



**Episcopal Relief & Development (ERD)
Ajula Pa Rwot**

FIRST ANNUAL REPORT

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ACRONYMS

ANC	Antenatal Care
C-IMCI	Community-Integrated Management of Childhood Illness
CSHGP	Child Survival & Health Grants Program
CSP	Child Survival Project
DIP	Detailed Implementation Plan
DHO	District Health Officer
DNU	Diocese of Northern Uganda
DPT	Diphtheria, Pertussis and Tetanus immunization
EBF	Exclusive Breastfeeding
EPI	Expanded Program on Immunization
ERD	Episcopal Relief and Development
HBC	Home-Based Care
HC	Health Center
HQ	Headquarters
IDP	Internally Displaced Persons
IPT	Intermittent Preventive Treatment
IPTp	Intermittent Preventive Treatment in Pregnancy
ITN	Insecticide Treated Net
KPC	Knowledge, Practice and Coverage
LLIN	Long-Lasting Insecticide-Treated Net
LQAS	Lot Quality Assurance Sampling
MAAIF	Ministry of Agriculture, Animal Industry, and Fisheries
MCH	Maternal and Child Health
MMR	Measles, Mumps, Rubella immunization
MOH	Ministry of Health
NGO	Non-Governmental Organization
NUMAT	Northern Uganda Malaria, AIDS and Tuberculosis Program
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
TT	Tetanus
USAID	United States Agency for International Development
VHT	Village Health Team
WHO	World Health Organization
WRA	Women of Reproductive Age

Introduction

Episcopal Relief & Development (ERD), working with the Diocese of Northern Uganda (DNU), have initiated a Child Survival and Health Grants Project (New Partner Category) (CSHGP) from October 1, 2008 to September 30, 2012. The project is being implemented in Amuru sub-county, Amuru district and Odek sub-county, Gulu district in Northern Uganda. These sub-counties are home to a transient population who moves among ten camps for internally displaced persons (IDP) and the surrounding villages. Maternal and child health indicators are very low in this area as there are no government health services and the population has been living in a conflict situation for over two decades. The project's goal is to contribute to sustained improvements in child survival and health outcomes in Northern Uganda by implementing an integrated community-based program in new and resettled communities in Amuru and Odek sub-counties. The project aims to achieve this goal through three major objectives: 1) increased health knowledge and behaviors to improve health outcomes for mothers and under 5 children at household and community levels, 2) increased access to Maternal and Child Health (MCH) services at community level, and 3) improved quality of health services by strengthening the service delivery capacity of Level II health centers and their staff.

Episcopal Relief & Development and local project partners assigned the name 'Ajula Pa Rwot' to the project in reference to an Acholi value that calls upon all to nurture the weak child. A lock of hair remains uncut to signify that a child's needs must be recognized. This first annual report reflects the project's accomplishments, activities, and challenges during the first year of implementation, from October 1, 2008 to September 30, 2009.

A. Main Accomplishments

Completion of Baseline Assessments:

Beyond the information gleaned in stakeholder meetings in November 2008 and March 2009, the Ajula Pa Rwot project used four sources of baseline data and information: 1) the March 2009 MAP International Rapid Health Facilities Assessment (R-HFA) in Amuru and Odek sub-counties; 2) the June 2008 Action Against Hunger/ACF International Nutritional Anthropometric Survey for Gulu and Amuru Districts; 3) an initial situational analysis performed by Alice Apio, the project's Health Supervisor, in Fall 2008; and 4) Alice Apio's Fall 2008 analysis of past and present child survival work in Northern Uganda. Episcopal Relief & Development reported these studies' results in the detailed implementation plan (DIP). In addition, a new Knowledge, Practices and Coverage (KPC) Survey will be completed by December 2009, as the one completed in March 2009 had problems with study design and implementation. The new survey has been translated, back translated, and approved by USAID. Episcopal Relief & Development is in the process of hiring an American/Ugandan consultant group to train surveyors and oversee data collection.

Preparation of a Detailed Implementation Plan:

Episcopal Relief & Development and DNU convened a four-day DIP development workshop, held from March 10-13, 2009 at the DNU offices. Stakeholders present included a team from Episcopal Relief & Development USA and Episcopal Relief &

Development Ghana, MAP International, district leaders from the districts of Gulu and Amuru, sub-county leaders from Amuru and Odek sub-counties, NGO representatives, political leaders, religious leaders, the Mother's Union and the project staff members. Results from the baseline assessments detailed above confirmed initial impressions and justification for choosing program priorities laid out in the project proposal. Therefore, the DIP's goal and primary intervention areas did not differ widely from the proposal. After adjustments to provide more specificity regarding program implementation activities, Episcopal Relief & Development is finalizing the revised DIP for USAID approval as of October 2009.

Recruitment of Project Staff: Currently, all staff positions are filled, vehicles have been procured, and the office set up. Given the challenge of finding qualified and available candidates in remote Northern Uganda, hiring took longer than expected. By March 2009, the project had hired an Executive Director, Program Director, M&E Supervisor, Finance Officer, Development Supervisor, Cooperative Support Officer, Functional Adult Literacy Supervisor, Health Supervisor, and two Asst. Health Supervisors. The Nutrition Supervisor and the Veterinary Officer were hired in August 2009.

Buy-In of Stakeholders: ERD/DNU held meetings with sub-county leaders and communities to sensitize them to the project's goals and objectives and to gain their buy-in. Community mobilization was accomplished through a series of three meetings: the first with the religious and political leadership, the village chiefs and elders, the program director and the health manager; the second with the whole community to present information on the project interventions; and the third with the whole community to select and confirm Village Health Teams (VHTs) and Traditional Birth Attendants (TBAs). Starting in March 2009, community meetings, open to all, were held in eight parishes monthly to discuss program progress.

Selection and Training of Village Health Teams (VHTs): Parishes were surveyed to find gaps in selecting VHTs.¹ In areas with need, VHTs were selected and confirmed in consultation with community members, community and parish leaders, district health officers and assistant health supervisors. By the end of the first year, 480 VHTs in all targeted areas were confirmed, with 20 more to be selected in quarter one of the second year. Of those 480 VHTs, the project trained 175 in the first year through participation in MoH training courses, as well as specific sessions implemented by DNU. This included:

- 175 VHTs (90 in Gulu and 85 in Amuru) were trained on community-based management of common childhood illnesses, community mobilization, record keeping and reporting. In Gulu, the VHTs have been assigned houses and given home-based care kits (see annex 3 for contents of kits). In Amuru, the VHTs have been given kits, but have not been assigned households yet.
- The nutrition officer, hired in August 2009, initiated nutrition training for the 175 new VHTs in September 2009. In addition, the nutrition officer provided training to eight farmers groups so that they could incorporate learning on nutritious crops into their planting decisions.

