



**Lira District Child Survival Project in Uganda  
September 30, 2009 – September 30, 2013**

**Medical Teams International  
In Partnership with the Lira District Health Office**

Child Survival and Health Grants Program (CSHGP)  
Cooperative Agreement No. GHS-A-00-09-00012

**Annual Report – Year 1  
October 1, 2009 to September 30, 2010**

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## Acronym List

CSP	Child Survival Project
CSSA	Child Survival Sustainability Assessment
DHO	District Health Office
ECD	Early Childhood Development
EPI	Expanded Program on Immunization
HHI	Hands to Hearts International
HMIS	Health Management Information System
HUMC	Health Unit Management Committee
ICCM	Integrated Community Case Management
KPC	Knowledge Practice and Coverage
MCHIP	Maternal Child Health Integrated Project
MCP	Malaria Communities Program
MNC	Maternal Newborn Care
MOH	Ministry of Health
MTI	Medical Teams International
NGO	Non-governmental organization
NUMAT	Northern Uganda Malaria AIDS & Tuberculosis
OCA	Organizational Capacity Assessment
R-HFA	Rapid Health Facility Assessment
U5	Under Five
VHT	Village Health Team
WRA	Women of Reproductive Age

## Background

To improve the health and nutritional status of women and children in the Lira, Ogur and Aromo sub-counties in Erute North Health Sub-District, Medical Teams International (MTI) is implementing a four-year (October 1, 2009 – September 30, 2013) \$2,010,799 Child Survival Project. The project uses a two-pronged strategy: a.) promoting social and behavior change and community mobilization to take appropriate responsibility for health; and b) building District Health Office (DHO) capacity to provide sustainable, quality service delivery at the facility and community levels.

The MTI Child Survival Project (CSP) directly benefits 22,457 children under age five and 22,907 women of reproductive age (WRA) for a total of 45,364 direct beneficiaries. Joint activities with the District Health Office (DHO) partners strengthens DHO capacity and benefits the remaining population of 253,646 WRA and children U5 in Lira District. The project has four key results/objectives:

*Objective No.1: Communities assume responsibility for their own health through strengthened community capacity (Village Health Teams, Parish Development Councils, and Health Sub-districts).*

*Objective No.2: Improved health (Community-based Integrated Management of Childhood Illness) and child care (Early Childhood Development) behaviors among mothers of children less than five years of age.*

*Objective No.3: Improved quality of health facility services through strengthened Integrated Management of Childhood Illness (IMCI) and Maternal and Newborn Care capacity.*

*Objective No.4: Strengthened institutional capacity of MTI and the Lira District Health Office to implement effective and efficient child survival activities.*

### A. Accomplishments of the Project

During the first year of implementation, the CSP focused on start-up and training activities including: 1) recruitment and orientation of project staff; 2) implementation of baseline assessments including a Knowledge Practice and Coverage (KPC) survey using the 30-cluster sampling technique and follow up community feedback sessions on the findings, Rapid Health Facility Assessment (RHFA), and focus group interviews; 3) development of the project's Detailed Implementation Plan (DIP) and social and behavioral change strategy; 4) training volunteer Village Health Teams (VHTs); and 5) training health facility staff in IMCI.

A description of the project start-up and DIP development processes is outlined in Annex 1. Below key accomplishments are outlined for each project objective. Progress meeting project indicators is summarized in the Monitoring and Evaluation (M&E) Table (Annex 2).

***Objective No. 1: Communities assume responsibility for their own health through strengthened community capacity (Village Health Teams, Parish Development Councils, and Health Unit Management Committees).***

The project supported a five-day training for 560 VHT members on the recently revised Ministry of Health (MOH) VHT strategy. The trainings focused on: 1) Integrated Community Case Management (ICCM) of diarrhea, pneumonia and malaria and recognition of danger signs for new mothers and newborns, a strategy rolled out by the MOH to replace IMCI and 2) the new VHT

operational guidelines. The CSP Manager is a national VHT trainer and used his expertise to lead this process. The training has built the VHTs' capacity to effectively implement the MOH strategy for Expanded Program on Immunization (EPI), control of diarrheal diseases, maternal and newborn care (MNC), and control of malaria and pneumonia in their local communities.

Results from the pre and posttests conducted during the VHT trainings revealed that 80% of participants achieved passing scores of 40% or higher. The 20% of the VHTs who did not pass will be provided with mentoring and refresher trainings during subsequent quarterly review meetings and supportive supervision visits. During these meetings, gaps are identified and addressed by both DHO VHT supervisors and MTI VHT mobilizers.

**Objective No.2:** *Improved health (Community based Integrated Management of Childhood Illness) and child care (Early Childhood Development) behaviors among mothers of children under 5 years of age.*

With technical support from Hands to Hearts International (HHI), MTI staff trained as early childhood development (ECD) Trainers carried out a training to equip health facility staff with skills in ECD. Participants included two MTI - CSP staff and 19 health workers from the four health units in Erute North Health Sub District. Table 1 shows the breakdown of workshop participants. Nurses and nursing aides constituted the largest cadre, as they more frequently interact with the mothers in clinics and during outreach services, ideal settings for the roll-out of ECD intervention messages to parents.

Cadre	Participants completing the course		
	Total	Female	Male
Nurses	5	3	2
Midwives	6	6	Nil
Clinical Officers	Nil	Nil	Nil
Medical Officers	Nil	Nil	Nil
Nursing Aides	7	6	1
Health Assistant	1	Nil	1
MTI Staff	2	2	Nil
Total	21	17	4

**Table 1. ECD training participants**

Training of 300 VHTs (500 male and 500 female) as ECD Peer Educators by health facility and MTI staff is scheduled for October, 2010. These VHTs come from 145 intervention villages in the project area and they will begin roll out of ECD trainings in their communities for parents of children below 3 years of age in November, 2010.

**Objective No.3:** *Improved quality of Health Center services through strengthened capacity for Integrated Management of Childhood Illness and Maternal Newborn Care.*

The project supported the Lira DHO to provide an eleven-day training in IMCI for 45 health facility and MTI staff. Fourteen training participants were nurses, seven midwives, four clinical officers, one a medical doctor, eight nursing assistants and 11 were MTI staff. Thirty one participants were female and 14 male. The practical component of the training was held at Lira Referral Hospital. Certified IMCI national trainers from the MOH conducted the training in two separate trainings. The training was based on the newly adopted IMCI training modules for high HIV settings. The pre and posttests conducted showed a remarkable improvement in the levels of knowledge as indicated in Table 2. Ninety six percent of participants received a passing score of 50% or higher.

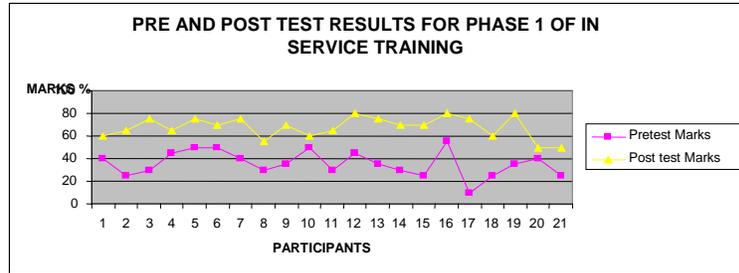


Table 2: IMCI Training Pre and Post Test Scores

Findings from follow-up visits conducted by DHO trainers and MTI staff indicated that all four health centers in the project area were implementing IMCI, with all of them using the treatment booklets provided by MTI. IMCI implementation continues to need strengthening especially due to shortages in commodities and low staff motivation. To address the issue of motivation, CSP staff regularly visits health workers in order to help them see that the work they do is appreciated.

From March 17-19, 2010, MTI-CSP carried out a rapid health facility assessment (R-HFA) to assess the capacity of the four health facilities in the project catchment area (Ogur, Aromo, Bar Apwo and Amucha SDA Health Units) to implement maternal and child health services. The assessment is part of the project’s efforts to improve the quality of care in health facilities through strengthened health center capacity from the health center II to health center IV level.

The R-HFA identified gaps in the areas of access (service availability), inputs (staffing and supplies), processes (training and supervision, and information systems) and health worker performance, (assessing health status, selecting appropriate treatment, and counseling of care-givers on the use of medicines prescribed).

To address some of the gaps in inputs, MTI provided curtains to each of the health facilities and repaired bed screens to enhance privacy, made examination beds using locally available materials, and provided clinical supplies including blood pressure kits and child weighing scales.

To address gaps in availability of EPI services, MTI-CSP is supporting the MOH’s bi-annual country-wide Child Days held in May and October each year by providing transport to carry vaccines, printing child health cards and supporting the VHTs and health workers involved in the campaign with lunch. In October of this year, 6,268 children benefited from Child Days and 570 expectant mothers received the tetanus toxoid vaccine. VHT mobilizers also supported the reactivation of formerly abandoned static immunization days held weekly at all health facilities by mobilizing VHTs to encourage mothers to attend static immunization days and adhere to scheduled immunization dates.

MTI VHT mobilizers, have breached the gaps between the DHO office and health centers by transporting drugs and gas cylinders as needed from the DHO stores to the health facilities and reproducing Health Management Information System (HMIS) forms. They have also provided logistical and technical support to health units to build thier capacity to effectively supervise VHTs.

***Objective No.4:*** *Strengthened institutional capacity of Medical Teams International and the District Health Office to implement effective and efficient child survival activities.*

In January 2010, an Organizational Capacity Assessment (OCA) was conducted with MTI Uganda as part of the DIP preparation process. To guide the assessment, the Organizational Capacity Assessment Tool developed by JSI was adapted to include a transformational development category within the Program Management section. MTI's Director of Technical Services and Director of Regional Programs facilitated the process. Six priority areas for improvement were identified:

- 1) Strategic Planning
- 2) Staff Salaries and Benefits policies
- 3) Communication
- 4) Decision-making
- 5) Succession Planning
- 6) Monitoring and Evaluation

An action plan to address these six priority areas was established to address these priority areas and included the following activities:

- 1) Trainings which have been available to CSP or MCP staff will also be extended to staff members from other projects (Pader, Nakivale). Examples of such opportunities include early childhood development (January, 2010); the social and behavior change (February, 2010); and Lots Quality Assurance Sampling.
- 2) M&E capacity for MTI Uganda will be developed through a variety of quantitative and qualitative research and monitoring areas. A three person M&E team will support all MTI Uganda projects and be backstopped by the MTI headquarters M&E Specialist.
- 3) Project cycle management refresher training will be provided for MTI-Uganda staff.

Annex 3, the OCA Action Plan, outlines progress made in address these priority areas.

Since 2004, MTI Uganda has focused mainly on relief/transitional programming. This CSP has presented an opportunity to implement development activities. During the first year of implementing this CSP, MTI Uganda has increased its capacity in M&E and implementation of social and behavior change activities. To improve its capacity to implement Child Survival Projects, MTI Uganda has learned from and shared lessons learned with HealthPartners which is implementing a Child Survival Projects in Bushenyi.

Quarterly joint supportive supervision with the DHO has been a key tool for strengthening DHO capacity, along with joint coaching activities for improved planning. Regular meetings with the DHO have identified needs, barriers, opportunities, and solutions.

**B. Activity Status:** See the Activity Status Table in Annex 4.

### **C. Factors Which Have Impeded Progress toward Achievement of Project Objectives**

- 1) The government's remapping of VHTs and changes in policy regarding the VHT training curriculum delayed the training of the VHTs in both CCM and ECD. The MOH requested that MTI wait until the remapping was completed and the new training guidelines were rolled out before commencing training VHTs. The VHTs were trained in CCM in September 2010 and will be trained in ECD during November.
- 2) Shortages of equipment and supplies in health facilities such as essential drugs, immunization cards, vaccines, blood pressure kits, and child weighing scales cause delays in routine health service delivery. For instance, health facility staff often run short of vaccines and immunization cards during static vaccination and Child Health Days. To prevent these stock outs, MTI-CSP transports immunization cards and vaccines from the DHO warehouses to the health facilities when needed. Additionally, at the beginning of Year 1, growth monitoring was provided at only two of the four health facilities the project supports. This was due to lack of weighing scales, as was found in the R-HFA. MTI has addressed this gap by providing weighing scales and child health cards. Growth monitoring now takes place at all four health facilities.
- 3) Lack of motivation among health facility staff adversely affects project implementation of health services. A principle reason for low motivation is delays in staff receiving their salaries from central government. In addition, some health facilities, such as Ogur, are remote and do not provide sufficient staff accommodation. Deficiencies and delays in the drug supply also contribute to low morale. Morale has been improved somewhat due to supportive supervision and logistical support provided by MTI. Staff attendance is now more regular, reporting has improved, and health facility staff attend coordination meeting facilitated by MTI.

### **D. Technical Assistance Required**

- 1.) Support from MTI HQ: During project start up, the HQ MTI Technical Services unit provided technical support to implement the baseline KPC survey and training in social and behavior change. The MTI HQ Senior Advisor in M and E assisted the team to develop the KPC questionnaire, establish a sampling strategy, and analyze the survey data.

The MTI HQ Child Survival Advisor supported a four-day social and behavior change workshop for 16 MTI Malaria Communities Program (MCP) and Child Survival staff and two DHO members from Lira and Dokolo. The training was based on the CORE Group Designing for Behavior Change Manual.

The Africa Deputy Regional Director visited MTI Uganda in August 2010 and met with the leadership team to review the OCA Action Plan, provide strategic planning guidance, meet with senior MTI Uganda staff (HR, Finance, Administration), conduct site visits of programs, meet district health partners and provide technical support for CSP budget realignments.

During Year 2, MTI HQ's Director of Finance will travel to Uganda to audit financial records. The MTI HQ Child Survival Advisor will travel to Uganda to co-facilitate a sustainability assessment with the Africa Health Advisor and provide any other technical assistance needed. During quarter 4 of Year 2, the MTI HQ Senior Advisor in M and E and Child Survival Advisor

will also travel to Uganda to support the midterm evaluation qualitative and quantitative assessments.

