Chief Administrative Officer and the District Director of Health Services for their various contributions to the exercise. Sincere gratitude is extended to Sub-county chiefs, LC III chairpersons and all health facility staff in Igara county. Special thanks go to all the respondents who freely shared their ideas and experiences that have been used in preparing this report. Last but not least we would like to acknowledge the people listed below for their input into data collection and management.

a) Interviewers

1. David Kintu
2. Juliet Amany
3. Benjamin Buhikire
4. Amelia Namanya
5. Dorah Musiimire
6. Arthur Kanyaryeru
7. Elisha Nshemirirwe
8. Duncan Akatukunda

b) Supervisors

1. Catherine Houchenwise
2. Lydia Gladys Kiwanuka
3. Moses Tibaingana
4. Gilbert Kansiime

c) HFA data collectors

1. Simon Kasasa
2. Grace Namaganda
3. Charles Tumwine

d) Support Staff

1. Julius Beijuna

e) Hired Drivers

1. Deo Kalenzi
2. Moses Byaruhanga
3. Gerald Kamugisha

f) Data entrants

1. Juliet Naddamba
2. Emily Kainobwisho

EXECUTIVE SUMMARY

Introduction: For the past 10 years, Uganda Health Cooperative has been working in Uganda. It is located in Bushenyi District in the western part of Uganda about 400km from the country's capital Kampala. According to Uganda Population and Housing census 2002 Bushenyi district has a population of over 8000,000 people with a population growth rate of 2% and fertility rate of 7 children. Children under five years account for 20% of the entire population. According to the National Household survey 2002/2003 (UBOS) Western Uganda is one the regions with the highest rates of maternal and child mortality (176 out of 1,000), as well as the highest prevalence rates of diarrhea and malaria with 16% of infants having diarrhea in the last two weeks, and low use of mosquito nets (9%).

UHC is implementing a project in the district where children under five and women are targeted.

In September 2005, Health Partners Uganda Health Cooperative was awarded a USAID Child Survival Health Program Grant. The goal is to link child survival interventions to prepaid health plans, building on the existing structure to sustainably reduce morbidity and mortality for Women in Reproductive Age (WRA) and children under 5 in Bushenyi district. To achieve the above objective, UHC adopted the child survival sustainability assessment strategy with slight variations on the three dimensions: community/social, health services, and local organizational dimension as the primary model for the program.

UHC implements the above dimensions in a phase manner in order to capitalize on opportunities to improve implementation of the program with the maximum amount of feedback from staff, stakeholders, partners, consultants and the management team. Before beginning the interventions in the district, a health facilities assessment Health Facility Assessment (HFA) and baseline Knowledge Practise and Coverage (KPC) survey were carried out in order to generate benchmark data for the various indicators. Interventions in Igara (phase 1) started in August 2006 and ended in January 2007.

At the end of Phase I in January 2007, a four day exercise to monitor and evaluate the effect of the child survival interventions for the past 6 months was conducted between 13th and 17th February 2007. This included a KPC in the 7 sub counties of Igara using the LQAS research methodology and a HFA in sixteen sampled health facilities.

Evaluation objectives: The general objective was to assess progress in health status and health service delivery in Bushenyi District in comparison to baseline survey results of January 2006. Data and reporting results will be used to improve interventions and trainings tools to; bridge gaps in results to achieve goals in Igara County and to update CS curricula and training tools in order to better achieve goals moving forward with interventions. Specifically the evaluation aimed at the following:

- Assessing the incidence of malaria in pregnant woman and children under five plus any improvement or change since 1/2006.

- Assessing the incidence of diarrhea for children under five and any improvement or change since 1/2006.
- Estimating the percentage of pregnant women receiving improved antenatal, delivery and post partum care.
- Understanding challenges and assessing improvement or changes in Health Service delivery in Bushenyi district since 1/2006.

Methods and materials: Phase one evaluation took place in February 2007 in Igara County. Data collection was carried out from the 13th – 17th February 2007. This was a cross-sectional study where LQAS methodology was used. A total of 133 households were selected from 7 sub-counties. Each sub-county was defined as a supervision area. For the health facilities, only 16 out of 28 were selected from the entire county.

Respondents for the KPC were women or caretakers with children between zero and twenty three months. A survey questionnaire was adopted from that used at baseline after making minor changes. Selection of villages was based on the list generated by Uganda Bureau of Statistics (UBOS). Systematic sampling using village populations was applied in each of the seven sub-counties.

Interviewers were trained for two days and third day was used for pilot testing and finalizing survey tools. Epi-info software was used for data entry and analysis. Later data was exported to SPSS version 12.0 for further cleaning and analysis.

Descriptive statistics were generated for almost all the questions. Few cross-tabulations were generated. Data was presented in the form of tables and graphs. All the indicators are summarized on the basis of the project objectives.

Findings: A total of 133 mothers/caretakers were included in the survey. Mothers' age ranged between 17 and 41 years. The number of children between 0-5 months (36%) was almost equal to those who were 13 months (37%) and above. The median age for children was 8 months. Below are the key findings by theme.

a) Malaria for pregnant women and children

Twenty out of 100 children had malaria in the past two weeks. For children with fever, only 72% sought treatment or advice. Mosquito nets were available in almost half (48%) of all households visited. Proportions of mothers and children who slept under the mosquito net in the past 24 hours were 22% and 35% respectively.

b) Diarrhea for children under five

Children with diarrhea in the past two weeks accounted for 32%. Of those children who were sick, only 16% used ORS for treating diarrhea. Almost 3 in every four households use improved water sources. Hand washing with water and soap was reported to be more practiced after defecation (79%) and least practices after attending to a child who has defecated (8%). Almost 1 in every four (29%) mothers reported giving a child more to eat during illness and only 14% reported giving something to drink more than usual. Toilet facilities with slabs were observed in 41% of all the households sampled.

c) ANC, delivery and post partum care

Out of 133 mothers interviewed, 95% sought prenatal care. According to mothers' cards, only 16% of mothers made the required 4 visits for ANC. Almost 3 in every four mothers sought VCT services. Mothers who attended ANC were counseled for breastfeeding (75%), child spacing (53%), danger signs during pregnancy (62%) and safe birth plans (53%). Mama kit was used by majority (80%) of the mothers during the previous delivery. More than half (68%) of the mothers were delivered by skilled health personnel. Less than half of the caretakers either stayed with the child immediately after delivery (44%) or breastfed within an hour (45%).

Exclusive breastfeeding was practice by more than half of the mothers (68%). However complete immunization for children who are twelve months and above at the right time was as low as 46%.

d) Health care management for women and children

Health workers received in-service training for IMCI (43%), AMTSL (48%) PMTCT (52%) and VCT (78%). All facilities visited provide IPT and ITN to pregnant mothers. MOH policy guidelines on ANC and Obstetric services were available in only 8 facilities out of the 14 total that provide Obstetric care services. All health facilities experienced stock outs for some drugs in the past six months. Amoxicillin Oral, ORS and Ciprofloxacin were the most affected types of drugs.

Conclusions

The prevalence for both fever and diarrhoea in the past two weeks for children under two years was reduced by the end of the first phase of intervention. Mama Kits were observed to be widely used by mothers. Gaps in proper hygiene practices such as hand washing with soap and presence of recommended toilet facilities do exist in Igara. More than half of the health facilities experience stock outs of ORS.

Recommendations

In order to improve both mothers and children's health status in Igara, there is a need to increase and encourage ITN use.

As a way of improving hygiene households should be encouraged to put-up facilities that will promote hygiene practices. Further more provision of IMCI training to health workers is vital. Communities can be reached through their CORP who received training in Community Based Integrated Management of Childhood Illness.

CHAPTER ONE

1.0 BACKGROUND

1.1 Project location and background of the area

Uganda Health Cooperative (UHC) has been working in Uganda since 1997. It is located in Bushenyi district in the western part of Uganda about 400km from the country's capital, Kampala. The project head office is in Kampala.

Bushenyi district has five counties; Buhweju, Ruhinda, Sheema, Bunyaruguru and Igara. These are further divided into several sub-counties and parishes up to LC 1 (villages) levels. The population of the district according to counties is summarized in the table below.

[Table: District Population According to Counties](#)

COUNTY	POPULATION
Buhweju	80,489
Bunyaruguru	102,757
Igara	207,396
Ruhinda	157,720
Sheema	172,827
Total	721,189

Source: 2002 Uganda Population and housing census

1.2 Characteristics of the Target Beneficiary Population

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

Bushenyi district has a very young population. Children below 5 years constitute about 20% of the total district population. The population for children 0-1 is 32,646, 12-23 months is 31,317 and children 24-49 months is 93,951. This situation is no doubt a result of high fertility experienced in the district. The projected fertility rate of women in Bushenyi is 7 children. For Igara, the total population as shown above is 207,396 with a sex ratio of almost one to one, implying that there are 100,516 males and 106,880 females. The county has approximately 38,455 households as per UBOS records.

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

1.3 Socio-economic indices

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

The Human Development Indices for Uganda show that Bushenyi has up to 0.488 Human Development Indices by the year 2005 according to the Uganda Human Development Report.

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

According to the UDHS 2000/2001, the infant mortality rate is 88 deaths per 1000 live births (UBOS 2000). This means that one in every 11 babies born in Uganda do not survive to the first birth day. Of those who do survive to their first birth day, 169 out of 1000 die before reaching their fifth birthday. The overall under 5 mortality is estimated at 152 deaths per 1000 live births, which means that one in every seven Ugandan babies does not survive to their first birthday. The maternal mortality ratio is estimated to be 505 maternal deaths per 100,000 live births (WHO/Hill 2004). These high rates are a result of severe malaria, pneumonia, anemia, diarrhea and poor handling of mothers before and after delivery and poor feeding/ sanitation practices for the new born.

Whereas the MOH has ensured that there are health facilities up to parish level (HC II), the baseline Health Facility Assessment revealed that most of these health facilities were not adequately staffed. Besides, the terrain of the area also acts as an impediment to easy access to these health facilities.

1.4 National Standards/Policies Regarding Maternal and Child Health (read HSSP)

The national policy classifies maternal and child health under one cluster (cluster 2 – maternal and child health). This classification emphasizes the link between maternal and child health mortality and the cumulative nature of health problems through the entire lifecycle. The cluster consists of five elements: Sexual and Reproductive Health (SRH), Newborn care, Common childhood illnesses, Immunization and Nutrition. maternal and child health comprises of the following maternal and newborn health services: preconception care; ANC; post abortion care; intra-partum care; emergency obstetric care; care of the new born and post natal care (MoH Uganda 2005).

The main objective under this cluster is to contribute towards the achievement of a level of reduction in maternal, neonatal and young child mortality that is commensurate with the timely achievement of the PEAP targets and related Millennium Development Goals.

1.4.1 Sexual Reproductive Health Rights

Specific targets for this element include: Increase the proportion of deliveries by skilled attendants from 38 to 50%; Reduce the unmet need for emergency obstetric care from 86% to 40%, Increase the attendance for 4 visits per pregnancy from 42 to 50%, Increase the Contraceptive Prevalence Rate from 23% to 40% (increase CYPs from 223,686 per annum to 500,000 per annum), Reduce the percentage of teenage pregnancy rates from 37 to 20% (MoH Uganda 2005).

1.4.2 Newborn Health and Survival.

Under this element the MoH targets to reduce the proportion of children with low birth weight by 30% and to reduce the proportion of neonates seen in health facilities with septicemia/severe disease by 30%. Core interventions include : Provision of essential care during pregnancy including Tetanus toxoid immunization, proper nutrition including iron/folate supplements and prevention and treatment of maternal infections such as malaria, STDs, Infection control during & after delivery including the distribution of Mama Kits, Provision of essential care during the postnatal period including promotion of immediate and exclusive breast-feeding, thermal control, clean cord practices and Vitamin A supplementation among others(MoH Uganda 2005).

1.4.3 Management of Common Childhood Illness

Integrated Management of Childhood Illness (IMCI) is a key strategy for delivery of integrated child health services through improvement of health worker skills in regard to integrated assessment and management of malaria, acute respiratory infections, diarrhoea, and malnutrition, which contribute to over 70% of overall child mortality. The strategy also focuses on improving health system issues that affect care for children in health facilities as well as working to improve key family care practices that have the highest potential for child survival, growth and development

Core interventions for common childhood illnesses include improvement of HW skills in managing childhood illness using IMCI guidelines, Community treatment of fever/malaria, diarrhea and pneumonia,; Family Care Practices message dissemination (care seeking, disease prevention, home treatment and compliance); Integrated sustained outreach services and bi annual Child Days and Provision of comprehensive management of pediatric HIV and support (MoH Uganda 2005).

1.5 Overview of the UHC Child Survival Project: Goals, Objectives and Interventions

Formed in 1997 by HealthPartners a Minnesota not for profit HMO, under USAID's Cooperative Development Program with a sub-grant from Land O'Lakes, HealthPartners Uganda Health Cooperative (UHC) has been implementing an innovative prepaid health scheme program in Bushenyi in south western Uganda. Through the scheme it was discovered that the major causes of morbidity and mortality in the Bushenyi community were preventable diseases.

1.5.1 The problem

According to the Health Sector Strategic Plan II (HSSP II) 75% of Uganda's disease burden is considered to be preventable as it is primarily caused by poor personal and

domestic hygiene and inadequate sanitation practices. Other preventable diseases include malaria, acute respiratory infections (ARI), diarrhoeal diseases (DD), HIV/AIDS and vaccine preventable diseases.

In addition to the above scenario, maternal and child health outcomes did not show improvement in the 1990s. Maternal and neonatal conditions contribute the highest (20%) to Uganda's total burden of ill health. This massive burden of disease results in diminished productivity and increased poverty.

This vicious cycle that affects most Ugandans can be reversed, as has already been proven in several other countries, through a well-integrated and coordinated deployment of existing resources. In particular, through the active engagement of the district extension staff, including Health Assistants, Village Health Teams, Community Development Workers and Education Officers together with Faith Based Organisations (FBOs), NGOs and CBOs, in focusing their coordinated activities down at household, community and parish levels.

In light of the health problems facing the health sector in Uganda, HealthPartners was interested in demonstrating that prepaid health schemes are viable strategies to address child survival interventions and can achieve large scale and community-wide impact.

In September 2005, HealthPartners Uganda Health Cooperative was awarded a USAID Child Survival Health Program Grant. The goal is to link child survival interventions to its prepaid health plans, building on the existing structure to sustainably reduce morbidity and mortality for Women in Reproductive Age (WRA) and children under 5 in Bushenyi district. To achieve the above objective, UHC adopted the child survival sustainability assessment strategy with slight variations on the three dimensions: community/social, health services, and local organizational dimension as the primary model for the program

1.5.2 Community and Social Dimension

UHC has three objectives under this dimension for Bushenyi district: To reduce incidence of malaria in children under 5 and pregnant women in the district; to reduce the incidence of diarrhea in children under 5 in the district for and to increase the percentage of pregnant women receiving improved antenatal care (ANC), delivery and post partum care.

Under this dimension, Community Owned Resource Persons (CORP) are trained to educate communities on maternal and new born care, prevention, identification and early treatment of malaria and diarrhea. The training covers: malaria warning signs, proper use of Insecticide Treated nets (ITNs), use of and advantages of IPT, warning signs of diarrhea, safe water practices and hand washing, home care of diarrhea, safe disposal of feces, importance of ANC, RCT , PMTCT and planning for safe birth.

UHC also distributes free long lasting ITNs to newborns born at health facilities; ITNs to pregnant mothers when they deliver babies in a health facility with skilled birth attendants and provides mama kits at the 4th ANC visit. These interventions are aimed at encouraging mothers to seek ANC and delivery services at the health facilities in the district.

1.5.3 Health and Services Dimension

The main objective under this dimension is to build capacity of providers to offer Integrated Management of Childhood Illness (IMCI) and Standard care management (SCM) so as ensure quality service delivery and reduction of childhood and maternal morbidity and mortality. The health workers are trained using Ministry of Health (MoH) guidelines and protocols. All the training is done in collaboration with staff from the MoH, Bushenyi District Directorate of Health Services and other partner organizations. Information Education and Communication materials (IEC) and guidelines/protocols are reproduced/reprinted and given to CORP and HWs as teaching aides and reference materials respectively.

Under this dimension, UHC also aims at demonstrating to providers the ability of prepaid health plans to address social health for adoption by the Ministry of Health to cover the poorest populations. Through the health plan groups in Bushenyi district are identified and mobilized to contribute premiums which are given to providers before hand so as to enable them access healthcare when they need it.

1.5.4 Local Organizational Dimension

Under this dimension, UHC has the following objectives: to build knowledge and capacity of UHC board to enable them to competently run UHC; to strengthen trust and ties between providers and community groups to enable best practices and continued coverage for members. Build incentive for member, leader and provider participation. Build capacity of UHC team, stakeholders and partners.

To achieve the above objectives, a board of directors (BOD) who are members of UHC health plans, was elected. This board is trained and involved in UHC's activities so as to ensure sustainability of the interventions. Also in line with the sustainability goal is the need for scheme growth which is ensured through marketing to active groups in the district. Such groups include: dairy cooperatives, coffee and tea cooperatives, micro-finance groups, burial societies, teachers and students at secondary boarding etc.

The implementation of the above interventions is phased by Sub County in order to capitalize on opportunities to improve implementation of the program with the maximum amount of feedback from staff, stakeholders, partners, consultants and the management team. Before beginning the interventions in the district, a Health Facility Assessment (HFA) and baseline Knowledge Practise and Coverage (KPC) survey using the LQAS methodology were carried out and baseline values were obtained by county for the various indicators monitored. Interventions in Igara (phase 1) started in August 2006 and ended in January 2007.

At the end of Phase I in January 2007, a four day exercise to monitor and evaluate the effect of the child survival interventions for the past 6 months was conducted between 13th and 17th February 2007. This included a KPC in the 7 sub counties of Igara using the LQAS research methodology and a HFA in sixteen sampled health facilities of Igara.

1.6 Objectives of the study evaluation:

1.6.1 General objective

To assess progress in health status and health service delivery in Bushenyi district in comparison to baseline survey results of January 2006. Data and reporting results will be used to improve interventions and training tools to; bridge gaps in results to achieve goals in Igara County and to update CS curricula and training tools in order to better achieve goals moving forward with interventions.

1.6.2 Specific objectives

1. To assess the incidence of malaria in pregnant woman and children under five and any improvement or change since 1/2006.
2. To assess the incidence of diarrhea for children under five and any improvement or change since 1/2006.
3. To determine the percentage of pregnant women receiving improved antenatal, delivery and post partum care.
4. To identify challenges and assess improvement or changes in Health Service delivery in Bushenyi district since 1/2006.

CHAPTER TWO

2.1 Methods and materials

The evaluation of phase 1 interventions took place in February 2007 in Igara County. Data collection was carried out from the 13th – 17th February 2007. There are seven sub-counties in Igara; Bumbaire, Kyabugimbi, Kyeizooba, Kyamuhunga, Kakanju, Nyabubare and Town council and they were all included in the survey.

2.2 Questionnaire development

The KPC survey questionnaire was adopted from the one that was used at baseline. Revisions were made based on the lessons learnt from the baseline survey. This was through a meeting between the consultant, former Monitoring and Evaluation officer plus HealthPartners' management. Further more, new questions were introduced in the questionnaire to cater for indicators that were not measured at baseline.

During training, members of the survey team reviewed the tools and helped in translating new questions and also to re-examine the translations that were done at baseline. The community questionnaire was further pilot tested by the study team in order to check for the flow and consistency of questions. A discussion meeting was held after the pilot test exercise and lessons learnt were used to generate a questionnaire that was finally used for data collection. The survey covered the following aspects; Respondent's Background, Age and weight as anthropometry measurement, Child Immunization, HIV/AIDS prevention, Hand-washing practices, Integrated Management of Childhood Illnesses (IMCI), Malaria Prevention, Maternal and Newborn Care, Breastfeeding and Nutrition, Diarrhea, Sanitation and Hygiene.

2.3 Study Indicators and definitions

Objective 1: Reduce the incidence of malaria in pregnant women and children under 5.

<i>Indicators</i>	<i>Definition of an indicator</i>	
	<i>Denominator</i>	<i>Numerator</i>
% of children under 2 with fever in the last 2 weeks	Number of children in the survey	Number of children who had fever in the last two weeks (QN 21)
% of children under 2 with fever in the last 2 weeks who received advice or treatment	Number of children who had fever in the last two weeks (QN 21)	Number of sick children who sought advice or treatment (QN22)
% of children under 2 with fever in the last 2 weeks who sought treatment on the same day	Number of children who had fever in the last two weeks (QN 21)	Number of sick children who sought treatment same day (QN24)
% of children under 2 with fever in the last 2 weeks who received anti-malarial treatment	Number of children who had fever in the last two weeks (QN 21)	Number of sick children who received anti-malaria treatment (QN25 A - H)
% of households with children 0-23 months that own at least one mosquito net/ITN	All households in the survey	Number of households with mosquito nets (QN30)
% of children under 2 who slept under mosquito nets last night	All children in the survey	Number of children who slept under a mosquito net (QN33=A)
% of pregnant women who slept under mosquito nets last night	All mothers in the survey	Number of mother whose children slept under a mosquito net (QN33=B)
% of pregnant women who received IPT during last pregnancy	All mothers in the survey	Number of mother who received IPT (QN28)

Objective 2: Reduce incidence of diarrhea for children under five

<i>Indicators</i>	<i>Definition of an indicator</i>	
	<i>Denominator</i>	<i>Numerator</i>
% of children under 2 with diarrhea in the last two weeks	All children in the survey	Number of children with diarrhea in the past 2 weeks (QN 63)
% of children 0-23 months with diarrhea in the last two weeks who received ORS	Number of children with diarrhea in the past 2 weeks (QN 63)	Number of children with diarrhea in the last 2 weeks who received ORS (Qn 64=B)
% of care takers/mothers who know at least 2 signs that a child under 2 needs treatment	All mothers in the survey	Number of mothers who mentioned at least 2 signs that a child needs treatment (Qn QN17 B-K)
% of care takers/mothers who know at least one signs that a child under 2 needs treatment	All mothers in the survey	Number of mothers who mentioned at least one sign that a child needs treatment (Qn Q17 B-K)
% of households who use improved water source (borehole, public tap, or protected dug well.)	All mothers in the survey	Number of mothers that reported improved water sources (Qn72= 1-3) This referred to Borehole, Public taps, Protected dug well
% of households with a designated hand washing facility	All mothers in the survey	Number of households where hand washing facilities were observed (Qn 77)
% of caretakers who usually wash hands with soap before food preparation, before feeding children, after defecation and after attending to a child who has defecated	All mothers in the survey	Number of mothers who reported washing hands under the mentioned 4 conditions (Qn 16 A-F)
% of caretakers who dispose off children's feces hygienically (dropped into toilet facility or rinsed and water discarded into toilet facility)	All Mothers/ caretakers in the survey	Number of caretakers who dispose off children's feces hygienically (Qn 75 =1 or 2)

% of children 0-23 months who were offered more fluids during the illness	Children who were sick in the past 2 weeks (Qn 18 either A-G)	Children who were offered more fluid during illness (Qn 19=3)
% of children 0-23 months who were offered the same or more food during the illness	Children who were sick in the past 2 weeks (Qn 18 either A-G)	Children who were who offered more to eat during illness (Qn 19=3)
% of children 0-23 months with diarrhea in the last two weeks who were offered the same or more amount of breastfeed during the illness	Children who had diarrhea the past 2 weeks (Qn 63)	Mothers who offered same or more breastfeeding to a sick child (Qn65=2or 3)
% of households with access to a pit latrine	All households survey	Number of household with access to pit latrines (Q76 =1 to 3)

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

<i>Indicators</i>	<i>Definition of an indicator</i>	
	<i>Denominator</i>	<i>Numerator</i>
% of pregnant women with 4 ANC visits	Mothers who sought prenatal care (Qn 42)	Mothers who had at least 4 ANC visits as verified by maternal card
% of pregnant women seeking VCT services	Mothers who sought prenatal care (Qn 42)	Mothers who sought VCT services (Qn 46)
% of mothers that were counseled on breastfeeding	Mothers who sought prenatal care (Qn 42)	Number of mothers who were counseled on breastfeeding (Qn 44B)
% of mothers that were counseled on child spacing (about 2 years)	Mothers who sought prenatal care (Qn 42)	Number of mothers with counseled about child spacing (Qn 44C)
% of caretakers mothers that were counseled on least 2 danger signs during pregnancy	Mothers who sought prenatal care (Qn 42)	Number of mothers who were counseled about pregnancy danger signs (Qn 44D)
% of pregnant women counseled on safe birthing plans (where to deliver, plan transport ,plan having a birth kit)	Mothers who sought prenatal care (Qn 42)	Number of pregnant mothers with birth plans (Qn 45 all the 3 aspects)

% of pregnant women counseled on where to deliver	Mothers who sought prenatal care (Qn 42)	Number of pregnant mothers counseled on where to deliver (Q45A)
% of pregnant women counseled on transport plans to delivery place	Mothers who sought prenatal care (Qn 42)	Number of pregnant mothers counseled on transport plans to delivery place (Q45B)
% of pregnant women counseled on having a birth kit	Mothers who sought prenatal care (Qn 42)	Number of pregnant mothers counseled on having a birth kit (Q45C)
% of pregnant women with access to a clean razor to cut the cord	All mothers in the survey	Number of care takers that used clean razor to cut the cord (Qn 55)
% of children 0-23 month who were put with mother immediately after birth	All mothers in the survey	Number of mothers who were put with mothers immediately after delivery (Qn 56)
% of children 0-23 month who were put to the breast within the first hour of delivery	All children in the survey	Number of children who were put on breast within the 1st one hour (Qn 59)
% of women who delivered with a skilled birth attendant (doctors, nurses and TBAs)	All mothers in the survey	Number of mothers who were delivered by skilled birth attendants (Qn 39)
% of mothers who used mama kits	All mothers in the survey	Number of mothers who used mama kits

Rapid catch indicators

<i>Indicators</i>	<i>Definition of an indicator</i>	
	<i>Denominator</i>	<i>Numerator</i>
% of children 0-23 months who are underweight (-2SD from the median weight for age, according to the WHO/NCHS reference population)	All children in the survey	Number of children below -2SD (Qn 6)
% of children aged 0-23 months whose births were attended to by a skilled health personnel	All caretakers/ mothers in the survey	Number of mothers who were delivered by skilled birth attendants (Qn39)
% of mothers of children aged 0-23 months who received at least 2 tetanus toxoid injections before the birth of their youngest child (self report and also from a card)	Mothers who reported to have received TT during pregnancy	Number of mothers who received at least two TT
% of infants aged 0-5 months who were exclusively breastfed in the last 24 hours	All children between 0-5 months (Q6)	Number of children 0-5 months with no supplementary feeds (Qn 62=2)
% of infants aged 6-9 months receiving breast	All children 6-9 months in	Number of children 6-9

milk and complementary foods	the survey (Q6)	receiving complementary feeding (Qn 62=1)
% of mothers with children 0-23 months who were ever given a vaccination card or health book for the youngest child	All mothers in the survey	Number of mothers with vaccination cards or books (q12= 1 or 2)
% of mothers with children 0-23 months who current have a vaccination card or health book for the youngest child	Number of mothers who reported to have received a vaccination card or book for the child (q12= 1 or 2)	Number of mothers currently with vaccination cards or a book for the youngest child (q12=1)
% of children 12-23 months who were fully vaccinated against the five vaccine preventable diseases before their first birth day (BCG, Polio1, Polio2, Polio3, DPT1, DPT2,DPT3,Hib, HepB, measles)	All children between 12 and 23 months (Qn6)	Children who received all the vaccination before their birthday (Qn13)
% of children 12-23 months who received a measles vaccine (both cards and mother's recall)	All children between 12 and 23 months (Qn6)	Children who received measles vaccine (Qn 13)
% of children 12-23 months who were fully vaccinated against the five vaccine preventable diseases (mother's recall and cards: BCG, Polio1, Polio2, Polio3, DPT1, DPT2,DPT3,Hib, HepB)	All Children between 12 and 23 months (Qn6)	Children who received all the vaccinations (Qn13)
% of children under 2 who slept under mosquito nets last night	Number of households with mosquito nets (Q30)	Number of mother whose children slept under a mosquito net (Q33=A)
% of care takers/mothers who know at least 2 signs that a child under 2 needs treatment	All mothers in the survey	Number of mothers who reported atleast 2 signs that a child needs treatment (Qn Q17 B-K)
% of children 0-23 months who were offered more fluids during the illness	Mothers/ caretakers who had a sick child in the past 2 weeks (Qn 18 either A-G)	Mothers /caretakers who offered more fluid during illness (Qn 19=3)
% of mothers to children age 0-23 who cited at least 2 known ways of reducing the risk of HIV infection	Number of mother in the survey	Number of mother with children 0-23 months who cited atleast 2 HIV preventive methods (Qn 15 B-K)
% of caretakers who usually wash hands with soap before food preparation, before feeding children, after defecation and after attending to a child who has defecated	All mothers in the survey	Number of mothers who reported washing hands under the mentioned 4 conditions (Qn 16 A-F)

Objective 4: Improved health care management especially for Women of Reproductive Age and children under 5

According to DIP, the following are the indicators used to measure improvement in health care management

- Percentage of stock outs in the past 30 days
- Percentage of Health workers who have received IMCI training the last 3 years
- Percentage of Health workers who have been supervised in IMCI in the last year
- Percentage of Health workers who have MOH policy and guidelines/ protocol on ANC and obstetric care services
- Percentage of Health workers who utilize AMTSL while delivering babies

The table below gives the details for the above indicators used in measuring health care management.

<i>Indicators</i>	<i>Definition of an indicator</i>	
	<i>Denominator</i>	<i>Numerator</i>
% trained in VCT in the past 3 years	Number of staff involved directly with client counseling diagnosis services (Section 1: QN 101)	Number of staff received in-service training related to VCT in the past three years (Section 1: QN 102)
% received in-service training in PMTCT	Number of staff involved directly with client counseling diagnosis services (Section 1: QN 101)	Number of staff received in-service training related to PMTCT in the past three years (Section 1: QN 103)
% received training in management of 3rd stage labour in last 3 year	Number of staff involved directly in management of antenatal/third stage labor and Emergency Obstetrics care services (Section 3: QN 301)	Number of staff received in-service training related to management of 3rd stage labor (Section 3: QN 302)
% of staff received in-service training in reproductive health life savings skills within the last 3 year	Number of staff involved directly in management of antenatal/third stage labor and Emergency Obstetrics care services (Section 3: QN 301)	Number of staff received in-service training related to management of 3rd stage labor (Section 3: QN 303)
% of facilities with MOH policy guidelines on ANC and Obstetric services	All facilities in survey that provided ANC service	Number of facilities with MoH guideline (QN323)

% of staff received in-service training in IMCI within the last 3 year	Number of staff involved directly in management of IMCI services (Section 4: QN 401)	Number of staff received in-service training related to IMCI (Section 3: QN 402)
% facilities supervised for IMCI regularly	All facilities in survey that provide IMCI services	Number of facilities supervised regularly for IMCI (Q 403=1)

2.4 Study design

This survey applied a descriptive cross sectional study design within Igara County. Igara County is made up seven sub-counties with 530 household registered by Uganda Bureau of Statistics. Only quantitative methods of data collection were applied between 13th and 17th February 2007.

2.5 Study population

Children in Igara County with ages of 0-23 and their mothers constituted the study population. Having stayed in Igara County for the past 12 months was used as an inclusion criterion.

2.6 Sampling design

Lot Quality Assurance Sampling (LQAS) technique was used during the survey. Igara County is made up of seven sub-counties, which were adopted as supervision areas to suit the LQAS design. Based on the LQAS methodology, each supervision area was supposed to contribute a sample of 19 measurement/ study units. Since the sub-counties are divided politically, we decided to maintain all of them hence having seven supervision areas. From each sub county a sample of 19 households was selected leading to a total sample size of 133 for the entire county. A household was defined as members who do not only sleep under the same roof but also eat together as per Uganda Bureau of Statistics (UBOS) definition.

Similarly, 17 health facilities were randomly selected from the seven sub-counties. The selected sample accounts for more than 50% of the total of health facilities (28 Health Units) in Igara County. Facilities selected ranged from HC II to hospital level.

2.7 Household selection process

A list of villages (LCI) for the entire county was obtained from Uganda Bureau of Statistics with their respective populations. Villages were grouped by sub-county which was defined as a supervision area. From each supervision area, 19 villages were selected

using systematic sampling technique. A table of random numbers was to obtain a random start. Other remaining villages within the sub-county (supervision area) were the selected systematically. This process was applied to all the seven sub-counties.

During the course of training and pilot testing, it was observed that most villages did not have updated lists of their households. A method of dividing a particular village into smaller sections (3-5) was then adopted as recommended by LQAS methodology. Interviewers with assistance from village leaders divided the villages into sections which were later assigned numbers randomly. Using a table of random numbers, one part of the village was selected from the entire village randomly. Local leaders further helped interviewers to list all households in the selected section. All households were assigned numbers randomly. A table of random numbers was then used to select one household.

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

2.8 Training

The field team including both supervisors and interviewers was recruited from Bushenyi district. These were from the local partner organizations, namely, the District Local Government and Local NGOs. Some of the members on the team had participated in the baseline survey. Others had spent some time in the community. This gave them a chance to review the LQAS methodology and also to improve on their community research skills.

After a thorough discussion, it was agreed to include both male and female on the field team. This is because most of the aspects considered in the study were not gender specific.

Both interviewers and supervisors went through an intensive two day training plus another extra day of pilot testing. This helped them build the necessary field skills. Checklists for both interviewers and supervisors were developed to enable them follow the necessary steps accordingly.

During training, LQAS participants' manual of December 2001 was followed. The consultant identified topics that were similar to those covered during training for the baseline survey in the entire district. The first four modules in the manual were emphasized.

Since weight was one variable to be measured, members also went through the process of measuring a child's weight using a weighing scale.

Training was conducted by a Biostatistician from Makerere University Institute of Public Health who is a TOST trainer. Participatory approach was used during training. Exercise

and role plays as recommended by the manual were applied. Training was followed by a full day of pilot testing.

Immunization cards for children and mothers' card given during pregnancy were also introduced to members to enable them extract the necessary data with almost no difficulty.

2.9 Data collection and Quality control

Face to face interviews and observation were the two methods that were used to collect the data. An average of 45 minutes per interview was established during the pilot testing phase. Data collection from all the seven sub-counties took place between 13th and 17th February 2007.

A number of quality control methods were put in place. This involved the following;

- Training of the field team before the exercise
- Grouping members in teams each under a supervisor
- Reviewing questionnaires before handing them back to the supervisor.
- A supervisor had to go through the days questionnaires before handing them over to Monitoring and Evaluation coordinator who was the overall field supervisor.
- There were developed checklists for both supervisors and interviewers by M&E coordinator.
- Most of the questions were pre-coded, this reduced on answers that were likely to be irrelevant to a particular questions
- Special instructions for questions that required them were written on the questionnaire such as, skip patterns and probes.
- Measurements on a weighing scale were taken more than once. Computing average weight for each of the child was done after data entry.

2.10 Data management and analysis

At the end of field day, data filled questionnaires were handed over to the overall field supervisors for further editing in order to check for completeness and consistency. When the entire data collection exercise was completed, questionnaires were handed over to the consultant for coding and entry. Two data entrants from MUIPH plus M&E coordinator participated in data management process. They spent the first day going through the questionnaire and electronic data screens. Epi info version 6.02 was used for designing data entry screens and data cleaning. A check program was designed in order to minimize errors. Further more, a unique identifier was assigned to each and every questionnaire prior to data entry. After data entry, all the three datasets were merged for cleaning.

Data were later exported to SPSS version 12.0 for further cleaning and analysis. EPINFO 3.2.2 was used to compute anthropometric data.

Frequencies with their corresponding 95% confidence intervals and cross tabulations were generated. However due to a limited sample size few cross tabulations were generated. No hypothesis testing has been done

Data was the presented in form of tables and graphs using the baseline format report. The process of data management and analysis was headed by the consultant.

2.11 Ethical considerations

Permission was sought from the district officials and other relevant local leaders who included sub-county, parish and village Local council officials. Verbal consent was sought before every interview. In case a person to be interviewed was not the head of the household, permission was obtained from the head thereafter consent from that individual.

2.12 Challenges faced

The major challenge during the HFA data collection was the difficulty in finding staff at health facilities in the afternoons especially in government health facilities. In order to overcome this, HFA data collection was limited to the mornings.

Data collection for the KPC on the other hand an array of challenges which included the following among many:

- Identifying a family with a child under 2 was not easy and some mothers did not know the exact ages of their children. In such instances mothers were asked for the child's immunization card, if available to verify the child's age or asked questions to help them remember when the child was born.
- Misspelling in some village names caused delays in locating them.
- Some women thought the data collection teams were District officials who had come to implement government policies on sanitation and hygiene, and would run away from their houses, particularly if they had no toilets. To overcome this problem the data collection teams used guides from the village who were given to the team by the LC1 chairman.
- The questionnaire was lengthy and some respondents would get tired with answering all the required questions. Also many of the respondents were busy with their businesses or in their gardens to offer assistance or answer the questions. The morning hours were especially challenging, as that is when most women work in the garden. To overcome this we asked for permission from the respondents and told them the estimated duration of the questionnaire.
- The limited number of drivers to transport the data collection team was one of the major challenges during data collection. This resulted in long waiting times before

moving to the next village this was worse in areas with no network for it was impossible to contact drivers or other group members.

- Some chairmen wanted to be paid for them to help us or wanted to be respondents for the survey.
- There was no rope with which to hang the scale, and the pants were too large for very small babies. So in most cases the team had to improvise with banana fibres.

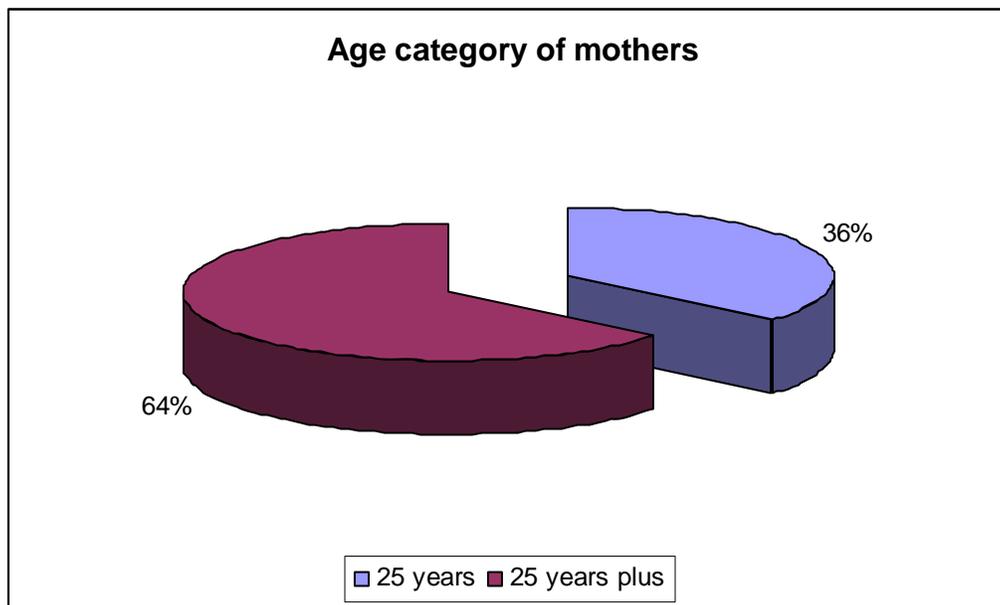
CHAPTER THREE

3.1 Study Findings

This chapter represents findings from both households and health facilities assessed in Igara county. Results are presented according to some specified themes or objectives the project is following. These include reduction in malaria and diarrhea incidence, increasing services for pregnant women (ANC, delivery and Post partum care), rapid catch indicators as well as improvement in health care management for women and children. A description of the study population is included in the next section.

