

# Midterm Evaluation for CONNECT Girls Center Activity

## Final Report

Submitted to



Submitted by



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## Acronyms

CDO	Community Development Officer
CGC	Connect Girls' Center
CHI	Cooperative Health Insurance
CDP	Cooperative Development Program
COVID 19	Corona Virus Infectious Disease
CPPT	Cooperative Performance Tracking Tool
DCO	District Commercial Officer
FGDs	Focus Group Discussion
HF	Health Facility
HPU	HealthPartners Uganda
KII	Key Informant Interview
KPC	Knowledge, Perception and Coverage
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MTIC	Ministry of Trade Industry and Cooperatives
PDR	Performance Data Review.
SACCO	Saving and Credit Cooperatives
SD	Standard Deviation
SoP	Standard Operational Procedures.
SQIS	Self-Regulatory Quality Improvement System
UCMB	Uganda Catholic Medical Bureau
UHF	Uganda Health Federation
UPMB	Uganda Protestant Medical Bureau
USAID	United States Agency for International Development.

## **Executive Summary**

### **Introduction**

Community access to reliable health care is desirable, although this most often comes with costs which the majority of people; especially girls and boys, young people can hardly afford. To overcome this problem, CONNECT Girls Center is training care providers to manage health cooperative businesses while increasing access to design strategies and solutions for international development partners. This is done by use of the Cooperative Health Insurance (CHI) as one of the easiest ways to provide access to medical care. The Cooperative Health Insurance model empowers members to collectively negotiate with health care insurance providers and the members are able to access health care at affordable costs. At the time of evaluation, a total of 115 health facilities were found to have been oriented on the cooperative health insurance scheme. There are 31 health facilities in the south western region, 36 in the northern, 35 in the eastern and 13 in the central trained to provide health cooperative insurance in Uganda. The findings revealed that the majority of the members, 94%, accessed health services before they subscribed to health cooperative insurance. HealthPartners Uganda commissioned Soland Associated Consults Limited to conduct a Mid-Term Review (MTR) study to evaluate the CHI model, pioneered and implemented by HealthPartners in Uganda under its five years Connect Girls Center project. The MTR aimed to assess the programs' design, scope, implementation status and capacity to achieve the expected outcomes.

### **Methodology**

The MTR employed quantitative and qualitative methods of data collection in addition to the desk review of relevant documents. Primary data collection was conducted in the southwestern (Mbarara, Bushenyi/Buhweju, Ibanda, Isingiro, Rukiga and Rukungiri), eastern (Sironko and Soroti) and northern (Oyam and Alebtong) regions of Uganda. A knowledge, perception and coverage (KPC) survey that targeted the members and non-members of cooperative health insurance, aged 18 years and above was conducted. A total of 448 out of 532 people responded to the survey. A total of 37 key informant interviews (KII) were conducted with national stakeholders (Ministry of Health, Ministry of Trade), CONNECT Girl Center staff, health facility (HF) and district technical staff. In addition, nine focus group discussions (FGDs) were held with children 15-18 years and adult women and men, both members and non-members of cooperative health insurance.

Mobile data collection was adopted for the KPC survey using the Kobotoolbox platform while for KIIs and FGDs, the discussions were audio recorded and notes taken. Descriptive statistics was generated for survey data while contextual analysis was the core for qualitative data.

### **Findings**

To improve the capacity of health care providers to offer cooperative health insurance services, 267 private care provider<sup>1</sup> staff were trained and mentored by HPU on how to manage cooperative health insurance and how to attract members. The trainings targeted health facility staff and

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<sup>1</sup> MoH Partnership Report, page 6.

governing boards. HPU conducted 17 support supervision visits to the health facilities<sup>2</sup> to further provide on-site mentorships to enable care providers to learn how to sustainably manage cooperative health insurance. The visits provided the health care providers with an opportunity for continuous monitoring and mentorship on aspects such as data capture and general management of the health cooperatives. The findings of the study established that the capacity building interventions supported the health facilities to improve the quality services delivered using the cooperative health insurance model and increased the numbers of clients accessing services at the respective health facilities.

The findings of the evaluation also revealed that HPU trained 115 health facilities to operate the cooperative health insurance across the country. The literature review established that at the time of the evaluation, there are 68 health facilities offering cooperative health insurance services.

The findings also revealed that cooperative health insurance increased provider cost recovery. In Mbarara, for instance, the Coordinator, Ankole Archdiocesan said that there was a noticeable surplus registered during that year of implementation. In Kakoma HC III, one staff mentioned that when people pay in time, it enabled the facility to procure the medicines in time. It also helps to project appropriate estimation of the quantity of medical supplies that will be required during that quarter. The Medical Director, Villa Maria, also reported that to a large extent the premium collected from community health insurance members enabled the hospital to recover all costs used to purchase medicines and other medical supplies.

The MTR established that HPU improved the capacity of health cooperative providers to make operational decisions. Among the operational decisions cited included the day to day implementation of the health cooperative model at the health facilities, stocking of medicines in the pharmacy, conducting outreaches, increasing staffing among others. At Bishop Ceasar of Asili hospital, for instance the in-charge said that the sales from the medicines increased significantly although he did not disclose details since this information was considered confidential. The increment was majorly attributed to the cooperative health insurance model. The management of medicines at the hospital also improved because there was regular inventory of drugs to reduce on stock outs due to the increased number of patients accessing services and the timely payment of the premiums by the cooperative members.

When the cooperative health members were asked to rate the quality of services offered, the majority, 67%, mentioned the services are good and only 2% reported that the services were very poor. The members were also asked if they were satisfied with the services that are offered and the majority, 39%, mentioned that they were satisfied with the services and only 2% were not satisfied with the services.

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<sup>1</sup>MoH Partnership Report, page 4.

**Overall, the cooperative care providers and their members are satisfied with the services and technical support provided by HPU.** The findings of KIIs with the cooperative health focal persons, facility in-charges from the 18 health facilities and community members, established that HPU conducted routine support supervision to the health facilities that deliver cooperative health insurance services. During the support supervision visits HPU provided technical guidance to the staff and addressed issues related to the management of the health cooperative model. The respondents mentioned that the timely guidance helped the health facility staff to resolve health cooperative management challenges. HPU also facilitated learning exchange visits amongst the cooperative health service providers. The exchange visits amongst the health cooperative facilities enabled the services providers to share knowledge, learn from each other, share lessons and best practices and to have them replicated in their respective health facilities.

HPU provided technical support to the health cooperative through capacity building to improve the legal and regulatory framework for cooperatives. The findings revealed that HPU built the capacity of the health cooperatives to register with the Ministry of Trade, Industry and Cooperatives (MTIC.) The support aimed at supporting the health cooperatives to have proper governance and management structures.

HPU also engaged the MTIC to ensure regulatory conducive environment for the cooperative health insurance scheme. Out of the five health cooperatives two are registered as Uganda Health Cooperative and Mt. Elgon Health Cooperative.

The mid-term evaluation revealed gaps in the areas of collaboration and networking with the District Local Government technical persons. Apparently, in all the 13 districts the MTR team visited, the technical persons that is; the District Health Officers, District Commercial Officers and Community Development Officers did not know about the role of health cooperatives in their respective districts. It was only in Alebtong and Oyam districts where the technical persons seemed to be aware of the activities of the health cooperatives. Generally, in those districts, the role of the health cooperatives was associated with the work done by Abt. Associates and not HPU.

The findings revealed that the majority of the members, 94%, accessed health services before they subscribed to health cooperative insurance. At least nine in 10 members that participated, 91% in the survey, reported that they received better services with insurance and paid less than 85% in costs compared to before they enrolled in health insurance.

The average difference in health seeking behavior for the cooperative members was 94% and 83% for non-members. This means that the cooperative members are more likely to seek for medical care compared to non-cooperative members.

Over all, the median age at first intercourse for health cooperative members was 19.6 years and 18.9 years for the non- members. The findings at the baseline showed that the median age at first intercourse for cooperative members was 18.5 years and 17.7 for the non-members.

The MTR revealed that there was a slight difference between the health cooperative members and non-members in terms of the days taken to seek medical advice on the on-set of symptoms of illness or sickness. The findings indicated that 41% of the members sought treatment the same day while 37% of the non-members also sought treatment on the first day. Those who sought treatment after one day were 20% and 21% for members and non-members respectively.

The findings established that 94% of the cooperative members and 84% of the non-members of the health cooperatives sought medical care from health facilities. The non-health cooperative members are likely to pay three times more for medical care than cooperative insurance members evidenced by reported spending at 201,308 UGX and 65,761 UGX respectively. The baseline value of the health care spending indicator is 77% for the cooperative insurance members and 51% for non-members.

The average annual health care expenditure made in form of premiums, copays and others was UGX 116,974 (32 dollars) amongst the members. The percentage difference between the average annual health care expenditure for members and non-members was 9.2%. The expenditure for members (premium, copay & out of pocket) was UGX 182,735 and the expenditure for non-members amounted to 201,308 UGX. The percentage difference between cooperative and non-cooperative members was 11% and 89% for non-members respectively at baseline.

### **Recommendations/Lessons:**

There is need for HealthPartners to improve the quality of relationships and partnerships with stakeholders at the implementation level especially District Local Governments, the tentacles of Government regulation, inspection and technical guidance. Training programs should demonstratively mentor documentation and engage staff to improve the quality of reports and the data collected by health facilities.

To increase coverage and improve cost recovery, HealthPartners should support care providers to develop and implement outreach plans to promote enrollment in cooperative health insurance.

To ensure sustainability, HPU should conduct more training on savings in order to aid the health insurance renewal rate. Saving Initiatives or cooperative investments could be explored as viable alternatives.

As an unanticipated positive consequence, the cooperative health insurance scheme has created a platform for building social cohesion and mobilization for savings initiatives which will likely improve accessibility to micro-credit to members. All HPU can do is to link these groups to other partners providing services so that they are supported to kick-start saving initiatives. This will eventually facilitate engagement in income generating activities which will enable members to pay their premiums and improve livelihoods.

## **Conclusion**

The health insurance scheme benefits are justified by the fact that 23.7% non-member health cooperative households compared to 9.5% health cooperative member households are likely to sell property in order to access health services in the event of sickness. Moreover, annual average health expenditure for cooperative members is much lower at UGX 88,667= compared to UGX 140,000= for non-members. The number of cooperative health insurance members seeking health care in the form of antenatal care (ANC) is higher than that of the non-members. This indicates that cost influences the health seeking behavior of both members and non-members. Cooperative Health Insurance therefore enables members to access quality health care affordably.

## **1.0 INTRODUCTION**

Soland Associated Consults Limited was contracted by HealthPartners to conduct the mid-term evaluation for the CONNECT Girls Center activity. As a deliverable, an inception report was prepared indicating in detail the evaluators' understanding of the evaluation exercise and how the evaluation questions were addressed. Specifically, it included the evaluation matrix summarizing the evaluation design, methodology, evaluation questions, data sources and collection analysis tools as well as the timelines.

### **1.1 Background**

The Cooperative Development Program (CDP) is a global initiative that strengthens cooperative businesses and credit unions across multiple sectors throughout Africa, Asia, and Latin America. The program partners with U.S.-based cooperatives and Cooperative Development Organizations for five-year activities. The purpose of the program is to foster sustainable cooperative systems that deliver value to cooperative members and their communities. This is accomplished by improving cooperative business performance, creating environments where cooperatives can thrive, and enhancing the development community's support to cooperatives.

At USAID, the project purpose for the CDP is to foster sustainable cooperative systems that deliver value to their members and contribute to the economic and social development of communities. The CDP theory of change anticipates that if cooperative performance is improved, if the enabling environment is improved to support cooperatives with access to key resources and appropriate legal frameworks and services, and if donor funded cooperative programs are improved through collaboration and learning, then cooperative systems, members, and communities will work to address the root causes of poverty and instability through increased social and economic value. In August 2018, the program awarded funding to Cooperative Development Organizations. CONNECT

Girls Center is a five-year project (2018-2023) that aims to improve cooperative business performance and strengthen the enabling environment under local leadership in order to increase health care access and quality for improved health outcomes and community resilience. CONNECT Girls Center expects to achieve its intended goal through three objectives defined as:

1. Improved cooperative business performance.
2. Improved cooperative enabling environment.
3. Development community's support to cooperatives.

The project is delivered through two primary interventions namely the cooperative training and technical assistance and connecting girls to cooperatives and cross sector networks. The Cooperative training approach and technical assistance intervention enhances the capacity of the informal sector to demand and access quality health care by training trainers and care providers to manage cooperative health insurance and to strengthen the sustainability and governance of new and existing cooperatives. Cooperative Girls Centers link health care to life skills, economic empowerment and leadership capacity strengthening with the ultimate goal of expanding membership and adding value for members and their communities with a focus on youth age 10-24.

### **Purpose and scope of the mid- term evaluation**

HPU commissioned a mid-term evaluation that aimed to understand progress towards achieving project objectives and outcomes, draw lessons for learning, increase the rate of sustainable change during the remaining project implementation period. The study also assessed the programs' design, scope, implementation status, the capacity to achieve expected outcomes, performance of the program against planned results and the preliminary indications of potential impact and sustainability of results. The MTR focused on implementation period August 14, 2018 -December 31, 2020.

### **1.4 Evaluation questions**

The mid-term evaluation was informed and guided by the following questions:

- i. To what extent has HPU supported health facilities to offer cooperative health insurance?
- ii. To what extent has HPU increased the number of health providers offering cooperative insurance?
- iii. To what extent is health cooperative insurance increasing provider cost recovery?
- iv. To what extent has HPU improved the capacity of cooperative care providers to make operational decisions?
- v. To what extent are members satisfied with benefits they are receiving through cooperative health insurance?
- vi. To what extent are cooperative care providers and their members satisfied with the services and technical support provided by HealthPartners? What factors contributed to satisfaction, and why?

- vii. To what extent has adoption of preventive behaviors (LLINs, hand washing, nutrition) and health-seeking behavior among girls age 10-24 improved? What activities have most facilitated that?
- viii. To what extent has HPU improved the legal and regulatory framework for cooperatives?
- ix. Has HPU improved the capacity of cooperatives to meet national regulatory requirements?
- x. How successful has HPU been in linking MTIC to support health cooperatives in terms of registering cooperatives
- xi. In what ways has HPU contributed to the improved collaboration between implementing partners?
- xii. What factors have constrained implementation? How are constraints being addressed?

To address the above questions, the evaluation team detailed a matrix and thereafter developed the indicators for each question, the data collection method, and determined the source of the data. The findings were organized around each of the evaluation questions.

## 2.0 APPROACH AND METHODOLOGY

### 2.1 Overall Approach

The mid-term evaluation team used a combination of data collection methods. These included: 1) a review of secondary data sources, 2) KIIs with health cooperatives, health provider facilities offering cooperative insurance, Uganda Catholic Medical Bureau (UCMB), Uganda Healthcare Federation (UHF) Uganda Protestant Medical Bureau (UPMB), Abt. Associates, central and local government officials and Technical Advisor Steering Committee (TASC) members from the Ministry of Health (MoH), Ministry of Gender, Labour and Social Development (MoGLSD), MTIC, District health and commercial officers, Development partners that include United States Agency for International Development (USAID), Cooperative Girls Center members age 15-24, and HPU staff. Quantitative and qualitative data were collected in addition to document what was done to review and evaluate project implementation and performance.

### 2.2 Selection of Sample Districts

The mid-term evaluation was conducted in 13 implementation districts. They include; Alebtong and Oyam in the northern region, Bushenyi, Ibanda, Isingiro, Mbarara, Rukiga and Rukungiri in the south western region, Kalungu, Luweero and Wakiso in the central region, Sironko and Soroti in the eastern region. Table 1 details the sampled districts.