- 2.) Technical Support from Hands to Hearts: During the DIP development process, Hands to Hearts International provided support to conduct focus group discussion with parents and community leaders on ECD issues, conducted pilot ECD training, and assisted the team to develop the ECD component strategy. After translating the ECD training manual into Luo, the consultant returned to train MTI staff as ECD trainers.

During Year 2, HHI will provide on-going technical support in ECD as needed.

- 3.) Technical support provided by MCHIP: During September 2010 Debra Prosnitz, Program Analyst for the Maternal Child Health Integrated Program (MCHIP), provided an orientation for MCP and Child Survival staff on the Lives Save Tool (LIST) and Child Survival Sustainability Assessment.

## **E. Substantial Changes in the Program Description and DIP**

Since approval of the updated DIP on August 30, 2010, there have been no substantial changes in the program description or the DIP.

A minor change MTI recommends to the M and E table is to replace the indicator “the percentage of Parish Development Councils with an emergency transportation / referral plan with at least one use in previous three months” with “the number of communities with emergency transport systems” (See Annex 2).

## **F. Plan for Sustainability**

This CSP is designed to strengthen existing government systems and community structures, thus improving quality, sustainability, and ownership of health services. By developing the VHT network and implementing social and behavior change activities, the project is increasing the capacity of the local communities to take responsibility for their own health. Changes in community norms for health behaviors will be self-sustaining and lead to improved health status. Providing IMCI training and follow-up supportive supervision for health facility staff will build DHO capacity to deliver maternal and child health services.

Participatory planning, implementation, and monitoring and evaluation with the DHO and project communities will build capacity of the DHO and communities to continue activities without the need for outside assistance. The DHO is fully engaged in self-evaluation and planning for new or improved systems to sustain staff performance, maintenance of facilities and equipment, consistent supplies, and efficient management.

During the second quarter of year 2, the MTI HQ Child Survival Advisor and Africa Health Advisor will facilitate a sustainability workshop for MTI CSP and MCP staff and DHO partners to develop a sustainability plan.

## **G. Response to Recommendations Made in the DIP Review**

During the DIP review, reviewers' requested specific information and recommended changes to the project strategy. MTT's response the reviewers' recommendations is included as Annex 5.

## **H. Social and Behavior Change Strategy**

The updated social and behavior change strategy is included as Annex 6. DIP reviewers recommended that the social and behavior change strategy better address the key role of grandmothers and fathers in supporting adoption of appropriate MNC health practices. To tailor project messages, focus group discussions were held with both of these groups in each of the three project sub-counties. The findings revealed that both groups believe their role in their families to be influential and important. Fathers, in particular, felt a sense of responsibility for the health of their families. The findings also showed that neither fathers nor grandmothers have information about danger signs for sick children or know the appropriate steps to take when caring for sick children. They also do not have information about maternal danger signs during pregnancy, delivery and postpartum, but they expressed interest in learning about each of these topics.

To address these needs, VHTs will include grandmothers and fathers in home visits and community education on the importance of antenatal and postnatal care, care-seeking for danger signs, skilled birth attendance at delivery and birth preparedness. They will also emphasize the important responsibility both grandmothers and husbands have in promoting MNC practices.

DIP reviewers also suggested addressing the lack of transport from communities to health facilities. During Year 2, the project will assist VHTs to establish emergency transport systems based on discussions they have with communities.

It is also important to mention that the MOH no longer recognizes traditional birth assistants as part of the national health strategy. However, former traditional birth attendants have been integrated into the VHTs and are a valuable resource for the project to support social and behavior change. They are included in the project social and behavior change strategy as VHT members.

## **I. Management System**

The project continues to be effectively managed by MTT Uganda with support from technical and regional management teams at MTT headquarters in Portland, Oregon as well as the regional office in Kampala. HQ provides backstopping in areas of behavior change, monitoring and evaluation and general capacity building is provided through monthly telephone coordination meetings and weekly e-mail exchanges. The Africa Deputy Regional Director and MTT Vice President for Finance provide oversight for managerial and financial operations of the project at HQ. Monthly project reports are submitted on time by field staff and receive feedback from relevant staff at HQ.

*Human Resources:* The general management structure of MTT focuses on field-based operational leadership supported by HQ management and is accompanied by technical support to facilitate successful performance in core competency areas. The Lira MTT-CSP is supported by two primary entities within MTT. The first entity is the MTT Uganda Child Survival Team, headed by the Child Survival Project Manager who is responsible for directly managing this project in Uganda and

coordinating with partners. HQ Africa management staff provides program management guidance and support, including financial oversight in collaboration with the Vice President for Finance.

The second entity is the US-based, cross-functional Child Survival Backstop Team, led by the HQ Child Survival Advisor who is responsible for the technical backstopping of the project and is the point person with USAID Global Health Bureau/CSHGP Office. The Child Survival Backstop Team also includes the MTI HQ Senior Advisor in M and E and Africa Health Advisor who reports to HQ but is based in Kampala. HQ staff provide technical backstopping to the Uganda staff in areas such as best practices in Child Survival program areas as well as monitoring and evaluation, and general capacity building.

All MTI Uganda CSP positions were hired on schedule, save for a slight delay in the hiring of VHT mobilizers until December, 2009 due to negotiations regarding their approval with MTI headquarters and USAID. Development of annual work plans in addition to the current practice of monthly planning, and a 90-day and annual performance review are conducted.

MTI Uganda's headquarters in Kampala is headed by the Country Director, who is assisted by the Director of Operations, Human Resource Manager and Administrator. This office provides the project and the team with management oversight, a sense of identity and facilitates contact with the MOH and USAID country mission in Kampala. MTI Uganda is guided by the MTI International Operational Procedures Manual and complies with all Government of Uganda rules and regulations.

*Financial Management:* Overall budget management for this project is supervised by MTI HQ Vice President of Finance. The MTI Uganda Finance Manger is responsible for reporting all expenditures against the budgetary lines and sending monthly reports and supporting documentation to the HQ Grant accountant using a computerized accounting software package, and is held accountable to the MTI Financial Policies and Procedures Manual. The MTI HQ Vice President of Finance receives and reviews financial reports monthly, and discusses any questions or concerns regularly with the MTI Uganda Finance Manager. Electronic time sheets are used to track individual staff time committed to the project. Senior HQ financial staff visit the Uganda field office annually and perform an internal audit, upgrade accounting skills of local staff, and review financial policies and procedures with management. An internal audit of MTI Uganda by the HQ VP of Finance is planned for January 2011. MTI's consolidated financial statements for fiscal year ending June 30, 2010, have been audited by Jones and Roth, PC.

A minor CSP budget realignment was proposed and approved on September 3, 2010 by USAID. The purpose of the budget realignment was to include all project activities included in the workplan but not included in the original budget and to accommodate the recent VHT remapping based on revised MOH protocol so that two to three VHTs were recruited per community effectively increasing the number of VHTs.

*Communication System:* In the beginning stages of MTI-CSP, adjustments had to be made to create a clear reporting structure and communication channel between MTI-CSP staff and MTI Uganda, especially considering the number of projects MTI Uganda oversees. After a visit from MTI headquarters' staff in January 2010 and discussions with the Country Director, the communication system greatly improved and now functions efficiently. MTI Uganda program supervision and team management is facilitated through weekly administrative meetings for Kampala based administration, human resources, and finance staff chaired by the Uganda Country Director and the

Director of Operations at their office in Kampala. These administrative meetings review plans and priorities for the week, observations from the field, and action plans.

Monthly management team meetings are chaired by the Country Director during which program managers brief the Country Director and team on program progress and on key issues. The Finance Manager and his assistants provide financial updates for each of MTI's various projects, and discuss issues arising from the monthly cash forecasting, review the financial status of projects, raise issues about financial reports and requests for reimbursements, and review policies and other administrative issues.

The CS Project Manager conducts weekly meetings with the MCH Coordinator, MCH Mentor, M&E Coordinator and the Community Outreach Coordinator to coordinate activities for the week and provide support as needed. He also attends quarterly meetings with USAID Gulu. The minutes of the meetings are shared with his direct supervisor, the Director of Operations, who also approves the budget, gives technical advice, communicates on behalf of the project with stakeholders in Kampala, and occasionally directly supervises the project sites. Monthly coordination meetings are held at the Lira MTI office for all field-based program staff. Initially the CSP was challenged with the government's remapping of the project area, making oversight and coordination difficult, but these constraints have been addressed.

*Team Development:* The MTI Child Survival and Malaria Communities Program projects are fortunate to share the same office in Lira. Both projects began October 1, 2010 and coordinated to conduct their respective baseline surveys and community feedback sessions. Staff from both projects were trained together in KPC methodology and attended the social and behavior change workshop during the DIP preparation process. This collaboration allowed the projects to share transportation and avoid conducting the surveys separately. Future surveys will be coordinated when possible. A second example of collaboration between the two projects is the opportunity for the CSP staff to participate in the training of trainers hosted by the Malaria Communities Project in April 2010.

The coverage area of the two projects overlaps in Lira sub-county which allows the two teams to work together in this sub-county to provide training and support for VHTs. The staff works together to conduct trainings and share monitoring responsibilities to ensure the VHTs are conducting home visits, making referrals, demonstrating appropriate use of LLINs, and providing community education on child survival issues.

*Coordination with stakeholders:* To date, there have been no challenges or constraints in coordinating with stakeholders. To ensure project implementation is coordinated with the Ministry of Health, USAID, UNICEF, DHO and other NGOs implementing child survival programs. The CSP Project Manager attends the monthly District health, nutrition and HIV coordination meeting led by the WHO and DHO to review and share progress, achievements, constraints, priorities for the month, as well as program updates and issues.

## **J. Local Partner Organization Collaboration and Capacity Building**

As a lead coordinating Agency in Health, Nutrition and HIV/AIDS in Lira district, MTI coordinates the activities of all partners in the district and is responsible for organizing the monthly health coordination meeting for all partners which are held at the DHO's office. Partners include PACE, NUMAT, RED Cross, Samaritans Purse, the Lira Medical Centre, Marie Stopes, Pathfinder

International, and AIDS Information, among others. The DHO, other NGOs implementing health programs and MTI come together to present their activities, achievements, lessons learned, best practices and challenges. They also map out the services they provide in order to minimize duplication of efforts. The partners help review performance against set targets and prepare a detailed plan of action. Currently MTI is supervising Prevention of Mother to Child Transmission of PMTCT activities in all health centers within the district supported by UNICEF and NUMAT. The inclusion of ECD in CSP has further enhanced the working relationship between VHTs and the health facility staff.

#### **K. Mission Collaboration**

MTI Uganda has been attending USAID regional quarterly mission meetings held in Gulu, during which regional partners funded by USAID meet and make presentations, discuss issues of funding and policies, and share best practices. MTI has a strong relationship with USAID in Washington as well. During Year 1, two USAID representatives visited the CSP program site and reported they were satisfied with their findings. MTI Uganda regularly interacts with USAID Kampala as well, staying abreast of USAID activities country-wide and look for opportunities for further collaboration.

## **Annex 1**

### **Description of Start up and Dip Preparation Processes**

Project start up and development of the Detailed Implementation Plan (DIP) was undertaken in three stages:

#### **A. Initiation of the Child Survival Project**

1. The MTI HQ Child Survival Advisor (backstop) assisted MTI Uganda to finalize Job Descriptions for the new CSP positions, via email and phone. MTI Uganda had a multi-stage process of CV review by committee including the MTI Uganda Director, Director of Operations, Assistant Director of Operations and DHO Administrator. Three candidates for Project Manager were short listed and several MTI HQ staff (CS Advisor, Directors of Regional Programs and International Programs) then participated in phone interviews with the three candidates. For the next level of CSP staff, the 4 Coordinators, MTI Uganda selected CVs, shared these with MTI HQ for comment, and did final interviews by committee. The Community Mobilizers were then hired through a process of CV review and interview by MTI Uganda staff.

The new MTI CSP staff underwent a one day induction with review of MTI's Mission and Vision, procedures and policies, and other relevant new employee information.

Based on the Work Plan submitted with the CSP proposal, the CSP Manager and the HQ CS Advisor developed a detailed work plan for the first quarter of Year 1. Key activities in the first months of the project were an orientation for CSP staff to the CSP plan and visits to Sub-County partners, including health facility staff and sub-county government authorities, to familiarize them with the CSP goal and objectives and to discuss the next steps in project implementation.

#### **2. Collection of baseline quantitative data to inform project priorities and strategies:**

##### **2a. 30 Cluster KPC Survey**

The MTI HQ Monitoring and Evaluation Specialist traveled to Uganda in September 2009 and provided a refresher training to the MTI Uganda Director of Operations who was responsible for leading the baseline KPC and the Administrator, who was in responsible for data entry. The MTI Uganda Director of Operations has considerable experience in performing KPC Surveys with the HQ Monitoring and Evaluation Specialist because they had performed 3 similar surveys in the past. The MTI Uganda Director of Operations, in turn, provided training to the DHO staff on use of KPC survey methodology, the KPC Report). The KPC survey questionnaire was finalized and translated into Luo. The translation was pre-tested and reviewed by the MTI Uganda Director of Operations, a Luo speaker.

Once the entire MTI CSP team was hired, the MTI Uganda Director of Operations trained the team in KPC survey methodology. This training was conducted utilizing the 7 Steps training Curriculum devised by the HQ Monitoring and Evaluation Specialist and used in the trainings for the 3 previous KPC Surveys that were performed by MTI Uganda. The MTI HQ M&E Specialist coordinated sampling selection with the team via email and the survey was conducted in December 2009. DHO partners participated in survey preparations and fieldwork. Data entry was done in Epi Info with

data review by MTI CSP M&E Coordinator; this data was then sent via email to MTI HQ M&E Specialist for statistical analysis and composition of the final Baseline Survey Report.