3.2 Demographics

Results of the survey were generated from seven supervision areas of Igara sub-county. A total of 133 respondents with children 0-23 months were interviewed. Mothers aged ranged between 17 and 41 years with mean of 26.9 ± 5.6 and a median of 27 years.



Majority of the mothers were 25 year and above

For the children between 0 -23 months, their average age was 10 months, median 8. The table below shows the distribution of children by age groups

Table: Age distribution of children

Age (in months)	Number	Percentage
0-5	48	36.1
6-9	26	9.5
10-12	9	6.8
13 plus	50	37.6
TOTAL	133	100.0

The number of children between zero to five was almost equal those with 13 and above months old age bracket.

The next section contains tables with all the indicators presented by project objective. Numerators, denominators and percentages with their respective 95% confidence interval (95% CI) are also included.

3.3 Findings by objective

Objective 1: Malaria treatment and prevention indicators

<i>Indicator</i>	<i>Denominator</i>	<i>Numerator</i>	<i>Percent</i>	<i>Confidence limits</i>
% of children under 2 with fever in the last 2 weeks	133	32	24.1	± 7.2
% of children under 2 with fever in the last 2 weeks who received advice or treatment	32	23	71.9	± 15.6
% of children under 2 with fever in the last 2 weeks who sought treatment on the same day	23	11	47.8	± 20.4
% of children under 2 with fever in the last 2 weeks who received anti-malarial treatment	23	16	69.6	± 18.8
% of households with children 0-23 months that own at least one mosquito net/ITN	133	63	47.4	± 8.5
% of children under 2 who slept under ITN last night	133	46	34.6	± 8.1
% of women who slept under ITN last night	133	29	21.8	± 7.0
% of pregnant women who received IPT during last pregnancy	133	91	68.4	± 7.9

Objective 2: Diarrhea disease and hygiene related practices indicators

<i>Indicator</i>	<i>Denominator</i>	<i>Numerator</i>	<i>Percent</i>	<i>Confidence limits</i>
% of children under 2 with diarrhea in the last two weeks	133	42	31.6	± 7.9

% of children 0-23 months with diarrhea in the last two weeks who received ORS	42	7	16.7	± 11.3
% of care takers/mothers who know at least 2 signs that a child under 2 needs treatment	133	102	76.7	± 7.2
% of care takers/mothers who know at least one signs that a child under 2 needs treatment	133	124	93.2	± 4.3
% of households who use improved water source (borehole, public tap, or protected dug well.)	133	104	78.2	± 7.0
% of households with a designated hand washing facility	133	26	19.5	± 6.7
% of caretakers who usually wash hands with soap/ash before food preparation, before feeding children, after defecation and after attending to a child who has defecated	133	38	28.6	± 7.7
% of caretakers who usually wash hands with soap/ash before food preparation,	133	51	38.8	± 8.3
% of caretakers who usually wash hands with soap/ash before feeding children	133	38	28.6	± 7.7
% of caretakers who usually wash hands with soap after defecation 23	133	105	78.9	± 6.9
% of caretakers who usually wash hands with soap after attending to a child who has defecated	133	11	8.3	± 4.7
% of caretakers who usually wash hands with soap/ash before food eating	133	62	46.6	± 8.5
% of caretakers who dispose off children's feces hygienically (dropped into toilet facility or rinsed and water discarded into toilet facility)	133	94	70.6	± 7.7
% of children 0-23 months who were offered more fluids during the illness	99	14	14.1	± 6.9
% of children 0-23 months who were offered the same or more food during the illness	99	29	29.3	± 8.9
% of children 0-23 months with diarrhea in the last two weeks who were not treated with anti-diarrheals or antibiotics (Herbal medicine)	42	9	21.4	± 12.4

% of children 0-23 months with diarrhea in the last two weeks who were breastfed the same or more amount of food during the illness (Q65)	42	26	61.9	± 14.7
% of households with access to a pit latrine	133	55	41.4	± 8.4

Objective 3: ANC, delivery and post partum care indicators

<i>Indicator</i>	<i>Denominator</i>	<i>Numerator</i>	<i>Percent</i>	<i>Confidence limits</i>
% of pregnant women with 4 ANC visits (From mother's card)	126	20	15.9	± 6.4
% of pregnant women seeking VCT services	126	92	73.0	±7.8
% of mothers that were counseled on breastfeeding	126	95	75.4	± 7.5
% of mothers that were counseled on child spacing (about 2 years)	126	67	53.2	± 8.7
% of caretakers mothers that were counseled on least 2 danger signs during pregnancy	126	78	61.9	± 8.5
% of caretakers that have knowledge of at least 2 danger signs during pregnancy	126	71	56.3	± 8.7
% of pregnant women with safe birthing plans (where to deliver, plan transport ,plan having a birth kit)	126	67	53.2	± 8.7
% of pregnant women counseled on where to deliver	126	111	88.1	± 5.7
% of pregnant women counseled on transport plans to delivery place	126	83	65.9	± 8.3
% of pregnant women counseled on having a birth kit	126	95	75.4	± 7.5
% of pregnant women with access to a clean razor to cut the cord	133	85	63.9	± 8.1
% of children 0-23 month who were put with mother immediately after birth	133	59	44.4	± 8.4
% of children 0-23 month who were put to the breast within the first hour of delivery	133	62	46.6	± 8.5
% of children age 0-23 months who	92	31	33.7	± 9.7

were born at least 36 months after the previous surviving child				
% of mothers who were delivered by skilled health workers (doctor, nurse/MW and TBAs)	133	76	57.2	± 8.41
% of mothers who used mama kits	133	107	80.5	± 6.7

Rapid catch indicators

<i>Indicator</i>	<i>Denominator</i>	<i>Numerator</i>	<i>Percent</i>	<i>Confidence limits</i>
% of children 0-23 months who are underweight (-2SD from the median weight for age, according to the WHO/NCHS reference population)	133	23	17.3	± 6.4
% of mothers who were delivered by skilled health workers	133	91	68.4	± 7.9
% of mothers of children aged 0-23 months who received at least 2 tetanus toxoid injections before the birth of their youngest child	133	60	65.3	± 8.5
% of infants aged 0-5 months who were exclusively breastfed in the last 24 hours	48	33	68.7	± 13.1
% of infants aged 6-9 months receiving breast milk and complementary foods	25	22	88.0	± 12.7
% of mothers with children 0-23 months who were ever given a vaccination card or health book for the youngest child	133	115	86.5	± 5.8
% of mothers with children 0-23 months who current have a vaccination card or health book for the youngest child	115	88	76.5	± 7.7
% of children 12-23 months who were fully vaccinated against the five vaccine preventable diseases before their first birth day (BCG, Polio1, Polio2, Polio3, DPT1, DPT2,DPT3,Hib, HepB, measles Cards)	52	24	46.2	±13.5
% of children 12-23 months who received a measles vaccine (cards and mother's recall)	52	39	75.0	±11.7
% of children 12-23 months who were fully vaccinated against the five	52	31	59.6	± 13.3

vaccine preventable diseases (BCG, Polio1, Polio2, Polio3, DPT1, DPT2,DPT3,Hib, HepB), (cards and mother's recall)				
Drop-Out rate using DPT1 and DPT3 for children 12-23 months (Card or mother's recall)	63.5	67.3	5.98	±
% of children under 2 who slept under ITN last night	133	46	34.6	± 8.1
% of care takers/mothers who know at least 2 signs that a child under 2 needs treatment	133	102	76.7	± 7.2
% of children 0-23 months with diarrhea in the last two weeks who were breastfed the same or more amount of food during the illness (Q65)	42	26	61.9	± 14.7
% of mothers to children age 0-23 who mentioned at least 2 known ways of reducing the risk of HIV infection	133	88	64.7	± 8.0
% of caretakers who usually wash hands with soap/ash before food preparation, before feeding children, after defecation and after attending to a child who has defecated	133	38	28.6	± 7.7

3.4 Detailed findings

3.4.1 Malaria treatment and prevention

As observed from the data, almost one in every four children had fever in the past two weeks. Among the children with fever, only 72% received advice or treatment. Use of mosquito nets for both children and mothers were reported to be 35% and 22% respectively.

Sleeping under the net for children with fever in the past two weeks was reported by only half of the mothers/caretakers as indicated in the table below.

Presence of fever in the past two weeks

Child with fever in the LAST 2 WEEKS				
Characteristics		Fever n =32	No fever n =101	Total n=133
Received anti-malarials	Yes	16 (50)	0	16 (12)
	No	16 (50)	101 (100)	117 (88)

Slept under a mosquito net	Yes	9 (28.1)	37 (36.6)	46 (34.6)
	No	23 (71.9)	64 (63.4)	87 (65.4)

Among the children with fever, only 28% slept under mosquito nets a night before the survey. This finding indicates a linkage between fever and mosquito nets use in Igara county. The prevalence of fever in the past two weeks from baseline to follow-up reduced 44.2% to 24.1% respectively. The overall number of children who slept under mosquito nets was as low as 31% yet for the follow-up estimate stands at 73%. It ought to be noted that baseline data considered even those with no mosquito nets. If an entire study sample at follow-up is considered, the percentage of children who slept under a mosquito net drops to 47.4% (63/133) which is again slightly higher than the baseline prevalence.

Confidence intervals for the percentage of children who slept under mosquito nets for baseline (31.0 \pm 0.008) and follow-up (34.1 \pm 8.1) do overlap indicating non significant changes in the practice.

This implies that there is a need to promote the use and ownership of mosquito nets specifically in households with children under five and pregnant women in Igara county. All stakeholders involved in training should emphasize the importance of children and pregnant women sleeping under ITNs.

3.4.2 Diarrhea Related Factors ad Hygiene Practices

The prevalence of diarrhea in Igara County in the past two weeks was reported to be 42%. Among the children with diarrhea, only 24% received ORS. One in every two children received less than usual to drink while sick. Similarly, almost one in every two (48%) also received less than usual for eating while sick as indicated in the table below.

Diarrhea status and practices

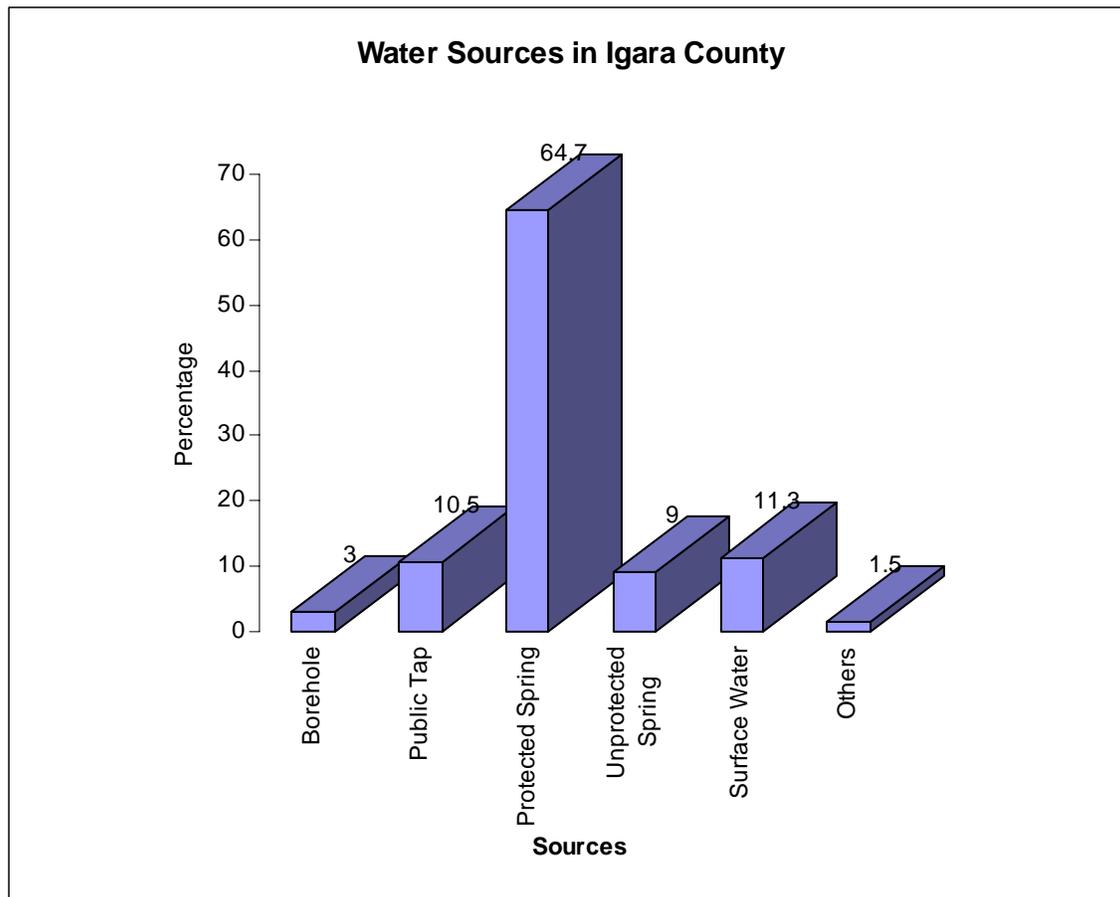
Child had diarrhea in the past two weeks				
Characteristics		YES n=42 (%)	No n =91 (%)	Total n=133 (%)
Received ORS	Yes	10 (23.8)	0 (0.0)	10 (7.5)
	No	32 (76.2)	91 (100.0)	123 (89.5)
Amount received for drinking while sick	Less than usual	21 (50.0)	27 (29.7)	48 (36.1)
	Same amount	11 (26.2)	26 (28.6)	37 (27.8)
	More than usual	6 (14.3)	10 (11.0)	16 (12.0)
	Not applicable/ stated	12 (28.6)	28 (30.8)	32 (24.1)

Amount received for eating while sick	Less than usual	20 (47.6)	27 (20.3)	47 (35.3)
	Same amount	8 (19.0)	19 (20.9)	27 (20.3)
	More than usual	2 (4.8)	6 (6.6)	8 (6.0)
	Not applicable/ stated	12 (28.6)	39 (42.9)	51 (38.3)

Out of 42 children with diarrhea in the past two weeks only 23 sought treatment or advice from a professional health worker. The main sources of advice or treatment were clinics (56.5%) followed by government health facilities (30.4%). The majority of the mothers/ caretakers knew at least one sign (93%) for a child that requires immediate medical attention.

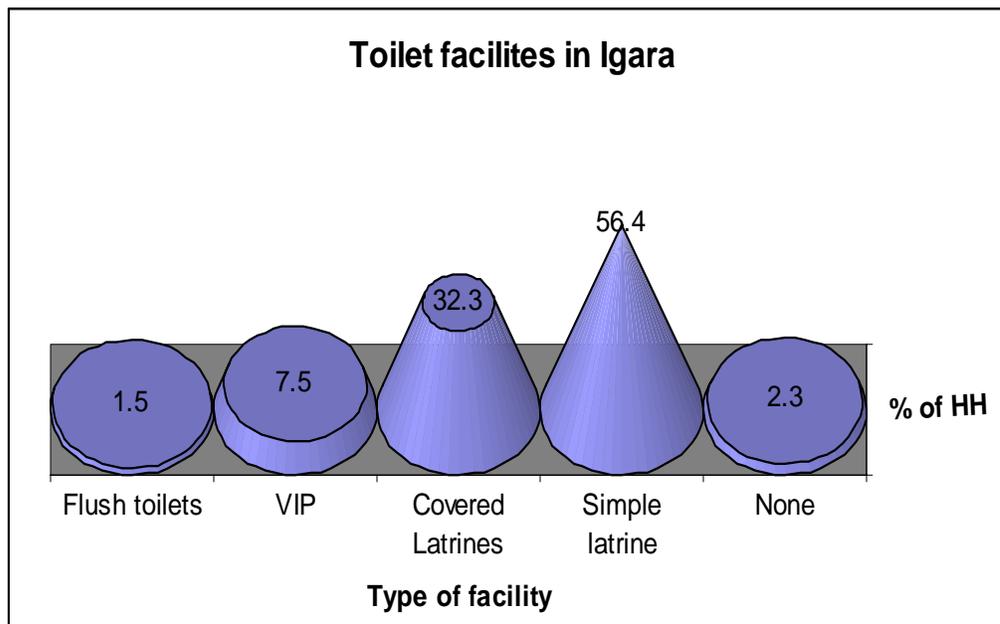
Households with designated hand washing facilities accounted for only 19.5%, implying that one in every five households has a designated hand washing facility. Hand washing with soap for the desired situations: before preparing food, before feeding a child, after defecating and after attending to a child who has defecated was as low as almost one in every four households (29%). Most caretakers reported washing their hands with soap after defecating (79%).

Residents of Igara county use various sources of water as indicated in the graph below;



As observed from the above graph, majority of the households (78.2%) use improved water sources. These include boreholes, public taps and protected springs. It ought to be noted that almost a quarter of the household get water from sources that are not recommended. Such sources include unprotected wells, surface water and other undefined sources.

Households with access to pit latrines accounted for 41%. That is flush toilets, VIP and covered pit latrines. Majority (56.4%) of the households observed use simple latrines without slab. Three households had no toilet facilities at all. Details are shown in the graph below;



Mothers/Caretakers need to be educated further on the importance of increased feeding for children during sickness. For children with diarrhea, ORS should always be looked at as the first choice type of treatment. This implies that proper preparation of ORS has to be emphasized to mothers during antenatal care and post natal care visits. Having a designated hand washing facility and the practice of washing hands at the desirable situations should be part of health education.

Having at least a pit latrine with a covered slab is a good hygienic practice. As observed from the above figure, more than half of the households sampled in Igara use pit latrines without slab. Such toilets put its members at risks of developing diarrhea related diseases including cholera. All stakeholders including local government must come and encourage people to put recommended pit latrines in their households. According to HSSP II the ministry recommended latrine coverage of at least 57%. However, from the sampled households about 41% had the recommended pit latrine.

If factors mentioned above are improved, diarrhea related diseases will likely be reduced especially in children. There is a need to involve all stakeholders in mobilizing the community for proper hygiene practices and proper feeding of sick children.

3.4.3 Antenatal Care (ANC) and delivery practices

Out of 133 mothers/caretakers interviewed in the survey, only 126 (94.7%) received prenatal care for the recent pregnancy. Majority of the mothers sought care from either nurses or midwives (103/126). Only two individuals visited a TBA.

Sixteen percent of the mothers surveyed managed to make at least 4 ANC visits which is a recommended practice. Self reports indicated a higher number of 61.9% who made at least four ANC visits. This large discrepancy supports the need for self reporting to be verified whenever possible. Only 25.4% mothers who sought prenatal care presented maternal cards to any of our survey team members.

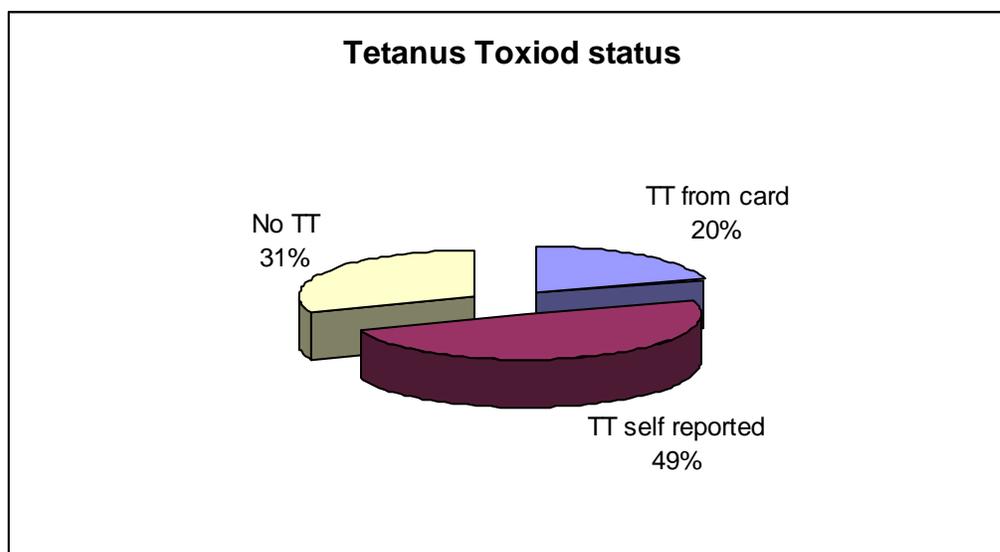
Based on maternal cards, the proportional of mothers that made the required number of prenatal visits in Igara is below the expected national of 42%. This implies that there is a need to involve all stakeholders including village health teams in mobilizing mothers and their spouses for better health actions.

The importance of keeping cards must be emphasized. One of the possible reasons as to why we recorded few mothers with the recommended ANC services is partly due to low card retention. Health workers need to encourage mothers to safely keep both maternal and child cards.

As observed from the data, more than half of the caretakers received counseling on various subjects. These included, breastfeeding (75%), child spacing (53%), danger signs during pregnancy (62%), arrangement for a place to deliver from (88%), prepare for transport to delivery place (66%) and having a birth kit (75%). These aspects reflect a fair knowledge of mothers about the mentioned practices. There is a need therefore to continue keeping mothers' knowledge high on the desirable practices.

Fever (35.7%) and bleeding (27.8%) were the two common risk signs for pregnancy mothers in the survey reported. Although, knowledge on danger signs during pregnancy is one of the important aspects emphasized in the minimum basic health care package, in Igara such knowledge is still low. All skilled health workers in all health facilities need be reminded about the importance of providing such information to pregnant mothers. This calls for a complete review of the counseling packages given to pregnant mothers in the entire county.

In regard to tetanus toxoid, 20.3% of the caretakers presented TT cards other reports were from recall as shown below.



Sixty-nine percent of mothers received at least one injection of TT. However, the reliable number from the card accounts for only 20% out of the entire sample. Those who never received TT or were not aware that they received TT accounted for 31%. Respondents who received TT at least twice (both self reported and card) accounted for 60%. Using card, only 18 out of 133 (13.5%) mothers received TT at least twice. By the end of 2010, government of Uganda aims at eradicating both maternal and neonatal tetanus. This implies that all mothers within a reproductive age (15-49) should get TT at the appropriate time. In Igara such a practice is still low. Also TT card retention still low.

Some of the recommended practices by the MOH after delivery include; put a child with the mother immediately after birth and putting a child on a breast within an hour. According to the survey only 44% of mothers and 47% were put next to the mother and put on breast in the first one hour respectively. There is a need to encourage all health providers to recommend such good practices to mothers after delivery. One has to establish whether those practices are mentioned in the counseling sessions to mothers who have come for prenatal care services.

3.4.4 Child feeding practices and nutrition status.

Feed practices by age

		Children's Age (month)			
		0-5	6-9	10 plus	Total
Currently breastfeeding	Yes	97.9	96.2	78	88.7
	No	2.1	3.8	22	11.3
Fed on anything else immediately after delivery	Yes	54.2	34.6	49.2	48.1
	No	45.8	65.4	50.8	51.9
Currently fed on additional food	Yes	31.3	88.5	94.9	70.7
	No	68.7	11.5	5.1	29.3
TOTAL		48	26	59	133

As observed from the table above, most of the children 0-23 months (89%) are still breastfeeding. Only 69% of children under 6 months are exclusively breastfed. According to national targets, Igara County is almost at the expected target of government for children who are exclusively breastfed. MOH aims at increasing the number of children who are exclusively breastfed from 70% to 80% between 2006 and 2010. Exclusive breastfeeding promotes proper child growth. Mothers should always be reminded about the benefits of such practices.

It was observed that 48% of mothers reported giving something else to a child immediately after delivery before breast milk. There is a need to design ways and means of reducing such undesirable practices.

In relation to children's nutrition status, out of 133 children, 17.3% were under weight (below -2SD weight for age). Igara County is so far within the expected target of government when national estimates are considered. By the end 2010, MOH expects to reduce under weight to 17% from the current 23%. Since Igara County is already lying within the expected range of measurements five years from now, it is important to maintain good practices that have led to improvement in the county's nutrition status.

3.4.5 Children's immunization status

About 87% of the caretakers reported to have received a vaccination card or book to the index child. Only 88 out of 115 presented immunization cards for their children. Ten percent of all children have never been immunized. Out of the 14 children who were not immunized, majority were between 0-5 months. Only one was found in the age bracket of 6-9 months.

For children 12-23 months (52/133), only 24 (46.2%) were fully immunized against the five diseases before their first birth. Seventy four percent reported their children 0-23 months to have received BCG while measles among children 12-23 months was found to be at 75%. Immunization dropout rate was estimated to be around 6.0%.

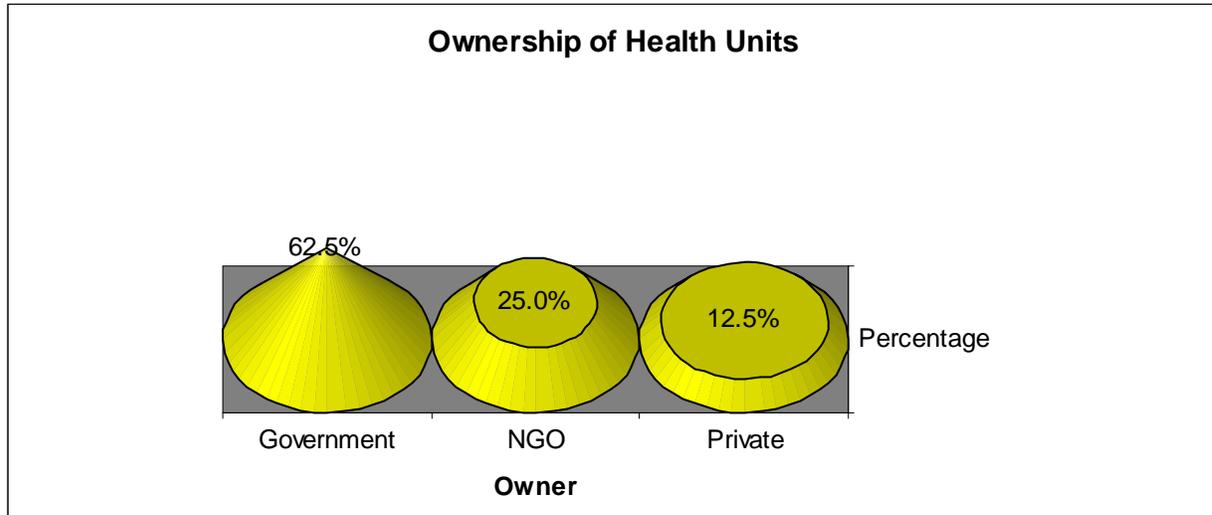
According to national targets, Uganda recorded full immunization of children as high as 71% by the end of HSSP I implementation. For measles, 91% received the vaccine by the end of 2005/2006. This implies that Igara County is still below the national target. This requires a lot of efforts starting from households up to county level in mobilizing all relevant stakeholders if the county is to move at the same pace with other parts of the country.

3.4.6 Improved health care management especially for Women of Reproductive Age and children

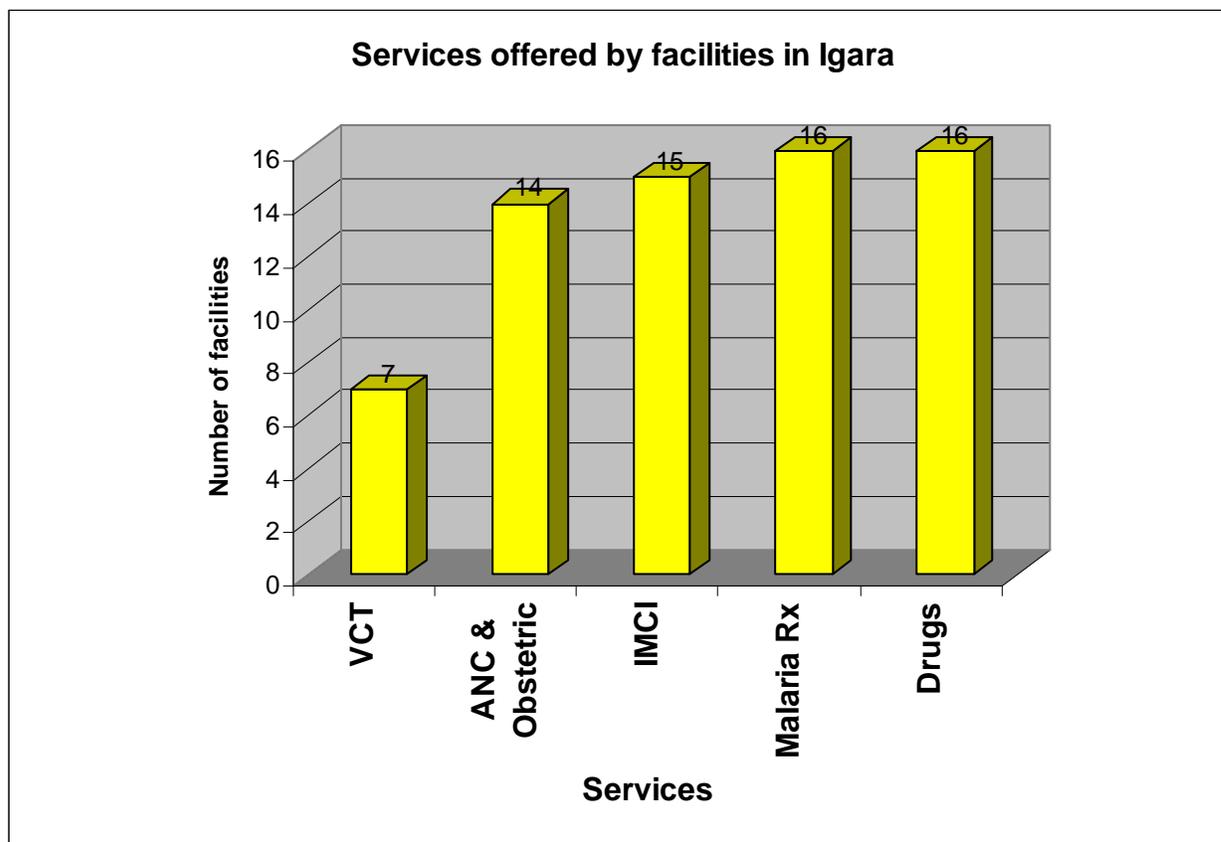
In order to establish whether there was a change in health care management especially for women, a health facility survey tool was administered to 17 facilities in Igara district.

However, only 16 health facilities were included in the analysis. Rwenjeru HC II was discarded because it does not offer most of the services.

The chart below displays the kind of ownership for the visited facilities:



Most health units were owned by government (63%) followed by NGO (25%) and Private had only 2. Services offered by the facilities ranged from VCT, ANC and Obstetric, IMCI, Malaria treatment and drug supplies as indicated in the chart below;



Health facilities provided the following services: VCT (7/16), Antenatal and emergency Obstetric Care services (14/16), IMCI (15/16), diagnosis and treatment of Malaria (16/16), Commodity management (16/16). A list of all facilities visited that provide various services are listed in Annex 1. Government through MOH plans to scale-up VCT to all HC III by the end of 2010 and PMCT to about 50% of all HC III as indicated in HSSP II.

Out of the 16 health facilities visited, only 4 (25%) have health plans. These include Bushenyi HC, Bushenyi Medical Clinic (BMC), Ishaka Adventist hospital and Comboni hospital.

As observed from the table below, health units staff were interviewed about the kind of services they offer, in-service training, supervision and drug stock out. The proportion of staff that reported to have received in service training for VCT, PMTCT, AMTSL, management of severe and complicated malaria plus IMCI ranged between 27% and 78%. For supervision, almost all HU (94%) had been supervised for IMCI. Details are shown in the table below:

Indicators from health facilities

Characteristic	Denominator	Numerator	Percentage
Percentage trained in VCT	33	26	78.8
% received in-service training in PMTCT	52	14	26.9
% received training in management of 3 rd	52	25	48.1

stage labour in last 3 year			
% of staff received in-service training in reproductive health life savings skills within the last 3 year	52	31	59.6
% of facilities with MOH policy guidelines on ANC and Obstetric services	14	8	57.1
%age of facilities that provide nutrition and hygiene for baby and mother	14	14	100.0
% of facilities that provide information on Malaria prevention	14	14	100.0
% of facilities that emphasize breasting and child welfare	14	14	100.0
% of facilities that provide information on STI/HIV	14	14	100.0
% of facilities that provide information on warning signs and pregnancy complications	14	14	100.0
% of facilities provide information on FP and Postnatal care	14	14	100.0
% of HF provide mama kits	14	12	85.7
% of HF that provide information on birth plans to pregnant mothers	14	14	100.0
% of facilities that provide information on dangers of self medication and use of traditional medicine	14	14	100.0
% of facilities administering antibiotics by injection of intravenous infusion	14	14	100
% of facilities administering anticonvulsants by injection	14	13	92.9
% of facilities that do remove or retain products of conception	14	3	21.4
% of facilities that do manual removal of the placenta	14	8	57.1
% of facilities with assisted virginal delivery	14	11	78.6
% of facilities that provide intravenous fluids	14	13	92.9
% of facilities that examine mothers to evaluate pregnancy	14	14	100
%age received IMCI training	61	26	42.6
% of facilities received supervision on IMCI	16	15	93.8
Knowledge about danger signs			
Convulsion	16	14	87.5
Loss of consciousness	16	10	62.5
Severe anaemia	16	4	25.5
Difficulty on breathing	16	11	68.8

% of staff received training in management of severe and complicated malaria	78	62	79.5
% of facility that provide ITP	16	16	100.0
% facilities that provide ITNs to pregnant mothers	16	16	100.0
% of HF with Guidelines for how lab conducts	8	6	75.0
% of HF with Capacity to test for HIV	8	6	75.0
% of HF with equipments and reagents for malaria	8	7	87.5

As indicated from the table above, guidelines from MoH for ANC and obstetric care services were available in only 8 facilities out of the 14 that offer the services. In-service training for VCT, PMTCT and management of third stage labour were not given to all health workers as indicated from the table above. HSSP II aims at increasing in-service training to all staff especially in the field of laboratory to enable MOH scale-up PMTCT. Further less than half (43%) of all health workers received in-service training for IMC yet the ministry of health recommends treating children using IMCI guidelines. Such a figure was partly because some health facility staff members were still new to those stations and others were initially working in others sections. This calls for a comprehensive training of all facility staff in IMCI and other areas which are not specific to individuals. A policy should be put in place for orienting all new staff in IMCI services.

Almost half (57%) of the facilities had guidelines for ANC and Obstetric care. This impacts the quality of services provided by facilities that do lack guidelines. In-charges of health facilities should make sure that all recommended protocols are available and used in their respective health facility. This calls for educating all health workers on the importance of such protocols in the facility.

Counseling services on issues such as breastfeeding, malaria prevention, FP, STI and making birth plans were provided by all health facilities. All the facilities in the survey provide IPT and ITN which are preventive measures for malaria during pregnancy. There is a need to encourage all health providers to continue in that line in order if Igara aims at improving maternal and child care services.

Although 14 health facilities reported that they provide ANC, some other services related to Obstetrics are not available especially in HC II and some HC III. As observed from above, services such as removal and retention of inception products, manual placenta removal are low. This partly due to the fact that all HC II and some HC III just provide only ANC service. All facilities are expected to provide intravenous fluids, however Kakanju HC II seems not to be doing this. There is a need to re-examine the facility and clearly find out whether the reported find is true before intervening.

Knowledge of danger sign for children who require immediate attention wasn't 100% for all the basic indicators/signs showed in the above table. Convulsion (88%) was mentioned by most providers as one of the danger signs however, severe anemia was the least prominent (26%). There is a need to orient all health workers on danger signs in

children as outlined by IMCI guidelines. Such a find is correlated to low level of in-service training in the county.

Information was also collected on the facilities including the capacity of the laboratory to carry out diagnostic tests especially HIV testing. Only 6 out of 8 HF with laboratories provide HIV testing services. Bitooma and Burungira have laboratory services but don't provide HIV testing. This implies that all facilities that provide HIV testing had guidelines for carrying out HIV testing.

In relation to malaria testing, only Bitooma HC II which is an NGO facility lacked the required reagents for conducting malaria tests on the survey day. Details of the missing reagents were not explored.

3.4.7 Stock outs

Issues of stock outs in facilities were also examined. As indicated in the table below, all units reported stock outs of some drugs in the past six months: Amoxicillin Oral, Injectable contraceptives and ORS were out of stock in more than half of all the facilities.

Health facilities with stock outs in the past six months

Commodity	Denominator	Numerator	Percentage
ORS	16	9	56.3
Cotrimoxazole	16	4	25.0
Mebendazole	16	2	12.5
Amoxicillin Oral	16	11	68.8
Naladixic Acid	16	5	31.3
Ciprofloxacin	16	9	56.3
Doxycycline	16	5	31.3
Metronidazole	16	7	43.8
Injectable contraceptives	14	8	57.1
Contraceptive pills	14	4	28.6
Condoms	14	1	7.1
Chloroquine	16	2	12.5
Fansidar	16	1	6.3
Quinine	16	1	6.3
Injectable diazepam	16	4	25.0
Home Pak	16	4	25.0
Iron/Folate	16	4	25.0
ITN	16	5	31.3
Mama Kits	16	5	31.3

Between 2006 and 2010, Ministry of Health plans to reduce drug stock out especially first line anti-malarial drugs, ORS and Cotrimoxazole from the current 35% to zero.

Although only one facility reported stock outs for anti-malaria drugs it is always important to eliminate such stock outs if mothers and children's lives are to be improved.

There is a need to sensitize in-charges about the dangers of stock outs in facilities especially for essential drugs. This calls for proper planning and use of records in making projections especially for drugs.

It was observed that health facilities that have Oxytocin, Egometrine and Misoprostol were not actually following conditions stated in HF tool. There is a need for training health workers on the proper storage of those drugs and other drugs that require special attention.

Facilities under the Catholic foundation were not stocking contraceptives pills/injectable and condoms. However health workers from such facilities do provide health education for FP but not the real service.

Facilities that reported stock outs of either Mama Kits or ITNs were Kakanju, Buyanja, Kyeizooba, Bitooma , Mashonga HC II and Bushenyi HC III. Such supplies are crucial especially to pregnant women. There is a need to ensure constant supply in all facilities. It ought to be noted that the CS project provides free ITNs to mothers who deliver at a health facility. Women who attend ANC services receive free IPT and mama kits from the CS project. The project provides the above mentioned supplies to health units that provide either ANC or delivery services in Igara County.

CHAPTER FOUR

4.0 Discussion/Findings compared to district baseline and EOP values by objective

This section compares the findings of this study to the baseline and other related published data. A systematic discussion is based on the objectives of this evaluation; baseline indicators are compared to establish a change between the two time points as indicated in the following tables.

