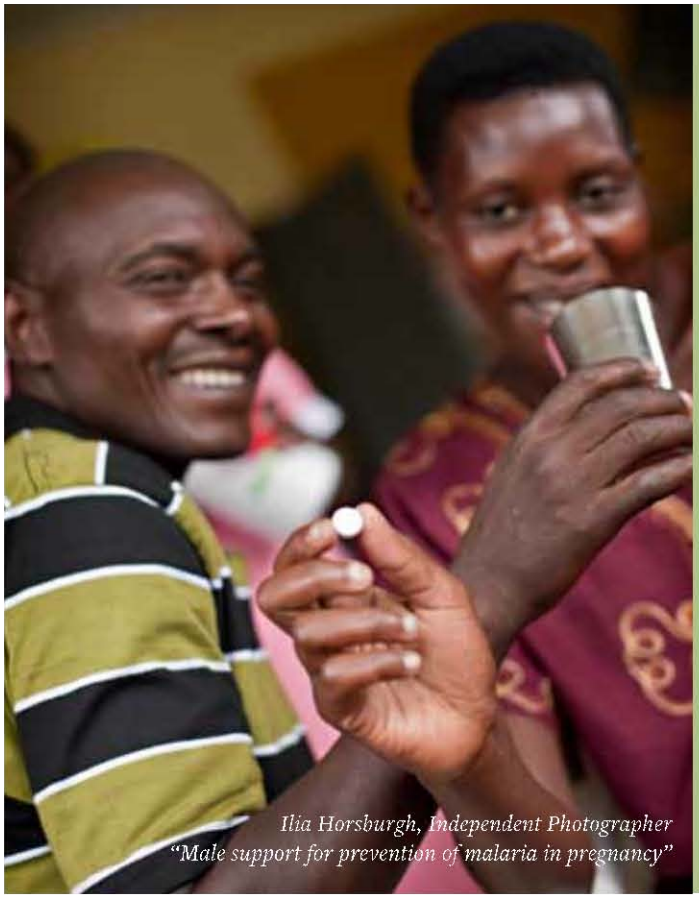
Uganda Health Cooperative

Third Annual Report FY11



Ilia Horsburgh, Independent Photographer
"Male support for prevention of malaria in pregnancy"

HealthPartners
Uganda Health Cooperative

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Abbreviations and Acronyms

ACT	Artemisinin-based Combination Therapy
ANC	Antenatal Care
AOTR	Agreement Officer's Technical Representative
BCC	Behavior Change Communication
DHT	District Health Teams
HBMF	Home Based Management of Fever
HCU	Healthy Child Uganda
HMIS	Health Management Information System
HW	Health Workers
ICCM	Integrated Community Case Management
ID	Identification (card)
IPT	Intermittent Preventive Treatment
LLIN	Long Lasting Insecticide Treated Bednets
MCP	Malaria Communities Program
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOU	Memorandum of Understanding
NMCP	National Malaria Control Program
PCV	Peace Corps Volunteer
PMI	President's Malaria Initiative
PMP	Performance Management Plan
SP	Sulfadoxine-Pyrimethamine
STAR SW	Strengthening TB and HIV/AIDS Response in the South-Western Region of Uganda
UHC	Uganda Health Cooperative
UMEMS	Uganda Monitoring and Evaluation Management Services
USAID	United States Agency for International Development
VHT	Village Health Team
VSLA	Village Savings and Loan Association

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I. Main Accomplishments

During the third year of implementation, HealthPartners Uganda Health Cooperative Malaria Communities Program (UHC/MCP) received national recognition and made strong progress toward program goals.

In 2011, UHC/MCP completed implementation of the Village Health Team (VHT) Cascade of Sensitization and Training with an emphasis on malaria prevention and treatment in Rubirizi and Buhweju districts. VHT were supported to meet routinely with the households in their villages to promote sleeping under long lasting insecticide treated bednets every night, early treatment seeking for malaria and preventive malarial treatment for women during pregnancy. VHTs met quarterly with health workers and local leaders for support supervision and five groups were trained to participate in Village Savings and Loan Associations (VSLA) as a sustainable strategy to maintain VHT commitment. A behavior change communication (BCC) plan including radio and drama shows with key malaria prevention and treatment messages strengthened VHT impact. The project continued to promote joining the Uganda Health Cooperative, a community-owned and managed prepaid health insurance scheme. Monitoring assessments helped identify gaps and opportunities to strengthen program impact in the final year.

UHC/MCP implementation of the VHT strategy was acknowledged as a model success story in the Annual Health Sector Strategic Performance Report by the Uganda MOH 2009/2010. The following excerpt is from that report, page 23.

> Support supervision findings during May 2010 showed that:
>
> 1. VHTs fill registers with little or no mistakes at all.
> 2. Most VHT members were selected by the community which is in line with the implementation guidelines.
> 3. All VHT members have undergone the mandatory VHT basic 5 days training in health promotion and this training was conducted by the trained health workers who had earlier on undergone a Training of Trainers workshop in adult learning methodologies and VHT.
> 4. VHTs know their responsibilities very well and they conduct such activities like Home Visits, Health Meetings, refer patients for treatment, community mobilization, and health education and are also showing a good example.
> 5. Quarterly meetings are in place conducted by Uganda Health Cooperative with health workers and community leaders.
> 6. VHTs have started their own saving scheme which has enhanced team work and togetherness.
> 7. VHTs are so enthusiastic about their responsibilities and they like being VHTs. This is based on the following reasons
>   - They see positive changes taking place in the community all attributed to their work.
>   - They have gained knowledge from the trainings they have undertaken and also from the work they are doing through sharing with fellow VHTs and the community members.

In his on site support supervision report December 2010, Gilbert Muyambi, National Coordinator VHT Program, Ministry of Health (MOH) Uganda, had the following to say about the impact of the UHC/MCP project in southwestern Uganda.

> VHTs were asked to mention any achievement as a result of the work and they say that hygiene in homes has improved; early treatment seeking behavior has improved as well, while more mothers are going for antenatal (ANC) visits and taking their children for immunization. And "Uganda Health Cooperative has continued to support the Ministry of Health not only in implementing VHTs but other components in the VHT strategy guidelines like holding quarterly meetings with all stakeholders and others. The experiences from Buhweju and Rubirizi will be shared among other partners to be used in other parts of the country."

The following key program indicators show the tangible impact that UHC/MCP trained VHTs are having:

- Number of pregnant women attending ANC who received the second dose of intermittent preventive treatment for malaria in pregnancy (IPTp): increased to 43% from 3,759 at the baseline to 5,384 in the most recent quarter, with steady increases shown each quarter in 2011.
- Percentage of pregnant women using LLINs increased from 5.5% at baseline to 60.1% and percentage of children under 5 using LLINs increased from 6.5% at baseline to 61.6%
- Percentage of Health facilities with no stock outs of Artemisinin-based Combination Therapy (ACTs) and Sulfadoxine- Pyrimethamine (SP) during the last month increased from 62% to 98.6% in the most recent quarter, with steady increases shown each quarter in 2011.

Partners at national and local levels expressed interest in UHC/MCP project innovations of linking VHT to village savings and loan associations and in the potential for community based health insurance to empower stakeholders to demand quality care, seek antenatal care four times per pregnancy and to seek treatment within 24 hours onset of fever for malaria. Paul Kagwa, PHD, Assistant Commissioner Health Services and Health Promotion at the MOH attended the UHC/MCP VHT launch ceremony in Rubirizi district in April 2011. At this event, he learned about the UHC model and was impressed by the strength of its sustainable impact and linkage to the VHT strategy. VHT are provided membership at reduced rates in exchange for helping their communities adopt healthier behaviors and for promoting UHC. Dr. Kagwa invited representatives from the project team to meet Dr. Lukwago Asuman, Deputy Permanent Secretary, MOH, who requested a concept paper on UHC. At the recommendation of Susan Youll, Agreement Officer's Technical Representative (AOTR,) a one-page summary on UHC was also developed to share the concept more widely.

While the UHC/MCP program includes a component of health insurance, this has not been the primary project focus and only a small fraction of project funds have been contributed to reaching these goals. In 2011, more time was allocated to assessing what was working and where there were gaps in the model. Since UHC empowers local stakeholders to plan for and access the health care they need, it is an important component of the project's exit strategy for sustaining improved malaria prevention and treatment. A Cascade of Sensitization and Training for UHC was developed for implementation in 2012. A BCC plan was developed to compliment and leverage the impact of the cascade. By implementing these activities, UHC/MCP expects to close the gaps in performance indicators to reach all goals by the end of the project. In August 2011, HealthPartners received funding from USAID Office of Development Partners to scale up the UHC model in other locations.

The following representatives from USAID, the MOH and HealthPartners conducted field site visits: Susan Youll, AOTR, USAID Washington; Joel Kisubi, PMS Uganda Mission; two visits from Gilbert Muyambi, MOH VHT Coordinator; one visit from Paul Kaggwa, Assistant Commissioner Health Services and Health Promotion at the MOH; and one visit each from HealthPartners Senior Vice President, Scott Aebischer and Project Director, Jennifer Stockert. Site visit reports are included as annexes to this report. A strong partnership was also developed with the Peace CORPS, with UHC/MCP staff coordinating and leading sessions for Peace Corps volunteer (PCV) training and field visits. Two PCVs will be placed with a partner health facility and one PCV will join the UHC/MCP team in 2012.