During January 2010, the MTI CSP team revisited communities where the survey was done to perform Community Feedback sessions. These sessions provided feedback on results to community members and afforded the opportunity to seek further qualitative information in relation to the results.

## **2b. Operational Capacity Assessment**

In January 2010, an Organizational Capacity Assessment was conducted with MTI Uganda as part of DIP preparation process. The objective of the OCA was to build MTI Uganda's organizational capacity to 1) comply effectively with USG regulations and requirements; 2) become stronger USG and other donor implementing partner; and 3) strengthen the quality of programs. MTI's Director of Technical Services and Director of Regional Programs facilitated the process.

## **2c. Rapid Health Facility Assessment**

In March 2010, the Child Survival team carried out a Rapid Health Facility Assessment (R-HFA) as part of the baseline assessment process to assess the capacity of the 4 health facilities presently functioning in Erute North Sub-District. The assessment measures capacity in the areas of access, inputs, processes, and performance. The team was supervised by the Child Survival Project Manager and utilized 2 teams of three individuals, consisting of one supervisor and two enumerators, which included members of the same staff that performed the baseline KPC. This staff was comprised of MTI Supervisors and DHO members. Each team contained at least two members with extensive experience in health.

## **3. Collection of qualitative data to inform project priorities and strategies**

The MTI HQ Child Survival Advisor traveled to Uganda and provided training to the CSP, Malaria Communities Program project team and MTI HIV Prevention among Youth Program teams on Social and Behavior Change and the use of the Doer /Non-Doer technique and accompanied the team during fieldwork. The CSP team, with guidance from the CSP M&E Coordinator, tallied results. Concurrently, the CSP team gave feedback to project communities on a few key KPC Survey results and solicited additional qualitative information from focus groups to better understand existing practices, facilitators and barriers to behavior change. This information was then used to inform development of the Behavior Change Strategy by the CSP team, MTI HQ CS Advisor, and external consultant during the DIP preparation process (See B.)

## **4. Development of innovative strategy – Early Childhood Development**

During the DIP preparation process Laura Peterson, Director of Hands to Hearts International (HHI), Sujatha Balaje, HHI Master Trainer from India, and the MTI HQ CS Advisor met with UNICEF, Right to Play and ChildFund to ensure coordination of ECD activities and strategies. Focus group discussions and individual interviews with mothers and VHT members were conducted to collect information on family composition, existing community support for children 0 – 3 years old, ECD knowledge, traditional care-giving practices and community requests for ECD support.

HHI led a two-day pilot training based on their ECD curriculum. Topics covered included a sampling of the following educational components: explanation of the four domains of development (physical, cognitive, social/emotional and language); connections across the domains; variations in development; early brain development; the importance of observation; bonding and attachment; the role of play; health and hygiene; and baby massage. The objectives of the demonstration training were:

1. Pretest HHI's materials in the new setting of Uganda, gaining a greater awareness of cultural sensitivity, local issues and fit within the CSP.
2. Have CSP staff and partners participate in ECD training to gain a greater understanding of ECD and how they can best integrate this knowledge into the CSP.

## **B. DIP Preparation (in-country)**

The actual preparation of the Detailed Implementation Plan built upon the previous steps of project initiation and the gathering of qualitative and quantitative data on the project area. The MTI HQ Child Survival Advisor, an external consultant and the CSP Manager led the following specific activities, with participation by the CSP team, the Assistant Director of Operations and the Malaria Communities Project Manager, as relevant:

- Meeting with Lira District Health Officer to review overall project goal and objectives, and discuss next steps.
- 1-1/2 day team review and discussion of CSP Goal, Objectives, Strategies and Key Activities as described in the project proposal, to discuss proposed activities (possible facilitating factors and/or barriers) at length and feed into the development of a more detailed Work Plan.
- 2 day participatory analysis of the Doer / Non-Doer survey and Community Feedback focus groups on KPC results to develop the Social and Behavioral Change Strategy.
- ½ day workshop with Lira DHO Senior Health Educator, staff in-charge of Village Health Teams, to review detailed strategies and activities, ensure a shared vision (DHO staff had strongly participated in proposal development, previously) and discuss next steps.
- ½ day team development of the first draft of a detailed Work Plan for the remainder of the LOP, with review and finalization by email.
- ½ day team review of CSP M&E indicators and baseline survey results, with adjustment of the targets proposed for three indicators based on baseline KPC results which were higher than those of a previous MTI project survey in 2007 in a sub-county adjacent to the CSP target area. These included: recommended handwashing practices, mother's recall of child vaccination for measles, and skilled birth attendance. Indicators were also refined for Village Health Team capacity-building, based on discussions of key strategies and activities.
- Meeting to discuss DIP with USAID Health Team Leader, Megan Rhodes and Janex M. Kabarangira, Deputy Team Leader for Health and Program Management Specialist.
- MTI Child Survival Project Manager, Asst Director of Operations, and M & E Officer met with DHO Asst District Health Officer, HIV/AIDS/TB/ and Malaria focal person and MCH Focal person to review project strategies and activities.

## **C. Follow-up and Finalization of DIP**

- Mapping of active VHTs, their level of previous training

- Mapping of active Parish Development Committees
- Mapping of health facilities to determine functional level, staff presence and existing community outreach (coordination with VHTs).
- Coordination with DHO to determine Health Center staffing and IMCI and BEmOC training status
- Sub-Agreement to MoU with DHO

**D. Finalization of Work Plan and M&E Targets based on information gathered**

Annex 2:

Monitoring and Evaluation Table

Objective/ Result	Indicators (by technical intervention or cross-cutting; should include output and outcome indicators)	Baseline Value	EOP Target	Results Year 1	Comments
Objective/ Result 1: Communities assume responsibility for their own health through the strengthening community capacity (Village Health Teams, Parish Development Councils, and Health Sub-districts).	% of VHTs who are women	5%	25%	24%	More female VHTs were recruited during district mapping of VHTs
	% of VHTs who received a supervisory visit during the last 6 months	0%	50%	49.3%	Trained and supervised 276 VHTs in Erute North
	The percentage of communities with an emergency/referral transportation system with at least one use within the past three months.	0%	70%	0%	MTI suggests changing this indicator to the number of communities with emergency transport systems
	% of PDCs and HUMCs that are using information from community HIS for decision making in the last year, with at least one concrete example of action taken	0%	70%	0%	During Year 1, MTI assisted the DHO to reactivate HUMCs at the four health facilities the project supports. They will hold first meeting late November together with VHTS

<b>Objective/ Result 2 Improved health IMCI child (ECD) behaviors among mothers children years</b>	<b>(C- and care</b>	% of children 0-5 months who were exclusively breastfed during the last 24 hours	73.6%	95%	To be measured during Jan 2011 LQAS survey	
	<b>of &lt;5</b>	% of children aged 0-23 months who were put to the breast within one hour of delivery	29.0%	60%	To be measured during Jan 2011 LQAS survey	
		% of children aged 0-23 months who <u>did not</u> receive prelacteal feeds during the first 3 days after delivery	46.6%	75%	To be measured during Jan 2011 LQAS survey	
		<b>IYCF:</b> % of children aged 6-23 months who are fed according to a minimum of appropriate feeding practices	23.14%	50%	To be measured during Jan 2011 LQAS survey	
		<b>CDD</b> % of children 0-23 months with diarrhea in the last two weeks who received Oral Rehydration solution (ORS) and/or recommended home fluids.	47.2%	70%	To be measured during Jan 2011 LQAS survey	
		% of children 0-23 months with diarrhea in the last two weeks who were treated with Zinc.	0.9%	30%	To be measured during Jan 2011 LQAS survey	

	% of mothers of children aged 0-23 months who live in households with soap at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during a 24 hour recall period	54.0%	80%	To be measured during Jan 2011 LQAS survey	
	<b>ARI</b> % of children aged 0-23 months with chest-related cough and fast/difficult breathing in the last two weeks who were taken to an appropriate health provider.	57.8%	80%	To be measured during Jan 2011 LQAS survey	
	% of children aged 0-23 months with chest-related cough and fast/difficult breathing in the last two weeks who were treated with an antibiotic	34.7%	70%	To be measured during Jan 2011 LQAS survey	
	<b>ANTHROPOMETRICS</b> % of children 0-23 months who are underweight (-2 SD for the median weight for age, according to WHO/NCHS reference population)	27.7%	12%	To be measured during Jan 2011 LQAS survey	
	<b>MNC</b> % of mothers with children aged 0-23 months who received at least two Tetanus Toxoid vaccinations before the birth	75.7%	90%	To be measured during Jan 2011 LQAS survey	

	of their youngest child.				
	% of mothers with children aged 0-23 months who received at least 2 doses of IPT during the pregnancy with this youngest child.	35.0%	60%	To be measured during Jan 2011 LQAS survey	
	% of children age 0-23 months whose births were attended by skilled personnel	35.3%	50%	To be measured during Jan 2011 LQAS survey	
	% of mothers of children 0-23 months who received a post-partum visit by an appropriate trained health worker within three days after the birth of the youngest child.	16.33%	50%	To be measured during Jan 2011 LQAS survey	
	% of mothers of children 0-23 m are able to report at least two known maternal danger signs during the postpartum period	2.0%	80%	To be measured during Jan 2011 LQAS survey	
	<b>IMMUNIZATION</b> Percent of children aged 12-23 months who received measles vaccine according to the vaccination card or mother's recall by the time of the survey	77.0%	90%	To be measured during Jan 2011 LQAS survey	
	% of children aged 12-23 months who are fully vaccinated (received BCG,	15.5%	50%	To be measured during Jan	

	DPT3, OPV3, and measles vaccines) by 12 months of age, card verified			2011 LQAS survey	
	ECD % of mothers of children aged 0-23 months who provide cognitive stimulation to their child in the form of games such as “where are your eyes”, etc.	38.0%	80%	To be measured during Jan 2011 LQAS survey	
	% of mothers of children aged 0-23 months who told their child a story, sang a song, or spent time naming objects for (CHILD) at least 2 times in the past week	22.7%	75%	To be measured during Jan 2011 LQAS survey	
	% of mothers of children aged 0-23 months who report that they talk or sing to the child while feeding the child	57.7%	80%	To be measured during Jan 2011 LQAS survey	
Objective/ Result 3 Improved quality of care in health facilities through strengthened capacity in IMCI and MNC	% of HC have a passing score with regard to the assessment of sick children (> 80% of patients observed in each facility have all 5 assessment tasks performed on them by the HW)	0%	75%	Will be assessed during midterm HFA	
	% of HC in which > 80% sick children treated according to protocol	25%	75%	Will be assessed during midterm HFA	

	% of HC staff received a supervisory visit within 3 months	25%	75%	Will be assessed during midterm HFA	
Objective/ Result 4: Strengthened institutional capacity of MTI and DHO to implement effective and efficient child survival activities.	Demonstrate improvement in 6 low-scoring priority areas identified during the Organizational Capacity Assessment	0	6		<p>Consistent progress is being made in each priority area as demonstrated by progress in implementing MTI Uganda OCA Action Plan.</p> <p>Progress made as of August 2010 includes:</p> <ul style="list-style-type: none"> <li>➤ Strategic Plan drafted - to be finalized in December 2010;</li> <li>➤ Job grading systems is under development and benefits policies drafted for review;</li> <li>➤ Projects ID for major donor visits; Funding opportunities monitored and new grants accessed;</li> <li>➤ Revised org chart completed; M&amp;E tools accessed from HHI;</li> <li>➤ Staff participated in KPC/RHA training and implementation;</li> <li>➤ Steps taken to improve communication;</li> </ul>
	Action plans for 6 priority areas implemented and scores improved	0	6		OCA scores will be updated at midterm.
	Lessons learned and best practices are disseminated utilizing at least three different media (program	No	Yes		MTI CSP staff visited the Health Partners CSP to learn about their project implementation strategies, means of relating with local

	<p>manual, presentations, web site, program guidance and meetings with stakeholders)</p>				<p>government systems and communities, reporting formats and how they work with the VHTs.</p> <p>MTP's has shared successes and lessons learned during quarterly meetings with the DHO and other partners. The most important success shared was the importance of working with local government and civic leaders to ensure input and support for project activities. The most significant lesson learned was the importance of transitioning from a paid VHT network to a voluntary network. The DHO passes on MTP's successes to other partners.</p>
	<p>% of health facilities received joint DHO/MTI supervision visits once per quarter</p> <p>❖ to be measured beginning Year 2</p>	0	75%	100%	<p>Joint supportive supervision was carried out at each health facility during quarters 3 and 4 of Year 1.</p>

### Annex 3 - MTI Uganda OCA ACTION PLAN

Issues	Action	Responsible Person	Time frame	Update
New Opportunities Development and Planning	<ol style="list-style-type: none"> <li>1. Develop business /resource mobilization plan</li> <li>2. Maintain proposal writing</li> <li>3. Assess program and align with donor interest e.g. PMTCT/Pader Program</li> <li>4. Identify projects for major donor visits</li> <li>5. Documentation of activities through report generation including success stories</li> <li>6. Initiate opportunities for subgrants to church partners or FBOs</li> </ol>	<p>Felix/David</p> <p>Debbie</p>	End of 4 <sup>th</sup> Quarter (fiscal year)	<ul style="list-style-type: none"> <li>➤ 2 new grants received (Bureau of Population, Refugees &amp; Migration and NUMAT);</li> <li>➤ 1 concept paper submitted to UNHCR for refugee program in SW Uganda; 1 concept paper in progress for UNICEF (PMTCT scale up in Lira);</li> <li>➤ Other funding opps. explored;</li> <li>➤ Regular monthly reports w/success stories completed;</li> <li>➤ funds received from major private donor visit</li> </ul>
Monitoring and Evaluation	<ol style="list-style-type: none"> <li>1. Conduct a Readiness Assessment for M&amp;E (capacity, resources, tools etc)</li> <li>2. Develop a comprehensive M&amp;E plan</li> <li>3. Adapt relevant M&amp;E tools from MTI HQ and</li> </ol>	Joel, Ronald, Hilda, all PMs	Oct – Dec 2010	<ul style="list-style-type: none"> <li>➤ Training in KPC and R-HFA methodology;</li> <li>➤ Project Cycle Management course in progress via CD</li> </ul>