4.1 Malaria disease and prevention in children under 5 and pregnant mother

<i>Indicator</i>	<i>Baseline</i>	<i>End of phase value</i>	<i>End of Program Target</i>	<i>Comment on the indicator</i>
% of children under 2 with fever in the last 2 weeks	44	21.4	19	Improved
% of children under 2 with fever in the last 2 weeks who received advice or treatment	NA	71.9	NA	NA
% of children under 2 with fever in the last 2 weeks who sought treatment on the same day	NA	47.9	NA	NA
% of children under 2 with fever in the last 2 weeks who received anti-malarial treatment	71	69.6	84	Declined
% of households with children 0-23	42	47.4	NA	Improved

months that own at least one mosquito net/ITN				
% of children under 2 who slept under ITN last night	32	34.6	55	Improved
% of women who slept under ITN last night	19	21.8	36	Improved
% of pregnant women who received IPT during last pregnancy as verified by maternal card	27	68.4	49	Improved

The proportion of children with malaria in the last two weeks reduced significantly between baseline and phase one follow-up 44 ± 0.1 and $24. \pm 0.63$ respectively. A reduction in malaria prevalence could have been as a result of applying preventive measures such as ITN and IPT. As observed from the above table, the percentage of children who slept under the net in the last 24 hours increased by 2.6%. On the other hand the percentage of mothers who received IPT more than doubled between baseline and follow-up. Preliminary finding from UDHS 2006 reported the proportion of children who slept under mosquito net to be 9.7% while the percentage of pregnant mothers who took anti-malaria drugs to prevent malaria was almost 50%. Findings from UDHS 2006 and follow-up finding align together.

It ought to be noted that use of nets by children under five is dependant on sleeping arrangements within the households (Mugisha F et al. 2003 and E.L. Korenromp et al 2003). Children who share beds with their mothers tend to use nets more than others. Nuwaha 2001 identified a number of factors that influence mosquito net use. These range from being a skilled worker, living in permanent house, not believing that convulsion cannot be cured by modern medicine and being in agreement that nets are worthy their costs.

Results also show a slight decline in the proportion of children with fever who sought treatment (71% to 70% at follow-up). However this figure is slightly higher than the national one reported in UDHS (62%) indicating slightly better health seeking behaviors in Igara. Good health seeking behavior is one of the many aspects that have to be promoted in order to reduce mortality due malaria especially in vulnerable groups.

4.3 Diarrhea for children under five

Comparison of diarrhea indicators

<i>Indicator</i>	<i>Baseline</i>	<i>End of phase value (%)</i>	<i>End of Program Target</i>	<i>Comment on the indicator</i>
% of children under 2 with diarrhea in the last two weeks	55	31.6	20	Improved
% of children 0-23 months with diarrhea in the last two weeks who received ORS	0	16.7	30	Improved
% of care takers/mothers who know at least 2 signs that a child under 2 needs treatment	76	76.7	84	Improved
% of care takers/mothers who know at	NA	93.2	NA	NA

least one signs that a child under 2 needs treatment				
% of households who use improved water source (borehole, public tap, or protected dug well.)	50	78.2	60	Improved
% of households with a designated hand washing facility	24	19.5	46	Declined
% of caretakers who usually wash hands with soap/ash before food preparation,	42	38.8	64	Declined
% of caretakers who usually wash hands with soap/ash before feeding children	15	28.6	35	Improved
% of caretakers who usually wash hands with soap after defecation	63	78.9	82	Improved
% of caretakers who usually wash hands with soap after attending to a child who has defecated	8	8.3	30	Improved
% of caretakers who usually wash hands with soap/ash before food eating	NA	46.6	NA	NA
% of caretakers who dispose off children's feces hygienically (dropped into toilet facility or rinsed and water discarded into toilet facility)	68	70.6	82	Improved
% of children 0-23 months who were offered more fluids during the illness	16	14.1	36	Declined
% of children 0-23 months who were offered the same or more food during the illness	42	29.3	63	Declined
% of children 0-23 months with diarrhea in the last two weeks who were not treated with anti-diarrheal or antibiotics Herbal medicine)	NA	21.4	NA	NA
% of children 0-23 months with diarrhea in the last two weeks who were breastfed the same or more amount of food during the illness (Q65)	NA	62.9	NA	NA
% of households with access to a pit latrine	19	41.3	36	Improved

The prevalence of diarrhea in children reduced significantly between baseline and follow-up. Knowledge on warning signs for children remained almost the same between baseline and follow-up. Treatment of diarrhea with ORS (17%) is still low as compared to UDHS (2006), 43%. Treatment of diarrhea with herbal medicine declined substantially between the two time periods.

Indicators that did not improve between baseline and follow-up were washing hands with soap before preparing food and giving a child more to eat or drink during illness. It is always important to promote child survival through preventive means. For diarrhea good hygiene and

sanitation are key. Some the strategies that promote good hygiene include washing with soap after facing any contaminating situations and proper disposal of human waste.

Another aspect related to hygiene and sanitation is the type of toilet facility that was observed in the household. Households with access to pit latrine account for only 41%. Although this figure doubled compared to the baseline, there is still a need to sensitize the population about the dangers of not having proper disposal facilities. Majority of the households use simple latrines without a slab. Proper disposal in this case should mean disposal in a pit latrine with a slab. Such a facility helps in reducing flies which are the main causative agents of diarrhea. There is a need for the project to work with local leaders and find a feasible way of improving latrine coverage.

4.4 ANC, delivery and post partum care

ANC, delivery and post partum care

<i>Indicator</i>	<i>Baseline</i>	<i>End of phase value</i>	<i>End of Project target</i>	<i>Comment on the indicator</i>
% of pregnant women with 4 ANC visits (As verified by maternal card)	18	15.9	30	Declined
% of pregnant women seeking VCT services	34	73.0	44	Improved
% of mothers that were counseled on breastfeeding	38	75.4	55	Improved
% of mothers that were counseled on child spacing (about 2 years)	95	53.2	99	Declined
% of caretakers mothers that were counseled on atleast 2 danger signs during pregnancy	76	61.9	90	Declined
% of pregnant women with safe birthing plans (where to deliver, plan transport ,plan having a birth kit)	38	53.3	NA	Improved
% of pregnant women counseled on where to deliver	70	88.1	NA	Improved
% of pregnant women counseled on transport plans to delivery place	45	65.9	NA	Improved
% of pregnant women counseled on having a birth kit	53	75.4	NA	Improved
% of pregnant women with access to a clean razor to cut the cord	81	63.9	NA	Declined
% of children 0-23 month who were put with mother immediately after birth	X	44.4	NA	NA
% of children 0-23 month who were put to the breast within the first hour	X	46.6	NA	NA

of delivery				
% of mothers who were delivered by skilled health workers (doctor, nurse/MW)	58	57.2	65	Declined
% of mothers who used mama kits	X	80	NA	NA

From the survey it was observed that not all mothers seek prenatal care. Out of 133 mothers interviewed, 5% never thought any prenatal care at all. Even for those who sought prenatal care, card retention was a challenge. For mothers who presented cards, only 16% were able to make four visits which is the recommended amount by the ministry of health through the minimum health care package. Although the indicator shows an improvement between baseline and follow-up, more effort is still needed in order to convince mothers to go for ANC services during pregnancy.

The proportion of mothers seeking VCT services during pregnancy doubled between baseline and end of phase one follow-up. This could have been attributed to other sensitization programs in the country and the district as a whole. ICOBI one of the NGOs in Bushenyi district has been implementing a home based VCT program. This is likely to have created an impact in the entire community. Further more, it is currently a requirement by the Ministry of Health that all women seeking ANC should be encouraged to test for HIV in order to promote PMTCT.

Findings also indicate that more than half of the mothers who sought prenatal care were counseled about breastfeeding, child spacing, plans for transport to a delivery place, STI, having birth kits and even warning signs for pregnant women.

Desirable practices immediately after delivery are still below average in Igara. Putting a child with the mother immediately after delivery was reported by only 44%. Further more, only 47% of the respondent's breastfed their children within one hour.

Mothers who were delivered by skilled personnel accounted for only 57.2%. This implies that not all mothers deliver in health facilities. Even from the preliminary UDHS (2006) findings only 31% of mothers deliver in health facilities.

Nydomugenyi R at al. (1998) observed that health seeking behaviour was influenced by several factors, including the perceived high cost of antenatal care services, or conducting a delivery and treatment, and perceived inadequacy of services provided by the formal health system. Inadequacy of formal health services was perceived by users to be partly due to understaffing and to irregular supply of essential drugs. Such perceptions need to be further investigated to determine if they exist in Igara County.

4.4 Rapid catch indicators

Rapid catch indicators

<i>Indicator</i>	<i>Baseline</i>	<i>End of</i>	<i>Comment on</i>
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		<i>phase value</i>	<i>the indicator</i>
% of children 0-23 months who are underweight (-2SD from the median weight for age, according to the WHO/NCHS reference population)	27	17.3	Improved
% of mothers who were delivered by skilled health workers	58	68.4	Improved
% of mothers of children aged 0-23 months who received at least 2 tetanus toxoid injections before the birth of their youngest child	66	65.3	Declined
% of infants aged 0-5 months who were exclusively breastfed in the last 24 hours	100	68.7	Declined
% of infants aged 6-9 months receiving breast milk and complementary foods	67	88.0	Improved
% of mothers with children 0-23 months who were ever given a vaccination card or health book for the youngest child	NA	86.5	NA
% of mothers with children 0-23 months who current have a vaccination card or health book for the youngest child	NA	76.5	NA
% of children 12-23 months who were fully vaccinated against the five vaccine preventable diseases before their first birth day (BCG, Polio1, Polio2, Polio3, DPT1, DPT2,DPT3,Hib, HepB, measles Cards)	77	46.2	Declined
% of children 12-23 months who received a measles vaccine (cards and mother's recall)	77	75.0	Declined
% of children 12-23 months who were fully vaccinated against the five vaccine preventable diseases (BCG, Polio1, Polio2, Polio3, DPT1, DPT2,DPT3,Hib, HepB) Reported and from card	NA	59.6	NA
Drop-Out rate using DPT1 and DPT3 for children 12-23 months (Card or mother's recall)	NA	5.9	NA
% of children under 2 who slept under ITN last night	32	34.6	Improved
% of care takers/mothers who know at least 2 signs that a child under 2 needs treatment	75.8	76.7	Improved
% of mothers to children age 0-23 who mentioned at least 2 known ways of reducing the risk of HIV infection	64.2	64.7	Improved
% of caretakers who usually wash hands with soap/ash before food preparation, before feeding children, after defecation and after attending to a child who has defecated	2.1	28.6	Improved

For the rapid catch indicators above, it observed that almost one in every five (17%) children in Igara County are properly nourished. When compared to the baseline, end of phase one findings show a significant improvement of about 15%. The current state of malnutrition in Igara is also below the national which currently stand at 20% (UDHS 2006). This calls for improvement in diet and environmental factors in order to improve children's immune function as recommended by Kikafunda j.K et al, (1998).

The proportion of children between 0-5 months who were exclusively breastfed declined from 100% to 69% between baseline and follow-up. Similarly, According to UDHS 2006, only 60% of children under six months are exclusively breastfed. Ingunn M. S E et al. (2007) observed that prelacteal feeding and early introduction of other food items is the norm in Mbale district. As observed such practices do exist in Igara. There is a need for designing relevant strategies that will improve infant feeding.

Immunization is another key aspect which is promoted under child survival. From the table above, it clearly observed that mothers don't follow a clear immunization schedule. Less than half (46%) of the children between 12 and 23 months were fully immunized before their first birthday. Further more this indicators shows a decline between baseline and follow-up. Drop out rates was estimated to be 6%. There is a need for strengthen the MoH communication strategy for immunization (MoH 2001).

4.6 Health care management especially for Women of Reproductive Age and children 0- 5

<i>Indicator</i>	<i>Details</i>	<i>Baseline</i>	<i>End of phase value</i>	<i>End of Program target</i>	<i>Comment on the indicator</i>
% of Health workers who have received IMCI training in the last 3 years		57	42.6	70	Declined
% of Health workers who have been supervised in IMCI within the last year		28	93.8	40	Improved
% of Health workers who have MOH policy and guidelines/protocol on antenatal and obstetric care services.		44.2	57.1	65	Improved
% of facilities who provide information on nutrition & hygiene, ITNs, breastfeeding, STI/HIV/AIDS prevention, warning signs, post natal care.	Nutrition and Hygiene	95.3	100.0	98	Improved
	Malaria prevention/ITN	95.3	100.0	98	Improved
	Breastfeeding	95.3	100.0	98	Improved
	STD/HIV AIDS	90.7	100.0	98	Improved
	Warning signs	95.3	100.0	98	Improved
	Post natal care & FP	90.7	100.0	98	Improved
% of Health workers who received		79	48.1	90	Declined

training in AMTSL in the last 3 years					
% of staff received in-service training in reproductive health life savings skills within the last 3 year		NA	59.6	NA	NA

Improving health of pregnant mothers is of great importance as plays an leading role in reducing both infant and maternal mortality rates employed in implementing the minimum health care package. This is done through the provision of services and training as recommended in the implementation of the minimum health care package of Uganda. As observed from above, health workers in Igara received training in IMCI, management of AMTSL and life saving skills. There was a decline in the number of health workers trained in IMCI and AMTSL between baseline and follow-up.

All the facilities also reported to be providing counseling in breastfeeding, ITN use, warning signs STI including HIV and postnatal care including FP. Facilities with MOH policy and guidelines/protocol on antenatal and obstetric care services increased from 44% to 57% between baseline and follow-up.

4.7 Drug Stock out Indicators

As facilities provide health care to the community, there is a need to have adequate stock of all the necessary drugs. The table below shows stock outs between baseline and follow-up. As observed from the table, stock out for ORS increased significantly between the two time periods. Stock outs for ITN, Mama kits and Quinine reduced significantly. Increased stock outs in health units lead to a decline in quality of service delivered. Ways and means of keeping stock outs at a minimum should be put place for all the facilities in Igara county and Uganda at large if the concerned parties are interested in improving health indicators.

Stock outs in the past 6 months for baseline and follow-up estimates

Commodity	Baseline (%)	End of phase (%)	Comment on the indicator
ORS	28	56.3	Declined
Cotrimoxazole	51	25.0	Improved
Mebendazole	19	12.5	Improved
Amoxicillin Oral	63	68.8	Declined
Naladixic Acid	63	31.3	Improved
Ciprofloxacin	63	56.3	Improved
Doxycycline	28	31.3	Declined
Metronidazole	42	43.8	Declined
Injectable contraceptives	33	57.1	Declined
Contraceptive pills	32	28.6	Improved
Condoms	35	7.1	Improved
Chloroquine	12	12.5	Declined
Fansidar	2	6.3	Declined
Quinine	49	6.3	Improved
Injectable daizepam	-	25.0	

Home Pak	35	25.0	Improved
Iron/Folate	16	25.0	Declined
ITN	70	31.3	Improved
Mama Kits	75	31.3	Improved

Since the project aims at improving health service delivery especially for women and children under five years, it should design a mechanism for reducing stock outs for anti-malarials, anti-diarrheals, ITNs and Mama kits in all the facilities served. Although a big improvement was shown; stock outs for ITN and mama kit reduced almost by a half, the target should always be 100% especially in facilities the project supports. This therefore calls for proper projections by health facility in-charges and also for timely reporting on supplies from the project. This objective can be achieved by giving comprehensive sensitization to all staff concerned at the facilities and also by ensuring that the project stocks necessary supplies in time.

CHAPTER FIVE

5.0 Conclusions and Recommendations

5.1 Conclusions

- Although the prevalence of fever and diarrhoea in the past two weeks reduced between baseline and follow-up, some cases still exist in Igara.
- Gaps still exist in children's feeding practices during illness, hand washing with soap and type of toilet facilities in households.
- Although mothers who attended the recommended number of ANC visits was low, their knowledge on breastfeeding and having birth kits were high.
- Fewer mothers recalled pregnancy danger signs especially fever and bleeding.
- It was observed that undesirable practices to children who have just been born still exist. These are observed from the low numbers of mothers whose children were put with next to them immediately and also from a high number of children who were fed on anything else immediately after delivery.
- Immunizations of both mothers and children in Igara were found to be low as depicted by low cards retention.
- Use of MOH policy guidelines on ANC and Obstetric care was just average
- Health facility results indicate that a comprehensive package of education is always given to mothers.
- Although almost all facilities were supervised for IMCI less than half of the providers had received in-service training for the same.
- Not all health workers were knowledgeable about dangers signs among children.
- Stock outs existed in some facilities for ORS, Anti-malarials, ITN, Mama kits and Injectable contraceptives.

5.2 Recommendations

- There is a need to emphasise the importance of using ITNs for both pregnant women and children in Igara. Whenever an opportunity arises, such information should be given to pregnant mothers and other caretakers.
- Use of ORS to children with diarrhoea should always be considered. Trainers need to encourage mothers/caretakers to use ORS in treating diarrhoea.

- Mothers/caretakers need to be encouraged to seek treatment from qualified health personnel within 24 hours of when the child falls sick and also to provide more food and fluids to the child.
- Hand washing with water and soap, having designated hand washing facilities plus a recommended toilet facility in a household are where emphasis should be put for proper hygiene.
- Counselling on best practices during pregnancy and after delivery should be scaled up in order to achieve all the desired practices.
- There is a need to review and update IEC materials used in counselling mothers during and after pregnancy in order accommodate all aspects that are expected to be covered in the process.
- Both mothers and health workers need to be further educated about the expected practices for a children that have just been born.
- Card retention is one of the practices mothers need to know since the program relies more on card than recall of mothers. This will help to improve some of immunization and ANC indicators.
- In order to achieve full possession and utilisation of various MOH guidelines, production and training of staff on how to use the guidelines could be adopted.
- In order to maintain counselling services in health facilities, there is a need for in-service training and even supervision.
- In order to improve child survival in Igara County, all health workers in facilities should be given basic training on IMCI. This will help to bridge the training gap even when transfers take place. It will also help in increasing health workers' knowledge for danger signs among children.
- In-charges of health facilities should aim at reducing stock outs especially for ORS and anti-malarials as recommended by the ministry. This could be done by utilizing all available sources of drugs in the district. Further more, health facilities need to be trained on proper planning for drug stock and storage.
- There is a need for constant monitoring of all interventions if the set targets are to be achieved by the program.

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Annex 1: List of Health Facility

NAME OF THE FACILITY (HC)	LEVEL	SUB-COUNTY
KAKANJU	III	KAKANJU
KAKANJU MOSLEM HC	II	KAKANJU
KYEIZOوبا	III	KYEIZOوبا
BUYANJA	II	KYEIZOوبا
KYABUGIMBI	IV	KYABUGIMBI
BURUNGIRA	II	KYABUGIMBI
KABUSHAHO	III	BUMBIRE
COMBONI HOSPITAL	HOSPITAL	KYAMUHUNGA
MASHONGA	II	KYAMUHUNGA
KYAMUHUNGA	III	KYAMUHUNGA
BITOOMA	III	KYAMUHUNGA
NYABUBARE	III	NYABUBARE
NYAMUGOTE	II	NYABUBARE
BUSHENYI HC	III	ISHAKA-BUSHENYI
BUSHENYI MEDICAL CENTER	III	ISHAKA-BUSHENYI
ISHAKA ADVENTIST HOSPITAL	HOSPITAL	ISHAKA-BUSHENYI

Annex 2: KPC and HFA tools

INFORMED CONSENT

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

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

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

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

Interviewer’s Name: _____ Signature _____

Sub-County Name _____ Village Name _____

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

1. RECORD INTERVIEW DATE

DAY		MONTH		YEAR	

2. How old are you? : _____ (in complete years)
3. How many children living in this household are under age five? _____
4. How many children living in this household are under 2 years _____
5. How many of those children are your biological children? _____

6. GET INFORMATION ON **ONLY 1 YOUNGEST CHILD 0-23 months**:("What is the name, sex, age and date of birth)?"

	NAME	SEX	AGE (Months)	DATE OF BIRTH
1		1. MALE 2. FEMALE		___/___/___ DD MM YY

7. How old was your previous surviving child when (NAME) was born _____ (in Months)
8. Are you member of a health Plan?
 - 1- YES
 - 2- NO SKIP TO Q.10
9. IF YES, how long have you been a member? _____ (In years)

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

Anthropometry

10. May I weigh (NAME)?
 1. YES
 2. NO → SKIP TO Q.12
11. IF MOTHER AGREES, WEIGH THE CHILD AND RECORD WEIGHT BELOW. *RECORD TO THE NEAREST TENTH.*

Weight One _____.____Kg Weight two _____.____ Kg : COMPUTE AVG WT _____.____ Kg

Child Immunization

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

- 1. YES, SEEN BY INTERVIEWER
- 2. NOT AVAILABLE (lost/misplaced, not in home)
- 3. NEVER HAD A CARD
- 4. CHILD NEVER BEEN IMMUNIZED → SKIP TO Q.14

13. RECORD INFORMATION EXACTLY AS IT APPEARS ON (NAME'S) VACCINATION CARD OR TICK THE VACCINE IN ABSENCE OF A CARD.

	vaccine	Tick	how given	date given
At Birth	BCG		Right Upper arm	
	Polio 0		Mouth Drop	
At 6 weeks	Polio 1		Mouth Drops	
	DPT- HebB + Hib 1		Left Upper thigh	
At 10 weeks	Polio 2		Mouth Drops	
	DPT- HebB + Hib 2		Left Upper thigh	
At 14 weeks	Polio 3		Mouth Drops	
	DPT- HebB + Hib 3		Left Upper thigh	
At 9 Months	Measles		Left Upper arm	

HIV/AIDS

14. Have you ever heard of an illness called AIDS?

- 1. YES
- 2. NO → SKIP TO Q.16

15. What can a person do to avoid getting AIDS or the virus that causes AIDS?
 CIRCLE ALL MENTIONED.

- A. NOTHING
- B. ABSTAIN FROM SEX
- C. USE CONDOMS
- D. LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PARTNER
- E. LIMIT NUMBER OF SEXUAL PARTNERS
- F. AVOID SEX WITH PROSTITUTES
- G. AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS
- H. AVOID INTERCOURSE WITH PERSONS OF THE SAME SEX

- I. AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY
- J. AVOID BLOOD TRANSFUSIONS
- K. AVOID INJECTIONS
- L. AVOID KISSING
- M. AVOID MOSQUITO BITES
- N. SEEK PROTECTION FROM TRADITIONAL HEALER
- O. AVOID SHARING RAZORS, BLADES
- W. OTHER _____
(SPECIFY)
- X. OTHER _____
(SPECIFY)
- Z. DON'T KNOW

Hand-washing Practices

16. When do you usually wash your hands with water and soap?
DO NOT PROMPT: CIRCLE ALL MENTIONED BY RESPONDENT.

- A. BEFORE FOOD PREPARATION
- B. BEFORE FEEDING CHILDREN
- C. AFTER DEFECATION
- D. AFTER ATTENDING TO A CHILD WHO HAS DEFECATED
- E. BEFORE EATING
- X. OTHER _____
(SPECIFY)

Integrated Management of Childhood Illnesses (IMCI)

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

- A. DON'T KNOW
- B. LOOKS UNWELL OR NOT PLAYING NORMALLY
- C. NOT EATING OR DRINKING
- D. LETHARGIC/ LACKS ENERGY
- E. HIGH FEVER
- F. FAST OR DIFFICULT BREATHING
- G. VOMITS EVERYTHING
- H. CONVULSIONS
- I. NOT BREAST FEEDING WELL
- J. OTHER _____
(SPECIFY)
- K. OTHER _____
(SPECIFY)

18. Did (NAME) experience any of the following in the past two weeks?

CIRCLE ALL MENTIONED BY RESPONDENT.

- | | | |
|--|--------|-------|
| A. DIARRHEA | 1- YES | 2- NO |
| B. BLOOD IN STOOL | 1- YES | 2- NO |
| C. COUGH | 1- YES | 2- NO |
| D. DIFFICULT BREATHING | 1- YES | 2- NO |
| E. FAST BREATHING/SHORT, QUICK BREATHS | 1- YES | 2- NO |
| F. FEVER | 1- YES | 2- NO |
| G. MALARIA | 1- YES | 2- NO |

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

1. LESS THAN USUAL
2. SAME AMOUNT
3. MORE THAN USUAL

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

1. LESS THAN USUAL
2. SAME AMOUNT
3. MORE THAN USUAL

Malaria Prevention

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
21	Did (NAME) experience a fever in the past two weeks?	YES 1 NO 2	27
22	Did you seek advice or treatment for (NAME'S) fever?	YES 1 NO 2	27
23	Where did you first go for advice or treatment? IF SOURCE IS GOVERNMENT, NGO OR CLINIC, WRITE THE NAME OF THE PLACE (NAME OF PLACE)	GOVERNEMTN HEALTH FACILTY. 1 NGO HEALTH FACILTY 2 CLINIC 3 OTHER SOURCE TRADITIONAL PRACTITIONER. 4 SHOP 5 PHARMACY 6 COMMUNITY DISTRIBUTORS 7 FRIEND/RELATIVE 8 OTHER _____ 9 (SPECIFY)	
24	How long after you noticed (NAME'S) fever did you seek treatment from that person/place?	SAME DAY 1 NEXT DAY 2 TWO DAYS 3 THREE OR MORE DAYS.. 4	

25	<p>Which medicines were given to (NAME) for his/her fever? CIRCLE ALL MEDICINES THAT WERE GIVEN. IF MOTHER IS UNABLE TO RECALL DRUG NAME(S), ASK HER TO SHOW THE DRUG(S) TO YOU. IF SHE IS UNABLE TO SHOW YOU THEM, SHOW HER TYPICAL ANTI-MALARIALS AND HAVE HER IDENTIFY WHICH WERE GIVEN.</p>	<p>CHLOROQUINEA FANSIDARB CAMAQUINNEC QUININED ARTUNUM.....E COARTEM.....F METAKELFIN.....G HOMAPAK.....H OTHER DRUGS ASPIRIN..... I PANADOL.....J CO-TRIMOXAZOLE.....K OTHER _____ L (SPECIFY)</p>	
26	<p>FOR ANTI-MALARIALS/MEDICINE RECEIVED ASK: How long after the fever started did (NAME) start taking the medicine? CIRCLE ONE CODE .</p>	<p>SAME DAY.....1 NEXT DAY AFTER THE FEVER.....2 TWO DAYS AFTER THE FEVER.....3 THREE OR MORE DAYS AFTER THE FEVER 4 DON'T KNOW 5</p>	
27	<p>What causes malaria? RECORD ALL MENTIONED Anything else?</p>	<p>MOSQUITO BITES A WITCHCRAFT B SHARING RAZORS/BLADES C BLOOD TRANSFUSIONS D INJECTIONS E KISSING F UNBOILED WATERG DON'T KNOWH OTHER _____ I (SPECIFY) OTHER _____ J (SPECIFY)</p>	
28	<p>When you were pregnant (NAME), did you take any drugs to prevent you from getting malaria? (CONFIRM FROM MATERNAL CARD/BOOKLET)</p>	<p>YES SEEN A CARD 1 YES CARD NOT AVAILABLE 2 NO3</p>	30
29	<p>Which drug did you take? RECORD ALL MENTIONED</p>	<p>FANSIDAR A CHLOROQUINE B OTHER.....C DON'T KNOWD</p>	
30	<p>Do you have a mosquito net in your house?</p>	<p>YES 1 NO 2</p>	36
31	<p>If yes where did you get/buy this mosquito net from?</p>	<p>HEALTH UNITS 1 SHOP/MARKET 2 PHARMACY3</p>	

		HAWKERS4 OTHERS _____ 5 (SPECIFY)	
32	Was that mosquito net mentioned above pre-treated?	YES 1 NO 2 DON'T KNOW 3	
33	Who slept under a mosquito net last night? RECORD ALL MENTIONED.	CHILD (NAME)..... A PARTNER B MYSELF C OTHER CHILDREN OR PEOPLE _____ D (SPECIFY)	
34	How long ago was the mosquito net bought or obtained? (LESS THAN 1 MONTH = 00)	MONTHS DON'T KNOW 98	
35	ASK TO SEE THE MOSQUITO NETS FOR HOLES OR TEARS. NO HOLES/TEARS= GOOD CONDITION. VISIBLE HOLES AND/OR TEARS=DAMAGED. (CHILD'S NET MOSTLY)	GOOD CONDITION 1 DAMAGED 2	
36	During your last pregnancy for (NAME), did you sleep under a mosquito treated net?	YES 1 NO 2 DON'T KNOW 3	

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

Maternal and Newborn Care

37. Before you gave birth to (NAME) did you receive an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth? (CONFIRM FROM MATERNAL CARD/BOOKLET)

- 1. YES SEEN A CARD
- 2. YES CARD NOT AVAILABLE
- 3. NO **SKIP TO 39**
- 3. DON'T KNOW **SKIP TO 39**

38. How many times did you receive such an injection?

- 1. ONCE
- 2. TWICE
- 3. MORE THAN TWO TIMES
- 4. DON'T KNOW

Now I would like to ask you about the time when you gave birth to (NAME).

39. Who assisted you with (NAME'S) delivery?

- A. DOCTOR
- B. NURSE/MIDWIFE
- C. TRADITIONAL BIRTH ATTENDANT _____
(NAME)

D. COMMUNITY HEALTH WORKER

E. FAMILY MEMBER _____
(SPECIFY RELATIONSHIP TO RESPONDENT)

F. OTHER _____
(SPECIFY)

G. NO ONE

40. Did you receive any post-partum visit three days after delivery by an appropriate health worker? (In case one wasn't delivered by A and B above)

1. Yes
2. No

41. For how long should a mother spend after delivery to get pregnant?

1. Less than 1 Year
2. One to two years
3. above two years

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
42	Did you see anyone for prenatal care while you were pregnant with (NAME)?	YES.....1 NO.....2	48
43	IF YES: Whom did you see? Anyone else? PROBE FOR THE TYPE OF PERSON AND RECORD ALL PERSONS MENTIONED BY THE MOTHER.	DOCTOR A NURSE/MIDWIFE B OTHER PERSON TRADITIONAL BIRTH ATTENDANT.....C COMMUNITY HEALTH WORKER D FAMILY MEMBER.....E OTHER _____ F (SPECIFY)	
42	How many times did attend Antenatal service during (NAME) pregnancy?	NUMBER OF TIMES _____	
44	During your prenatal check, were you counseled on the following: Delivery preparations? Breastfeeding? Child spacing? Danger signs of pregnancy?	YES NO 1 2 1 2 1 2 1 2	
45	Did the Health Care Giver ask you to plan for the following in advance? • Where to deliver • transport to place of delivery • Having a birth kit	YES NO 1 2 1 2 1 2	
46	During your pregnancy, were you given any counseling on HIV/AIDS?	YES.....1 NO.....2	
47	Did you test for HIV while pregnant?	YES.....1 NO.....2	
48	Do you have a maternal health card for your	YES, SEEN 1	

	pregnancy with (NAME)?	NOT AVAILABLE 2 NEVER HAD A CARD 3	50 50
49	LOOK AT CARD AND RECORD THE NUMBER OF PRENATAL VISITS WHILE MOTHER WAS PREGNANT WITH (NAME).	NUMBER OF VISITS _____	
50	What are the symptoms during pregnancy indicating the need to seek health care? RECORD ALL MENTIONED.	FEVER.....A SHORTNESS OF BREATH B BLEEDING C SWELLING OF THE BODY/HANDS/FACE... D OTHER _____ E (SPECIFY)	
51A	When you were pregnant with (NAME), did you receive or buy any iron tablets or iron syrup?	YES 1 NO 2	52
51B	How many days did you take the tablets or syrup? IF ANSWER IS NOT NUMERIC, PROBE FOR APPROXIMATE NUMBER OF DAYS.	NUMBER OF DAYS _____	
52	Where did you give birth? IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE _____	HOME1 GOVERNEMTN HEALTH FACILTY. 2 NGO HEALTH FACILTY3 CLINIC4 TRADITIONAL BIRTH ATTENDANT 5 FRIEND/RELATIVE 6 OTHER _____ 7	
53	Did you use a mama kit while giving birth to (NAME)	YES 1 NO 2	55
54	Which of the following birth kit elements were used during delivery? • Cotton wool • Polythene paper • New Razor • Thread • Gloves • Others (specify) _____	YES NO 1 2 1 2 1 2 1 2 1 2 1 2	
55	What instrument was used to cut the cord?	NEW RAZOR/SURGICAL BLADE 1 SISSORS2 OTHER INSTRUMENT 3 (SPECIFY NAME) _____	
56	Where was (NAME) put immediately after birth?	WITH MOTHER 1 OTHER _____ . 2 (SPECIFY)	
57	What did you do with (NAME) immediately after birth?	BREASTFED 1 BATHED 2 LET SLEEP 3	

	OTHER _____ 4	
	DON'T KNOW 5	

Breastfeeding and Nutrition

58. Have you ever breastfed (NAME)?

- 1. YES
- 2. NO **SKIP TO Q.63**

59. How long after birth did you first put (NAME) to the breast?

- 1. IMMEDIATELY/WITHIN FIRST HOUR AFTER DELIVERY
- 2. AFTER THE FIRST HOUR

60. Did (NAME) feed on anything else before breast milk immediately after delivery?

- 1. YES
- 2. NO

61. IS (NAME) currently breastfeeding?

- 1. YES
- 2. NO

62. Have you started giving additional food stuff to (NAME)?

- 1. YES
- 2. NO

Now we would like to talk about Diarrhea...

Diarrhea, sanitation and hygiene

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
63	Has (NAME) had diarrhea in the past two weeks?	YES.....1 NO.....2	70
64	What was given to treat the diarrhea? Anything else? RECORD ALL MENTIONED	NOTHING A ORS PACKET. B HOME-MADE FLUID. C PILL OR SYRUP D INJECTION.....E (IV)INTRAVENOUS FLUID.....F HOME REMEDIES/HERBAL MEDICINES.....G OTHER _____ X (SPECIFY)	
65	When (NAME) had diarrhea did you breastfeed	LESS1	

	him/her less than usual, about the same amount, or more than usual?	SAME.....2 MORE.....3 CHILD NOT BREASTFED.....4	
66	Did you seek advice or treatment from a professional health worker for (NAME'S) diarrhea?	YES.....1 NO.....2	68
67	Where did you first go for advice or treatment? IF SOURCE IS HOSPITAL, HEALTH CENTRE, OR CLINIC, WRITE THE NAME OF THE PLACE _____	GOVERNEMTN HEALTH FACILITY.1 NGO HEALTH FACILTY2 CLINIC3 OTHER SOURCE TRADITIONAL PRACTITIONER...4 SHOP.....5 PHARMACY.....6 COMMUNITY DISTRIBUTORS...7 FRIEND/RELATIVE.....8 OTHER _____9 (SPECIFY)	
68	Who decided that you should go there for (NAME'S) illness? RECORD ALL MENTIONED	MYSELFA HUSBAND/PARTNER.....B RESPONDENT'S MOTHER.....C MOTHER-IN-LAW.....D FRIENDS/NEIGHBOURS.....E OTHER _____ F (SPECIFY)	
69	Where did you go next for advice or treatment? IF SOURCE IS HOSPITAL, HEALTH CENTRE, OR CLINIC, WRITE THE NAME OF THE PLACE _____	GOVERNEMTN HEALTH FACILITY.1 NGO HEALTH FACILTY2 CLINIC3 OTHER SOURCE TRADITIONAL PRACTITIONER...4 SHOP.....5 PHARMACY.....6 COMMUNITY DISTRIBUTORS...7 FRIEND/RELATIVE.....8 OTHER _____9 (SPECIFY)	
70	Have you ever heard of ORS?	YES.....1 NO.....2	72

71	<p>IF YES, ASK CARETAKER TO DESCRIBE ORS PREPARATION FOR YOU. ONCE CARETAKER HAS PROVIDED A DESCRIPTION, RECORD WHETHER SHE/HE DESCRIBED ORS PREPARATION CORRECTLY OR INCORRECTLY.</p> <p>CIRCLE 1 [CORRECTLY] IF THE CARETAKER MENTIONED THE FOLLOWING:</p> <ul style="list-style-type: none"> • USE 1 LITER OF CLEAN DRINKING WATER (1 LITER=3 SODA BOTTLES) • USE THE ENTIRE PACKET • DISSOLVE THE POWDER FULL 	<p>DESCRIBED CORRECTLY.....1 DESCRIBED INCORRECTLY.....2</p>	
72	What is the main source of drinking water for members in this household?	<p>Borehole.....1 Public tap.....2 Protected Spring.....3 Unprotected spring.....4 Rain water collection.....5 Surface water (river/pond/lake/dam/stream).....6 Other _____7 (specify)</p>	
73	Do you do anything to make your water safe for drinking?	<p>YES.....1 NO.....2</p>	75
74	What do you do?	<p>PUR.....1 Waterguard.....2 Boiling.....3 Other _____4 (SPECIFY)</p>	
75	The last time (name) passed stool, where were the feces disposed of? (IF "WASHED AWAY", PROBE WHERE THE WASTE WATER WAS DISPOSED OF. IF "DISPOSED" PROBE WHERE IT WAS DISPOSED OF SPECIFICALLY.	<p>Dropped into toilet facility.....1 Rinsed away Water discarded into toilet facility....2 Water discarded into sink or tub connected to drainage system.....3 Disposed Into solid waste/ trash.....4 Somewhere in Yard.....5 Outside premises.....6 Buried.....7 Did nothing.....8 Other _____9 (Specify)</p>	
76	What kind of toilet facility does this household use? (CONFIRM BY OBSERVING)	<p>Flush toilet.....1 Ventilated Improved Pit latrine.....2 Covered pit latrine.....3</p>	

		Simple pit latrine without slab.....4 Bucket latrine.....5 No facility(field/bush/plastic bag) etc..6	
77	<u>Observation only.</u> Is there a hand washing device such as a tap, basin, bucket, or sink? This item should be within view or brought by the interviewee within one minute. If item is not present within one minute, check no even if brought later.	YES.....1 NO.....2	

Thank You
END OF SURVEY

INTEGRATED HEALTH FACILITY ASSESSMENT:

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

ASSESSMENT OF SERVICES OFFERED FROM HEAD OF INSTITUTION

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

Does this facility offer the following services? ENTER YES OR NO IN BOX FOR RESPONSE

Note: If service not offered, do not ask for in-charge staff for that service, and skip that service's section

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

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

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

SECTION 1: HIV: VOLUNTARY COUNSELING & TESTING (VCT) AND PMTCT SERVICES

NAME OF RESPONDENT: _____ TITLE OF RESPONDENT: _____

	QUESTION	CODING CATEGORIES
101	How many staff are directly involved with client counseling, diagnosis or management for this service? INCLUDE ALL STAFF WHO HAVE RESPONSIBILITY FOR ANY OF THESE ACTIVITIES, EXCLUDING THE LAB TECHNICIAN.	<input type="text"/> <input type="text"/> <input type="text"/>