Table 1: Main Accomplishments

Indicators (with current measurement or result)	**Key Activities (as outlined in the work-plan)**	**Status of Activities (including outputs)**	**Comments**
Objective 1: To increase the proportion of pregnant women and children under 5 that sleep under an LLIN every night.			
Percentage of pregnant women using LLINs increased from 5.5% at baseline to 60.1% Percentage of children under 5 using LLINs increased from 6.5% at baseline to 61.6%	**1.1:** Distribute free LLNs to ALL with emphasis of pregnant women and children under five	**Status**: Not done **Outputs**: None	UHC/MCP planned to facilitate Global Fund LLINs however these were not released.
	1.2: Track demonstration kit use by VHT for correct use of LLIN to communities	**Status:** Not done **Output:** None	Health workers and VHT did not track LLIN demonstration kit use.
	1.3: Commission integrated interactive drama shows to promote appropriate use of LLINs	**Status:** Done. **Output:** Nine (9) interactive and integrated drama shows were conducted**.**	
	1.4: Air MOH radio jingles and talk shows to encourage pregnant women and children below 5 to sleep under a mosquito net every night and demonstrate that preventing malaria is cheaper than treating it	**Status:** Done. **Output:** 161 radio jingles and 2 radio shows aired.	
	1.5: Print and distribute MOH revised VHT job aids and VHT registers to support VHT home visits	**Status:** Done. **Output:** Printed and distributed 32,889 job aids to HW and VHT including 1,744 VHT quarterly Household summaries, 1,744 VHT household registers, 486 VHT quarterly village summaries and 59 VHT facilitator guides.	Job aides updated by the MOH were distributed per guidelines. Resources were introduced with demonstration and return demonstration at HW support

			supervision.
	1.6:VHT conduct home visits to encourage pregnant women and children below 5 to sleep under mosquito net every night and demonstrate that preventing malaria is cheaper than treating it	**Status**: Done **Output**: 83,080 Households have been reached this year by VHT visits and a total of 463,962 (241,456 females and 222,506 males) household members received BCC on malaria prevention.	
Objective 2: To increase the proportion of pregnant women receiving 2 or more doses of SP for IPTp			
Percentage of pregnant women attending ANC who receive at least two doses of SP increased from 16.2% to 37.3%	**2.1:** Refill supplies to ensure clean water, cups and job aids in health facilities to enable health workers directly observe SP dosing	**Status:** Done. **Output:** 116 health facilities have been supported for DOT of SP dosing of pregnant women by being supplied with safe water stations.	This has increased uptake of SP by pregnant women.
	2.2: VHT conduct home visits to encourage pregnant women to attend at least 4 ANC visits, starting at the second missed period and complete SP dosing.	**Status:** Done. **Output:** 179,741 females have been reached through VHT household visits.	
	2.3: Commission integrated interactive community drama shows on use of IPTp to complement VHT BCC efforts	**Status:** Done. **Output:** Nine (9) interactive and integrated community drama shows were commissioned.	
	2.4: Air MOH radio jingles and talk show to promote use of IPTp	**Status:** Done. **Output:** 161 radio jingles and 2 radio shows aired.	
Objective 3: To increase the proportion of children under 5 with suspected malaria receiving treatment with an ACT within 24 hours of onset of symptoms			
Proportion of sick children who received ACTs	**3.1:** VHT conduct home visits to encourage caregivers to treat their sick child within 24 hours	**Status:** Done. **Output:** 83,080 Households have been reached through VHT household visits and a total of 463,962 (241,456 females and 222,506 males) household members have received malaria prevention BCC messages.	
	3.2: Conduct interactive drama shows to encourage caregivers to	**Status:** Done. **Output:** Nine (9) interactive and integrated community drama	

	treat their sick child within 24 hours	shows were commissioned.	
	3.3: Air MOH radio jingles and talk shows to encourage caregivers to treat their sick child within 24 hours	**Status:** Done. **Output:** 161 radio jingles and 2 radio shows aired.	
Objective 4: To build sustainable, local organizational capacity to reduce malaria and to manage health insurance schemes.			
86.8% and 88.9% male and female trained VHT attend quarterly meetings with health workers	**4.1:** Health workers conduct quarterly meetings with VHT and local leaders to sustain linkages of communities with health facilities for care and support	**Status:** Done. **Output:** 223 quarterly HW support supervision meetings for VHTs were held.	
12 out of 20 planned district review meetings conducted.	**4.2:** Conduct quarterly district review meetings to share lessons learned, determine implementation gaps and develop joint implementation plan	**Status:** Done. **Output:** 12 district level review meetings were held.	The support for conduct of district review meetings was transitioned to STAR SW another USAID supported program.
	4.3: Facilitate MOH/NMCP quarterly visit to the districts for support supervision at the district, health facility and community level implementation	**Status:** Done. **Output:** 4 MOH/NMCP visits were conducted by the National VHT Program Coordinator and the Regional VHT Coordinator South Western Region.	
Percentage of UHC member owned community health financing groups recovering 100% of treatment costs from their pooled funds increased	**4.4:** Conduct support supervision of village savings and loans associations for VHT	**Status:** Done. **Output:** Five (5) VSLA groups received support supervision for one year.	
	4.5: UHC Board members conduct support supervision of community health financing providers to strengthen capacity to manage health financing schemes	**Status:** Done. **Output:** 27 UHC groups and 11 UHC providers were supervised quarterly by UHC board members;	The supervision included the UHC group leaders, UHC provider representatives and the Board member supervisors.

from 60.8% in FY10 to 66.4%			
93.1% of Health facilities had no stock outs of ACTs during the last month	**4.6:** District HMIS Focal persons collect quarterly data using Health Management Information System for problem identification, work planning, monitoring report preparation and dissemination	**Status:** Done. **Output:** Quarterly HMIS meetings with HMIS Officers have been held for VHT and HMIS data sharing, interpretation and planning**.**	
	4.7: UHC Board of Directors holds meetings to strengthen capacity to manage health financing schemes	**Status:** Done. **Output:** 4 quarterly UHC board meetings were held.	
100% health facilities have data centers and guidelines for malaria management	**4.8:** Complete installation of data centers with support for utilization in health facilities for improved communication and data management between VHT/HW/DHT	**Status:** Done. **Output:** 116 health facilities provided data centers and support supervision for ownership and maintenance.	Support for integrated support supervision has been transitioned to and SDS STAR SW; USAID supported programs in SW Uganda
	4.9: Conduct integrated interactive community drama shows to encourage communities to join prepaid member-owned health insurance plans to reduce financial barriers to seeking treatment in public health facilities	**Status:** Done. **Output:** Nine (9) interactive and integrated community drama shows were conducted.	
	4.10: Air radio jingles and talk shows to mobilize communities to join prepaid member-owned health insurance plans to reduce financial barriers to seeking treatment in public health facilities	**Status: Done.** **Output:** 161 radio jingles on community health insurance were aired as a means of community mobilization to join community health plans.	
	4.11: Official 5 district ceremonial launch and mass campaign of	**Status:** Done. **Output:** 2 official VHT launch ceremonies were held in Rubirizi	District partnership meetings were held in the other 3 districts to

	malaria prevention and treatment after all VHT trained	and Buhweju districts.	support completion of the VHT cascade that is necessary before launch.

II. Factors Impeding Progress

This was a challenging year for health care in Uganda as documented in several reports. The Foundation for Human Rights Initiative 2010 report titled, *The Right to Health Care in Uganda*, shows the government is in default on its commitments to health. Its allocation of 9.8% of the national budget this fiscal year to the sector, down from 10.3% in the 2009/10 financial year (FY), contrasts with the 2001 Abuja Declaration that obliges African states to dedicate at least 15% of their revenues, excluding donor financing, to health. According to the World Bank's 2010 report, *Fiscal Space for Health in Uganda*, "approximately 36 Billion USH or 13% of health sector spending was lost due to waste… Health worker absenteeism represents a major source of waste in the sector." The Uganda National Health Users'/Consumers' Organization (UNHCO) May 2010 study, *Prevalence and Factors Associated with Absenteeism of Health Providers from Work,* confirmed that this is a major challenge in the program location. Below is an excerpt from that report:

> UNHCO draws results from the study made to 78 health facilities in Bushenyi District, including literature review and unannounced visits. The intention of the study was to document the prevalence, determinants and consequences of absenteeism of health providers in the health sector of Uganda, and recommend appropriate remedies for the identified causes in order to promote efficiency and effectiveness in the utilization of public resources.
>
> The average rate of absenteeism was 47.9% and after desegregation of key health cadres, 24% of the nursing officers were not present at the health facility, followed by nursing assistants and enrolled nurses both at 18%. The enrolled 15% of the enrolled midwives were not present. The important determinants of health provider absenteeism found from this study included the work environment, supervision, Job satisfaction with different incentives, level of education, and location of health facility (remoteness), length of service in the current facility, job stress, and marital status.

"Ghost" workers are frequently included on government health facility payrolls. As documented in the World Bank's 2010 report, *Fiscal Space for Health in Uganda*, "ghost workers are those who appear erroneously on a payroll because they have died, resigned, retired or absconded but have not been removed from the payroll due to delays in updating records or possible fraud."

These challenges hinder the program's goals to build community confidence in the health system and to increase demand for early treatment seeking and malaria prevention at antenatal care. Additionally, the practice of "ghost" worker reporting directly impacted the project when UHC/MCP discovered health workers' were over reporting VHT and leader attendance at quarterly support supervision meetings in order to collect higher facilitation reimbursement.