¹ A VHT is the local term for a community health worker. It does not refer to a group of people, but just one person.

- While the work plan called for advanced training sessions specifically related to maternal and newborn care, M&E, and project management, for VHT coordinators, ERD/DNU is currently negotiating with the District Health Offices (DHOs) in each sub-district to agree on the number of overall coordinators.

In the course of their household visits, the VHTs started household education on malaria prevention and treatment. VHTs also held more formal ongoing monthly community sensitization sessions related to malaria and other childhood diseases. Once newly trained VHTs were equipped with their kits, they were overwhelmed with malaria cases. Vitamin A supplements and deworming medicines were delivered to health facilities in August 2009. Instead of having deworming medicines and Vitamin A in the kits, VHTs were allowed to pick up small quantities from the health facilities to distribute as needed, as a safeguard against misuse. Net distribution will begin after a source of nets is identified.

Formation of Farmers Groups and Literacy Projects: Using \$28,600 in matching funds, Episcopal Relief & Development formed 8 farmers groups, trained them in good farming practices related to high-nutrient crops, and gave each group an oxen team and plough. Seventeen other groups were formed, and will be supported and trained in the next year. In the coming year, the project also will introduce agroforestry techniques and demonstration kitchen gardens with farmer group members, who will in turn be responsible for sensitizing and training their neighbors. Ten literacy circles were formed which weave health and nutrition messages into basic literacy training, and classes are being held for 710 women. Realizing that there was an unmet need for women with some basic literacy skills (who would most likely become bored in the introductory classes), Episcopal Relief & Development is developing a ‘fast track’ program for these women to achieve full literacy. The fast track program’s goal is for the women to quickly develop the literacy status needed to enter the VHT training program.

B. Activity Status

Table 1. Activity Status of Project Objectives

Objective	Activities	Status of Activities	Comments
Objective 1: Increased health knowledge and behaviors to improve health outcomes for mothers and children under 5 at household and community levels.	<ul style="list-style-type: none"> • Community sensitization on causes, identification, treatment and prevention of common childhood illnesses such as malaria, ARI, malnutrition, acute diarrheal disease and immunization-preventable diseases 	Not yet on target	Completed through VHT trainings with expectation they will pass the messages to the community. Ongoing in 2/3 of parishes.
	<ul style="list-style-type: none"> • Train Village Health Teams on IMCI. 	Not yet on target	175 VHTs trained as of 09/09. The other 325 will be trained in 11/09 and 2/10.
	<ul style="list-style-type: none"> • Identify common maternal and childhood health problems through VHT training 	On target	On target for trained VHTs; see above bullet for remaining VHT trainings.
	<ul style="list-style-type: none"> • Distribute nets 	Not yet on target	A source for in-kind procurement of nets has not been found; but ERD is working with local PMI partner to

			ensure in-kind LLITNs in Y2
	<ul style="list-style-type: none"> Distribute deworming medicines & Vitamin A supplements 	Not yet on target	Deworming medicines and Vitamin A supplements were distributed to health facilities in 8/09. In Aug/Sept 09, deworming meds were given to 7,972 children aged 0-5years and Vitamin A to 4,922 children aged 0-5years.
	<ul style="list-style-type: none"> Provide nutrition training to mothers, care givers and community members 	Not yet on target	Nutrition officer not hired until 8/09; training program is now rolling out with sessions planned Oct/Nov 09, Feb/Mar 10, June/Jul 10
	<ul style="list-style-type: none"> Provide agronomic training on Vitamin A-rich crops to farmers groups, households who cultivate backyard gardens and other community members 	Not yet on target	Trainings will take place in March and June 10 in advance of planting seasons.
Objective 2: Increased use of key maternal and child health services and practices to reduce maternal and infant mortality, to reduce morbidity and increase effective treatment of childhood illness	<ul style="list-style-type: none"> Identify VHTs by community 	On target	480 VHTs have been identified. 20 others will be selected in Oct/Nov 09.
	<ul style="list-style-type: none"> Train 500 Village Health Teams (VHTs) to provide basic health services, with an emphasis on child and maternal health 	Not yet on target	175 VHTs trained as of 09/09 using MOH VHT/TBA manual, with a test mark of 45% to pass. Other 325 VHTs to be trained in 11/09 and 2/10.
	<ul style="list-style-type: none"> Provide quarterly refresher training 	On target	The first refresher training is scheduled before end 2009. ERD completing verification exercise to determine which VHT are still active with DHO.
	<ul style="list-style-type: none"> Distribute kits to VHTs 	Not yet on target	Kits were distributed to 175 VHTs in 8/09. Kits for other 325 VHTs will be distributed after training.
	<ul style="list-style-type: none"> Train 50 VHT coordinators 	Not yet on target	Still determining with DHO the ratio of VHT coordinators to VHTs.
	<ul style="list-style-type: none"> Train 50 TBAs 	Not yet on target	Given political considerations with DHOs, details of training are still being finalized.
	<ul style="list-style-type: none"> Distribute TBA Kits 	Not yet on target	See above.
	<ul style="list-style-type: none"> Refill VHT and TBA kits. 3 major refills on quarterly basis but periodic monitoring by supervisors to top off as needed avoiding shortages 	On target	First refill for VHT kits is scheduled for 11/09 with caveat that restocking of drugs is subject to additional discussions with DHOs.
	<ul style="list-style-type: none"> Incentivize VHTs by offering membership to a Savings & Loan Group 	Not yet on target	Sensitized trained 175 VHTs in 7/09. Will sensitize others after VHT training.
	<ul style="list-style-type: none"> Form savings groups 	On target	8 groups formed.
<ul style="list-style-type: none"> Train savings groups on loans, savings, group dynamics, and basic 	On target	In planning stage. In workplan to be implemented in year 2, quarter 1.	

	mgmt.		
	<ul style="list-style-type: none"> Form farmers groups 	On target	Selected 25 farmers groups after community mobilization. A total of 32 oxen and 8 ox-ploughs have been distributed to 8 of the groups. The other 17 groups will get oxen and ox-ploughs b/f end 2009.
	<ul style="list-style-type: none"> Provide agronomic trainings 	On target	Trained 111 people in 8 farmers groups on animal traction, animal husbandry, and plough repair and maintenance.
	<ul style="list-style-type: none"> Provide nutrition training for mothers who are care-givers and mothers in Mothers' groups and Literacy Circles 	Not on target	Nutrition officer hired in 8/09; trainings will begin in 10/09.
	<ul style="list-style-type: none"> Form literacy circles 	On target	Identified and trained 10 literacy coordinators. Literacy circles are meeting.
Objective 3: Improved quality of health services by strengthening the service delivery capacity of Level II health centers and their staff	<ul style="list-style-type: none"> Train clinical staff on IMCI strategies 	Not yet on target	Still at planning stage.
	<ul style="list-style-type: none"> Make mentoring visits to Level II clinicians 	Not yet on target	Still at planning stage.

