

Uganda Health Cooperative



Child Survival Fourth Annual Report FY09 October 25, 2009

Program Area: Bushenyi District, Uganda

Cooperative Agreement: GHS-A-00-05-0031-00

Program Dates: September 30, 2005 – September 29, 2010

Subject: Child Survival

Authors: Dr. James Mukankusi, Director UHC Child Survival

Jennifer Stockert, Program Manager, UHC Child Survival

Editors: UHC Child Survival Team





A. Key Progress and Main Accomplishments in Year Four.....	3
B. Activity Status	6
C. Contextual Factors that May Have Impeded Progress	8
D. Technical Assistance.....	8
E. Substantial Changes.....	9
F. Sustainability	9
G. Specific Information: Mid Term Evaluation Response	10
I. Management System.....	11
J. Local Partner organizational collaboration and capacity building.....	12
K. Mission Collaboration.....	12
Annex 1. M&E Table.....	13
Annex 2: Year Five Work Plan.....	17
Annex 3: Papers or Presentations	20

A. Key Progress and Main Accomplishments in Year Four

The Uganda Health Cooperative Child Survival Program (UHC/CS) goal is to increase the capacity of local stakeholders and to link child survival interventions to prepaid health plans building on existing structures to sustainably reduce morbidity and mortality for women of reproductive age and children under 5 in Bushenyi, a rural district in south western Uganda. In year four UHC/CS completed phased implementation of training and support supervision for health workers and volunteers in all health sub districts (HSD), increased strategic partnerships and learned many important lessons. Memorandums of understanding (MOUs) were signed with the District Health Team (DHT), Child Development Centers (CDC), Healthy Child Uganda (HCU) and four new UHC health care providers increasing the program's ability to leverage resources, share lessons learned and to strengthen systems that empower local stakeholders to sustainably reduce maternal and child morbidity and mortality. Health worker interventions and quarterly meetings with volunteers led to strong partnerships and volunteer commitment and activity that greatly exceeded program goals. District wide knowledge practice and coverage (KPC) and health facility assessments (HFA) showed areas that need attention for closing gaps toward reaching program goals but overall program impact and strong progress toward goals is evident. Local capacity, leadership and ownership of UHC prepaid health plans is strong but membership growth has remained a challenge to be addressed in year five.

Nineteen health workers in Buhweju HSD and 28 health workers in Bunyaruguru HSD received training and support supervision in Integrated Management of Childhood Illness (IMCI.) Nineteen maternal newborn care (MNC) providers in Buhweju and 17 MNC providers in Bunyaruguru received training and quarterly support supervision using MOH support MNC tools for best practices. Oral rehydration therapy (ORT) stations were implemented in health units level II, III and IV in both HSD. These stations include safe water, ORS, and cups so health workers can give first aid to children brought to the health unit with diarrhea and for learning and practice demonstrations. Ministry of Health (MOH) information, education and communication tools were distributed and displayed in health units to guide the health workers.

In Buhweju, 22 volunteers were trained using community-IMCI (C-IMCI) and MNC resources with follow up support supervision. These volunteers held 1,210 behavior change communication (BCC) sessions, reaching 54,133 people as verified by signatures turned in from attendees. Volunteers received refresher training after 6 months and 2 quarterly meetings with health workers. All volunteers met their monthly session goals and received bicycles at the end of the phase as motivation and facilitation to enable them to reach more people. Phase IV concluded with knowledge practice and coverage (KPC) and health facility assessment (HFA) monitoring and a stakeholders' workshop to share results and receive input on the way forward.

Support supervision in partnership with the HSD heads and the DHT was also conducted for health workers in Igara, Ruhinda, Sheema and Buhweju. Health worker knowledge and implementation skills were observed, on the job training was done, questions on policies and best practices were answered and performance gaps were reduced improving service delivery. Health worker self assessments were implemented to reinforce best treatment practices and to identify areas where additional support would be helpful. Activity and performance reports and work plans were shared with the DHT for partnership, coordination and improved service delivery. Follow up strengthened linkages between health units, HSD headquarters and the DHT.



Prior to the inception of Phase V in Bunyaruguru HSD, UHC/CS learned that the MOH changed support for C-IMCI training materials to the Village Health Team (VHT) Manual and the DHT received funding from the MOH to support the Health Sector Strategic Plan II with implementation of the VHT concept in Igara East and Ruhinda HSD. Additionally, the Malaria Communities Program (UHC/MCP) received funding from the President's Malaria Initiative to implement a cascade of sensitization and training for home based management of fever. At the district sensitization meeting, leaders requested UHC/MCP begin implementation in Bunyaruguru where malaria rates are the highest in the district. This presented an opportunity for UHC/CS to develop key partnerships signing an MOU with the DHT and UHC/MCP to leverage resources and increase impact by dividing the responsibilities for the cascade of sensitization and training between partners.

Due to financial limitations, UHC/CS played a relatively small role in implementation focusing on Kicwamba sub county in Bunyaruguru but the lessons learned from the partnership were important. The cascade approach to sensitization and training beginning with district leaders then district trainers, HSD leaders, communities and finally volunteers was particularly effective. The partnership was also important because partners agreed to use the same terminology (VHT), training and support materials (Training Manual for VHT, Trainers Guide to Home Based Management of Fever, etc.), strategies (ex. incentives need to be community driven and sustainable) and budgets (local meal and transport reimbursement rates) for implementation. UHC/CS was able to reach out to two additional USAID supported programs, Healthy Child Uganda (HCU) and Integrated Community Based Initiatives (ICOB) to encourage them to join this partnership. VHT training and support supervision resources cover the same topics as C-IMCI tools but the training is longer, includes more information on building communication and adult training skills and includes several forms that volunteers are expected to turn in to health facilities monthly. Instead of training 25-35 volunteers per HSD the VHT strategy is to train 2 volunteers per village (approximately 1,000-2,500 per HSD.)