**Table 1. List of health facilities and health cooperatives assessed**

Region	District	Health Facility/Cooperative
Western region	Rukungiri	Kadoth Clinic
	Rukiga	Kitanga HC III
		Ankole Diocese Health cooperative (ADHC)
	Mbarara	Ruharo Mission Hospital
	Ibanda	Ibanda Mission Hospital
		West Ankole Health cooperative (WADHC)
<b>South Western Region</b>		
	Bushenyi	Katungu Mission health center
		Archdiocese of Mbarara Health cooperative (ADMHC)
	Isingiro	Kakoma Health Center III
Eastern Region	Soroti	
		Bethesda Hospital

		Elgon Community Health Cooperative
	Sironko	Divine health center
<b>Central Region</b>	Luwero	Bishop Asili Hospital
	Kalungu	Villa Maria hospital
	Wakiso	St. Francis of Asisi Naddangira HC
<b>Northern Region</b>	Alebtong	Alleluyah Joint Maternity Clinic
	Oyam	Aero Medical Clinic

**2.3 Data Sources and Methods of Data Collection**

The midterm evaluation adopted a mixed methods approach to data collection. This was in line with the objectives and evaluation questions highlighted in the evaluation matrix. A participatory and consultative approach was adopted and ensured that all stakeholders are involved including HPU staff and stakeholders at various levels of implementation and the development partners.

Data for the mid-term evaluation were drawn from both secondary and primary data sources. The data collection methods included a desk review of relevant documents such as records and KIIs at health cooperative provider facilities listed in Table 1, and consultative meetings with selected stakeholders, survey with individual members and non-members of cooperatives (KPC) and facilitated group discussions with selected members of the community. The next sub-sections discuss the data sources and data collection methods in detail.

**2.3.1 Document review**

Document review was performed to gain a deeper understanding of the project including the project theory of change, to gather secondary data from various sources, and to identify milestones and challenges.

The evaluation team reviewed and compiled information from documents or records available with cooperatives and implementing health provider facilities. These included; the Cooperative Performance Tracking Tools (CPTTs) available with cooperatives, and provider treatment records, reports submitted by the Cooperative Coordinators and partners, studies done in the health sector to provide information related to the project outcomes e.g. Uganda Demographic Health Survey (UDHS), health management information system (HMIS), and nutrition data from the cooperative Girls Center assessment reports. Other documents reviewed included the partnership report that was submitted to MoH, Connect Girls Center

baseline survey report, HealthPartners CONNECT Girls Center Monitoring, Evaluation and Learning Plan (MELP) and annual progress reports. The evaluation team reviewed and compiled information from documented the records of the cooperatives and health provider facilities which included CPTT forms and membership lists, among other documents.

### 2.3.2 Key Informant interviews

A total of 37 KIIs were conducted, three with informants from the national-level institutions: MoH, MTIC, UHF, 31 district technical staff, cooperative/group leaders and health facilities and three HPU staff. The data from the KIIs was used to validate information obtained from the KPC data and to provide deeper insight into the extent to which the cooperatives complied with the regulatory framework, the challenges encountered by the healthcare providers and the changes brought about by the project. (A list of informants is presented in the annex 4).

### 2.3.3 Focus group discussions

FGDs comprising of not more than five participants were conducted with selected members of the community and the Girls Centers committees. The FGDs aimed to assess the participants' perception about the different components of the project including its contribution, challenges and areas that needed to be improved. The participants were purposively selected in consultation with the leadership of the different health cooperatives, health facility providers and community leaders. Each FGD was facilitated by a moderator and note-taker, the proceedings were audio recorded and followed the COVID\_19 standard operating procedures. The discussions were conducted in the local language. A total of nine FGDs were conducted, each with five participants, from Isingiro, Mbarara, and Sironko as detailed in Table 2., The MTR was designed for 16 FGDs, but during data collection it was observed that some could not be conducted because of the inactive membership at time of data collection. The table details the number of FGDs achieved.

**Table: 2. Number of FGDs conducted**

Category	Number of FGDs
Girls Center Committee members, Isingiro	1
Boys and girls 15-18years in Isingiro District	1
Women 25-49 years, non- health insurance members, Mbarara	1
Men non- health insurance members, Mbarara	1
Men, coop/health insurance members, Mbarara	1
Females aged 25-49 years cooperative members, Sironko	1
Females aged 25-49 years, non -cooperative members, Sironko	1
Males aged 25-54 years, cooperative members, Sironko	1

### 2.3.4 Knowledge, Perception and Coverage Survey

The KPC survey aimed to gather data related to health services seeking behavior, satisfaction of members with the benefits got at the health facility, and satisfaction with the services of the health facilities and HPU. The respondents of the KPC survey tool were adult members and non-members of health cooperatives between 18 to 24 years and those above 25 years in the selected districts.

The sampling design adopted the Lot Quality Assurance Sampling method that required at least 19 respondents of a given category in one cluster to facilitate comparison of members and non-members of health insurance cooperatives. The table below shows the number of KPC interviews conducted by district and type of respondent.

**Table 3: KPC interviews**

District.	Member Status		Total
	Health Cooperative member	Non-member health insurance/cooperative	
Alebtong	21	18	39
Bushenyi	<b>18</b>	<b>22</b>	<b>40</b>
Ibanda	20	15	35
Isingiro	21	17	38
Kalungu	19	18	37
Luwero	18	19	37
Mbarara	<b>19</b>	<b>19</b>	<b>38</b>
Oyam	17	26	43
Rukiga	16	25	41
Rukungiri	0	19	12
Sironko	15	18	33
Soroti	14	20	34
Wakiso	20	17	37
<b>Total</b>	<b>218</b>	<b>253</b>	<b>464</b>

The response rate was 84%, out of the 532 target responses, a total of 448 responses were obtained from the KPC study. Of these 213 (48%) were for members of health insurance/cooperatives (42% males and 58% females) and 235 (40% males and 60% females) were non-members. A total of 73 respondents (16 %) were aged 18-24 years and 375 (84 %) were aged 25 years and above.

### 2.4 Data collection tools

The evaluation team used nine broad types of tools to gather information attached in in annexes two and three. The tools were translated into the local languages Runyankole, Langi, Luganda and Atesot to ensure that the respondents understood the questions. The tools

were administered while adhering to the COVID-19 standard operating procedures. The data collection tools include KII guides, FGDs, KPC and health facility assessments. The guides were tailored to different informants at different levels of participation in the planning and implementation of the cooperative health insurance scheme.

- FGD guides for the various categories of participants detailed in table 2
- KPC survey for members and non-members of health cooperatives
- Health cooperative provider facility assessment tools

## **2.5 Data processing**

The evaluation team used different methods of data capture and analysis in line with the methods of data collection. For the quantitative data, descriptive statistics was used to generate the information while for the qualitative data, themes and patterns were developed to address the evaluation questions. Information from the primary data sources were triangulated with the findings from the desk review.

### **2.5.1 Quantitative data**

**Data Coding:** Field coding was minimized given that most questions were closed. For the open-ended questions, the interviewer entered the verbatim which was coded to numerical values.

**Data capture:** Data was captured using Kobo Toolbox collect on tablets/ smart phones. Data was uploaded onto the main server daily to avoid data loss. The data analyst downloaded the uploaded data for storage and checks. In addition, data compiled from records of health facilities and HMIS was captured in MS Excel.

**Data analysis:** The collected data for this study was analyzed using the Statistical Package for Social Scientists (SPSS) computer software, version 22. MS Excel software was also used for drawing interactive graphs. Descriptive statistics was generated and relevant comparisons were made between the different groups of informants in consonance with the objectives of the study.

### **2.5.2 Qualitative data**

The team used contextual analysis as the core analytical framework for qualitative data. The process involved analyzing documents, KIIs, group discussions and focus groups notes to identify emerging common trends, themes and patterns for each objective. Content analysis was also used to highlight diverging views and opposing trends.

## **2.5 Limitation of the study.**

The mid-term evaluation was affected by the incomplete and sometimes inaccurate data from CPTTs. This proved a challenge and in many instances the evaluation team held back and forth discussions in order to verify the data.

### **3.0 Findings:**

The Midterm review was guided by a number of evaluation questions already stated above in section 1.4. These focused on the different aspects and result areas of the project. The next sections within this chapter presents the findings of the MTR. The sections, highlight the status of the different indicators as per the evaluation question that guided the mid-term evaluation.

#### **3.1 Status of indicators as per the evaluation questions**

##### **1. To what extent has HPU supported health facilities to offer cooperative health insurance?**

*The extent to which HPU supported health facilities to offer cooperative health insurance.*

HPU built the capacity of health facilities that offer cooperative health insurance during trainings and mentorship sessions on the operations of the cooperative health insurance model. The trainings targeted health facility staff and governing boards.

HPU conducted 17 support supervision visits to the health facilities<sup>3</sup>. The visits provided the health cooperative workers with an opportunity for continuous monitoring and mentorship on aspects such as data capture and general management of the health cooperatives. The findings further established that the capacity building interventions supported the health facilities to improve the quality services delivered using the cooperative health insurance model and increased the number of clients accessing services at the respective health facilities.

The findings from the FGDs established that the HPU built the capacity of the health facility staff on data collection, interpretation, and utilization to guide reporting and decision making. This was evidenced when a respondent from Villa Maria Hospital said “HealthPartners trained and oriented staff on cooperative health insurance management, how to complete CPTT forms

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<sup>3</sup>MoH Partnership Report, page 4.

*and interpret data during the monthly review meetings*". Similar responses were obtained from 16<sup>4</sup> other health facilities the evaluation team visited.

This was further evidenced by the responses from the proprietor Aero Medical Centre, in Oyam District who mentioned that the learning exchange visit that was conducted to Bishop Asili Hospital exposed him to the health cooperative health insurance model, its operation and management. The knowledge he got made him appreciate the model and internalize the best practices. The focal person of cooperative health insurance at Bishop Asili Hospital also said "HPU facilitated online performance data review (PDR) trainings that led to improved implementation of the model and data utilization at his health facility.

When the cooperative and non-cooperative health insurance members were asked about their opinion on the quality of services obtained at the health facilities in the last two years, during the KPC, the majority, 78%, reported that the services are better, while 19% reported that they remained the same and only 2% were not able to tell a difference in the services. The findings affirmed that, to an extent, the improvement in the quality of services at the cooperative health facilities was attributable to the capacity building interventions provided by HPU.

The Desk Officer, Cooperative health insurance at the MITC, in an interview mentioned that HPU pioneered the registration of health cooperatives in Uganda. It was established that out of the ten registered cooperatives in the database five of them were registered much earlier. Despite the limited implementation period, a lot was done to market the concept of health cooperatives in different parts of the country.

## **2. To what extent has HPU increased the number of health providers offering cooperative insurance?**

The findings of the evaluation established that HPU accepted applications and trained 115 health facilities to manage cooperative health insurance across the country. The literature review established that, at the time of the evaluation, there were 68 health facilities offering cooperative health insurance and reporting consistently.

In 2019, there were 27 health facilities (two in the North, 24 in the South Western and one in central region) offering cooperative health insurance services. During 2020, an additional 41 facilities (four in the North, two in the East, 30 in the Southwestern and five in Central region)

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<sup>4</sup>Kadoth Clinic, Kitanga HC III, Ankole Diocese Health cooperative (ADHC), Ruharo Mission Hospital, West Ankole Health cooperative (WADHC), Katungu Mission HC III, Archdiocese of Mbarara Health cooperative (ADMHC), Kakoma Health Center III, Bethesda Hospital, Elgon Community Health Cooperative, Divine HC II, Bishop Asili Hospital, Villa Maria hospital, St. Francis of Asisi Naddangira HC III, Alleluyah Joint Maternity Clinic, Aero Medical Clinic

were trained to offer health insurance services. This reflected a increase in the number of health facilities offering cooperative health insurance services by 60%.

However, the regional distribution of the health facilities is uneven. For instance, in the south-western region there are 51, Central six, Eastern region two and in the northern region 10 health facilities. In terms of regional distribution, the evaluation team noted that the health cooperative insurance model is more rooted in the south-western region and the eastern region has the lowest number of health providers offering cooperative health insurance. Albeit the imbalance in the regional distribution, it is valid to conclude that to a big extent, HPU increased the number of health providers offering cooperative health insurance.

### **3. To what extent is health cooperative insurance increasing provider cost recovery?**

In all the health facilities the evaluation team visited, the findings of the MTR established the cooperative health insurance increased provider cost recovery. In Mbarara, for instance, the Coordinator, Ankole Archdiocesan said that there was a noticeable surplus registered during that year of implementation. In Kakoma Health Center III, one staff mentioned that when people pay in time, it enables the facility to purchase the medicine in time. It also helps to project appropriate estimation of the quantity of medical supplies that will be required during that quarter. The Medical Director, Villa Maria, also reported that to a large extent the premium collected from CHI members enabled the hospital to recover all costs used to purchase medicines and other medical supplies.

It was however noted that there are some stakeholders who reported that they did not believe the cooperative health insurance increased provider cost recovery. The Cooperative Health Insurance Desk Officer at the MITC reported that “There was no cost recovery for health providers because the fees paid as co-pay and membership fees are very low. She mentioned that the health providers are likely not to provide quality services at 1,000 UGX as copay.”

### **4. To what extent has HPU improved the capacity of cooperative care providers to make operational decisions?**

The evaluation team established that operational decisions included the day-to-day implementation of the health cooperative model at the health facilities, stocking of medicines in the pharmacy, conducting outreaches, increasing staffing among others. At Bishop Asili hospital, for instance the in-charge said that the sales from the medicines increased significantly although he did not disclose details since this information was considered confidential. The increment was majorly attributed to the cooperative health insurance model. The management of medicines at the hospital also improved because there was regular inventory of drugs to reduce on stock outs due to the increased number of patients accessing services and the timely payment of the premiums by the cooperative members.

The proprietor Aero Medical Centre, in Oyam District, also mentioned that at every end of month, the staff compiled the monthly reports that are submitted to HPU. The feedback that HPU provides was used to discuss challenges affecting the implementation of the health cooperative model. Together with HPU staff, the health facilities are supported to get solutions to overcome the challenges. Consequently, data utilization helped the health providers to make informed decisions. In addition, sex disaggregated data enabled the health care providers to target potential members during outreaches. In Villa Maria Hospital, the health cooperative focal person also said that he used the cooperative health insurance data to inform outreach programs. The data showed poor health seeking behavior compared to the women. This was one example how the data was used to inform operational decisions on stock management, management of outreaches and improve staffing.

**5. To what extent are members satisfied with benefits they are receiving through cooperative health insurance?**

When the cooperative health members were asked to rate the quality of services offered, as detailed in table 4, the majority (67%) mentioned the services are good and only 2% reported that the services were very poor. The members were also asked if they were satisfied with the services that are offered. The majority (39%) mentioned that they were satisfied with the services and only 2% were not satisfied with the services.

**Table 4: level of satisfaction of cooperative health services**

Rating	Level of satisfaction for members N=203	Percentage level of satisfaction for non-members N=	Sex	
			Male = 85 %	Female = 118 %
<b>Satisfaction with the quality of services offered</b>				
Very poor	2	2	2	1
Poor	1	1	1	2
Average	16	16	17	15
Good	67	67	67	67
Excellent	15	15	14	15
<b>i) satisfaction with the management of health cooperative insurance</b>				
Very Dissatisfied	5	5	6	5
Dissatisfied	2	2	1	2
Average	21	21	24	20
Satisfied	39	39	32	44
Very Satisfied	33	33	38	30

To further appreciate the level of satisfaction with how cooperative insurance is managed, the survey focused on assessing the satisfaction level among members. The findings in table 4 shows, 39% said they are satisfied, 33% are very satisfied, 21% are average while those who are very satisfied and dissatisfied combined at 7%. The findings showed that to a great extent, the majority of the members are satisfied with the services they received at the health facilities.

**6. To what extent are cooperative care providers and their members satisfied with the services and technical support provided by HPU? What factors contributed to satisfaction, and why?**

The findings of KIIs with the cooperative health focal persons, facility in-charges from the 18 health facilities<sup>5</sup> and the community members, established that HPU conducted routine support supervision to the health facilities that deliver cooperative health services. During the support supervision visits HPU provided technical guidance to the staff and addressed issues related to the management of the health cooperative model. The respondents also mentioned that the timely guidance helped the health facility staff to resolve health cooperative management challenges. HPU also facilitated learning exchange visits amongst the cooperative health service providers. The exchange visits amongst the health cooperative facilities enabled the services providers to share knowledge, learn from each other, share lessons and best practices and to have them replicated in their respective health facilities.