Please see Annex 2 for 'progress by technical implementation area' information.

C. Factors of Impeded Progress

Procurement of project vehicles. The project began by using existing motorbikes for transportation, but these continued to break down, resulting in delays in reaching project sites. Therefore, Episcopal Relief & Development South Africa procured two Nissan double-cabin project vehicles for the Ajula project team. There was a delay in picking these up while waiting for a tax exemption letter from USAID. In June 2009, Episcopal Relief & Development learned that USAID would not issue a letter of tax exemption, after which Episcopal Relief & Development picked up the vehicles from South Africa immediately. The budget needed modification to account for the \$19,000 in unanticipated tax paid by the project. Funding from salary cost-savings (staff hired later than budgeted) and foreign exchange gains covered the additional vehicle cost.

Polio Outbreak: A polio outbreak before the DIP workshop in March 2009 precluded a number of project stakeholders, including the USAID representative, from participating and resulted in a delay in obtaining their input on the project and its planned activities.

Population Movement: Families in both sub-counties are in the process of resettling from the camps to the villages where they lived before the conflict. However, many people still move back and forth between the camps and their homes in the villages, making it difficult to determine an accurate number of households and population in a given area. In order to obtain more accurate figures, in September the Ajula team completed an

informal household census in several villages to verify DHO information about the number of needed VHTs and how to assign VHTs to households. The project will continue to work with local government to monitor this situation and adjust programmatic activities accordingly.

VHT system: The VHT structure for collecting, analyzing and disseminating information is weak. Currently, a supervisory VHT is located in each parish, and is responsible for approximately 40-50 VHTs. This does not allow the supervisory VHT enough time to oversee all VHTs, support them, and ensure information is being collected accurately. The Amuru district health officer (DHO) has agreed to appoint a supervisory VHT, partially supported by the Ajula project, for each village (responsible for approximately 4-7 VHTs) in order to ensure better supervision. Negotiations are ongoing with the Gulu DHO on this point. The project team hopes this change will result not only in better information to monitor the progress of the Ajula project, but also for the DHOs to use in making decisions to prioritize health problems and choose effective interventions.

Procurement of LLITNs: Given that the cost of LLITNs could not be included in the project budget, Episcopal Relief & Development had to look elsewhere for a source of ~10,000 LLITNs a year to use for community distribution by the VHTs. However, the project has not yet found an in-kind source of nets. In Year Two, Episcopal Relief & Development will liaise with Malaria Consortium and NUMAT, who are the designated President's Malaria Initiative (PMI) partners in Uganda, to ensure that the Ajula project's request can be included in the PMI net order.

Training of TBAs: Negotiations are ongoing to determine how to address the TBA training issue. While the official Government of Uganda policy is to phase out TBAs by 2015, by which time all deliveries should take place at Health Centers Level III or higher, the Ajula project decided to maintain an emphasis on TBA training as a strategy to improve ante-natal care (ANC) and safe delivery. This decision was made as infrastructure improvements necessary to implement the government's policy are unlikely to occur in N. Uganda in the project's timeframe. To remove TBAs from the picture could result in an increase in infant and maternal mortality as the gap between community need and health service provision remains wide.

As of August 2009, the Amuru DHO agreed to include current TBAs in the VHT retraining sessions, with the caveat that no new TBAs will be recruited and trained. Negotiations are still ongoing with the DHO from Gulu to determine an acceptable solution. Given the sensitivity of the issue and the need for higher-level support for the Ajula project staff in negotiations with the DHOs, the time and responsibilities of a staff member from MAP International (see D. below) have been increased. He will provide more consistent and timely follow up with the DHOs to ensure this issue is resolved quickly so that TBA training can start.

Malaria Medicines: After the home-based care kits were distributed to VHTs, the 175 VHTs treated 1600 cases of suspected malaria in a week. Without a refill supply available at health centers, the VHTs, who each had 9 doses of Coartem in his/her kit,

exhausted their supply of malaria medicines in that first week. The VHTs were not originally conceived of as the only source of appropriate malaria medication in the community and distributing the drugs at this rate is outside the Ajula project's scope and budget. However, without drugs available at health centers, the community has begun to view the VHTs as the only source of appropriate malaria treatment. The Ajula project is currently in discussions with the DHOs and USAID to figure out a strategy to ensure adequate supplies of malaria medicines to the health facilities and VHTs.

D. Technical Assistance Needs

In order to avoid challenges with annual data collection in the future, the project team plans to strengthen its monitoring and evaluation (M&E) efforts internally, as well as seek outside technical assistance. Episcopal Relief & Development is hiring an external consultant team to train its own staff and data collectors (most likely from Makerere University or a similar institution) to perform annual KPC surveys, using several shorter, focused instruments.

Other technical assistance comes from the contributions of MAP International, one of the Ajula project partners, for broad-based health activities related both to the training of VHTs and TBAs and strengthening of clinical skills and services within the Level II health centers in the target camps. MAP staff supervise assistant health supervisors at Level II centers, and coordinate with Ministry of Health (MOH) on the logistics of the replacement of health kit supplies and drug procurement. Emmanuel Odongo from MAP International will also be playing a greater role (increasing from 10% LOE to 50% LOE) in liaising and negotiating with MOH staff at central and district levels.

Episcopal Relief & Development currently is searching for technical expertise related to health facility staff capacity development and mentoring. The project originally planned to use internal staff, who now are unavailable due to other project commitments.

E. Substantial Changes to Project Description

The final first-year project strategy deviated in only two areas from the original proposal: 1) expansion of the targeted geographic area and 2) elimination of several of the interventions related to community water and sanitation. Originally, the geographic focus of the project's efforts was ten IDP camps. Given the relative stability in the region, a large percentage of former IDP camp residents have moved back to their villages to work their land. As a result of this change, the project is now targeting the entire population—individuals in camps and back in their villages—in Amuru and Odek sub-counties instead of only the ten camps. The program's original concept included the creation and training of four community water and sanitation committees and the protection of five springs as sources of safe water. However budget constraints did not allow for this element to be included in the implementation plan. While the project strategy still incorporates community sensitization around hygiene practices as a strategy for preventing diarrheal disease, Episcopal Relief & Development currently seeks additional funding for the provision of potable water or to link Ajula communities with other actors who may be to support this element. USAID approved both these changes in June 2009.