In Phase V, UHC/CS implemented a cascade of sensitization and training in Kicwamba while UHC/MCP led implementation in the other three sub counties in Bunyaruguru. UHC/CS sensitized 67 local leaders and 11 health workers. Through these leaders and their communities, 190 VHT were elected, trained and linked to health workers for quarterly meetings in the 4 parishes of Kicwamba, Kirugu, Rumuri and Kikumbo. Since October 2008, UHC/CS trained community volunteers held 3,276 community health education sessions reaching 98,211 community members as verified by signatures collected at the end of each session. VHT have not turned in signatures from events that they have held because they are using MOH supported data tracking tools.

Quarterly meetings to link volunteers and health workers for support supervision and data collection were held in Igara, Ruhinda, Sheema and Buhweju counties. At these meetings, health workers mobilized volunteers to assist with national antenatal care and Uganda National Expanded Program on Immunization outreach sessions. In addition to community sessions, volunteers carried out health education sessions at the health facilities which helped to relieve the health worker work load. Quarterly meetings motivated volunteers and helped those who were lagging behind improve their performance.



The UHC board led the annual general meeting in January where two new office bearers (Chairperson and his deputy) were elected to the board of directors to steer the organization for the next year. Scott Aebischer, HealthPartners Senior Vice President, visited to observe the annual general meeting and to provide technical support to the team. Four new health care providers signed MOUs with UHC. Two new member groups joined bringing the total average membership to 4,220. The cooperative maintains a sustainable cost balance; premiums plus copayment are greater consistently than treatment costs leaving a small provider surplus. Monthly board meetings/training were held and improved capacity can be seen from board self assessments (Annex 1.) Board members have taken on greater responsibilities including assessing monthly group performance, making recommendations for improved cost balancing, meeting regularly with stakeholders especially when follow up action is required and participating in community mobilization.

The UHC manager held a series of capacity building sessions for data entrants and quarterly meetings with providers and their contracting groups to build capacity and transition her role to these stakeholders. The UHC manager is on the board of directors of the Uganda Community Based Health Financing Association (UCBHFA) a national organization for capacity building and sharing lessons learned.

The UHC board of directors partnered with UHC/CS, DHT, UHC/MCP in August to develop a strategy to provide UHC membership at a discounted rate to VHT as a sustainable incentive for their time spent working to improve healthy behaviors at the community level. Systems for UHC training, data tracking and use, accountability and audit procedures, a BCC strategy and marketing plan are being developed in preparation for VHT health plan coverage. Pilot coverage will begin for VHT in one parish of Bunyaruguru in October 2009 with scale up to begin in January after lessons learned are incorporated in the plan. VHT membership in UHC will make it possible for VHT to be healthy role models in the community by seeking care within 24 hours onset of fever, seeking antenatal care at least 4 times per pregnancy, delivering babies with a skilled health professional, etc. VHT will be able to promote joining UHC from first hand experience.

In September district wide KPC and HFA assessments (Results in Annex 1) were conducted to understand program impact to date and to determine areas that need focus for closing gaps in the next year. This was ahead of schedule from the detailed implementation work plan since in year three Phases III and IV in Sheema North and South were combined into one phase. Phase end monitoring looked at individual HSD results and the mid-term assessment was conducted in Igara, Ruhinda and Sheema where the first three phases were implemented.

At the end of Phase V, September 2009, district wide results showed that indicators were lowest in Bunyaruguru especially for malaria and Buhweju especially for MNC. This result was to be expected since implementation has had the least time to impact those counties but in retrospect, the program should have held district wide sensitization before the launch and should have started Phase I in Bunyaruguru. These were important lessons learned. UHC/CS follow up activities in Bunyaruguru will benefit from being able to work with the large number of VHT have been trained. Since global fund and other planned partner LLIN distribution campaigns have yet to reach this area, LLINs will be purchased and distributed to pregnant women and

children under 5 in this HSD to close gaps. Buhweju has the fewest number of health facilities offering MNC and deliveries. Buhweju terrain makes accessibility to water difficult likely a strong contributing factor to the poor hand washing practices. Additional insight into results is expected to be gained from discussions at the stakeholder workshop. This will be an important opportunity to enlist DHT, leader and partner support with commitments and follow up for coordinated efforts to increase healthy behaviors.

The program team will use KPC and HFA results to strategically plan their time and interventions closing performance gaps throughout the district in year five. UHC/CS trained volunteers will be “promoted” to become focal VHT to mentor and build the capacity of VHT and to use their bicycles to turn VHT forms in to the health facility each month. Staff will meet with health workers and focal VHT quarterly to build their training and support supervision skills. During these meetings they will be able to prepare and practice leading effective quarterly meetings to improve behavior change communication in strategic areas for VHT. Focal VHT will be provided ITN, hand washing and ORS demonstration kits with a book for tracking kits borrowed and returned by VHT Use of the kits will be reviewed, lessons learned shared and supplies will be replenished at quarterly planning meetings.

B. Activity Status

Below is a table highlighting the status of key activities for each project objective.