The final factor that has impacted UHC/MCP is increase in new development partners in the project area. UHC/MCP is committed to coordinating efforts with partners at the district level to leverage resources and avoid redundancy. These efforts had a powerful impact from 2008-2010 with partnerships that included setting standard reimbursement rates for government and community partners involved in project activities. With the addition of Strengthening Decentralization for Sustainability project and Strengthening TB and HIV/AIDS Response in the South-Western Region of Uganda, UHC/MCP was asked to step back from district health team interventions. In one district, health officers ended a contract with UHC/MCP to engage in higher reimbursement rates with a new partner. Partnership discussions were held with UNICEF where UHC/MCP recommended that they close the remaining gaps in the VHT Cascade of Sensitization and Training for VHT in Bushenyi, Sheema or Mitooma districts. These districts received some funding from partners and from the Ministry of Health however the cascade has yet to be completed. UNICEF selected Buhweju district for their implementation of the VHT cascade. As a result, UHC/MCP will no longer conduct HW/VHT quarterly support supervision in Buhweju.

III. Program Changes

In June 2010, the MOH introduced new VHT training guides, job aids and data tracking tools. UHC/MCP printed and distributed the revised resources for adoption by health workers and VHT for use in data tracking and reporting. The new VHT registers are printed in the local language which is imperative for the VHT to have great impact. However, these registers are bulky to carry. Additionally, new VHT materials posed a number of changes in the project's reporting requirements since the new materials do not capture data on many of the indicators that were selected from the old materials. There was an increase in the number of parishes from 49 to 74 for Rubirizi and Buhweju districts due to creation of more districts out of greater Bushenyi.

The program M&E Coordinator left in April 2011 and a new coordinator joined the team shortly thereafter. The transition reduced the depth and breadth of monitoring and evaluation activities that had been prioritized for the second half of the year.

In response to inflated attendance reporting at health worker/VHT support supervision, the team proposed tracking and accountability changes to the MOH and after receiving approval implemented new rules. In order to receive reimbursement for quarterly meetings, health workers must turn in a work plan and list of active VHT with their phone numbers to DHT at a district planning meeting early in the quarter. After quarterly meetings, HW turn in VHT registers, action items lists, and signatures from VHT attendance. Funds are collected for VHT who did not attend, or topped off in the case of additional leader attendance. UHC/MCP staff develops schedules to visit HW/VHT meetings in areas where reporting or support has been problematic and after accountabilities are collected, the accountant makes follow up spot check calls to verify participation.

IV. Monitoring and Evaluation Activities

In 2011, VHTs continued to receive support for accurate, timely tracking and reporting of data from household to village and parish levels using the tools designed by the MOH. The data collected by VHT at

the village level is aggregated at parish level by the VHT parish coordinators to generate parish summaries which are forwarded to health workers for aggregation at sub county levels. UHC/MCP facilitates quarterly meetings for capacity building at parish levels to enable feedback on data quality and data sharing on issues identified for action by local leaders, health workers and VHT.

UHC/MCP has continued to mentor district data collectors as they use basic excel spreadsheets to aggregate parish register data into quarterly and annual health sub district and district reports. In particular the program has strengthened its support to the District HMIS focal persons to collect quarterly VHT data following the MOH approved tools for problem identification, work planning, monitoring, report preparation and sharing results with appropriate stakeholders. The program team emphasized quality, consolidation and use of data to fill MOH expectations for data reporting. As a result, district data collector capacity in sharing data and evidenced based decision making has increased.

A brief monitoring study was conducted to assess the knowledge of VHTs about UHC and whether these VHTs cover health insurance in their health behavior talks within their communities. While almost all VHTs are emphasizing malaria prevention and treatment and, covering almost all of the other VHT job aid health topics in their community talks, only 77.2% talk about health insurance. Most VHTs (89.9%) acknowledged that they have never been asked about health insurance by community members. An additional 41% of VHTs said that when asked about UHC they failed to provide responses to community members. Most VHTs did not know where to obtain UHC registration forms. It was also noted that most of the VHTs have heard about UHC though VHT meetings and trainings, a good number of them acknowledged radio jingles as their primary source of information about UHC.

When asked about frequency of topics covered in the last month VHT has the following responses:

Topic	No. of times	Frequency (n=92)	Percentage (%)
Seeking treatment for malaria in pregnancy	0	0	0
	1-2	27	29.3
	3-5	48	52.2
	>5	17	18.5
Sleeping under insecticide treated bed nets	0	0	0
	1-2	12	13.0
	3-5	34	37.0
	>5	46	50.0
Seeking treatment for malaria within 24 hrs of fever onset	0	0	0
	1-2	31	33.7
	3-5	30	32.6
	>5	31	33.7
Health Insurance	0	23	25.0
	1-2	41	44.6
	3-5	19	20.7

	>5	9	9.8
HIV/AIDS	0	0	0
	1-2	23	25.0
	3-5	34	37.0
	>5	35	38.0

In response to this study and other program indicators, the project's UHC Cascade of Sensitization and Training includes an improved VHT training of trainer's course to close these gaps.

Monitoring also included a Radio Focus Group Discussion to assess what is working and what can be improved in UHC radio copy. In addition to suggesting the best station, days and times to reach the primary target audience, this monitoring exercise exposed a major gap in UHC expansion. When respondents were asked about the action that they would or have taken to become a UHC member most answered that they would call UHC. To date no system to track or follow up telephone enquiries was in place. As a result and as part of the new UHC cascade, a Question and Answer guide will be developed to support consistent and correct answers to UHC enquiries. Staff will be trained on this task and a routine schedule for tracking and responding to enquiries is being developed. The radio transcript is being updated to include key information that was noted to be lacking by focus group respondents.

Finally, monitoring was conducted to measure the impact of VSLAs on VHT. VSLAs are self managed groups that do not receive any external capital and provide people with a safe place to save their money, access small loans, and obtain emergency insurance. The approach is characterized by a focus of saving, asset building, and provision of credit proportionate to the needs and repayment capacities of the borrowers. Groups are low cost, simple to manage and can be seen as a first step for people to reach a more formal and wider array of financial services. VSLAs can dramatically raise the self-respect of individual members and help to build up social capital within communities, particularly among women who represent 70 percent of members.

In addition to the saving fund, the cash box holds the social fund/welfare fund which can provide members with a small amount in the case of emergencies. Each member contributes a set value, each week, depending on the group. In the event of an emergency such as death of a family member, the fund dispenses a fixed amount towards their group member. No interest is charged for loans from the welfare fund and although members are expected to pay back the loans, repayment is not strictly enforced. This fund is managed separately from the savings and loan fund and is not shared out at the end of the cycle and is thus carried over to the next cycle.

After several months, the savings shares accumulated by the group become large enough to launch the loan function. All members have the right to take out a loan regardless of the number of shares they have contributed, but can only take out a loan equal to at most three times the value of their shares. Most loans are short term, generally around one month, at an interest rate determined by group members, usually not more than 5 percent per month—this is low compared to other money lenders who often charge up to more than 20 percent per month. Each group is able to share their own repayment terms.

VSLAs were adopted by the project as a sustainable strategy for increasing the financial stability of VHT and UHC members to increase investing in health. The assessment confirmed that VSLA improves the health status of members especially when combined with community health financing that guarantees access to care when needed. Compared to the general population, VSLA members adopt more healthy behaviours like use of LLINs and childhood immunization. Ninety-six point four percent (96.4%) of respondents reported an improvement in the health status of their households since joining the VSLA groups and 100% reported full immunisation of their children. Sixty-seven point three percent (67.3%) of VSLA members indicated that their children sleep under LLINs compared to the average 41.2% of children under five sleeping under LLINs reported by VHTs.

This is a low cost, high impact donor investment. All respondents reported that since they joined VSLAs their status in the community has increased, their status in their families has increased and their self confidence has improved.

Thirty-five point seven percent (35.7%) of respondents were UHC members before joining VLSAs. An additional 21.4% joined UHC during the year. Of the respondents who were both VHT and VSLA members, no member reported a decline in effort, 20% reported that they continue to commit the same amount of time to VHT activities as they did before joining a VSLA, while 80% stated that they contribute more time to VHT activities than they did before joining a VSLA. A summary of VLSA group performance can be found in Annex E.

IV. Technical Assistance

The program continues to receive support from UMEMS and USAID/PMI and this has resulted in high quality and timely deliverables. The program Community Health Coordinator and M&E coordinator attended a one week managing for results training workshop for USAID/PMI Uganda implementing partners organized by UMEMS. This event was held in Mbarara, Uganda from May 16-20, 2011.

UHC/MCP staff attended skills improvement courses at various institutions of learning in country. The M&E Coordinator attended a two week short course training in Applied Biostatistics at Makerere University School of Public Health. The Community Ventures Manager and M&E Coordinator also attended a four day workshop on Action Research organized by Uganda Community Based Health Financing Association.

The Program Director led a course on Criterion Referenced Instruction, Training Trainers for Measureable Results in April. The goal of this course was to improve the team's ability to prepare agendas and tools for activities that include behavioral objectives, so, the impact of any training can be measured by the end of the event. Additionally the course helped the team learn to develop pre and post tests and criterion checks to be sure session attendees are on track to meet course objectives. The training also covered the five teaching and learning principles of appropriate practice, knowledge of results, graduated sequence, individual differentiation, and perceived purpose. These same principles can be applied to setting and tracking personal goals each month. This capacity building was followed by a brief introduction to the newly revised Sustainability Framework, the philosophy behind the UHC/MCP project design.