	<p>other partners</p> <p>4. Provide M&amp;E support to all MTI Uganda projects</p> <p>5. All M&amp;E staff and PMs go through PCM</p>			
Transformational Development	<p>1. Identify FBOs/churches to be linked with MTI Ug</p> <p>2. Link US Churches with MTI Uganda projects</p> <p>3. Implement activities through identified churches</p> <p>4. Modify already existing activities to embrace TD</p> <p>5. Develop/Adapt TD M&amp;E tools</p> <p>6. Hire a church relations person for MTI Uganda to be focal point with US churches</p>	<p>All PMs Steve W, Felix</p> <p>Anna + M&amp;E Human Resource</p>	By Dec 2010	Church engagement strategy in progress as part of strategic planning process
Staff Salary & Benefits Policy	<p>1. Adopt a salary and benefits policy</p> <p>2. Revise the annual salary increase policy</p> <p>3. Make uniform health insurance policies in all project sites.</p> <p>4. Provide medical insurance for immediate family members</p> <p>5. Streamline/clarify sick and maternity leave policies</p> <p>6. Set standards on bereavement support</p> <p>7. Review and disseminate end of project or end of contract policy</p>	HR Departments at HQ and Uganda	April 2010 & ongoing	Policies regarding job grading system (waiting for feedback from HR at HQ), standardize bereavement leave, maternity leave, performance evaluation, and staff development drafted in Staff Manual and under review by Project Managers

	8. Conduct assessments of staff capacity to identify gaps 9. Approve funding for staff development; utilize consultants for professional development activities			
Communication & Decision-making	1. Finalize organizational structure with clearly defined channels of supervision and communication. 2. Organize regular staff meetings or other fora for staff to contribute ideas and improvement recommendations 3. Ensure communication is copied to all pertinent staff	Leadership Team  HR All	March 2010 and ongoing	➤ Org. chart revised;  ➤ staff meeting notes kept for reference; communication ongoing
Succession Planning	1. CD to bring member of management team to lobby and advocate for funding 2. Establish delegation policy 3. Provide equal opportunity for managers to serve as designated officer in charge 4. Create awareness among staff and ensure delegation is communicated to staff 5. Build capacity of management team; invite/hire reputable consultants to present to and/or train the management team; managers attend short courses e.g. U.M.I. and L.D.C.	CD & Director of Program Ops  CD & leadership team  CD, HR and HQ	When opportunity permits Ongoing  Ongoing  Ongoing	Ongoing
Strategic Planning	1. Request guidelines from HQ for developing SP 2. Develop a plan to develop a SP; identify external support needed from HQ or local consultant;	CD CD/Director of Program	Feb 2010 June 2010	➤ Working groups established and research conducted;

	<p>gather information on funding sources and regional needs; meet with potential FBO partners; and conduct a SWOT analysis</p> <p>3. Complete an MTI-Uganda SP (an off-site workshop)</p>	<p>Ops/Management team</p> <p>MTI-Uganda staff</p>	<p>October 2010</p>	<ul style="list-style-type: none"> <li>➤ Strategic Planning workshop held</li> <li>➤ Draft Strategic Plann will be sent to HQ for review in Dec. 2010</li> </ul>
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## Annex 4 - Activity Status Table

Project Objectives/ Results	Related Key Activities (as outlined in DIP)	Status of Activities (Completed, on target, not yet on target)	Comments
<b>Objective No.1:</b> Communities assume responsibility for their own health through strengthened community capacity (Village Health Teams, Parish Development Councils, and Health Unit Management Committees).	Training of VHTs in ICCM and MNC	Completed	560 VHTs trained using the recently revised training curriculum from August to October
	Health unit Management committees hold regular meetings	Not yet on target	HUMC will hold first meeting in November
<b>Objective No.2</b> Improved health (Community based Integrated Management of Childhood Illness) and child care (Early Childhood Development) behaviors among mothers of children under 5 years of age.	Qualitative research conducted and social and behavior change strategy developed	Completed	To refine the social and behavior change strategy, focus group discussions were conducted with grandmothers and fathers in October
	Develop home based newborn care messages and maternal care messages if needed using local tools	Completed	MNC messages included in updated MOH VHT training materials
	Train VHTs on MNC	Completed	
	ECD TOT training	Completed	Delayed due to remapping and subsequent basic training for VHTs; Completed in October
	Strengthen community referral system	Not yet on target	VHTs are referring community members to health services using the MOH referral form.  VHTs have begun discussions with their communities to establish emergency transport plans and

			will support their implementation during Year 2.
	TOT mother groups	N/A	During the DIP development process, it was decided not to train mothers groups as trainers in ECD but instead to meet with them quarterly
	ECD Training in intervention areas	Not yet on target	Delayed due to remapping and subsequent basic training for VHTs;  ECD training will begin in November, 2010
<b>Objective No.3:</b> Improved quality of Health Center services through strengthened capacity for Integrated Management of Childhood Illness and Maternal Newborn Care.	Health Facility Assessment conducted	Completed	Completed March, 2010
	IMCI Training	Completed	Training conducted by DHO trainers and CSP manager
	MNC refresher training	Not yet on target	Planned for first quarter Year 2
	Clinical mentoring	On target	Monthly by the MNC Mentor
	Supportive supervision	On target	Quarterly by DHO/MTI team
	Support provided to Child Health Days	On target	Took place in May, 2010
<b>Objective No.4:</b> Strengthened Institutional capacity of Medical Teams International and the District Health Office to implement effective and efficient child survival activities.	MTI and DHO staff underwent training and joint meetings on child survival implementation strategies	Completed	Facilitated by MTI Child Survival Advisor and DIP and ECD consultants in January and February, 2010 during DIP development process
	Provided clinical supplies	Completed	Provided four health facilities with HMIS cards, curtains, bed screens, examination beds, scales and blood pressure kits
	Joint supportive supervision and regular meetings	On target	Joint supportive supervision conducted quarterly, by DHOs, and Health Sub District and MTI staff

	Exchange visit to HealthPartners Child Survival Project in Bushenyi	Completed	CSP Project Manager, MCH Mentor and M and E Coordinator visited Bushenyi project in April, 2010.
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**Annex 5 - MTI Response to DIP Reviewer Comments**

Section	DIP reviewer comments	MTI Response
<i>Project Data Form/ Number of Beneficiaries</i>	<p>1) The <u>number of beneficiaries</u> reported in the text does not match up with the beneficiary numbers reported in the table (page 5). Additionally, the numbers reported in the table add up to a different total than what is shown. The table reports that there is the same number of WRA and children under 5, estimated using the same proportion of the total population. However, populations typically have more WRA than children under 5. Please review and revise beneficiary numbers.</p>	<p>The population figures cited were provided to the team by the District Health Office and are projections based on the 2002 census.</p> <p>In the DIP, there was an error in the population figure for children 23-24 months in Lira subcounty. This has been corrected in the DIP beneficiary table and narrative.</p>
<i>Community based services and community mobilization</i>	<p>2) It is not clear if MTI will be involved in recruiting additional <u>CHWs</u>, and if so, how this will be done. It is also unclear how MTI will promote the involvement of female <u>VHTs</u>. Will there be an effort to increase the CHW/population ratio to fulfill the national suggestion of 9-10 CHWs per VHTs? How will female CHWs, in particular, be recruited? The reason for the low female membership of the VHT was not stated in the DIP. It is important to understand the underlying reason(s) for the low levels of involvement so that appropriate strategies for recruiting women are implemented.</p>	<p>The MoH no longer uses the term “CHW” which in the past referred to volunteers working in specific programs such as vaccinators, disease outbreak monitors, and TB monitors. All community volunteers are now referred to as VHTs.</p> <p>DHO and health facility staff are presently re-mapping the VHTs to ensure full teams of 9-10 VHTs and higher participation of women. Guidelines for VHTs suggest one third of VHT members should be women. The present low participation of women as VHT members is due to the selection requirements which include being able to read and write. At 42%, literacy levels for women in the North are lower than the levels for males in the North.</p>
	<p>3) What is missing is whether the project would be building the capacity of the VHT to use data that they collect to</p>	<p>Through supportive supervision, MTI will encourage VHTs to meet on a</p>

	<p>monitor what is happening in their communities and make any necessary adjustment to their activities. Do the VHT meet regularly (e.g., monthly) to share information? If not, would the project encourage them to do so and assist them to collate a few of the indicators they are collecting in a simple format to track their progress, etc. MTI or MOH/Uganda may already have existing training manuals and job aides for this already and just was not mentioned in the DIP. If there are no existing manuals, MTI could review and see if sections of the ACCESS or HCP community mobilization training manual could be adapted for their use.</p>	<p>monthly basis. The project will also support health facility staff and health unit management committees to arrange and facilitate quarterly coordination meetings with the VHTs.</p> <p>During joint support visits, health facility and MTI staff will assess the quality of the information collected by the VHTS and provide guidance on how to analyze and use the data for planning.</p> <p>The MoH has standard reporting formats for VHTs and standard training manuals.</p>
	<p>4) Coverage of households (HH) by VHT members – it is not clear how the project will ensure all the VHT members have the knowledge and skills that is required for them to provide the HH education given that each VHT member is expected to cover 25 HH. The training protocol for the Peer Educators for the ECD is clearly described but not that for the VHT members who conduct the HH visits. Also would all the VHT members be equipped with counseling cards?</p>	<p>MTI will support the DHO to train VHT members. Training will be based on the VHT training package developed by the MoH which includes the following topics:</p> <ul style="list-style-type: none"> <li>a) Environmental sanitation</li> <li>b) Nutrition</li> <li>c) Immunization.</li> <li>d) Importance of ANC</li> <li>e) Family planning</li> <li>f) Home based management of fever</li> <li>g) Identifying danger signs in newborns, children and pregnant women</li> <li>h) Prevention and home management of diarrhea using ORS</li> <li>i) Mobilization for health</li> <li>j) ARI and pneumonia</li> </ul> <p>After initial training, project VHT Mobilizers will provide</p>

		<p>support and supervision for the VHTS on a monthly basis. During quarterly coordination meetings with health staff, VHT members will receive training. Topics for quarterly updates will be identified during monthly supervision visits with input from the VHTs.</p>
<i>Community Case Management</i>	5) The Community Case Management approach needs to be clarified. Is UNICEF still supporting the MoH in rolling out comprehensive CCM in Lira? (page 18). It is good that MTI is aware and monitoring this national level activity. What is not clear to me is, if MTI and/or its DHO partner have communicated their willingness to introduce CCM in their district. It is important that MTI/DHO let MOH and UNICEF know of their interest to introduce CCM in their impact area early in the process so that they are included in the national roll-out plan.	<p>MTI has participated in ICCM technical working group meetings. The Lira DHO has expressed interest in introducing ICCM. At this time the MoH and UNICEF have not prioritized Lira district for roll out of ICCM. If the district is prioritized in the future, commodities are available, and piloting in other districts shows ICCM is working effectively, MTI will support the DHO to roll out ICCM in the subcounties supported by this Child Survival Project.</p> <p>To ensure appropriate monitoring and quality of ICCM services, MTI suggests supporting the roll out on a small scale before scaling up to all three districts.</p>
	6) Will CHWs/VHTs be distributing zinc at the community level?	<p>Supplies of zinc provided by the MoH have been irregular. The Lira DHO plans to involve VHTs in distribution of zinc at the community level when regular supplies of zinc have been secured.</p>
<i>Mothers groups</i>	7) Mothers groups are mentioned once in the DIP narrative, and then appear in “Facilitated Meetings” table. This is a potentially powerful strategy, but they are scheduled to meet just twice a	<p>The VHTs will work with women's groups formed through churches and mosques. The church and mosque women’s groups</p>

	<p>year, making them less viable as a peer education and support approach and more a vehicle for health education. Can you explain the purpose of these groups, how they will be formed, and if there will be any follow-up between meetings? The description on p. 11 says that the group discussion will focus on specific barriers uncovered during BC research—what are those barriers?</p>	<p>involve community women in church and mosque activities, offer support to families in need and in some cases have resources to support income generation activities.</p> <p>The project will meet with the groups quarterly to provide maternal and child health information and encourage women's group members to disseminate these messages in their communities. They will also discuss challenges the women and the community face and possible solutions.</p> <p>The barriers discussed during behavior change research will focus on IYCF.</p>
<p><i>Equity Mapping</i></p>	<p>8) From p. 11: “MTI Uganda will conduct an “<u>equity mapping</u>” of the community groups with whom the VHTs are collaborating, to identify any geographic sub-areas or sub-groups that are not yet being reached through this approach. Based on this assessment, additional approaches may be developed to ensure that all are reached.” This is missing from the workplan.</p>	<p>VHT members will receive initial training during the fourth quarter of Year 1. Equity mapping is planned for the third quarter of Year 2, after the VHTs have established themselves and are functioning. This will be added to the work plan.</p>
<p><i>Interventions</i></p>	<p>9) There is no LOE allocated for <u>malaria</u>. While this project area overlaps with the MCP project area, not all of the CS project area is covered by MCP malaria interventions. How will the CS address malaria in non-MCP areas, especially considering that malaria is a primary cause of mortality among children under 5 in this area?</p>	<p>The decision not to include malaria as a technical component was based on the fact that NUMAT is working in Erute and Ogur subcounties. The MTI MCP Project covers Lira subcounty.</p> <p>In Ogur and Erute, NUMAT supplies malaria test kits and LLITNs. The government health facilities provide malaria</p>