Project Objectives	Key Activities	Status of Activities FY09	Comments
Reduce incidence of malaria in Bushenyi District for children under 2 and pregnant women	<p>Activity 1: ITN distribution</p> <p>Activity 2: Train ITN retreatment and proper use</p> <p>Activity 3: Train malaria warning signs and SCM</p> <p>Activity 4: Increase IPT demand</p>	<p>Activity 1: On hold. No ITNs distributed or sold in year four.</p> <p>Activities 2 - 4: On target.</p> <ul style="list-style-type: none"> ▪ 23 volunteers trained in BCC for C-IMCI and MNC. 190 VHT trained using MOH materials covering C-IMCI and MNC topics. ▪ Volunteers held 3,276 BCC sessions reaching 98,211 people. Sessions include ITN use, most at risk groups, malaria prevention, warning signs, treatment and importance of receiving IPT at ANC. 	<p>In year four, UHC/CS sent requests and data to be included in global fund and national level ITN distribution campaigns. Distribution did not reach Bushenyi.</p>
Reduce incidence of Diarrhea in Bushenyi district for children under 5	<p>Activity 1: Train diarrhea warning signs</p> <p>Activity 2: Improve access to safe water</p> <p>Activity 3: Increase safe water practices and hand washing</p> <p>Activity 4: Improve sanitation practices</p> <p>Activity 5: Train diarrhea home care, SCM</p> <p>Activity 6: Distribute and train zinc use (pending)</p>	<p>Activities 1-5: On target.</p> <ul style="list-style-type: none"> ▪ Held 2 district wide BCC refresher trainings for volunteers. ▪ 23 volunteers and 190 VHT trained on sanitation and prevention of diarrhea. ▪ ORT corners established in 16 H/U and are functional. ▪ 1,285 PUR sachets distributed ▪ 3,276 volunteer sessions held including topics on good sanitation practices and safe water ▪ 460 ORS sachets distributed to volunteers for demonstration during sessions <p>Activity 6: Not implemented.</p>	<p>Promotion of Zinc was not included in interventions since it was initially not approved and then not part of standard MOH/DHT supported volunteer training materials.</p>

<p>Increased % of pregnant women receiving improved ANC, Delivery and post partum care</p>	<p>Activity 1: Create demand for ANC</p> <p>Activity 2: Train community on importance of RCT and PMTCT</p> <p>Activity 3: Train MNC</p> <p>Activity 4: Distribute mama kits and train importance of planning for safe birth</p>	<p>Activities 1-3: On target.</p> <ul style="list-style-type: none"> ▪ 23 volunteers trained in MNC, 190 VHT trained ▪ 2 volunteer refresher trainings held on MNC using BCC ▪ 3,276 volunteer sessions held ▪ 16 quarterly meetings held between CORP and Health workers <p>Activity 4: Completed.</p> <ul style="list-style-type: none"> ▪ Mama Kit distribution halted in response to MOH/DHT plan for mamakit distribution. 	<p>Mama kits were distributed free to encourage ANC attendance in the first 3 years. The program advocated for the DHT to take up this practice and when the district program to supply mama kits began, program distribution ended.</p>
<p>Build local organizational capacity to manage health schemes</p>	<p>Activity 1: Improve Board mtgs & capacity</p> <p>Activity 2: Change health scheme benefit structure</p> <p>Activity 3: Promote health scheme membership</p> <p>Activity 4: Build Board capacity and train self assessment</p> <p>Activity 5: Update UHIS for CS and train users to manage data and make results based decisions</p>	<p>Activity 1: Exceeding targets.</p> <ul style="list-style-type: none"> ▪ 10 BOD meetings and trainings were held ▪ Board led Annual General meeting including election of new officers ▪ Built stakeholders capacity to track and use monthly UHC performance reports to make decisions to improve health <p>Activity 2: Completed. Sustainable cost balance reached.</p> <p>Activity 3: Increased membership goals are behind target.</p> <ul style="list-style-type: none"> ▪ 3 new providers contracted ▪ Began VHT enrollment into UHC with reduced premiums as incentive for active BCC. Partnered with DHT for support and to strengthen impact. ▪ 2 stakeholder meetings were held to review performance and grow scheme through marketing <p>Activity 4: Completed.</p> <ul style="list-style-type: none"> ▪ Board self assessments show improvement (Annex 1) ▪ Cooperative leadership successfully transitioned to UHC board ▪ Increased member reserve fund contribution to UHC passed by member vote <p>Activity 5: Completed. UHIS was updated, users were trained.</p>	<p>Since few health care providers have computers, consistent power or staff trained in computer use, in year four it was determined that UHIS was not sustainable. UHIS program resources were allocated to strengthen sustainable data collection and use between volunteers and health workers.</p>
<p>Improved Health care management especially for WRA and children under 5</p>	<p>Activity 1: Improve resource stock maintenance</p> <p>Activity 2: SCM for malaria and diarrhea according to IMCI & MOH</p> <p>Activity 3: SCM for ANC</p> <p>Activity 4: SCM for post partum care</p>	<p>Activity 1: Completed in 2006.</p> <ul style="list-style-type: none"> ▪ Partnered with UHC/MCP for stock management refresher training for 32 health sub district supervisors in 2009 ▪ Advocacy and collaborations to improve stock maintenance continue. <p>Activities 2-5: On target.</p> <ul style="list-style-type: none"> ▪ 37 health workers trained in IMCI ▪ 37 health workers trained in MNC ▪ Support supervision conducted quarterly for all health workers 	

	<p>Activity 5: SCM for safe/clean delivery and AMTSL</p> <p>Activity 6: Train and follow up on self assessments</p>	<p>Activity 6: On target.</p> <ul style="list-style-type: none"> ▪ Health worker self assessment implemented in 4 counties 	
--	---	--	--

C. Contextual Factors that May Have Impeded Progress

Volunteer expectations: there are still high expectations by some volunteers and the community that resources and money will be provided free as motivation and for attendance. This is because of comparisons with other programs in the district that give money to motivate their volunteers. In some instances this has led to volunteer drop outs. In Igara county volunteers were working for more than one program which led to over load and inefficiency. **Action:** This challenge was addressed by health workers with volunteers at quarterly meetings volunteers. In nearly every meeting through discussion volunteers reinforced to each other why they continue to contribute their time and how the results in the community reinforce the value of their efforts. To address this challenge at the district level, the director increased partnerships with NGOs and the DHT the outcome of which was two MOUs where the DHT, HCU, and UHC/MCP agreed to set standard rates for training, support and incentives and agreed to increase meetings and coordination of efforts to reduce redundancy, overload and competition. Meetings with ICOBI have been taking place but this MOU is yet to be signed. More information on these efforts is included in the FY10 work plan. Finally, local leaders were sensitized on their role in volunteer support and sustainability. They are increasingly recognizing volunteers at events while health workers and the DHT are involving them in health matters like immunization campaigns.