A Canadian photographer visited the project site contributing her expertise to document project impact and to build staff capacity to "take a photo worth a thousand words." Photographs from this visit are included in this report and are being used in the 2012 BCC campaign.

UHC/MCP provided technical assistance to Peace Corps Uganda in training fresh Peace Corps Volunteer in MOH supported VHT strategies and sustainable community malaria interventions implemented through VHT. UHC/MCP also provided support to Peace Corps Uganda in planning, budgeting and scheduling the training of selected VHTs together with all Peace Corps Volunteer supervisors and counterparts in southwestern Uganda scheduled for FY12.

VII. PMI Team Collaboration In-Country

Joel Kisubi, the President's Malaria Initiative Uganda Mission technical support representative, conducted a site visit on August 9-10, 2011. The purpose of the visit was to assess UHC/MCP implementation progress, project activities and to conduct field visits to meet key stakeholders including UHC service providers, VHTs and HW. See the attached copy of the USAID/Mission site visit report in Annex A. Mr. Kisubi follows UHC/MCP implementation on a monthly basis, works to coordinate UHC/MCP efforts with UMEMS and routinely provides recommendations to support and increase project outcomes and impact.

The Chief of Party attended a Mission led Implementation Partners meeting on May 26th where among others, the guidance for USAID support for FY11-15 was provided.

IX. Publications / Presentations

The Chief of Party and Community Ventures Manager travelled to Malawi to attend the President's Malaria Initiative MCP Regional Workshop with 42 other participants from throughout Africa. The team led two presentations, one on Malaria in Pregnancy and one on innovative strategies for sustainable outcomes including linking interventions to community based health financing and linking volunteers to village savings and loan associations. Many valuable lessons were learned and shared with the team for adoption into the final year of the UHC/MCP program.

The MCP Chief of Party led a presentation at a regional VHT meeting Organized by the Ministry of Health in Mbarara. The presentation shared the VHT implementation modalities and shared the project current issues and VHT sustainability efforts.

The MCP Chief of Party participated in a consultative meeting on the Development of the 5-Year Global Strategic Framework for Malaria SBCC at Country level in Nairobi in July 2011 where Partners like National Malaria Control Programs, PSI, JHU-CCP, Roll Back Malaria Partnership Secretariat met to provide input on a comprehensive framework outlining the future of malaria communication interventions.

X. Success Stories

Saving Lives through Village Health Teams!

A VHT is a non-political health implementing structure; an equivalent of Health Centre I responsible for the health of community members at household levels. A VHT comprises of 4 – 5 people selected on a popular vote in a village. Each VHT member is in charge of 25 – 30 households.

HealthPartners has played a vital role in implementing and supporting the Village Health Team (VHT) strategy in Rubirizi and Buhweju districts. The organization has trained and provided VHT materials to 856 VHT volunteers in Buhweju and 889 VHT volunteers in Rubirizi district respectively. In addition, HealthPartners supports health worker (HW) led quarterly meetings of VHT in Rubirizi and Buhweju districts and it's during these quarterly meetings that Feedback is given to VHT on issues concerning data quality and Feedback on performance on various parishes provided, areas for improvement cited and a way forward generated.

To casual observers', winning comes easy, but this has not been the case for HealthPartners. Having been the pioneer of the VHT strategy in these districts and with the continuous updating of the VHT strategy guidelines and materials from the Ministry of Health (MOH) since 2008, the organization has adjusted its strategies, plans and budgets to keep-up with these changes, thus has treaded a thorny path to achieve its current positioning.

Village Health Team Strategy

The Village Health Team consists of members who work together to promote healthy practices at the community level such as the use of pit latrines, washing hands, sleeping under mosquito nets etc…

Mr. Mugume Bernard in his plantation, Nyakambi Village, Buhweju district

"The knowledge I have received from the organization and the respect earned from the community forced me to go ahead and become a Community Owned Resource Person (CORP) under the Child Survival Program (CS) and currently a VHT under the Malaria Community Program (MCP) to improve the lives of my community"

The Uganda Health Cooperative Malaria Communities Program recognizes that planning and managing interventions by thinking systematically about the essential components and stakeholder involvement is crucial for the long-term maintenance of health outcomes in areas of the organization's operations in order to leave behind a lasting impact. Since sustainability is a dynamic process and is most effective when -- approached from a "systems perspective", the VHT, Health workers (HW), Local leaders and the District Health Team (DHT) have all been involved in the planning and sustaining the health of their community.

Mr. Mugume Bernard is a good example of a committed VHT. Having started as a volunteer in 1996 for Health Plan in Nyakashaka health center (HC) to increase membership that could sustain the HC, he says "the knowledge I have received from the organization and the respect earned from the community forced me to go ahead and become a Community Owned Resource Person (CORP) under the Child Survival Program (CS) and currently a VHT under the Malaria Community Program (MCP) to improve the lives of my community." He was later elected as a Parish Coordinator supervising 24 VHTs in his Parish.

VHTs have played a pivotal role towards promoting health at individual, family and community levels. The proportion of pregnant women that sleep under long lasting insecticide treated bed net every night has increased from 5.5% in 2008 to 60.2% in 2011 and that of children under 5 has increased from 6.5% in 2008 to 61.6% in 2011 for Rubirizi and Buhweju districts respectively.

This success is directly attributed to the good work the VHTs are doing in the community with guidance from Uganda Health Cooperative Malaria Communities Program and support from USAID that has attracted various implementing partners to these districts such as STAR-SW, UNICEF and Peace Corps to learn from them.

Village Savings and Loans Associations a strategy for Village Health Team Sustainability

HealthPartners Uganda Health Cooperative Malaria Communities Program (UHC/MCP) is committed to sustainably improve the health and livelihoods of communities. UHC/MCP trained 1,745 Village Health Teams volunteers (VHTs) in community case management of malaria in both Rubirizi and Buhweju districts. UHC/MCP piloted Village Savings and Loans Associations (VSLA) with a view of improving incomes of these VHTs but mostly to ensure sustainability of the VHT groups.

Mrs. Nuwagaba Jane a widow, mother of three, VHT and VSLA member from Kamacumu village, Buzenga parish, Ryeru Sub County in Rubirizi district shares her VSLA experience with us. When asked about her life after joining the VSLA, this is what she said; “As a result of participating in VSLA, I feel there is a great difference within my life. I have realized and appreciated the importance of having a saving culture. I have always saved a little that I have on a weekly basis with hopes of sharing much more money as my payout at the end of the cycle, of which I do not feel the impact of its accumulation. In fact there are so many benefits I have had as a VSLA member”, she says. “As a VSLA, we have a welfare fund which we have used to pay our premiums and enrolled into Uganda Health Cooperative, community health financing. I can now seek health care at a time when I need it and this has improved my health care seeking behaviors. I have just enrolled into UHC, but it looks to be a great idea since a member saves a lot of money on treatment.” She further explains that, “as a member, I have also been able to get loans from this VSLA group to settle most of my family financial affairs like school fees while saving my property and livestock that would have been sold in the name of school fees. It has also increased my trust and bondage with my fellow VHT since I am a VSLA committee secretary and I have always been part of decisions of offering loans to my fellow members as we have not experienced any problems with loan re-payments among our members”, she said.

“Being a VSLA and VHT member, I now feel more secure in my family and community as a whole, I am sure that we shall remain together as Buzenga VHT group courtesy of this VSLA, thanks to the Uganda Health Cooperative Malaria Communities Program which trained us as VHT and in VSLA strategy.”

Annex A: AOTR Site Visit Report

Presidents Malaria Initiative Malaria Communities Program
Health Partners / Uganda Health Cooperative in Uganda
AOTR Project Site Visit, January 19-22, 2010
Purpose of travel:

To conduct a field site visit to the President's Malaria Initiative (PMI) Malaria Communities Program (MCP) grantee, Health Partners and the Uganda Health Cooperative (UHC) in Bushenyi District in Uganda to monitor and review progress on activities and meet with key project staff, district health representatives, community health groups and project beneficiaries.

Site Visit Itinerary

January 19: In-briefing with the PMI team at the USAID/Uganda Mission and discussion of MCP project activities and PMI strategies underway.

January 20: Arrival at Health Partners project office in Bushenyi district and meet with MCP project staff for a project overview presentation and to discuss progress on activities. Travel to Buhweju district, met with the District Health Officer (DHO), Village Health Team (VHT) Village Savings and Loan Association (VSLA) and attend a VHT quarterly meeting.

January 21: Site visit to a UHC health provider, Nyakasiro Health Center, in Mitooma district to discuss community health financing scheme. Field site visit to Kishenyi fishing village in Rubrizi district to meet with health post worker and VHTs and to observe a drama show.

January 22: Attend the UHC members' Annual General Meeting in Bushenyi and interview health providers and board members.

January 23 – 28: Field site visit to MCP grantee, Medical Teams International, in Lira and Dokolo districts.

