FINAL EVALUATION REPORT: LIRA DISTRICT CHILD SURVIVAL PROJECT IN UGANDA

December 2013

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Sue Leonard, Evaluation Team Leader, Mary Helen Carruth, MTI HQ Senior Advisor, Maternal and Child Heath, Todd Nitkin, MTI HQ Senior Advisor, Monitoring and Evaluation, and Lydia Akulo, Child Survival Project Manager

Acknowledgements

This final Evaluation is the result of the work of many people over the course of several months. Many thanks go to all of those who organized, implemented, and analyzed the surveys that provided the information base for the qualitative review. Thanks also go to the Evaluation Team who worked many long hours to gather and analyze the information from the field; and to the community volunteers, health facility staff and community and facility committee members who shared their wisdom with us. Most especially, thanks go to the CSP staff and management for implementing a successful program in collaboration with the District Health Office as well as the headquarters people who often work behind the scenes to help make such a program happen.

Thank you to you all,

Sue Leonard, Evaluator

Final Evaluation Report: Lira District Child Survival Project in Uganda

EDUCATING COMMUNITY HEALTH WORKERS, CAREGIVERS, AND HEALTH PROVIDERS REGARDING MATERNAL CHILD HEALTH AND EARLY CHILDHOOD DEVELOPMENT IN A POST-CONFLICT ENVIRONMENT

December 1, 2013

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ACRONYMS

ANC	Antenatal Care
BL	Baseline
CSHGP	Child Survival and Health Grants Program
C-IMCI	Community-based Integrated Management of Childhood Illness
CSP	Child Survival Program
DHO	District Health Office
ECD	Early Childhood Development
ER	Emergency
EBF	Exclusive Breastfeeding
FE	Final Evaluation
HE	Health Education
HF	Health Facility
HH	Household
HHI	Hands to Hearts International
HP	Health Provider
HUMC	Health Unit Management Committee
iCCM	Integrated Community Case Management
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IYCF	Infant and Young Child Feeding
KPC	Knowledge, Practice and Coverage
LC1	Local Council One (village level elected political official)
MLG	Mother Leader Groups
ML	Mother Leaders
MNC	Maternal Newborn Care
MoH	Ministry of Health
MTE	Mid-Term Evaluation
MTI	Medical Teams International
NU-Heights	Northern Uganda-Health Integration to Enhance Services
PE	Peer Educators
RHFA	Rapid Health Facility Assessment
SBC	Social and Behavior Change
USAID	U.S. Agency for International Development
VHT	Village Health Team (individual volunteers not teams)

Executive Summary
Final Evaluation Report: Lira District Child Survival Project in Uganda

This project was funded by the U.S. Agency for International Development through the Child Survival and Health Grants Program.

December 2013

Growth Monitoring - Apuce Health Center, Aromo

Key Findings:

- 88.2% of children 0-5 mo. were EBF during the last 24 hours
- 83.9% of children 0-23 were attended by skilled personnel at birth
- In 100% of HF, care-takers could correctly describe how to administer all prescribed drugs
- Reports from all community groups indicated that health facility staff are "friendly and do not harass any more"
- 83.6% of mothers of children aged 0-23 mo. report they talk/ sing to the child while feeding

Evaluation, Purpose, and Evaluation Questions

The FE provided an opportunity for all project stakeholders to take stock of accomplishments and lessons learned and to listen to beneficiaries at all levels. The FE Report will be used by the following audiences as a source of evidence to help inform decisions about future program designs and policies:

- The Lira District Health Office, health facility staff, and Health Unit Management Committees (HUMC)
- Uganda Ministry of Health
- Village Health Teams (VHT) and Mothers Leader Groups volunteers
- Hands to Hearts International (HHI)
- The USAID CSHGP and the Uganda USAID Mission
- Medical Teams International (MTI) HQ and field staff

Key Evaluation Questions

1) To what extent did the project accomplish objectives stated in the DIP?
   Objective No.1: Communities assume responsibility for their own health through strengthened community capacity

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

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

   Objective No.4: Strengthened institutional capacity of MTI and the Lira District Health Office to implement effective child survival activities.
2) To what extent was the project implemented as planned? What changes were made to the planned implementation, and why those changes were made?
3) How were gender considerations addressed through the project? Are there any specific gender-related outcomes?
4) Which elements of the project have been or are likely to be sustained or expanded?

FINAL EVALUATION EXECUTIVE SUMMARY

The Northern region of Uganda is one of the poorest parts of the country, (DHS 2011 found 40% of the population in the lowest wealth quintile) was marginalized from development benefits, and has suffered the effects of roughly 20 years of conflict and displacement. MTI collaborated on this four-year entry grant with the Lira District Health Office (DHO) team for operation in Erute North Sub-District (including Lira, Ogur and Aromo sub-counties) to revitalize the capacity for maternal and child primary health care. The project area had four health facilities (HF) at the onset of the project, three with delivery services; an additional four were reopened in April 2012, all four basic facilities are without delivery capacity.

The 2011 DHS found a national infant mortality rate (IMR) of 54 per 1,000 live births while in Northern region the rate was 66, a child mortality rate (U5MR) of 90 per 1,000 live births with a rate of 105 in the North and a maternal mortality ratio (MMR) of 438 per 100,000 live births for the mid-2004 to mid-2011 period, higher than the MMR of 418 in the 2006 DHS.