Inadequate facilities at health centre’s: through community health education sessions there has been an increase in demand for health care. But this has not been matched with adequate supplies mama kits, ITNs, ACTS and health worker staffing. Clients are disappointed with stock outs of supplies and may not come back next time, preferring to go elsewhere (self medication) or delaying treatment. **Action:** Additional stock management training was carried out in partnership with UHC/MCP to improve systems and the availability of essential medicines. Regular meetings with the DHT have improved staffing especially of the midwives at health centre III and clinical officers at HC III and IV. Also timely release of funding from the MOH has been discussed but more advocacy on this initiative is needed.

D. Technical Assistance

External training opportunities have been offered to staff in alternating years with in-house capacity building. Staff selected courses for continuing education in individual strategic areas in year five. After each course, staff will present their lessons learned to the rest of the team.

An area noted for staff capacity building is improved training of trainers where results from the training can be used to immediately determine how effective the training was making it easy to make adjustments right away. The Criterion Referenced Instruction (CRI) manual by Tom Carter, USAID, will be used to build staff skills in developing training plans for all activities with measurable behavioral objectives, pre and posts tests that measure each participant’s ability to fulfill the objective and providing sufficient practice activities for participants to develop and gain confidence in the skills. The final deliverable of this training for staff will be for them to



develop CRI training plans to close the gaps toward reaching program goals in their respective areas.

E. Substantial Changes

In year three the program received approval to combine implementation of phase III and IV in Sheema North and South HSD. Thus in year, four phases IV and V were completed ahead of the detailed implementation work plan schedule. This change makes it possible for the team to provide strategic training and support to close performance gaps in each HSD in year five.

CTO approval was also received for the partnership between UHC/CS, UHC/MCP and the DHT. In this partnership, the strategy changed from training 25 volunteers per HSD using C-IMCI tools to contributing to implementation and building sustainable support for the MOH supported VHT strategy, training 1,000-2,500 VHT per HSD. The MOH adopted this approach in lieu of C-IMCI, to strengthen the delivery of health services at the household level and to establish a health information system that will enable national and local planners to provide targeted health interventions. UHC/CS conducted a cascade of sensitization of community leaders, facilitating community election of VHT and training 190 VHT to carry out health education sessions and to promote UHC using the BCC strategies.

F. Sustainability

The UHC/CS program was designed using a variation on Child Survival Sustainability Assessment theory in order to build local organizational, health services and community social dimensions. Data that had been entered into SUSPRO was lost in a computer upgrade and training on the SUSPRO database was by delayed by access challenges and competing priorities. The results of the final UHC/CS KPC assessment will be entered into the CSSA framework for comparison of changes since program inception. The sustainability dashboard will be shared in the final program report and at the final stakeholder workshop.

Sustainable linkages from that national level to the village level have increased incrementally each year. Extension of program activities like local religious leaders inviting volunteers to give BCC sessions after services evolved from including community leaders in activities and workshops. Similarly through the health worker volunteer relationships that were developed, volunteers were enlisted to contribute to national health campaigns.

In the beginning of year five the UHC/CS team will be preparing for the full transition of their roles and responsibilities to local stakeholders. This preparation includes the training of trainer course for staff and improved training plans and materials to strategically address gaps in healthy behaviors by HSD.

A new UHC logo for sustainable local ownership has been designed by stakeholders with support from a HealthPartners Marketing and Communication Consultant and a BCC campaign was developed locally to accompany the transition. A UHC handbook has been including all of the resources and tracking materials necessary to sustain the cooperative, to support marketing for increased membership and to orient new member groups, was drafted by the CS team and the UHC board. The hand book is currently being reviewed by local stakeholders. Training plans and tools in the handbook will be updated after the training of trainers course.



Simple data exchange centers will be implemented in health facilities to improve communication between stakeholders. Volunteers will be able to access replacement support materials and blank forms when dropping off filled forms. A checklist of data going in and coming out will improve follow up and accountability. Focal VHT will be provided ITN, hand washing and ORS demonstration kits with a book for tracking kits borrowed and returned by VHT.

Partnerships at national and district levels will continue to be expanded improving collaboration and coordination of activities. End of year four KPC and HFA results and HW/Focal VHT and VHT data forms will guide targeted interventions by program staff to close gaps. A final district wide KPC and HFA assessment will be led by an external evaluator in July and results will be shared in a final stakeholder workshop.

G. Specific Information: Mid Term Evaluation Response

Implementation of the new BCC strategy: After the site visit from Ms. Elaine Menotti, USAID technical advisor, BCC training and improved BCC approaches were recommended for the program. BEHAVE Framework training was held for the program team in April and June 2008. After conducting barrier analysis, the team developed a new BEHAVE framework which was shared with stakeholders in the following workshop and in the UHC Board work plan for 2008-2014. New training and support materials were developed for use by health workers to enable volunteers to move beyond “educating” groups, to planning and carrying out strategic interactive activities with strong follow up for targeted audiences. Support materials highlighting key behaviors and messages were created for use by volunteers in their sessions. New UHC brochures were developed to specifically target employers, parents of school children and community groups each addressing the primary barriers for that group, concerns, and testimonies from sources important to those audiences.

Technical support in training of trainers will help the program team to further improve the understanding and application of BCC strategies at health worker, focal VHT and VHT levels. By January 2010, staff training plans will include specific, measurable behavioral objective(s), pre-tests to ensure training engages participants at the appropriate level, practice activities to allow participants to fulfill the objective during the course and post-tests whereby each trainee will be required to demonstrate his/her ability to fulfill the objective(s).