102	Among these staff, how many have received any in-service training related to VCT within the last 3 years?	<input type="text"/> <input type="text"/> <input type="text"/>
103	Among these staff, how many have received any in-service training related to PMTCT within the last 3 years?	<input type="text"/> <input type="text"/> <input type="text"/>
104	Observe if the posters are displayed openly, translated in the local language and at least 5 posters	Adequate.....1 Inadequate.....2
105	Does the facility have any visual aids to use when providing VCT or PMTCT services?	YES..... 1 NO..... 2
106	Is HIV counseling and testing for pregnant women upon request, required or recommended?	Upon request..... 1 Required..... 2 Recommended.... 3
107	For pregnant women who test positive, do you offer ARVs (antiretrovirals) for the prevention of HIV transmission from the woman to her child?	YES..... 1 NO..... 2
108	Does the facility offer post-test infant feeding counseling to pregnant women who test positive for HIV?	YES..... 1 NO..... 2
109	Do you have a private space for delivering VCT and PMTCT services?	YES..... 1 NO..... 2
110	Ask: Can I see it? If seen, is it spacious; private; and clean? (meets the criteria= adequate; doesn't meet the criteria= inadequate)	Adequate1 Inadequate.....2
111	Does the facility have a register or other record where you record information on clients who receive this service?	YES..... 1 NO..... 2
112	Of those tested in the last six months, how many tested positive for HIV? Total: <input type="text"/> <input type="text"/> <input type="text"/>	Males: <input type="text"/> <input type="text"/> <input type="text"/>
		Females: <input type="text"/> <input type="text"/> <input type="text"/>
113	How many of the overall clients tested for HIV were pregnant women?	Total: <input type="text"/> <input type="text"/> <input type="text"/>
114	How many of the clients who tested positive for HIV were pregnant women?	Total: <input type="text"/> <input type="text"/> <input type="text"/>
115	Does this facility have the MOH policy and guidelines/protocols on HIV/AIDS VCT services? Ask to see.	Yes, seen by Interviewer.....1 No, Not seen by interviewer.....2
116	Does this facility have the MOH policy and guidelines/protocols on PMTCT? Ask to see.	Yes, seen by Interviewer.....1 No, Not seen by interviewer.....2

SECTION 2: LABORATORY SERVICES

NAME OF RESPONDENT: _____ TITLE OF RESPONDENT: _____

	QUESTION	CODING CATEGORIES
201	What is the qualification of the person who is in charge of the quality of the laboratory work?	Lab assistant certificate.....1 Lab technician diploma2 Lab technologist diploma or higher.....3 None.....4 Other.....6
202	Does the facility have guidelines or protocols for how the laboratory is to conduct diagnostic testing for HIV?	YES.....1 NO2
203	Ask to see.	Yes seen.....1 No not seen.....2
204	Does this facility have the laboratory capacity to conduct HIV tests?	YES.....1 NO2
205	Does the laboratory have a separate register where laboratory test results for HIV tests are recorded?	YES.....1 NO2
206	Does the facility have all equipment and reagents required to conduct a malaria test today?	YES.....1 NO2
207	Is there a separate register where laboratory test results for malaria are recorded?	YES.....1 NO2

SECTION 3: ANTENATAL, PRENATAL AND EMERGENCY OBSTETRIC CARE SERVICES

NAME OF RESPONDENT: _____ TITLE OF RESPONDENT: _____

	QUESTION	CODING CATEGORIES
301	How many staff are directly involved with management of antenatal and/or third stage of labor/ emergency obstetric care services? INCLUDE ALL STAFF WHO HAVE RESPONSIBILITY FOR ANY OF THESE ACTIVITIES, EXCLUDING THE LAB TECHNICIAN.	<input type="text"/> <input type="text"/> <input type="text"/>
302	Among these staff, how many have received training in active management of the third stage of labor in the last 3 years?	<input type="text"/> <input type="text"/>
303	Among these staff, how many have received in-service training in reproductive health life saving skills within the last 3 years?	<input type="text"/> <input type="text"/> <input type="text"/>

<i>Does this facility provide the following services:</i>		
304	Administration of antibiotics by injection or by intravenous infusion?	YES.....1 NO2
305	Administration of anticonvulsants by injection or by intravenous infusion?	YES.....1 NO2
306	Administration of anticonvulsants for pre-eclampsia and eclampsia by injection or by intravenous infusion?	YES.....1 NO2
307	Manual removal of placenta?	YES.....1 NO2
308	Removal of retained products of conception (e.g., manual vacuum aspiration)?	YES.....1 NO2
309	Assisted vaginal delivery?	YES.....1 NO2
310	Intravenous fluids?	YES.....1 NO2
311	Provision of iron and folic acid supplements	YES.....1 NO2
312	Examination of the mother to evaluate the pregnancy (fetal growth and maternal health)	YES.....1 NO2
313	Surgery or caesarian section?	YES.....1 NO2
314	Blood transfusion?	YES.....1 NO2
315	Does this facility provide the following products to expectant mothers? A. Mama Kits B. Making a Birth Plan prior to delivery	YES.....1 NO.....2 YES.....1 NO.....2
<i>Does this facility provide the following Information:</i>		
316	Proper nutrition and hygiene for baby and mother	YES.....1 NO.....2
317	Malaria prevention/ Insecticide Treated Nets use	YES.....1 NO.....2
318	Importance of continued breastfeeding and child welfare	YES.....1 NO.....2
319	Prevention of STI/HIV/AIDS	YES.....1 NO.....2
320	Warning signs of pregnancy and complications	YES.....1 NO.....2
321	Post natal care and family planning	YES.....1 NO.....2
322	Dangers of self medication and use of traditional medicines during labor	YES.....1 NO.....2
323	Does this facility have the MOH policy and guidelines/protocols on antenatal, prenatal and obstetric care services? Ask to see.	Yes, seen by Interviewer.....1 No, Not seen by interviewer.....2

SECTION 4: INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI)

NAME OF RESPONDENT: _____ TITLE OF RESPONDENT: _____

	QUESTION	CODING CATEGORIES			
401	<p>How many staff are directly involved with management of IMCI services?</p> <p>INCLUDE ALL STAFF WHO HAVE RESPONSIBILITY FOR ANY OF THESE ACTIVITIES, EXCLUDING THE LAB TECHNICIAN.</p>	<div style="text-align: center;"> <table border="1" style="margin: auto;"> <tr> <td style="width: 30px; height: 30px;"></td> <td style="width: 30px; height: 30px;"></td> <td style="width: 30px; height: 30px;"></td> </tr> </table> </div>			
402	<p>Among these staff, how many have received any in-service training related to IMCI within the last 3 years?</p>	<div style="text-align: center;"> <table border="1" style="margin: auto;"> <tr> <td style="width: 30px; height: 30px;"></td> <td style="width: 30px; height: 30px;"></td> <td style="width: 30px; height: 30px;"></td> </tr> </table> </div>			
403	<p>Does this facility receive regular supervision for IMCI?</p>	<p>YES.....1 NO2</p>			
404	<p>When was your last IMCI supervision?</p>	<p>This month1 This quarter2 In the last 6 months3 In the last year4</p>			
405	<p>What are the danger signs that indicate that a child needs urgent medical care?</p> <p>CIRCLE ALL THAT IS MENTIONED – DO NOT PROMPT</p>	<p>Convulsions1 Loss of consciousness2 Severe anemia or “lack of blood” shown by pale lips or palms3 Difficulty in breathing4 Extreme weakness (unable to sit or stand)5 Vomiting everything/severe vomiting6 Child not able to drink or breastfeed7</p>			

SECTION 5: DIAGNOSIS & TREATMENT OF MALARIA

NAME OF RESPONDENT: _____ TITLE OF RESPONDENT: _____

	QUESTION	CODING CATEGORIES
501	How many staff are directly involved with management of malaria? INCLUDE ALL STAFF WHO HAVE RESPONSIBILITY FOR ANY OF THESE ACTIVITIES, EXCLUDING THE LAB TECHNICIAN.	<input type="text"/> <input type="text"/> <input type="text"/>
502	Among these staff, how many have received any in-service training in management of severe and complicated malaria within the last 3 years?	<input type="text"/> <input type="text"/> <input type="text"/>
503	During their antenatal checks, are pregnant mothers provided with Antimalarial tablets like Fansidar?	YES.....1 NO.....2
504	Does the facility provide ITNs for pregnant mothers to protect them and the baby from getting malaria?	YES.....1 NO.....2

SECTION 6: COMMODITY MANAGEMENT (DRUG STORE OR PHARMACY)

NAME OF RESPONDENT: _____ TITLE OF RESPONDENT: _____

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

11. Condoms	YES.....1 NO.....2
12. Chloroquine	YES.....1 NO.....2
13. Fansidar	YES.....1 NO.....2
14. Quinine	YES.....1 NO.....2
15. Injectable diazepam (valium)	YES.....1 NO.....2
16. Ergometrine	YES.....1 NO.....2
17. Anesthesia	YES.....1 NO.....2
18. Homa Pak	YES.....1 NO.....2
19. Oxytocin	YES.....1 NO.....2
20. Misoprostol	YES.....1 NO.....2
21. Zinc	YES.....1 NO.....2
22. Iron/Folate	YES.....1 NO.....2
23. ITN	YES.....1 NO.....2
24. Mama Kits	YES.....1 NO.....2

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

THANK YOU!

END OF CHECKLIST

Annex 3: Institutional Strength Assessment Report

**HealthPartners
Uganda health Cooperative
Institutional Strength Assessment Report**

February 2007

Table of contents

Introduction

Numerous frameworks for describing or assessing the institutional capacity of development organizations such as private voluntary organizations (PVOs) and local non-governmental organizations (NGOs) are in development and use. Fortunately there is a lot of similarity in these frameworks, reflecting the fact that there is agreement on the most fundamental characteristics for effective and sustainable institutions. Where frameworks differ the difference is either in emphasis, semantics, definition or classification of certain characteristics (VanSant undated).

The purpose of carrying out an institutional assessment (IA) is not simply to judge the organization's capacity but rather to provide a learning tool for institutional self-understanding so as to act as a foundation for capacity improvement. In addition, IAs also help managers and administrators to see the relationships among the institution's sub-units as well as the interrelationships and interdependencies with other partnering institutions in the task environment (Morgan and Taschereau 1996).

On the other hand the major limitations with IAs are that institutional development efforts usually require long-term commitment. In the absence of such a commitment, IA may be seen by the institutions more as an evaluation of their performance and possibly a threat rather than an opportunity to take stock of their capacities and improve their management of the institution. Additionally whereas the use of IA frameworks can yield a great deal of information, the sheer amount of information could be overwhelming and fail to help to focus on the dynamics of the relation between those factors (Morgan and Taschereau 1996).

The Institutional Strength Assessment (ISA) Methodology is a product of the Child Survival Technical Support Project (CSTS) funded by the Office of Private and Voluntary Cooperation. The ISA tool for the participatory self-assessment is itself a compilation of common areas of institutional capacity based on a review of sixteen instruments developed in the 1995-1999 period. In its present form ISA reduces 55 separate capacity areas into eight general capacity areas. These areas to be assessed include: management practices and governance, administrative infrastructure and procedures, organizational learning, financial resource management, human resource management, technical knowledge of the institution's staff and use of technical knowledge and skills (VanSant undated: CSTS 2001)

Background to HealthPartners UHC Uganda Health Cooperative

In 1997, HealthPartners a Minnesota not for profit HMO received a USAID cooperative development sub agreement from Land O' Lakes, Inc to develop a system for affordable prepaid health care in Uganda. This followed a realization by Land O' lakes that had been working with Ugandan dairy farmers that members of communities were frequently falling ill and would sell their only income generating assets to receive health care. Often these families would wait until illness was life threatening to seek care (Wenborg etal 2006).

HealthPartners formed the Uganda Health Cooperative (UHC) to organize members of groups to pay quarterly premiums to health care providers in order to reduce barriers to

care when they need it. UHC began working with dairy cooperatives and in 2002 it expanded to offer health schemes to coffee and tea cooperatives, micro-finance groups, burial societies, teachers and students at secondary boarding schools among others (Wenborg et al 2006).

In September 2005, HealthPartners and its NGO affiliate UHC was awarded a USAID Child Survival And Health Program Grant. Under this grant the goal of UHC is to link child survival interventions to prepaid health schemes, building on the existing structure to sustainably reduce morbidity and mortality for women in reproductive age (WRA) and children under 5 in Bushenyi district in rural Uganda.

HealthPartners UHC Child Survival strategy is a three tiered approach addressing the Community Social Dimension, Health Service Delivery and strengthening the Local Organizational Dimension. 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 UHC is also 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 UHC sustainability strategy is to improve the local capacity and viability of health systems by building capacity of partners, members, leaders and the elected board of directors to sustain a cooperative health care environment.

Management Structure

The management structure of HealthPartners Uganda Health Cooperative is composed of three major offices. The headquarter office based in Minnesota USA has The HQ Technical Backstop who is responsible for executive program management and the HQ Program Manager responsible for program planning, design, and monitoring. The country office based in Kampala has the program accountant/administrator and Director/Field Program Manager who is responsible for managing the program and staff. The rest of the staff are based in the field office in Ishaka Bushenyi district (Wenborg et al 2006).

Objectives of the assessment

1. UHC conducted an ISA in order to find out its strengths, weakness and opportunities for improvement in the following areas:
 - a. Management Practices and Governance
 - b. Administrative Infrastructure and Procedures
 - c. Organizational Learning
 - d. Financial Resource Management
 - e. Human Resource Management
 - f. Technical Knowledge of Health Unit Staff
 - g. Use of Technical Knowledge and Skills

2. To get staff's recommendations on what could be done to improve the performance of the organization.

Methodology

The ISA for HealthPartners UHC (the organizational unit that is responsible for supporting field-based child survival activities) was conducted at the end of phase one on the 8th February 2007. Of the thirteen staff, only twelve participated in the assessment because the thirteenth staff was less than three weeks old in the organization at the time of the assessment.

The questionnaire for the assessment was a modification of the tool for ISA assessments developed by the child survival technical support project. The questionnaire had eight major dimensions to be assessed. These dimensions included: management practices and governance, administrative infrastructure and procedures, organizational learning, financial resource management, human resource management, technical knowledge of UHC Staff, use of technical knowledge and skills and staff's recommendations on ways to improve the performance of the organization. Under each dimension was a set of questions which staff were asked to select the most appropriate answer in regard to the statements i.e. agree, disagree and do not know.

Before answering the questionnaire, each of the questions in the tool was read out to the staff and discussed to ensure uniform understanding. The staff were asked to answer the questionnaire as soon as possible. Before being accepted for data entry all questionnaires were checked for completeness.

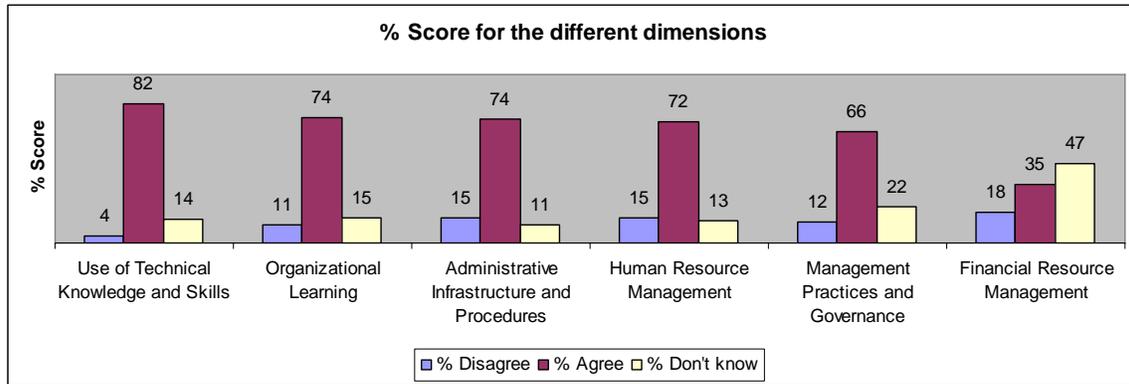
Data was entered and analyzed in MS Excel and the results are presented in narrative and figures as was found appropriate.

Results

Summary results for all the dimensions assessed are presented in figure one. The strengths i.e. the areas the staff agreed to and weaknesses i.e. areas to which the staff disagreed plus the areas which the staff had no knowledge in are presented per dimension. Lastly the staff's recommendations on what can be done to improve UHC performance are outlined.

Summary of findings

Figure 1 Percentage score for the dimensions assessed



From figure 1 it can be noted that the majority of the staff (82%) agree that there is use of technical knowledge and skills in the organization. On the other hand financial resource management had only 35% of the staff in agreement while 47% did not know most of the issues pertaining to financial management in the organization.

Use of Technical Knowledge and Skills

The questions in this section required staff to assess the knowledge and skills of backstop staff related to specific technical interventions that are featured in UHC's health portfolio. These interventions included such areas as breastfeeding, control of diarrheal disease, malaria, maternal and newborn care, child spacing, STI/HIV/AIDS Prevention, Integrated Management of Childhood Illness (IMCI), and others. The assessment also covered issues of technical knowledge and skills related to monitoring and evaluation, capacity building, and sustainability.

Results from this assessment show that the majority of the staff (82%) agreed that there is use technical knowledge and skills in the organization. However 4% of the staff disagreed and 14% did not know.

The areas in which the staff were in agreement include:

1. UHC provides the appropriate level of support to project (s) in the design and implementation of activities with active community involvement (11/12)
2. Overall, UHC provides the appropriate level of guidance and support to project(s) in order to continuously improve the quality of health interventions (11/12)
3. UHC presently participates in health policy dialogue at the district level in the district where our project(s) operate (10/12)
4. Overall, UHC provides our project(s) with the appropriate level of support on technical health questions (10/12)
5. UHC provides the appropriate level of support to our project(s) in the design and implementation of behavior change communication interventions (10/12)
6. UHC provides the appropriate level of support to our project(s) in conducting operations research during interventions (10/12)

7. UHC provides the appropriate level of support to our project(s) in the use of qualitative research (10/12)

The areas in which the staff were in disagreement include:

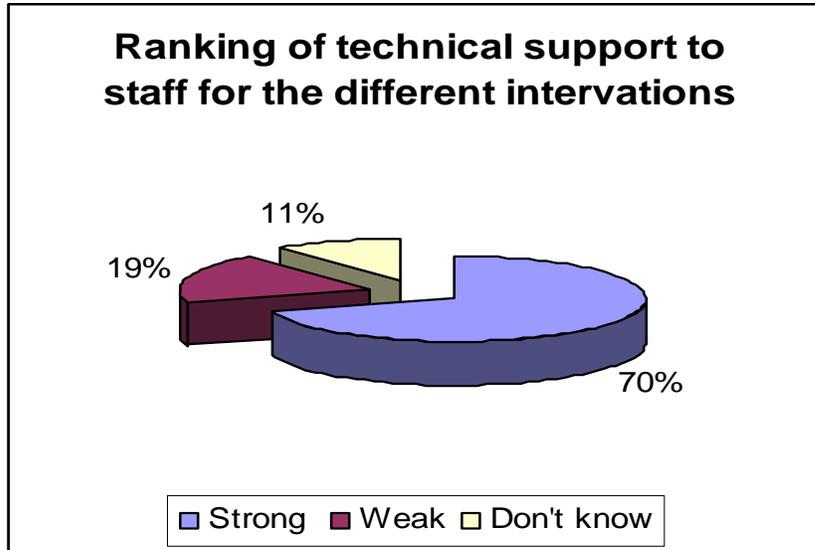
1. UHC provides the appropriate level of support to our project(s) in monitoring and evaluation (2/12).

The areas in which the staff were unknowledgeable include:

1. UHC presently participates in health policy dialogue at the national level in the districts where our project operate (4/12)
2. In responding to technical requests from the field, health backstop staff routinely access state of the art resources/information (3/12))
3. UHC provides the appropriate level of support to our project(s) in conducting Health Facility Assessments (3/12)
4. UHC provides the appropriate level of support to our project(s) in conducting organizational capacity assessment (for example of local partners) (3/12)

When staff were asked to rank the level of technical support they receive for the different intervention areas of the program, the majority said that overall the technical support is strong as illustrated in figure 2.

Figure 2 Ranking of technical support to staff for the different interventions



Organizational Learning

In assessing UHC's ability to learn, staff were asked to assess whether UHC makes adjustments to its programs/projects based on data collected from the field, and whether it documents its learning and innovative strategies that have emerged from those adjustments. Questions in this section also assessed whether the organization values teamwork, and it promotes an environment in which staff at all levels are comfortable to contribute ideas which might improve the overall performance of the organization..

Overall the majority of staff 74% agreed that there was organizational learning in the organization while 15% did not know and 11% disagreed.

The areas in which the staff were in agreement include:

1. We regularly re-examine strategies for designing and implementing health programs in this organization (12/12).
2. Field visits from health backstop staff are used as opportunities to motivate and encourage field-based project teams (12/12).
3. Lessons learned are regularly converted into tangible actions that benefit the overall portfolio of our CS and other health projects (10/12).
4. UHC staff is regularly informed of the latest developments and lessons learned from projects outside the organization(10/12)
5. We regularly disseminate relevant state of the art information to our field projects (10/12).

The areas in which the staff were in disagreement include:

1. Field staff are regularly informed of the latest developments and lessons learned from other projects in the organization's health portfolio (4/12)
2. Field staff are periodically asked for feedback on performance of our designated health backstop staff (3/12).

The areas in which the staff were unknowledgeable include:

1. There are annual opportunities for field staff from different projects/countries to meet to exchange information and experiences (4/12).
2. We regularly use M&E data to inform our management and planning for existing projects (3/12).
3. We have documented examples of how lessons learned from our experience with health programs have been applied to other parts of the organization's (3/12).
4. We regularly re-examine our strategies for managing and backstopping health programs in this organization (3/12).

Administrative Infrastructure and Procedures

The staff were asked to assess the range of administrative procedures that impact on UHC's capacity to efficiently implement and support its programs. Questions in this dimension ranged from the ability of UHC to procure supplies and equipment, to the administrative support necessary for producing reports and other key correspondence, to the capacity to hire consultants for specific tasks. Staff were also asked to assess administrative and communications infrastructure such as computer hardware and software that also facilitate the organization's ability to manage its work.

Results from this assessment show that the majority of the staff (74%) agree that there are adequate administrative procedures and infrastructure, 15% disagree while 11% do not know.

The areas in which the staff were in agreement include:

1. Field staff have access to an internet connection (12/12)
2. Supplies and equipment are procured and delivered to field projects in a timely manner (12/12).
3. We receive regular progress reports from our field projects (11/12).
4. Overall, the health unit provides appropriate administrative support to its field projects (11/12).
5. Quality consultants are routinely identified for assignments that cannot be undertaken by UHC or field staff (10/12).
6. There are staff in the organization designated to provide administrative support to health backstop staff (10/12)

The areas in which the staff were in disagreement include:

1. We routinely translate project key project documents (e.g., Detailed Implementation Plans, Evaluation Guidelines, and Grant Application) into local languages for field staff (7/12)
2. UHC staff receive training and technical support in use of computer Software/hardware as needed (4/12).
3. Field-based project managers receive training and technical support in the use of computer software/hardware as needed (4/12).
4. Our computer systems are regularly upgraded to reflect industry standards (3/12).
5. UHC staff regularly access the internet for technical health information (3/12)

The areas in which the staff were unknowledgeable include:

1. Field-based project managers receive training and technical support in the use of computer software/hardware as needed (4/12)
2. The UHC administrative procedures are regularly reviewed and updated (3/12)

Human Resource Management

Under the assessment of the human resource dimension, the staff were asked to assess UHC on issues of staff development, deployment, recruitment; performance appraisal; professional growth; supervision; and other areas related to the management of the organization's human resources.

According to the assessment results, majority of the staff (72%) agree that there is good management of the organizational human resource, 15% disagree while 13% don't know.

The areas in which the staff were in agreement include:

1. The organization consistently recruits quality staff to support its health portfolio (12/12).

2. Field staff and health unit staff assigned to backstop their projects share fluency in at least one common language (11/12)
3. A performance review system is used to motivate employee performance (10/12).
4. There are clearly documented procedures for orienting new staff to the organization (10/12).
5. Roles and responsibilities of health unit staff are regularly reviewed and updated (10/12).
6. The workplace environment is supportive of staff at all levels in the health unit (10/12).

The areas in which the staff were in disagreement include:

1. There are clearly documented policies for handling employee grievances (5/12).
2. New field staff are recruited in a timely manner (5/12)
3. We routinely staff up new projects without incurring delays in project start up (3/12).

The areas in which the staff are unknowledgeable include:

1. The organization has a clear policy that supports the retention of staff during bridge periods (5/12).
2. Backstop staff understand the local cultural dynamics that impact implementation of the projects they are assigned to support (4/12).
3. We have clearly documented policies on hiring staff (4/12).

Management Practices and Governance

Under management practices and governance, the staff were asked to assess the management practices and systems that impact on the success of UHC. Overall 66% of the staff agree that there are good management and governance practices in the organization while 12% disagree and 22% do not know.

The areas in which the staff were in agreement include:

1. The management structure of the health unit facilitates the successful implementation of projects in the field (12/12).
2. There is a clearly designated point of contact for backstop support for each field-based project manager (12/12).
3. There is regular communication between field-based project managers and their designated backstop person (12/12).
4. Designated backstop personnel respond to field requests in a timely manner (11/12).
5. Overall, we provide appropriate management-related support to our field projects (11/12).

The areas in which the staff were in disagreement include:

1. Representatives from our field projects' local partner organizations are regularly included in monitoring and evaluating those projects (5/12).
2. Representatives from our partner organizations are regularly included on the design teams for our programs at the field level (4/12).
3. Representatives from our target communities are regularly included on the design teams for our programs at the field level (4/12).
4. Representatives from our target communities are regularly included in monitoring and evaluating the projects which serve their communities (3/12).

The areas in which the staff are unknowledgeable include:

1. Health backstop staff regularly receive training in project/program management (7/12).
2. Representatives from our target communities are regularly included in monitoring and evaluating the projects which serve their communities (5/12).
3. The organization has a clearly outlined strategy/protocol for starting up new projects upon confirmation of funding (5/12).
4. Representatives from our field projects' local partner organizations are regularly included in monitoring and evaluating those projects (4/12).
5. Primary healthcare is formally included in UHC strategic plan for the next year (4/12).
6. UHC appropriate support if/when issues of conflict or disaster disrupt program operations (4/12).

Financial Resource Management

The staff were asked to assess how UHC manages its finances .Questions in this section examined the availability of funds for planned activities, the ability of management staff in the unit to have access to up-to-date budget information, the status of financial management and accounting systems, the accuracy of financial data, budgeting, and other relevant financial issues.

This dimension had the least score with 35% of the staff in agreement, 18% in disagreement and 47% not knowing the presence of different financial managerial practices.

The areas in which the staff were in agreement include:

1. Financial resources are transferred from HQ to the field in a timely manner (9/12).
2. UHC encourages and supports the identification of new/emerging funding sources for programs/projects (7/12).

3. Field-based managers have access to up-to-date budget information on their projects (6/12).
4. We have a sufficiently diverse array of funding sources to sustain and build upon our present health portfolio (5/12).
5. Backstop staff have easy access to up to- date information on the budgets for each of their projects (5/12).

The areas in which the staff were in disagreement include:

1. Field-based managers receive regular training on budget management, costing, and other financial management issues (5/12).
2. Backstop staff receive regular training on budget management, costing, and other financial management issues (4/12).
3. Field-based managers have access to up-to-date budget information on their projects (4/12)
4. Backstop staff have easy access to up to- date information on the budgets for each of their projects (4/12).

The areas in which the staff were unknowledgeable include:

1. The organization conducts regular financial audits of its health projects (9/12).
2. Our financial contingency measures prevent operational disruptions (9/12).
3. Budget information provided to field staff is in a format that is easy to use for the purposes of project management (8/12).
4. Budget information provided to backstop staff is in a format that is easy to use for the purposes of project management (8/12).
5. We have a sufficiently diverse array of funding sources to sustain and build upon our present health portfolio (6/12).
6. Backstop staff receive regular training on budget management, costing, and other financial management issues (6/12).

Staff's recommendations

1. 6/12 of the staff recommended regular trainings for staff in their areas of intervention.
2. 6/12 staff recommended continuous training and involvement in planning of major stakeholders like the board of directors, scheme leaders, community leaders, providers etc to ensure sustainability of the program.
3. 3/12 staff suggested that the UHC could consider advertising the project activities using a variety of strategies for example radio so as to make its presence known in the district and the country as a whole.

4. 4/12 staff recommended field visits tours to other projects with similar interventions so as to learn from their experience on best practices and vice versa
5. 4/12 staff had recommendations pertaining to salary these included: a clear salary structure for the different departments, salary increment to cope with the economy, provision of allowance / benefits like housing, medical and overtime allowance etc
6. 3/4 staff recommended the involvement of field managers in budgeting and planning.
7. 3/4 staff recommended meetings and supervision of project activities in collaboration with the district health staff.
8. 2/12 staff recommended that UHC could find solutions to the transport problem so as to be able to provide transport to cover long distances and large area of operation because motorcycles have limitations like rain etc.
9. Staff also recommended the need to improve access to the internet i.e. reliability and speed to enable field staff access state of the art information.
10. Staff also recommended timely response to problems reported by the field office.
11. Backstop staff should regularly visit and work with field staff to improve motivation and performance.

Discussion

From the results it is clear that HealthPartners UHC has got much strength and some weaknesses and areas for improvement.

Strengths

Notable among the strengths is technical support to field staff, which could be attributed to the technical expertise and experience of the technical backstops. Organizational learning is also strength of this organization as evidenced by lessons learnt regularly being translated into tangible actions that benefit the program. This can only be possible with close monitoring and documentation of lessons learnt which in turn is only possible if there is good and regular communication and availability of communication infrastructure. This brings into light yet another strength i.e. good administrative procedures and infrastructure that support effective program implementation and timely reporting hence explaining the organizational learning strength.

Human resource management is another strong dimension in this organization especially concerning performance appraisal, supervision and to a lesser extent recruitment, staff development and deployment. Although most of the staff agree that the organization consistently hires quality staff, the major challenge is in the timeliness of the recruitment. Most staff feel that staff recruitment is not timely and this could be explained by the fact that the field site is rural in location. Staff recruitment and retention in rural areas is a major challenge to most organization as many people prefer to work in the city and major towns.

Weaknesses

The major weaknesses cited included limited involvement of partners and target communities in the design, monitoring and evaluation of the program. Target community involvement has been a challenge to many projects for a long time. But if programs are to be self sustaining after donor withdrawal it is an area that cannot be over looked. Major challenges pertaining to this include low levels of technical training of these communities, deciding on who and how to involve the whole community etc. According HealthPartners's project detailed implementation plan, the details on how the communities will be involved so as to ensure sustainability are out lined. Among which is the election of a board of directors, group leaders, training of community resource persons etc. Presently six members from the target community have been elected as board of directors, twenty two group members have also been selected and their training in different aspects of the program is being planned. In addition several CORP in the first county of intervention were identified and trained and the same process will continue in the next county of intervention. The major challenge however that is being faced by this strategy is the level of volunteerism of the selected community members.

Another weakness highlighted by the staff is the lack of training and technical support in the use of computer software and hardware as required, irregular upgrading of computer systems to reflect industry standards and irregular internet access. These in the long run could impact negatively on the staff's quality of work and reports hence the need to improve this area.

The staff also feel that they are not provided with the appropriate level of support in monitoring and evaluation and that M&E data is not used to inform management and planning of the existing projects. This may be a signal that communication on and staff involvement in designing and planning of the project maybe limited. This is also echoed by the fact that some staff think that field managers and backstop staff do not have up to date budget information on their projects. Another explanation for this observation could also be because the majority of the staff (8/13) are less than one year old in the organization.

Other weaknesses highlighted include lack of a clearly documented policies for handling employee grievances, difficulty in recruiting staff on when required, and non involvement of staff in giving feedback on the performance of their designated backstops.

Areas for improvement

These are issues in which ought to be knowledgeable but were found not knowledgeable during the assessment. They included among others the need for HealthPartners UHC involvement in health policy dialogue at district and national level. Others included: Communication to staff on policies concerning recruitment, staff retention during bridge periods, appropriate support when issues of conflict/ disaster disrupt program operations, financial contingency measures to prevent operational disruptions, sources of funding, available budgets and trainings.

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Annex 4: Summary of Travel Reports

Gordon Lindquist-Assessment of health scheme management and Board issues

Report Title Page

Health Partners Uganda Health Cooperative (UHC)

Request for sustainability reviewing assessment and recommendations

Location: UHC, Ishaka, Bushenji District, Uganda, East Africa

Date: January 20-February 15, 2007

Volunteer: Gordon E. Lindquist
St. Paul, Minnesota

Scope of Work

Conduct a review and analysis of Uganda Health Cooperative and offer a critical assessment and recommendations of sustainability of the organization and UHC Scheme.

The assessment will include review of documents, meetings with management, board of directors, field scheme managers, and health care providers in targeted region.

Expected outcomes:

Recommendations to improve system

An assessment of adequacy of premiums, co-payments and cost of services.

An analysis of level of participation to achieve relative to membership.

Benchmarks on number of participants to achieve sustainability

Recommendations for board oversight and other areas for cooperative management training

Recommendations for the Host Organization

1. The premiums and co-payments collected are transferred directly to the providers to pay for the cost of services. In order for the plan to be sustainable, a portion of the premium needs to be allocated for expenses. Currently all of the expenses are paid for by the supporting organizations. (Health Partners, LOL International and USAID). When this support is discontinued, UHC will need to assume the expenses to operate the plan. .

It is my recommendation that 10% of the premium be withheld and deposited in a reserve account which will accumulate interest. This fund should not be used to defray expenses but allowed to develop a capital fund. When the funding from the donor organizations terminates, UHC will have a start up fund to help assure sustainability. Based on the

current numbers, taking the 10% now would not adversely affect the providers. The 23 groups are experiencing 150% recovery. After withholding 10% for expenses, the cost recovery would still be 105%. 8 of the 23 groups have a negative cost recovery, but this includes a group of more than 1000 members that was recently put into effect. It is typical for new groups to have a higher utilization of services to begin with.

2. The current premium and co-payments are more than adequate to cover the cost of services provided to the UHC members. In my opinion, it is too early to conduct an in-depth actuarial analysis. It could be conducted at a later time when the membership is larger and the numbers are more mature. Currently the plan has only 4000 members and some of the groups are relatively new.

3. Level of participation relative to membership

All 23 groups are achieving the level of participation required (60%). Of the 23 groups, 2 have 100% participation. The premiums are paid by the organization and charged to the individual members.

Three groups have less than 30 members, and they are required to have 100% enrollment, and they are meeting the requirement.

The remaining 18 groups are meeting the 60% enrollment requirement.

The scheme managers are monitoring the level of participation on a regular basis.

4. Benchmarks on number of members to achieve sustainability

In my opinion, it is difficult to do at this time. Currently the budget for UHC is \$50,000 USD annually. If you were to apply a 10% expense ratio, in raw numbers it would require 175,000 members to be sustainable. Inflation and operating at a lower expense level could reduce these numbers. Currently, the management expects to increase the membership to 8000 by year end 2007. Again, the in-depth analysis should be conducted at a later time when more experience has been developed.

5. Recommendation for Board Oversight and other areas for cooperative management training.

a. Board development

More training needs to be provided for the board of directors. They need to develop a better understanding that their role is to represent the members and serve the cooperative versus their personal interests. For example, at the board meeting I attended, the first issue raised by a member of the board was compensation for the board members, which included a specific level of compensation.

A self evaluation for the board members is in place and the results of the first evaluation were reported to the board. On a scale of 1 to 10, they rated 3.4 as a group. They complete this evaluation at the end of each board meeting, an over time should result in a better understanding of their role. It is a relatively new board, this being their 3rd meeting.

b. Management Development

I would strongly recommend further management training, particularly for the manager. The management team is dedicated and committed to the success of the organization. My assessment is based on sitting through one of their monthly meetings where past performance is reviewed and goals set for the following month. The manager was well prepared and had studied the reports provided to him. During his inquiry, he was not satisfied with general responses, but expected detailed accounting. I was impressed.

Also, I met with several of the scheme managers individually.

At some point in the future, it would be helpful to bring the manager to the U. S for further training by Health Partners. In my opinion, he has potential.

3. Impact/Accomplishment

I believe my most important recommendation is to allocate 10% of the premium to a reserve fund which will begin to prepare for sustainability. Evidence that this recommendation has been implemented will have a positive impact.

I had several discussions with the manager as relates to his role. At this stage, he clearly understands what he needs to do and has a desire for additional training;

During my meeting with the board of directors, I stressed on the importance of serving the cooperative versus personal interests. I specifically addressed the compensation issue, reminding them that as a fledging organization funds are not available at this time. I gave examples of well developed cooperatives in the U. S. do not provide for compensation for the board and when expenses are reimbursed, they are subject to limits.

Short term impact will be a better trained management and board of directors. This will manifest itself in growth and a well managed organization.

Long term impact will be the establishment of a reserve that will assure the sustainability of UHC

4. Conclusions

UHC is meeting a specific need in providing better health care for the people in the Bushenji district in Uganda. The plan offered is very unique, simple, easy to understand. Preventative health care is a foreign concept for most of the people. They seek health care when sick and are not accustomed to preventative measures. This represents a significant cultural change which will take time. Positive results shared with the community will help. The successful development of UHC will have a major positive impact in the community.

Catherine Houchen-Wise-Internship in Bushenyi

INTERN'S REPORT

Background:

In February 2007, I traveled to Bushenyi District in western Uganda, to spend about 5 weeks as an intern at HealthPartners Uganda Health Cooperative's (UHC) office in Ishaka. UHC offers pre-paid health plans to existing groups such as tea factories, schools and organized community groups. The program received a Child Survival grant in September 2005 to improve child and maternal health and educate the community on disease prevention and treatment.

The main objectives of Child Survival are divided into a Community Social Dimension, a Local Organizational Dimension, and a Health Services Dimension. The three objectives of the Community Social Dimension are to reduce malaria and diarrhea in children under 5, and increase the number of pregnant women receiving antenatal care and giving birth in health facilities. The objective of the Local Organizational Dimension is to enable individuals in the community, who together make up the Board of Directors to manage health schemes. The objective of the Health Services Dimension is to improve the ability of local health providers to care for the community (especially women of reproductive age and children under 5). These objectives are achieved by a number of specific strategies, which are implemented in each county of the district during different phases.

A key component in these strategies involves Community Owned Resource Persons (CORP), who are trained to educate their communities in various areas including Malaria prevention, Diarrhea prevention, Maternal and Newborn Care (MNC), HIV/AIDS, and Sanitation and Hygiene. In addition, local health workers are trained in development of stock order plans, Integrated Management of Childhood Illness, and Standard Care Management of malaria, diarrhea, Antenatal Care (ANC), and Active Management of Third Stage Labor (AMSTL). Finally, the Board of Directors, which is made up of health plan members from local groups, is being trained in various aspects of health scheme management so they will be able to run UHC without the assistance of the current staff. A baseline Knowledge, Practice, and Coverage (KPC) Survey was conducted at the outset of the program, and at the end of each phase Lot Quality Assurance Sampling (LQAS) and a Health Facilities Assessment (HFA) are conducted to monitor progress being made toward achieving the objectives.

During my time as an Intern, I primarily focused on Child Survival and spent most of my time working with the Community Education Coordinator, Dorah. She works closely with the Health Services Trainer, Grace, so I spent a fair amount of time with her as well. In addition, I had the opportunity to observe a number of other activities conducted by the Marketers and Monitoring and Evaluation Coordinator.

Activities:

- Attended CORP community education sessions on sanitation and HIV/AIDS
- Accompanied Community Education Coordinator to collect feedback and work plans from CORP
- Assisted Scheme Marketers (Arthur and Charles) and Community Education Coordinator (Dorah) with typing monthly reports
- Assisted all staff with Excel troubleshooting

- Accompanied Scheme Manager (Charles) to health plan providers to collect information on services provided and co-payments collected for his monthly scheme manager report
- Accompanied Monitoring and Evaluation Coordinator (Gilbert) to various health centers to deliver notification letters about the upcoming Health Facilities Assessment
- Participated in the LQAS exercise at the end of Phase 1 (Igara County) to monitor progress toward end of program targets for various interventions
- Accompanied staff members as they delivered invitations to the dissemination workshop
- Assisted with editing power point presentation for dissemination workshop
- Attended the dissemination workshop and helped edit the dissemination report
- Accompanied Community Education Coordinator to hospitals and government health centers to collect ITN and Mama Kit distribution reports; compiled information in Excel
- Typed letters for health providers notifying them about follow-up of Maternal and Newborn Care (MNC) training
- Typed letters for government officials and health providers in preparation for Phase II (Ruhinda County)
- Attended staff meetings

I spent the majority of my time with Dorah, helping her collect information from CORP and health centers and typing reports. I also attended two CORP sessions in which the community was educated on clean water and sanitation, and HIV/AIDS. In preparation for HFA and LQAS, notification letters were written to give to the local leaders and health facilities. Gilbert and I took these letters first to get a stamp from the Director of District Health Services, and then distributed them. I also participated in the LQAS exercise, during which Benjamin and I went to houses in various villages and completed the survey. Obviously with the language barrier I could not do very much, but I helped with marking the answers on the surveys, weighing the children, and observing the condition of the latrines.