Site Visit Team Member:

Susan Youll, USAID Washington, PMI MCP Agreement Officer's Technical Representative (AOTR) for Health Partners Uganda MCP project

Key Persons Met with:

Health Partners MCP Project staff:
Dr. Wilberforce Owembabazi, MCP Project Director
Maale Julius Kayongo, MCP Community Venture Manager
Michael Oturu, MCP M&E Coordinator
Asiimwe Herbert, MCP Communication and Logistics Manager
Mudashir Matsiko, MCP Community Health Coordinator

Buhweju District:
Mr. Wycliffe Twyasingura, District Health Officer
Mr. Gumisiriza Frank, Health Center Worker, Nyakitooko parish
Village Health Team members of Nyakitooko

Nyakatsiro Catholic Mission Health Center:
Sr. Rosemary Kyatukwire, Administrator/Accountant
Sr. Christine Kakarwagi, Registered Nurse/Midwife

Kishenyi village, Rubrizi district:
Tibamyendera Wilson, Health Post Worker
VHTs and VHT Coordinator
Bwera Drama Group

USAID/Uganda PMI team:
Gune Dissanayake
Sussann Nasr
Joel Kisubi

Project Background and Overview:
The Health Partners MCP project is based in Bushenyi district in Southwestern Uganda with a total population of 830,000 people and directly reaching 160,906 women of reproductive age and 124,599 children under five. The total program amount is $1,560,900 with USAID funding in the amount of $1,290,000 and a recipient cost share contribution of $270,900. The four-year project runs from October 2008 to September 2012. Last year, as part of the Ugandan government's redistricting strategy, Bushenyi district was divided into five districts: Nsiika (formerly Bunyaruguru), Rubirizi (Buhweju), Mitooma (Ruhinda), Bushenyi (Igara) and Sheema. The project continues to support all five districts and implements VHT activities in two districts (Nsiika and Rbuirizi).

Health Partners MCP project supports the PMI strategies of building strong linkages and partnerships with local organizations, developing local capacity and increasing local ownership, and contributing to sustainable scale-up of activities. The project supports the USAID Uganda Strategic Objective 8: Improved Health and Education status of Ugandans by 1) delivering a package of effective and appropriate core interventions that promote positive behavior change and prevent and treat malaria; and 2) achieving rapid and sustainable high coverage levels for this intervention package. To help achieve this goal, the project applies integrated approaches that reach recipients at multiple levels, including: behaviour change interventions at the individual, household, and community levels, service delivery strengthening at the health facility level, institutional capacity building at the district level and improved communication and coordination of stakeholders at every level for sustainable outcomes.
The objectives of the project are to:

1) Increase the proportion of pregnant women and children under five that sleep under a long lasting insecticide-treated bed net (LLIN) every night from 5.5% to 85%;
2) Increase the proportion of pregnant women receiving two or more doses of intermittent preventive treatment of pregnant women (IPTp) during their pregnancy from 16.2% to 85%;

3) Increase the proportion of children under 5 with suspected malaria receiving treatment within 24 hours of onset of symptoms from 1% to 85%; and to
4) Build sustainable, local organizational capacity to reduce malaria and to manage health schemes protecting at least 14,000 members.

Observations and Findings:

The project is making solid progress on its objectives, increasing demand for malaria services and building capacity of communities to prevent and control the disease. The project has formed strong district and community partnerships with the district health teams, health facility workers, village health teams, parish coordinators, and UHC health service providers. Under the government redistricting strategy, the project is implementing activities in five new districts (formerly Bushenyi district) to promote the use of LLINs, increase uptake of IPTp, and encourage prompt treatment with an artemisinin-based combination therapy (ACT). The project also promotes a community-based health insurance (CBHI) initiative at the community level and the establishment of VSLAs. Observations and findings from the site visit are summarized as follows:

District-level malaria services:

District health facility staff and UHC providers reported sufficient quantities of ACTs and SP (fansidar) for IPTp in their pharmacies. They mentioned long-standing stock outs of LLINs for pregnant women (at ANC services) and no rapid diagnostic tests (RDTs) for malaria diagnosis (although most health center III laboratories have access to microscopy). Two of the five new Bushenyi districts benefited in the first phase of the Global Fund LLIN distribution, targeting pregnant women and children under five. With some resources from PACE (the designated lead partner coordinating LLIN distribution), the project supported the recent campaign by transporting LLINs to the parish-level and mobilizing and sensitizing communities with trained VHTs. A second campaign phase, beginning in June 2011, will provide LLINs (one net for every 1.8 people) in all five districts to achieve universal coverage. IPTp coverage is low in the districts despite reportedly high ANC attendance among pregnant women. In addition to promoting BCC messages on the importance of IPTp, the project supplies cups and clean water to facilitate the administration of directly observed treatment of SP for pregnant women attending ANC clinics.

BCC interventions and activities:

The project's BCC messages are comprehensive and focus on the key malaria interventions – promotion of LLINs, IPTp and prompt treatment with an ACT. Key target groups were able to demonstrate their knowledge of malaria; for example, during the site visited, VHTs and beneficiaries in communities visited, mentioned all three malaria interventions to prevent and control malaria. The project adapted the NCMP's BCC messages, translated them into local language, and incorporated them in posters and flip charts for use by the VHTs. With the MOH's newly simplified VHT register books and VHT job aids, the project will assist the NMCP and DHOs with their translation and distribution at VHT quarterly meetings. The project supports three primary communication channels: interpersonal communications by VHTs, mass media radio messages and local drama sessions.

VHTs are part of Uganda's national strategy to strengthening the delivery of health services and the promotion of healthy practices at the community level. The project has trained a total of 1,745 VHT members in two districts (Nsiika and Rbuirizi). The MOH, with its own funding, trained an additional 2,018 VHT members in two other districts (Mitooma and Bushenyi). Each VHT visits 25 – 30 households in his/her catchment area with four to five VHTs per village depending on the population size, number of

households and proximity of houses (rural vs urban settings). The Health Partner's VHTs are well trained and knowledgeable about key malaria interventions. The project enhances their capacity at each quarterly meeting, facilitated by the health worker and local parish coordinator. They collect and review VHT quarterly reports, share feedback on progress in their target areas (based on the previous quarter's reports), guide VHTs on issues that require more intensive BCC messaging and provide information and updates. A strength of the project is its approach to encouraging local ownership of activities and it was evident that the VHTs consider their efforts as aiding and benefiting their communities. Although MOH-supported VHTs have been trained, the districts have limited capacity and resources to carry out supportive supervision or hold quarterly meetings; as a result, the VHTs are considered only marginally active. Given the important role and function of VHTs in the districts, Health Partners may wish to consider supporting their capacity within the scope of existing program activities and resources (e.g. help facilitate/coordinate regular quarterly meetings, build health worker skills to facilitate VHT meetings, review and provide feedback on quarterly reports submitted by VHTs, ensure quality of VHT malaria messages, etc.).

The project supports four key radio messages (three on malaria and a fourth on community-based health insurance) aired 28 times a month, with the same topic on malaria repeated on the air for one consecutive week. Radio messages are based on the NMCP's BCC messages and radio transcripts. A local women's group incorporates the four messages into their skits, role play/acting, and songs, and carries out drama sessions at local venues on a rotating schedule throughout the month. The project staff work closely with the drama group to develop the messages and ensure their consistency.

Opportunities for collaboration and coordination

The project maintains regular communications with the Mission PMI team as well as USAID implementing partners by phone, email and attending quarterly partner meetings. The project staff remarked that these opportunities are informative, facilitate informal networking and sharing of experiences and help coordinate district partnerships. At district level, the project coordinates with STAR-South West, UMEMS, PACE, and Strengthening Decentralization for Sustainability (SDS), resulting in harmonized activities with the DHO teams. The Integrated Community Based Initiatives (ICOBI), a USAID funded project and district partner, has supplied the Sheema district with funding to implement VHT selection and training. SDS has provided grants to Bushenyi district to conduct needs-based capacity building and training to strengthen district capacity to deliver services. The STAR-South West project is conducting annual LQA surveys on key health indicators, including malaria, in all five of the Bushenyi districts. The project benefits from these annual surveys by using the information to inform project activities and to measure progress toward achieving targets on project indicators.

Building local capacity

The project implements two effective capacity building initiatives; VSLA and CBHI, in part as motivation and incentive to the VHTs. The VSLA is a method of saving money in rural areas where there are no banks or payment options. The purpose is to help the VHTs increase their financial security and savings in the absence of a paid salary. The VSLA is a small pilot activity with six VHT groups formed (30 members in each group) and functioning out of a total of nine groups proposed. Members received village savings and loan training from the project. At the one VSLA meeting that I attended, members purchased "shares" in increments of Uganda Shillings (Ugx) 1,000 (or $0.42) and submitted proposals for loan requests. Approximately Ugx 240,000 was collected during this meeting and Ugx 390,000 was loaned to members for specific projects. In total, the group has saved over Ugx 2,000,000 in the last six

months. The project hopes that VSLA membership will serve as incentive to the VHTs and help fund VHT participation in the CBHI plan.