F. Progress Towards Sustainability

The project addresses sustainability issues primarily through working with local organizations that have been – and will be - part of the community long before and after the project is finished. The DNU is a well-respected and stable member of communities in Northern Uganda and is aware of and responds to local needs. By building the management and technical capacity of DNU staff, the project works to ensure that DNU will have the structures and capabilities to implement future community-driven projects effectively. In particular, the farmers groups and literacy circles, both of which have been enthusiastically received by the villagers, can continue and adapt to changing community needs, even after the Ajula project is over, with small inputs from the DNU.

G. Specific Information Requested

USAID approved the organizational capacity plan in September 2009, and agreed that Episcopal Relief & Development would submit an M&E plan after the KPC survey is completed in November 2009. The DIP plan is in process of being revised for USAID approval as of October 2009. The social and behavior change strategy will be submitted in late 2009 after making any revisions resulting from the KPC and barrier analysis studies.

H. Baseline Data and Assessment Results

In terms of health facilities, the R-HFA found that 65% of the daily visits at health units both level II and III in Amuru and Odek sub-counties were children under five and the majority of the cases, in order of incidence, were malaria, RTI, diarrhea, intestinal worms, and injuries. The survey found that the combination of inadequate health services and lack of transportation make it difficult, if not impossible, for villagers to seek referral care to Level III centers and above. In terms of maternal health, 43% of the women in the two targeted sub-counties use TBAs for labor. See Annex 4 for more information about the capacities of the health centers.

The results of the initial KPC study, performed in March 2009, were found to be inconsistent with other baseline data sources. Potential sources of bias were interviewees wanting to give the correct answers, interviewees only sampled from camp populations (which may have better access to care), and interviewees not understanding the qualifications of the persons providing the care. In order to gather more accurate data, the Ajula team will conduct another KPC survey in November 2009. The goals will be to 1) determine the knowledge, attitudes and practices of people in Amuru and Gulu districts in the areas of maternal and newborn care, breastfeeding/infant and young child feeding, Vitamin “A” supplementation, malaria-treatment of fever of children, ARI/pneumonia, water and sanitation, and health contacts and sources of health information; and 2) establish benchmarks and identify indicators for monitoring the activities of the project in order to measure impact and change.

I. Challenges and Updates to Project Management System

The results of Episcopal Relief & Development’s ongoing strategic planning process included two recommendations for project management capacity building within

Episcopal Relief & Development and with partner organizations – to enhance administrative and financial systems for more effective management and to enhance technical skills in participatory M&E for more effective monitoring and communication of project impact. USAID funding under this cooperative agreement is helping address this vision.

Financial Management System: The Episcopal Relief & Development Finance Manager traveled to Northern Uganda in August 2009 to train DNU program staff to ensure compliance with USAID guidelines for timesheet management and accounting norms.

Human Resources: Alice Apio, the health supervisor, is technically strong, but has not had much management experience. As she now is responsible for overseeing a small team, Episcopal Relief & Development is arranging management training for her in the coming year. In addition, the time of MAP International staff member Emmanuel Odongo will be increased from 10% LOE to 50% LOE in order to provide more support and informal capacity building to DNU staff. Specifically, he will be a consistent and respected presence who will follow up on potentially sensitive issues with the MoH, such as TBA training. He also will assume primary responsibility for liaising with other NGOs, including attending the bi-weekly Gulu coordination meetings.

Due to various issues within the Episcopal Church, including Bishop Nelson's retirement and the election of a new Bishop in N. Uganda, the DNU staff has endured a period of some uncertainty and transition during the past year. Those issues have been resolved and the staff is looking forward to working with the new Bishop, who is a development professional and has indicated strong support for this project.

Communication System and Team Development: The project experienced minor issues in the course of seconding MAP staff to the DNU, including ensuring that the seconded staff received the same package of health benefits as they had at MAP. Episcopal Relief & Development held full team meetings to discuss these and other concerns. These open conversations helped resolve the issues and build trust among the various partners, a critical element in building esprit de corps during the start-up process.

Local Partner Relationships: The relationship with DNU has been productive and collegial, resulting in strong team cohesion and excellent management capacities of the on-the-ground staff. The resolution of the church political issues also has made the partnership easier. The relationship with the District Health Offices has been mostly supportive and fruitful. However, there is an ongoing issue with the DHO's VHT focal people, who are less open towards joint planning with the Ajula project. Episcopal Relief & Development is aware of this issue and hopes that the designation of Emmanuel Odongo as the primary contact point will help resolve this issue, by providing follow up from someone perceived to have status and credibility by the DHO staff.

PVO Coordination/Collaboration: Since March 2009, DNU staff have attended the bi-weekly UN NGO Coordinating Group Health Cluster meetings in Gulu to share information, programmatic challenges, and lessons learned. In order to provide more

consistency, Emmanuel Odongo has been assigned as the primary contact person responsible for attending these meetings and fostering relationships with the other NGOs. An issue often raised by DHOs and communities is why the Ajula project isn't focusing on issues of HIV/AIDS, given the high burden in the area. In the coming year, the Ajula project will work more closely with Northern Uganda Malaria AIDS & Tuberculosis Program (NUMAT) to figure out how to respond to these community concerns. In addition, Episcopal Relief & Development will work with the Malaria Consortium to order LLITNs.

J. Local Partner Organization Collaboration and Capacity Building

In the first year, 11 DNU project staff were trained in program management, in M&E, and in MCH. Episcopal Relief & Development will continue to work with DNU to foster skills in participatory M&E, including how to integrate community leaders in monitoring program indicators, use of guided focus groups for regular community feedback, and how to share information routinely with communities. Training in KPC surveys, as well as on software and templates for budgeting and tracking finances, is planned for the first six months of the project's second year.

K. Mission Collaboration

In preparation of the original proposal, DNU visited the USAID Mission in Gulu to inform staff there of the proposed project and seek their guidance on how it might best collaborate with the Mission to achieve the project goals. Due to various issues (vacancies at USAID, polio outbreaks), no USAID staff were able to attend the DIP planning meetings in November 2008 and March 2009. However, since May 2009, the Ajula Pa Rwot team has made every effort to be in regular communication with James Okello, the USAID Health Advisor. The staff has met with him twice to solicit his advice on technical issues and help solve administrative problems.

Going forward, there is a need to strengthen the relationship between the Ajula project and other mission-funded projects. Episcopal Relief & Development has assigned Emmanuel Odongo responsibility for NGO coordination (see D. and I. above) in order to improve these relationships. However, Ajula project staff also would welcome the opportunity to participate in regular monthly USAID partner meetings in order to share information and jointly plan strategies. In the United States, Janette O'Neill, Episcopal Relief & Development's headquarters' backstop, is in close communication with Jennifer Yourkevitch, the USAID new partner advisor.