Following the LQAS and HFA exercises was a dissemination workshop, to which local government leaders, health group leaders, local partners, CORP, and health providers were invited. In preparation for this workshop, we delivered letters to all people invited, and at the workshop itself, Dorah and I took pictures to be used in the report. When the report was typed summarizing the information from the workshop, I helped edit it.

Typing reports in Excel proved to be challenging for many because of complications with formatting, so I was able to help sort out some difficulties and assist several members of the staff in compiling their reports. I also typed some documents pertaining to health provider trainings for Grace, who had written them by hand and needed them typed.

Lessons Learned:

During the 5 weeks I spent in Ishaka I had a great opportunity to see how the health plans work – from marketing to groups, to collecting premiums, working with

providers, and meeting with the Board of Directors. I also got to participate in Child Survival activities and monitoring and evaluation.

I learned a lot not only about how people live and how health care is provided, but also about how this organization is helping people become healthier by focusing on community education. It was great to see from the findings of the LQAS that many of the interventions are proving effective. From the time the baseline KPC survey was conducted, the percentage of people giving birth in health centers and receiving antenatal care increased, as did the percentage of people sleeping under ITNs. Frequency of hand-washing also increased, and the number of children experiencing fever or diarrhea in the previous 2 weeks declined. Some areas showed far more improvement than others, but overall, progress was made.

When I attended the CORP sessions, it was heartening to see so many people eager to learn how they can make themselves and their children healthier, and learn ways that they can prevent disease. I was surprised when Dorah told me people were reluctant to use Pur or Waterguard because they feared it would kill them, preferring instead to make their water safe by the chemical-free method of boiling it.

In helping Arthur and Charles with their marketing reports, I saw how challenging it can be to enroll groups. There were some groups that marketers had met with more than five times, but still had not committed. Every day I saw Elisa, Arthur, and Charles work hard to make new contacts and answer questions from groups with which they had already had multiple meetings.

One of the most educational things for me was visits to hospitals and government health centers. Before coming here I assumed naively assumed that hospitals everywhere were pretty much like those in America. When I saw how far some people, who had no transportation other than walking, had to go to receive very basic care in a run-down building, I was shocked. Not only are the government health centers wide-spread, many are severely understaffed and frequently run out of medication.

Seeing families whose entire livelihood depends on their banana plantation and one or two cows, I appreciate how much a prepaid health scheme can benefit them. The newspaper occasionally features stories about mothers who either give fake names or abandon their children in the hospital because they know they will not be able to pay the medical bills. With widespread outbreaks of diseases such as cholera, plague, and meningitis, there is no guarantee that a child won't fall sick at any time, no matter how healthy they appear to be. Therefore it makes sense to pay a small amount up-front to allow the family to access medical care without having to sell a cow or use all their savings in case someone falls sick.

Challenges:

The LQAS exercise included many challenges, particularly when working with local chairmen. They often were skeptical about what we intended to do, and some were reluctant to help us because we were not paying the survey respondents. In other cases, they wanted to answer the survey about their own family, rather than providing a list of village residents from which a respondent would be picked at random.

One of the major challenges that everyone in the office seemed to have was the issue of communication. Even when people have cell phones, there are large areas with no network coverage. This was especially prevalent during the LQAS exercise, when the four people in our group had just one driver, and were spread out over a large area. Benjamin and I ended up walking about 8 Km from one village to another because we

could not contact the driver and didn't know when he would be coming. Similarly, when Dorah and I went to pick up feedback and work plans from CORP, we could not contact all of them by phone to see if they were at home. We drove all day from village to village on very bumpy roads, and occasionally found the CORP was not home, and family members did not know when he/she would return.

Another challenge faced is that many people in the community still do not know about HealthPartners or health schemes. During one of the meetings, Dr. Grace mentioned that when she went to different clinics for the HFA, people knew who Dorah was because she brought ITNs and Mama Kits, but did not know about the health schemes offered by UHC. Also, many of the CORP wear UHC T-shirts but do not know about health plans that the organization offers.

With the inconsistent power, many of the computers in the office have been damaged. Dorah's computer works only half the time, and one of the other computers does not work at all. As a result, when it is time to type reports, there are far more employees who need to use the computer than there are computers available.

As the project moves into phase 2, in Ruhinda County, the challenges with contacting all the CORP and distributing supplies to health centers will increase, because there will now be two counties to be covered. The long distances between facilities and CORP households will increase as another county is included.

Suggestions:

Suggestions for addressing the above challenges have been made in the staff meetings, and it was agreed that new computers would be purchased, as well as potentially getting another car. Additionally, marketers have been asked to provide a training session for CORP so they can include information about health plans during their education sessions. During the last community education session I attended, Arthur took a few minutes to explain UHC's health schemes and distributed some brochures

To increase community knowledge about UHC and the plans they provide, posters will be made and distributed to health centers, and a sign will be made for the main road through Ishaka. It was also suggested that a UHC brochure be distributed with ITNs and Mama Kits, so the recipients of these items can learn about health plans. At large meetings such as the dissemination workshop, UHC employees should be easily identified, so in the future they will have shirts to wear like those worn by CORP.

Linda Buchfinck-Installation and Training UHIS **UHIS Installation and Training Trip Report**

By: Linda Buchfinck

Friday, 2 February: Arrived in Kampala.

Arrived at UHC offices mid-afternoon. Installed file transfer software on PC in Kampala UHC office. Tested sending file to HealthPartners. File transfer failed to reach the designated HealthPartners EDI server. (Did not receive confirmation of this failure until Tuesday, February 6, due to time differences in Minnesota.)

Trained Lydia and Grace on procedure for sending file to HealthPartners.

Saturday, 3 February: Travel from Kampala to Mbarara, then to Ishaka.

Began installation on the PC in Ishaka UHC office with assistance from Raymond Twinko. Discovered that the UHIS PC had been used for several months by the Monitoring and Evaluation Coordinator and other team members. No one was available to identify files that were needed, so a clean install could not be performed. Changed the machine name to Uganda2. Uninstalled all Yahoo applications and deleted all associated files. There was 45GB of space in use on the PC that could not be freed up. Could not determine what was using the space. Windows XP Service Pack 2 was not installed (Service Pack 1 was the most recent update).

Successfully installed the additional Microsoft tools, Oracle 10g XE database and Oracle Forms and Reports Application Services.

Saturday evening attended Team Dinner hosted by Jennifer Wenborg. Met most of the team members that would be involved in training and ongoing use and support of the UHIS.

Sunday, 4 February: Ishaka, Bushenyi

Continued installation of software in Ishaka UHC office. Discovered that internet access was available from the office. Consulted with team members and decided to attempt to use the file transfer software on that PC. Successfully installed the software, but the file transfer failed to reach the designated HealthPartners EDI server

Sunday afternoon and evening attended team building activity, trip to Queen Elizabeth National Park.

Monday, 5 February: Ishaka, Bushenyi

Completed installation of software.

Installation Notes:

1. Security Center tools not available:
 - a. Firewall and
 - b. Change the way Service Center alerts: deselect all
2. UPS does not work when the electricity is off and the generator is the primary power source.
3. Tested Printer to confirm that correct printer drivers were installed. Also tested and adjusted properties so that reports would print correctly using the new Adobe Acrobat tool.
4. GNUPG, the export file application, was installed. The pass phrase should be Uganda_74. The file had to be manually changed later. The key ID is 6E73E76D. Part of the set up was run again during testing for the file transfer piece. The second import file is: uganda-ppub-keyb.txt.
5. All files; documentation, program file, reports, forms, etc., were copied to the C:\downloads folder on Uganda2 for future reference.

Began training for support and maintenance of UHIS with Gilbert, Duncan and Lydia: Database Backup, Procedures for Exporting Data Files, Back up and Recovery of Oracle Forms Reports Application, Restoring the UHIS Database.

Completed Data Entry training with Gilbert, Duncan and Lydia:

1. Security
2. Login
3. Diagnosis Maintenance
4. Fee Plan
5. Group/Coop Maintenance
6. Subscriber Dependent Definition Maintenance
7. Encounter Entry Maintenance

Continued working on the file transfer from Ishaka office.

Tuesday, 6 February: Ishaka, Bushenyi

Conducted UHIS Reports training for Director, Field Manager, Scheme Managers, Scheme Marketers, Community Communications Coordinator, M&E Coordinator, and Administrative Team members.

Training included:

1. How to log on to the computer
2. How to properly log out of the system
3. Security and changing passwords
4. A brief overview of Data Entry buttons
5. In depth discussions of each of the reports:
 - a. Drug List
 - b. Service List
 - c. Member History
 - d. Diagnosis Utilization Summary
 - e. Service Utilization Summary
 - f. Top Diagnosis
 - g. Coop Enrollment Summary
 - h. Coop Current Enrollment
 - i. Clinic Membership Summary
 - j. Clinic Current Membership
 - k. Provider Income and Loss

Review of the Reports grid document resulted in the following suggestions:

1. Add a column for Educators
2. For Scheme Managers/
 - a. Service Utilization Summary, add: Review premium plan
3. For Marketing Coordinator/
 - a. Service Utilization Summary, add: Show common disease and savings by using the plan
 - b. Top Diagnosis, add: Capacity to monitor diagnoses and improve health.
 - c. Coop Enrollment reports, add: Shows a general picture of membership and shows gains and losses in membership counts.
4. For Provider/
 - a. Service Utilization Summary, add: Review fee plan.

Note: Lydia and Dr. Grace also took notes. Their input would probably have significant value.

Two groups tied as winners of the quiz. Prizes were presented to Gilbert, Lydia, Duncan and Dorah.

Tuesday afternoon: Attended the UHC Board of Directors meeting. A brief overview of the UHIS was presented to the Board members and UHC staff present. The presentation included:

- The purpose of the UHIS.
- A technical flow chart of the UHIS process.
- The list of reports available from the UHIS.
- A brief demonstration of the UHIS, showing only the screens used for requesting reports.
- A brief description of the profit/loss report with a sample report.

Continued working on the file transfer from Ishaka office.

Wednesday, 7 February: Ishaka, Bushenyi

Reviewed maintenance and system support with Duncan and Gilbert. Worked with Duncan and Gilbert on:

1. Testing for fee plan for members with more than three dependents (family of 1-4 is standard, more dependents are charge a per dependent fee)
2. Tracking encounters for non-members without impacting the profit/loss reports
3. Training on cleaning up the cache of pdf files (from viewing and printing reports)
4. Adding new user names to security

Resulting decisions:

1. Attempting to prorate a second fee plan for the additional number of dependents doesn't appear to work because the number of paid members doesn't allow partial numbers, and the profit/loss report doesn't appear to allow for multiple entries.
2. Adding encounters to the schemas will add expenses to the profit/loss reports without the corresponding premium fees that would be included for a member. It was decided that the best solution would be to add (at a future date) a separate database schema for non-members.
3. Added directions to the maintenance documents for deleting the pdf files from the cache folder on the hard drive. Practiced deleting files that had accumulated during training.
4. Noted that new users need to be added to each provider/schema in the database first, before adding security through the data entry tools. Practiced adding new users with Cate's information (intern working in Ishaka until March 2007).

Thursday, 8 February: Traveled from Mbarara to Kampala

Completed testing of file transfer to HealthPartners at the UHC office. Successfully sent file, received confirmation email and confirmation from co-worker in Minnesota that the file was received.

9 February – 11 February: Travel from Kampala to Duluth, MN

Jennifer Wenborg-Program assessment and training in Bushenyi
Program Assessment and Training

By: Jennifer Wenborg

Monday, January 29

AM Meet with Dr. Grace, Lydia, Moses, Simon and Daniel. Covered details of contract for LQAS and HFA monitoring. Answered some programmatic questions with Dr. Grace.

PM Travel to Bushenyi

Tuesday, January 30

AM Team meeting with all staff. Discussed current challenges and requests.

PM Marketing meeting observation led by Elisa attended by Moses, Arthur, Jen and CORP

Wednesday, January 31

AM Monitoring and Evaluation Training with Gilbert. Covered Phase End Monitoring, LQAS, HFA, ISA, Gordon's report. Reviewed CS interventions and how monitoring relates. Reviewed UHC structure and monitoring, discussed BOD backgrounds, goals, issues, strategies and way forward.

PM CORP meeting observation led by CORP attended by Dorah, Moses, Elisa, Gilbert and Jen

Thursday, February 1

AM CS review of program Phase I, Planning for Phase II. Discussed plans for TBAs, Stock Order Planning and HW Self Assessment training which could not be covered in Phase I. Reviewed distribution plan for key CS items. Reviewed/revised training materials. Gilbert, Dorah and Jen

PM CS Monitoring and Evaluation Training with Gilbert. Reviewed Gilbert's priorities and plan for Feb, March, April, May and June. Visited Amelia and Lead Nurse at Comboni to see health plan systems and first hand accounts of impact from distribution of incentive items for ANC and skilled birthing.

Friday, February 2

AM Management training with all staff. Q&A Brain storm. Participatory activity to determine how to answer the most difficult common questions. Completed session in the PM.

Saturday, February 3

AM Gather notes from the week and incorporate for training with Dr. Grace

PM Program training with Dr. Grace: Background of the program, Management Structure, Staffing, Budget, M&E, BOD, Vision, Work Plan issues for 2007 and review of team activities/lessons learned from the week. Team dinner: welcome guests, new staff, show appreciation, award marketing commission.

Sunday, February 4

AM Program/policy training continued with Dr. Grace.

Monday, February 5

AM Monthly marketing meeting observation. Dr. Grace, Gordon, Catherine and Jen observe Marketing team. Some private coaching with Moses. Key action item meeting with Lydia. Final check in with staff and visitors. Meet Grace at her home.

PM Depart for Kampala

Response to Staff Requests January/February 2007

Item	Quantity	Cost/ea	Total	Approval
1. Bicycles for CORP	87	100,000	8,700,000	Approved
2. BOD Reimbursement/benefit	6*5	20,000	600,000	Approved through 11/07
3. Additional signage/posters for health facilities and groups	24	9,610	230,640	Approved
4. Group visits (1 group transport to another group)	10	232,128	2,231,280	Approved
5. ITNs for scheme pg women & CU5	1000	10,156	10,155,600	Approved
6. Health Fair	1	1,990,200	1,990,220	Approved
7. IAA health insurance + additional beneficiaries	13	1,613,049	20,969,640	Not Approved
8. Staff salary increases and higher range	13	variable	27,900,000	Approved
9. At least 1 Laptop computer	1-3	3,868,800	3,868,800	1 Approved
10. Vehicle				Scott working on donation
11. 1 more boda boda + jacket, gloves, boots	1	186,000/mo	2,232,000	Approved
12. Projector	1	3,956,220	3,956,220	Approved
13. Laminator	1			Approved
14. Higher marketing commission	40	50,000	2,000,000	Approved
15. Subsidies for women & CU5 now	100	10,000	1,000,000	Beginning 08
16. Additional training	13	Variable	Up to 9,653,400	Approved
17. Advance/microfinance/loan support	13	Variable	Variable	Loan support Approved
Total Cost of Items Approved			73,518,160	

Scott Aebischer-Partnerships and management in Kampala
Summary of meetings held with Scott and Partners

Monday 29, January 2007

Scott arrived. AM meeting with Scott Aebischer, Jennifer Wenborg, Dr. Grace Namaganda and Moses Tibanagia. PM meetings between Scott and Dr. Grace.

Tuesday 30 January 2007

Scott, Lydia and Dr. visited UPHOLD. Meet with Chief of Party Dr. Samson Kironde. Briefed him on activities. UPHOLD was pleased to learn we are using LQAS for monitoring as they also use this tool. Dr. Kironde promised to invite UHC to their dissemination workshop on results gathered from 20 districts between Nov-Dec 2006.

Wednesday 31 January 2007

Changed bank signatories. Met with UCBHFA, AFRICARE and Simon Kasasa.

Thursday 1, February 2007

Met with Dr. Charles Mugeru and Mr. James Mugisha from the Maternal and Child Health division of the Ministry of Health. Met with Gordon Lindquist, Consultant. Met with Enid Wamani of MACIS.

Annex B: Uganda Health Cooperative Financial Management by Provider

HealthPartners Uganda Health Cooperative
Scheme Manager Summary Monthly and Year to Date by Provider

Ishaka	January		February		March		April		May		June		July		August		September		Totals		
	Total Member	Surplus / Deficit	Total Members	Surplus / Deficit																	
BMC	January		February		March		April		May		June		July		August		September		Totals		
	Total Member	Surplus / Deficit	Total Members	Surplus / Deficit																	
Bumbaire	52	- 104,133	52	42,067	52	25,667	56	- 6,367	56	10,333	56	- 58,967	56	- 92,567	56	- 10,833	56	82,333	55	-90,800	
Bwera	48	80,000	48	60,000	48	- 42,500	53	35,833	53	18,133	53	30,833	55	77,667	55	69,967	55	79,167	52	409,100	
Kanyinya	60	26,000	60	45,900	60	- 12,200	60	- 35,900	60	20,000	60	1,500	60	- 5,400	60	73,500	60	98,000	60	211,400	
WAD	300	79,250	300	66,300	300	108,500	300	172,000	300	144,500	300	168,000	300	107,100	300	136,100	300	166,500	300	1,148,250	
Plus 2 H/school	600	600,000	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	600	600,000	
	212	681,117	115	214,267	115	79,467	117	165,567	117	192,967	117	141,367	118	86,800	118	290,400	118	426,000	1067	2,277,950	
Mitooma	January		February		March		April		May		June		July		August		September		Totals		
	Total Member	Surplus / Deficit	Total Members	Surplus / Deficit																	
Mitooma Jr	85	66,000	203	- 82,000	203	- 91,000	203	6,500	198	- 30,510	198	- 280,500	198	- 72,160	198	- 51,000	198	84,000	187	-450,670	
Rushoroza	114	- 196,500	114	- 90,000	114	63,500	114	66,000	126	87,000	88	- 15,567	88	- 43,833	88	- 4,833	90	20,500	104	-82,600	
Mitooma Transport	80	- 25,000	82	- 104,000	82	62,000	74	33,333	77	4,333	77	39,333	58	3,167	58	35,167	58	46,667	72	95,000	
	93	- 155,500	133	- 276,000	133	34,500	130	105,833	134	60,823	121	- 225,600	115	- 112,827	115	- 20,667	115	151,167	363	- 438,270	
Nyakasiro	January		February		March		April		May		June		July		August		September		Totals		
	Total Member	Surplus / Deficit	Total Members	Surplus / Deficit																	
Igara Nyakasiro	819	138,600	819	298,800	819	377,500	819	377,500	767	225,400	767	245,300	767	143,400	767	64,500	636	206,900	776	2,077,900	
	819	138,600	819	298,800	819	377,500	819	377,500	767	225,400	767	245,300	767	143,400	767	64,500	636	206,900	776	2,077,900	
Comboni	January		February		March		April		May		June		July		August		September		Totals		
	Total Member	Surplus / Deficit	Total Members	Surplus / Deficit																	
Igara Comboni	#####	- 244,800	###	139,300	#####	- 191,400	#####	- 311,100	#####	- 211,700	1,088	11,233	1,044	- 135,300	1,044	- 496,580	1,044	42,220	1069	-1,398,127	
Catechists	55	35,233	55	- 20,167	55	7,333	56	- 10,167	56	5,833	58	55,633	43	- 9,000	43	34,200	43	4,600	51	103,500	
St. Mary School	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	
Agri-Security	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	
Mashonga	58	2,167	58	50,667	58	51,267	64	21,233	64	58,833	64	- 105,067	55	48,167	55	48,967	55	310,167	59	484,400	
Gongo	147	77,300	147	113,000	147	43,800	140	114,700	140	28,300	140	81,300	143	37,867	143	66,667	143	81,767	143	644,700	
HealthPartners/Co	15	672,000	15	84,200	15	74,500	15	62,800	15	90,500	15	97,500	15	88,800	15	7,820	15	84,000	15	1,272,220	
CDC Kyamuhunga	-	-	-	-	-	-	-	-	-	-	304	73,100	301	72,400	301	19,700	301	94,400	302	259,600	
Comboni Staff	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	231	332,124	231	-332,124	
	338	786,700	338	227,700	338	176,900	341	188,567	341	183,467	417	129,367	400	165,833	64	155,753	64	490,533	1640	2,764,420	
BB	January		February		March		April		May		June		July		August		September		Totals		
	Total Member	Surplus / Deficit	Total Members	Surplus / Deficit																	
HealthPartners	-	-	-	-	-	-	30	333,000	25	203,167	25	73,167	25	- 26,333	25	54,733	25	45,867	26	574,133	
	0	-	0	-	0	-	30	333,000	25	203,167	25	73,167	25	- 26,333	25	54,733	25	45,867	26	574,133	

HealthPartners Uganda Health Cooperative
Scheme Manager Summary Monthly and Year to Date by Provider

	January		February		March		April		May		June		July		August		September		Totals	
	Total Member	Surplus / Deficit	Total Members	Surplus / Deficit																
Nyakshaka	-	-	-	-	-	-	-	-	-	-	-	-	244	19,000	244	- 80,700	244	- 110,700	244	- 180,400
<i>Nyakshaka group</i>	-	-	-	-	-	-	-	-	-	-	-	-	244	19,000	244	- 80,700	244	- 110,700	244	- 180,400
	0	-	0	-	0	-	0	-	0	-	0	-	244	19,000	244	- 80,700	244	- 118,700	244	- 180,400
School Groups	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
<i>Adventist Students</i>	183	160,125	-	-	183	- 290,475	-	-	-	-	-	-	-	-	-	-	-	-	183	-130,350
<i>Nyabubale</i>	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0
<i>Kyamuhunga P sch</i>	44	38,500	44	38,500	44	19,100	-	-	-	-	-	-	-	-	-	-	-	-	44	96,100
<i>Plus 2 H/school</i>	600	600,000	600	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	600	600,000
<i>Mitooma Jr</i>	85	66,000	203	- 82,000	203	- 91,000	203	6,500	198	- 30,510	198	- 280,500	198	- 72,160	198	- 51,000	198	84,000	187	-450,670
<i>St. Mary School</i>	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0
<i>CDC Kyamuhunga</i>	-	-	-	-	-	-	-	-	-	-	304	73,100	301	72,400	301	19,700	301	84,400	302	33,940
	228	864,625	212	- 43,500	143	- 362,375	203	6,500	198	- 30,510	50	- 280,500	50	- 72,160	50	- 51,000	50	84,000	1316	149,020

Annex C: Top Diagnosis Report for Igara Tea January through July 2007

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Top Diagnoses

Page 1 of 4

January 2007 thru July 2007

Month/Year	Count	Category	Diagnosis A	Diagnosis B
2007 January	12	Malaria	Simple	Adult
	6	Others	Typhoid	
	2	Admission	Adult	Adult
		Malaria	Simple	Child
		Others	Hypoglycaemia	
			Urinary Tract Infection	UTI
		RTI	Simple	Simple
	1	Others	Gastro enteritis	Gastro enteritis
			Neuropathies	
			Peptic Ulcers Diseases	PUD
2007 February	18	Malaria	Simple	Adult
	4	Others	Amoebiasis	
		RTI	Simple	Simple
	3	Malaria	Simple	Child
	1	Others	Asthmatic	
			CORYZA	CORYZA
			Dental	Abscess Pulpitis
			Helminthiasis	
			Hypoglycaemia	
			Otitis	
2007 March	53	Malaria	Simple	Adult
	12	RTI	Simple	Simple
	11	Others	Amoebiasis	
	10	Others	Urinary Tract Infection	UTI
	7	Others	Typhoid	
	6	Others	Helminthiasis	
	3	Others	CORYZA	CORYZA
	2	Others	Asthmatic	
	1	Others	Backache	
			Crystitis	
		Dental	Pulpitis	
		Gastro enteritis	Gastro enteritis	

Top Diagnoses

January 2007 thru July 2007

Month/Year	Count	Category	Diagnosis A	Diagnosis B
2007 March	1	Others	Hypoglycaemia Myalgia Otitis Pelvic Inflammatory Disease Peptic Ulcers Diseases Pharyngitis Phyconephritis Skin disease	PID PUD Phnyigitis Neuritis Tinea Coprits
2007 April	31	Malaria	Simple	Adult
	11	RTI	Simple	Simple
	4	Others	CORYZA Typhoid	CORYZA
	3	Malaria	Simple	Child
		Others	Helminthiasis Pelvic Inflammatory Disease Urinary Tract Infection	PID UTI
	2	Malaria	in Pregnancy	
		Others	Ganicoccal Infection Hypoglycaemia Lumbago Peptic Ulcers Diseases	PUD
	1	Others	Abortion Allergic Apendecetomy Burns Dental Fungal Infection Ganicoccal Infection HT Orchidechomy Stye Testicular Tumour Urinary Tract Infection	Missed Allergic Burns Abscess Caries Pulpitis Fungal Infection In pregnancy UTI in pregnancy

Combani
1 Xava TEA

Top Diagnoses

January 2007 thru July 2007

Month/Year	Count	Category	Diagnosis A	Diagnosis B
2007 May	17	Malaria	Simple	Adult
	8	Others	Amoebiasis	
	4	Malaria	Simple	General
	3	Others	Eye infection	Conjunctivitis
			Helminthiasis	
	2	Others	Allergic	Allergic
			Peptic Ulcers Diseases	PUD
			Typhoid	
			Pneumonia	Simple
			RTI	Simple
	1	Malaria	in Pregnancy	
		Others	Abscess	
			Asthmatic	
			CORYZA	CORYZA
			Candidiasis	Vaginal
			HT	
			Hypoglycaemia	
			Pyelonephritis	Renal
			Skin disease	Tinea Coprits
			Ulcer	Septic
2007 June	41	Malaria	Simple	General
	10	Others	Amoebiasis	
			Typhoid	
	8	Others	Helminthiasis	
	6	Others	Peptic Ulcers Diseases	PUD
			RTI	Simple
	5	Others	Urinary Tract Infection	UTI
	3	Others	HT	
			Lumbago	
			Myalgia	
	2	Malaria	Simple	Adult
			in Pregnancy	
		Others	Allergic	Allergic
			Asthmatic	

*Comboni
Igarra Tera*

Top Diagnoses

January 2007 thru July 2007

Month/Year	Count	Category	Diagnosis A	Diagnosis B
2007 June	2	Others	Candidiasis	Candidiasis
	1	DM	Pelvic Inflammatory Disease	PID
2007 July	1	Others	DM	DM
			Abortion	Missed
			CORYZA	CORYZA
			Dental	Abscess
			Dysmenorrhoea	Dysmonorrhoea
			Ear infection	Externa
			Eye infection	Otalgia
			Otitis	Otalgia
			Phimosis	Phimosis
			Road Traffic Accident	Soft tussue Innjury
			Skin disease	Endometrisis
				Rash
				Tinea Coprits
			Tensional Headache	Headache
			Tensolits	Tensolits
			Urinary Tract Infection	UTI in pregnancy
				Severe
	Simple			
	Pneumonia	Pneumonia		
	Amoebis			

Comboni
1 Sara

Annex D: A Report on UHC's 10th Anniversary Health Fair and June Dairy Month Celebrations
Held on the 22nd June 2007



at
KIZINDA PLAY GROUNDS, NYABUBARE SUB COUNTY, BUSHENYI DISTRICT
on
22nd JUNE 2007



Authors:

- UHC Staff
- UHC BOD
- UHC CORP

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HealthPartners Uganda Health Cooperative with grate pleasure acknowledges the following Partners and Stakeholders for the financial and technical support given during the preparation of the 10th anniversary health fair and June Dairy month celebrations.

1. USAID
2. Land O' Lakes
3. Uganda Crane Cremaries Cooperative Union
4. UHC BOD
5. UHC CORP
6. UHC Staff
7. Bushenyi Local Government
8. Bushenyi District Police Commander
9. Comboni Hospital
10. Bushenyi Medical Centre – Katungu
11. ICOBI
12. Family Planning Association of Uganda
13. Red Cross
14. Mbarara Regional Blood Bank
15. AIDS Information Centre
16. Kampala International University – Western Campus
17. Igara Tea Factory
18. Health Plan members
19. Ishaka Vocational College
20. Cooper Uganda
21. LC V Chairman Bushenyi District
22. Bwera Women's Dance and Drama Group
23. Little Stars Primary School
24. Health Plan Service Providers

Acronyms

UHC	Uganda Health Cooperative
BOD	Board of Directors
AIC	Aids Information Centre
UCCCU	Uganda Crane Creameries Cooperative Union
BMC	Bushenyi Medical Centre
ICOB	Integrated Community Based Initiative
LC	Local Council
CORP	Community Owned Resource Person
LOL	Land O' Lakes
KIU	Kampala International University
IEC	Information Education Materials
ITNS	Insecticide Treated Nets
ORS	Oral Rehydration Salts
BMI	Body Mass Index
FPAU	Family Planning Association of Uganda
DDHS	Director District Health Services

Executive Summary

In 1997, with a Cooperative Development grant from Land O' Lakes, HealthPartners Uganda Health Cooperative (UHC) introduced prepaid health schemes to members of the community and dairy cooperatives in Bushenyi district. The goal of UHC was to create affordable community health schemes so as to reduce barriers to seeking health care. UHC has been working with the Bushenyi community in partnership with the local health care providers to organize members of groups who pay quarterly premiums to health care providers in order to access health care when they need it.

On 22nd June 2007, UHC in conjunction with her long time partner LOL celebrated its 10th anniversary and the June diary month with a health fair at Kizinda grounds Bushenyi district. The theme of the 10 year celebrations was *"Sustaining a healthy community through partnership since 1997."* The health fair was well attended with over 2,500 participants who included health plan members, diary farmers and processors, health plan providers, school executives, members of the Bushenyi local government, in charges of all health units in Bushenyi district, school children and distinguished guests. The distinguished guests included the state minister of health Hon. Richard Nduhura who was the guest of honor, the Member of Parliament for Igara West, the vice chairman of Bushenyi local government, the District Health Officer (DHO), diary executives and religious leaders. A number of partnering organizations participated in the exhibitions and in the provision of free health services. The organizations included: Kampala International University (KIU) Family Planning Association of Uganda (FPAU), Aids Information Center (AIC), Red Cross, Blood Bank, Quality Chemicals, and Cooper Uganda.

Various free medical services were provided ranging from blood pressure and Body Mass Index (BMI) measurements, HIV counseling and testing, de worming, malaria testing, administration of Vitamin A, to the sale of subsidized items like ITNS, Mama Kits and T-Shirts. Exhibitors demonstrated on the proper use of ITNS, safe birth kits (mama kits), water purification using PUR, milk testing in detection for infections prior to processing and veterinary drugs and supplies.

Entertainment groups presented educative and informative skits, poems, dance and drama, acknowledging the contributions that UHC and Land O'Lakes have made in improving health and household income in the communities. Awards of appreciation in recognition of various people's contribution towards the successful implementation of the UHC program were awarded while Land O' Lakes awarded prizes to best performing farmers. Participants also answered questions about UHC and were awarded prizes for correct answers.

The guest of honor launched the Kyamuhunga Child Development Center (CDC) as a new health plan group. The new members were also given their health plan identity cards by the guest of honor. The UHC director signed a MoU with the director BB clinic with the later becoming the sixth health plan provider.

The day's celebrations were crowned with a dinner at African Village that started at 4:00pm.

ACTIVITIES

Marching Procession

The 10 year health fair and June diary month celebrations began at 9:00am with a march from the UHC offices situated on Kabirisi road, Katungu cell, ward 3 in Rwemirokora. The march was led by Mitooma Junior school band with the LCV Vice Chairman, Mr. Karyaija Benon as the chief walker. The chief walker, UHC's Director and UHC's field Manager in the company of two traffic control policemen led the band through Ishaka town to Kizinda grounds the venue of the health fair.

Participants in the march included: UHC Staff, the members of the UHC BOD Land O' Lakes staff, Ishaka Adventist College students, Little Stars Primary school pupils, Igara and Ruhinda CORP, Members from Igara Tea factory, Students from Ishaka Vocational school, Comboni hospital staff and the general public.

The group marched through Ishaka town to the venue which is situated approximately 2 kilometers out of Ishaka town. Members of the public could be seen peering from their shops at the band procession an.



Participants march through Ishaka town

Arrival of Invited guests

The State Minister for Health who arrived at the venue soon after the marching procession was welcomed by the Project director, field manager and a CORP from Igara country.



Guest of honor arrives

The National Anthem was played by Mitooma Junior Band and opening prayers said by religious leaders present. The guest of honor accompanied by the Project Director and other invited guests later inspected the stalls exhibiting various products and offering a range of services.



National Anthem by Mitooma Band

Exhibition Stall Inspection

The guests moved around inspecting the stalls where free services were obtained and subsidized products availed to the general public. Exhibitors included organizations and Institutions like Family Planning Association of Uganda (FPAU), Uganda Health Cooperative (UHC), AIDS Information Centre (AIC),Kampala International University (KIU), Land O'Lakes (LOL), Quality chemicals, Blood bank, Cooper Uganda, and Bushenyi Medical Centre (BMC) /ICOB.

Activities in the various stalls

Uganda Health Cooperative : This stall was comprised of UHC staff , CORP and BOD members . Information education materials such as brochures, posters, stickers were displayed and also distributed to the

participants. Placards were displayed all round the tent with information about Child Survival interventions, how Health plans operated, and benefits to members. T-shirts, Mama Kits and Insecticide Treated Nets (ITNs) were among the items that were availed to the public at subsidized rates. UHC sold 33 T-Shirts, 2 mama kits and 6 ITNS during this event.

CORP demonstrated how to make water safe for drinking using PUR, preparation of Oral Rehydration Salts, how to hang an Insecticide Treated Net., display of safe birth kit contents. These demonstrations were followed with appropriate explanations on importance, proper use. UHC Staff were available to answer any questions and to provide all the information about the Health Plans, and the child survival interventions.



A CORP demonstrates on the Water Purification using PUR



A CORP demonstrates on Malaria prevention using ITN



Scheme Marketer/ Manager, Tumwiine Charles explains on Health Plan benefits

AIDS Information Centre

AIC offered free HIV counseling and testing services during the event. 101 individuals (34 female, 67 males) tested for HIV, 95 individuals tested negative while 6 tested positive.

Family Planning Association of Uganda (FPAU)

FPAU educated people on the various birth control methods i.e. use of contraceptives, IUD's, condoms, use of the moon beads to determine safe days, injector plan for child spacing etc, checked blood pressure, counseled about the side effects that could result in misuse of contraceptives. FPAU Staff appealed to the men to give support to women during antenatal. Free condoms and IEC materials were distributed to youth.

Kampala International University – Western Campus.

Medical Students from the faculty of Health Sciences participated in the educating of the public on various health related issues. Laboratory tests were done to test for malaria, deworming, checking of blood pressure and Body Mass Index measured. 34 individuals tested for malaria, 141 dewormed (89 infants, 52 adults).

Land O Lakes

Demonstrations on the various stages in milk processing were done using samples of fresh milk.

Comboni Hospital

Representatives from the Hospital had several free clinical services open to public. These included general out patient services, Reproductive health such as antenatal care, HIV counseling and testing, Tetanus Toxoid injections

for pregnant women, Immunization, administering of Vitamin A to the infant, deworming and health education talks on PMTCT. Comboni hospital also offered a standby ambulance to handle any emergencies that occurred and needed referral. 130 individuals tested for HIV, 1 pregnant woman given a tetanus toxoid (TT) injection, 4 children given vitamin A and 15 young and adults dewormed.



Guests inspect Comboni Stall

Mbarara Regional Blood Bank

Activities in this stall included, first aid, blood donation and counseling. 10 received first aid services, 20 donated blood and 30 were counseled. Also results for those individuals who had donated blood much earlier could be got from this stall.

ICOBI and BMC

Health education was given on HIV/AIDS, Reproductive Health and IEC materials such as hand books, brochures distributed. A video show on HIV/AIDS and other health related issues was shown to the public.

SPEECHES

Chairman LC I, Kizinda

- The Kizinda LC1 chairman was represented by chairman LC11 who welcomed the gathering to his area.
- He informed the crowd that they were in the right place at the right time.
- He wished the gathering a peaceful celebration.

UHC Director

- Welcomed and thanked participants for having honored our invitation to join UHC as we celebrated the 10 years of service in Bushenyi district.

- Gave a background on the program since 1997 and that was on call by Land O Lakes to help the dairy farmers seek timely and appropriate medical services at affordable prices such that they could stop selling off their property i.e. cattle..
- She explained how the prepaid health plans operated with the Community already organized groups and service providers, and also mentioned that amongst the benefits of one being a health plan member was that of financial security incase of illness.
- Currently, UHC has 22 health plan groups with approximately 4,000 members who access medical care using the five service provider hospitals. This was made possible with the support from the district local government, political leaders, health workers in the district, partners, the community and various stakeholders.
- Pointing out the major challenge of self sustainability, the director mentioned that UHC has a BOD in place. In her speech, she recognized Board of Directors and Health plan groups, Launched new Health plan group-Kyamuhunga Child Development Centre, signed a Memorandum of Understanding with BB Clinic as a 6th Health service provider.
-



BOD member self introductions

Committee members have been trained to build their capacity to manage the health plans, CORPS had been identified and were being trained on disease prevention and early treatment seeking behaviors. The CORP in turn hold sessions to train their community members on the same. She encourages everybody to attend these sessions.

- Mentioned that UHC was also implementing Child Survival interventions aimed at improving the health of the community especially for the vulnerable groups like children under 5 and pregnant women. She gave highlights on the kind of activities involved in the three intervention areas of Maternal Newborn Care, Diarrhea and Malaria. The director called for teamwork with the stakeholders and partners to enable sustain a healthy community.

- Presentation of awards was done in recognition of the under listed efforts' and contribution towards the program's success
 - a) Ms. Rebecca Joy Batusa Former UHC Director (1997 – 2007)
 - b) Mr. Wilson Baguma First UHC BOD Chairman
 - c) BMC Katungu Dedicated Health plan providers.
 - d) Ishaka Adventist Hospital Dedicated Health plan providers.
 - e) Comboni Hospital Dedicated Health plan providers.
 - f) Nyakasiro Health centre III Dedicated Health plan providers.
 - g) Mitooma Nursing Home Dedicated Health plan providers.
 - h) BB Clinic – Dedicated Health plan providers.
 - i) Igara Tea Factory - Largest Health plan group
 - j) Kigoma Dairy Cooperative – Longest active health plan group
 - k) West Ankole Diocese (WAD) –Best performing health plan group
 - l) Bushenyi Local government - Sustained partnership in healthcare delivery
 - m) DDHS Bushenyi - Sustained partnership in Healthcare delivery



Guest of Honor Launching CDC as a New Health plan group, looking on is the Director and the Field Manager



Guest of Honor witnessing the Signing of MoU between BB Clinic and Chairman Uganda Crane Creameries Cooperative Union/ Land O' Lakes

- The chairman thanked Land O' Lakes, Uganda Health Cooperative and Uganda Crane Creameries Cooperative Union partners-the Swedish Cooperative Centre for tremendous work and financial assistance given to the occurrence of the function. He further thanked the local community members for having turned up in big numbers for the event.
- Mentioned the seven districts of operation, and the total number of farmers that worked with UCCCU as 10,500. He further highlighted UCCCU'S roles achievements, challenges and also gave the company's future plans and its expectations from the government of Uganda.
- Land O Lakes representative gave a history on the Programs activities in collaboration with the dairy cooperatives in Uganda, the existing partnership with UHC and the aim of the June dairy month celebrations. He recognized the dairy cooperative executives who attended the ceremony, and also awarded the best performing farmers with prizes ie metallic milk cans, spraying gadgets for cows..