Local health service providers and community members enrolled in the CBHI initiative form the membership base of the Uganda Health Cooperative (UHC). The health providers are private-non-profit health care providers, owned/operated by church- and faith-based organizations. The CBHI is implemented by seven UHC health providers who have recruited over 4,300 members or groups of members from the community to participate in the UHC CBHI plan. The project has trained 12 local providers but five have had difficulties recruiting sufficient members, possibly because they are located in remote or economically-depressed areas. Members' coverage includes all health services including outpatient, inpatient, preventative care, health education and health products. The plan does not cover chronic illnesses or self-inflicted injuries. The project supports the CBHI by training providers and developing communication materials (brochures, pamphlets, radio messages) to promote on-going member enrollment in CBHI and to attract new members. The VHTs help advocate and recruit new members. This health insurance network made up of health providers, community members, and VHTs is locally owned and operated. The project staff assist in strengthening the network's management, troubleshooting issues and challenges, and building capacity of members to sustain the network for the long-term. At the provider level, a data entry/accountant position manages the insurance plan by registering all current and new CBHI members quarterly and maintaining a filing system (referred to as a data center) containing relevant reporting forms, member enrollment information, photos of members, log books, and financial information on premiums, co-payment, etc.

While each CBHI group has approximately 20-30 members, the average premium per member is approximately Ugx 5,000 (US $2.00) per quarter and members pay a small co-payment (Ugx 1,000) upon using provider services; however the premium and co-pay amounts vary according to the composition and profile of the members. For example, the tea estate workers and their family members each pay US 1,000 (US $0.40) per person per quarter. A lower premium was established in part because the tea estate management company ensures payment of the premium and co-pay directly to the providers for all its workers who are members of the plan. As a result, the provider is assured of regular payments and is better able to plan monthly service needs and procure drugs and supplies. It appears that the average premium amount has not changed since the CBHI was initiated in 2000. The performance of the CBHI plan seems to be sensitive to the price of drugs, particularly when providers purchase costly drugs through the private sector. On occasions when the MOH provides stocks of essential drugs to the providers, the overall performance of their accounts improves. This is illustrated in 2008, when the UHC CBHI account's annual performance reported profits of over Ugx 12 million and the MOH provided free anti-malarial drugs to the health providers. In contrast, the account's performance was significantly lower in 2009 and 2010, Ugx 160,000 and Ugx 745,000, and covering a period when expensive ACTs were only available for purchase in the private sector (see summary of provider accounts in attached UHC Annual Performance presentation). In addition, the plan's performance also appears sensitive to the burden of malaria and number of malaria cases treated by the providers; malaria cases represent about 50% of all cases treated by UHC providers. It would be interesting to further investigate the impact of malaria on the insurance plan. The project may want to consider strengthening and improving UHC provider skills in malaria case management and diagnostics to (potentially) improve their overall performance and operating costs.

The UHC CBHI partnership is managed by a board of directors, elected by the member groups and health care providers. The UHC annual general meeting (AGM) for its 50 member representatives was held during the site visit and chaired by a nine-member board (of which two are health provider representatives). This year's AGM agenda included holding board member elections, reviewing the year's profits (surpluses and deficits) and status of the general account which supports the AGM, proposing actions and addressing issues such as raising individual premium rates. The project staff support the board of directors to manage the details and complexities of the CBHI and provide guidance to ensure continued operations. Health Partners and the UHC experience in implementing this community-based health insurance model is timely and potentially a good model to help inform decision-makers; currently the MOH is promoting health insurance options as a priority and the Ugandan parliament will consider approval of a mix of insurance options including private, social and community-based insurance plans.

Project management

The project staff were well organized and provided helpful insights on project activities. Some personnel changes were noted while reviewing the detailed budget of April 2009. One position, Health Service Trainer, was reallocated to support the Community Venture Coordinator (who helped initiate the VSLA activities) and one position has been dropped from the program budget – the Health Scheme Manager. It would be good to document these staffing changes in the annual workplan submission with justification for these changes.

<u>Considerations/Recommendations:</u>

- Develop a concise one-pager with information about the CBHI to help explain costs, member benefit plans, project and donor inputs vs. member inputs, coverage, etc. (Already completed – see attached documents)

- Since VHTs play such an important role and function, consider opportunities within exiting available resources to lend support to the cadre of MOH-trained VHTs in two other districts to strengthen their district-level performance in BCC efforts and key malaria messages (e.g. promoting correct LLIN use, IPTp uptake and prompt treatment).

Consider reviewing the effectiveness and frequency of mass media radio and drama messages to better target BCC outcomes and messages. If general knowledge and awareness about malaria is already high in the project area, perhaps some adjustment can be made to the focus or scope of messages to address any barriers or behaviors and engage specific target groups. Focus group discussions could help guide a review of the messages as well as the delivery channels. A few specific questions could be incorporated into VHT home visiting sessions and quarterly reports. During the site visit, we also discussed possible barriers to increasing uptake of IPTp and I shared a journal article on assessing IPTp coverage and barriers. During quarterly home visits, VHTs could ask pregnant women whether they perceive barriers or have any concerns to taking IPTp. Based on this information, the project could tailor BCC messages to address these concerns and engage health workers to improve services.

Annex B: Uganda Mission Site Supervision Report

Field Visit Report to Bushenyi
August 8-10, 2011
Joel Kisubi, PMS – PMI

Objectives:

1. Monitoring visit to observe Health Partners/Uganda Health Cooperative (HP/UHC) project activities.

Background:

PMI work with HP/UHC

HealthPartners Uganda Health Cooperative (HP/UHC) is one of two Malaria Communities Projects (MCP) supported by the President's Malaria Initiative (PMI) in Uganda. MCP projects are field support projects with the Agreement Officer's Technical Representative (AOTRs) based at USAID/Washington, and an activity manager at the United States Mission in Kampala. HP/UHC follows the Ministry of Health/National Malaria Control Program (MOH/NMCP) health system plans, using MOH/NMCP developed resources, and linking interventions to community owned prepaid health insurance with strong support supervision and behavior change communication, in this way empowering communities to sustainably prevent and treat malaria.

Districts visited:

- Bushenyi district, south western Uganda.

Observations:

Visit to Katerera Health Center (HC) III

- HP/UHC supported the center with a set of Intermittent Preventive Treatment in pregnancy (IPTp) items including jerry cans, cups, buckets, bottles of a water purification solution (water guard), and job aids to facilitate Directly Observed Treatment (DOT) of pregnant women.
- The HMIS records for May 2010 were sampled, and it was observed that IPTp uptake is high at 112 for IPT 1 and 72 for IPT 2 out of an average attendance/new ANC attendance of approximately 200 pregnant women per month. From records reviewed, the HC receives Sulphadoxine-Pyrimethamine (SP) for IPTp from the national medical stores fairly consistently, with the last reported stock out in the period April-September 2010.
- In terms of malaria cases, it was observed that the HC had completely empty wards. This is attributed to four reasons: the dry season at the time of the visit, the fact that this area is epidemic in nature in terms of malaria transmission i.e. fewer upsurges of malaria in a year as compared to other parts of Uganda, Village Health Team (VHT) home visiting program, and the distribution of Long-Lasting Insecticide Treated Nets (LLINs). HP/UHC has supported VHTs in the area reach 34,300 households with malaria control messages quarterly, and also distributed 55,000 Global Fund procured LLINs, which could have contributed to fewer malaria cases.

Participation in VHT quarterly meeting

- Participated in a quarterly meeting for the VHTs of Kirugu parish in Kirugu sub county, Katerera County. There were 15 VHT members and four Local Council (LC) chairmen in attendance.

- HP/UHC recently printed revised VHT materials for all 6,980 VHTs in Bushenyi. Part of this meeting was therefore used to train VHTs in how to capture data for their villages such as general village information, population data, and safe water sources. This data feeds into the Ministry of Health (MOH)'s health promotion and education division information management system. A follow up visit to this division is planned in the near future to find out how this data informs decision making at the national level.
- Four data collection books were sampled and it was noted that all VHTs reported torn LLINs from at least three out of every 10 households visited. The PMI team will discuss this issue further and arrive at a way forward on how to address this finding at the national level with all stakeholders involved.

De-brief with UHC/MCP team

- HP/UHC plans to continue supporting joint support supervision with the District Health Team (VHTs) starting Fiscal Year (FY) 2012. The HP/UHC team will use this opportunity to provide feedback on project performance and challenges to the DHT, and seek DHT support in addressing gaps. Also in terms of addressing gaps, the team will need to work with a USAID implementing partner working on direct health facility support.
- HP/UHC plans to meet with VHTs about a way forward on carry bags for carrying the set of books for data collection. In the meeting, VHTs had noted that the books are getting torn due to being carried frequently during data collection. Sustainability issues will need to be considered and addressed by the HP/UHC team in this effort.

Annex C: Uganda Ministry of Health Site Supervision Report

REPORT ON SUPPORT SUPERVISION ON VILLAGE HEALTH TEAMS IN BUSHENYI DISTRICT
15th – 18th Dec 2010

Supervisors:

1. Gilbert Muyambi
   National Coordinator VHT Program,
   Ministry of Health Hqs
2. Arsen Nzabakurikiza
   Principal Health Educator and VHT Coordinator South Western Region

BACKGROUND

The Ministry of Health (MoH through the Health Sector Strategic Plan (HSSP) I, II &III established and is implementing Village Health Teams (VHTs) strategy as a vehicle to deliver basic health care services to the households. The strategy is aimed at effectively bringing services nearer to the people; strengthen the link between the service providers and the beneficiaries therefore enhancing accountability of the service provider to the communities/population and as well as enhance development in communities particularly the remote communities. Many opportunities for VHT implementation have been available such as the supportive government policies (decentralization policy; gender mainstreaming policies and health policy emphasizing the implementation of Primary Health Care); the MoH strategic plan which spells out strategies in the implementation of Uganda National Minimum Health Care Package through the different levels of health service delivery; the existing and planned facilitative local structures including LCs (Local Councils), Women councils; Local NGOs and CBOs, planned Functional Adult Literacy and CDAs (Community Development Assistants).