HPU also built the capacity of the health care providers. At the time of the MTR a total of 90 service providers were trained in the south western region of Uganda. This was evidenced during the KIIs where 90% reported that they are satisfied with the capacity building that was provided to the health cooperatives during the mentorship and training sessions that addressed data management and reporting, the management of cooperative health insurance, and financial management of health insurance. Interviews with HPU staff also revealed that HPU is in a process of developing a virtual training package that will be offered to health cooperative providers during a series of eight sessions.

The findings from the KIIs also established that 10/13 of the service providers that participated in the MTR are satisfied with the timely feedback provided by HPU on the reports that are submitted. The health facility staff used the feedback to make informed decisions to address management and operational challenges faced during implementation.

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<sup>5</sup>Kadoth Clinic, Kitanga HC III, Ankole Diocese Health cooperative (ADHC), Ruharo Mission Hospital, West Ankole Health cooperative (WADHC), Katungu Mission HC III, Archdiocese of Mbarara Health cooperative (ADMHC), Kakoma Health Center III, Bethesda Hospital, Elgon Community Health Cooperative, Divine HC II, Bishop Asili Hospital, Villa Maria hospital, St. Francis of Asisi Naddangira HC III, Alleluyah Joint Maternity Clinic, Aero Medical Clinic

The findings also established that HPU, in collaboration with UHF, initiated the use of the Self-Regulatory Quality Improvement System (SQIS) tool at the cooperative health facilities. The tool is a comprehensive checklist with guiding questions and clear definitions focusing on 19 key quality health management standards including infrastructure and amenities, laboratory services, occupational health and safety, infection control and prevention, records, imaging and radiology, and mortuary services. SQIS is aimed at improving and standardizing the quality of health services availed to the general public through the private health sector. The findings of the KIIs with the health facility staff revealed that they used the tool to assess quality of their health facilities and services offered and also developed action plans to address the gaps identified.

The findings of the KPC further established that the cooperative health facilities made investments to improve the quality of care. Half of the participants in the KPC agreed to this and 78% of the members interviewed reported that the services provided at the cooperative health facilities are better compared to the time they visited the facilities the last 12 months. This was an indication that the support provided by HPU to the health facilities improved the quality of health care offered by health providers thus yielding good results.

Despite the improvement in the quality of services, the respondents from five out of the 13 cooperative health facilities reported that they were doing a lot of work without any additional payment. To them, the delivery of services through the cooperative health insurance model was viewed as additional work and considered a burden. They advised HPU to engage with the management of the health facilities to devise a mechanism of addressing this issue.

## **7. To what extent has HPU improved the legal and regulatory framework for cooperatives?**

HPU provided technical support through capacity building to improve the legal and regulatory framework for cooperatives. This was done during trainings to the pre-cooperatives and the existing cooperatives to ensure that they operate in conformity with the Uganda policies and regulations. HPU engaged MITC to play the pivotal role in the regulation and supervision of cooperatives aimed to increase access to quality and affordable health care.

Currently there are five health cooperatives that are registered with the MITC. It is anticipated that the conducive and supportive working relationship that HPU established with MITC will be leveraged to ensure cooperatives meet the regulatory requirements especially pre-cooperatives that have not yet registered.

The document review established that HPU organized a two-day sensitization meeting that was attended by 15 members of parliament. The meeting aimed to sensitize the participants about health cooperatives and to create an enabling environment for health cooperatives to operate in Uganda. The meeting was also attended by the district technical staff from three

districts<sup>6</sup>. It is envisaged that the lessons will be utilized by legislators to inform the National Health Insurance Scheme bill. HPU also conducted a number of support supervision and mentorship visits to the health cooperatives to improve compliance with the legal framework that governs cooperatives.

#### **8. Has HPU improved the capacity of cooperatives to meet national regulatory requirements?**

The contribution of HPU towards the cooperatives to meet national regulatory requirements is demonstrated through the capacity building to support health cooperatives to register with the MITC. HPU supported the health facilities to have proper governance and management structures. Out of the 18 cooperatives visited, the facility in-charges mentioned that HPU trained them on the need to have the health cooperatives to be registered. From the document review it was noted that HPU conducted a number of support supervision visits to 11 facilities in partnership with Abt. Associates and 43 staff were engaged to ascertain whether they had completed steps necessary to prepare them to manage the health cooperative before enrolling members. Support supervision was also conducted for six providers in the central region and aimed to guide on proper documentation, reporting and timely payment of premiums by members<sup>7</sup>. Working with the MITC, a number of activities prior to successful registration were conducted. Activities included training health care providers, training health cooperatives on the operations of the health cooperative model, training the Board of Directors in governance as well as sensitization on the legal and institutional framework for cooperatives in Uganda.

HPU, in partnership with UHF, launched implementation of SQIS among the private health providers offering cooperative health insurance. It is anticipated that the tool will be used to standardize the delivery of services in private sector health facilities to identify gaps and challenges during the delivery of services.

#### **9. How successful has HealthPartners been in linking MTIC to support health cooperatives in terms of registering cooperatives**

The Desk Officer for Cooperatives, reported that HPU engaged the MTIC to ensure a sound regulatory environment for health cooperatives. Out of the five health cooperatives, two are registered: Uganda Health Cooperative and Mt. Elgon Health Cooperative. Four of the health cooperatives are not registered because their temporary registration expired. HPU will continue to engage with the cooperatives to ensure that their registration is renewed. In addition, HPU was working with MITC to build the capacity of the health cooperatives and pre-cooperatives to engage board members and create awareness on the statutory requirements for registration of the cooperatives to fast track the registration process. HPU

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<sup>6</sup>Buhweju, Bushenyi and Mbarara

<sup>7</sup> Ministry of Health and HealthPartners Uganda Partnership Report March to June 2020

also built the capacity of health care providers on how to sustainably manage cooperative health insurance and offer quality health care.

**10. In what ways has HealthPartners contributed to the improved collaboration between implementing partners?**

To appreciate the level of collaboration and the extent to which HPU improved collaboration with the implementing partners, a collaboration matrix was developed. This matrix shows the level of collaboration between HPU and partners and not between the partners because this is not something HPU can directly influence. From the Table 6 and as per the findings, the level of collaboration between HPU and the different partners including MTIC, Abt. Associates, MoH, UHF, UCMB, UPMB, and key policy makers at the national level is high. The collaboration between HPU and Abt Associates and UHF is at a moderate level.

**Table 6: HealthPartners’ Stakeholder Collaboration Matrix**

Name of Stakeholder	Level of Collaboration ( High, Medium, Low)			Comments
District Local Governments	Low			MoUs not signed
Ministry of Trade Industries and Cooperatives.			High	Mou Signed
Abt Associates		Moderate		MoU not signed
Uganda Healthcare Federation		Moderate		MoU not signed
Uganda Catholic Medical Bureau			High	MoU signed
Uganda Protestant Medical Bureau			High	MoU signed
Private Health Facilities			High	MoU signed
MoH			High	MoU signed
Policy Makers-Parliament		Moderate		

The mid-term evaluation also revealed gaps in the area of collaboration and networking with the District Local Government technical persons. Apparently, in all the 13 districts the MTR team visited, the technical persons like the District Health Officers, District Commercial Officers and Community Development Officers did not know about the role of health cooperatives in their respective districts. It was in Alebtong and Oyam districts where the technical persons seemed to be aware of the activities of the health cooperatives. The role of the health cooperatives was associated with the work done by Abt. Associates and not HPU.

**11. What is the penetration rate of health cooperative membership in different regions in Uganda?**

At the time of evaluation, a total of 115 health facilities were oriented on the cooperative health insurance scheme as indicated in Table 7.

**Table 7. Stakeholders oriented on Cooperative Health Insurance**

Region	Health Care Provider Category			Total	Providers Offering CHI
	Private Health Provider	Uganda Catholic Medical Bureau	Uganda Protestant Medical Bureau		
Northern	33	-	3	36	6
Eastern	33	-	2	35	4
Central	3	5	5	13	6
South Western	4	13	14	31	54
<b>Total</b>	<b>73</b>	<b>18</b>	<b>24</b>	<b>115</b>	<b>68</b>

In the south western region of Uganda, the number of health facilities providing health cooperative insurance as indicated in table 7 are more than those oriented. This is majorly attributed to the fact that health providers were recruited after the formal orientation was done.

Considering the number of health care providers trained and those currently offering cooperative health insurance in table 7, it is evident that apart from the south western region, the coverage in the northern, eastern and central is very low. As already noted above, there is a regional imbalance in the distribution of health facilities offering cooperative health insurance. The Eastern region has the lowest number of health providers offering cooperative health insurance.

HPU should focus on addressing the low coverage in the northern, eastern and central regions where the health cooperative insurance model is lowest. Efforts should be made to strengthen the implementation of the model in the central and south western regions among the private healthcare providers. There is also need to engage the UCMB on the possibility of piloting the model in northern and eastern regions. Overall, there was lot of unmet need for this model. Across the different regions, there was low uptake of the health cooperative model. HPU should devise deliberate strategies on how to increase the numbers of health facilities implementing the model and also ensure that the issue of regional imbalance is fully addressed.

To further appreciate the current coverage of health cooperative insurance, the MTR established that 23% of the non-members were not aware of cooperative health insurance as shown in table 10. This calls for sensitization about health insurance in all districts of implementation.

## **12. Non-health Household Economic Benefits of Cooperative Health Insurance.**

The findings in table 7 indicate that health insurance members are more aware of the household benefits compared to non-members. Of the 203 members interviewed, access to quality health care was ranked highest (80%) as the major benefit, 74% mentioned lower cost due to shared risk, 62% mentioned that they avoided borrowing to pay for care, while those who mentioned avoiding high bills and reduced worry and stress were both at 54%. This means, HPU should focus on improving the quality of services offered at the health facilities and since health cooperative members are accessing health services at small private facilities especially in the northern and eastern regions.

**Table 7. Realized benefits of cooperative health insurance by members.**

Benefits	Total		Sex				Age Group			
			Male		Female		18-24		25 and above	
	N	%	N	%	N	%	N	%	N	%
Lower cost due to shared risk	150	74	58	68	92	78	23	77	127	73
Access to quality health care	163	80	64	75	99	84	27	90	136	79
Avoid borrowing to pay for care	126	62	45	53	81	69	19	63	107	62
Avoid unexpected possibly catastrophic bills	109	54	40	47	69	58	15	50	94	54
Ability to plan to pay premiums	55	27	12	14	43	36	11	37	44	25
Reduced worry and stress	109	54	33	39	76	64	18	60	91	53
Improved relationship with partner now that care seeking is no longer an issue	63	31	14	16	49	42	15	50	48	28
Other specify	1	0	0	0	1	1	0	0	1	1
Don't know/None	2	1	1	1	1	1	0	0	2	1
Total	203		85		118		30		173	

The findings in table 8 indicate that the majority of the members (94%) realized that it is easier to access health services now than before they subscribed to health cooperative insurance. At least nine in 10 members indicated that they received better services (91%) with insurance and they paid less (85%) compared to before they enrolled in health insurance.

**Table 8: Other benefits by members**

	Number	Percent (%)
<b>Based on your experience, does being a member of a health cooperative make it easier, more difficult or the same in accessing health services?</b>		
Much easier	190	94
The same	12	6
More difficult	1	0
<b>Total</b>	<b>203</b>	<b>100</b>
<b>In your opinion, do you get a better service or not from a health facility if you are a member of a health cooperative compared to a non-member?</b>		
Better	185	91

Same	17	8
Worse	1	0
<b>Total</b>	<b>203</b>	<b>100</b>
<b>In your opinion, do health cooperative members pay less, the same or more than non-members?</b>		
Less	172	85
Same	14	7
More	3	1
Don't Know	14	7
<b>Total</b>	<b>203</b>	<b>100</b>

The findings further revealed that 93% of the health insurance members reported that they recommended to their neighbors and friends to enroll for health cooperative insurance having realized or experienced the benefits.

From the above findings and testimonies, it is evident that health cooperatives provided a number of household benefits to members. One community member, just like several others who accessed a health facility from the group said;

*“The mode of upfront payment made my life easy when my wife came for treatment at the facility. I was scared to borrow money from friends and microfinance institutions to pay for her treatment, though at first I never saw the use paying money when no one was sick”. When I learnt that I was [not required] to pay any money at all for treatment, I went and encouraged other men to have their families join saving groups for health,” Wamboga ERIC.*

The above conclusion was corroborated with the responses given by a member during the FGDs who said that the health cooperatives helped him to reduce expenditure on health care and he used the savings to cater for other household needs. Kamuntu Fredrico (not his real name) also told us that his income boosted through the savings made on health expenditure through the health cooperatives. Murebembezi Tanasio (not his real name) told us that the saving made was channeled to paying school fees.

The findings in table 9 show that non- members were aware of benefits associated with being health cooperative members. The majority (78%) indicated access to quality health care, 77% mentioned lower cost due to shared risk, and 67% mentioned that they avoided borrowing, while those who mentioned avoiding high bills and reduced worry and stress and both were 60%. As per non-member responses, the quality of services was paramount; facilities needed to be supported to provide quality services to attract more members.

**Table 9. Perceived benefits of being a health insurance cooperative member by non-members.**

Perceived benefits	Gender				Age group				Total	
	Male		Female		18 to 24		25 and Above			
	No	%	No	%	No	%	No	%	No	%
Lower cost due to shared risk	19	73	26	77	2	67	43	75	45	77
Access to quality health care	21	81	26	77	2	67	45	79	47	78
Avoid borrowing	17	65	23	68	3	68	37	65	40	67
Avoid unexpected possibly catastrophic bills	16	61	20	59	2	67	34	60	36	60
Ability to plan to pay premiums	1	4	4	12	1	33	4	7	5	8
Reduced worry and stress	15	58	19	56	1	33	33	58	34	57
Improved relationship with partner now that care seeking is no longer an issue	9	35	12	35	1	33	20	35	21	35
Other specify	1	4	1	3	0	0	2	4	2	3
Don't know/None	0	0	0	0	0	0	0	0	0	0

### Awareness about Health Insurance by non-members

The evaluation also inquired on the level of awareness of the non-members about the health insurance scheme. Table 10 shows that majority mentioned that they lacked information and knowledge on the benefits of health insurance and how to join the model. Other reasons included the high cost of premiums while others also indicated an outright lack of interest. This showed the area of investment for HPU was although there was no baseline figure for this indicator at the beginning of the project.

**Table 10. Awareness about Health Insurance by non-members**

Awareness about Health Insurance	Gender				Age group				Overall	
	Male		Female		18 to 24 yrs		25+ years			
	No	%	No	%	No	%	No	%	No	%
Aware	26	70	34	77	3	43	57	80	60	77
Not Aware	11	30	7	23	4	57	14	20	18	23

To further understand the reasons why non-members have not joined the insurance schemes, the MTR inquired why the non-members were not enrolled in the health insurance scheme. As indicated, in table 11, the majority, 47% said they had limited information about the benefits, 40% said they did not know how to join and the rest mentioned other reasons such as long distance to the health facilities, high cost of premium and lack of interest.

**Table 11 Reasons why non-members of health insurance scheme have not joined**

Awareness about Health Insurance	Gender					
	Male = 91		Female = 139		Total = 230	
	No	%	No	%	Total	%
Long distance to health care facility	3	3	8	6	11	5
Limited information on benefits	37	41	70	50	107	47
High cost of premium	19	21	26	19	45	20
Don't know how to join	34	37	59	42	93	40
Not interested	22	24	19	14	41	18
Other specify	19	21	20	14	39	17

The MTR also investigated the non-members who would like to join cooperative health insurance. The mid-term evaluation findings as detailed in table 12 show that 66% (56 males and 95 females) of the non-members would like to join cooperative health insurance. The baseline value for this indicator was 87%. This showed a slight reduction of 11% of the non-members who would like to enroll. Of those that reported, 34% (35 males and 13 females) are not interested. The mid-term evaluation findings found a decline in the percentage of people interested in joining the health cooperatives at 21%.