Plans to increase UHC membership: To increase membership in year four the team encouraged UHC stakeholders to take ownership and responsibility for marketing. The UHC board and stakeholders (members, community volunteers, health care providers, data entrants, group leaders, local leaders and health workers) were trained and given brochures to promote UHC in their routine interactions. A leadership contest with rewards for registering new member groups was implemented at the annual general meeting but several new ideas were presented at this meeting and groups did not register for the contest. Promotion of the leadership contest continued after the meeting but the activity was still not taken up by stakeholders. Board members and group leaders did increase marketing but membership in some groups decreased and overall growth objectives were not met.

Through the MCP program, UHC/CS learned how important a cascade of sensitization and training is for implementing large scale initiatives. As a result the team shared the challenge of



increasing UHC coverage to benefit more people in the district with the DHT. After discussions and feedback, the DHT, the UHC board of directors, UHC/MCP and UHC/CS agreed to support discounted premium rates for health plan coverage for VHT and their families as a sustainable incentive for their efforts. By being able to seek care early through UHC membership, VHT will be able to model and promote these behaviors from first hand experience. An MOU was signed with the DHT to enlist their support in the implementation and sustainability of this incentive. UHC/CS is working with HCU, CDC and ICOBI to develop partnerships for UHC coverage for their volunteers as well.

Collaboration between UHC/MCP and UHC/CS also led to the implementation of UHC marketing in MCP programs. A prepaid health plan training component was added to VHT training and quarterly meeting follow up to enable VHT to promote UHC membership for health improvement at the community level. A brochure for VHT to use in these sessions was developed and will be able for patients and VHT to pick up at health facility data centers.

Since the VHT group is very large (about 10,000) even at a reduced rate premiums will off set adverse selection making this rate sustainable. Audit forms have been developed and are being tested to ensure UHC stakeholders fulfill their roles and responsibilities. A plan was developed by the UHC board of directors to help providers and the board systemitize actions to be taken to enforce accountability. These and other tools for sustainable health plan management are included in the UHC handbook.

I. Management Systems

Human Resources: Policies for Human Resource management in Uganda are documented in the Employee Manual that is distributed to new staff and updated annually. Human resource policies were reviewed in March, suggestions were discussed through call conferences and adjustments and clarifications were documented. Changes were rolled out in participatory training for staff. Team suggestions from these trainings were included in the final document.

The organizational organogram was slightly restructured to improve efficient use of available human resources at the inception of UHC/MCP. The monitoring and evaluation coordinator and the accountant/administrator provide services and track their time contributions separately for each program. One of the scheme managers was assigned the role of UHC manager to train and support the board and other stakeholders while the other manager assumed the role of marketing and training to expand UHC membership.

Communication system and team development: the communication system as detailed in the DIP is fully functional. UHC conducted an Institutional Strengths Assessment (ISA) in order to determine strengths, weaknesses, opportunities and for feedback on how management can be improved. Results of the ISAs are below.

Latent Construct	Percentages		
	Phase III	Phase IV	Phase V
Management Practices and Governance	81.1	76	75.3
Administrative Infrastructure and Procedures	77.5	71	77.5
Organizational Learning	72.5	72	84.5



Financial Resource Management	50.1	58.7	55.5
Human Resource Management	74.9	80.4	85.3
Total average score	71.2	71.6	75.6

J. Local partner organizational collaboration and capacity building

UHC/CS follows MOH policies and uses MOH supported training and data tracking resources and tools. National and district trainers are hired as appropriate for health worker interventions and in year four the MOH provided IEC materials to support health worker and volunteer interventions. Over the past year the partnership and routine communication with the DHT was greatly strengthened. An MOU was signed for support of program efforts and providing UHC membership to VHT. HW training, supporting stock management training, quarterly HW follow up, HW/Volunteer meetings and providing ORT stations at health facilities have improved health resources and sustainable systems in the district. Data entrant training at UHC providers and training and support of UHC board meetings has further strengthened systems. Stakeholder workshops have provided opportunities for data sharing, improving ownership, planning and coordination of activities by district leaders. Increasing the skills of volunteers and ensuring their support supervision has been another key component of strengthening partnerships.

PVO coordination/collaboration in the country: Child Development Center staff and children in their Bushenyi programs are enrolled in UHC. An MOU was signed with HCU to improve communication and collaboration with routine meetings and 17 HCU volunteers in Kicwamba sub county, Bunyaruguru were trained as VHT by the program. Several meetings with ICOBI have allowed the programs to share plans and an MOU for partnership is being reviewed. The UHC/CS accountant continues to be co-located in the Program for Accessible Health Communication and Education (PACE, formerly PSI) program offices and collaboration with PACE has been ongoing.

The UHC manager is a member of the board of directors of Uganda Community Based Health Financing. This board is directly involved in the promotion and advocacy for community health insurance at the national level. This organization brings together all the community health financing stakeholders and health care providers. The board is also a member of the national social health insurance working group that is developing the national social health insurance policy. UHC/CS participated in the Community Health Financing Association for East Africa regional conference with the director providing a presentation on UHC lessons learned in May.

K. Mission Collaboration

UHC/CS has invited Uganda mission representatives to visit the program site and has sent copies of program reports. The program will continue to pursue efforts to improve communication and collaboration with the Uganda mission.