INTRODUCTION

The team was invited by Uganda Health Cooperatives ministry to conduct an independent supervision of the VHT implementation in Buhweju and Rubirizi districts formerly under Bushenyi District. The activity was conducted between 15th and 18th December 2010 using the standard Ministry of Health VHT supervision tools.

Activities conducted

Meetings at Health Cooperatives: we held a meeting with the staff at Uganda Health Cooperative office to get a brief about the entire exercise of VHT training and the different projects

Meeting at district: The team paid a courtesy call on the District Health Officers of the respective districts in their offices to brief them on the purpose of our visit

Field visits: The Team then conducted field visits where we visited both Bunyaruguru and Buhweju Health sub-district but on different days. During the field visits we were able to meet the VHT members, Community Leaders and Health Workers and hold meetings with them. We also visited community members and talked about Village Health Team.

Radio Talk Show

The team together with the DHO for Rubirizi district, and the director at Uganda Health Cooperative, also participated in the radio talk show transmitting from Rubirizi District.

Findings: Community

Activities conducted by VHTs

The VHTs reported the number of activities that they are currently engaged in including: - health education on hygiene and disease prevention, de-worming children, hygiene and sanitation, early treatment seeking, data collection using a VHT registers.

Availability of Work plan

The VHTs do not have any work plans for their activities but we helped them to develop one.

Register

All the VHTs met had registers although they are the old types of registers. The Ministry of Health has developed new materials including registers, therefore the old types of registers should be withdrawn and new ones distributed. However these old registers were all well filled. The VHTs further reported that the VHT Registers help them to follow up on the homesteads depending on the problems identified e.g. lack of latrines and also to know which people have died or are born.

Home Visits

There is evidence that VHTs are conducting home visits. On average a VHT member has 30households and they reported to have visited around 9homesteads in the last one month.

Community support

There is apparently no community support from the community members and leaders to the VHTs. This shows that maybe the VHT is not yet well entrenched in the community for the members to realize the usefulness of the VHT and this requires a number of interventions from different stakeholders.

Achievements

The VHTs were asked to mention any achievement as a result of the work and they say that hygiene in homes has improved; early treatment seeking behavior has improved as well, while more mothers are going for ANC visits and taking their children for immunization.

Constraints

Among the constraints faced by the VHTs is non availability of identification cards for people to be able to identify that this is a VHT member and then offer the required assistance. In case of the rain, following up of patients becomes very difficult and considering the terrain in rural areas there is need for gumboots and rain coats. There is also insufficient support from the community especially leaders by not enforcing recommendations from the VHTs. This leads to frustration.

Assistance from Health Facilities

Health workers help them to supervise and advise them about their work and when the VHTs are in need of services they do not line up but are given special treatment.

Encouragement to serve as VHT

It was interesting to learn that amidst the challenges VHTs face including serving the community on voluntary basis, there are certain motivational factors that encourage them to keep serving as VHTs; these are

a) the desire to help people improve their health status
b) the remarkable difference between VHTs and the ordinary people (feeling of superiority)
c) the identification with the health system (they feel like they are nurses or other health workers)
d) they feel they are well informed and are a target for most of health related activities
e) Respect from the community

Quarterly meetings: these meetings are in place conducted by Uganda Health Cooperative with health workers and community leaders. This is a very important tool in the sustainability of the VHT. It keeps the whole program vibrant we attended two meetings one in Rubirizi District and the other in Buhweju district.

As we moved around the homes of the VHTs we were able to observe that, there is an availability of a mosquito net hanging over the bed, a hand washing facility near the toilet, a garden of greens and other food crops, the home environments clean and organized with separate house for animals, and bathing shelter.

Recommendations

Use of harmonized VHT materials: the Ministry of Health recently launched new VHT materials. It is the recommendation of the Ministry of Health that all the activities of the VHT be based on those materials. These are:-

1) VHT Job Aide
2) VHT Referral Forms
3) VHT Strategy and Operational Guidelines
4) VHT Register
5) VHT Participants' Manual
6) VHT Facilitators' Guide

Translation of VHT materials: all the VHT materials are in English yet VHTs are those members of the community who may have least levels of education, this therefore calls for translation of materials into local languages.

Scale up to other areas: Uganda Health Cooperatives is implementing a number of projects in different areas of the former Bushenyi district. We suggest that UHC scales up the VHT implementation to cover those areas that do not have VHTs.

Analysis of VHT achievements: Through our meetings, interactions and observation during field visits we realize that a lot has been done by UHC in the establishment and maintenance of VHT. It is our recommendation therefore that UHC find some funds to conduct an analytical or comparative study into

the achievements and or the contribution of VHTs in the area where they exist. This can be used as an advocacy tool by the Ministry of Health in lobbying for support for the VHT country wide and the need to increase allocations to support VHT.

Conclusion

Uganda Health Cooperatives has continued to support the Ministry of Health not only in implementing VHTs but other components in the VHT strategy guidelines like holding quarterly meetings with all stakeholders and others. The experiences from Buhweju and Rubirizi will be shared among other Partners to be used in other parts of the country.

Annex D: Site Supervision Report by Director for International Development

UGANDA HEALTH COOPERATIVE
MALARIA COMMUNITIES PROGRAM SITE VISIT REPORT
April 15-May 5, 2011

By: Jennifer Stockert, Director International Development

Purpose of Site Visit: to better understand cultural context of project partnerships and implementation; to increase communication and coordination of efforts with the Uganda Mission and Ministry of Health (MOH); to increase staff capacity in training trainers including writing behavioural objectives in order to measure actual versus intended outcomes of training, developing effective training plans and tools, documenting outcomes of training and using lessons learned to improve training; introduction to sustainability strategies and improved monitoring and evaluation; and to audit project management, spending and accountability reporting.

Purpose of Consultant Visit: to increase staff capacity to take photos worth a thousand words; to take photos for the project to use in annual reports and to create an updated behaviour change communication campaign.

Persons Met

Staff: Dr. Owembabazi, Lydia, Herbert, Maale, Mudashir, Pascal, Julius
Previous staff: Dr. James, Grace, Edidah, Arthur, Dr. Grace Namaganda, Capacity Project; Joy Batusa, Family Health International.
Uganda Health Cooperative (UHC) Board members: Apollo (UHC Board Chair), Agaba (UHC Board Vice Chair), Jacinta (UHC board member and Bwera Drama group leader)
Partners: Joel Kisubi, Uganda Mission; Gilbert Muyambi, National VHT Coordinator, Ministry of Health (MOH); Dr. Paul Kagwa, Assistance Commissioner Health Services and Health Promotion and Education, MOH; and Dr. Lukwago Asuman, Deputy Permanent Secretary, MOH; District Health Officer and leaders of Rubirizi; Teddy Kyomuhangi, Healthy Child Uganda; Fred Tumwine, Executive Director, BUREDO.

Observations and Findings

Cultural Context: Corruption at the national level is serious and widespread. Newspapers report money missing from government investments, Uganda Revenue Authority, Uganda Wildlife Authority, etc.; reports of mob justice, child abuse and neglect and violence against women are routine. Bribery is common. Vehicles are pulled over and harassed by police until money is dropped on the ground. Government officials expect to be "facilitated" with transport, fuel reimbursement, meals, and per diems often for more days than work requires, in order to fulfill their roles. Obfuscation-- the practice of intentionally making communication confusing; and "the ambush"—waiting to provide information (often requests for budget approval) until insufficient time remains to do necessary research without negatively impacting outcomes, are common practices to avoid accountability.

Requests Received, Responses and Deadlines

Requestor	Request	Response	Date	Comments
MOH—Dr. Kagwa	HealthPartners to conduct a study on the impact of the VHT strategy in Rubirizi to enable the Ministry to secure government funding to complete VHT training country-wide;	The team is planning a study to document impact of the VHT strategy in Rubirizi	July or so-- after catching up with implementation according to the 2011 work plan and after monitoring to assess impact of current interventions	
MOH—Dr. Lukwago	HealthPartners to share a concept paper on UHC	Concept paper sent (Annex 3)	May 16	
The Uganda Mission—Mr. Kisubi	confirmation that MOH VHT resources are the final version for at least a few years	MOH confirmed finalized resources in email copied to the Mission	April 12	
The Uganda Mission—Mr. Kisubi	A report on UHC suggestion boxes—how are they being used?	Report on UHC provider suggestion boxes will be included in the UHC/MCP third quarter report.	July 15	
Bwera drama group	Several requests for a bus and t-shirts	Donating a bus is beyond the scope of the project. T-shirts will be considered during the 2012 work plan and	September 30	Since Bwera increased their fees to double the original contract, additional resources may not

Requestor	Request	Response	Date	Comments
		budgeting process		be available to meet this request.
UHC board of directors	T-shirts and salary for one full time staff to support them	UHC t-shirts will be considered during the 2012 work plan and budgeting process. As soon as contract is awarded, the UHC board will be supported to hire and manage one person to support board growth.	September 30 As soon as possible	A contract for HealthPartners scale up of support for cooperative development is in the final negotiation stages.
Julius and Lydia	HealthPartners shirts.	T-shirts in the correct sizes have been ordered and sent	June 14	

Outcome of Criterion Referenced Instruction (CRI) training trainers for measurable results: Average score on the pretest was 8.6/11 while average score on the post test was 10.9/11. Overall training went very well and staff showed strong improvement in understanding concepts of training trainers. Some staff were able to go beyond the training in terms of applying lessons and concepts to overcome challenges that they have in implementation. Several team members expressed appreciation for skills acquired and one person commented near the end of the course that he was already applying the lessons that he had learned from this course in his life. One person included in the training did not possess the pre-requisite skills and four people did not have time to complete the course. **Lessons learned:** adjust pre-test to ensure performance on it reflects pre-requisite skills. Reduce distractions. Reinforce lessons learned for the team by sending reminders and increasing expectations for submission of activity agendas that include behavioral objectives and requiring reports that quantify outcomes with post-test results.