Land O' Lakes staff gives a speech

District Director of Health services

- The Acting DDHS Bushenyi district and In-charge Kyabugimbi H/C1V delegated Mr.Tumusiime , who welcomed all participants to the UHC 10 year celebration and was grateful to the management and staff of UHC for the fantastic work done in Bushenyi district .
- He acknowledged that UHC is an NGO with credibility that one can reckon with. He added that UHC is the first health insurance scheme that was taking root in the district and that it was an infant that needed their support at all levels so as to help it grow into a vibrant scheme.
- He commended UHC's approach in implementing their activities where by they take on one HSD (Health Sub District) after another in a phased manner saying that this had helped the organization to learn from past mistakes and take the necessary precautions before embarking on the next phase.
- He mentioned that health schemes were recognized mechanisms for health financing world wide and that Uganda was taking positive steps towards this venture. He called upon everybody to mobilize their communities towards this move and reminded people that life is a personal concern and that it is made at home.
- Emphasized that by empowering communities to manage the scheme, sustainability was ensured, and requested UHC to train both the health workers and the Community Owned Resource Persons in its Child Survival program as such strategies would help improve on the district indicators.
- The DDHS acknowledged the cordial working relationship between UHC and the DDHS's office and called upon other organizations to emulate such partnership.

LC V Chairman

- Welcomed participants to the event and thanked UHC and Land O Lakes for having organized such a colorful function.
- Congratulated UHC for at its 10 year anniversary and expressed gratefulness for the good work the program has done for Bushenyi District and the local communities at large in helping better their health through the health plans.

- He urged the community members to enroll in the health plans as this would be cost effective incase one fell sick.

Area MP's Speech

- Congratulated UHC for having marked 10 years in service in the district and commended the program for the good work it was doing for the community.

Guest of honor's Speech

- Welcomed participants at the 10 year celebrations and UHC for having invited him to this event where he has been able to get more information on health cooperatives. He commended UHC for its activities and services it was rendering in the district. The guest of honor called upon people to join Health Cooperatives because health insurance was being recommended by the government.
- He further commented on the advantages of partnership in health where by one had the chance to pay less money in order to get enough treatment compared to when one was not in the health partnership. He cautioned the crowd on the importance of early treatment seeking behaviors.
- Mentioned that Government had put up a program to distribute mosquito nets to children under 5 and pregnant mothers so as to protect them from malaria, and that plans by the government were underway to put in place rules and regulations that would govern Non-Governmental Organizations to enable them work effectively. He thanked HealthPartners for working hard to ensure people's lives were in good conditions.
- The guest of honor thanked Land O'Lakes for having looked for markets of their farmers' products. And mentioned that government was planning to install machines to transform milk into powder so as to reduce on wastage.



Guest of Honor gives his speech

To crown the day's celebrations, all the invited guests were hosted to a dinner courtesy of Land O' Lakes in conjunction with Uganda Crane Creameries Cooperative Union Limited at the African Village Motel in Ishaka town. The diner lasted for about an hour, thereafter the guests departed.

ENTERTAINMENT

Entertainment was by various groups which presented dance, poems, skits and songs on health plans, importance of milk towards an individual's health. The skits praised UHC and Land O Lakes for the good work they both rendered to the communities in Bushenyi district. These entertainment groups included Bwera women Dance and Drama group, Little stars Primary School, Ishaka Vocational school, and Ishaka Adventist College



Students of Little stars primary school presenting a Health plan song



Bwera Women's Health plan members entertaining guests on Health Fair Theme

HEALTH QUIZ

A raffle was among the activities during the celebrations where questions on Health plans and Child Survival Interventions were asked in the local language and for each correct response, an individual won a prize i.e. T-shirts, ITNS, and a mama kit. The questions follow below:-

- a) Health plan neki ? (What is a health plan?)
- b) Gamba ebirungi 3 ebyokuba memba wa health plan. (Give 3 advantages of being a health plan member)
- c) Nooba ota memba wa health plan? (How do you become a health plan member?)
- d) Tugambire ebintu bishatu ahabwaki omukazi ashemereirwe kukyeba enda? (Give us 3 advantages why is it important for a pregnant woman to attend ANC)
- e) Waba oine akatimba kamwe nokaha oha omuri aba? (If you had one ITN, who would you give it to amongst these?)



Participants identified for quiz [Question (e)]



Area MP giving a prize of T-Shirt to a Raffle winner

Participant's Expectations

- People were expecting to be given free T-shirts, Free ITNS, free mama kits and Caps.
- Lunch was expected since the program of the Event was starting in the morning up to evening.

Lessons Learnt and Opportunities

- Local leaders take protocol very seriously so there is need to always observe the acceptable protocol especially when sending out invitations for it can affect the acceptability of our program.
- Involving staff , stakeholders and partners in the planning and preparation of events is very important as it increases acceptability and sense of ownership of activities etc
- Land O' Lakes is open to suggestions on how we can work more closely during our day to day operations and suggested more collaboration in the management of other events like the annual June Dairy month; this would be a great opportunity to promote the health plans.
- The district local government is willing to support the program and would want to be involved more in mobilizing the community to join the pre paid schemes.
- Community members still believe projects are there to give free goods
- Mobilization is expensive in terms of money and time
- Radio is a strong media for mobilization and to pass on information to the community but seems rather expensive.
- High levels of advocacy are still needed
- Teamwork and collective responsibility plays a very big role in production of better results.

Suggestions on how we can improve on the Health plans

- Consider using media both print and Radio more
- Involve Local suppliers in the procurement of things like T-shirts, Jerry cans, Buckets, and Stationery to promote the project's awareness and collaborations.
- Step up mobilization campaign by holding several seminars and workshops on health plan (facilitated by health insurance consultants)
- Move with local leaders to marketing meetings whenever feasible
- Increase on mobilization and sensitization of targeted groups and recruited groups
- Service Providers should be of good quality
- Leaders and Scheme members should be trained on their roles and responsibilities to target sustainability.
- Promotional materials should be taken seriously since they can do publicity.

- ATTACHMENTS

1. Program summary to enable guests write their speeches
2. 10 year celebration Program / Agenda
3. Roles and responsibilities of various staff , BOD members

1-HEALTHPARTNERS UGANDA HEALTH COOPERATIVE (UHC)

Who we are:

HealthPartners Uganda Health Cooperative is a not for profit Non Governmental Organization. It was formed in 1997 by HealthPartners a Minnesota not for profit NGO with a USAID cooperative development sub grant from Land O' Lakes to develop a system of affordable prepaid health care in Uganda. Members of communities were frequently falling ill and would sell their only income generating assets to receive health care. Often these families would wait until illness was life threatening to seek care. HealthPartners formed the Uganda Health Cooperative (UHC) to organize members of groups to pay quarterly premiums to health care providers in order to reduce barriers to care when they need it. UHC began working with dairy cooperatives and in 2002 UHC expanded to offer health schemes to coffee and tea cooperatives, micro-finance groups, burial societies, teachers and students at secondary boarding schools among others.

Presently UHC has approximately 4,000 members and these form the Uganda Health Cooperative that is the only registered health cooperative in Uganda. Members of the cooperative enjoy the following benefits:

1. Timely access to quality health care
2. Financial Security in case of illness
3. Predictable health care costs
4. No selling of property and borrowing of money to cover medical bills
5. Better security and less worry if they or their family members have a catastrophic (very expensive) illness as less money is spent on the illness
6. Long term relationship between them and their providers (health workers)
7. Health education and subsidized health products

The members elected a board of directors whose capacity to manage the schemes is being built. HealthPartners's long term goal is to have the members fully in charge of the schemes so as to ensure sustainability.

Child Survival interventions

In 2005 UHC received a USAID grant with the goal of linking child survival interventions to prepaid health schemes, building on the existing structure to sustainably reduce **morbidity (illness)** and **mortality (death)** for women of reproductive age (WRA) and children under 5

1. Under this grant UHC trains Community Owned Resource Persons (CORP) on disease prevention, early detection and the importance of seeking healthcare early. The CORP in turn hold health education trainings in their communities to educate the community members.
2. Health workers are given refresher training and supervised in collaboration with MoH so as to ensure the quality of health care delivered
3. Women who deliver in health units are given Mama Kits so as to ensure clean births and the babies given free mosquito nets to encourage delivery at health facility.
4. Members of health plans are able to buy nets at subsidized prices

2-PROGRAM FOR UHC HEALTH FAIR AND JUNE DIARY MONTH

Date: 22ND JUNE 2007

Venue: Kizinda Grounds Ishaka

Arrival of Invited Guests at UHC-Ishaka Office
Marching procession through Ishaka Town (from UHC office to Kizinda grounds)
General Inspection of Stalls
Arrival of the Guest of Honour
National Anthem
Prayer
Inspection of stalls by the Guest of Honour and Other Invited Guests/Music interlude
SPEECH: Chairman LC 1, Kizinda
SPEECH: UHC Director <ul style="list-style-type: none"> ▪ <i>Recognition of UHC BOD and Health Plan groups</i> ▪ <i>Launching of new health plan group</i> ▪ <i>Signing of MoU with new provider</i> ▪ <i>Presentation of Awards</i>
SPEECH: BUDICO chairman
A Presentation from Little Stars <ul style="list-style-type: none"> ▪ SPEECH:UCCCU/ Land O' Lakes-Recognitions
SPEECH: District health officer- Bushenyi
Presentations from Promise Kindergarten and Ishaka Vocational Sec. School
SPEECH: LCV Chairman, Bushenyi District
SPEECH: RDC Bushenyi District
Presentation by Bwera Women's Music Dance and Drama
Health Quiz and prizes
SPEECH: Area MP
Presentation from Ishaka Adventist college
SPEECH: Guest of Honour <ul style="list-style-type: none"> ▪ <i>Official Closure by Guest of Honour</i>
DEPARTURE AT LEISURE

3-ROLES AND RESPONSIBILITIES ALLOCATED TO DIFFERENT PEOPLE ON THE HEALTH FAIR.

NO	ACTIVITY	RESPONSIBLE PERSONS
1	Ushering and Refreshments	Gilbert, Edidah, Amelia, & Mr.Buhangwa
2	Transport Coordinators0	Elisa, & Mr.Asaph
3	VIP tent	Charles, & Mr.Buhangwa Adam
4	Stalls' Coordinators	Moses, & Mr.Baguma
5	Decorations	Dorah and Edidah
6	Entertainment	Arthur and Mr.Apolo
7	Transport refund for CORPS	Dorah
8	Identification and Registration of in coming people and Groups	Gilbert and Mr.Banyanga
9	Welcoming guests at UHC office Ishaka in the morning	Lydia and Nyehangane Lucy

4-ROLES AND RESPONSIBLE PERSONS ON UHC STALL

NO	ACTIVITY/STALLS	RESPONSIBLE PERSONS
1	Information desk	Charles, Mr.Banyanga Ara
2	ITN demonstration- Malaria prevention	Amelia, CORP, Ms Nyehangane Lucy
3	PUR demonstration -Diarrhea prevention	Moses, CORP,
4	Mama kit demonstration- Maternal and Newborn Care	Edidah, Apollo, CORP
5	ORS demonstration-Diahorea prevention	Dorah, CORP, Asaph

Annex E: Igara County CORP Refresher Training on Community Integrated
Management of Childhood Illnesses

**IGARA COUNTY CORP REFRESHER TRAINING ON
COMMUNITY INTEGRATED MANAGEMENT OF
CHILDHOOD ILLNESSES**

**CONDUCTED AT
HOT SPRINGS GUEST HOUSE
ISHAKA - BUSHENYI DISTRICT**

FROM 29TH - 31ST MAY 2007.

Report By:

**Musiimire Dorah
Community Education Coordinator,
HealthPartners
Uganda Health Cooperative**

1.2. Acknowledgement:

HealthPartners Uganda Health Cooperative acknowledges USAID for fully funding this three days training. Also gratitude goes to the Director and the entire management of UHC for all their input that made this training a reality.

In addition, the District Health Educator Bushenyi district, Mr. Charles Babikunyamu is commended for his great contribution as a trainer along with the Field manager, the Health Services Trainer and Community Education Coordinator UHC as co- facilitators. Credit also goes to the ever committed Igara County CORPs for their active participation and attendance during the training, forsaking their tasks back home.

The Bushenyi local Government partnership and support can not be over looked as it was a great contribution to spur on the morale. Not least, the Hot Springs Hoteliers who hosted the training deserve applause.

1.3. Summary

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

1.4. Introduction

HealthPartners Uganda Health Cooperative organized and carried out refresher training for 23 Igara County CORPs in Community Integrated Management of Childhood Illnesses (C-IMCI). The training took place from 29th May -31st May 2007 at Hot Springs Guest House Ishaka-Bushenyi district.

This training was funded by USAID. The facilitators were 4 in total, 3 from UHC and one from Bushenyi district Health department. The Field manager UHC Mr. Tibaingana Moses gave opening remarks while the Secretary Social Services, Bushenyi District, Mr. Akambikira officiated at the closure of the training.

The trained Community Owned Recourse Persons (CORPS) are the Community Educators who promote key healthy practices through community mobilization.

1.4.1. Training Objectives

- The main objective of this workshop was to create an opportunity for CORPs to share experiences about community mobilization for positive behavior change.
- To remind CORPs of the key messages about healthy family care and household practices to communicate in their communities.

1.4.2. Participants' expectations:

Participants had the following expectations:

- To get more and new information on C-IMCI
- To be reminded of what was previously learnt
- To assess achievements, failures, weaknesses and challenges experienced in community education.
- To share field experiences.
- To get money as a token of appreciation for voluntary work done by CORPs.
- To consider giving CORPs means of transport during community education.
- To know the out come of CORP feedbacks that are submitted to UHC
- To know whether we (CORPs) are still working with UHC.
- To meet Ruhinda CORPs.

1.4.3. 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 speak one at a time.
- (e) Keep all mobile phones off or in silent mode

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

- **Chair Person** : **Muteguya Archangelo**
- **Time keeper** : **Muhumuza Laban**
- **Welfare Secretary** : **Mujuni Justine**

1.4.4. Methodology

The following methods were employed during the training:

- Discussions & presentations in groups. These were greatly used to get feedback largely from the CORPs.
- Brain storming was used to find out what participants still recollected about C-IMCI.
- Mock presentations and collective critique by all participants
- Charts were also used to help participants grasp the C-IMCI concept better.
- Testimonies where CORPs shared their different experiences in the community, achievements, challenges and how they handled them.
- Take home assignments were also used in this training.
- Energizers were employed to keep the participants awake and active.
- Tailor-made lectures were also used few times to help CORPs catch up in some areas of C-IMCI that were not well understood.
- Pre & post test, daily and end of workshop evaluations were also applied.



A facilitator takes participants through a session.

2. Course Content

Following the objectives of the training as already high lighted above, this content was developed to cover all the key messages for community mobilization. These were mainly customized guides & questions tackled in plenary discussions by the CORPs.

Malaria

- a) What causes malaria fever?
- b) How does malaria fever spread from one person to another?
- c) How can one tell that a child has malaria fever (simple and severe malaria)?
- d) How is malaria treated in your area?
- e) In which of the above activities were involved?
- f) Which people are involved in treating and managing malaria cases in your area?
- g) What problems have you identified in treatment and management of malaria cases?
- h) What is being done to reduce malaria fever in your area?
- i) What physical features lead to malaria transmission in your area?
- j) What activities have you been involved in to prevent malaria in your area?
- k) What problems have you observed/met in malaria prevention
- l) What suggestions do you have to improve malaria prevention in our area?

Health Plan:

- a) What is Health Plan?
- b) How does Health Plan operate?
- c) Who should join Health Plan?
- d) What is the difference between HealthPartners and Health Plan?
- e) What is the use of Health Plan?
- f) What does one pay to join Health Plan?
- g) How long has Health Plan been in Bushenyi?
- h) What is the difference between Health Plan & Family Planning?
- i) Where are the offices of HealthPartners and who is responsible for them?

Diarrhea, Water & Sanitation

- a) What is diarrhea and what causes it?
- b) What brings about diarrhea in our homes?
- c) What should one do to a child experiencing diarrhea?

- d) How should a mother / caretaker prepare ORS? (*Demonstration*).
- e) How is PUR used to purify water for drinking? (*Demonstration*).
- f) What advice should a CORP give to a community to prevent diarrhea?
- g) How have you as CORPs been involved in diarrhea prevention activities in your areas?

HIV/AIDS

- a) What is HIV and AIDS?
- b) How is it transmitted?
- c) How can one prevent him/herself from catching HIV/AIDS?
- d) What is VCT, RCT and PMTCT; why are they important?
- e) What should an HIV positive person do to live longer?
- f) What HIV/AIDS service providers do you know in your area?

Maternal and New Born Care

- a) What are some of the danger signs that show that a pregnant woman should see a trained health worker?
- b) What is ANC and why should pregnant women attend it?
- c) What should a CORP advise an expectant mother to prepare for birth?
- d) What advice should a CORP give an expectant mother about exclusive breastfeeding, and complementary feeding when the baby is six months?
- e) Why should children be immunized and how many diseases are immunisable in Uganda so far?
- f) How can one verify/be sure or tell that a child has been immunized?

Roles at different levels in implementing house hold and C-IMCI

- a) What are the roles and responsibilities of a CORP in his/her community? (*discussion aimed at finding out how CORPs do mobilization, education, counseling, & coordination/links*)
- b) How can a CORP encourage male participation in child care and reproductive health activities?
- c) Can you identify other people (stakeholders) that are involved in improving the health of your community
- d) As a CORP how have you worked with these people?



CORP presenting group work.

Health Fair

- a) The aim/ objective.
- b) Activities involved
- c) The role of CORPs in the event

CORPs promised to participate in different activities of the health fair such as being available to answer questions at the stalls, marching, arranging the venue, ushering, serving refreshments...

Community Education Evaluation

- a) What topics/ key messages have you taught/ passed on in your area?
- b) Which groups have you been reaching with community education in your area?
- c) How did you involve local leaders in community mobilization in your area?
- d) What challenges did you face as CORP?
- e) How did you overcome these challenges to improve community sensitization in your area?
- f) What can you as CORP do to sustain community education in your community?
- g) What were the commonly asked questions in community education sessions by participants?

There was a great deal of rich responses from the CORP many of which were already captured in the community education monthly feedbacks. Nonetheless, some responses were noted.

Topics/ key messages in Community Education

All key intervention areas were covered i.e. malaria, diarrhea, water, sanitation, MNC, HIV/ AIDS.

Groups reached

- ♣ Mothers at immunization sessions
- ♣ Expectant mothers at ANC clinics
- ♣ Congregations at churches
- ♣ Attendees at funerals
- ♣ Authorities at Local Council meetings.
- ♣ People in trading centers and villages

Local Leaders' Involvement

- ♣ CORP share with them work plans
- ♣ Local leaders call/ mobilize community education meetings, because their subjects trust and know them.
- ♣ Local Leaders participate in enforcing certain interventions such as apprehending people who don't have toilet facilities.
- ♣ Local leaders champion CORP's programs and people easily take their example, for instance adapting to a new healthy practice.

Challenges

- ♣ Limited transport means to reach remote areas.
- ♣ Attendees refuse to sign in on attendance lists.
- ♣ There are low turn ups in village meetings and for men as well.
- ♣ There is poor time management for sessions.
- ♣ People demand for free health products such as ITNs.
- ♣ Some local leaders and politicians do not support CORP activities.

CORPs' Initiatives to Overcome the Challenges

- ♣ Self sacrifice. For instance moving on foot to far areas.

- ♣ Through personal tactics/ initiative e.g. developing a good relationship with local leaders and involving them in mobilization where the leaders gain popularity.
- ♣ Use of local teaching aides
- ♣ Refer people to health workers if they ask difficult questions which CORP can not answer or promise to ask other knowledgeable people and return with answers.

Frequently Asked Questions in Community Education Sessions

- ♣ Why does UHC not give us (adults) free ITNs?
- ♣ Why are there few drugs in our health units?
- ♣ Why shouldn't government build health units nearer to the people?
- ♣ Why don't individuals also enroll in Health Plans?
- ♣ Where can we buy PUR or ITNs in our villages?

Discussion on CORP Sales Plan

This was the out come of the discussion about the CORP sales plan. Some CORPs thought the plan is difficult and can not work, however others thought it can work if certain things are put in place.

- Transparency: UHC should first ensure that the program is introduced to the district authorities such as the chief administrative officer (CAO), LC5 Chairman, copied to LC3, LC2 Chairpersons; and give CORPs introductory letters.
- If a receipt book is given to CORP to receipt every sale
- If local leaders are told about the plan so that people do not think CORPs are selling them products which are intended to be given for free.
- To clarify which products are for free and for sale and to which categories of the population.
- Small quantities of the products should be given to CORP to reduce insecurity of theft.
- That UHC could learn from PSI-Uganda which has such a program and it is working, and some CORPs are participating in it.



CORPs show contents of a mama kit

2.2 Daily Evaluation Results

These are the results from the daily evaluation done by all participants.

These were the most useful topics/sessions to the participants.

- ◆ Learning about Health Plans
- ◆ Learning that childhood immunisable diseases in Uganda are not six any more but have been increased to eight.
- ◆ Getting knowledge about the immunizing schedule and sites on children. Hence better informed to educate our communities,
- ◆ All topics were useful to the participants.
- ◆ Having good facilitators
- ◆ Having good meals was also important.
- ◆ The prevention of diseases caused by poor sanitation
- ◆ The provision of learning aids such as charts, notebooks, and pens.
- ◆ Teaching methods of group discussions were also beneficial to the participants.

On the other hand, participants encountered some difficulties while in this training, and according to them, these were the most difficult sessions/ topics.

- ◆ Some CORPS did not understand some issues about Health Plans, immunization schedule, and some thought the hotel facilities and management was not good enough.

Consequently, participants suggested ways how these difficulties could be overcome.

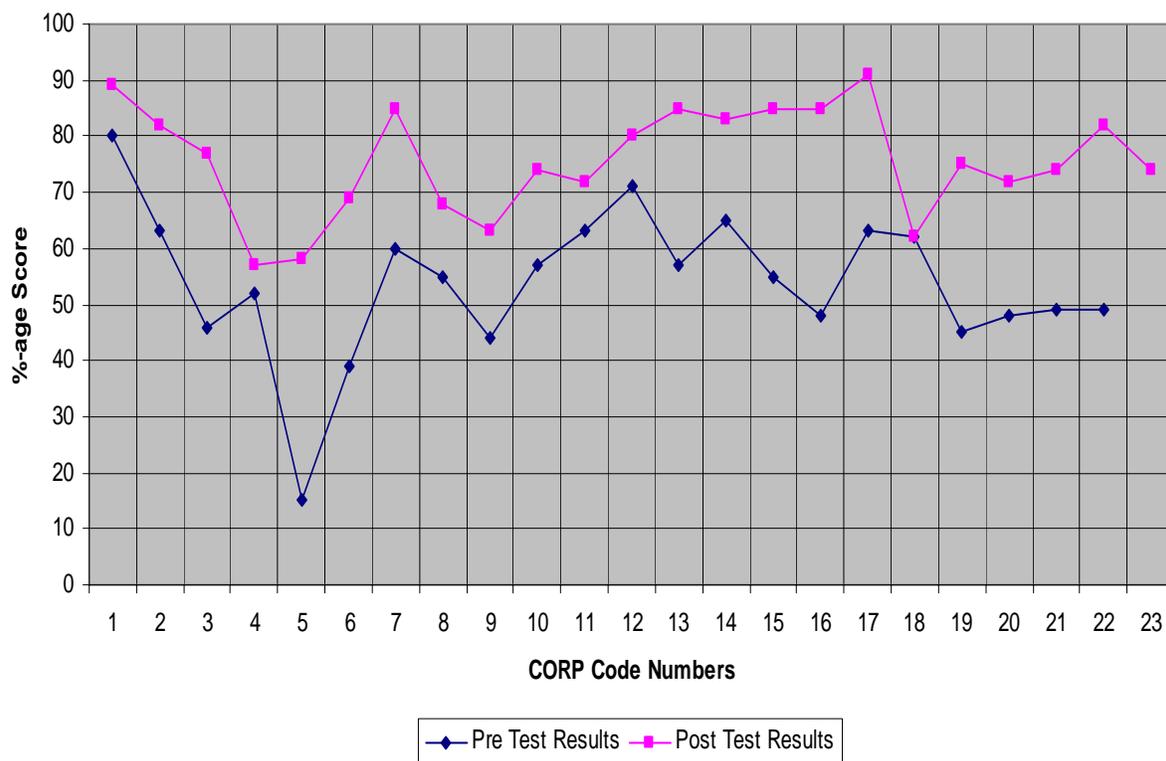
- ◆ They thought that more time is needed to learn about Health Plans,
- ◆ They also suggested that workshop organizers should consider using another training venue.
- ◆ Participants shared the idea that they needed facilitation in form of gumboots, umbrellas and t-shirts while in the field.
- ◆ They also expressed the need to have such refresher trainings regularly.
- ◆ CORPs also suggested that they would like to be given bicycles to facilitate them to mobilize communities.
- ◆ More so, CORPs thought regular revision of notes and chart booklets is good to remind CORPS of key messages.
- ◆ Not least, CORPs were of the view that Health Plans should consider admitting individuals as members also instead of only groups.



CORPs get ready for an energizer exercise.

Pre & Post Test Results

Graph showing Pre & Post Test Results for CORPs



2.3 Lessons Learnt:

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

- Healthy family care & house hold practices can help prevent a big %-age of diseases that people suffer from in communities.
- Male participation is key improving the health of house hold members.
- Poor feeding leads to malnutrition.
- It is very important to give more food and fluids to a sick child because it rejuvenates its energy.
- That voluntary work is not useless and time wasting but beneficial to the community and to the CORP as an individual.
- Refresher trainings are very important for sustaining community mobilization.

2.4 End of Workshop Evaluation Results

This was the %-age rating of the items by participants.

No	Item	Very Good	Good	Fair	Poor	No Response	Total (%) Responses
----	------	-----------	------	------	------	-------------	---------------------

1	Topics	87	13	Nil	Nil	Nil	100
2	Teaching materials	61	26	9	Nil	4	100
3	Teaching methods	74	4	9	Nil	13	100
4	Participatory training	30	66	Nil	Nil	4	100
5	Time management	30	26	27	13	4	100
6	Workshop administration	40	47	9	Nil	4	100
7	Venue	4	13	83	Nil	Nil	100
8	Meals	Nil	22	61	13	4	100
9	Accommodation	17	30	49	Nil	4	100

Comments & suggestions by Participants:

- ◆ All CORPs concluded that the workshop was beneficial to them and to the program; however, they recommended that another venue should be used next time.

2.4 Achievements

- ❖ All 23 CORPs attended and completed the training successfully.
- ❖ Course content planned was fully covered.
- ❖ CORPs were given bicycles to help them in conducting education sessions.



CORP listen attentively to trainer.

- ❖ There was team work between UHC and the district facilitator
- ❖ There was district local government political support where the LC5 chairman authorized a delegate to officiate at the closure of the training.



Guest of Honor officiating at closure

2.5 Constraints

There were very few constraints in this training. The major constraint was that participants were constantly complaining about the hotel management. CORPs also kept on asking for teaching materials.

2.6 Way Forward

- CORPs to be given introductory letters by UHC and to introduce the CORPs to local authorities as well.
- CORPs to work together with local councils to develop their education programs.
- UHC to follow up CORPS- to collect work plans at designated areas, preferably health units.
- CORPs to use bicycles to reach distant areas with community education.



Guest of Honor hands over bicycles to CORPs at UHC offices.

APPENDIX

Opening remarks by Field Manager UHC, Mr. Tibaingana Moses

- He thanked CORPs for honoring the invitation to attend the refresher training
- He also thanked them for their commitment to doing community education.
- He hailed them for looking healthy and he hoped that they were practicing what they educate in communities.
- He wished them a good time during the training.

Closing remarks by one of the trainers, Mr. Charles Babikunyamu, District Health Educator, Bushenyi.

- He gave a high light of what transpired during the training and was convinced that the objectives of the training were achieved.
- He was positive that CORPs would help improve the health of communities in the district.
- In addition, he thanked the CORPs for their commitment and participation in the workshop.
- He also applauded UHC for taking on a great task of implementing C-IMCI which the district can not afford at the moment.
- He thanked the Guest of Honor as well for honoring the invitation to officiate at the closure of the workshop.
- The trainer encouraged CORPs to implement what they had learnt in the three days workshop.

Closing remarks by Field Manager UHC, Mr. Tibaingana Moses

- He thanked CORPs for their dedication and hard work in the community. He commended UHC for creating a “family” of CORPs where CORPs had an opportunity to interact and learn from each other.
- He hoped that refresher trainings would be regularly organised for UHC to keep afoot with CORPs’ activities.
- He highlighted about the health fair and invited CORPs to participate in the function.

Closing remarks by the Guest of Honor, Mr. Akambikira, Secretary for Social Services, Bushenyi Local Government.

- He began by passing on the apologies of the LC 5 Chairman who could not make it and delegated him instead.
- He also hailed CORP for forsaking their families and other businesses to attend the training.
- More still, he appreciated UHC for coming in to help the district where it is most needy.
- He wondered whether UHC was going to roll out to other areas because its programs are very relevant to all people of Bushenyi.
- He also commended the bicycle incentive as a good motivation to CORPs.
- Not least, he called up on CORPs to implement what they had learnt in the training.

The Guest of honor officially closed the workshop and thereafter handed over the bicycles to the CORPs.

A. 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

Males = 14

Females = 9

Total = 23

B. TIME TABLE

TIME & DATE	TOPIC	RESPONSIBLE PERSON
<i>DAY 1 29/05/07</i>		
8:00 –9:30 am	Arrival & Registration	UHC
9:30 – 10:30am	Welcome remarks. Introduction, participants' expectations, workshop objectives, norms, leaders.	UHC
10:30- 11:00am	Break tea	All
10:30am - 1:00 pm	<i>Pre Test</i> Introduction to prepaid health insurance schemes	Facilitators
1:30 – 2:00pm	Lunch Break	All
2pm – 5:30pm	Malaria: cause, prevention, warning signs, home management. Use, maintenance, benefits of ITNs <i>(Group discussion on lessons learnt from the community)</i>	
5:30 – 5:30pm	Daily Evaluation. ▪ <i>Group assignment on reports on community mobilization</i>	All
5:30 - 5:45pm	Evening tea. Facilitators meeting.	All , facilitators
<i>DAY 2 30/05/07</i>		
8:00-10:30am	- <i>Group presentations on assignment</i> Maternal & New born care. ANC, TT, IPT, danger signs during pregnancy, birth plan.	Facilitators
10:30am- 11:00am	Break Tea	All
11:00am- 1:30pm	- Exclusive breastfeeding for the first six months and complementary feeding at six months, Complete a full course of immunization <i>open discussions about experiences in the community</i>	Facilitators
1:30pm – 2pm	Break	All
2pm –5pm	-Diarrhea prevention, danger signs, safe drinking water, safe disposal of feces, hand washing. <i>Demonstration of PUR & ORS.</i>	Facilitators
5pm- 5: 15pm	Evaluation ▪ <i>Health fair preparations- the CORP's role</i>	All

5:15pm- 5:50pm	Evening tea. Facilitators meeting	All. Facilitators
DAY 3 31/05/07		
8:00- 9:00am	HIV/AIDS; Transmission, VCT, PMTCT	All
9:00-10:30am	- -Encourage male participation in child care and reproductive health -Roles at different levels in implementing house hold & community IMCI -Brief on Bikes -Discussion on CORP sales Plan	All Facilitators
10:30-11:00am	Break tea	All
11:00-12:00pm	Way forward: sustaining Community mobilization-open discussion	Facilitators.
12:00-2:00 pm	Closure and lunch	Guest of honor. All

C. LIST OF FACILITATORS

- i. Babikunyamu Charles : Bushenyi District Health Services Department
- ii. Musiimire Dorah : Community Education Coordinator UHC
- iii. Tibaingana Moses : Field Manager UHC
- iv. Karungi Grace : Health Services trainer UHC

D. DAILY EVALUATION FORM

1. What was the most useful topic/ session for you today?

.....
.....

2. What was the most difficult topic/ session for you today?

.....
.....

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

.....
.....

3. What suggestions do you have for tomorrow?

.....

E. END OF WORKSHOP EVALUATION FORM

Rate the following items by ticking in the box.

No	Item	Very Good	Good	Fair	Poor	Comments
1	Topics					
2	Teaching materials					
3	Teaching methods					
4	Participatory training					
5	Time management					
6	Workshop administration					
7	Venue					
8	Meals					
9	Accommodation					



PRE/ POST TEST FOR REFRESHER TRAINING ON C-IMCI FOR IGARA COUNTY CORP

1. List 3 roles of the CORP in the community?

.....

2. List 5 danger signs of Malaria?

.....

3. How is malaria passed from one person to another?

.....
.....
.....
.....

4. How can a person prevent him/ herself from getting malaria?

.....
.....
.....
.....

5. List atleast 6 danger signs to show that a child is sick.

.....
.....
.....
.....

6. What should the caretakers/ parents do to a sick child?

.....
.....
.....
.....

7. Give 3 causes diarrhea in our homes especially among children under five?

.....
.....
.....
.....

8. Mention 4 times when mothers should wash their hands with water and soap?

.....
.....
.....
.....

9. As a CORP give 4 ways how diarrhea can be prevented in our communities?

.....
.....
.....
.....

10. How do you prepare ORS? (*circle the correct response*)

- a) Mix 1 Sachet of ORS in 2 Litres of water
- b) Mix I Sachet of ORS in I Litre of Hot Water
- c) Mix I Sachet of ORS in 1 Litre of Clean drinking water
- d) Mix I Sachet of ORS in 1 Litre of water

11. List 4 ways how a person can get HIV/AIDS?

.....
.....

.....
.....
.....

12. List 3 ways how you can prevent the spread of HIV/AIDS

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.....
.....
.....

13. What should a Person Living With HIV/AIDS do to live longer?

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.....
.....

14. List 3 good things about Breast Milk.

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.....
.....
.....

15. A mother should give other foods apart from breast milk when the baby is: *(circle the correct response)*

- a) 4 Months
- b) 8 Months
- c) 6 Months
- d) At birth

16. How many minimum times should a pregnant mother attend Antenatal clinics?

.....
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.....
.....

17. List 4 of any of the birth kit elements that should be used by mothers during delivery?

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18. List any five killer diseases among children which can be prevented by immunization.

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19. What is Health plan?

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20. Who can join Health Plan?

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.....
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21. List 5 benefits of joining UHC health Plan?

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END

Draft report for End of phase 2 - Ruhinda County Knowledge Practices and Coverage Survey

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

September 2007

Uganda Health Cooperative in Partnership With, Bushenyi District Local Government And Uganda Bureau Of Statistics.

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ABBREVIATIONS AND ACRONYMS

AMTSL	Active Management of Third Stage Labor
CORPS	Community Owned Resource Persons
IMCI	Integrated Management of Childhood Illness
DHO	District of Health Officer
HFA	Health Facility Assessment
HIV	Human Immunodeficiency Virus
IPT	Intermittent Preventive Treatment
IMR	Infant Mortality Rate
ITN	Insecticide Treated Nets (Long Lasting)
KPC	Knowledge, Practice and Coverage Survey
LQAS	Lot Quality Assurance Sampling
MMR	Maternal Mortality Rate
MNC	Maternal Newborn Care
MOH	Ministry of Health
NGO	Non-government Organization
ORS	Oral Rehydration Solution
RCT	Routine Counseling and Testing (Updated from VCT)
SCM	Standard Care Management
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
UHC	Uganda Health Cooperative
WRA	Women of Reproductive Age
UDHS	Uganda Demographic and Health Survey
HCI	Health Center Two
HCII	Health Center Three
HCIV	Health Center four
SRH	Sexual and Reproductive Health
PEAP	Poverty Eradication Action Plan
CYPs	Contraceptive Years of Protection
HW	Health Workers
HMO	Health Management Organization
USAID	United States Agency for International Development
ANC	Ante Natal Care
PMTCT	Prevention of Mother to Child Transmission
IEC	Information Education and Communication
BOD	Board of Directors
CAO	Chief Administrative Officer
LCI	Local Council Chairman I

BACKGROUND

A- Project Location and background of the area

Uganda Health Cooperative (UHC) has been working in Uganda since 1997. The project is located in Bushenyi District in the South Western part of Uganda about 400km from the country's capital Kampala. The project has its head office in Kampala with a field office in Bushenyi.

Bushenyi district has five counties; Buhweju, Ruhinda, Sheema, Bunyaruguru and Igara. These are further divided into several sub-counties and parishes up to LC 1 (villages) levels. The population of the district according to counties is summed up in the table below.

Table: District Population According to Counties

COUNTY	POPULATION
Buhweju	80,489
Bunyaruguru	102,757
Igara	207,396
Ruhinda	157,720
Sheema	172,827
Total	721,189

Source: 2002 Uganda Population and housing census

B-Characteristics of the Target Beneficiary Population

According to the 2002 population and housing census, the population of Bushenyi district is 731,392 persons with a growth rate of 2% per annum. Females make up 51% of the population in the district. Bushenyi's population is overwhelmingly rural with only 5% of the district total population classified as urban.

Bushenyi district has a very young population. Children below 5 years constitute about 20% of the total district population. The population for children 0-1 is 32,646, 12-23 months is 31,317 and children 24-49 months is 93,951. This situation is no doubt a result of high fertility experienced in the district. The projected fertility rate of women in Bushenyi is put at 7 children.

Under the Child Survival and Health Grant Program, UHC is planning to directly reach at least 50,000 women and infants in Bushenyi District – South Western Uganda where the overall, likelihood of dying in infancy is greatest as well the high prevalence rates of diarrhea and malaria with 26.9% and 30.6% of infants having fever and diarrhea respectively in the last two weeks, and use of ITNs at a dismally low 7% (UBOS 2006).

C- Socio-economic indices

According to the Demographic Household and Health Survey (UDHS) of 2006, South Western Uganda has a literacy rate of 67.6% (UBOS 2006). The higher literacy rate is due to improvements in enrolments and the functional adult literacy program. The Universal Primary Education program also had its impact on the literacy rates country wide.

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

The main economic activity in the district is agriculture, accounting for over 90% of all economic activity in the district. The district draws most of its income from agricultural produce which is sold outside the

district, particularly the capital city Kampala. Much of this agricultural production is by small scale farmers who generally do not have access to credit. Consequently, it has proved difficult for them to break out of the vicious cycle of poverty.

At current mortality levels, one in every 13 Ugandan children dies before reaching age one, while one in every seven does not survive to the fifth birthday. Infant mortality declined from 89 deaths per 1,000 live births in the 2000-2001 UDHS to 75 in the 2006 UDHS while Under- five mortality declined from 158 deaths per 1,000 live births to 137.