		<p>treatment.</p> <p>This project supports IMCI training and services which includes malaria diagnosis and treatment and also supports training for VHTs in C-IMCI which addresses malaria.</p>
<i>Newborn</i>	<p>10) The DIP states that IEC materials for newborns will be developed and integrated into the existing C-IMCI materials. It is great that the team identified this deficiency however it was not clear whether the HH visit will include more than just educating mothers on danger signs for sick newborns. Research shows that an assessment by the community health worker (i.e., VHT member) during HH visits would provide a higher yield of sick newborns compared to reliance on mothers' recognition of danger signs alone. It is not clear from the DIP whether VHT members will be provided with the skills to be able to assess newborns for danger signs. It was also not clear whether they will be provided with the knowledge and skills to support breastfeeding. That is would they be taught to support mothers to deal with BF problems such as proper latching, correct positioning of the babies, breast health, feeding frequency, etc.? It is also not clear when and how often HH visits would be conducted. Given the recommendations of the WHO/UNICEF joint statement on PNC home visits for at least two HH visits in the first seven days of life, and the availability of the WHO/UNICEF training manual for PNC home visits, I think it would be a missed opportunity for this project not to incorporate a structured PNC home visits in their package.</p>	<p>The project social and behavior change strategy mentions that MTI will provide supportive supervision for health facility staff to ensure the WHO recommendations for home visits for newborns are followed.</p> <p>The maternal newborn care component of the MoH VHT curriculum addresses assessing newborns for danger signs, cord care, and establishing good breast feeding practices including maternal nutrition, breast hygiene, attachment, positioning, and frequency of breastfeeding.</p> <p>MTI VHT Mobilizers will support VHTs to provide two to three home visits to mothers with newborns during the first seven days after birth.</p>
<i>Neonatal Resuscitation</i>	<p>11) Since many women deliver with TBAs, could they be trained in <u>post-partum care</u>?</p>	<p>The MoH no longer recognizes TBAs and discourages them from providing delivery or post-partum care.</p>

	<p>Will post-partum visits include family planning counseling (or referral)? CORE's Safe Motherhood Standards and Indicators Compendium provides information about what should be included in post-partum care</p>	<p>Post partum care is presently provided at the facility level. Training for VHT members includes recognition and referral of postpartum problems, however, VHT members will not be expected to provide post-partum care.</p> <p>VHTs will also provide information and referrals for family planning services but the services themselves will be provided at health facilities.</p>
<p>AMTSL</p>	<p>12) The DIP mentions that through on-job visits, MTI CSP staff will review safe and clean delivery including AMTSL. It also states that oxytocin is available only in Ogur HCIV. There was no explanation for why oxytocin is only found at this facility. Is it because of MOH policy, shortage of supplies or something else? In the same paragraph the use of breastfeeding to "control hemorrhage" is mentioned. Promoting immediate and exclusive BF as part of hemorrhage control is great but at the health facility level we really want them to use AMTSL and would be important for the project to facilitate the availability of this intervention at all the health facilities in their impact area by addressing the necessary barriers.</p>	<p>The lack of availability of Oxytocin at health facilities is due to gaps in supplies from the MoH.</p> <p>Midwives at health facilities have been trained in the active management of the third stage of labor by the MoH and UNFPA. The Child Survival Maternal and Child Health Coordinator and Mentor will monitor staff skills and provide mentoring in AMTSL.</p>

<p><i>Maternal Nutrition</i></p>	<p>13) It is important to have VHTs promote good maternal nutrition as noted on page 19. Can you provide more information on this—what specifically will be recommended?</p>	<p>Maternal nutrition messages will be based on Essential Nutrition Actions recommendations specifically:</p> <ul style="list-style-type: none"> <li>a) Pregnant and lactating women should have one extra meal per day including one serving of a staple food and one protein food.</li> <li>b) The importance of preventing anemia during pregnancy by consuming food rich in iron and taking iron/folic acid supplementation.</li> <li>c) The importance of de-worming during pregnancy</li> <li>d) The importance of post-partum vitamin A supplementation.</li> <li>e) Promotion of consumption of iodized salt.</li> </ul>
<p><i>Early Childhood Development</i></p>	<p>14) The ECD section has a lot of information, but raises a few questions:</p> <ul style="list-style-type: none"> <li>a. How will mothers be recruited to attend ECD sessions?</li> <li>b. How will MTI ensure that the same mothers attend all 5 sessions for a complete training?</li> <li>c. Are 2.5 hour sessions a feasible amount of time for mothers to be away from other activities?</li> <li>d. If men are also targeted with ECD messages, will men be attending the mothers' group sessions or will they be reached separately?</li> <li>e. ECD indicator: why 2x in past week? Are you promoting a daily practice? Why not measure "in past 24 hours?"</li> </ul>	<ul style="list-style-type: none"> <li>a) How will mothers be recruited to attend ECD sessions?</li> </ul> <p>Community leaders and VHT members will recruit mothers to attend ECD sessions.</p> <ul style="list-style-type: none"> <li>b) How will MTI ensure that the same mothers attend all 5 sessions for a complete training?</li> </ul> <p>Trainings will be held during afternoons, when mothers are most available, after they have returned from the fields. The training sets will be repeated at least once so mothers or fathers who missed a session can catch up. VHT members will also verify</p>

	<p>That will be easier for mothers to recall.</p>	<p>the attendance and encourage participation in all five sessions.</p> <p>c) Are 2.5 hour sessions a feasible amount of time for mothers to be away from other activities?</p> <p>Experience during the ECD training of trainers field practice and Hands to Hearts' experience providing training to groups in Kampala has shown that having fewer slightly longer sessions but still reasonable in length ensures mothers attend the full ECD course. It is easier for mothers to attend 5 - 2.5 hour sessions than 10 or 12 shorter sessions.</p> <p>d) If men are also targeted with ECD messages, will men be attending the mothers' group sessions or will they be reached separately?</p> <p>One man and one woman in each community will be trained as ECD peer educators. Trainings Hands to Hearts has conducted in Kampala indicate that it is well accepted and advantageous for husbands and wives to attend the trainings together. MTI and HHI will use the same approach within this project.</p>
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		<p>e) ECD indicator: why 2x in past week? Are you promoting a daily practice? Why not measure “in past 24 hours?” That will be easier for mothers to recall.</p> <p>The peer educators will encourage mothers to tell stories, sing songs and do and other activities which provide language stimulation with their children on a daily basis.</p> <p>The indicator “% of mothers of children aged 0-23 months who told their child a story, sang a song or spent time naming objects for (CHILD) at least two times in the past week” was determined based on the results of the baseline KPC. The survey showed that 61% of mothers reported not doing any of the activities mentioned in the past week. 16% of mothers reported doing one of these activities once a week and 12% twice a week. No mother reported engaging her child in one of these activities 7 times during the past week.</p> <p>If the Year 1 LQAS or midterm KPC shows a marked improvement in this indicator, MTI will</p>
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		reconsider reframing it to reflect a daily basis.
<i>HIV/AIDS</i>	15) This is an area with prevalence of HIV, yet there is no mention of that impact on families and health behaviors. MTI's PMTCT work in Uganda should inform the nutrition work in this CS program, namely infant feeding guidance to mothers.	<p>Messages on breastfeeding practices will follow the 2009 Ministry of Health guidelines for breastfeeding which recommend that women should exclusively breastfeed for the first six months. Health workers should determine the HIV status of pregnant and breastfeeding women to prevent mother-to-child HIV transmission. HIV-positive women should still breastfeed for the first six months, regardless of their infants' HIV status, unless adequate breastmilk replacements are available. Current guidelines recommend HIV testing among infants at age six weeks if they are born to HIV-positive women and if infant diagnostic tests are available.</p> <p>Breastmilk replacements are not readily available or safe to use in Lira so the project will recommend that all women breastfeed for 6 months.</p>
<i>CDD</i>	16) One piece missing from the description of the CDD intervention is increased feeding after illness (catch-up feeding). There is more information in the TRM; also ENA.	<p>MTI accepts this recommendation. The social and behavior change strategy will include the following messages: After illness, a child should eat extra meals until he or she regains lost weight and is growing well. Children younger than six months should be breastfed more frequently. Children 6-24 months should continue to breastfeed and be offered</p>

		<p>more frequent feeding and larger amounts of complementary foods.</p> <p>These messages are included in the IMCI algorithms and training curriculum for VHTs.</p>
<i>Exclusive Breastfeeding</i>	<p>17) Since EBF is relatively high, MTI will need to conduct a barrier analysis to home in on an approach for the last 26% of mothers who are not exclusively breastfeeding. Increasing knowledge is the only BC activity for this intervention, but it is not likely to impact behavior. How will MTI address the other barriers, like mother and child separation? From the background information it seems that grandmothers are a barrier to EBF, but that is not mentioned in the BC plan.</p>	<p>The project is planning to conduct qualitative research to address key practices that have not improved at midterm. If the year one LQAS survey results indicate that exclusive breastfeeding is still a concern we will consider conducting barrier analysis at that time.</p> <p>The social and behavior change strategy includes educating husbands and other family members, including mothers in law, on the importance of exclusive breastfeeding and encouraging them to support mothers. (page 14)</p>
<i>Maternal Nutrition</i>	<p>18) Food variety/availability was not discussed in the IYCF intervention description.</p>	<p>Food availability in Lira is improving as households previously displaced by insecurity are slowly rebuilding their livelihoods. The district is an important supply source for sorghum, millet and beans. Most families in the district cultivate a small vegetable garden and raise chickens.</p> <p>Even though a reasonable variety of foods is available, families need information on how best to use local foods. Nutrition education provided by the project will focus on helping families use locally</p>

		available foods to meet their nutritional needs.
<i>Behavior Change</i>	19) See <u>postnatal visits</u> in the Framework. Transport is a barrier, but there is no activity to ameliorate it. The text indicated that VHTs would provide postnatal visits. However, this is not in the BC plan. Could TBAs be trained for this, too?	<p>VHTs will visit families of newborns to assess newborns for danger signs, cord care, and assist the mother to establish good breast feeding practices</p> <p>Postnatal care for women is provided at the facility level by midwives. Since TBAs are not recognized by the MoH, they are not allowed to provide postnatal visits.</p> <p>The barrier of transportation for postnatal visits will be addressed by working with the DHO and health facility staff to improve postnatal care outreach services. The project will also discuss the issue of transportation with village leaders and local council authorities to assist them to identify possible solutions.</p>
	20) The BC monitoring table is not filled in correctly. If this is not useful, then perhaps MTI does not need to fill it in. Please contact MCHIP to discuss the purpose of and expectation for this table. Regarding family/household, lack of knowledge is rarely the only barrier and behavior generally doesn't change by improving knowledge only.	Could MCHIP please clarify expectations for completing the behavior change monitoring table.
	21) Are the "facilitators" and "barriers" listed in the BC Framework based on formative research? It is confusing that knowledge of appropriate practices is listed as a facilitator and also lack of knowledge is listed as a barrier for the same intervention.	<p>Facilitators and barriers were identified through the baseline KPC survey and follow up community feedback, doer/ non-doer surveys conducted during the DIP development process, and focus groups conducted during the proposal development process.</p> <p>If formative research revealed that communities do not have appropriate information about a</p>

		health practice, for example, postnatal care, lack of information was considered a barrier to adopting the practice. The project providing appropriate information about postnatal care, on the other hand was considered a facilitator.
<i>Gender</i>	22) Gender issues should be examined in more depth. It is great that fathers, mothers-in-law, and elders will be targeted with BCC messages. However, there is not a clear strategy outlined as to how these groups will be reached, and how messages will be tailored to each group for any of the interventions. For example, how will messages on exclusive breastfeeding be tailored for men, and how (where) will these messages be delivered?	<p>The VHTs will reach men, mothers-in-law and other family members with social and behavior change messages during home visits. Mothers-in-law will also be reached through women's groups.</p> <p>After the year one LQAS, the project will conduct focus groups with these influencing groups and use the finding to develop appropriate and consistent messages.</p>



**Lira Child Survival Project**  
➤ **Social and Behavior Change Strategy**

Updated November 2010

## Social and Behavior Change Strategy: Maternal and Newborn Care

**Broad behavior change goal:** To improve key family and child health practices and use of health services

**Specific behavioral objectives:**

- Pregnant women receive at least 4 antenatal visits
- Mothers and family members recognize danger signs during pregnancy and post natal period and seek appropriate care
- Women have deliveries attended by skilled birth attendant
- Mother and baby receive post-natal visit after 24 hours, after three days, and, if possible, after one week

**Summary of Strategy:** The project will improve key maternal and newborn care practices including uptake of antenatal and postnatal care services and skilled birth attendance at delivery. VHTs will provide community education through home visits and community education sessions with women's and men's groups on the importance of antenatal and postnatal care, care-seeking for danger signs, skilled birth attendance at delivery and birth preparedness. Family members will be provided with education on maternal and newborn issues and encouraged to support mothers to access maternal and newborn care services. Clinical care will be strengthened by providing mentoring and supportive supervision for ANC staff at health facilities.

**Channels of Communication:**

Interpersonal communication: Community education and home visits provided by VHTs members and health education provided by health facility staff.

Traditional ways of Learning: VHT members will utilize drama, stories, and songs to disseminate messages during education sessions and social gatherings

Social Support: Social support will be strengthened by educating family members about how they can support mothers to access maternal and newborn care services. VHTs will provide community education through home visits and community education sessions with women's and men's groups on the importance of antenatal and postnatal care, care-seeking for danger signs, skilled birth attendance at delivery and birth preparedness.

Community Mobilization: The VHT approach mobilizes the community to reinforce health messages and create an environment that supports maternal and newborn services.

Print education materials: The project will adapt the MoH birth planning card used at the health facility so it is appropriate for use at the household level.