L. Other Relevant Aspects

All relevant project aspects are covered in the report.

Annex 1: M&E Plan

* *Baseline values and targets will be filled out in early December, after the KPC survey is complete.*

Technical Areas	Indicators	Source/ Measurement Method	Frequency	Baseline value	EOP Target	Related Activities
Objective 1	Increased health knowledge and behaviors to improve health outcomes for mothers and under 5 children at household and community levels.					
Malaria Prevention and Treatment	% of children age 0-23 months with febrile episode of malaria within the last 2 weeks who were treated with an effective anti-malaria drug within 24hrs after the fever began	KPC Survey	Baseline, Mid-term, Final			House-to-house distribution of LLITNs with education on correct and consistent use Train and equip VHTs (500 VHTs)
	# of LLITNs distributed	Project Reports	Quarterly	0		
	% of households with children age 0-23 months who have at least one LLITN	KPC Survey	Baseline, Mid-term, Final			
	% of households with pregnant women with at least one LLITN	KPC Survey	Baseline, Mid-term, Final			
	% of children age 0-23 months who slept under LLITN the previous night	KPC Survey	Baseline, Mid-term, Final			
	% of pregnant women who slept under LLITN the previous night	KPC Survey	Baseline, Mid-term, Final			
	% of caregivers who know that malaria is caused by infected mosquitoes	KPC Survey	Baseline, Mid-term, Final			

Technical Areas	Indicators	Source/ Measurement Method	Frequency	Baseline value	EOP Target	Related Activities
	% of caregivers who can recognize the signs & symptoms of uncomplicated and complicated malaria	KPC Survey	Baseline, Mid-term, Final			
	% of expectant mothers who received at least 2 doses of IPT during pregnancy	KPC Survey	Baseline, Mid-term, Final			
ARI/ Pneumonia Care and Treatment	% of children age 0-23 months with a chest related cough and fast and/or difficult breathing in the last 2 weeks who were taken to an appropriate health provider	KPC Survey	Baseline, Mid-term, Final			Train and equip VHTs (500 VHTs)
	% of caregivers who can identify the cardinal signs and symptoms of pneumonia cases	KPC Survey	Baseline, Mid-term, Final			
	% of caregivers who know prevention practices for ARI	KPC Survey	Baseline, Mid-term, Final			
Maternal and Child Nutrition	% of children age 0-5 months who were exclusively breastfed during the last 24 hours	KPC Survey	Baseline, Mid-term, Final			Train and equip VHTs (500 VHTs)
	% of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	KPC Survey	Baseline, Mid-term, Final			Distribute deworming medicines & Vitamin A supplements
	% of children age 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)	KPC Survey	Baseline, Mid-term, Final			Provide nutrition training to mothers Provide nutrition sensitization

Technical Areas	Indicators	Source/ Measurement Method	Frequency	Baseline value	EOP Target	Related Activities
	% of children age 6-23 months who receive a dose of Vitamin A in the last 6 months	KPC Survey	Baseline, Mid-term, Final			Provide agronomic training on Vit. A-rich crops to farmers groups
	# of Vitamin A capsules offered to children age 6-23 months	VHT Records	Quarterly	0		
	% of children age 6-23 months who have been de-wormed during the last six months	KPC Survey	Baseline, Mid-term, Final			
	Quantity of de-worming tablets administered to children age 6-23 months	VHT Records	Quarterly	0		
Immunizations	% of mothers with children age 0-23 months who received at least 2 tetanus toxoid vaccinations before the birth of their youngest child	KPC Survey	Baseline, Mid-term, Final			Train and equip VHTs (500 VHTs)
	% of children aged 12-23 months who received a measles vaccination	KPC Survey	Baseline, Mid-term, Final			
	% of children aged 12-23 months who received DPT1 vaccination before the received 12 months according to vaccination card or mother's recall by the time of the survey	KPC Survey	Baseline, Mid-term, Final			

Technical Areas	Indicators	Source/ Measurement Method	Frequency	Baseline value	EOP Target	Related Activities
	% of children aged 12-23 months who received DTP3 vaccination before they reached 12 months according to the vaccination card or mother's recall by the time of the survey	KPC Survey	Baseline, Mid-term, Final			
	% of children under 2 years who are fully immunized	KPC Survey	Baseline, Mid-term, Final			
Control of Diarrheal Diseases	% of children age 0-23 months with diarrhea in the last 2 weeks who received ORS and/or recommended home fluids	KPC Survey	Baseline, Mid-term, Final			Train and equip VHTs (500 VHTs)
	% of households of children age 0-23 months that treat water effectively	KPC Survey	Baseline, Mid-term, Final			
	% of mothers of children age 0-23 months who live in households with soap or a locally appropriate cleanser at the place for hand washing	KPC Survey	Baseline, Mid-term, Final			
Maternal and Newborn Care	% of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child	KPC Survey	Baseline, Mid-term, Final			Identify common maternal and childhood health problems
	% of women of childbearing age who know early danger signs of delivery	KPC Survey	Baseline, Mid-term, Final			Train and equip VHTs (500 VHTs) Educate and support

Technical Areas	Indicators	Source/ Measurement Method	Frequency	Baseline value	EOP Target	Related Activities
	% of children age 0-23 months whose births were attended by skilled personnel	KPC Survey	Baseline, Mid-term, Final			pregnant women and newborn babies (how?)
	% of children age 0-23 months whose births were attended by trained TBAs	KPC Survey	Baseline, Mid-term, Final			Train and equip TBAs
	% of children age 0-23 months who received a postnatal visit from an appropriate trained health worker within 2 days after the birth of the youngest child	KPC Survey	Baseline, Mid-term, Final			
	% of mothers of children of age 0-23 months who are using a modern contraceptive method	KPC Survey	Baseline, Mid-term, Final			
Cross-Cutting: Community IMCI	# of community sensitization sessions held	VHT Supervisors Register	Quarterly	0		Community sensitization on causes, identification, treatment and prevention of common childhood illnesses such as malaria, ARI, malnutrition, acute diarrheal disease and immunization-preventable diseases
	# of people reached through community sensitization sessions	VHT Supervisors Register	Quarterly	0		
	# of mothers and caregivers who have received nutritional training	VHT Supervisors Register	Quarterly	0		
	# of people sensitized on nutritional food supplement	VHT Report	Quarterly	0		
Cross-Cutting: Nutrition	# of farmers trained on agronomic dynamics and basic management	Training reports	Quarterly	0		Form farmers groups Provide agronomic