**Table 12. Non-members who would like to join Cooperative Health Insurance**

Non-members who would like to join cooperative health insurance	Total	Gender		Age Group	
		Male	Female	18-24 Yrs	25+ Yrs
	230	91	139	37	192
Would you like to Join the Health Cooperative Insurance	151	56	95	24	127
	66%	62%	68%	65%	66%
Don't like to join the health cooperative health insurance.	79	35	44	13	65
	34%	39%	32%	35%	40%

The evaluation also probed further to find out whether those who would like to join are willing to attend a sensitization session on aspects of cooperative health insurance. Table 13 details the findings. Out of the 230 non-members interviewed, 69% (61 males, 99 females) are willing to attend the session. The analysis, presents an opportunity for HPU to engage in sensitizations to recruit additional members to the health cooperative insurance scheme in the different districts of implementation as an initiative to increase coverage of the model. There was no baseline value for this indicator.

**Table 13: Percentage of non-members willing attend a sensitization event on Cooperative Health Insurance by Sex and Age group.**

	Gender	Age Group (Yrs)
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Willingness to attend a sensitization of cooperative health insurance.	Male = 91		Female = 139		Total = 230		18 to 24 = 230		25 and Above = 91		Total = 321	
	No	%	No	%	Total	%	No	%	No	%	Total	%
Yes	61	67	99	71	160	70	160	70	61	67	221	69
No	30	33	40	29	70	30	70	30	30	33	100	31

**Table 14: Percentage of Non-members’ willing to attend sensitization as they wait to be attended to at the health facility.**

Willingness to wait at the health facility	Gender						Age Group (Yrs)					
	Male		Female		Total		18 to 24 yrs		25 + yers		Total	
	No	%	No	%	Total	%	No	%	No	%	Total	%
Yes	37	57	71	66	108	63	23	79	85	60	108	63
No	28	43	36	34	64	37	6	21	57	40	63	37
<b>Total</b>	<b>65</b>		<b>107</b>		<b>172</b>	<b>100</b>	<b>29</b>		<b>142</b>		<b>171</b>	<b>100</b>

The non-members of health cooperatives were also asked whether they were willing to learn about health insurance while they waited at the health centre during a visit for any health service. The mid-term evaluation findings in table 14 above indicated that majority of the non-members represented (63%) are willing to wait and learn about the health insurance scheme while 37% are not willing to wait.

This analysis presents an opportunity for organizing health facility-based sensitization meetings for non-members. This was further supported by the findings that indicated that the average waiting time most non-members spent before getting a service at the health facility was an average of 34 minutes and 44 minutes for men and women respectively.

This shows there is an opportunity for increasing awareness about the health cooperative if at all health cooperative facilities, sensitizations can be organized targeting non-members who come to seek health services. There was no baseline value for this particular indicator.

**13. Quantify the difference in health seeking behavior of cooperative members overall and for those age 10-24 versus the non-health cooperative members the same age.**

Table 15 details the difference in health seeking behavior for the cooperative members which is 94% and for non-cooperative members it was registered at 83%. Which means that the members are more likely to seek medical care compared to non-cooperative members. This shows that insurance increases the rate at which people seek needed care. The baseline survey indicated that 77% of the members and 51% of the non-members seek medical or health

care. This clearly shows there was an increase by 17% increase in seeking behavior services amongst members 32% amongst the non-members.

**Table 15. Difference in health seeking behavior**

		Member status		Gender		Age Group	
		Member	Non-member	Male	Female	18-24	25 and above
<b>Total</b>	<b>448</b>	<b>213</b>	<b>235</b>	<b>184</b>	<b>264</b>	<b>71</b>	<b>375</b>
Sought health care services	88%	94%	83%	89%	87%	90%	88%
Did not seek health services	12%	6%	17%	11%	13%	10%	12%

### Median age at first intercourse

Table 16 shows the median age (in years) at first intercourse for the different categories of respondents interviewed. In the age group of respondents between 18-24 years, the median age of first intercourse was 18 years while in the age category above 25 years, the median age was 19.3 years. The evaluation has also noted that there was a remarkable difference between median age at first intercourse for males and females represented by 17.9 years and 20.5 years for males. This means females engage in sexual intercourse at a very early age.

Over all, the median age at first intercourse for health cooperative members was 19.6 years and for the non-health cooperative members, it is 18.9 years. The baseline survey findings indicated that the median age at first intercourse for cooperative members was 18.5 years while for the non-members, it was 17.7 years. Which means, the average number of members reporting their first age of sexual intercourse increased from 18.5 to 19.6 years while that reported by non-members also increased from 17.7 to 18.9 years. The delay in age at first intercourse has a great impact on the health of the population, reducing total birth rates overall and other associated negative effects of beginning sexual intercourse at an early age.

**Table 16: Median Age (in years) at first intercourse**

		Member status		A2: Sex of Respondent		Age Group	
		Member	Non-member	Male	Female	18-24	25 and above
Median	19.2	19.6	18.9	20.5	17.9	18.0	19.3
Standard deviation	3.7	4.0	3.5	3.8	3.1	1.5	3.8

### Maternal and child behavior

Findings from the KPC survey indicate that 55% (117) and of the member and 59% (139) non-member women or spouses to male respondents had given birth.

### Age when women gave birth to first child

From Table 17 below, it is observed that the age at which the woman gave birth to her first child averages 23 years with slight differences between members and non-members overall. A comparison between regions, shows that for members, women in the North are most likely to give birth to their first child at a lower age (20 years.) Women in the central region are more apt to give birth at an older age compared to other regions.

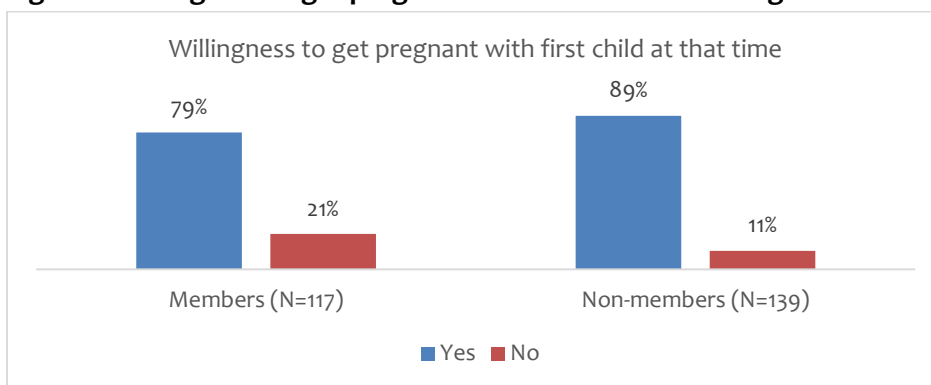
**Table 17: Age at which woman gave birth to first child**

Category	Members			Non-members		
	N	Mean years	SD	N	Mean years	SD
<b>Age Group</b>						
18-24	3*	18	2.309	8*	20	2.925
25 and above	109	24	5.663	124	23	4.676
<b>Region</b>						
Southwestern	44	25	5.032	59	24	4.657
East	23	21	2.741	30	22	3.589
North	18	20	2.635	22	22	4.200
Central	27	26	7.979	21	25	6.013
<b>Overall</b>	<b>112</b>	<b>23</b>	<b>5.658</b>	<b>132</b>	<b>23</b>	<b>4.673</b>

\*The sample is so small to make any statistical conclusions

Further analysis in Figure 1 shows that of the women who have given birth, the majority wanted to get pregnant at the time they conceived their first child. It was observed that there was a significant difference among members and non-members of health insurance, with the latter more likely to have wanted to get pregnant (89%) compared to the members (79%).

**Figure 1: Willingness to get pregnant at the time of conceiving first child**



**Table 18: When last child was born**

When last child was born	HC members		HC Non-members	
	N	%	N	%

In the last 12 months	18	15	15	11
1-2 years ago	23	20	37	27
More than 2 years ago	76	65	87	63
<b>Total</b>	<b>117</b>	<b>100</b>	<b>139</b>	<b>100</b>

From table 19, it is evident that there is a difference between members and non-members where their last child was born. For members, most mothers gave birth in private health facilities (44%), a proportion significantly higher than their non-member counterparts (36%.) Given that health insurance targeted more private health facilities, there might be a relationship between having health insurance and place where child is born. Notable is that it is a common practice for both members and non-members to utilize health facilities for maternal services.

**Table 19: Place where last child was born**

Place of giving birth	Members		Non-members	
	N	%	N	%
Public Health Facility	36	31	59	42
Private Health Facility	51	44	50	36
At home alone	6	5	6	4
At home with a traditional birth attendant	9	8	8	6
At traditional birth attendant’s home	7	6	9	6
Other	8	7	7	5
<b>Total</b>	<b>117</b>	<b>100</b>	<b>139</b>	<b>100</b>

Table 20 reveals that the quest for better services and existence of health insurance highly influenced the decisions for HC insurance members where they gave birth to their last child born prior to the survey. Although better services also influenced non-members, the health facility being closer to home is an important factor. Therefore, health insurance owners are most likely to use the facilities that provide insurance services even if they are not closer to their homes but can also provide better services.

**Table 20: Factors influencing choice of health facility**

Factors influencing choice of place for giving birth	Members		Non-members	
	N	%	N	%
Health insurance	31	26	-	-
Better services	34	29	52	37
Nearer to my home	15	13	51	37
Was an emergency thus I had no control	19	16	16	12
Privacy	5	4	7	5
Other specify	13	11	13	9

<b>Total</b>	<b>117</b>	<b>100</b>	<b>139</b>	<b>100</b>
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### **Incidence of having a child Under 2-year child Health**

Of the households with a woman that has given birth, 33% of members and 38% of non-members, indicated having a child less than two years old. This was most common in the central region(49%), followed by the east (44%), north (43%) and the south western (22%). The average age in months of these children was 12 months.

### **Number of health facility deliveries and Number of pregnant women attending four antenatal visits**

During the pregnancy of the children aged less than two years, 90% members and 91% of non-members attended antenatal care. The baseline value for this indicator was 74% for members and 85% for non-members. Table 21 shows that the majority of both members and non-members attended four or more antenatal care visits. Members of health insurance (64%) were more apt to go for all four recommended antenatal care visits compared to non-members (59%.)

**Table 21: Number of ANC visits**

Number of visits	Overall		Members		Non-Members	
	N	%	N	%	N	%
Less than 4 visits	89	39	37	36	52	41
4 or more visits	140	61	66	64	74	59
Total	229	100	103	100	126	100

Table 22 presents a summary of information obtained from the health facilities. It is important to note that information for some months within the reference period was not obtained.

**Table 22. Number of Deliveries and pregnant women attending antenatal care**

Health facility	No. of deliveries	Number of pregnant women attending antenatal (cumulative visits)	Reference period	No. of months for which information was collected
Kitanga HC III	218	148	August 2019 – December 2020	17
Ibanda Mission	300	202	April 2019 – Dec 2020	21
Bishop Asili Hospital	405	880	April 2019 – Dec 2020	6
Aero Medical Clinic	504	376	May 2019 – Dec 2020	21
St. Francis of Asisi Naddangira HC	242	169		12

Health facility	No. of deliveries	Number of pregnant women attending antenatal (cumulative visits)	Reference period	No. of months for which information was collected
Alleluyah Joint Maternity Clinic	582	317	Sept 2019 - Dec 2020	12

Note: One of the key challenges faced by the health facilities is having up-to-date records. Additionally, the information is seldom categorized by health insurance members or non-members especially information on maternal and child health indicators. Thus, it was difficult to ascertain the health seeking behavior by insurance membership. The baseline value for cooperative members was not indicated while the one for non-members was 60.

**Under 2 child health status**

**Immunization**

Similar to the baseline, the mid-term review assessed the extent to which respondent households had immunized their children under two years. Overall, at least 9 out of 10 children under 2 years had been fully or partially immunized at mid-term review. Full immunization was most likely to occur among children from households with health insurance as shown in Table 23 which represents a similar trend to the baseline.

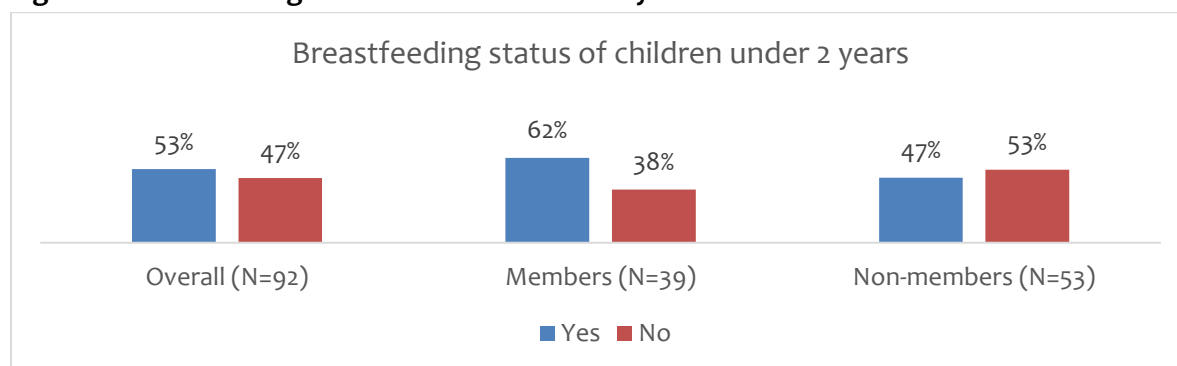
**Table 23: Immunization status of children under 2 years**

Immunization status	Members		Non-members	
	N	%	N	%
Fully immunized	25	64%	32	60%
Partially immunized	13	33%	16	30%
No record	1	3%	5	9%
<b>Total</b>	<b>39</b>	<b>100</b>	<b>53</b>	<b>100</b>

**Breastfeeding status**

In Figure 2 the proportion of mothers with a form of health insurance (62%) was higher than that without (47%). This trend or characteristic was similar to that observed at the baseline.

**Figure 2: Breastfeeding status of children under 2 years**



**14. Average number of sick days before seeking care.**

The MTR revealed that there was a slight difference between the health cooperative member and non-member in terms the number of days after on-set of symptoms before seeking medical advice as shown in Table 24. Forty-one (41%) percent of members and 37% of non-members sought treatment on day they fell sick. There was no baseline value for this indicator to provide a basis for comparison.

**Table24: Average number of sick days before seeking care**

Average number of sick days before seeking care	Member status				Gender				Age group				Overall	
	Members		Non-members		Male		Female		18-24 yrs		25+yrs			
	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Same day	82	41	71	37	63	38	90	39	27	42	126	38	153	39
One day	40	20	40	21	34	21	46	20	10	16	70	21	80	20

**15. Percentage difference in treatment seeking behavior between cooperative members and non-members**

The mid-term evaluation findings established that 94% of the cooperative members and 84% of the non-members of the health cooperatives sought medical care from health facilities. The interviews with the health facility staff established that cooperative health insurance members sought medical care and medical diagnostics more than non-members and this is attributed to insurance-- the lower costs involved for cooperative member care seeking. The findings of the KPC established that non-insurance members are likely to pay three times more for medical care compared to insurance members represented by self-reported total annual expenditure on care at 201,308 UGX by non-members and at 65,761 UGX by members.

The baseline value for the indicator is 77% for the cooperative insurance members and 51% for non-members.

The findings further revealed that the health seeking behavior for members was at 4.8 times while for non- members it was at five times per . This shows that there was no significant difference in the health seeking behavior between members and non-members. The MTR established an increase in the treatment seeking behavior by 16.9% amongst the cooperative health insurance members and 31.6% amongst the non-members.

One Cooperative Health focal person mentioned during the KIIs that “Unlike non-members, community health insurance members have better health-seeking and preventive behaviors because they do not worry about medical bills when they feel unwell. They timely seek for care and services.”