## Designing for Behavior Change Framework: Maternal and Newborn Care

Priority and Supporting Groups	Behavior	Key factors	Activities
<b>Individual</b>			
Women of reproductive age, pregnant women, and mothers of children under five years of age	Pregnant women receive at least 4 antenatal visits	<p><u>Facilitators:</u></p> <ul style="list-style-type: none"> <li>➤ Desire for healthy pregnancy and delivery</li> <li>➤ Support from husband to attend ANC</li> </ul> <p><u>Barriers:</u></p> <ul style="list-style-type: none"> <li>➤ Few skilled health workers available</li> <li>➤ Lack of “Mama Kits”</li> <li>➤ Lack of privacy at ANC</li> <li>➤ Pregnancy is seen as a natural state not needing medical attention</li> <li>➤ Lack of confidence between health workers and community</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education through home visits and group sessions with women’s and men’s groups to encourage ANC attendance. Men will be encouraged to support their wives to access ANC services.</li> <li>➤ VHTs promote birth preparedness</li> <li>➤ VHTs provide referrals to health facilities</li> <li>➤ VHTs support outreach activities by mobilizing communities and providing health education on importance of outreach services.</li> <li>➤ CSP VHT Mobilizers provide transport for health facility staff to provide ANC outreach.</li> <li>➤ Birth preparedness card adapted for community use</li> <li>➤ Privacy at health facility ensured by providing curtains and dividers</li> </ul>

	<p>Mothers recognize danger signs during pregnancy and post natal period and seek appropriate care</p>	<p><u>Facilitators:</u></p> <ul style="list-style-type: none"> <li>➤ Desire for healthy pregnancy outcome</li> </ul> <p><u>Barriers:</u></p> <ul style="list-style-type: none"> <li>➤ Lack of information about danger signs</li> <li>➤ Low appreciation of severity of danger signs</li> <li>➤ Transportation to health facility not available</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education on danger signs</li> <li>➤ VHTs provide referrals to health facilities</li> <li>➤ VHTs promote birth preparedness</li> <li>➤ MTI will assist VHTs to establish emergency transport systems in their communities.</li> </ul>
	<p>Women have deliveries attended by skilled birth attendant</p>	<p><u>Facilitators:</u></p> <ul style="list-style-type: none"> <li>➤ Desire for safe delivery</li> <li>➤ Access to skilled birth attendant</li> <li>➤ Support from family to have delivery attended by skilled birth attendant</li> </ul> <p><u>Barriers:</u></p> <ul style="list-style-type: none"> <li>➤ Perception of quality of labor and delivery services as poor</li> <li>➤ Poor relationship between health workers and community</li> <li>➤ Birth seen as a natural event not needing medical assistance</li> <li>➤ Informal fees charged at health facility</li> <li>➤ Long distance to health facility</li> <li>➤ Lack of transportation</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education to encourage birth preparedness and importance of having a delivery kit</li> <li>➤ VHTs provide referrals to health facilities</li> <li>➤ MTI will assist VHTs to establish emergency transport systems in their communities.</li> <li>➤ CSP advocates at the sub county and facility levels for cost free delivery</li> </ul>

	<p>Mother and baby receive post-natal visit after 24 hours, after three days, and, if possible, after one week</p>	<p><u>Facilitators:</u></p> <ul style="list-style-type: none"> <li>➤ Husbands support their wives to access postnatal care</li> </ul> <p><u>Barriers:</u></p> <ul style="list-style-type: none"> <li>➤ Lack of information about and appreciation of importance of postnatal visits</li> <li>➤ Lack of transport to health facility</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education on importance of post-natal care</li> <li>➤ VHTs provide post-natal visits and referrals to health facilities</li> <li>➤ MTI will assist VHTs to establish emergency transport systems in their communities.</li> </ul>
<b>Family/ Household</b>			
Grandmothers and fathers	<p>Support pregnant women to seek antenatal and postnatal care</p> <p>Support pregnant women to seek medical care when they have danger signs</p> <p>Support pregnant women to have their births attended by a skilled birth attendant</p>	<p><u>Facilitators:</u></p> <ul style="list-style-type: none"> <li>➤ Desire for healthy pregnancy and safe delivery</li> </ul> <p><u>Barriers:</u></p> <ul style="list-style-type: none"> <li>➤ Lack of information about and appreciation of importance of antenatal and postnatal care and importance of having delivery attended by skilled birth attendant</li> <li>➤ Transportation to antenatal and postnatal care not available</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs include grandmothers and fathers in community education on the importance of antenatal and postnatal care, care-seeking for danger signs, skilled birth attendance at delivery and birth preparedness</li> <li>➤ VHTs provide community education through both home visits and quarterly “health talks” with fathers and grandmothers on the important responsibility they have in promoting MNC practices</li> <li>➤ VHTs refer women to ANC, delivery and postnatal services</li> <li>➤ MTI will assist VHTs to establish emergency transport systems in their communities.</li> </ul>

Community			
VHTs	<p>Support pregnant women to seek antenatal and postnatal care</p> <p>Support pregnant women to have their births attended by skilled birth attendant</p>	<p><u>Facilitators:</u></p> <ul style="list-style-type: none"> <li>➤ Desire for healthy pregnancy and safe delivery</li> <li>➤ VHTs receive the support they need to do their work</li> </ul> <p><u>Barriers:</u></p> <ul style="list-style-type: none"> <li>➤ Lack of information about and appreciation of importance of antenatal and postnatal care</li> <li>➤ Lack of information about and appreciation of importance of having delivery attended by skilled birth attendant</li> <li>➤ Lack of transport to health facility</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provided with training on importance of antenatal and postnatal care, skilled birth attendance at delivery and birth preparedness</li> <li>➤ VHTs provide education sessions to men's and women's groups on the importance of antenatal and postnatal care, care-seeking for danger signs, skilled birth attendance at delivery and birth preparedness</li> <li>➤ Community referral system established and VHTs trained to refer pregnant women</li> <li>➤ MTI will assist VHTs to establish emergency transport systems in their communities.</li> <li>➤ Supportive supervision provided to VHTs</li> </ul>
Health Facility			
Health facility staff	<p>Provide quality antenatal and postnatal care with sensitivity</p>	<p><u>Facilitators:</u></p> <ul style="list-style-type: none"> <li>➤ Desire to provide quality maternal and newborn health services</li> </ul> <p><u>Barriers:</u></p> <ul style="list-style-type: none"> <li>➤ DHO staff uninformed about or do not follow WHO recommendations for postnatal visits</li> </ul>	<ul style="list-style-type: none"> <li>➤ The CSP provides mentoring and supportive supervision for ANC services</li> <li>➤ The CSP provides mentoring and supportive supervision for health facility staff on WHO recommendations for postnatal visits</li> </ul>

		<ul style="list-style-type: none"> <li>➤ Health facility staff unaware of women's perceptions of maternal services</li> <li>➤ Few skilled health staff</li> <li>➤ Shortages of supplies and drugs</li> <li>➤ Health facility staff have little time with each client</li> </ul>	
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**Indicators**

- % of mothers of children 0-23m received at least 2 TT injections before birth of their youngest child <24 months
- % of mothers of children 0-23m received at least 2 doses IPT during pregnancy with their youngest child <24 months
- % of children 0-23 months whose births were attended by skilled personnel.
- % of children 0-23 months received a post-natal visit from an appropriately trained health worker within 3 days of birth.
- % of mothers of children 0-23 months able to report at least two known maternal danger signs during the postpartum period.

**Monitoring Table:**

Priority Group	Awareness	Knowledge	Attitudes/Skills	Trial	Behavioral Maintenance
Women of reproductive age pregnant women, and mothers of children under 5 years of age	Women of reproductive age, pregnant women and mothers of children under 59 months are provided with information on antenatal care, birth preparedness, danger signs during pregnancy, safe delivery and post-natal care	KPC survey and focus group interviews indicate women know danger signs during pregnancy, delivery and postpartum	KPC and LQAS surveys show improvements in indicators for uptake of TT and IPT, ANC coverage, skilled birth attendance at delivery, and postnatal care visits	Mid-term LQAS indicates improvements in indicators for uptake of TT and IPT, ANC coverage, skilled birth attendance at delivery, and postnatal care visits	Year 3 LQAS and final KPC indicate improvements in indicators for uptake of TT and IPT, ANC coverage, skilled birth attendance at delivery, and postnatal care visits

## Social and Behavior Change Strategy: Pneumonia Case Management

**Broad behavior change goal:** To improve key family and child health practices and use of health services

**Specific behavioral objectives:**

- Caregivers recognize danger signs of respiratory infections and seek timely health care
- Caregivers provide appropriate home care for children with respiratory infections

**Summary of Strategy:** The project will improve key health practices related to prevention and treatment of respiratory infections among caretakers of children under five years of age. Appropriate practices will be promoted through providing education about prevention and treatment of respiratory infections, addressing misconceptions towards treatment of respiratory infections and strengthening social support for mothers to practice appropriate prevention and care seeking measures. Clinical care will be strengthened by training health facility staff in IMCI.

**Channels of Communication:**

Interpersonal communication: Community education and home visits provided by VHT members and health education provided by health facility staff.

Traditional ways of Learning: VHT members will utilize drama, stories, and songs to disseminate messages during education sessions and social gatherings

Social Support: Social support will be strengthened by educating family members about how they can support mothers to practice appropriate prevention and care-seeking practices.

Community Mobilization: The VHT approach mobilizes the community to reinforce health messages and create an environment that supports appropriate prevention and care-seeking practices.

Print education materials: The project will adapt MoH materials to deliver the C-IMCI curriculum developed for VHTs.

## Designing for Behavior Change Framework: Pneumonia Case Management

Priority and Supporting Groups	Behavior	Key factors	Activities
<b>Individual</b>			
Mothers and caretakers of children under 5 five years of age	Practice appropriate measures to prevent ARI/pneumonia	<p><u>Facilitator:</u></p> <ul style="list-style-type: none"> <li>➤ Desire to prevent ARI and pneumonia</li> <li>➤ Access to vitamin A and immunization services</li> </ul> <p><u>Barrier:</u></p> <ul style="list-style-type: none"> <li>➤ Lack of information in ARI/pneumonia prevention</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education on ARI/pneumonia prevention and referrals to health facilities for immunization and vitamin A supplementation</li> </ul>
Mothers and caretakers of children under 5 years of age	Early recognition of danger signs for ARI/pneumonia	<p><u>Facilitators:</u></p> <ul style="list-style-type: none"> <li>➤ Desire to provide appropriate care for child with ARI/pneumonia</li> </ul> <p><u>Barriers:</u></p> <ul style="list-style-type: none"> <li>➤ Inability to differentiate between common cold and pneumonia</li> <li>➤ Both parents do not have information about danger signs of ARI /pneumonia</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education sessions and home visits to provide information on danger signs</li> <li>➤ Health education provided at health facilities</li> </ul>
	Appropriate care for children with serious ARI/pneumonia	<p><u>Facilitator:</u></p> <ul style="list-style-type: none"> <li>➤ Desire to provide appropriate care for child with ARI/pneumonia</li> <li>➤ Support from husband to reach health facility</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education on care for ARI/pneumonia</li> <li>➤ VHTs provide referrals to health facilities</li> <li>➤ Health education provided at health facilities</li> </ul>

		<p><u>Barriers:</u></p> <ul style="list-style-type: none"> <li>➤ Both parents do not have appropriate information on care seeking for ARI/pneumonia</li> <li>➤ Harmful practices such as uvulectomy and cutting on chest</li> <li>➤ Long distance from health facility</li> <li>➤ Stock outs of drugs at health facilities</li> <li>➤ Community Case Management services not available</li> <li>➤ Lack of trust in health facility staff</li> </ul>	<ul style="list-style-type: none"> <li>➤ Promotion of rational use of drugs</li> <li>➤ MTI will assist VHTs to establish emergency transport systems in their communities.</li> </ul>
<b>Family/ Household</b>			
Grandmothers and fathers	Encourage and support mothers to practice appropriate prevention and care seeking measures	<p><u>Facilitator:</u> Desire to prevent ARI and pneumonia</p> <p><u>Barrier:</u> Lack of knowledge about causes, prevention and danger signs of ARI /pneumonia</p>	<ul style="list-style-type: none"> <li>➤ VHTs include fathers and grandmothers in community education on prevention and care for ARI/pneumonia</li> <li>➤ VHTs provide referrals to health facilities</li> <li>➤ VHTs provide community education through both home visits and quarterly “health talks” with fathers and grandmothers on the important responsibility they play in promoting appropriate ARI/pneumonia prevention and care-seeking practices</li> </ul>

<b>Community</b>			
VHTs	VHTs provide information to families on ARI/pneumonia prevention and care	<p><u>Facilitator:</u></p> <ul style="list-style-type: none"> <li>➤ Desire to prevent ARI and pneumonia</li> <li>➤ VHTs receive the support they need to do their work</li> </ul> <p><u>Barrier:</u> Lack of knowledge about causes, prevention and care of ARI /pneumonia</p>	<ul style="list-style-type: none"> <li>➤ VHTs trained in pneumonia prevention and care and rational use of drugs</li> <li>➤ Referral system established and VHTs trained to make referrals</li> <li>➤ VHTs provided with supportive supervision</li> </ul>
<b>Health Facility</b>			
Health facility staff	<ul style="list-style-type: none"> <li>➤ Treat patients with ARI/pneumonia according to IMCI protocol</li> <li>➤ Provide education for mothers on prevention, danger signs, and home care of children with cough or cold, and when to return to health facility</li> </ul>	<p><u>Facilitators:</u></p> <ul style="list-style-type: none"> <li>➤ Desire to prevent ARI/pneumonia and improve home care practices</li> <li>➤ Training in IMCI protocols and materials available in health facility</li> </ul> <p><u>Barriers:</u></p> <ul style="list-style-type: none"> <li>➤ Heavy workload</li> <li>➤ Drug stock outs</li> </ul>	<ul style="list-style-type: none"> <li>➤ Refresher training for health staff in IMCI protocol for pneumonia case management especially rational drug use</li> <li>➤ Mentoring and supportive supervision for health facility staff</li> </ul>
<b>Indicators</b>			
<ul style="list-style-type: none"> <li>➤ % of children age 0-23 months with chest-related cough and fast/difficult breathing in the last two weeks who were taken to an appropriate health provider.</li> <li>➤ % of health facility clinical encounters in which the caretaker whose child was prescribed antibiotic and can correctly describe how to administer all prescribed drugs</li> </ul>			