Annex 1. M&E Table

Objective 1: Reduce incidence of Malaria in Bushenyi District for children under 2 and pregnant women.	Base-line	Mid-term 3 HSD	Buhweju	Bunyanguru	Igara	Ruhinda	Sheema	District Total	EOP Goal
% of children under 2 with fever in the last two weeks	44.2	37.7	42.1	57.9	36.8	36.8	47.4	44.2	19
% of children under 2 who slept under an ITN last night.	32	65.8	47.4	26.3	63.2	52.6	63.2	50.5	55
% of mothers who slept under an ITN last night.	19	53.5	47.4	26.3	52.6	57.9	57.9	47.4	36
% of children under 2 with fever in the last 2 wks who received anti malarial treatment	71	88.4	25	9.1	0	42.9	44.4	23.8	84
% of pregnant women receiving IPT as verified by maternal card/ book	27	97.4	60	80	100	100	100	88.6	49

Objective 2: Reduce incidence of Diarrhea in Bushenyi district for children under 5	Base-line	Mid-term 3 HSD	Buhweju	Bunyanguru	Igara	Ruhinda	Sheema	District Total	EOP Goal
% of children under 2 with diarrhea in the last two weeks	55	42.1	47.4	31.6	42.1	36.8	52.6	42.1	20
% of mothers who know at least two signs that a child under 5 needs treatment.	76	99.1	63.2	57.8	57.8	63.2	73.6	63.1	84
% of households who use improved water source (borehole, public tap, or protected dug well.)	50	62.3	52.6	57.9	68.4	68.4	78.9	65.3	60
% of households with a designated hand washing station with a covered container for water	24	7.0	0	5.3	10.5	5.3	10.5	6.3	46
% of caretakers who usually wash hands with soap before food preparation	42	0	21.1	26.3	26.3	26.3	26.3	25.3	64
% of caretakers who usually wash hands before feeding children	15	21.1	10.5	5.3	5.3	5.3	21.1	9.5	35
% of caretakers who usually wash hands after defecation	63	66.7	47.4	57.9	78.9	52.6	84.2	64.2	82
% of caretakers who usually wash hands and after attending to a child who has defecated	8	19.3	0	10.5	10.5	0	5.3	5.3	30
% of households who safely disposed of their child's feces the last time s/he passed stool	68	57.0	26.3	47.4	42.1	36.8	73.3	45.3	82
% of households with access to a covered pit latrine	19	39.5	47.4	52.6	68.4	57.9	68.4	58.9	36
% of children 0-23 months with diarrhea in the last two weeks who received ORS	0	15.7	11.1	0	25	14.3	10	12.5	30
% of children aged 0-23 months who were offered more fluids during illness	15.8	29.2	0	50	37.5	28.6	40	30	20
% of children aged 0-23 months who were offered same or more food during illness	42.1	72.7	11.1	30	12.5	14.3	20	20	63

Objective 3: Increased % of pregnant women receiving improved ANC, delivery and post partum care	Base-line	Mid-term 3 HSD	Buhweju	Bunyaruguru	Igara	Ruhinda	Sheema	District Total	EOP Goal
% of women with 4 ANC visits as verified by maternal card/ book.	18	38.3	20	44.4	25	50	28.6	34.3	30
% of pregnant women seeking RCT services	34	79.6	68.4	89.5	89.5	73.7	94.7	83.2	44
% caretakers counseled on breastfeeding	38	60.6	31.6	63.2	52.6	42.1	57.9	49.5	55
% caretakers counseled on importance of child spacing	95	70.2	47.4	57.9	73.7	68.4	73.7	64.2	99
% caretakers counseled on danger signs of pregnancy	76	70.2	42.1	63.2	63.2	52.6	84.2	61.1	90
% of pregnant women counseled on where to deliver	69.5	94.2	84.2	78.9	89.5	57.9	100	82.1	
% of pregnant women counseled on transport plans to delivery place	45.3	76.0	57.9	68.4	78.9	52.6	94.7	70.5	
% of women who delivered with a skilled health professional as verified by maternal card/ book	47.4	62.3	31.6	73.7	84.2	36.8	94.7	64.2	65

Objective 5: Improved health care mgmt especially for WRA and children under 5	Baseline	Midterm	Year 4	EOP Goal
% of stock outs in the past 30 days	41%	30%	43.75	18%
% of HWs who have received IMCI training the last 3 years	57%	60.6%	40.8	70%
% of HWs who have been supervised in IMCI within the last year	28%	92.6%	77.8	28%
% of HWs who have MOH policy and guidelines or protocols on ANC and obstetric care services.	44%	67.9%	77.8	65%
%age of facilities that provide nutrition and hygiene for baby and mother	94%	100%	100%	98%
% of facilities that provide information on Malaria prevention	94%	100%	100%	98%
% of facilities that emphasize breastng and child welfare	94%	100%	100%	98%
% of facilities that provide information on STI/HIV	94%	100%	100%	98%
% of facilities that provide information on warning signs and pregnancy complications	94%	100%	100%	98%
% of facilities provide information on FP and Postnatal care	94%	100%	100%	98%
% of HWs who received training in AMSTL in the last 3 years	79%	57%	21	90%
% of HWs who filled out a self assessment in the last year	0%	0%		25%

% of HW self assessments that showed higher ratings over the past year	0%	0%	18%
--	----	----	-----

Item	Baseline	Midterm	Item	Baseline	Midterm
Cotrimoxazole	51	18	Injectable diazepam		7
Mebendazole	19	11	Egometrine	9	25
Amoxicillin Oral	63	50	Iron/Folate	16	29
Naladixic Acid	63	50	Injectable contraceptive	33	14
Ciprofloxacin	63	36	Contraceptive pills	33	18
Doxycycline	28	18	Condoms	35	25
Metronidazole	18	18	ITN	70	71*
Chloroquine	12	36	Mama Kits	74	79*
Fansidar	2	4	ORS	28	14
Quinine	49	18			

Objective 4: Build local organizational capacity to manage health schemes				Baseline	Year 4	EOP goal
IR 1: Increased capacity of Board	performance scale	Review of Board meeting notes	Quarterly/M&E	Minimal	Medium	Strong
IR 2: Growth of health scheme	performance scale	Scheme manager monthly reports	Monthly/Scheme Mgrs to M&E	Minimal	Minimal	Strong
IR 3: Increased ability of scheme to financially cover service & admin	performance scale	Self assessment and UHIS reports	Monthly, semi-annual/M&E	Minimal	Promising	Strong

Year 4 indicators status in bold.