The findings of the document review revealed that despite the impact of COVID- 19 and the lockdown imposed by the government, the members accessing health services through the health cooperatives increased significantly from 24,560 UGX in 2019 to 26,000 UGX by July 2020 as well as the number of health care providers from 41 in 2019 to 58 in 2020UGX<sup>4</sup>

#### **16. What is the Annual health care expenditure reported by members and non-members?**

Analysis of this question focused on the expenditure made using out of pocket payments for health related costs. The findings of the KPC conducted among health cooperative members established that the average annual health care expenditure made in form of premiums, copays and others was 116,974 UGX (32 dollars).

The MTR also inquired into the estimated out of pocket household expenditure in 2020. The findings indicated that the health cooperative insurance members paid less compared to the non-members represented by 65,761 UGX (20 dollars) and 201,308 UGX respectively. The percentage difference on this category of payment is 67.3% (61.7 dollars) for non-members. There was no baseline value for the indicator.

#### **17. Percentage difference of average annual health care expenditure reported by members and non-members**

The percentage difference between the average annual health care expenditure for members and non-members of the health cooperative was almost 9.2%. The expenditure for members (premium, copay & out of pocket) was UGX 182,735 and the expenditure for non-members was purely out of pocket and amounted to 201,308 UGX. At the baseline, the percentage difference between cooperative and non-cooperative members was 11% and 89% for non-members respectively. This indicates that the health cooperative non-members spend higher on health -related expenses compared to the health cooperative members. This correlates with the responses obtained regarding the challenges faced by both health cooperative members and non-members.

### **3.2 What factors have constrained implementation? How are constraints being addressed?**

The MTR established factors constraining the implementation of the health cooperative model they include the lack of good documentation and data in some of the health facilities the MTR team visited. In some of the health facilities the data was incompletely filled for example the in St Francis of Asili Naddangira Health Center III, data for 2019 was incomplete, and the health providers also did not have skills on how to complete the data collection tools such as the CPTT. This data was dis-regarded by the MTR team. In some instances, the computations on the CPTT were inaccurate and some of the tools were not signed off by the in charges of the health facilities as recommended by HPU. Inconsistencies were also noted in the data that was computed on the CPTTs. The interaction with the health care providers that complete the data collection tools established that the completing the CPTT is additional work thus viewed as tedious task in addition the routine roles at the health facilities since it does not fetch any additional payment. This is one of the likely causes of poor records at the health cooperative health facilities.

The MTR also established that HPU changed tools or added variables to the existing CPTTs. During that period, HPU introduced three versions of CPTTs to the health facilities. The MTR revealed that between June 2019 and December 2020 HPU introduced three versions of the CPTT. This is a likely cause of validity issues in the quality of data that is collected and submitted to HPU.

The KIIs with MITC revealed that the coverage of the model is in a few districts. It was cited that in the central region there is hardly any significance of the presence for the model. HPU is not reaching out to other health providers to have the model embraced.

Another factor that has affected implementation and achievement of sustainable results is the limited involvement of key stakeholders such as the district technical staff at the implementation level. Some of the participants in the MTR such as the District Commercial Officers, District Community Development Officers and District Health Officers in the districts the MTR team visited did not know about HPU and the role of the health cooperatives in the districts. There is a possibility that if the model is introduced to the districts this will facilitate the increase in the coverage of the model in the districts as well as provision of technical support through the offices of the District Commercial Officers and other relevant offices.

In Alebtong, for example, the Acting DHO/Maternal child health officer said “I don’t know the details about HPU and the health cooperative insurance scheme in the district but sometime back I was told about its presence” Similar responses were obtained from Kalungu, Wakiso, and Luwero districts. In some of the districts, the MTR was the first time the district staff heard about health cooperatives in the districts. In Oyam and Alebtong, Abt Associates was more pronounced and associated with cooperative health insurance than HPU.

COVID-19 affected the implementation of the health cooperative services in the districts. The trainings, support supervision visits, review meetings and all other stakeholder engagement

activities that required direct interaction with clients could not take place. Many of the newly recruited health providers as well as the cooperatives could not start operating until when HPU rolled out a virtual support supervision tool.

### **3.3 Unanticipated effects, both positive and negative?**

The evaluation also established the positive unanticipated effects related to the Connect Girls Center activity. Below are some of the incipient signs of the positive effects.

The interaction with cooperative members showed an increased number of cooperative health insurance schemes and an increase in the number of members who had enrolled. The increased number of cooperative health insurance schemes and the members who have enrolled provided a good platform for networking and building social cohesion among the members at the community level. This social capital is a stepping stone for the community to utilize to self-organize and mobilize. It was noticed that the cooperative health insurance groups in some areas such as Wakiso and Sironko started mobilizing themselves to utilize the group as a platform to bring members together and form a savings group. It is envisaged that the savings initiative will improve the accessibility to micro credit for members to engage in different income generating activities and thereby improve upon their earnings and affordability for the premiums.

One of the anticipated negative effects lies in the relationship between the CONNECT Girls Centers and the health cooperatives.

During the KII, an Officer from the MTIC said “Connect Girls Center is straining the cooperatives it is intended to serve. Buhweju Girls Center is not adding value to the cooperative. There is no satisfaction because there is a gap between the boards and the cooperative members. The cooperatives were not ready to take on Connect Girl Centers. Connect Girl Center is not in any way linked to the board and they therefore lack the capacity to influence decision making.”

During the KIIs, eight facility focal persons mentioned that health cooperative insurance led to an increase in the demand for health services and products at the health facilities. In some of the health facilities, the demand was so sudden that it presented challenges due to the lack of capacity of the health care provider to offer adequate services to the big numbers of clients they received. The health facilities are gradually beginning to adjust their mode of operation to accommodate this sudden surge in numbers of members seeking health care services.

There was another challenge of health cooperative members abusing the scheme. In some of the facilities, it was reported that health cooperative members sought medical services for even the slightest health related issues. This, apart from depleting the profits, made it hard for the facilities to recover their costs. This was shared by the facility in charge of Villa Maria Hospital, Alleлуйah and Bishop Asili hospital in Luwero.

The evaluation established that out of the CONNECT Girls Centers established in Isingiro, Buhweju, Ibanda and Rukungiri, there are only two active Girls Centers. The KIIs with the districts in Isingiro revealed that while Girls Centers were established in the districts, the district technical staff was not aware of HPU presence in the district and the role of health cooperative insurance.

The District Health Officer for Isingiro said *“I have never heard about HealthPartners or Girls Connect project in Isingiro District. I advise the organization to go and register with the office of the Chief Administrative Officer and the District Communications Officer for it to be recognized in Isingiro district.”*

### **3.4 What adjustments, if any, should HealthPartners make to improve the likelihood of achieving indicator targets by the activity’s end?**

The findings of the MTR revealed that seven<sup>8</sup> out of the 13 districts were not aware of HPU presence and operation in the districts and the role of health cooperatives. HPU needed to improve the collaboration with the respective District Local Governments since they are in charge of regulation, inspection and providing technical guidance to such initiatives in the districts.

The Acting DHO in Alebtong said *“Personally I think partnership as far as the program is concerned is good for our community members and the question is how is it implemented? How was Alleluia Joint Medical Clinic selected to be a health cooperative provider? Can the facility be disqualified if it’s not giving quality services? The last question is how is the district involved in this project? The district is not involved but when it comes to evaluation, the district is involved. Does the district have any say, any contribution or whatever?”*

- a) Provide more support towards the health facilities to improve the quality of the reports and data collected from the health facilities. This will help to address the gaps regarding accuracy, completeness and correctness of the reports especially the CPTTs. It is also recommended that a conversation with the staff at the facility should be explored in order to comprehensively map the different challenges they find in documentation and thereby jointly come to amicable solutions.
- b) The KPC survey findings indicated that 70% of the non-members are willing to attend sensitization events while 63% of those willing to learn more about the health insurance expressed willingness to be sensitized as they wait for services at the facility. Additional support should be extended to the health facilities to develop sensitization plans and also implement them. This will facilitate uptake of the cooperative health insurance scheme.

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<sup>8</sup> Please name these seven districts here

- c) HPU should continue to facilitate learning and experience sharing visits amongst the health cooperative service providers. These should be structured in a way that they facilitate learning and sharing of experiences on the cross cutting emerging issues, best practices, innovations and adaptive mechanism being adopted by different health providers. The learning exchange visits brought together different stakeholders to learn and share experiences amongst themselves. The knowledge gained was replicated elsewhere in the respective health centers.
- d) A review of the data submitted to HPU established that out of the 24 health cooperative providers under UPMB, only six are currently reporting. Under the UCMB, 17 out of 18 are reporting while under the category of Private health Facility, 3 out of 73 are currently reporting to HealthPartners. HPU should devise ways to improve reporting by the health facilities. It is important that HPU appreciates the challenges faced by the health facilities and devise solutions to overcome them.
- e) HealthPartners should invest more into the management of the Girls Centers and align this investment with the felt needs of the girls as opposed to leaving the management of the Girl Centers entirely to the cooperatives. This is because Girls Centers are owned by cooperatives but the cooperatives that are already constrained are unable to support the activities of the Girls Centers.

In an interview with the Chairperson of the cooperative Girls Centers said, “There is need for a change of the name to accommodate both boys and girls. The documents indicated that the Girl Centers are supposed to host children and youth of both sexes aged from 10-24. However, Girls Centers did not host boys until Feb 2021 when four boys joined Buhweju Girls Center. The untrained boys continue to exercise their socially given right to be ‘men,’ they will consequently water down whatever training, information and empowerment that is given to girls. This is so much the case because these same girls will end up getting married to the boys who are not enlightened. To create an enabling environment for both boys and girls, there is a need to adopt an accommodating name, for example, ‘Youth Centers’ to recruit boys into the centers.”

### **3.5 Lessons learnt**

#### **1. Changes in program implementation that will lead to achieving set targets.**

The consulting team recommends timely and consistent follow-up on plans and commitments made between HPU and the different partners especially the health cooperatives and health facilities in Rukungiri. One a staff from potential partner, Kadoth, informed the evaluation team that she established the center even though her application was not approved then waited for funding from HPU in vain. So, another partner got in touch and took over the project. According to the responses from the key informant interviews in Mbarara, initial contacts and discussions were made but no follow up was made so the process of establishing the Girl Center stalled.

The limited collaboration between the health providers and the health cooperatives on one side and the district local governments on the other side might affect the smooth implementation of the Connect Girls Center activity and the level of achievement of results. Much as the health cooperatives are linked to the MTIC, it would be better to have them linked to the District to be able to access technical support cheaply and conveniently.

The mid-term evaluation revealed that the coverage rate of cooperative health insurance is very minimal in Northern, Eastern and Central regions of Uganda. On that note, it is important to invest effort in ensuring that more health care providers are enrolled into the scheme.

## Annex 1: KPC Respondent Characteristics

### A1.1 Demographic characteristics

Out of the 532 target responses, a total of 448 responses were obtained from the KPC study, giving a response rate of 84.2%. Of these 213 (48%) were for members of health insurance/cooperatives (41.8% males and 58.2% females) and 235 (40.4% males and 59.6% females) were non-members. The average age for respondents was 40 years with 42 years among the health insurance members and 39 years for non-members. A total of 73 (15.8%) were aged 18-24 years and 375 (84.2%) were 25 years and above.

The majority of the respondents were married or cohabiting (65.2%).

A similar trend is observed by membership to health cooperative/insurance and gender. Notable is that females were more likely to be separated/divorced or widowed compared to males.

Almost 88% of the respondents had ever attended school with most obtaining primary education as the highest level (37.3%). Further analysis showed that women were most likely not to have attended school (15.9%) compared to their male counterparts (6.5%). With majority of the members of health insurance have ever attended school, it is envisaged that it becomes easier for them to understand the operations and the need to participate in health insurance and given that a majority (74.8%) are able to read and write in any language. The major source of income for the majority of households was crop production (45.3%). With this source of income, it is envisaged that beneficiaries will often earn seasonally, and hence, find difficulties to incur expenses related to health more often, if they are not part of a health insurance scheme. Similarly, affects the salaried workers who earn mostly on a monthly basis.

The average household size is six persons with health insurance members having a lower household size (about six) compared to non-members (about seven). Of these, overall, only four persons earn an income in the household; a big difference is observed between members and non-members of health insurance with the latter (five persons) having a bigger number of household members contributing than the former (around four persons). Therefore, it is implied that with many persons contributing to household income, the non-members most probably do not see the need to have insurance.

**Table: 25. Selected demographic characteristics of respondents.**

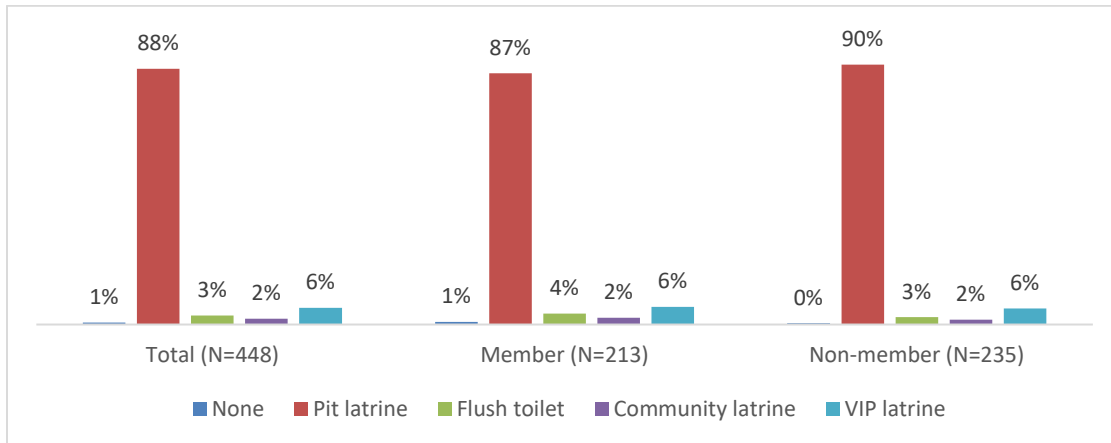
Characteristics	Total	Health insurance/Health Coop Member status		Sex	
		Member	Non- Member	Male	Female
<b>Total Number</b>	<b>448</b>	<b>213</b>	<b>235</b>	<b>184</b>	<b>264</b>
<b>i) Marital Status</b>					
Single	103	44	59	50	53
	23.0%	20.7%	25.1%	27.2%	20.1%
Married/cohabiting	292	146	146	123	169
	65.2%	68.5%	62.1%	66.8%	64.0%

Divorced/separated	28	12	16	9	19
	6.3%	5.6%	6.8%	4.9%	7.2%
Widowed	25	11	14	2	23
	5.6%	5.2%	6.0%	1.1%	8.7%
<b>ii) Highest level of education attained</b>					
Never attended	54	26	28	12	42
	12.1%	12.2%	11.9%	6.5%	15.9%
Primary	167	90	77	63	104
	37.3%	42.3%	32.8%	34.2%	39.4%
O level	122	45	77	49	73
	27.2%	21.1%	32.8%	26.6%	27.7%
A level	39	23	16	23	16
	8.7%	10.8%	6.8%	12.5%	6.1%
University	39	12	27	25	14
	8.7%	5.6%	11.5%	13.6%	5.3%
Other tertiary	27	17	10	12	15
	6.0%	8.0%	4.3%	6.5%	5.7%
<b>iii) Literacy level</b>					
Neither able to read nor write	74	35	39	17	57
	16.5%	16.4%	16.6%	9.2%	21.6%
Able to read only	27	12	15	7	20
	6.0%	5.6%	6.4%	3.8%	7.6%
Able to read and write	335	160	175	156	179
	74.8%	75.1%	74.5%	84.8%	67.8%
Able to write, not read	12	6	6	4	8
	2.7%	2.8%	2.6%	2.2%	3.0%
<b>iv) Main income generating activity for the household</b>					
Salaried worker	83	45	38	43	40
	18.5%	21.1%	16.2%	23.4%	15.2%
Self-employment e.g personal shop, Grocery	86	33	53	36	50
	19.2%	15.5%	22.6%	19.6%	18.9%
Farming (livestock)	22	15	7	8	14
	4.9%	7.0%	3.0%	4.3%	5.3%
Farming (crop production)	203	97	106	78	125
	45.3%	45.5%	45.1%	42.4%	47.3%
Casual labourer	33	12	21	16	17
	7.4%	5.6%	8.9%	8.7%	6.4%
Remittances/gifts	21	11	10	3	18
	4.7%	5.2%	4.3%	1.6%	6.8%
<b>v) Household size</b>					
Average household size	6.2 (SD =10.2)	5.7 (SD =6.8)	6.7 (12.5)		
Average members earning income	4.4 (SD=0.9)	3.6 (SD=1.0)	5.2 (SD=0.74)		