**Monitoring Table:**

<b>Priority Group</b>	<b>Awareness</b>	<b>Knowledge</b>	<b>Attitudes/Skills</b>	<b>Trial</b>	<b>Behavioral Maintenance</b>
Mothers and caretakers of children under 59 months	Mothers are provided with information on causes, prevention, and care for children with ARI/pneumonia	KPC and focus groups indicate women know danger signs for ARI/ pneumonia	KPC and LQAS surveys show an improvement in indicators for home care and care seeking practices for children with ARI/pneumonia	Mid-term LQAS indicates a reduction in the number of reported cases of ARI/pneumonia and an improvement in indicators for home care and care seeking practices for children with ARI /pneumonia	Year 3 LQAS and final KPC indicate a reduction in the number of reported cases of ARI /pneumonia and an increase in indicators for home care and care seeking practices for children with ARI/pneumonia

## Social and Behavior Change Strategy: Infant and Young Child Feeding

<p><b>Broad behavior change goal:</b> Improve breastfeeding and infant and young child feeding practices</p>
<p><b>Specific behavioral objective:</b> Mothers will practice immediate and exclusive breastfeeding until 6 months of age and provide appropriate complementary foods for infants after 6 months of age.</p>
<p><b>Summary of Strategy:</b> The project will improve infant and young feeding practices among caretakers of children under five years of age. Appropriate practices will be promoted through providing education about infant feeding, addressing attitudes and misconceptions about breastfeeding and complementary feeding and strengthening social support for mothers to practice appropriate breastfeeding and infant feeding practices. Clinical services will be improved through training in IMCI.</p>
<p><b>Channels of Communication:</b></p> <p><u>Interpersonal communication:</u> Community education and home visits provided by VHT members and health education provided by health facility staff.</p> <p><u>Traditional ways of Learning:</u> VHT members will utilize drama, stories, and songs to disseminate messages during education sessions and social gatherings</p> <p><u>Social Support:</u> Social support will be strengthened by educating family members about how they can support mothers in appropriate breastfeeding and complementary feeding practices.</p> <p><u>Community Mobilization:</u> The VHT approach mobilizes the community to reinforce health messages and create an environment that supports appropriate infant and young child feeding practices.</p> <p><u>Print education materials:</u> The project will adapt MoH materials to deliver the C-IMCI curriculum.</p>

## Designing for Behavior Change Framework: Infant and Young Child Feeding

Priority and Supporting Groups	Behaviors	Key factors	Activities
<b>Individual</b>			
Mothers and caretakers of children under 6 months	Immediate breastfeeding – put baby to breast within one hour of birth with no prelacteal feeds	<p><u>Facilitators:</u></p> <ul style="list-style-type: none"> <li>➤ Support from family and health facility staff</li> <li>➤ Good health and adequate nutrition for mother</li> </ul> <p><u>Barriers:</u></p> <ul style="list-style-type: none"> <li>➤ Belief that colostrum is harmful</li> <li>➤ Lack of bonding between mother and baby</li> <li>➤ Shyness and stigma of young mothers</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education sessions on breastfeeding</li> <li>➤ Health education provided by health facility staff during ANC and family planning sessions</li> </ul>
	Exclusive breastfeeding during the first 6 months	<ul style="list-style-type: none"> <li>➤ Support from husband and other family members</li> <li>➤ Good health and adequate nutrition for mother</li> <li>➤ Appreciation of benefits of exclusive breastfeeding</li> </ul> <p><u>Barriers:</u></p> <ul style="list-style-type: none"> <li>➤ Lack of confidence in quality and quantity of breast milk they produce</li> <li>➤ Mother separated from infant during work or studies</li> <li>➤ Lack of bonding between mother and baby</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education sessions on breastfeeding</li> <li>➤ Health education provided by health facility staff during ANC and family planning sessions</li> </ul>

		<ul style="list-style-type: none"> <li>➤ Shyness and stigma of young mothers</li> </ul>	
Mothers and caretakers for children 6 to 59 months	<p>Introduce appropriate complementary foods at 6 months of age</p> <p>Offer complementary foods to children 6 -24 months 3-5 times per day</p>	<p><u>Facilitators:</u></p> <ul style="list-style-type: none"> <li>➤ Availability of appropriate complementary foods</li> <li>➤ Household support for preparing complementary foods and feeding child.</li> </ul> <p><u>Barriers:</u></p> <ul style="list-style-type: none"> <li>➤ Lack of knowledge of locally available complementary foods</li> <li>➤ Lack of knowledge of appropriate complementary feeding practices, especially quality, frequency and active feeding</li> <li>➤ Cultural beliefs and practices about complementary foods</li> <li>➤ Mother separated from infant during work or studies</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education sessions on recommendations for appropriate complementary feeding, active feeding and demonstrations on preparing complementary foods</li> <li>➤ Health education provided by health facility staff</li> </ul>
Family/Household			
Grandmothers and fathers	<ul style="list-style-type: none"> <li>➤ Encourage and support mothers to practice immediate and exclusive breastfeeding</li> <li>➤ Participate in feeding child</li> </ul>	<p><u>Facilitators:</u></p> <ul style="list-style-type: none"> <li>➤ Desire for healthy children</li> <li>➤ Willingness to engage in child's meal preparation and feeding</li> </ul> <p><u>Barriers:</u></p> <ul style="list-style-type: none"> <li>➤ Lack of knowledge on breastfeeding and complementary feeding</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education sessions for fathers and grandmothers on infant and young child feeding</li> <li>➤ VHTs provide community education through both home visits and quarterly "health talks" with fathers and grandmothers on the important responsibility</li> </ul>

		➤ Lack of information about and appreciation of benefits and importance of immediate and exclusive breastfeeding	they play in promoting appropriate infant and young child feeding practices
<b>Community</b>			
VHTs	VHTs reinforce messages on breastfeeding and complementary feeding  VHTs facilitate dialogue with communities on barriers and facilitate to optimal infant and young child feeding	<u>Facilitators:</u> VHTs have the training and support they need to carry out their work  <u>Barrier:</u> Lack of updated information on breastfeeding and complementary feeding	VHTs provided with training on IYCF
<b>Health Facility</b>			
Health facility staff	Provide education for mothers on appropriate infant and young child feeding practices	<u>Facilitators:</u> ➤ Desire to improve infant feeding practices  <u>Barriers:</u> ➤ Lack of current information on IYCF practices  ➤ Lack of time  ➤ Heavy workload at health facility	➤ Refresher training and follow up supportive supervision in IYCF component of IMCI training provided to health facility staff
<b>Indicators :</b>			
<ul style="list-style-type: none"> <li>• % of infants 0-5 months were exclusively given breast milk in the last 24 hours.</li> <li>• % of children 0-23 months were put to the breast within 1 hr of birth.</li> <li>• % of children 0-23 months received a pre-lacteal feeding during the first 3 days after delivery.</li> <li>• % of children 6 to 23 months were fed according to a minimum of appropriate feeding practices.</li> </ul>			

### Monitoring Table:

Priority Group	Awareness	Knowledge	Attitudes/Skills	Trial	Behavioral Maintenance
Mothers and caretakers of children under 6 months	Mothers are provided with information on immediate and exclusive breastfeeding, including the importance of feeding colostrums	Focus group interviews indicate mothers understand importance of immediate and exclusive breastfeeding and can overcome breastfeeding problems	KPC and LQAS surveys show mothers report practicing immediate and exclusive breast feeding	Mid term LQAS survey shows improvement in immediate and exclusive breastfeeding practices	Year 3 LQAS and final KPC surveys show increase in rates of immediate and exclusive breastfeeding
Mothers and caretakers for children 6 to 59 months	Mothers are provided with information on appropriate complementary feeding	Focus group interviews indicate mothers have knowledge of appropriate IYCF practices.	KPC and LQAS surveys show mothers report practicing appropriate infant feeding	Mid term LQAS survey shows improvement in appropriate infant feeding practices	Year 3 LQAS and final KPC surveys show increase in complementary feeding practice indicators

## Social and Behavior Change Strategy: Control of Diarrhea Diseases

**Broad behavior change goal:** To improve key family and child health practices and use of health services

**Specific behavioral objectives:**

- Care givers practice appropriate hand washing practices
- Families practice appropriate methods for treating of drinking water
- Caregivers recognize danger signs of diarrhea and seek timely health care
- Caregivers provide appropriate home care for children with diarrhea

**Summary of Strategy:** The project will improve key health practices related to prevention and treatment of diarrhea among caretakers of children under five years of age. Appropriate practices will be promoted through providing education about prevention and home treatment of diarrhea, addressing misconceptions regarding treatment of diarrhea and strengthening social support for mothers to practice appropriate prevention and care seeking measures. Clinical care and counseling skills will be strengthened by training health facility staff in IMCI.

**Channels of Communication:**

Interpersonal communication: Community education and home visits provided by VHT members and health education provided by health facility staff.

Traditional ways of Learning: VHT members will utilize drama, stories, and songs to disseminate messages during education sessions and social gatherings

Social Support: Social support will be strengthened by educating family members about how they can support mothers to practice appropriate prevention and care-seeking practices.

Community Mobilization: The VHT approach mobilizes the community to reinforce health messages and creates an environment that supports appropriate prevention and care-seeking practices. .

Print education materials: The project will adapt MoH materials to deliver the C-IMCI curriculum.

## Designing for Behavior Change Framework: Control of Diarrhea Disease

Priority and Supporting Groups	Behavior	Key factors	Activities
<b>Individual</b>			
Mothers who have children younger than 5 years of age	To wash hands with soap or ash before preparing food, eating or feeding child, after defecation or helping child to defecate	<p><u>Facilitator:</u></p> <ul style="list-style-type: none"> <li>➤ Desire to prevent diarrhea</li> <li>➤ Support to access water and soap</li> </ul> <p><u>Barrier:</u></p> <ul style="list-style-type: none"> <li>➤ Lack of information about modes of transmission and prevention of diarrhea</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education sessions on transmission and prevention of diarrhea</li> <li>➤ Health education provided by health facility staff</li> <li>➤ Health Assistants provide outreach</li> </ul>
	Respond to recognized danger signs for severe diarrhea and dehydration by giving ORS and taking child to health facility	<p><u>Facilitators:</u></p> <ul style="list-style-type: none"> <li>➤ Desire to provide appropriate care for children with diarrhea</li> </ul> <p><u>Barriers:</u></p> <ul style="list-style-type: none"> <li>➤ Both parents do not have information about danger signs for diarrhea and dehydration</li> <li>➤ Unavailability of ORS</li> <li>➤ Cultural practices such as teeth, chest or throat cutting                             <ul style="list-style-type: none"> <li>➤ Lack of skills in preparing ORS</li> </ul> </li> <li>➤ Transportation to health facility not available</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education sessions on danger signs of and treatment of diarrhea</li> <li>➤ VHTs distribute ORS and provide demonstrations on preparation</li> <li>➤ VHTs provide referrals to health facilities</li> <li>➤ Health education provided by health facility staff</li> <li>➤ MTI will assist VHTs to establish emergency transport systems in their communities.</li> </ul>
	Continue breastfeeding, increase fluids and maintain/increase foods	<p><u>Facilitators:</u></p> <ul style="list-style-type: none"> <li>➤ Desire to provide</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education sessions on home</li> </ul>

	offered during an episode of diarrhea	<p>appropriate care for children with diarrhea</p> <ul style="list-style-type: none"> <li>➤ Support from family members to breastfeed and feed child</li> </ul> <p><u>Barrier:</u></p> <ul style="list-style-type: none"> <li>➤ Both parents do not have information about appropriate home treatment of diarrhea and feeding during illness</li> </ul>	<p>treatment of diarrhea</p> <ul style="list-style-type: none"> <li>➤ Health education provided by health facility staff</li> </ul>
Mothers who have children younger than 5 years of age	Children with diarrhea are treated with zinc for 14 days	<p><u>Facilitator:</u></p> <p>Desire for sick child to recover rapidly</p> <p><u>Barrier:</u></p> <ul style="list-style-type: none"> <li>➤ Lack of knowledge of benefits of zinc</li> <li>➤ Unavailability of zinc at the community level</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education sessions on zinc</li> <li>➤ VHTs provide zinc when available or refer child to health facility</li> <li>➤ VHTs provide information on <i>Restor</i> and <i>Zinkid</i> as options for treating diarrhea</li> </ul>
Family/ Household			
Grandmothers and fathers	Encourage and support mothers to practice appropriate prevention and care seeking measures for diarrhea	<p><u>Facilitator:</u></p> <ul style="list-style-type: none"> <li>➤ Desire to protect health of children</li> <li>➤ Availability of hand washing stand, water and soap or ash</li> </ul> <p><u>Barrier:</u></p> <ul style="list-style-type: none"> <li>➤ Lack of information about appropriate prevention, home care and care seeking practices</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs include fathers and grandmothers in community education sessions on diarrhea prevention and care seeking</li> <li>➤ VHTs provide referrals to health facilities</li> <li>➤ VHTs provide community education through both home visits and quarterly “health talks” with fathers and grandmothers on the important responsibility they play in promoting healthy</li> </ul>

			practices with regard to diarrhea prevention and care seeking
<b>Community</b>			
VHTs	<ul style="list-style-type: none"> <li>➤ VHTs provide information to families on prevention, home care and care seeking during diarrhea</li> <li>➤ VHTs provide ORS to families with children who have diarrhea</li> <li>➤ VHTs provide referrals for children with danger signs</li> </ul>	<p><u>Facilitator:</u></p> <ul style="list-style-type: none"> <li>➤ Desire to protect health of children</li> <li>➤ VHT receive the support they need to carry out their work</li> </ul> <p><u>Barrier:</u></p> <ul style="list-style-type: none"> <li>➤ Lack of knowledge about prevention, home care, danger signs and care seeking for diarrhea</li> <li>➤ Unreliable supplies of ORS and Zinc</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provided with training in C-IMCI</li> <li>➤ Referral system established and VHTs trained to refer child with diarrhea with danger signs</li> <li>➤ MTI and VHTs identify opportunities for water/sanitation improvements through PDCs and the Lira District Health and Nutrition Cluster</li> </ul>
<b>Health Facility</b>			
Health facility staff	<ul style="list-style-type: none"> <li>➤ Provide appropriate treatment for children with diarrhea</li> <li>➤ Counsel mothers on diarrhea prevention, danger signs and home care of children with diarrhea and when to return to health facility</li> </ul>	<p><u>Facilitators:</u></p> <ul style="list-style-type: none"> <li>➤ Desire to prevent diarrhea and improve home care practices</li> <li>➤ Training in IMCI protocols and materials available in health facility</li> </ul> <p><u>Barriers:</u></p> <ul style="list-style-type: none"> <li>➤ Workload at health facility</li> <li>➤ Low motivation of health facility staff</li> </ul>	Refresher training and supportive supervision in CDD component of IMCI training provided for health facility staff
<b>Indicators</b>			
<ul style="list-style-type: none"> <li>➤ % of children 0-23 months with diarrhea in last 2 wks received ORS and/or recommended home fluids.</li> <li>➤ % of children 6-23 months with diarrhea in last 2 wks were treated with zinc</li> <li>➤ % of mothers of children 0-23 months who live in households with soap at the place for hand washing that washed their hands with soap before feeding a child</li> </ul>			