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

		Average Board of Director Self Assessment Ratings by Quarter										
S/N	Considerations	Oct 2006	Feb 2007	April 2007	July 2007	Oct 2007	Jan 2008	Apr 2008	July 2008	Oct 2008	May 2009	July 2009
1	Board has full and common understanding of their roles & responsibilities	3.3	4.1	6.4	5.6	7.9	5.7	6.8	7.1	6.7	8.1	7.8
2	Board members understand the organization's mission and its products/programs	3.5	6.3	7.1	6.7	7.6	6.2	6.1	5.7	7	8.1	8.0
3	Structural pattern (board, officers, committees, executive and staff is clear)	4.3	4.8	6	6.4	8.1	5.1	7.7	6.4	6.6	7.8	7.6
4	Board has clear goals and actions resulting from relevant and realistic strategic planning	2.6	3.8	5.8	6.7	7.1	6.1	5.8	6.9	7.2	7.5	7.5
5	Board attends to policy related decisions which effectively guide operational activities of staff	2.1	4.6	4.8	3.9	6.4	6.0	5.6	4.0	6.8	5.8	8.1
6	Board receives regular reports on finances/budgets, products/program performance and other matters	1	3.4	3.2	1.6	4.7	3.5	3.1	5.5	6.2	7.8	7.9
7	Board effectively represents the organization to the community	5.6	6.3	7	5.7	7.7	6.8	6.8	8.5	8.1	7.8	8.6
8	Board meetings facilitate focus and progress on important organizational matters	3.6	6.1	7.9	7.1	6.7	5.6	7.6	7.1	7.8	8	8.1
9	Board regularly monitors and evaluates progress toward strategic goals and product/program performance	3.1	3.6	5.4	4.1	5.1	5.8	6.1	7.5	7.5	8.2	7.9
10	Board uses self assessment to build capacity and maintain management	4.1	7	7.5	5.7	8.1	7.6	7.8	7.2	8.5	8.8	8.4
11	Each member of the board feels involved and interested in the board's work	4.8	7	8.5	6.6	7.7	7.8	8.5	8.1	8.4	8.6	8.5
12	All necessary skills, stakeholders and diversity are represented on the board	2.8	5	6.6	5.1	7.5	6.3	8.2	8.8	7.7	7.2	7.9
	Average per quarter	3.4	5.2	6.4	5.4	7.1	6.0	6.7	6.9	7.4	7.8	8.0
	Performance Scale	Minimum	Emerging	Emerging	Emerging	Medium	Emerging	Emerging	Medium	Medium	Promising	Promising



Annex 2: Year Five Work Plan

In the first year of implementation UHC/CS staff learned skills in child survival sustainability assessment strategy, BCC and training trainers. Each year the team learned from stakeholders to improve participatory planning, leveraging of resources and to increase the impact of activities. At the year five work plan development workshop with the program manager in August 2009, the team brainstormed on strategies to employ and systems that can be improved to facilitate transition of their roles to local stakeholders. Tools are being developed to support local stakeholder fulfillment of the roles and responsibilities necessary for improving maternal and child health and “sustaining a healthy community through partnership.”

Health worker training and support supervision is being transitioned back to the DHT with support and advocacy by the UHC/CS team to help close gaps. Health workers fill self assessment forms, reminders of where improvements can be made and helpful tools for district health trainers to use for follow up support supervision. Health workers will continue support supervision of community volunteers trained by UHC/CS. The program will help these volunteers (25-35 per county) transition into focal VHT roles in order to support data collection and BCC efforts of the VHT (1,000-2,500 per HSD.)

Training will be held to improve team skills in developing more effective training plans with better measurements of success. UHC/CS will use these training plans and tools to help health workers close performance gaps with VHT in quarterly meetings. Focal VHT will be provided ITN, hand washing and ORS demonstration kits and a book for tracking kits being checked out for use by VHT. Focal VHT will use the bicycles they received through UHC/CS to collect and turn in MOH supported VHT monthly data tracking forms to their supervising health worker. Basic data exchange centers will be created at health facilities for improved communication, sustainable access and data sharing by stakeholders. UHC/CS will build the capacity of stakeholders to consolidate data into reports and graphs to share lessons learned and to be able to use data to generate discussions and determine the way forward to overcome challenges and to reach goals for improved health.

UHC/CS will continue to work closely with the DHT and will work to improve coordination of efforts and collaborations between partners. The key partners for year five will be the DHT, Healthy Child Uganda (HCU), Uganda Health Cooperative Malaria Communities Program (UHC/MCP), health facilities in the district both private and public, Uganda Community Based Health Financing association (UCBHFA), VHT, local leaders and the civil society.

Roles and Responsibilities

The district health team will recruit and retain health workers, release health workers and facilitators to attend trainings, carry out integrated support supervision, quarterly meetings, ensure availability of drugs and equipment to enable health workers carry out their duties, train VHTs in Ruhinda and Igara West counties, and will coordinate stakeholder activities in the district.

Health facilities provide essential medicines, appropriate case management, supervision of community volunteers, provide BCC outreach to communities, ensure availability of health workers on duty, and support accurate, timely data collection.



UHC/MCP will implement a cascade of sensitization and training in Buhweju county, consolidate data collected from the community in formats that the DHT, health workers, community and leaders can utilize through quarterly meetings in Buhweju, Igara West, Ruhinda and Bunyaruguru health sub districts.

UCBHFA brings community-based health financing organizations together from across the country in order to share lessons learned and strengthen skills through stakeholder training and study tours.

UHC/CS staff will provide capacity building for health workers who will meet quarterly with Focal VHT to prepare support supervision and training of VHT. Focal VHT will facilitate monthly data collection and mentorship of VHT improving their capacity to hold health improvement sessions using BCC strategies. Health workers will lead quarterly support supervision of VHT and VHT will hold village level BCC sessions to support and improve healthy behaviors. UHC/CS staff will monitor data collection, performance and results to close gaps and improve outcomes in these systems.

Local Leaders and Civil society will participate in program launches/stakeholder meetings, provide support to important linkages in the community, sustainably encourage behavior change, and will participate in planning, selection and support of volunteers.