## A1.2 Water Sanitation and Hygiene

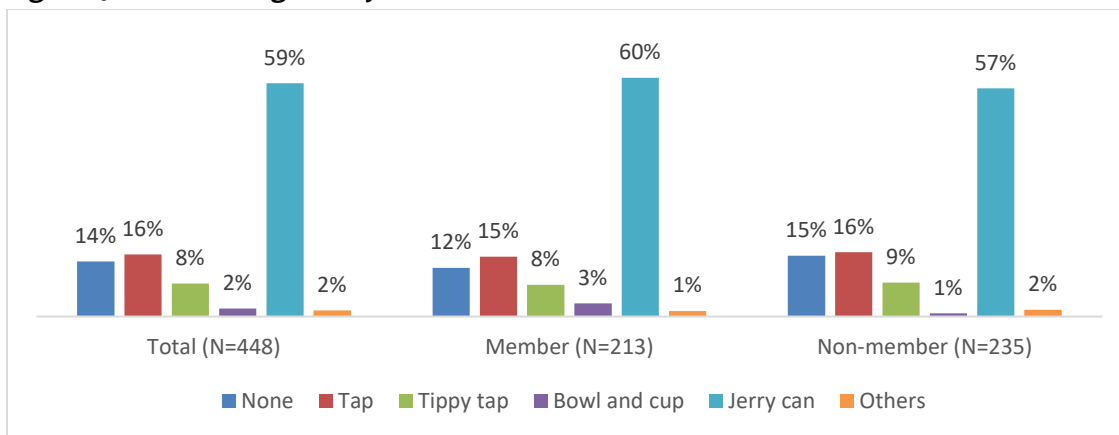
Figure 3 below shows that the most common toilet facility used is the pit latrine by almost nine (9) in 10 households (88%). Only 6 percent have a VIP latrine. The type of toilet facility owned or accessed by most households does not differ from what is normally used in rural and upcountry areas.

**Figure 3 Type of toilet facility**



By type of hand washing facility owned, majority use the jerry can (59%) with no significant differences observed between members and non-members of health insurance as shown in Figure 4 below. Use of the jerry can might not necessarily imply there is a designated item for hand washing but probably any jerry can with water can be used.

**Figure 4 Handwashing facility**



Results of Hand-washing behavior at mid-term do not differ much from the baseline as the most common behaviors are similar between the two periods. Majority was hands after visiting the toilet (94.6%) followed by before meals (90.8%) and after meals (89.7%) as shown in Table 20 below. The likelihood to wash hands before preparing the meal is low (35.9%) which behavior is mostly likely to cause spread of diseases.

**Table 26: Hand-washing behavior**

Hand-washing behaviour	Total	Health insurance Member status		Gender	
		Member household	Non-member household	Male	Female
<b>Number</b>	<b>448</b>	<b>213</b>	<b>235</b>	<b>184</b>	<b>264</b>
After Visiting the toilet	424	199	225	169	255
	94.6%	93.4%	95.7%	91.8%	96.6%
Before meals	407	194	213	161	246
	90.8%	91.1%	90.6%	87.5%	93.2%
After meals	402	190	212	159	243
	89.7%	89.2%	90.2%	86.4%	92.0%
After changing baby's diaper	48	26	22	3	45
	10.7%	12.2%	9.4%	1.6%	17.0%
Before breastfeeding	61	33	28	11	50
	13.6%	15.5%	11.9%	6.0%	18.9%
Before preparing meals	161	77	84	40	121
	35.9%	36.2%	35.7%	21.7%	45.8%
Other specify	24	12	12	14	10
	5.4%	5.6%	5.1%	7.6%	3.8%

In regards to water sources, Table 27 shows that majority of the households use protected sources (88.8%) like boreholes, taps etc. Results further reveal that 77.7 percent of the households do treat water to make it safe for drinking. The most common method used is boiling (86.2%). This is common amongst both members and non-members of health insurance. However, observed is that there is a difference amongst the proportion of members and non-members with the former most likely to boil (88%) than the latter (84%).

**Table 27. Treatment of water for drinking**

Treatment	Total	Health insurance Member status		Gender	
		Member	Non-member	Male	Female
	348	170	178	148	200
By chlorination (adding aquatab, Watergate etc)	48	18	30	19	29
	13.8%	10.6%	16.9%	12.8%	14.5%
By boiling	300	150	150	127	173
	86.2%	88.2%	84.3%	85.8%	86.5%
Other specify	5	3	2	5	0
	1.4%	1.8%	1.1%	3.4%	.0%
None	0	0	0	0	0
	.0%	.0%	.0%	.0%	.0%

### A1.3 Use of Mosquito nets

Overall, 96 percent of the households interview least at least one mosquito net with health cooperative insurance members (97%) most likely to do so compared to non-members (94%). Of those owning a mosquito net, these 95.1 percent of the household had at least a member sleeping in a net a night before the interview. The household members who slept under the mosquito net mostly included the respondent (61.3%) (either male or non-pregnant woman), spouse (44.6%) and other household members who are not children (20.3%) as shown in Table 28. Observed is that male respondents and their spouses were most likely to sleep under a mosquito net than the females.

**Table 28 Persons who slept under a mosquito net**

Hand-washing behaviour	Total	Health insurance Member status		Gender	
		Member household	Non-member household	Male	Female
<b>Number</b>	<b>448</b>	<b>213</b>	<b>235</b>	<b>184</b>	<b>264</b>
Myself, pregnant	60	26	34	12	48
	14.7%	13.1%	16.2%	7.2%	19.9%
Myself, not pregnant	250	119	131	108	142
	61.3%	60.1%	62.4%	64.7%	58.9%
Spouse	182	80	102	86	96
	44.6%	40.4%	48.6%	51.5%	39.8%
Child Under 5	127	59	68	48	79
	31.1%	29.8%	32.4%	28.7%	32.8%
Child 5-10	87	35	52	34	53
	21.3%	17.7%	24.8%	20.4%	22.0%
Child 11-18	105	45	60	38	67
	25.7%	22.7%	28.6%	22.8%	27.8%
Other specify	83	43	40	28	55
	20.3%	21.7%	19.0%	16.8%	22.8%

## **Annex 2: Tools-FGD & KII Guides**

### **(a) FGD Guide for Cooperative Members.**

#### **Introduction**

HealthPartners CONNECT Girls Center is a five-year project (2018-2023) to increase community resilience and cooperative business performance, to improve the cooperative enabling environment and to increase access to design strategies and solutions in Uganda, sharing lessons and exploring potential to create impact in Kenya and with partners more broadly. At the moment, the CONNECT Girls Center is due for the planned mid-term evaluation. The objective of the mid-term evaluation is to understand progress so far towards achieving project objectives and outcomes to draw out lessons for learning and increasing the rate of sustainable change in the remaining project implementation period.

The mid-term evaluation will capture effectively lessons learnt and provide information on the nature, extent and where possible, the potential impact and sustainability of the health cooperative insurance model.

You have been identified as a key stakeholder to participate and inform the mid-term evaluation study. The information you provide will be solely for the purpose of getting information to inform the above stated objectives and will be treated with confidentiality.

#### **Guiding Questions**

- Kindly introduce yourselves; your name, the health cooperative you belong to and your position?
- To what extent has HealthPartners supported health cooperatives to expand?
  - To what extent has CONNECT Girls Center increased the number of health providers offering cooperative insurance? What activities have most facilitated that?
  - To what extent has CONNECT Girls Center improved the capacity of cooperative boards and cooperative care providers to make operational decisions? To what extent are members satisfied with benefits they are receiving through their cooperative? To what extent are members satisfied with decision-making in cooperatives? (for South West only-Ruharo, Kyabirikwa, Buhweju)
- To what extent are cooperative care providers and their members satisfied with the services and technical support provided by HealthPartners? What factors contributed to satisfaction, and why?
- Have HealthPartners activities led to any unanticipated effects, both positive and negative?

- What adjustments, if any, should HealthPartners make to improve the likelihood of increasing cooperative membership by the activity's end?
- Are you satisfied with benefits being received from your cooperative membership?  
(Note)
- If so why? If not, not why?
- Are you satisfied with your partnership with your cooperative care provider?
- If so why? If not, why not?
- Do you have any questions for me?

**Thank you for taking part in this study.**

## **(b) FGD Guide for Girls age 15-18(SW only)**

### **Introduction**

HealthPartners CONNECT Girls Center is a five-year project (2018-2023) to increase community resilience and cooperative business performance, to improve the cooperative enabling environment and to increase access to design strategies and solutions in Uganda, sharing lessons and exploring potential to create impact in Kenya and with partners more broadly. At the moment, the CONNECT Girls Center is due for the planned mid-term evaluation. The objective of the mid-term evaluation is to understand progress so far towards achieving project objectives and outcomes to draw out lessons for learning and increasing the rate of sustainable change in the remaining project implementation period.

The mid-term evaluation will capture effectively lessons learnt and provide information on the nature, extent and where possible, the potential impact and sustainability of the health cooperative insurance model.

You have been identified as a key stakeholder to participate and inform the mid-term evaluation study. The information you provide will be solely for the purpose of getting information to inform the above stated objectives and will be treated with confidentiality.

### **Guiding Questions**

- Kindly tell me more about yourself (name and where you come from).
- To what extent has preventive health-seeking behavior among girls age 10-24 improved?
  - In what ways has preventive health-seeking behavior among girls age 10-24 improved through CONNECT Girls Center support, and what activities have most facilitated that?
- At what age do majority of girls engage in sexual intercourse in this community?
- Do most pregnant girls that give birth do so in a health facility? Yes or No?
- If so why? If not, why not?
- Are pregnant women aware they are supposed to attend all 4 antenatal visits as a result of the project activity?
- How many days does it take for you to seek health services whenever you fall sick?
- Have CONNECT Girls Center activities led to any unanticipated effects, both positive and negative?
- What adjustments, if any, should CONNECT Girls Centers make to improve your health seeking behavior?
- Do you have any questions for me?

**Thank you for taking part in this study.**

## (c) FGD Guide for Girls age 19-24

### Introduction

HealthPartners CONNECT Girls Center is a five-year project (2018-2023) to increase community resilience and cooperative business performance, to improve the cooperative enabling environment and to increase access to design strategies and solutions in Uganda, sharing lessons and exploring potential to create impact in Kenya and with partners more broadly. At the moment, the CONNECT Girls Center is due for the planned mid-term evaluation. The objective of the mid-term evaluation is to understand progress so far towards achieving project objectives and outcomes to draw out lessons for learning and increasing the rate of sustainable change in the remaining project implementation period.

The mid-term evaluation will capture effectively lessons learnt and provide information on the nature, extent and where possible, the potential impact and sustainability of the health cooperative insurance model.

You have been identified as a key stakeholder to participate and inform the mid-term evaluation study. The information you provide will be solely for the purpose of getting information to inform the above stated objectives and will be treated with confidentiality.

### Guiding Questions

- Kindly tell me more about yourself (name and where you come from).
- To what extent has preventive health-seeking behavior among girls age 10-24 improved?
  - In what ways has preventive health-seeking behavior among girls age 10-24 improved through CONNECT Girls Center support, and what activities have most facilitated that?
- At what age do majority of girls engage in sexual intercourse in this community?
- Do most pregnant girls that give birth do so in a health facility? Yes, or No?
- If so why? If not, why not?
- Are pregnant women aware they are supposed to attend all 4 antenatal visits as a result of the project activity?
- How many days does it take for you to seek health services whenever you fall sick?
- Have CONNECT Girls Center activities led to any unanticipated effects, both positive and negative?
- What adjustments, if any, should CONNECT Girls Centers make to improve your health seeking behavior?
- Do you have any questions for me?

**Thank you for taking part in this study.**

## (d) FGD Guide for Men age 25-54 (Cooperative Members)

### Introduction

HealthPartners CONNECT Girls Center is a five-year project (2018-2023) to increase community resilience and cooperative business performance, to improve the cooperative enabling environment and to increase access to design strategies and solutions in Uganda, sharing lessons and exploring potential to create impact in Kenya and with partners more broadly. At the moment, the CONNECT Girls Center is due for the planned mid-term evaluation. The objective of the mid-term evaluation is to understand progress so far towards achieving project objectives and outcomes to draw out lessons for learning and increasing the rate of sustainable change in the remaining project implementation period.

The mid-term evaluation will capture effectively lessons learnt and provide information on the nature, extent and where possible, the potential impact and sustainability of the health cooperative insurance model.

You have been identified as a key stakeholder to participate and inform the mid-term evaluation study. The information you provide will be solely for the purpose of getting information to inform the above stated objectives and will be treated with confidentiality.

### Guiding Questions

- Kindly tell me more about yourself (name and the health cooperative where you come from and your position there?).
- How did you get to know or become aware of health cooperatives (one that you are a member of)?
- Why did you make a decision to become a member? What encouraged you?
- What are the main benefits you have realized as a result of being a member?
- Do you feel there is value in being a member? If yes, what do you value most about your health cooperative membership? If no, explain why?
- In what ways are these health cooperatives of benefit to you as an individual? (Probe)
- How has joining the health coop improved your health? (Probe for ability to seek and use treatment at the facility when you are ill).
- What role does the health cooperative play in the health of the mothers in this community (Further probe on access and use of specific services such as ANC, PNC, and health facility-based delivery).
- Does being a member of a health cooperative improve your household financial status? How? (Probe for ability to save, pay for children's education, etc.)
- Are you satisfied with the benefits being received from the health cooperative? (Note numbers)
- If not, why?

- Are you satisfied with the decision-making that happens in the health cooperative?
- If not, why?
- Are you satisfied with services and technical support provided by HealthPartners? If no, why?
- Are there any challenges you face as a health cooperative member? (Probe)
- Do you have any questions for me?

**Thank you for taking part in this study.**

## **(e) FGD Guide for Men age 25-54 (non-Cooperative Members)**

### **Introduction**

HealthPartners CONNECT Girls Center is a five-year project (2018-2023) to increase community resilience and cooperative business performance, to improve the cooperative enabling environment and to increase access to design strategies and solutions in Uganda, sharing lessons and exploring potential to create impact in Kenya and with partners more broadly. At the moment, the CONNECT Girls Center is due for the planned mid-term evaluation. The objective of the mid-term evaluation is to understand progress so far towards achieving project objectives and outcomes to draw out lessons for learning and increasing the rate of sustainable change in the remaining project implementation period.

The mid-term evaluation will capture effectively lessons learnt and provide information on the nature, extent and where possible, the potential impact and sustainability of the health cooperative insurance model.

You have been identified as a key stakeholder to participate and inform the mid-term evaluation study. The information you provide will be solely for the purpose of getting information to inform the above stated objectives and will be treated with confidentiality.

### **Guiding Questions**

- Kindly tell me more about yourself (name and where you come from?).
- Have you ever heard of cooperative health insurance? (note number)
- If yes, what have you heard? (note number)
- If yes (above), why haven't you joined one?
- From what you have heard or know about health cooperatives, what are the benefits?
- Are you interested in becoming a member of a health cooperative? Yes/No (note number)
- Why or why not?
- Are you interested in sharing information with others to join? (note number)
- If yes, what information about cooperative health insurance would make it easy for more people to join?
- Do you have any questions for me?