**Monitoring Table:**

<b>Priority Group</b>	<b>Awareness</b>	<b>Knowledge</b>	<b>Attitudes/Skills</b>	<b>Trial</b>	<b>Behavioral Maintenance</b>
Mothers and caretakers of children under five years of age	Mothers are provided with information on causes, prevention, home care, and care seeking for children with diarrhea	KPC survey and focus group discussions indicate mothers know danger signs for diarrhea and appropriate home care and care seeking practices	KPC and LQAS surveys show an improvement in indicators for hand washing, treating water, providing appropriate home care for children with mild diarrhea and care seeking for children with severe diarrhea	Mid- term LQAS survey indicates a reduction in the number of reported cases of diarrhea and improvement in indicators for hand-washing, drinking water treatment, appropriate home care and care seeking for children with diarrhea	Year 3 LQAS and final KPC indicate a reduction in the number of reported cases of diarrhea and improvement in indicators for hand-washing, drinking water treatment, appropriate home care and care seeking practices for children with diarrhea

## Social and Behavior Change Strategy: Expanded Program of Immunization

**Broad behavior change goal:** To improve key family and child health practices and use of health services

**Specific behavioral objectives:**

- Children are fully vaccinated by one year of age
- Pregnant women receive two doses of tetanus toxoid vaccine before delivery

**Summary of Strategy:** The project will improve key health practices related to immunization of children and pregnant women among caretakers of children under five years of age and women of child bearing age. Appropriate practices will be promoted through providing education about immunization, addressing cultural misconceptions about immunization and strengthening social support for mothers to utilize immunization services. Clinical care will be strengthened by training health facility staff in IMCI.

**Channels of Communication:**

Interpersonal communication: Community education and home visits provided by VHT members and health education provided by health facility staff.

Traditional ways of Learning: VHT members will utilize drama, stories, and songs to disseminate messages during education sessions and social gatherings

Social Support: Social support will be strengthened by educating family members about how they can support mothers to utilize immunization services.

Community Mobilization: The VHT approach mobilizes the community to reinforce health messages and create an environment that supports immunization services.

Print education materials: The project will adapt MoH materials to deliver the C-IMCI curriculum.

**Designing for Behavior Change Framework: Expanded Program of Immunization**

Priority and Supporting Groups	Behavior	Key factors	Activities
<b>Individual</b>			
Women of child bearing age, especially pregnant women and mothers of children under one year of age	Pregnant women receive tetanus toxoid vaccine at least twice before delivery	<p><b>Facilitators:</b></p> <p>Support from family to access immunization services</p> <p><b>Barriers:</b></p> <ul style="list-style-type: none"> <li>➤ Concerns about side effects and cultural beliefs about vaccines</li> <li>➤ Long distance to health facility</li> <li>➤ Infrequent outreach services</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education sessions</li> <li>➤ Health education provided by health facility staff</li> <li>➤ CSP supports for Child Health Days by mobilizing communities to support immunization sessions, providing education on importance of attending outreach services, and providing health staff with assistance with transportation and printing immunization cards</li> </ul>
	Children are fully vaccinated, according to national Ministry of Health protocol, by one year of age	<p><b>Facilitators:</b></p> <p>Support from family to access immunization services</p> <p><b>Barriers:</b></p> <ul style="list-style-type: none"> <li>➤ Concerns about side effects and cultural beliefs about vaccines</li> <li>➤ Experiences and concern about side effects from vaccines</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education sessions</li> <li>➤ Health education provided by health facility staff</li> <li>➤ CSP supports for Child Health Days by mobilizing communities to support immunization sessions, providing education on importance of attending outreach services, and assisting health staff with transportation and printing immunization</li> </ul>

			cards
<b>Family/ Household</b>			
Grandmothers and fathers	<ul style="list-style-type: none"> <li>➤ Encourage and support parents to take their children to immunization services for complete series during first year</li> <li>➤ Encourage and support pregnant women to have two tetanus toxoid vaccines</li> </ul>	<p><b>Facilitators:</b></p> <p>Desire to protect health of children</p> <p><b>Barriers:</b></p> <ul style="list-style-type: none"> <li>➤ Concerns about side effects and cultural beliefs about vaccines</li> <li>➤ Experiences and concern about side effects from vaccines</li> </ul>	<ul style="list-style-type: none"> <li>➤ VHTs provide community education sessions for grandmothers and fathers</li> </ul>
<b>Community</b>			
VHTs	<ul style="list-style-type: none"> <li>➤ VHTs support vaccination outreach activities and national immunization days</li> <li>➤ VHTs provide education to mothers on immunization</li> <li>➤ VHTs provide referrals for immunization</li> </ul>	<p><u>Facilitator:</u></p> <ul style="list-style-type: none"> <li>➤ Desire to protect health of children</li> <li>➤ VHTs have the support they need to carry out their work</li> </ul> <p><u>Barrier:</u></p> <p>Lack of knowledge of benefits of immunization</p>	<ul style="list-style-type: none"> <li>➤ VHTs provided with training in C-IMCI</li> <li>➤ Supportive supervision provided to VHTs</li> </ul>
<b>Health Facility</b>			
Health facility staff	<ul style="list-style-type: none"> <li>➤ Provide health education for mothers on importance of tetanus toxoid vaccine</li> <li>➤ Health providers screen vaccination status of all children and provide information for mothers on the importance of vaccinating their children</li> </ul>	<p><u>Facilitators:</u></p> <ul style="list-style-type: none"> <li>➤ Desire to prevent childhood illnesses through immunization</li> <li>➤ Refresher training for health facility staff in IMCI EPI protocol</li> <li>➤ Desire to prevent tetanus in newborns and pregnant women through immunization</li> <li>➤ Functional cold chain system</li> </ul> <p><u>Barriers:</u></p>	<ul style="list-style-type: none"> <li>➤ Supportive supervision of EPI services</li> <li>➤ CSP supports EPI outreach by assistance with community mobilization, health education, transportation and printing immunization cards</li> </ul>

		<ul style="list-style-type: none"> <li>➤ Shortage of vaccines</li> <li>➤ Transportation not available for immunization supplies.</li> </ul>	
<b>Indicators</b> <ul style="list-style-type: none"> <li>➤ % of children aged 12-23 months who received measles vaccine.</li> <li>➤ % of children aged 12-23 months fully vaccinated before the first birthday</li> </ul>			

**Monitoring Table:**

<b>Priority Group</b>	<b>Awareness</b>	<b>Knowledge</b>	<b>Attitudes/Skills</b>	<b>Trial</b>	<b>Behavioral Maintenance</b>
Women of child bearing age, pregnant women and caretakers of children under one	Mothers are provided with information on tetanus toxoid vaccine during pregnancy and childhood immunizations	Focus group discussions indicate mothers understand the importance of immunization for themselves and their children	Health facility records indicate improved vaccination coverage for pregnant women and children under one	Midterm LQAS shows increase in immunization coverage for both pregnant women and children under one	Year 3 LQAS and final KPC show increase in immunization coverage for both pregnant women and children under one

### Annex 7. Work plan Year 2

Activities Year 2		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Staff Responsible
<b>IMCI/ Support</b>	Conduct clinical IMCI mentoring	X	X	X	X	X	X	X	X	X	X	X	X	IMCI coordinator and mentor
	Conduct joint supervision of IMCI services			X			X			X			X	IMCI coordinator and mentor and DHO staff
<b>C-IMCI and Community Case Management</b>	VHTs provide community education with support from mobilizers	X	X	X	X	X	X	X	X	X	X	X	X	VHT members and Child Survival VHT Mobilizers
<b>Newborn Care</b>	VHTs provide community education with support from mobilizers	X	X	X	X	X	X	X	X	X	X	X	X	Child Survival Community Outreach Coordinator and VHT Mobilizers
	Supportive Supervision of perinatal services				X			X			X		X	Child Survival MCH Coordinator and Mentor
	Conduct MNC refresher trainings at the health facility level			X										Child Survival Program Manager, IMCI trainers from MOH, Maternal and Child Health Mentor
<b>EPI</b>	VHTs provide community education with support from mobilizers	X	X	X	X	X	X	X	X	X	X	X	X	VHT members and Child Survival VHT Mobilizers
	Support Child Health Days / national immunization days.	X							X					VHT members and Child Survival VHT Mobilizers
<b>Early Childhood Development</b>	VHT Trainers train community members in intervention areas		X	X										VHT trainers with support from Certified ECD trainers and Child Survival MCH Coordinator, MCH Mentor and VHT Mobilizers
	Coordinate, support and	X	X	X	X	X	X	X	X	X	X	X	X	MTI and DHO ECD

	supervise VHTs													trainers	
<b>VHT Support</b>	Provide joint supportive supervision				X		X				X			X	Child Survival Outreach Coordinator and VHT mobilizers
	Support health facility staff to arrange and facilitate coordination meetings with VHTs				X		X				X			X	Child Survival MCH Mentor
	Health Unit Management Committee members attend VHT – health facility coordination meetings on a quarterly basis				X		X				X			X	Child Survival MCH Mentor
<b>M&amp;E</b>	LQAS Surveys				X										Child Survival Project Manager and M and E Coordinator with support from MTI HQ M and E Specialist

## Annex 8: Results Highlight: VHT Mobilizers

*The Problem.* Formation of VHTs is a strategy of the National Health Policy that focuses on the first and second Health Sector Strategic Plan (HSSP) for the MoH. The VHT is the equivalent of a Health Center (HC) I level, links with HC II, and is responsible for identification of community health needs, mobilization and monitoring of resources (including HC performance), oversight of specific support activities by trained Community Health Workers (CHWs), and maintenance of registers of population and health status. Assessment of the HSSP I found that the establishment of VHTs had been slow and not well-coordinated, with poor linkage to the health system.

*Promising Practice.* MTI-CSP created the role of “Village Health Team (VHT) mobilizer,” a position in the health sector that never existed previously in Uganda. MTI-CSP has chosen to highlight the successes of this strategy, as it is a promising practice that can be replicated elsewhere in Uganda. The VHT mobilizers serve as a link between the 560 VHTs and the four health centers in the project area (three HC III and one HC IV) with a total of 55 health workers. Six VHT mobilizers who are based at sub-county level provide training and support to VHTs; support implementation of community HMIS; and assist in development of referral networks.

*Results.* The addition of the VHT mobilizers to the existing health system has built the **governance capacity** of the VHTs in relation with the district MoH and improved **health service delivery**. All in-charges for the health facilities in the project area have called the Project Manager to inform him that the work of the VHT mobilizers has significantly improved their work, making their jobs easier. In addition to their improved relationship with the VHTs, they expressed that they also feel that their health facilities have a stronger link to the DHO due to their positive relationship with MTI.

**Health worker motivation** has improved as they are regularly encouraged by the VHT mobilizers to connect with their VHTs. VHTs in turn are more motivated to carry out their responsibilities and interface more with the communities themselves and, in so doing, build their rapport with individuals. Overall, community **understanding of health messages** has improved as VHT mobilizers are monitoring the quality and frequency of behavior change communication messages by VHTs. Every time a VHT mobilizer goes to the field s/he meets with the health facility staff and encourages them in their **implementation of ICCM**. VHT mobilizers were trained in ICCM and the VHT strategy and assess the ICCM carried out at the facility level. Because of VHT mobilizers’ follow-up and mentoring, health workers are better adhering to the IMCI guidelines.

**Healthcare service quality** has improved due to VHT mobilizers demonstrating proper health worker/patient interactions. If a health worker mistreats someone in the community, the VHT mobilizers negotiate this relationship, addressing problems and finding solutions. Also, when the DHO lacks transport mechanisms for transporting vaccines, the VHT mobilizers travel to the DHO to pick up the vaccines and deliver them to the outreaches, therefore keeping outreaches on schedule. The existence of VHT mobilizers improved the **communication system** for community members with VHTs, the VHTs with health workers, and the health workers with the DHO. Historically, VHTs were hesitant to approach health workers and the DHO was less engaged with health centers. Now communication is more open, as VHT mobilizers engage with all three cadres of people. VHTs bring community issues to the mobilizers who can direct their query to the appropriate place. As community members feel more comfortable with the VHTs themselves, they are increasingly **seeking care** and interacting with the health system more often, thus improving the health of the community and carrying out CPS’s goal to reduce mortality and morbidity in Lira.