Technical Areas	Indicators	Source/ Measurement Method	Frequency	Baseline value	EOP Target	Related Activities
	# of farmers groups who use improved agricultural techniques and livestock management	Activity Evaluation	Annually	0		trainings dynamics, and basic management
	% of households which consume locally-produced foods rich in Vit A and micronutrients	KPC Survey	Baseline, Mid-term, Final	8% (Source: ACF Survey)		
Cross-Cutting: Gender Imbalance	# of literacy meetings held in the last three months	Training/ Program report	Quarterly	0		Form literacy circles
	# of women newly literate and numerate	Project report (Post-test results)	Annually	0		
Objective 2	Increased use of key maternal and child health services and practices to reduce maternal and infant mortality, to reduce morbidity, and increase effective treatment of childhood illness					
Maternal and Newborn Care	# of VHT Coordinators who have received training in maternal & newborn care	Training Report	Quarterly	0		Identify VHTs by community
	# of training sessions organized for VHT Coordinators in maternal & newborn care	Training Report	Quarterly	0		Train 500 VHTs to provide basic health services, with an emphasis on child and maternal health
	# of Diocesan staff who have received training in maternal & newborn care	Training Report	Quarterly	0		
	# of TBAs who have received training in maternal & newborn care	Training Report	Quarterly	0		Train 50 VHT coordinators
	# of training sessions organized for TBAs	Training Report	Quarterly	0		Train 50 TBAs
	# of TBAs who have been equipped with safe-delivery kits	Logistics Log book	Quarterly	0		Provide quarterly refresher training
Cross-Cutting:	# of VHTs trained with CSHGP Funds	Training Report	Quarterly	0		Distribute kits to VHTs

Technical Areas	Indicators	Source/ Measurement Method	Frequency	Baseline value	EOP Target	Related Activities
Community IMCI	# of training sessions organized for VHTs	Training Report	Quarterly	0		Distribute TBA Kits
	# of home-base care kits distributed to VHTs	VHT Records	Quarterly	0		Refill kits as needed
	# of VHT Coordinators who have been trained in project management	Training Report	Quarterly	0		VHTs to provide basic health services, with an emphasis on child and maternal health
	# of training sessions organized for VHT Coordinators in project management	Training Report	Quarterly	0		Incentivize VHTs by offering membership to a Savings & Loan Group
	# of Diocesan staff who have received project management training	Training Report	Quarterly	0		
	# of VHT Coordinators who have received training in M&E	Training Report	Quarterly	0		Form savings groups
	# of training sessions organized for VHT Coordinators in M&E	Training Report	Quarterly	0		Train savings groups on loans, savings, group
	# of Diocesan staff who have received M&E training	Training Report	Quarterly	0		
	% of VHTs that received supervision visits	Project Report	Quarterly	0		
	% of VHT Coordinators' reports that are accurate and complete	Project Report/VHT Coordinator Report Review	Quarterly	0		
# of Savings & Loan Groups formed	Project Report	Annually	0			

Technical Areas	Indicators	Source/ Measurement Method	Frequency	Baseline value	EOP Target	Related Activities
	Average amount saved per group	Project Report	Annually	0		
Objective 3	Improved quality of health services by strengthening the service delivery capacity of Level II health centers and their staff					
Cross-Cutting: Clinical IMCI	# of nurses and nurse assistants who have received training in improving service delivery	Training Report	Quarterly	0		Train clinical staff on IMCI strategies Make mentoring visits to Level II clinicians
	# of training sessions organized for nurses & their assistance in service delivery	Training Report	Quarterly	0		
	Type and quantity of health service delivery inputs distributed to health facilities	Logistics log book	Quarterly	0		
	# of mentoring visits made by external expert medical team	Mentoring Trip Report	Quarterly	0		

Annex 2. Activity Status by Technical Intervention Areas

** Specific targets in project objectives will be filled in after KPC and barrier analysis are complete in November 2009.*

Malaria (20% level of effort)

Project Objectives:

1. xx% of expectant mothers take in a minimum of 2 doses of IPT during pregnancy.
2. xx% of expectant mothers and children age 0-23 months sleep under LLITNs every night
3. xx% of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began.
4. xx% of caregivers are able to identify early symptoms and signs of malaria and seek appropriate care promptly.

Key Activities: LLITN distribution, education and community mobilization to increase LLITN and IDP uptake, training to increase health clinicians' skills in diagnosing and treating malaria

Activity Status: Not yet on target

Comments: While training of VHTs and community mobilization has begun throughout the two sub-counties, nets have not yet been procured and distributed. In addition, training has not yet begun for health clinicians in malaria diagnosis, treatment and referral. The Ajula project is also in discussions with provincial MOH to develop a strategy to increase availability of malaria drugs such as Coartem and ACTs at health facilities in the area.

ARI/Pneumonia (20% level of effort)

Project Objectives:

1. xx% of caregivers of children age 0-23 months know the predisposing factors to ARI and how to prevent them through EBF, immunization, hand washing, avoiding cooking fires indoors.
2. xx% of caregivers are able to identify early symptoms and signs of ARI and seek appropriate care promptly.
3. xx% of children age 0-23 months with chest-related cough and fast and/ or difficult breathing (in the last two weeks) are taken to an appropriate health provider.

Key Activities: Training VHTs and caregivers to recognize early signs of ARI/Pneumonia, education on prevention, diagnosis and community treatment, improving supply of medications

Activity Status: Not yet on target

Comments: Of the 480 VHTs selected, 175 have taken the MOH training course that includes ARI/pneumonia diagnosis and home-based management. These VHTs have conducted community mobilization activities to educate caregivers on prevention of ARI and recognition of early signs.

Maternal and Child Nutrition (10% level of effort)

Project Objectives:

1. Pregnant women and lactating mothers consume adequate quantities of nutrient rich foods and supplements (iron, folate, vitamin A).
2. xx% of children age 0-5 months are exclusively breastfed during the last 24 hours.
3. xx% of infants and young children age 6-23 months are fed by caregivers according to a minimum of appropriate feeding practices.
4. xx% of children 0-23 months who are underweight (-2 SD for the median weight for age, according to
5. Caregivers provide optimal nutritional care of sick and severely malnourished children, including continuing to feed during illness and increasing feeding after illness.
6. xx% of children age 6-23 months receive deworming medications in the last six months.
7. xx% of children age 6-23 months receive a dose of Vitamin A in the last six months.