Outcome of photo training: prior to photo capacity building all project photos taken by team members were documentary. Staff learned to craft a photo: identifying the intention or goal for the photo, practiced communicating with subjects and practiced taking photos for reports and promotional materials that convey a strategic message to the intended audience. Team members showed tremendous growth by the final day when each shared his/her photo presentation reflecting individual roles within the project.

Accomplishments: The UHC/MCP rigorous implementation schedule is producing strong results. Both the Uganda Mission and MOH expressed interest in the potential for scale up of the UHC model to overcome national challenges and to support national health priorities.

The VHT launch in Rubirizi district was a celebration of improved health attended by all levels of district leaders, health workers, VHT, community members, press, the national VHT coordinator and the Assistant Commissioner, Health Promotion and Education from the MOH. The event was preceded the night before by a radio show featuring HealthPartners Uganda staff and representatives from the District and MOH. Speeches on the day of the launch included sharing data on health statistics that showed marked improvement since the initial training of VHT in 2009. The MOH expressed appreciation for HealthPartners Uganda's commitment to follow MOH policy exactly using MOH resources. HealthPartners application of the sustainability framework strategy was also acknowledged by the MOH as a promising approach that is leading to increased impact.

Stalls enabled VHT to show off their skills to MOH and other officials. One stall highlighted the use of new VHT registers—data collection tools that help VHT track where preventive health measures can have the greatest impact and that allow the MOH to track health practices and outcomes at the national level to prioritize their services and interventions. New registers are bulky to carry but intuitive to fill and reproduced in the local language which is critical for VHT to have the intended impact. One stall highlighted Village Savings and Loan Associations (VSLAs.) Members explained how VSLAs work; how they build VHT skills to save money, work together, hold one another accountable and how this supports them to have more time and more effective skills to increase healthy practices in their villages. One stall was dedicated to demonstrating preparation of PUR for safe water, erecting hand washing stations, how to properly hang long lasting insecticide treated bednets and who is the priority for sleeping under them. The celebration included singing, dancing and a drama show to promote healthy practices and treatment seeking behavior in pregnancy.

Challenges: Uganda Mission and Ministry of Health officials' schedules are very full rendering support supervision visits less frequent than the quarterly ideal. The project team will continue to share reports and invitations for these officials to join events and all requests from the Mission and MOH will be prioritized to ensure program support of national priorities.

The delay in the USAID Cooperative Development award for a five year Collaborations project has taken a toll on partnerships and motivation. HealthPartners applied for funding to scale up expansion of community based health insurance initially scheduled to begin June 2010. This project was to be a transition for HealthPartners Uganda Child Survival program staff and a transition to 100% leadership of UHC by the UHC board of directors. HealthPartners was awarded the grant in August 2010 but the Uganda Mission did not provide the necessary concurrence because they were not familiar with HealthPartners Uganda and UHC. Initiating a dialogue and conducting a site visit in November with the Mission led to a revised proposal that was approved by both USAID Uganda and USAID Washington; the contract for this project is being negotiated.

HealthPartners Uganda Child Survival staff have been out of work since October 2010. While UHC was always an initiative supported by the UHC/MCP project unfortunately, a rumor spread that HealthPartners stopped support for UHC. As a result, approximately 300 UHC members dropped coverage and the UHC/MCP team needed to visit partners to correct misinformation. In meeting the UHC board during this site visit, apologies were provided for the confusion that they experienced as a result of the transition. In reality, the UHC/MCP project scaled up support of UHC initiatives in 2011 and will continue to provide capacity building and support to close gaps in stakeholder fulfillment of roles and responsibilities and to support expansion of UHC membership in 2012. The UHC board shared some frustration, requesting more time for support from their current UHC/MCP contact. Allocation of one full time support person was also requested. This request will be filled by the Collaborations project.

The UHC/MCP team is composed of capable, dynamic personalities with differing, complementary skills. Teamwork is strong but lacking leadership to set a positive example and hold staff accountable. The following instances of corruption were identified: use of project vehicles and fuel for personal transport, false reporting of distances traveled and locations traveled to, false reporting of attendance at events with submission of forged signatures, false reporting of petty cash purchases, and failure to take responsibility for ending corruption. A laptop computer and flash drives were reportedly but not actually collected from Child Survival staff at the end of that project.

Advanced planning and coordination with partners needs improvement. The drama show on danger signs in pregnancy is strong however the drama show script for malaria prevention included sub context of gender bias and unhealthy family practices. Staff understanding of the UHC model also needs improvement. Critical UHC concepts and differentiating factors are not well known and need to be able to be shared by all staff using common talking points. There continues to be confusion between HealthPartners Uganda and the Uganda Health Cooperative.

Lessons learned: Staff struggle with long emails—keep to bullet points.

Annex 1: Ways Forward

Action Item	Person Responsible	Date Due/Done

Clearly define and communicate that all project work and resources are HealthPartners Uganda. The key partner organization is the Uganda Health Cooperative. To support this change, notify the Uganda Mission and Ministry of Health and register HealthPartners Uganda as an Non-Governmental Organization within Uganda.	Jen	April 28 June 15
Designate 3rd week of every month to UHC activities with full staff support for the entire week	Owe	May 16
Send concept paper to Dr. Lukwago (Annex 3)	Jen	May 17
Give employee manual and CRI Complete to Apollo, UHC Board Chair	Herbert	May 20
Complete Financial Accountability Manual (FAM)	Lydia/Jen	May 20
• Orient staff on FAM • Build staff capacity to follow FAM • ENFORCE FAM	Owe/Lydia	May 20
Follow up action on breech of policy: issued warning	Jen	May 20
Operational plan for May/June to include: • West Ankole Diocese UHC activities • UHC board activities—support supervisions • CRI completion and UHC Stakeholder Manual training for all staff • Health worker support supervisions per UHC/MCP work plan • District quarterly meetings	Maale	May 20
Send continued education course requests: • Leadership-Owe • M&E, representing data graphically-Pascal	 Owe Pascal	June 1
Dr. Paul, MOH, site visit to HealthPartners	Jen	June 10
Conduct field guide study to assess radio jingle impact and collect VHT feedback on knowledge and promotion of UHC.	Pascal	June 13
Revise drama show, video tape and collect feedback to determine impact	Jen/ Mudashir	May 2/ June 30
Collect Dr. James' computer. Reallocate to Pascal or Herbert	Owe	June 13
Send Dr. Grace Namaganda blank template of HealthPartners Uganda Monthly Financial Tracking Tool for Capacity Project	Jen	June 13
Send adhesive for posters, 2 HealthPartners shirts for staff, return Lydia's book	Jen	June 14
Use monitoring results to develop a new Behavior Change Communication plan using new photos.	Pascal/Jen/Owe HealthPartners Marketing staff	July 30

Annex E: Summary of VLSA Performance 2011

Member satisfaction	**Aggregate**	**%**	**Average**
Total number of current members	**153**		
Total number of men	**54**	**35%**	
Total number of women	**99**	**65%**	
Total number of Associations	**6**		
Average association membership			**25.5**
Membership growth rate		**22%**	
Attendance rate		**100%**	
Dropout rate	**3**	**1.9%**	**0.5**
Total number of people assisted by the programme	**153**		
Financial performance (Association level)	**Aggregate**	**%**	**Average**
Composition of assets, liabilities and equity			
Assets	**9,511,650**		**1,585,275**
Liabilities	**0**	**0%**	**0**
Member equity	**9,511,650**	**100%**	**1,585,275**
Savings			
Cumul. value of savings this cycle	**6,346,500**		
Average member savings to date			**41,480**
Profit/Loss this cycle	**2,764,650**	**43.6%**	**460,775**
Average member investment			**62,168**
Loans			
Cumul. value of loans this cycle	**6,207,200**		**1,034,533**
Cumul. N° of loans this cycle	**118**		**19.7**
N° of loans outstanding ☐	**81**		**13.5**
Average loan size this cycle			**52,603**
Value of loans outstanding	**7,817,550**		**1,302,925**
Average outstanding loan size per borrower			**96,513**
Average loans outstanding per Association			**1,302,925**
Loan principal repaid to date	**-1,610,350**		**-268,392**
Current yield			
Average profit per member to date		**43.6%**	**18,070**
Annualised average profit per member			**22,654**
Annualised return on savings		**55%**	
Portfolio quality			
Value of loans past due ☐	**65,000**		**10,833**
Portfolio at risk ☐		**0.8%**	
Write-off ratio (archived Associations)		**N/A**	
Risk coverage ratio ☐		**4253%**	
Operating efficiency (Association level)	**Aggregate**	**%**	
% of members with loans outstanding		**53%**	
Loan fund utilisation rate ☐		**86%**	