The 2006 UDHS measured a maternal mortality ratio (MMR) of 435 maternal deaths per 100,000 live births with a variation from 345 to 524. These high rates are as a result of severe malaria, pneumonia, anemia, diarrhea and poor handling of mothers before and after delivery and poor feeding/ sanitation practices for the new born.

Whereas the Ministry of Health (MOH) has ensured that there are health facilities up to parish level (HC II), the baseline Health Facility Assessment (HFA) revealed that most of these health facilities were not adequately equipped, stocked with essential medicines or adequately staffed. Besides, the terrain of the area also acts as an impediment to easy access to these health facilities.

D -National Standards/Policies Regarding Maternal and Child Health

The national policy classifies maternal and child health under one cluster (cluster 2 –maternal and child health). This classification emphasizes the link between maternal and child health mortality and the cumulative nature of health problems through the entire lifecycle. The cluster consists of five elements: Sexual and Reproductive Health (SRH), Newborn care, Common childhood illnesses, Immunization and Nutrition.

The cluster comprises of the following maternal and newborn health services: preconception care; ANC; post abortion care; intra-partum care; emergency obstetric care; care of the new born and post natal care (MoH Uganda 2005).

The main objective under this cluster is to contribute towards the achievement of a level of reduction in maternal, neonatal and young child mortality that is commensurate with the timely achievement of the PEAP targets and related Millennium Development Goals.

Sexual Reproductive Health Rights

Specific MoH targets for this element include: Increase the proportion of deliveries by skilled attendants from 38 to 50%; Reduce the unmet need for emergency obstetric care from 86% to 40%, Increase the ANC attendance, 4 visits per pregnancy from 42 to 50%, Increase the Contraceptive Prevalence Rate from 23% to 40% (increase CYPs from 223,686 per annum to 500,000 per annum), Reduce the percentage of teenage pregnancy rates from 37 to 20% (MoH Uganda 2005).

Newborn Health and Survival.

Under this element the MoH targets to reduce the proportion of children with low birth weight by 30% and to reduce the proportion of neonates seen in health facilities with septicemia/severe disease by 30%. Core interventions include : Provision of essential care during pregnancy including Tetanus toxoid immunization, proper nutrition including iron/folate supplements and prevention and treatment of maternal infections such as malaria, STDs, Infection control during & after delivery including the distribution of Maama Kits, Provision of essential care during the postnatal period including promotion of immediate and exclusive breast-feeding, thermal control, clean cord practices and Vitamin A supplementation among others (MoH Uganda 2005).

Management of Common Childhood Illness

Integrated Management of Childhood Illness (IMCI) is a key strategy for delivery of integrated child health services through improvement of health worker skills in regard to integrated assessment and management of malaria, acute respiratory infections, diarrhoea, and malnutrition, which contribute to over 70% of overall child mortality. The strategy also focuses on improving health system issues that affect care for children in health facilities as well as working to improve key family care practices that have the highest potential for child survival, growth and development

Core interventions for common childhood illnesses include improvement of HW skills in managing childhood illness using IMCI guidelines, Community treatment of fever/malaria, diarrhea and pneumonia.; Family Care Practices message dissemination (care seeking, disease prevention, home treatment and compliance); Integrated sustained outreach services and bi annual Child Days and Provision of comprehensive management of pediatric HIV and support (MoH Uganda 2005).

E-Overview of the UHC Child Survival Project:

Formed in 1997 by HealthPartners, a Minnesota not for profit HMO, under USAID's Cooperative Development Program with a sub-grant from Land O'Lakes, the Uganda Health Cooperative (UHC) has been implementing an innovative prepaid health scheme program in Bushenyi in south western Uganda. Through the schemes it was discovered that the major causes of morbidity and mortality in the Bushenyi community were preventable diseases.

In September 2005, HealthPartners Uganda Health Cooperative was awarded a USAID Child Survival Health Program Grant. With the goal of linking child survival interventions to its prepaid health plans, building on the existing structure to sustainably reduce morbidity and mortality for Women in Reproductive Age (WRA) and children under 5 in Bushenyi district. To achieve the above objective, UHC adopted the child survival sustainability assessment strategy with slight variations on the three dimensions: community/social, health services, and local organizational dimension as the primary model for the program

Community and Social Dimension

UHC has three objectives under this dimension: 1- To reduce incidence of malaria in children under 5 and pregnant women in the district; 2- to reduce the incidence of diarrhea in children under 5 in the district and 3- to increase the percentage of pregnant women receiving improved antenatal care (ANC), delivery and post partum care.

Under the community social dimension, UHC implements various interventions to improve the health status of the population by mobilizing communities on behaviors that have been proven to reduce morbidity and mortality and removing barriers to these behaviors. Community Owned Resource Persons (CORP) are trained to educate communities on maternal and new born care, prevention, identification and early health care seeking behavior.

UHC also distributes free long lasting ITNs to newborns born at health facilities; ITNs to pregnant mothers at second IPT and mama kits at the 4th ANC visit. These interventions are aimed at encouraging mothers to seek ANC and delivery services at the health facilities in the district. Children who are under five years and are members of the health plans are also given free ITNs.

Health Services Dimension

The main objective under this dimension is to build capacity of providers to offer Integrated Management of Childhood diseases (IMCI) and Standard care management (SCM) so as to ensure quality service delivery and reduction of childhood and maternal morbidity and mortality. The health workers are trained using Ministry of Health (MoH) guidelines and protocols. All the training is done in collaboration with staff from the MoH, Bushenyi District Directorate of Health Services and other partner organizations. Information Education and Communication materials (IEC) and guidelines/protocols are reproduced/reprinted and given to CORPs and HWs as teaching aides and reference materials respectively.

Under this dimension, UHC also aims at demonstrating to providers the ability of prepaid health plans to address social health insurance for adoption by the MoH to cover the poorest populations. Groups in Bushenyi district are identified and mobilized to contribute premiums which are given to providers before hand so as to enable them access health care when they need it.

Local Organizational Dimension

Under this dimension, UHC has the following objectives: 1-to build knowledge and capacity of UHC board to enable them to competently run UHC, 2- to strengthen trust and ties between providers and community groups to enable best practices and continued coverage for members, 3- to build incentive for membership, leadership and provider participation, 4 – to build capacity of UHC team, stakeholders and partners.

In a bid to achieve the above objectives, UHC elected a board of directors (BOD) who are members of UHC health plans. This board is trained and involved in UHC's activities so as to ensure sustainability of the interventions. Also

in line with the sustainability goal is the need for scheme growth which is ensured through marketing to active informal groups in the district. Such groups include: dairy cooperatives, coffee and tea cooperatives, micro-finance groups, burial societies, teachers and students at secondary boarding schools etc.

Model of implementation

The implementation of the above interventions is phased by County in order to capitalize on opportunities to improve implementation of the program with the maximum amount of feedback from staff, stakeholders, partners, consultants and the management team. Before beginning the interventions in the district, a Health Facility Assessment (HFA) and baseline Knowledge Practise and Coverage (KPC) survey using the LQAS methodology were carried out and baseline values obtained by County for the various indicators monitored. Interventions in Igara (phase 1) started in August 2006 and ended with an end of phase evaluation in January 2007.

Implementation of activities in Ruhinda County (phase 2) started in April 2007 for six months and will end with an end of phase evaluation in the seventh month i.e. October 2007.

Objectives of the evaluation:

General objective

To assess progress in health status and health service delivery in Ruhinda County in comparison to baseline survey results of January 2006. Results from this assessment will be used to improve interventions and training tools so as to bridge gaps in results and to achieve the set objectives for Ruhinda and to update CS curricula and training tools in order to better achieve program goals in the remaining Counties.

Specific objectives

5. To assess the incidence of malaria in pregnant woman and children under five and progress towards the end of project target.
6. To assess the incidence of diarrhea for children under five and progress towards the end of project target
7. To find out the percentage of pregnant women receiving improved Ante Natal, delivery and post partum care.
8. To determine the percentage of population who know about Health plan and those who are members.

Process and Partnership Building

The End of Phase 2 LQAS evaluation for Ruhinda County will involve different stakeholders and partners. The DHO contributed to the drafting of the proposal for the survey, the selection of volunteers for data collection, consultation on reporting of results, and dissemination and use of the results.

The District Health office provided a car and driver for data collection while the local council's chairmen (LCs) with permission from the Chief Administrative Officer of Bushenyi Medical Center assisted in the selection of households for the study. The interviews were carried out by UHC staff together with volunteers from Bushenyi district in line with the objective of building local capacity to carry out community surveys in the district. Due to limited financial resources it will not possible to involve more partners as would have been desirable.

METHODS AND MATERIALS

Background to the study area

For the last six months UHC has been implementing child survival interventions in Ruhinda County aimed at reducing morbidity and mortality for Women in Reproductive Age (WRA) and children under 5 in Ruhinda County.

Ruhinda County is one of the largest Counties of Bushenyi district with seven sub counties and accommodating approximately 18% of the total population of Bushenyi. Its population broken down by Sub County is as illustrated in table

Sub county	Population
Bitereko	22,931
Kabira	30,227
Kanyabwanga	14,022
Kasheshero	16,012
Mitooma	37,981
Mutara	21,168
Kiyanga	14,324
Total	156,665

The county has a total of twenty two health units ranging from HCII to HCIVs but with no hospital. Majority of the health units are public health facilities. Like the rest of the district the major causes of morbidity and mortality in the County are malaria and diarrhea.

Study design

The evaluation of phase II interventions employed a descriptive cross sectional study design where mainly quantitative data was collected. Data was collected between 4th and 9th of October 2007.

Study population

Children in Ruhinda County with aged 0-23months and their mothers constituted the study population. Having stayed in Ruhinda County for the past 12 months was used as an inclusion criterion.

Sampling Technique and sample size determination:

There are seven Sub-Counties in Ruhinda County: Mitooma, Kashenshero, Kabira, Mutara, Kanyabwanga, Kiyanga, and Bitereko and they were all included in the survey each constituting a Supervision Area.

The sample size was determined using Lot Quality Assurance Sampling (LQAS) Technique where 19 respondents were selected from each of the 7 supervision areas of Ruhinda County. So in total 133 households were studied.

Selecting the Villages to be studied

Villages Lists (LCI) for Ruhinda County were obtained from Uganda Bureau of Statistics with their respective populations. The Villages were grouped by sub-county (supervision Area) and from each supervision area, 19 villages were selected using systematic sampling technique.

A sampling interval for each supervision area was calculated and with the use of random numbers a random start was obtained. Systematically from the random start, the sampling interval was used to obtain the 19 villages from which the interviews would be carried out. This process was applied to all the seven sub-counties of the Study area

to obtain the villages from which the 133 interviews will be carried out. The list of the villages selected for the interviews are attached in [annex](#)

Selecting Households to be Studied

The interviewers obtained lists from the village chairpersons and in instances where the lists were not available, the interviewers sought help of the local leaders or key informants in drawing the village maps showing the key features. These maps would then be further subdivided into smaller sections (3-5) and each section would be assigned a number randomly. Using a table of random numbers, one part of the village was selected from the entire village randomly. The local leader/key informant would further help the interviewers to list all households in the selected section. These households were assigned random numbers and with the use of the table of random numbers one household was selected. The first interview in the village was carried out in the next household to the one that was selected randomly.

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

Questionnaire Development

The questionnaire that was used for the survey was an adaptation of that that was approved for monitoring the child survival program. Changes were made on how the questions were phrased based on lessons learned from the evaluation done at the end of phase one.

Three questions to capture data on the health plans were also added. The questionnaire was further be reviewed by the data collection team during training to ensure uniform understanding of the questions and pre tested to ensure clarity and validity of the questions.

Most of the questions in the original questionnaire were translated into Runyankore the local language during the baseline. So for each of the questions in the monitoring questionnaire the corresponding translated question was used to formulate the translated monitoring questionnaire.

After the pre test final editing was done depending on the findings from the pre test and the questionnaire was finalized.

The questionnaire had six major sections which include: Background information, Integrated Management of Childhood illness (IMCI), Diarrhea, sanitation and hygiene, maternal and newborn care, malaria prevention and Health Plans.

Indicators to be monitored

<i>Objective 1: To assess the incidence of malaria in pregnant woman and children under five and any improvement since the baseline.</i>		
<i>Indicators</i>	<i>Definition of an indicator</i>	
	<i>Denominator</i>	<i>Numerator</i>
% of children under 2 with fever in the last 2 weeks	Number of children in the survey	Number of children who had fever in the last two weeks (QN 8)
% of children under 2 with fever in the last 2 weeks who received advice or treatment	Number of children who had fever in the last two weeks (QN 8)	Number of sick children who sought advice or treatment (QN9)

% of children under 2 with fever in the last 2 weeks who sought treatment on the same day	Number of children who had fever in the last two weeks (QN 8)	Number of sick children who sought treatment same day (QN11=1)
% of households with children 0-23 months that own at least one mosquito net/ITN	All households in the survey	Number of households with mosquito nets (QN12)
% of children under 2 who slept under mosquito nets last night	All children in the survey	Number of children who slept under a mosquito net (QN13=A)

<i>Objective 2: To assess the incidence of diarrhea for children under five and any improvement since the baseline</i>		
<i>Indicators</i>	<i>Definition of an indicator</i>	
	<i>Denominator</i>	<i>Numerator</i>
% of children under 2 with diarrhea in the last two weeks	All children in the survey	Number of children with diarrhea in the past 2 weeks (QN 15)
% of children 0-23 months with diarrhea in the last two weeks who received ORS	Number of children with diarrhea in the past 2 weeks (QN 15)	Number of children with diarrhea in the last 2 weeks who received ORS (QN 16=B)
% of care takers/mothers who know at least 2 signs that a child under 2 needs treatment	All mothers in the survey	Number of mothers who mentioned at least 2 signs that a child needs treatment (QN7 B-K)
% of care takers/mothers who know at least one signs that a child under 2 needs treatment	All mothers in the survey	Number of mothers who mentioned at least one sign that a child needs treatment (QN B-K)
% of households who use improved water source (borehole, public tap, or protected dug well.)	All mothers in the survey	Number of mothers that reported improved water sources (Qn72= 1-3) This referred to Borehole, Public taps, Protected dug well
% of households with a designated hand washing facility	All mothers in the survey	Number of households where hand washing facilities were observed (Qn 21)

% of caretakers who usually wash hands with soap before food preparation, before feeding children, after defecation and after attending to a child who has defecated	All mothers in the survey	Number of mothers who reported washing hands under the mentioned 4 conditions (Qn 27A-F)
% of caretakers who dispose off children's feces hygienically (dropped into toilet facility or rinsed and water discarded into toilet facility)	All Mothers/ caretakers in the survey	Number of caretakers who dispose off children's feces hygienically (Qn 24 =1 or 2)
% of children 0-23 months who were offered more fluids during the illness	Number of children with diarrhea in the past 2 weeks (QN 15)	Children who were offered more fluid during illness (Qn 17=3)
% of children 0-23 months who were offered the same or more food during the illness	Number of children with diarrhea in the past 2 weeks who can eat (QN 15)	Children who were who offered more to eat during illness (Qn 18=3)
% of households with access to a pit latrine	All households survey	Number of household with access to pit latrines (QN25=1 to 3)

Objective 3: To find out the percentage of pregnant women receiving improved Ante Natal, delivery and post partum care.		
<i>Indicators</i>	<i>Definition of an indicator</i>	
	<i>Denominator</i>	<i>Numerator</i>
% of pregnant women with 4 ANC visits	Mothers who sought prenatal care (Qn 29)	Mothers who had at least 4 ANC visits as verified by maternal card(QN35=4)
% of pregnant women seeking VCT services	Mothers who sought prenatal care (Qn 29)	Mothers who sought VCT services (Qn 33)
% of mothers that were counseled on breastfeeding	Mothers who sought prenatal care (Qn 29)	Number of mothers who were counseled on breastfeeding (Qn 31)
% of mothers that were counseled on child spacing (about 2 years)	Mothers who sought prenatal care (Qn 29)	Number of mothers with counseled about child spacing (Qn 31)

% of caretakers mothers that were counseled on least 2 danger signs during pregnancy	Mothers who sought prenatal care (Qn 29)	Number of mothers who were counseled about pregnancy danger signs (Qn 31)
% of pregnant women counseled on where to deliver	Mothers who sought prenatal care (Qn 29)	Number of pregnant mothers counseled on where to deliver (QN32)
% of pregnant women counseled on transport plans to delivery place	Mothers who sought prenatal care (Qn 29)	Number of pregnant mothers counseled on transport plans to delivery place(QN32)
% of pregnant women counseled on having a birth kit	Mothers who sought prenatal care (Qn 29)	Number of pregnant mothers counseled on having a birth kit (QN32)
% of mothers who know at least one danger sign during pregnancy	All mothers in the survey	Number of mothers who mentioned at least 2 signs during pregnancy (QN36A-D)
% of women who delivered at a health facility)	All mothers in the survey	Number of mothers who delivered at a health facility (Qn 37)

<i>Objective 4: To determine the percentage of population who know about Health plan and those who are members of Health Plans.</i>		
<i>Indicators</i>	<i>Definition of an indicator</i>	
	<i>Denominator</i>	<i>Numerator</i>
% of mothers/caretakers who know about Health Plans	All mothers/caretakers in the survey	Number of mothers/caretakers who know about Health Plans(QN 38)
% of mothers/caretakers who are members of Health plans	All mothers/caretakers in the survey	Number of mothers/caretakers who are members of Health plans (QN40)

Training of the Evaluation Team

The survey team consisted of ten UHC staff and six student volunteers from Bushenyi district. This team was responsible for collecting data for both the HFA and KPC surveys. The team underwent a one day refresher training on the LQAS methodology and how to carry out HFAs. During this training the purpose of the surveys was explained, the roles and responsibilities of supervisors and interviewers, proper interviewing and supervision techniques and quality control procedures in the field discussed. The KPC and HFA questionnaire was reviewed item by item to ensure uniform understanding with particular emphasis on the skip patterns and special instructions.

After the training, the team was divided into seven pairs of interviewers with two supervisors. One supervisor was in charge of three groups while the other took charge of four groups. Each interviewing team (consisting of one male and one female interviewer with at least one of them fluent in Runyankore) was asked to carry out at least two KPC interviews and one HFA as a pre test in Igara County. Using the feedback from the pre test, the questionnaires were further reviewed before making final copies to be used for data collection.

Survey team

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Robert II	Arthur	Amelia	Moses	Edidah	Gilbert

Charles	Pias	Robert 1	Irene	Silver	Pedson	
Supervisors						
Grace				Duncan		
Group I,II and III				Group IV , V and VI		

Data collection and quality control procedures

Data was collected over five days starting from 4th – 9th October. Face to face interviews and observation were the two major methods of data collection that were used. In each Sub County i.e. supervision area nineteen household interviews were carried out with all the interviews totaling to 133.

Due to the limited number of vehicles and the long distances between Sub Counties it was not possible to assign a group to a supervision area. Therefore at least three groups were assigned to each supervision area per day to collect both KPC data. Each group was able to carry out four – six household interview .

The supervisors coordinated the data collection exercise. This entailed observation of at least one interview per interviewer and giving feedback on performance and areas that needed improvement. Although the supervisors were not able to observe every interview conducted, they reviewed every questionnaire for completeness and errors while still in the field so as to resolve any problems identified.

The survey team had daily briefing and debriefing meetings to discuss the planned activities and share experiences and challenges from the field so as to come up with appropriate and timely solutions.

Training of the survey team, pre testing, and reviewing the questionnaires, assigning supervisors to the data collection teams and having daily briefing and debriefing meetings were measures aimed at improving the quality of data collected.

To ensure quality data entry and analysis the questionnaires were coded and numbered when entered just incase they needed to be referred to. Data entrants were trained on the use of SPSS 12.0 which was used for data analysis. Data cleaning was done before analysis started.

Data management /data analysis

Data was analyzed using SPSS 12 for windows statistical package. The SPSS variable view page was filled out before data collection and edited when the questionnaire was finalized after the pre test. Analysis basically entailed the determination of descriptive statistics for the variables under the study.

Results are presented in narrative form, tables and graphs as was found appropriate.

Challenges Faced

1. The major challenge during the survey was difficult terrain with poor road network aggravated by the heavy rains which washed away bridges. Interviewers had to walk long distances to locate the villages and respondents thus minimizing the number of interviews that could be accomplished per day.
2. Most mothers were out in the gardens during morning hours hence not found in their homes. This called for interviewers having to wait for the mothers to be called from the gardens or walk there to carryout the interview. This resulted in each interview taking longer than had been planned.
3. In Betereko and Mutara Sub Counties, some community members were not cooperative because of past experiences like child abductions and compulsory immunization.
4. Involvement of local leaders in the process of household selection was limited because some of them were found to be too drunk to help. In such cases, the interview team had to rely on other key informants.
5. Poor communication network was also a challenge in cases where interviewers needed to consult their supervisors.

6. Ensuring privacy during interviews was difficult because husbands and other community members were interested in knowing what the interviews were about.
7. The key informants and guides who walked long distances with the survey teams requested for a payment.

Lessons learnt

1. The whole survey team going to a Sub County in a day was motivating to members as they knew that they would complete all the interviews in that supervision area without having to go back the next day. This was particularly evident for remote and hard to reach supervision areas.
2. Majority of community members were cooperative and willing to guide the interviewers or act on behalf of LC officials in case they were not available for the Village mapping, household and respondent selection.
3. Interviewers are key in ensuring data quality.
4. Entering data as soon as collection has been done in a given day helps identify errors in data collection early which reduces data cleaning workload and creates a sense of optimism to the whole exercise.
5. The exercise was a great learning opportunity for staff to do evaluations and in particular to master the LQAS methodology.
6. Student volunteers proved to be committed to the whole exercise and this eliminated the problems of curb stoning.
7. Carrying out the pretest was very instrumental in imparting the required skills to the interviewers and supervisors especially those who were using this methodology for the first time.
8. Each pair of interviewers can comfortably carryout on average five interviews per day.
9. The fact that more than one interview team moved in one vehicle was inefficient in the use of the interviewers' time as pick-ups would delay after the drop-offs.
10. HFA and KPC data collection needs to be done by different teams to ensure consistency and data quality. The KPC team needs at least one of the interviewers to be a trained.

Recommendations

Basing on the lessons learnt from this survey, the following recommendations are made for future surveys:

1. Survey teams are encouraged to storm a particular supervision area as a team and complete it in a day.
2. To ensure data quality, all LQAS surveys should have an adequate number of supervisors.
3. Students should be encouraged to volunteer as interviewers so as to build local capacity and minimize program evaluation costs.
4. Where sufficient funds are available, each supervisor should be located a vehicle.

RESULTS

Introduction

In this chapter the results of end of phase II Ruhinda County Knowledge, Practice and Coverage (KPC) survey are presented. The presentation of the results starts with demographic characteristics of the respondents and the study units followed by a summary of all the indicators studied with their confidence intervals and finally detailed results for each objective are presented.

Data collection for the KPC took place from 5th – 9th October 2007. Ruhinda County was subdivided into seven supervision areas basing on the sub counties. From each supervision area, 19 house holds were studied bringing the total number of house holds studied to 133.

Of the 133 mothers interviewed, 59% were above 25 years and 41% below. Their ages ranged from 18 -50 years with an average of 27. On the other hand 57.1% of the children studied were male while 42.9 were female. Their age ranged from 1 – 23 months.

Table 1: Results per Indicator

Malaria Indicators	Numerator	Denominator	Percentage	Confidence Limits
% of children under 2 with fever in the last 2 weeks	68	133	51.1	± 8.5
% of children under 2 with fever in the last 2 weeks who received advice or treatment	66	68	97.1	± 4.0
% of children under 2 with fever in the last two 2 weeks who sought treatment on the same day	11	68	16.2	± 8.8
% of households with children 0-23 months that own at least one mosquito net / ITN	105	133	78.9	± 6.9
% of children under 2 who slept under mosquito nets last night	86	133	64.7	± 8.1

Diarrhea Indicators	Numerator	Denominator	Percentage	Confidence Limits
% of children under 2 with diarrhea in the past 2 weeks	61	133	45.9	± 8.5
% of children 0-23 months with diarrhea in the last 2 weeks who received ORS	7	61	11.5	± 8.0
% of caretakers / mothers who know at least 2 signs that a child under 2 needs treatment	95	133	71.4	± 7.7
% of care takers/mothers who know at least one sign that a child under 2 needs treatment	131	133	98.5	± 2.1
% of households who use improved water source (borehole, public tap, or protected dug well)	83	133	62.4	± 8.2
% of households with a designated hand washing facility	16	133	12	± 5.5
% caretakers who usually wash their hands with soap before food preparation	24	133	18	± 6.5
% caretakers who usually wash their hands with soap before feeding children	15	133	11.3	± 5.4
% caretakers who usually wash their hands with soap before after defecation	80	133	60.2	± 8.3
% caretakers who usually wash their hands with soap after attending to a child who has defecated	13	133	9.8	± 5.1
% caretakers who usually wash their hands with soap before eating	61	133	45.9	± 8.5
% of caretakers who dispose off faeces hygienically (dropped into toilet facility or rinsed and water discarded into toilet facility)	91	133	68.4	± 7.9
% of children 0-23 months who were offered more fluids during the illness	13	61	21.3	±10.3
% of children 0-23 months who were offered the same or more food during the illness	38	48	79.2	± 9.5
% of households with access to a pit latrine	37	133	27.8	± 7.6

Maternal and newborn care Indicators	Numerator	Denominator	Percentage	Confidence Limits
% of pregnant women with 4 ANC visits	13	133	9.8	± 5.1
% of pregnant women seeking VCT services	83	133	62.4	± 8.2
% of mothers that were counseled on breastfeeding	62	133	46.6	± 8.5
% mothers that were counseled on child spacing (about 2 years)	65	133	48.9	± 8.5
% of caretakers/mothers that were counseled on at least 2 danger signs during pregnancy	61	133	45.9	± 8.5
% of pregnant women counseled on where to deliver	112	133	84.2	± 6.2
% of pregnant women counseled on transport plans to delivery place	69	133	51.9	± 8.5

% of pregnant women counseled on having a birth kit	84	133	63.2	± 8.2
% mothers who know atleast one danger sign during pregnancy	78	133	58.6	± 8.4
% of women who delivered at a health facility	77	133	57.9	± 8.4

Health Plan Indicators	Numerator	Denominator	Percentage	Confidence Limits
% of mothers/caretakers who know about Health plans	48	133	36.1	± 8.2
% of mothers/caretakers who are members of health plans	2	133	1.5	± 2.1

Objective 1: To assess the incidence of malaria in pregnant woman and children under five and progress towards the end of project target

An assessment of the incidence of malaria in pregnant women and children under five and evaluation of the progress towards the end of project target revealed the results in Table 2.

Table 2: Comparing malaria indicator results with EOP targets

Indicators	Percentage	EOP Target	Comment
% of children under 2 with fever in the last 2 weeks	51.1	19	Target not yet achieved
% of children under 2 with fever in the last 2 weeks who received advice or treatment	97.1		
% of children under 2 with fever in the last two 2 weeks who sought treatment on the same day	16.2	84	Target not yet achieved
% of households with children 0-23 months that own at least one mosquito net / ITN	78.9		
% of children under 2 who slept under mosquito nets last night	64.7	55	Target achieved

It can be noted from the table 2 that although 78.9% of the households owned at least one ITN, incidence of malaria is still high. Further analysis of those who slept under the net the night before the interview are presented in table 3.

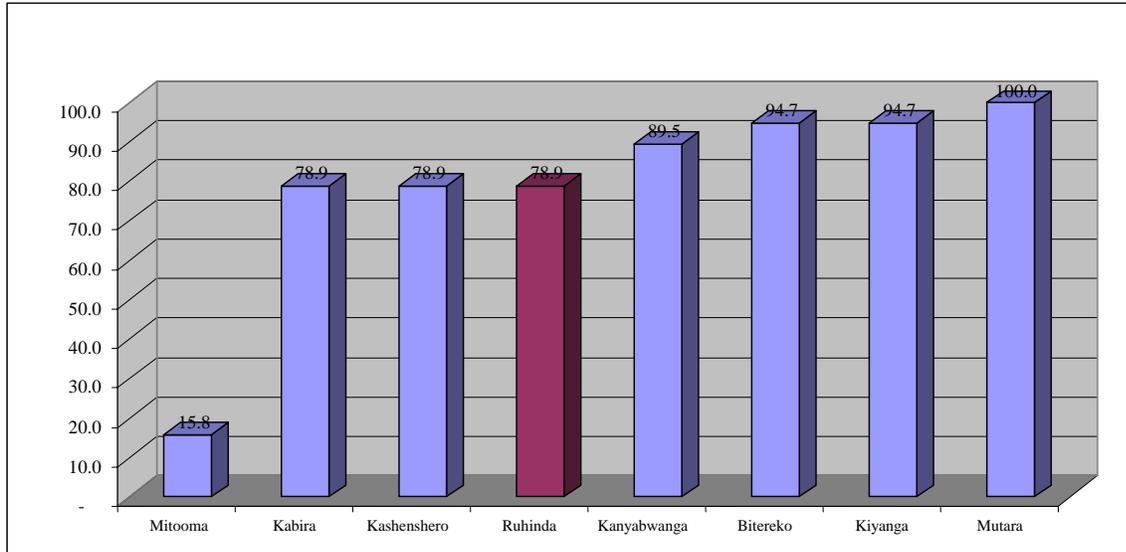
Table 3: Persons who slept under a net the night before the interview

Who slept under a net	Counts	% of responses
Child	86	37.4
Mother	75	32.6
Partner	28	12.2
Other children	23	10.0
Not used	18	7.8
Total	230	100.0

From table 3, it can be seen that 37.4% of the responses show that it is the child who slept under the net the night before the interview, but it is also worth noting that 7.8% of the responses indicated that the net was not used. Observation revealed intact nets still in their packages for those that were not used and

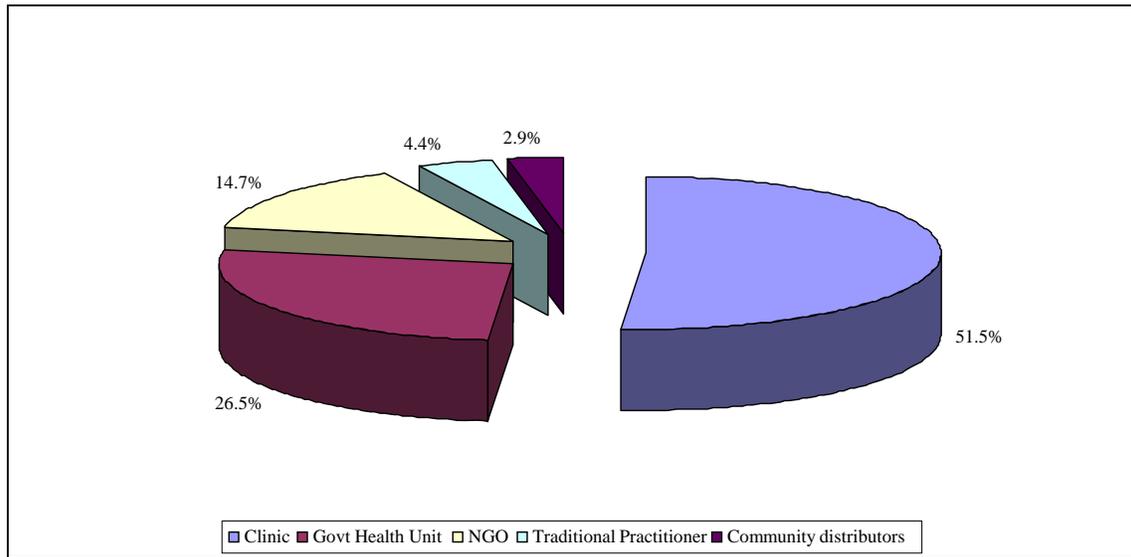
66.2% of the nets that were being used were draped appropriately and in good condition without holes or tears. Although net ownership is high in the county, one sub county has only 15.8% coverage as seen in figure 1.

Figure 3: Percentage of households with at least one net



Of the 51.1% children who had fever, at least 97.1% sought treatment or advice but only 16.2% sought treatment / advice the same day. When asked where they went first for treatment, the figure below presents their responses.

Figure 4: Place where mothers first sought treatment or advice



From the results in figure 2, it can be noted that 51.5% of the mothers sought treatment from a clinic whereas only 2.9% went to a community drug distributors.

Objective 2: To assess the incidence of diarrhea in under fives and progress towards the end of project targets

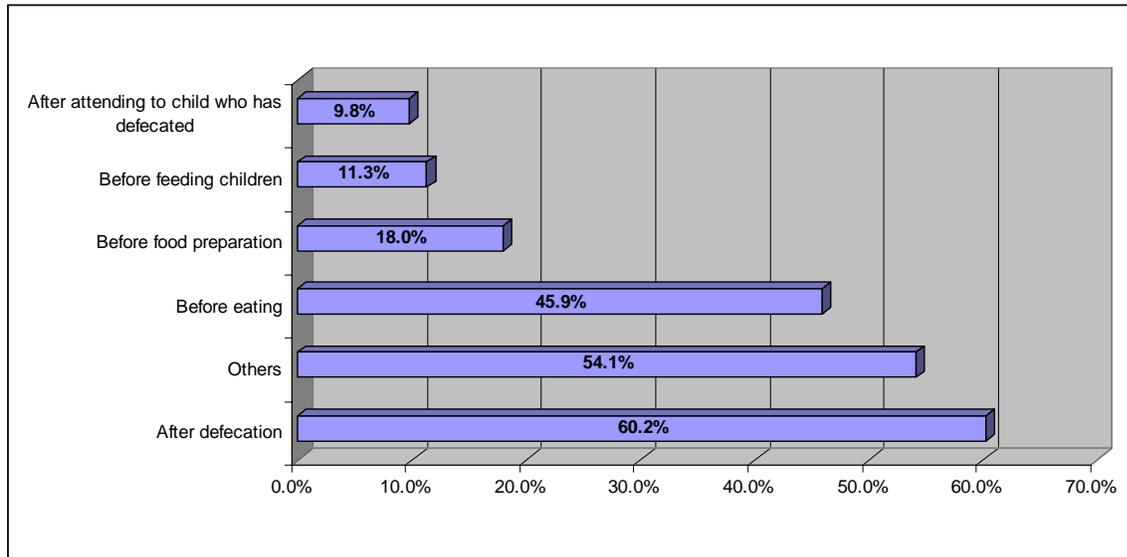
An assessment of the incidence of diarrhea in under fives and evaluation of the progress towards the end of project target was made and the results are as seen in Table 4.

Table 4: Diarrhea indicator results compared EOP targets

Indicators	Percentage	EOP Target	Comment
% of children under 2 with diarrhea in the past 2 weeks	45.9	20	Target not yet achieved
% of children 0-23 months with diarrhea in the last 2 weeks who received ORS	11.5	30	Target not yet achieved
% of caretakers / mothers who know at least 2 signs that a child under 2 needs treatment	71.4	84	Target not yet achieved
% of care takers/mothers who know at least one sign that a child under 2 needs treatment	98.5		
% of households who use improved water source (borehole, public tap, or protected dug well)	62.4	60	Target Achieved
% of households with a designated hand washing facility	12	40	Target not yet achieved
% caretakers who usually wash their hands with soap before food preparation	18	64	Target not yet achieved
% caretakers who usually wash their hands with soap before feeding children	11.3	35	Target not yet achieved
% caretakers who usually wash their hands with soap before after defecation	60.2	82	Target not yet achieved
% caretakers who usually wash their hands with soap after attending to a child who has defecated	9.8	30	Target not yet achieved
% caretakers who usually wash their hands with soap before eating	45.9		
% of caretakers who dispose off feces hygienically (dropped into toilet facility or rinsed and water discarded into toilet facility)	68.4	82	Target not yet achieved
% of children 0-23 months who were offered more fluids during the illness	21.3	36	Target not yet achieved
% of children 0-23 months who were offered the same or more food during the illness	79.2	63	Target achieved
% of households with access to a pit latrine	27.8	36	Target not yet achieved

From the table, it can be noted that most of the diarrhea targets have not been achieved; sanitation and hygiene are still a major problem in this county. Although the majority of the mothers (68.4%) said that they disposed off the child's feces into a toilet, only 27.8% have a toilet with a solid slab. When mothers were asked when they washed their hands with soap and water, the figure below shows the results.

Figure 5: Hand washing practices



From the figure 3 it is evident that very few mothers (9.8 %) wash their hands with soap and water after attending to a child who has defecated while only 60.2% wash their hands after defecation. From observation, only 12% of the households studied had a designated hand washing facility. Mothers mentioned the other times when they washed their hands with soap and water, and the table 5 illustrates their responses.

Table 5: Other times when mothers wash hands with soap and water

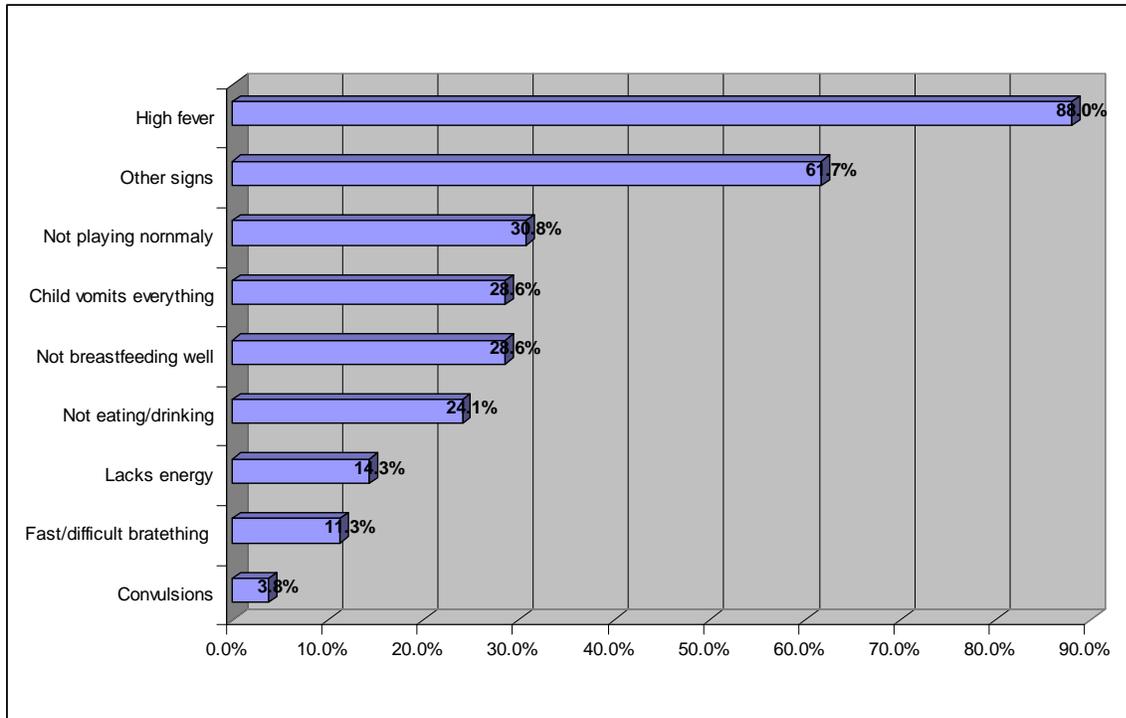
Other times when mothers wash hands	Counts	%
From Garden	44	61.1
Not usually	1	1.4
When washing	5	6.9
After eating	3	4.2
After peeling	5	6.9
Before sleeping	2	2.8
In the morning	12	16.7
Total	72	100.0

From table 5, it can be noted that majority (61.1%) of the mothers wash their hands when they are from the garden.