Key Activities: distribution of deworming medicines and Vitamin A supplements, training on appropriate infant and young child feeding, promotion of optimal breastfeeding during the first six months (e.g., timely initiation within one hour of birth and exclusive breastfeeding for six months) and optimal complementary feeding starting at 6 months with continued breastfeeding to 2 yrs and beyond, promotion of optimal nutritional care of sick and severely malnourished children, promotion of adequate intake of iron, folic

acid, and iodine, trainings of VHTs and TBAs on locally-grown nutrient-rich foods and the nutritional needs and practices for teenage mothers and HIV positive mothers

Activity Status: Not yet on target

Comments: Of the 480 VHTs selected, 175 have taken the MOH training course that includes sessions on food and nutrition and identifying malnutrition in children. Deworming medications and Vitamin A supplements have been delivered to health facilities in Amuru and Odek sub-counties. They are not included in VHT kits in order to discourage misuse. Instead, VHTs are requested to pick up these medicines in small quantities to distribute as needed.

Immunization (10% level of effort)

Project Objectives:

1. Pregnant women seek vaccination against maternal and neonatal tetanus, i.e. xx% of mothers with children age 0-23 months receive at least two Tetanus toxoid vaccinations before the birth of their youngest child.
2. xx% of children age 12-23 months receive a DPT1 vaccination before they reached 12 months.
3. xx% of children age 12-23 months receive a measles vaccination.
4. xx% of children age 12-23 months receive a DPT3 vaccination before they reached 12 months.
5. xx% of children under two years are fully vaccinated and on schedule.

Key Activities: education on benefits of and how to access immunization, improved supply and cold chain, immunization campaigns

Activity Status: Not yet on target

Comments: Of the 480 VHTs selected, 175 have taken the MOH training course that includes a session on immunization. The project has not yet assisted with any immunization campaigns.

Control of Diarrheal Disease (20% level of effort)

Project Objectives:

1. xx% of mothers of children age 0-23 months live in a household with soap or a locally appropriate cleanser at the place for hand washing.
2. xx% of households of children age 0-23 months that treat water effectively, i.e. with chlorine solution, filtration, or boiling and protection from contamination.
3. xx% of children age 0-23 months with diarrhea (in the last two weeks) receive oral rehydration solution (ORS) and/or recommended home fluids.

Key Activities: education on control and treatment of diarrhea, prevention through hygiene and good sanitation (particularly promotion of proper hand washing at critical times), and drinking clean water, i.e. treated with chlorine solution, filtration or boiling and protected from contamination; improved supplies of ORS with zinc; training of health center staff in counseling skills related to diarrheal diseases

Activity Status: Not yet on target

Comments: Of the 480 VHTs selected, 175 have taken the MOH training course that includes diarrheal disease diagnosis and home-based management. These VHTs have conducted community mobilization activities to educate caregivers on prevention of diarrheal disease and recognition of early signs. Training has not yet begun for health clinicians in diarrheal disease diagnosis, treatment and referral. In addition, ERD is currently looking for outside funding to implement safe water projects in the area.

Maternal and Newborn Care (20% level of effort)

Project Objectives:

1. xx% of mothers of children age 0-23 months have 4 or more antenatal visits when they were pregnant with the youngest child.
2. Pregnant women will recognize and report promptly with their problems to the appropriate center.
3. TBAs and health personnel will adopt clean practices when conducting deliveries and newborn care. These include the six cleans: of hands, perineum, delivery surface, in cutting the umbilical cord, in caring for the newborn baby's cord and for the eyes with application of 1% tetracycline ointment or 1% silver nitrate.
4. xx% of children age 0-23 months whose births were attended by skilled personnel.
5. Mothers of newborns breastfeed immediately following delivery and frequently thereafter.

6. Mothers of infants frequently breastfeed when child has diarrhea and ARI.

Key Activities: community education on benefits of improved maternal and neonatal care, TBA and health center staff training, improved supplies for TBAs and level II centers. Plan for delivery at health facility if possible. In cases where access to health facilities is low, TBAs will be able to provide safe deliveries using knowledge acquired through their training. TBA training curriculum will be in line with WHO guidelines on “care for the maternity patient”.

Activity Status: Not on target

Comments: Of the 480 VHTs selected, 175 have taken the MOH training course that includes sessions on care of the newborn and record keeping and home-based care (HBC) registers. These VHTs have conducted community mobilization activities that include education of caregivers on newborn care. As mentioned in the report, the Ajula team is still negotiating with MOH for the inclusion of TBAs into training sessions and distribution of TBA kits. In addition, training has not yet begun for health clinicians in maternal and newborn care.

Cross-Cutting: Community IMCI

Project Objectives:

1. To build greater community awareness and trust with regard to use of the health centers.
2. To develop skills at the home and community level to prevent the greatest causes of childhood illness and treat less complicated conditions.
3. To strengthen the ability of VHTs, TBAs and health center clinicians to treat infections that are more complicated and to make referrals to Level II, III and higher centers in the region when warranted.

Key Activities: training VHTs on management of childhood fevers, acute diarrheal disease and malnutrition, improving the linkage/referral system between the community and level II centers.

Activity Status: Not on target

Comments: Of the 480 VHTs selected, 175 have taken the MOH training course that is focused on community IMCI. These VHTs have conducted community mobilization activities to increase knowledge of community members on how to prevent common diseases and treat uncomplicated conditions. As mentioned in the report, the Ajula team is still negotiating with MOH for the inclusion of TBAs into training sessions.

Cross-Cutting: Clinical IMCI

Project Objectives:

1. To strengthen the ability of VHTs, TBAs and health center clinicians to treat infections that are more complicated and to make referrals to Level II, III and higher centers in the region when warranted.

Key Activities: training on diagnosing and treating childhood fevers, acute diarrheal disease and malnutrition, improving linkages with the community and with Level III centers

Activity Status: Not on target

Comments: Of the 480 VHTs selected, 175 have taken the MOH training course that includes sessions on referrals to health centers. The Ajula team is still negotiating with MOH for the inclusion of TBAs into the training sessions. The training and mentoring of health center clinicians has not yet begun. ERD is currently looking for technical expertise related to health facility staff capacity development and mentoring in order to implement these activities in Year 2.

Cross-Cutting: Nutrition

Project Objectives:

1. 25 farmers groups use improved agricultural techniques and livestock management to grow high-nutrient, drought-resistant crops.
2. xx% of households consume locally produced foods rich in vitamin A and micronutrients.

Key Activities: training for farmers groups in improved agricultural techniques and livestock management, training with farmers’ and literacy groups to provide nutrition education

Activity Status: Not on target

Comments: 25 farmer groups have been formed and 8 groups have been trained and supported through the purchase of oxen and ploughs. A nutrition expert has been hired by the Ajula project and will begin nutrition trainings for Literacy circles in October 2009.