**Thank you for taking part in this study**

## (f) FGD Guide for Women age 25-49 (Cooperative Members)

### Introduction

HealthPartners CONNECT Girls Center is a five-year project (2018-2023) to increase community resilience and cooperative business performance, to improve the cooperative enabling environment and to increase access to design strategies and solutions in Uganda, sharing lessons and exploring potential to create impact in Kenya and with partners more broadly. At the moment, the CONNECT Girls Center is due for the planned mid-term evaluation. The objective of the mid-term evaluation is to understand progress so far towards achieving project objectives and outcomes to draw out lessons for learning and increasing the rate of sustainable change in the remaining project implementation period.

The mid-term evaluation will capture effectively lessons learnt and provide information on the nature, extent and where possible, the potential impact and sustainability of the health cooperative insurance model.

You have been identified as a key stakeholder to participate and inform the mid-term evaluation study. The information you provide will be solely for the purpose of getting information to inform the above stated objectives and will be treated with confidentiality.

### Guiding Questions

- Kindly tell me more about yourself (name and the health cooperative where you come from and your position there?).
- How did you get to know or become aware of cooperative health insurance?
- Why did you make a decision to become a member? What encouraged you?
- What are the main benefits you have realized as a result of being a member?
- Do you feel there is value in being a member? If yes, what do you value most about health cooperative membership? If no, explain why?
- In what ways does health cooperative membership benefit you? (Probe)
- What role does the health cooperative play in the health of the mothers in this community (Further probe on access and use of specific services such as ANC, PNC, and health facility-based delivery)
- Does being a member of a health cooperative improve your household financial status? How? (Probe for ability to save, pay for children's education etc.)
- Are you satisfied with the benefits being received from the health cooperative? (Note numbers)
- Why or why not?
- Are you satisfied with level with decision-making in cooperatives?
- If not, why?

- Are you satisfied with the decision-making that happens in your health cooperative?
- Are there any challenges you face as a health cooperative member? (Probe)
- Do you have any questions for me?

**Thank you for taking part in this study**

## **(g) FGD Guide for Women age 25-49 (Non-Cooperative Members)**

### **Introduction**

HealthPartners CONNECT Girls Center is a five-year project (2018-2023) to increase community resilience and cooperative business performance, to improve the cooperative enabling environment and to increase access to design strategies and solutions in Uganda, sharing lessons and exploring potential to create impact in Kenya and with partners more broadly. At the moment, the CONNECT Girls Center is due for the planned mid-term evaluation. The objective of the mid-term evaluation is to understand progress so far towards achieving project objectives and outcomes to draw out lessons for learning and increasing the rate of sustainable change in the remaining project implementation period.

The mid-term evaluation will capture effectively lessons learnt and provide information on the nature, extent and where possible, the potential impact and sustainability of the health cooperative insurance model.

You have been identified as a key stakeholder to participate and inform the mid-term evaluation study. The information you provide will be solely for the purpose of getting information to inform the above stated objectives and will be treated with confidentiality.

### **Guiding Questions**

- Kindly tell me more about yourself (name and where you come from?).
- Have you ever heard of health cooperatives? (note number)
- If yes, what have you heard about them? (note number)
- If yes (above), why haven't you joined one?
- From what you have heard or know about health cooperatives, what are the benefits?
- Do you have interest to be a member of a health cooperative? Yes/No (note number)
- Why or why not?
- Would you be interested to share information with others to join a cooperative insurance scheme? (note number)
- Why or why?
- If yes, what information would about health cooperatives would make it easy for you to join?
- Do you have any questions for me?

**Thank you for taking part in this study**

## 7.2 KPC Tool.

### CONNECT GIRLS CENTER ACTIVITY MIDTERM EVALUATION HOUSEHOLD QUESTIONNAIRE

#### Part A: Identification particulars

District:	
Sub county	
Parish	
Village	
Name of Respondent	
Name of Interviewer	
Name of Supervisor	
Member status: Health Cooperative member household..1 (10 F and 9 Males) Non-member health cooperative household..2 (10 F and 9 Males)	

#### Introduction

Hello, my name..... working on behalf of Soland Associated Consults Limited, a legally registered research consultancy firm in Uganda. Soland was contracted to carry out a study on behalf of HealthPartners Uganda. The study aims at understanding people's knowledge, attitudes and practices towards access to health services in your community and their contribution to healthcare. The information you provide will guide HealthPartners to effectively implement its project intervention in support of health cooperative development in Uganda. Your participation in this survey is completely voluntary and all of your answers will be kept in the strictest confidence. Your responses will be combined with that of others to show aggregated views and opinions.

Can I continue with the interview? Yes..1 No..2(**IF NO TERMINATE**)

START TIME: |\_\_|\_\_| :|\_\_|\_\_| AM / PM

## SECTION A1: DEMOGRAPHICS

Question	Answer Options
A1: Age (Completed years)	
A2: Sex of Respondent	1.Male 2.Female
A3: Marital Status	1. Single 2. Married/cohabiting 3. Divorced/separated 4. Widowed
A5: Highest level of education attained	1. Never attended 2. Primary 3. O level 4. A level 5. University 6. Other tertiary
A6: Can you read or write in any language?	1. Neither able to read nor write 2. Able to read only 3. Able to read and write 4. Able to write, not read
A7: What is the main income generating activity for this household?	1. Salaried worker 2. Self-employment e.g personal shop, Grocery 3. Farming (livestock) 4. Farming (crop production) 5. Casual laborer 6. Remittances/gifts

## HOUSEHOLD DETAILS

Question	Answer Options
A8: How many people live in this HH?	
A9: Do any member(s) of the household have any physical or mental impairment or chronic illness?	Yes... 1 No..2
A10: If yes, How many member(s) of the household have any physical or mental impairment or chronic illness?	
A11: How many people in your household earn some income that directly benefits the household?	

<p>A12: What are the different sources of livelihood/income in your household?</p> <p>(CIRCLE ALL THAT APPLY)</p>	<ol style="list-style-type: none"> <li>1. Agriculture (Crop, Livestock And Animal Product Sales)</li> <li>2. Unskilled Wage Labor/casual Labor</li> <li>3. Sale of Charcoal, Bricks</li> <li>4. Petty Trading (e.g. Sale of Firewood, Poles, Thatch, Wild Greens)</li> <li>5. Remittances and/or Gift From Family/Relatives</li> <li>6. Begging, Assistance</li> <li>7. Skilled Labor (Artisan)</li> <li>8. Salaries, Wages (Employees)</li> <li>9. Fishing</li> <li>10. Brewing</li> <li>11. Handicrafts</li> <li>12. Government Allowance (Pension)</li> <li>13. Any Other Not Listed _____</li> </ol>
<p>A13: What is the estimated household monthly income from all income sources mentioned?</p>	<p>UGX _____</p>
<p><b>SANITATION AND HYGIENE</b></p>	
<p>A14: What kind of toilet facility does your household use?</p>	<ol style="list-style-type: none"> <li>a. None</li> <li>b. Pit latrine</li> <li>c. Flush toilet</li> <li>d. Bush</li> <li>e. Community latrine</li> <li>f. VIP latrine</li> </ol>
<p>A15: What kind of hand washing facility do you have?</p>	<ol style="list-style-type: none"> <li>a. None</li> <li>b. Tap</li> <li>c. Tippy tap</li> <li>d. Bowl and cup</li> </ol>

	<p>e. Jerry can</p> <p>f. Others (specify).....</p>
<p>A16: Can you show me where you usually wash your hands and what you use to wash hands?</p> <p>ASK TO SEE AND OBSERVE</p> <p>OBSERVATION ONLY: IS THERE SOAP OR DETERGENT OR LOCALLY USED CLEANSING AGENT? THE ITEM SHOULD EITHER BE IN PLACE OR BROUGHT BY THE RESPONDENT WITHIN ONE MINUTE. IF THE ITEM IS NOT PRESENT WITHIN ONE MINUTE, CHECK NONE EVEN IF BROUGHT OUT LATER.</p> <p>Tick all that apply</p>	<p>There is evidence of clean water used to wash hands...1</p> <p>There is evidence of use of soap/detergent/cleansing agent for hand washing...2</p>
<p>A17: When do you wash hands? Tick all that apply</p>	<ol style="list-style-type: none"> <li>1. After Visiting the toilet</li> <li>2. Before meals</li> <li>3. After meals</li> <li>4. After changing baby's diaper</li> <li>5. Before breastfeeding</li> <li>6. Before preparing meals</li> <li>7. Other..specify</li> </ol>
<p>A18: What is the main source of drinking water for members in your household?</p>	<p>a. Protected E.g. Bore holes, taps</p> <p>b. Unprotected e.g. Rivers, ponds</p>
<p>A19: Do you treat your water in any way to make it safe for drinking?</p>	<p>Yes...1</p> <p>No..2</p>
<p>A20: If yes, what do you usually do to make it safer to drink?</p>	<p>a. By chlorination (adding aqua tab, Watergate etc)</p> <p>b. By boiling</p> <p>c. Others (specify).....</p> <p>d. None</p>
<p><b>USE OF MOSQUITO NETS</b></p>	

A21: Does your household have any mosquito nets that can be used while sleeping?	Yes... 1 No..2
<b>For each mosquito net ASK:</b>	
A22: ASK THE RESPONDENT TO SHOW YOU ALL THE NETS IN THE HOUSEHOLD. RECORD FOR EACH NET OBSERVED	1. Observed hanging 2. Observed Not hanging or packaged 3. Not observed
A23: Did anyone sleep under this mosquito net last night?	Yes... 1 No..2
A24: Who slept under this mosquito net last night? (Do not prompt. Circle all that are mentioned.)	1. Myself, pregnant 2. Myself, not pregnant 3. Spouse 4. Child Under 5 5. Child 5-10 6. Child 11-18 7. Other specify.....

#### SECTION B: HEALTH SEEKING BEHAVIOUR AND HYGIENE

B1 In the last 12 months, has any member of your household needed medical care? SELECT ONE ONLY	1. Yes 2. No
B2 How many times did you/any member of your family visit a health facility mentioned in the last 12 months (1 year)?	List number of times each facility
B3 How many days after the symptoms began did you first seek advice or treatment?	1. Same day 2. One day 3. Two days 4. More than two days 99. Did not seek treatment
B4 If no treatment was sought, why was this?	1. Did not need treatment 2. Did not have money 3. Health facility is too far off 4. Due to religious reasons 5. Due to cultural reasons 6. Other..specify
B5 What is the distance to the nearest health facility from your house? WRITE IN	Distance in KMS

<p>B6 Please tell me all the facilities where members of your household have sought advice or treatment in the last 12 months?</p>	<ol style="list-style-type: none"> <li>1. Government Hospitals</li> <li>2. Government Health Centers</li> <li>3. Private Hospitals</li> <li>4. Private Clinic or health center</li> <li>5. Pharmacy/drug shop</li> <li>6. Other facility, specify _____</li> </ol>
<p>B7 What type of service did you/family seek at the health facility/is you mentioned? Probe for the entire year for each facility visited</p>	<p><b>OUTPATIENT</b></p> <ol style="list-style-type: none"> <li>1. Family planning</li> <li>2. ANC/Delivery/PNC</li> <li>3. Newborn care</li> <li>4. Malaria</li> <li>5. Fever</li> <li>6. Diarrhea</li> <li>7. Typhoid</li> <li>8. HIV/AIDS/STI</li> <li>9. High Blood Pressure</li> <li>10. EAR/Nose/Throat Infection</li> <li>11. Diabetes</li> <li>12. Eye Infection</li> <li>13. Check up/preventive care</li> <li>14. Accident/Injury</li> <li>15. Other outpatient services (specify)</li> </ol> <p><b>INPATIENT</b></p> <ol style="list-style-type: none"> <li>16. Pregnancy/Delivery</li> <li>17. Child Illness</li> <li>18. Accident/Injury</li> <li>19. Other inpatient (specify)</li> </ol>
<p>B8 Do members of your household pay insurance premiums?</p>	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>
<p>If yes, what was your estimated household expenditure in terms of premiums, copy, dues and/or shares in 2020?</p>	<p>UGX _____</p>
<p>B9: If no, what was your estimated out of pocket household expenditure on health care, including health facility visits and medications in 2020?</p>	<p>UGX _____</p>
<p>B10 If you do not have health insurance, where did you get money to pay for medical treatment or drugs in the last 12 months? SELECT ALL THAT APPLY</p>	<ol style="list-style-type: none"> <li>1. Had saved enough money</li> <li>2. Sold property</li> <li>3. Borrowed money</li> <li>4. Treatment on credit</li> <li>5. Other, specify _____</li> </ol>

<p>B11Do you have to pay out of pocket for medicine and services you receive in health facilities?</p> <p><b>INTERVIEWER: THIS DOESN'T INCLUDE THE AMOUNTS PAID FOR HEALTH COOPERATIVE INSURANCE</b></p>	<p>3. Yes 4. No</p>
<p>B12What challenges if any did you encounter in the health facilities visited?</p> <p>SELECT ALL THAT APPLY AND ASK FOR EACH FACILITY VISITED</p>	<p>1. None 2. Drugs out of stock 3. Lack of transport money 4. High cost of treatment 5. Facility is very far 6. Other, specify _____ 7. None</p>
<p>B13Was the service you sought available? List for each service sought.</p>	<p>1. Yes 2. No</p>
<p>B9 Please rate the quality of services you received from the facilities you/members of your family visited on a scale of 1 to 5 where 1 is very poor and 5 is very good</p> <p>SELECT ONE ONLY AND RATE FOR EACH FACILITY VISITED</p>	<p>1. Very Poor 2. Poor 3. Neutral 4. Good 5. Very Good 6. No response</p>
<p>B10Referring to health facility/is visited in the last 12 months would you say their services are better, same or worse compared to previous years? RATE FOR EACH VISITED</p>	<p>1. Better 2. Same 3. Worse 4. Can't tell/Don't know</p>
<p>B11To what extent do you agree that: the health facility you visit invests each year to improve the quality of care provided?</p>	<p>1. Strongly Disagree 2. Disagree 3. Neutral 4. Agree 5. Agree Strongly</p>

<p><b>SEXUAL ACTIVITY</b> <b>ASK ALL</b></p>	
<p>B12: Check for the presence of others before continuing and make every effort to ensure privacy Now I would like to ask about your sexual activity in order to gain a better understanding of some important life issues.</p>	<p><b>Age:</b></p>

<p>How old were you when you had sexual intercourse for the very first time?</p> <p>Never Had Sexual Intercourse (Record 00)</p> <p>First time when started living with first husband/partner (95)</p> <p>Refused to answer (record 99)</p>	
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**SECTION B: MATERNAL AND CHILD HEALTH**

<b>MATERNAL HEALTH</b>	
B13: Have you or has your partner (for men) ever given birth before?	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>
B14 IF YES: When was the last child born? SELECT ONE ONLY	<ol style="list-style-type: none"> <li>1. In the last 12 months</li> <li>2. 1-2 years ago</li> <li>3. More than 2 years ago</li> </ol>
B15 Where did you/your partner give birth?	<ol style="list-style-type: none"> <li>1. Public Health Facility</li> <li>2. Private Health Facility</li> <li>3. At home alone</li> <li>4. At home with a traditional birth attendant</li> <li>5. At traditional birth attendant home</li> <li>6. Other..specify</li> </ol>
B16 What influenced the decision to give birth at the place you have mentioned.	<ol style="list-style-type: none"> <li>1. Health insurance</li> <li>2. Better services</li> <li>3. Nearer to my home</li> <li>4. Was an emergency thus I had no control</li> <li>5. Privacy</li> <li>6. Other..specify</li> </ol>
B17 Was it a normal delivery or caesarian section	<ol style="list-style-type: none"> <li>1. Normal delivery</li> <li>2. Caesarian</li> </ol>