62.4% of the households had an improved water source with the major method of making this water safe was by boiling (84.2%).

Mothers' knowledge on at least one sign that indicates that child needs treatment was assessed and the results are illustrated in figure 4.

Figure 6: Signs indicating child needs treatment



Among the signs that indicate that a child needs treatment, high fever was mentioned most (88%), 61.7% mentioned other signs as illustrated in the table 6.

Table 6: Other signs mentioned by mothers

Other signs mentioned by mothers	count	%
Oversleeping	1	1.1
Body rash	2	2.1
Shivering	2	2.1
Abdominal Pain	3	3.2
Headache	4	4.3
Too much crying	9	9.6
Diarrhea	34	36.2
Cough and flu	39	41.5
Total	94	100.0

Of the 45.9% children with diarrhea in the last two weeks, only 11.5% were treated with ORS. 65.4% of the mothers interviewed had heard about ORS and of these only 24.8% could describe its preparation correctly. When mothers were asked what treatment they gave the child the last time she/he had diarrhea, there were multiple responses and these are illustrated in figure 5.

Figure 7: Treatment given for diarrhea

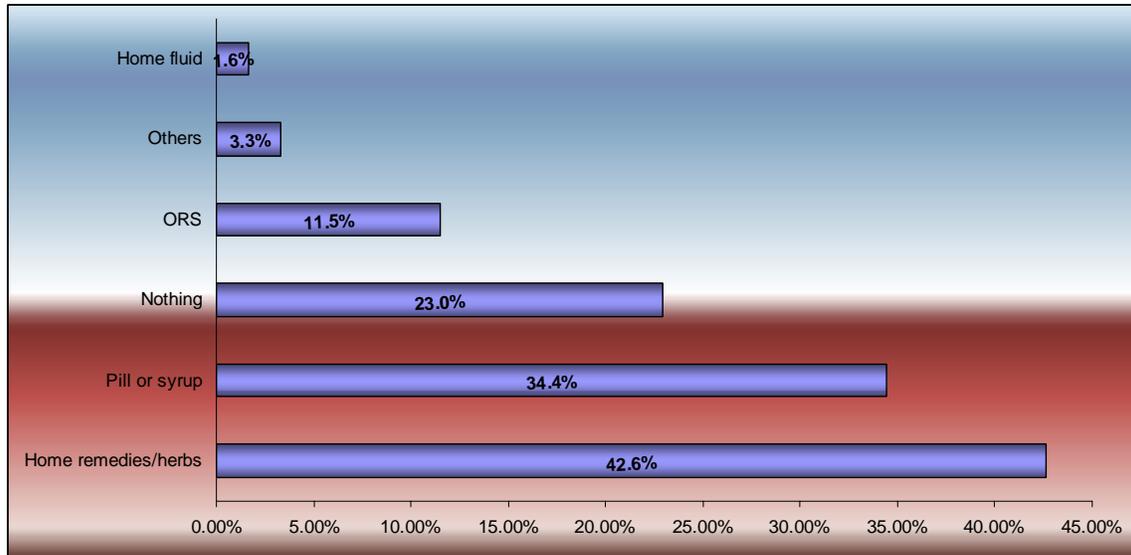
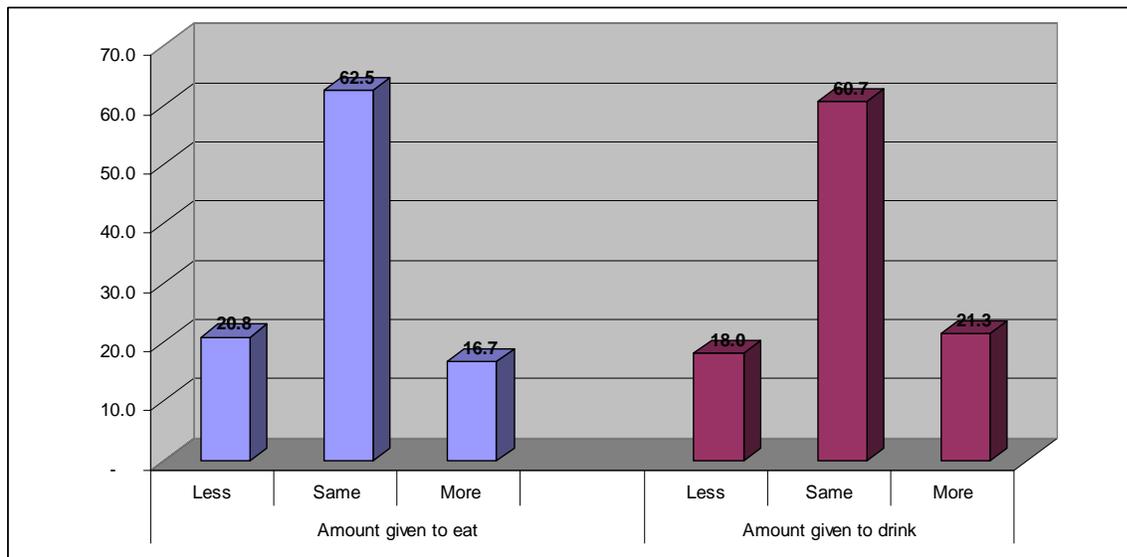


Figure 8 Feeding practices for sick child



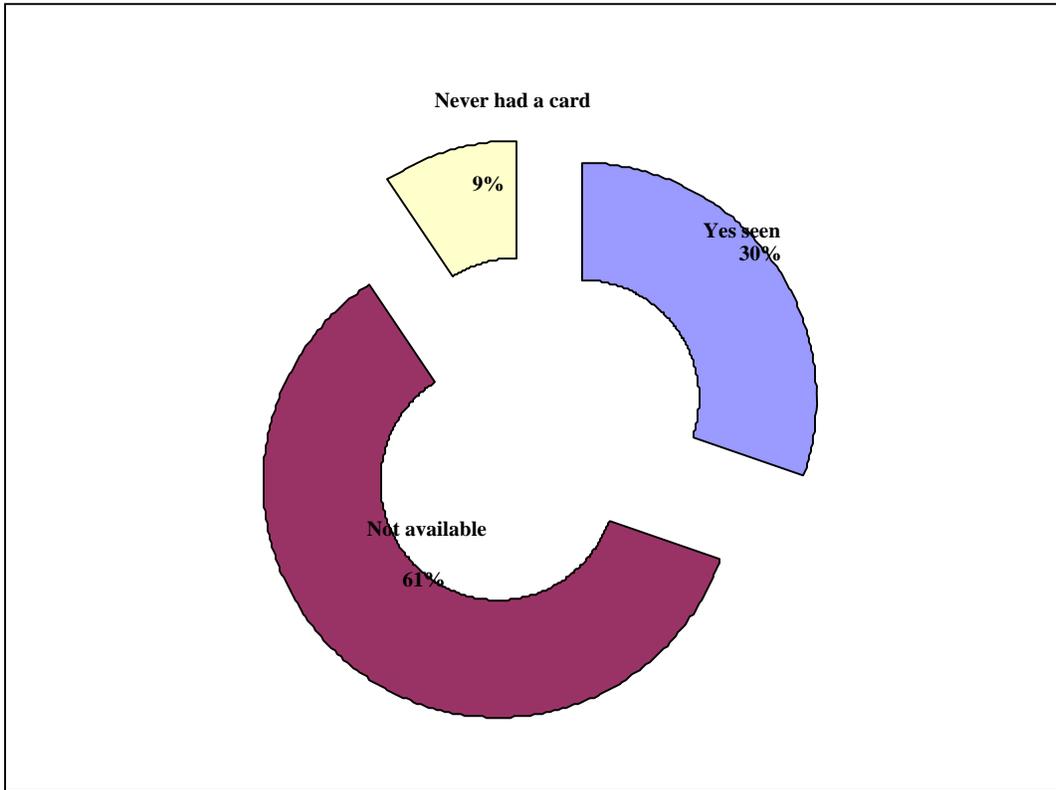
From the figure 5, it can be seen that the majority of the mothers 42.6% treated diarrhea with herbal medicine while 23% gave nothing. Most of the mothers offered the same to drink and eat when the child was sick with diarrhea.

Objective 3: To find out the percentage of mothers receiving improved antenatal, delivery and post partum care

An evaluation was done to find out the percentage mothers receiving improved antenatal, delivery and post partum care. Results show that 100% of the mothers went for prenatal care and majority of them (93.2%) saw a nurse/ midwife while some reported to have seen either a community health worker or a TBA in addition. Many of the mothers (62.4%) who went for prenatal care voluntarily tested for HIV.

Mothers were asked for their maternal cards and card retention was found to be low at 30.1% only 9 (figure 6).

Figure 9: Ownership of maternal card



Although the mothers reported to have attended more ANC visits and received at least 2 IPTs, results indicate that only 33% and 26% ANC visits and IPT 2 doses respectively could be verified on the maternal cards (figures 7 and 8).

Figure 10: Number of ANC visits as verified by Maternal Card

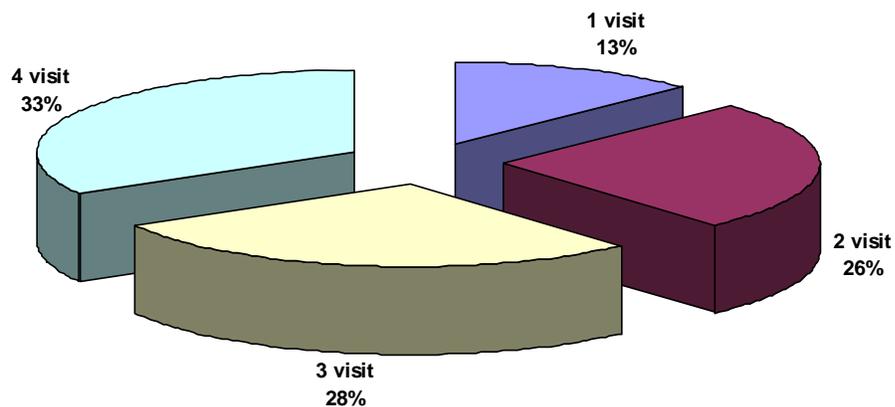
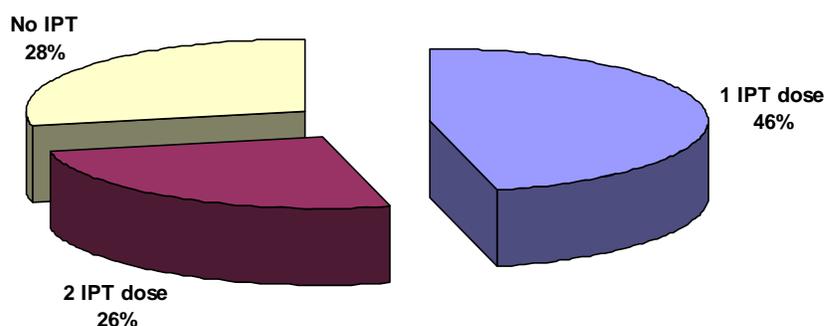


Figure 11 Number of IPTs as verified by Maternal Card



It is also worth noting that 28% of the mothers who had ANC cards did not have IPT recorded on their maternal card.

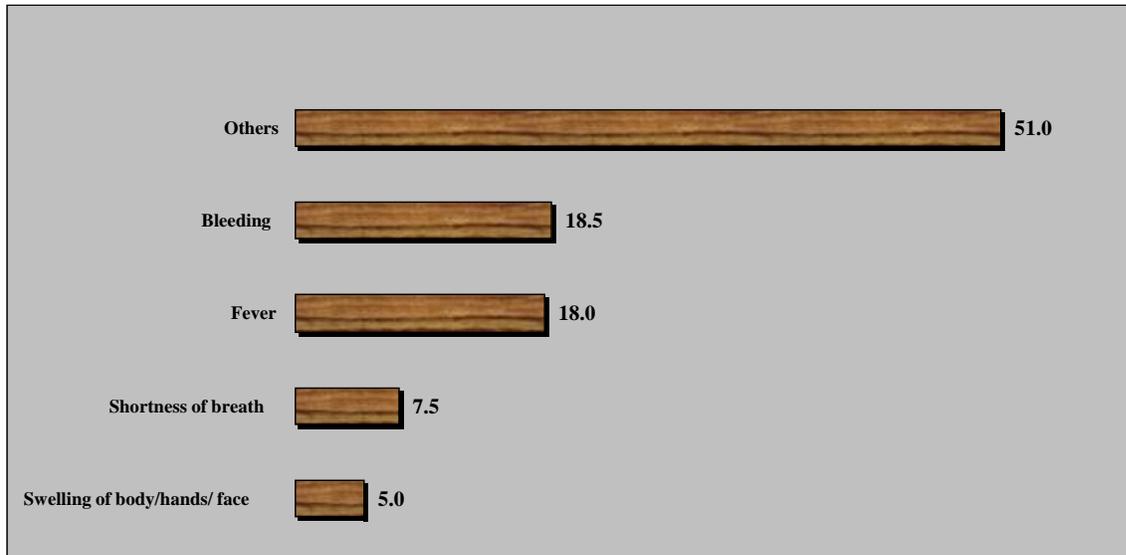
Results of the other maternal indicators are as illustrated in the table 7.

Table 7: Maternal and newborn care indicators

Maternal and Newborn Care Indicators	%	EOP target	Comment
% of pregnant women with 4 ANC visits	33	85	Target not yet achieved
% of pregnant women seeking VCT services	62.4	44	Target Achieved
% of mothers that were counseled on breastfeeding	46.6	55	Target not yet achieved
% mothers that were counseled on child spacing (about 2 years)	48.9	99	Target not yet achieved
% of mothers that were counseled on at least 2 danger signs during pregnancy	45.9	90	Target not yet achieved
% of pregnant women counseled on where to deliver	84.2		
% of pregnant women counseled on transport plans to delivery place	51.9		
% of pregnant women counseled on having a birth kit	63.2		
% mothers who know at least one danger sign during pregnancy	58.6		
% of women who delivered at a health facility	57.9	65	Target not yet achieved

Mothers' knowledge on danger signs during pregnancy that indicate the need to seek health care was assessed and the results are illustrated in figure 6.

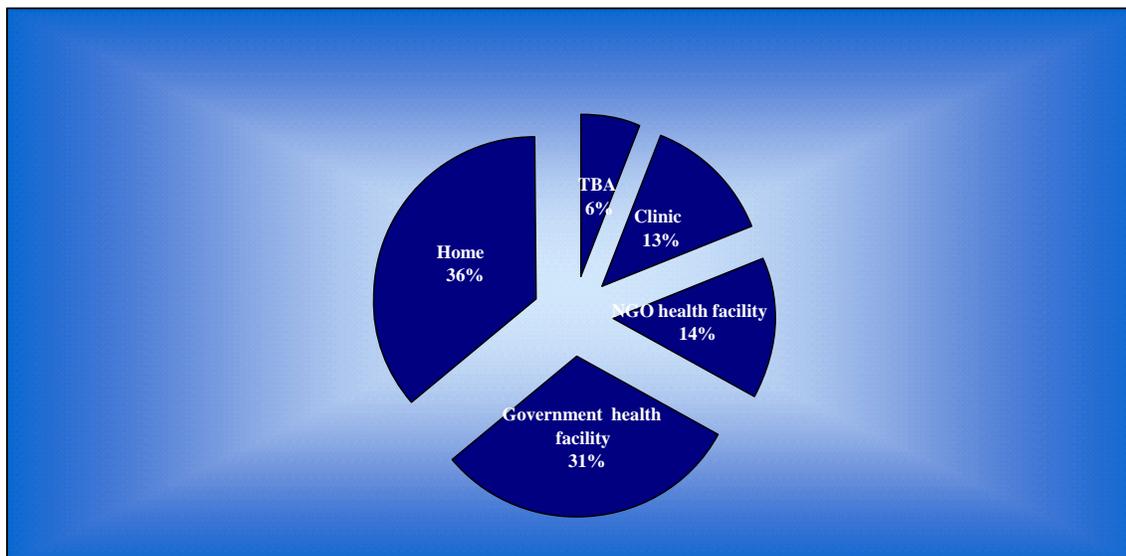
Figure 12: Dangers during pregnancy



It can be noted from figure 6, that mothers are not knowledgeable on the most crucial danger signs during pregnancy requiring medical attention. Under “others”, the signs mentioned included abdominal pain, failure to walk, watery discharge, pain during sex, general weakness, dizziness, vomiting, baby not kicking, palpitations etc.

Of the 133 mothers interviewed, only 57.9% reported to have delivered at a health facility. Details of place of delivery are in the figure 7 below.

Figure 13: Place of delivery



From figure 7 it can be seen that a significant number of mothers (36%) gave birth at home. Of the mothers who delivered had health facilities, they mentioned the following as the people who assisted them during delivery- table 8

Table 8: Person who assisted mothers during delivery

Persons who assisted	Frequency	Percent
Nurse/midwife	76.0	57.1
Family member	24.0	18.0
TBA	18.0	13.5
No one	7.0	5.3
Other	5.0	3.8
Doctor	2.0	1.5
Community health worker	1.0	0.8
Total	133.0	100.0

It can be noted from table 8 that majority of the mothers who delivered at home were assisted by a nurse/midwife during delivery (57.1%) with those assisted by a family member also comprising a significant percentage (18%). Of these who gave were assisted by a family member at home, they mentioned the following as the people who assisted them during delivery.

Table 9: Persons who assisted mothers during delivery

Persons who assisted	Frequency	%
Co wife	1	3.4
Friend	1	3.4
Grand mother	2	6.9
Husband	5	17.2
Mother	5	17.2
Mother in law	11	37.9
Neighbour	2	6.9
Sister	2	6.9
Total	29	100.0

Objective 4: To determine the percentage of population who know about Health plan and those who are members.

Respondents were asked if they had ever heard or were members of health plans and results of this assessment are in the table 9.

Table 10: Health plan indicator results

Health plan Indicators	Percentage
% of mothers who know about Health plans	36.1
% of mothers who are members of health plans	1.5

From table 9, 36.1% of the mothers interviewed had heard about health plans while only 1.5% were members. The mothers who knew about health plan had heard it from the following sources

Table 11: Where respondents heard about health plans

Where they heard about Health plans	Count	%
Local leader	1	1.6
Church	4	6.5
Health plan members	4	6.5
Friends	7	11.3
Health centre	14	22.6
Radio	32	51.6
Total	62	100.0

Majority of the mothers heard about health plans from the radio, health centre and friends in the descending order.

DISCUSSION

In this chapter the results presented in the previous chapter are discussed and compared with finding from other studies like results from the recently concluded UDHS, the annual sector performance report and also with the national targets as outlined in the HSSPII. The discussion will be presented according to the key intervention areas i.e. malaria prevention, improvement of sanitation, hygiene and control of diarrheal diseases and maternal and new born care.

Prevention of Malaria

Malaria remains the single most common cause of mortality and morbidity in Uganda accounting for 30-50% of outpatient burden and 35% of hospital admissions (MoH 2007). One of UHC's child survival objectives is to reduce the incidence of malaria in Bushenyi district for children under five and pregnant women.

To ensure the achievement of this objective UHC promotes the demand for ITNs and distributes ITNs free to members of health schemes and to pregnant women at health facilities. ITNs are also sold at subsidized prices. All ITNs distributed are long lasting in order to reduce the need for re treatment. The community is mobilized against malaria through training on proper ITN use the importance of ANC and receiving IPT 2 times during pregnancy, early recognition and care seeking for fever, compliance with prescribed treatment and appropriate malaria recognition and case management at the provider level.

Results from the Ruhinda survey show that the percentage of children with fever in the last two weeks was high at 51.1% compared to the program target of 19% and the UDHS national level of 41%. This is not very surprising given that incidence of malaria is high during the rainy season a season in which data for Ruhinda was collected.

The prevalence of malaria was high in Ruhinda despite the high net coverage of 78.9% which surpassed the national target of 70%. The high net coverage is attributed to the free net distribution in the district by the WHO, MoH and other partners. The high malaria prevalence could mean that either the nets are not being used or if they are they are not being used correctly. Results further show that actually 13.5% of those who owned nets did not use them. Most of the nets were found still in their packs and kept safely either in the suitcases or under the bed. In A Qualitative Study on the Practices and Their Behavioral Determinants among Women, Men and Health Workers in Bushenyi District, July 2006, the Child Survival program team found that pregnant women explain that they do not sleep under nets because they lack information on proper net use; they also believed that nets can cause death to human beings sleeping under them and complained that nets cause discomfort. This finding was the basis of the program's behavior framework which emphasizes training on proper use before distribution of nets. This component was lacking in the recent massive net distribution hence creating a need for scaled up training on proper net use in the County. ITN use especially for children under five and pregnant women is emphasized because these two categories are prone to severe disease and anemia. It was therefore encouraging to find that 37.4% of the children in Ruhinda had slept in a net the night before the interview. This was much better than the UDHS finding of 22% in 2006.

One of the objectives of the Uganda Malaria Control Strategic Plan (UMCSP) is to enhance prompt treatment of children under five within 24 hours of onset of fever. In Ruhinda it was found that although 97.1% of the children with fever sought treatment, only 16.2% sought the treatment on the same day. This is far below the program and national targets of 84% and 80% respectively. This presents itself as a major challenge to all partners to find ways on how this can be improved.

Sanitation, hygiene and control of diarrheal diseases

Through the CORP UHC mobilizes and trains the community on warning signs of diarrhea and dehydration, home management of diarrhea, ORS information and proper preparation, importance of continued feeding and when to seek treatment. The community is also educated on safe disposal of human feces; improved hygiene including hand washing practices, safe water sources, safe water use and storage.

Sanitation and hygiene

Poor sanitation and hygiene has remained a major predisposing factor to the high disease burden in Uganda with 70-80% of the preventable disease burden attributed to poor sanitation, hygiene and poor living conditions (MoH 2007). The chances of getting diarrhea are high among those who use contaminated water, unhygienic practices in food preparation and have poor excreta disposal. The UDHS of 2006 found that children who lived in households with non improved toilet facilities were more likely to get diarrhea than those with improved toilet facilities.

In Ruhinda the percentage of households with an improved water source i.e. (Bore hole, public tap and protected spring/well) at 62.4% surpassed the end of program target of 60% this could be attributed to the multisectoral approach to water provision and the participation of various partners.

Safe excreta disposal however performed poorly with only 68.4% of the mothers interviewed disposing off the children's excreta hygienically i.e. dropped into toilet or rinsed away and water discarded into toilet. This performance is much lower than the UDHS finding for the Southwestern region and national coverage level of 86.5% and 77% respectively. The level is also below the set program target of 82%.

To aggravate the sanitation problem, is the low coverage with improved toilet facilities i.e. VIP latrines and latrines with a solid slab which is at a dismal 27.8 % compared to the program target of 36% and national target of 100%. Nationally coverage is at 58.5%. The difference in coverage could be due to the difference in what was accepted as improved toilet facility. In the Ruhinda KPC study only those latrines with a solid slab were considered as having an improved toilet facility. Majority of the respondents 69.2% had simple latrines with no solid slab while only 1.5% had no toilet facility at all. Emphasis therefore needs to be put on improving the quality of the latrines available. This is because the high coverage with simple latrines with no slab is still not beneficial in preventing diarrheal diseases.

Hand washing practices were found to be poor in Ruhinda County compared to the program targets. Only 12% of the households studied had a designated hand washing facility while 60.2% of the mothers washed their hands with water and soap after defecation as compared to the program target of 82% and still very few mothers washed their hands with soap and water after attending to a child who has defected. During the survey majority of the mothers mentioned other times when they washed their hands with soap and water and the most prominent of these was "from garden" to them a soiled hand is more dangerous warranting to be washed with soap and water than one that is not visibly dirty yet potentially more dangerous.

The poor hand washing practices can be explained by findings from the qualitative study done at the baseline. At the baseline, mothers said they do not wash hands with water and soap for most of the recommended times because: They did not see anything bad with children's feces, they also believed that a person should only wash hands if he/she has touched feces, some thought that Using soap for washing hands is waste of soap while some actually did not know the dangers of not washing hands or poor disposal of children's feces.

These findings suggest that change in behavior is occurring at a very low rate and therefore calls for concerted effort from all partners to ensure that these simple yet key behaviors are adopted if the health of the community is to be improved. Some of the lessons learnt from Kaliro district which is highlighted as a success story in improving sanitation in the Annual Health Sector Performance Report (AHSPR) of 2006/07 were:

1. Collaboration between district departments and political leadership is crucial for improving sanitation
2. There is need for a deliberate effort from all departments to achieve a given objective
3. Mobilization using local media like FM stations is very useful
4. There is need to sustain the efforts so that communities appreciate the role of appropriate sanitation (AHSPR 2006/07)

5.

The same deliberate effort by all partners could be adopted for Bushenyi district so as to improve the sanitation and ultimately the health status of the people of Bushenyi.

Prevalence and management of diarrhea

Diarrheal diseases remain among the five major causes of morbidity and mortality in Uganda (MoH 2007). The number of children with diarrhea in the last two weeks in Ruhinda County was found to be high at 45.9% compared to the program target of 20% and the Southwestern level of 30.6% (UDHS 2006). It should however be noted that diarrhea and malaria prevalence varies with the season being high in the rainy season a time when the data for Ruhinda was collected.

The major complication of diarrhea is dehydration which can be easily treated with oral rehydration therapy (ORT). During community mobilization sessions the CORP train mothers on how to prepare ORS and other home made fluids and the importance of increased fluids and feeding for a child with diarrhea so as to reduce dehydration and minimize the adverse consequences of diarrhea on the child's nutritional status.

Results from the Ruhinda County survey however show that although majority of the mothers interviewed (66.9%) have ever heard about ORS only 37% could describe its preparation correctly and only 11.5% of the children with diarrhea in the last two weeks had been treated with ORS. It should be noted too that the percentage of the mothers who have ever heard about ORS in Ruhinda although higher than what was found for the Southwestern in the UDHS of 2006, is still lower than the national figure of 86.4% (UDHS 2006).

Despite the fact that Oral Rehydration Therapy (ORT) with ORS or other home made fluids has been found to be a simple and effective method of managing dehydration in diarrhea its uptake is still low in Ruhinda County Bushenyi district. In A Qualitative Study on the Practices and Their Behavioral Determinants among Women, Men and Health Workers in Bushenyi District, July 2006, the Child Survival program team found that barriers to the use of ORS include the belief by mothers that ORS is merely water and therefore does not work, also that ORS increases water in a child who has a lot of water already. The other reason why mothers do not use ORS was found to be the fact that some of them cannot afford it. Ruhinda mothers were found to depend highly on herbal medicines and home remedies to treat diarrhea (42.6%) while 34.4% were given a pill or syrup for the diarrhea.

Feeding practices for a sick child were comparable with the UDHS findings of 2006 for drinks with 21.3% for Ruhinda compared to the UDHS national finding of 20.4%. Nevertheless this level was lower than the program target of 36%. The other key behavior that is promoted by the program is giving the same or more to eat for a sick child. This behavior seems to have been achieved basing on the survey results which show that 79.2 % of the sick children were either given the same (62.5) or more (16.7) to eat when they were sick. This too is much higher than what was found in the UDHS results of 2006 where only 45% were given the same to eat while only 7% were given more than usual to eat with a total of 52%.

Another important result worth noting is that majority of the mothers did not know the crucial signs that indicate a child needs treatment. This could delay the mother seeking health care for the child and hence the outcome of the treatment.

This scenario calls for more training and BCC on the crucial signs that indicate a child needs treatment, importance of ORT and ORS in particular in the management of diarrhea and reemphasizing the importance of giving a sick child more to drink and to eat. This is a role that has to be done by every stakeholder but the program and the district health office in particular may have to consider innovative ways to make ORS more easily accessible to the community.

Maternal and Newborn Care

HealthPartners Uganda health Cooperative's objective under this intervention area is to increase the percentage of women receiving improved ANC, delivery and post partum care. Expected results include: increased demand for ANC and RCT, improved mother's knowledge of delivery preparations, breast feeding, child spacing and danger

signs of pregnancy and increased access to safer birthing. Major activities geared at realizing the above results include the mobilization and training of mothers and the community at large through the CORP on the importance of planning for safe birth, ANC, RCT, and PMTCT and training on maternal and newborn care (MNC). To encourage ANC and delivery at health facilities, UHC distributes free mama kits to mothers at the IPT2 and ITNs to babies born at health facilities. Health workers are also given refresher training in reproductive health and life saving skills and active management of third stage of labor so as to ensure standard care management of the mothers.

Results from the assessment show that all the mothers studied received antenatal and 96.2 % saw a skilled health personnel i.e. 93.2% and 3% saw a nurse or midwife and doctor respectively. This result is comparable to the finding from the UDHS of 2006 where nationally 94% of the women received ANC from qualified health personnel with 84% seeing a nurse or midwife. UDHS results for South Western Uganda where Bushenyi district is found showed 91.4% of the mothers receiving ANC from skilled health personnel with 70.4 and 20.3% seeing a nurse or midwife and doctor respectively. This finding is encouraging meaning that at least mothers in Ruhinda County are able to have their medical problems during pregnancy detected early and treated. Given that Ruhinda is a rural County it is not surprising therefore that the most common health worker seen for ANC is a nurse or midwife with very few mothers being able to see a doctor. The fact that some of the mothers reported to have seen a TBA for ANC raises concern in regard to the quality of ANC that can be offered by the TBA and therefore more training of the mothers on the importance of seeing a skilled health worker for ANC should be continuous. TBAs should also be encouraged to refer such mothers to skilled health personnel since according to the national policy guidelines for sexual and reproductive health and rights TBAs are not mandated to provide ANC services.

In line with WHO guidelines, the Ministry of Health (MOH) recommends that a woman who is having a normal pregnancy attend four antenatal care visits. The MOH target is to increase the attendance of four visits per pregnancy from 42 to 50%. This indicator was at 47% according to the results from the UDHS of 2006 and the Annual Health Sector Performance Report of 2006/07. Results from the Ruhinda survey found that only 33% of mothers attended the recommended four ANCs as compared to the project target of 85% and the national target of 50%. The low ANC visits observed in Ruhinda could partly be due to omissions especially in instances where mothers had books instead of maternal cards. So in case one book was misplaced only those visits recorded in the available book would be recorded. Nevertheless it is obvious that the project target which was set basing on the baseline results is very high. This is because during the baseline the four ANC visits were based on mother's recall and the results were therefore high. Given that the verification of the four ANCs has changed, the project target may have to be changed accordingly.

The MOH's target is to have 60% of pregnant women receiving a complete dose of IPT2. By the end of 2006/2007 FY the coverage was at 42%. In Ruhinda the results show that IPT2 coverage was at 26% which is a slight improvement from the 2006 UDHS finding of 24.6% for Southwestern Uganda. This could partly be attributed to the fact that the interviewers were not medically trained personnel so found it hard to read the medical forms and books provided by the mothers. This is further supported by the fact that most of the mothers interviewed insisted that they had actually got the recommended two IPTs but in line with the study protocol only those seen on the cards/books were recorded.

Despite the fact that most of the mothers reported to have been counseled on Breastfeeding, child spacing, danger signs during pregnancy, where to deliver, transport plans to delivery place and having a birth kit and even if in Ruhinda the performance for the above variables was found to be better than the findings of the 2006 UDHS, Ruhinda performance was still below the set project targets. This is most likely due to heavy workloads experienced by the health workers therefore not having adequate time to counsel mothers. Nevertheless effort to ensure that all mothers attending ANC do not miss this opportunity should be put in place. One strategy would be to carry out group counseling during ANC. HealthPartners on the other hand needs to emphasize to the health workers the need to adhere to the goal oriented ANC protocol during the MNC trainings.

Counseling mothers on danger signs during pregnancy is essential if mothers are to recognize early the need to seek health care during pregnancy. From the Ruhinda survey it was found that only 45.9 % of the mothers were counseled on at least two danger signs during pregnancy compared to the target of 90%. Further more it was clear from interviewing the mothers that very few knew the crucial danger signs during pregnancy like bleeding, fever, shortness of breath, swelling of face, hands and feet. Most of the mothers mentioned other signs like abdominal pain, failure to walk, watery discharge, pain during sex, general weakness, dizziness, vomiting, baby not kicking,

palpitations which are not necessarily the most critical signs. There is need therefore to scale up the counseling on danger signs if mothers are to seek health care early and hence improve their health and that of their babies.

It was encouraging to find that 57.9% of the mothers delivered at a health facility this is much higher than was found in the UDHS of 2006 where nationally only 41% of the mothers delivered at a health facility with the figure for South Western Uganda being 31.3%. Assistance during childbirth is an important variable that influences the birth outcome and the health of the mother and the infant. This is because the skills and performance of the birth attendant determine whether or not he or she can manage complications and observe hygienic practices. So it was also encouraging to find that 58.6% of the mothers were assisted by trained health personnel (57.1% by nurse or midwife and 1.5% by a doctor). The national target is 50%.

It is worth noting that although the percentage of mothers delivering with TBA has reduced from the 17% stated in the national policy guidelines and service standards for sexual and reproductive health and rights, a sizable proportion (13.5%) of the mothers delivered with a TBA. Further sensitization on the importance of delivering with a skilled health personnel therefore needs to be re-emphasized so as to improve birth outcomes and the health of the mothers and their babies.

Like has been found in many studies for mothers who delivered at home, it was found that the majority were assisted by either their mothers or mothers in-law. This finding has significant bearing on who to target when delivering key behavior change messages. It is important for the program and all stakeholders to note the importance of the mothers and mothers in law and target them for the trainings. This is because they will determine whether or not the mothers choose to deliver with skilled personnel or not.

Health plan membership

One of UHC's objectives is to build local organizational capacity to manage health schemes and growth of the schemes is a fundamental in the achievement of this goal. The end of program target is to have at least 16,000 members which is approximately 2% of the total population of Bushenyi. This target is yet to be achieved is compounded by many challenges among which is the problem of providers especially in rural areas with the marketers reporting that they identify interested groups but fail to get an appropriate provider for them. It should be noted that the most well distributed health facilities in Bushenyi are government health facilities but the services in these hospitals is free hence making government facilities unsuitable for the prepaid health schemes.

In addition the marketers report difficulty in decision making by groups to join the plans, high drop outs of members, unaffordability of premiums by some sections of the community, limited number of active groups and the fact that the concept of prepaid health schemes and health insurance is a new concept and its benefits not tangible as some of the challenges they face.

Nevertheless feedback from the community suggests that the program is not communicating clearly and effectively with the community. For example some of the mothers interviewed report to have been educated about health plans at churches but no follow ups were done to recruit those interested. Those who heard about health plans from the radio and from the health facilities did not exactly understand how the health plans work and what was required to become a member. These findings indicate that there is need to change the marketing strategy so that when members are introduced to the concept of health plans, a plan for follow up is done so as to recruit those interested.

CONCLUSIONS

Malaria

1. Ownership of mosquito nets has improved in the county with the exception of Mitooma Sub County where coverage was considerably very low. Majority of the nets are well hang and in good condition.
2. The community's knowledge of who is priority in sleeping under a mosquito net is fairly good with the practice being that more children and mothers are sleeping under the net as compared to partners.
3. Incidence of malaria is still high in the County and the mother's healthcare seeking behavior is still deficient in that mothers are not seeking treatment for fever on the same day as the onset of the fever.
4. IPT2 coverage is still unacceptably low in the county
5. A significant number of homes with nets are not using them.

Sanitation, hygiene and control of diarrheal disease.

1. Access of the County's population to improved water source is fairly good.
2. Mothers in Ruhinda County were found to be fairly knowledgeable on at least one danger sign that a child needs treatment.
3. Poor sanitation characterized by poor fecal disposal, poor hand washing practices, and low coverage with latrines that have a solid slab remain a major challenges in the County.
4. Prevalence of diarrhea in Ruhinda is still high compared to the target
5. Home management of diarrhea in the County is poor with minimal use of ORS in the management of the diarrheas and poor feeding practices of the sick child.

Maternal and Newborn Care

1. Ruhinda County mothers' ANC seeking behavior is very good with all the mothers reporting to have at least attended one ANC with a qualified health professional however very few mothers are attending the recommended four ANC visits. Maternal card retention is still very poor.
2. Uptake of VCT services is fairly high among mothers attending ANC.
3. Delivery at health facility and with a skilled birth attendant has improved though a significant number of mothers are still giving birth at home or with TBAs.
4. Majority of the mothers are not knowledgeable on the crucial danger signs during pregnancy that indicate the need to seek medical treatment.

Health plans

Low membership is a challenge to the sustainability of the health plans and this is made worse by limited availability and distribution of providers and the fact that majority of the population are not knowledgeable how the schemes work.

RECOMMENDATIONS

HealthPartners Uganda Health Cooperative

1. UHC could consider lobbying for more funds so that it can continue distributing free ITNS to babies born at the health centers in Ruhinda. This in addition to reducing the incidence of malaria would encourage health facility deliveries.
2. UHC should continue community mobilization and BCC through the CORP on use of ITNS especially addressing the misconceptions and who is priority in sleeping under the nets. UHC needs to also continue with the distribution of IEC materials that encourage ITN use, sensitization on proper use of ITNS, malaria warning signs and importance of early treatment seeking behaviors
3. UHC should continue training and BCC on the importance of pregnant mothers seeking four ANC visits and IPT II. To improve IPT2 coverage, UHC could consider lobbying for more funds to enable the continued distribution of mamakits at 2nd IPT
4. UHC needs to continue training the community on improved water sources, how to make water safe for drinking and also consider strategies of making water purification products more available to the community. This could be through the use of CORP to sell the product or liaising with other partners like PSI to ensure that these products are available even in the remote parts of the community.
5. During the training of the CORP and CORP sessions emphasis needs to be put on the following arrears during
 - a. Diarrhea warning signs
 - b. Safe water and hand washing practices
 - c. Sanitation and hygiene
 - d. Proper feeding of a child with diarrhea and the importance and proper use of ORS
 - e. Re-emphasize the importance of card retention during the CORP MNC and community training sessions
 - f. The importance of RCT and PMTCT
 - g. The importance of mothers delivering at health centers and
 - h. The danger signs during pregnancy that indicate the need to seek treatment.
6. HealthPartners to work with the district health team, local government and MOH to introduce private wings in government health facilities so that they can become scheme providers
7. Marketing team to change marketing strategy to consider using the proven channels like radios, Posting health plan information at health facilities , holding marketing sessions at health units and making plans for follow-up on those who have been marketed to District health Office

District health office, local government and other partners

1. District health office and the local government could also lobby other partners for ITNS for Mitooma or guide those with nets on which sub counties to distribute them.

2. District health office and health workers should continue educating / counseling the community on the importance of sleeping under ITNS especially for children and mothers
3. District health office to liaise with MOH/MCP for IEC materials on ITN use
4. District health office and local government could consider procuring mamakits to be distributed free to mothers who complete IPT II
5. District local government, district health office, district water department and other partners to work together to further improve the community's access to improved water sources i.e. protected springs , tap water and boreholes
6. District health office and local government to sensitize the community on :
 - a. On the importance of having an improved toilet facility i.e. with a solid slab
 - b. Hand washing practices and having a designated hand washing facility
7. Ensure that each household has got an improved toilet and designated hand washing facility
8. District local government, district health office to enforce the TBA policy as stated in the national policy guidelines and service standards for sexual and reproductive health rights which mandates TBAs to only deliver incase of emergency situations
9. District local government, district health office should consider introducing private wings in government health facilities so as to be able to serve the population better and hence improve their health.