Cross-Cutting: Gender Imbalance

Project Objectives:

1. Improve opportunities for women with limited literacy to become health volunteers.
2. **xx** women are newly literate and numerate.

Key Activities: special training for women VHTs and TBAs with limited literacy, formation of literacy circles through Women's Union

Activity Status: On target

Comments: 710 women have joined 10 Literacy Circles and are meeting on a regular basis. The community has responded enthusiastically to this intervention and the Ajula project is developing a 'fast track' literacy program for women with basic literacy. In addition, ERD is working with MOH and the DHOs to find ways to increase the percentage of VHTs and TBAs that are women (currently 17.5% of the 480 VHTs selected are women).

Annex 3. Contents of Home-Based Care Kits

S/No.	Item description	Quantity
1	Tablets Coartem	72
2	Tablets paracetamol	100
3	Iodine solution	2
4	Gentian violet solution	2
5	Chlorexidine + centrimide solution 100 ml	1
6	BBE lotion	3
7	Surgical blades	10
8	Bowl for swabs	1
9	Examination gloves	100
10	Gauze roll 2.5 cmx 5m	3
11	Cotton wool roll 100 gm	1
12	Adhesive plaster 2.5 cm x 5 m roll	1
13	T- shirt pc	1
14	A pair of gum boots pair	1
15	Torch pc	1
16	Battery pair	1
17	Register book pc	1
18	A pen pc	1

Annex 4. R-HFA Results

Ownership and functionality of Health Unit Visited

Health Unit	level	Ownership	Comments
St Peter's	II	DNU	Non functional
Dino	II	GoU	<ul style="list-style-type: none"> • Functioning but poorly staffed and equipped, • does not offer ANC, NNC and laboratory services
Acet	III	GoU	<ul style="list-style-type: none"> • Functioning • Has 80% of required staffing level • Carries out ANC, NNC, laboratory testing • There is a maternity ward
Binya	II	GoU	<ul style="list-style-type: none"> • Is a new structure, with a matching staff house • Because of lack of a pit latrine, this unit is not functional • The unit is not stocked
Oberabic	II	DNU	<ul style="list-style-type: none"> • Functioning with staffing level lower than MoH requirement • Not equipped for ANC, NNC and laboratory services
Okungedi	II	GoU	<ul style="list-style-type: none"> • Functioning • Staffing level meets MoH minimum requirement • Staff and patient attendance poor
Omee I	II	GoU	<ul style="list-style-type: none"> • Non functional • OPD complete, no latrine or staff quarters
Lacor	III	The Catholic mission	<ul style="list-style-type: none"> • Well staffed (surpasses minimum level requirement) • Equipped for ANC, NNC and laboratory services • Pharmacy, laboratory, and equipment store were well stocked

Annex 7: Social Behavior Change Strategy

USAID has agreed that Episcopal Relief & Development will submit the final social behavior change strategy after analysis of the KPC survey and the barrier analysis in late 2009.

The Ajula project staff were trained in July 2009 on the BEHAVE framework and were very receptive to using this approach to behavior change. Outcome indicators in the M&E Plan were linked to desired changes in behavior at the household level. The workshop included lessons on building capacity of key stakeholders, or boundary partners, including VHTs, TBAs, health centers staff, community members, and DNU technical staff, as well as how to deliver behavior change communication (BCC) messages through community stakeholder meetings, training for community volunteers and staff of the health Centers and DNU, and community groups (women, youth, literacy circles, etc.). The barriers and the key factors that may influence behavior were also discussed. Barrier analysis research through focus group surveys is ongoing.

Final messages will be determined after the KPC survey in November 2009. These messages will be incorporated into the VCT and TBA training and VCTs and TBAs will be given pre-tested materials for community mobilization and household visits. In addition, the literacy circle and farmers group facilitators will use these messages and similar materials to increase knowledge and stimulate behavior change with these audiences. There is a potential to incorporate the same key messages into radio shows and public service announcements if radio is deemed an appropriate source of health messaging in the communities.

Annex 8. Papers or Presentations

As this project spent the majority of the first year establishing an office, hiring staff, and starting up activities, no papers were published and no presentations were given at major conferences or events.

Annex 9. Results Highlight

An ongoing challenge for community-based health projects is ensuring the motivation and commitment of volunteers. In many projects, volunteers are expected to contribute five to ten hours a week, in addition to their other responsibilities and income-generating activities. Community health volunteers often are selected by their communities, a process which is supposed to instill in the volunteers a sense of pride and dedication to the position. In addition, projects often give the volunteers other small reimbursements, such as bicycles, t-shirts, and notebooks, as partial in-kind compensation for all their hours of work. Even with these tangible and intangible benefits, it can be difficult to retain volunteers throughout and beyond a project's time span.

The Ajula project is piloting an innovative approach to motivate the community health volunteers, or village health teams (VHTs) as they are called in Northern Uganda, by providing them with concrete opportunities to gain skills and generate income. Specifically, the project is supporting VHTs and TBAs to form village savings and loan (VSL) associations of 15-30 members each. Within the first year, the project has sensitized and recruited 175 VHTs into 8 associations. In order to provide this service for all VHTs and TBAs in the area (not just those trained by the Ajula project), the project aims to support 670 members through 28 associations. Each association meets weekly to discuss their community health work, collect and manage the funding for the savings accounts, and support the development of each other's income-generating ideas. Groups have been extremely motivated, and have put aside a total of US\$878 in savings during the project's first year. One group has raised 188,000 shillings (US\$97) in the past two months – this in an area where the average daily income is less than US\$1.00.

Eight of the VSL associations have been trained in managing these savings and loan associations and in developing individual business plans. Mentoring visits are being conducted to ensure proper management and further training on selection, planning and management of Income generating activities will occur in the project's second year. After individual business plans are developed, Episcopal Relief & Development will use leveraged funding to inject capital into the VSL associations, so that the first group of loans can be made and VHTs and TBAs can begin their own local business projects.

To our knowledge, this is the first time such a scheme has been piloted in a recently post-conflict situation. Not only do these activities help to bring the VHTs and TBAs together, where they can informally share challenges and lessons learned related to their volunteer work, but it also develops their skills to generate income and contribute to the rebuilding of their households and their community. Over the next three years, Episcopal Relief & Development aims to show the effectiveness of this model in motivating and retaining VHTs. Monitoring the success and lessons learned from this project will help inform not only the Ugandan Ministry of Health, but will also contribute to the global evidence base for community-based health projects in post-conflict situations.

Annex 10: Child Survival and Health Grants Program (CSHGP) Data Form

See online form for updates.