The UHC board will remain active members of UCBHFA for capacity building and sharing lessons learned. The UHC board will lead the annual general meeting in January to share performance results, recommend changes to management policies and procedures and to incorporate stakeholder feedback. Finally the board will support UHC advocacy at the district level, provide training to new UHC providers and support supervision and accountability for UHC stakeholders. UHC providers will receive the UHC handbook and will be trained to register, orient, launch, track performance and follow up new member groups. Active VHT who turn in complete data tracking forms each month will be offered UHC membership at a discounted rate. VHT will be able to seek care early without fear of paying costly bills. This will help them to be positive role models in the community and will enable them to promote joining prepaid health plans from first hand experience.



Below is the UHC/CS work plan for year five.

Activity	Person Responsible	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept
DHT collaboration/ advocacy	Director/HST												
Stakeholder workshop, document partner commitments	All staff												
Increase partnership collaborations	Director												
HW follow up w DHT in MNC	HST												
HW follow up w DHT in IMCI	HST												
Complete CORP/VHT transition	CE												
Training trainers staff capacity building	PM												
UHC board study tour	UHC Board												
UHC provider audits, data collection and local follow up	All staff												
Coordinate feedback and finalize UHC handbook	UHC mgr and trainer												
Transition all UHC roles to sustainable stakeholders	UHC mgr												
Implement focal VHT demo kits	CE												
Implement data centers with training and support in HCs	M&E												
Train HW and focal VHT to effectively support and improve VHT BCC	CE												
Improve systems for sustainable use of VHT demo kits	CE												
Analyze VHT data and create simple systems for HW to use data to support VHT to close gaps	M&E												
Stakeholder workshop follow up partner commitments, share data	Director												
Implement UHC handbook, train and follow up UHC Providers	UHC trainer												
Close gaps in UHC stakeholder performance esp. re: VHT coverage	UHC mgr												
UHC Annual General Mtg	UHC Board												
UHC board self assessments	UHC Board												
Provide HW and VHT data analysis to staff to aid planning interventions	M&E												
Work at the district level to improve data collection systems and use	M&E												
HW/Focal VHT/VHT support, data tracking, replenish data center, PUR &ORS	HST and CE												
UHC board meetings	UHC Mgr												
Partnership collaboration, DHT, HCU, ICOBI, UCBHFA, MACIS	Director												
Annual staff reviews	Director												
Staff continuing education	All staff												
Final LQAS data collection	All staff												
Consultant Final LQAS report	External consultant												
Stakeholder workshop, document partner commitments	All staff												
Program close out and final transitions	All staff												

Annex 3: Papers or Presentations

Dr. James, Director UHC/CS presented “HIV/AIDS and it’s impact on Community Based Health Financing” at the Seventh Annual Community Health Financing Workshop sponsored by the Uganda Community Based Health Financing Association and Community Health Financing Association for Eastern Africa (CHeFA), May 17-22, 2009 at the Imperial Resort Beach Hotel, Entebbe, Uganda. The presentation looked at the cost of treating HIV positive members in comparison to treating HIV negative members, effects of HIV on the cooperative like adverse selection, high treatment costs, stigma, dropout rates, etc. It also highlighted how UHC was trying to mitigate the effects of HIV/AIDS on the cooperative.

Annex 4: Result Highlight: Quarterly meetings between health workers and volunteers

Maintaining volunteer motivation to hold community behavior change sessions and to collect and turn in timely, consistent data tracking is a challenge. The Uganda Health Cooperative Child Survival program trained volunteers by health sub district closely tracking motivational strategies and performance results over time. Volunteer performance was highest when clear goals were set and incentives were given for consistently reaching goals.

Since financial incentives are not sustainable, UHC/CS focused on building the systems for support supervision as a means to keep volunteers active and motivated. Quarterly meetings between health workers and volunteers were facilitated by UHC/CS team and led by health workers. Results of volunteer performance were shared, volunteers who exceeded their goals were acknowledged and those whose performance declined were asked about challenges. The meetings provided an opportunity for sharing strategies that worked well and linking poorly performing volunteers to those who were successful. The result was reduced attrition and increased volunteer satisfaction and performance. Quarterly meetings led to additional collaborations: several volunteers work closely with the health workers at the health facility especially in the Antenatal clinic and providing health education sessions for patients at the facility. Additionally, volunteers now assist health workers during community outreach activities like immunization days.

One volunteer per health plan group was trained in conjunction with volunteers in Ruhinda health sub district. These volunteers were not linked to health workers and did not attend quarterly follow up meetings. Below is a table showing comparative results providing evidence in support improved volunteer impact as a result of quarterly support supervision meetings.

Indicator	Igara	Ruhinda	UHC	Sheema	Buhweju	Bunyaruguru
Period of initial training and follow up activities	8/06-1/07	4/07-9/07	4/07-9/07	12/07-5/08	8/08-1/09	4/09-9/09
Number of volunteers trained per county	23 CORP	34 CORP	21 UHC CORP	25 CORP	23 CORP	190 VHT
Quarterly follow up meetings for support supervision between HW and volunteers	4/yr	4/yr	NONE	4/yr	4/yr	NA
Average # of sessions held per volunteer per month during the first 6 mos after training	1.41	0.87	0.58	3.95	2.93	NA
Average # of attendees per	45.22	23.42	47.59	328.97	150.11	NA



volunteer-led session per month during the first 6 mos after training						
Average # of sessions per volunteer per month project to date	1.66	1.69	1.26	1.32	3.50	NA
Average # of attendance reached by volunteer per month project to date	55.86	46.10	55.57	109.94	147.65	
Average # of sessions per active volunteer Jan-Jul 09	21.88	17.71	10.82	24.57	25.00	
Average # of attendance per active volunteer Jan-Jul 09	422.25	445.65	371	513.19	763.05	
Rate of attrition	26%	9%	48%	16%	4%	