B18 How much was paid at the time of delivery of this child where you mentioned the birth took place?	Amount UGX Other specify.....
B19 During the pregnancy of this child, did you attend antenatal clinics	1. Yes 2. No
B20 How many ANC visits did you attend	WRITE IN
B21 How old were you when you/your partner gave birth to your first child?	WRITE IN
<b>FAMILY PLANNING</b>	
B22 When you got pregnant, did you want to get pregnant at that time?	1. Yes 2. No
B23 Are you currently doing something or using any methods to delay or avoid getting pregnant?	1. Yes 2. No 3. Not sexually active
B24 Which method are you using?  DO NOT PROMPT  Write all responses given	1. Female Sterilization 2. Male Sterilization 3. IUD/Coil 4. Injectable 5. Implants 6. Pill 7. Male condom 8. Female condom 9. Rhythm Method/Safe days 10. Withdrawal 11. Emergency pills 12. Any other, specify _____ 13. None

<b>HEALTH OF CHILDREN UNDER TWO (2) YEARS (IMMUNIZATION AND FEEDING PRACTICES)</b>	
B25 Do you have any child aged less than two years?	1. Yes 2. No
B26 How old (in months) is the child? If more than one child under two, ask for responses for the older child.	
INTERVIEWER, PLEASE ASK FOR THE CHILD VACCINATION CARD/BOOK AND CHECK FOR RELEVANT VACCINATIONS	1. Yes 2. No
B27 Child Vaccination Card/Book available	
B28: Child not immunized, no record, or only partially immunized	1. Fully immunized 2. Partially immunized 3. Not immunized 4. No record
B29: State reason for no immunization, partial immunization, or no record	1. Not able to access health facility 2. Against immunization 3. Other..specify
B30: Is the child still getting breastmilk?	1. Yes 2. No 3. Don't know
B31: How old was the child when he/she started drinking/eating anything else apart from Milk?	1. 1 Month or Younger 2. 2 Months 3. 3 Months 4. 4 Months 5. 5 Months 6. after 5 months

**SECTION C: COOPERATIVE MEMBERSHIP AND BENEFITS**

**ASK ALL**

C1: Do you or any member of this household belong to a health cooperative?	1. Yes 2. No
How many members of your household are currently enrolled in health cooperative insurance	
C2a: Give the name of the health cooperative care provider	Actual Name.....
C3: Do you belong to other cooperatives? If so, what type of cooperative?	1. Farmers/Agricultural Cooperative 2. SACCO 3. Other: specify
C4: For how long (YEARS/MONTH) have you benefitted from cooperative health insurance?	
	1. Once a month 2. 1 time every 3 months

C6: How often do you pay premiums?	<ol style="list-style-type: none"> <li>3. 1 time every 4 months</li> <li>4. 2 times a year</li> <li>5. Once a year</li> <li>6. Can't recall</li> </ol>
C7: Have you ever not paid premiums for health insurance for one or more periods?	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>
C8: Did you need to seek health care for a family member when you had not paid?	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>
C9: If yes, what did you do?	
C10: What services does the health cooperative give you as a member?	.....
C11: How would you rate the quality of services offered to you through cooperative health insurance?	<ol style="list-style-type: none"> <li>1. Excellent</li> <li>2. Good</li> <li>3. Average</li> <li>4. Poor</li> <li>5. Very Poor</li> </ol>
C12: To what extent are you satisfied with how your health cooperative insurance is managed/run? (READ OUT SCALE)	<ol style="list-style-type: none"> <li>1. Very Satisfied</li> <li>2. Very satisfied</li> <li>3. Average</li> <li>4. Dissatisfied</li> <li>5. Very Dissatisfied</li> </ol>
C13: How have you benefitted from cooperative health insurance? TICK ALL THAT APPLY	<ol style="list-style-type: none"> <li>1. Lower cost due to shared risk</li> <li>2. Access to quality health care</li> <li>3. Avoid borrowing</li> <li>4. Avoid unexpected possibly catastrophic bills</li> <li>5. Ability to plan to pay premiums</li> <li>6. Reduced worry and stress</li> <li>7. Improved relationship with partner now that care seeking is no longer an issue</li> <li>8. Other specify _____</li> <li>9. Don't know/None</li> </ol>
C14: Based on your experience, does being a member of a health cooperative make it easier, more difficult or the same in accessing health services?	<ol style="list-style-type: none"> <li>1. Much easier</li> <li>2. The same</li> <li>3. More difficult</li> </ol>
C15: In your opinion, do you get a better service or not from a health facility if you are a member of a health cooperative compared to a non-member?	<ol style="list-style-type: none"> <li>1. Better</li> <li>2. Same</li> <li>3. Worse</li> </ol>
C16: In your opinion, do health cooperative members pay less, the same or more than non-members?	<ol style="list-style-type: none"> <li>1. Less</li> <li>2. Same</li> <li>3. More</li> <li>4. Don't Know</li> </ol>

<p>C17: Do you recommend that your neighbors or friends enroll in health cooperative insurance? Why or why not?</p>	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol> <p>Why or why not?</p>
<p><b>(ASK ONLY THOSE WHO ARE NOT MEMBERS OF A HEALTH COOPERATIVE)</b> C18: Are you aware of a health insurance scheme?</p>	<ol style="list-style-type: none"> <li>3. Yes</li> <li>4. No</li> </ol>
<p>C19: Please tell me all the health insurance schemes you are aware of</p>	
<p>C20: How did you find out about health insurance? <b>(MENTION SCHEME AWARE OF IN C15)?</b></p> <p>SELECT ALL THAT APPLY</p>	<ol style="list-style-type: none"> <li>1. TV</li> <li>2. Radio</li> <li>3. Church</li> <li>4. Written Material</li> <li>5. Friends/Relatives</li> <li>6. Group, list type_____</li> <li>7. Cooperative Staff, board member</li> <li>8. School</li> <li>9. Health worker</li> <li>10. Village health team volunteer</li> <li>11. Other, specify _____</li> <li>12. Don't know/Can't recall</li> </ol>
<p>C21: Are you aware of some of the benefits of being a health insurance cooperative member?</p>	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>
<p>C22: What are some of the benefits of being a health insurance cooperative member? SELECT ALL THAT APPLY</p>	<ol style="list-style-type: none"> <li>1. Lower cost due to shared risk</li> <li>2. Access to quality health care</li> <li>3. Avoid borrowing</li> <li>4. Avoid unexpected possibly catastrophic bills</li> <li>5. Ability to plan to pay premiums</li> <li>6. Reduced worry and stress</li> <li>7. Improved relationship with partner now that care seeking is no longer an issue</li> <li>8. Other specify _____</li> <li>9. Don't know/None</li> </ol>
<p>C23: In your opinion, do health cooperative members pay less, the same or more than people who pay out of pocket for care?</p>	<ol style="list-style-type: none"> <li>1. Less</li> <li>2. Same</li> <li>3. More</li> <li>4. Don't Know</li> </ol>
<p>C24: What is the distance to the nearest Cooperative health facility from your house? WRITE IN</p>	<p>Distance in KMS</p>

<p><b>C25: Ask if not a health cooperative member in C1&amp;C3:</b> Why are you not a member of a cooperative health insurance scheme? SELECT ALL THAT APPLY</p>	<ol style="list-style-type: none"> <li>1. Long distance to health care facility</li> <li>2. Limited information on benefits</li> <li>3. High cost of premium</li> <li>4. Don't know how to join</li> <li>5. Not interested</li> <li>6. Other, specify _____</li> </ol>
<p><b>C26: Ask if not a health cooperative insurance member in C1 &amp; C3: C27:</b> Would you like to join a cooperative health insurance scheme</p>	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>
<p>C28: Would you attend a session at a health facility to learn how to join a health cooperative?</p>	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>
<p>C29: On average, how long (in minutes) did you wait for care after you arrived the last time you visited the health center?</p>	
<p>C30: If you could learn about health insurance while you are waiting at a health center, would you want to? Why or why not?</p>	<ol style="list-style-type: none"> <li>5. Yes</li> <li>6. No</li> </ol> <p>Why or why not?</p>

**THANK YOU.END.**

## Annex 3 Health Facility Assessment Tool

### A: IDENTIFICATION

#### Introduction

Hello, my name..... working on behalf of Soland Associated Consults Limited, a legally registered research consultancy firm in Uganda. Soland was contracted to carry out a study on behalf of HealthPartners Uganda. The study aims at understanding people’s knowledge, attitudes and practices towards access to health services in your community and their contribution to healthcare. The information you provide will guide HealthPartners to effectively implement its project intervention in support of health cooperative development in Uganda. Your participation in this survey is completely voluntary and all of your answers will be kept in the strictest confidence. Your responses will be combined with that of others to show aggregated views and opinions.

Can I continue with the interview? Yes..1 No..2**(IF NO TERMINATE)**

START TIME: |\_|\_| :|\_|\_| AM / PM

District	
Sub county	
Name of Health Facility	Level: HC II, III, IV, Hospital
Ownership status	Public... 1 Private... 2
Year and Month Facility began offering Cooperative Health Insurance	
Name of respondent	
Position/title of respondent	

### B: PATIENT ATTENDANCE; MATERNAL & CHILD HEALTH INDICATORS & COST RECOVERY TOOL

Note to Interviewer: For this part we need to collect information for each and every month from January 2019 to December 2020.

- 1. Cost Recovery-** Actual data for each month/year where available will be documented from Cooperative Performance Tracking Tools (CPTT) for Coops (CR2, 3, 4,6 & 7) and from the

Health Management Information System (HMIS) tools for out of pocket (OOP) treatment costs, number of treatments and payment received.

CR 1 Does the health facility have current records for last two financial years[**the month**](Ask to see HMIS 105, 108, 109, Financial Summary and CPTT data.)

	Seen	Complete filled	Most recent date on filled form
HMIS (Health Management Information System) 108- Inpatient Monthly report. Census Information (Number of admissions)			
HMIS (Health Management Information System) Form 105: Health Unit Outpatient Monthly Report			
HMIS Form 109: Health Unit Population Report			
CPTT (Cooperative Performance Tracking Tools)			

Please list the data that your facility includes in HMIS Section 7.

	Yes	No	Don't Know
Out of pocket payment Received that month			
Payment received from OOP outstanding bills or line of credit			
Government funds			
Voucher reimbursement			
Coop premiums			
Coop copay			
Other _____ Please specify			

**COST RECOVERY TARGETING HEALTH CARE PROVIDER (should be collected for each financial year 2019 and 2020)**

		2019 and 2020	List data available and calculate for each month for the [ <b>the month</b> ]	Calculation	Data Source at facility
CR 2	What was the total amount of premiums plus copay received			Total of Premiums plus copay for the [ <b>the month</b> ]	CPTT

	from health co-op members?				
CR 3	What was the total number of co-op members treated [ <b>the month</b> ]			Total number of co-op members treated	CPTT
CR 4	What was the total cost of the treatment given to co-op members?			Total cost of treatment given to co-op members in	CPTT
CR 5	What was the total number of out of pocket payers treated?			Total number of OOP payers treated in	HMIS, OPD, IP registers
CR 6	What was the total cost of care provided for out of pocket payers treated?			Calculate the total cost of care given to OOP treated minus the total premiums and copay from coop members for each month (CPTT)	HMIS Financial Summary
CR 7	What was the total amount of money received for care provided? Calculate [ <b>the month</b> ]				HMIS Financial summary) and CPTT
CR 8	What was the total amount of money received from out of pocket payers for care provided?			Calculate the total cost of care received from all patients who received treatment at the facility from [ <b>the month</b> ] minus the total cost of premiums and copay received from coop members for the same period	HMIS 105 (Section 7 Financial summary) and CPTT
CR 9	What was the average cost recovery from coop members from Jan 2019 to December 2020			The sum of premiums plus copay (CR 2) minus treatment costs, CR4. Divide by the # of Co-op members CR2. $(CR2 - CR4) = X \quad X/CR3$	CR2, CR4, CR3
CR 10	What was the average cost recovery from out of pocket payers between [ <b>the</b>			The sum of the total cost of care given to OOP, CR6 minus the amount of funds	CR5, CR6, CR8

	<b>month]</b> (Calculate the total cost of care given to OOP (CR6) minus the amount of funds received from OOP (CR8) divided by the number of OOP visits (CR5).			received from OOP, CR7 divided by the number of OOP visits, CR5. (CR6-CR7)=X X/CR5	
--	---	--	--	--	--

\*CR=Cost recovery

- Patient's Served to determine demand and to compare coop members vs. number of non-coop members served-** data will be collected from HMIS (Form 105 for outpatient report and 108 Inpatient Census Monthly report (total for the year will be taken)

Department	Male Patients [the month]		Female Patients [the month]		Total Patients by department	
	Coop	Non-c	Coop	Non-c	Coop	Non-c
Outpatient						
Inpatient						
Total Overall						

- Maternal and Child Health Indicators-** data will be collected from HMIS Form 105: health Unit Outpatient Monthly Report

	Number tallied for the year[the month]		
	Cooperative members	Not cooperative members	%
ANC 4 <sup>TH</sup> Visit			
Number of Deliveries in the unit			
Babies born with low birth weight (less than 2.5 kgs)			
New Born Deaths			
Maternal Deaths			
Deliveries with TBA			

**For child health indicators, HMIS 105: Health Unit Outpatient Monthly Report**

Child Health Indicators	Number tallied for the year[the month]	
	Cooperative member	Out of pocket payers
Fully immunized ( Male and Female) Year 1		
Children underweight below line -2sd (6-11 months)		
Children overweight above line +3sd (6-11 months)		
Babies born with low birth weight (less than 2.5 kgs)		
Total number of children weighed at measles vaccination		

### END OF INTERVIEW

#### Annex 4: List of participants

	Name	Contact	Area
1.	Wetaka pies	0707616247	Sironko
2.	Dijambogo Patrick	0777396238	Sironko
3.	Wojukira Stephen	0783208226	Sironko
4.	Nadunga Joan		Sironko
5.	Matrilluda Juliet	0751132823	Sironko
6.	Kimono Hadijah	0789331216	Sironko
7.	Neumbe Doreen	0751703394	Sironko
8.	Mugidelnat	0702277132	Sironko
9.	Nafunaphiona	0702277133	Sironko
10.	WegosasaKotida	0702277133	Sironko
11.	Bwayirisa Susan	0788719277	Sironko
12.	Kyatusimire Prossy	0756896629	Sironko
13.	Nafuna Margret	0784491800	Sironko
14.	Nadudu Prossy	0784763824	Sironko
15.	Neumbe Priscilla	0789487598	Sironko
16.	NambozoShifah		Sironko
17.	NambafuShanitah		Sironko
18.	Nambe Vincent		Kalungu Villa Maria Hosp
19.	Jimmy Edema		Luwero Bishop Asili Hosp

19.	Dr.SSemwanga Edward		Kalungu-Villa Maria Hosp
20.	Ms.Akellosaranedi	0781512110	Alebtong District
21.	Mr.RichardAgemu	0776059657	ADHO/MCH- Alebtong District
22.	Mr. Ogwal Moses	0757925329	District agriculture Officer/Acting DCO- Alebtong District
23.	Mr.OgwalPaulino	0783933703	Acting CDO- Alebtong District
24.	Mr.Enon Alex	0782562447	District Commercial Officer- Oyam District
25.	Mr.FelixOyuge	0782793074	Proprietor Aero Medical center- Oyam District
26.	Mr.JohnsonAdinda		Program Manager
27.	Ms. Connie Ainebyona		Connect Girl centre
28.	Pamela KomugishaTumwesigye,	0782402208	Desk Officer for Health cooperatives- MTICD
29.	Natuhherwa Judith		Clinical Officer Kakoma Health Center III- Isingiro District
30.	MrMugarura Edward		Commuity development Officer Isingiro District
31.	MrsKalungu Clemence		maternal child health officer Isingiro district
32.	Evas Naturinda		Ankole Archdiocesan Coordinator for HealthPartners
33.	John		Biharwe Health Center
34.	Kirabo Alexander		Deputy District Commercial Officer –Ibanda District
35.	Dr Julius Bamwine		District Health Officer – Ibanda District
36.	Moses Baguma		Senior Commercial Officer – Ibanda District
37.	Dr. Sarah Byakika		Commisioner for Planning MoH



KPC Tables members  
and non members.xls