Evaluation Design, Methods, and Limitations

MTI used a two-pronged strategy to improve the health and nutrition status of women and children under age five: a) to promote behavior change and community mobilization to take appropriate responsibility for health; and b) through training and mentoring, to build the DHO capacity to provide sustainable, quality service delivery at the facility and community levels. The primary project partner was the Lira DHO and all project interventions supported the district five-year development plan. Secondary partners were the sub-county governments and their extensions. MTI's supporting partner was HHI, an Oregon-based NGO specializing in early childhood development (ECD) for infants and very young children.

The Final Evaluation (FE) consisted of a combination of quantitative and qualitative methods using participatory techniques. The preparation began with alerting all partners to the future evaluation and gaining their commitment to be involved in the process. Both a 30 cluster Knowledge, Practice and Coverage survey (KPC) and a Rapid Health Facility Assessment (RHFA) were conducted and preliminary data reports were provided to the evaluation team. The consultant, Director of HHI, HQ Senior Advisor, Maternal and Child Health, and the Child Survival Project (CSP) Manager prepared qualitative interview guides and the evaluation process in accordance with USAID's Evaluation Guidelines.

A one-day orientation and training was conducted for the evaluation team to review focus group interview techniques and guides. Focus group discussions were held in selected communities in each of the sub-counties to gather qualitative information from representatives from each target population group. Those interviewed were: groups of mothers and, separately, fathers, VHTs and Mother Leader Groups (MLGs), HF staff, HUMCs, Parish Development Committees (PDC), and Sub-county chiefs. CSP staff participated in interviews in geographic areas where they were not working. Qualitative data collection followed the interview guides designed to triangulate results of the RHFA and KPC as well as to assess the effectiveness of project processes and ascertain projections concerning project sustainability. The external consultant led evaluation team members through a participatory analysis of the findings from focus group interviews, the KPC and RHFA.

Because four new HF were opened in April 2012 there was little time for improvements to be made; to report on RHFA data in a meaningful way, only data from the original four clinics is included in this narrative report. Lira and Ogur communities were included in the ECD qualitative evaluation however did not receive services the final 18 months. Because the remaining project was implemented in all communities, non-ECD intervention communities were chosen for focus groups limiting the qualitative ECD information gained in Lira and Ogur.

Findings and Conclusions

Question 1: To what extent did the project accomplish the objectives stated in the DIP? Both the KPC and the RHFA showed improvements, many statistically significant, in all indicators from baseline and those improvements were born out by focus group discussions with all interviewed groups.

Focus groups of parents, various community volunteers and health providers all reported project promoted changes in behaviors in households (HH) they thought impacted the health of the community.

Finding/Behavior Change	KPC	RHFA
Increase in immunization completion by one year of age	Baseline (BL) 15.5% to 56% at final	
Exclusive Breastfeeding	BL 73% to 88.2% at final	
Women are attending ANC for 4 visits, receiving TT, and delivering at the health facility	ANC: BL 35% to 58%; TT: 76% to 86%; Deliver at HF: 35% to 84%	
Increased availability and use of latrines with hand washing resources	BL 54% to 88% at final	
Mothers talking or singing to their child while feeding	BL 23% to 64% at final	
Caretakers able to correctly describe how to administer all prescribed drugs		BL 0%,100 at final

Question 2: To what extent was the project implemented as planned? MTI implemented a solid child survival (CS) project essentially as planned.
Question 3: How were gender considerations addressed through the project? MLGs were formed and trained to deliver health education (HE) to HHs as 75% of VHTs were men, and the ECD intervention actively included men in HE regarding options for interacting with children and child care.
Question 4: Which elements of the project have been or are likely to be sustained or expanded? See conclusions.

Conclusions:

- MTI implemented a solid CS project with many statistically significant results both at the community and health facility levels.
- District and Local Government are assuming responsibility for continuing interventions through government mandated, project strengthened, structures, health personnel and community volunteers.
- Positive relationships were developed between the HFs and communities they serve, reducing animosity and increasing trust.
- Strong community volunteer cadre was developed, trained and supported; support continues through government mandated structures and health personnel. MLGs and peer educators (PE) were added to existing volunteer cadre increasing HH coverage.
- ECD intervention also had statistically significant results as well as enthusiastic community and HF staff acceptance with reported increases in male involvement in child care and decreases in family violence. More research would be required to determine the extent of the ECD effect on household violence.
- Project management continued to evolve and improve over the life of the project.

Recommendations:

- Implement projects in close collaboration with governmental systems, especially in decentralized countries.
- DHO and Sub counties continue to support HF staff, HUMCs, PDCs and community volunteer cadres.
- Formally integrate MLGs and PEs into DHOs community volunteer cadre and replicate the model in other areas of the District.
- MTI replicate HH volunteers in any new community behavior change project.
- MTI include strategies for improving HF/community working relationships in future health project designs.
- Collaborate with HHI to design an effective strategy for ECD implementation at scale.
- MTI Africa Regional Team continue monitoring OCA progress and support MTI Uganda staff.

The Lira District Child Survival Project in Uganda in Erute North Sub-District, Uganda is supported by the American people through the United States Agency for International Development (USAID) through its Child Survival and Health Grants Program. The Lira District Child Survival Project in Uganda is managed by Medical Teams International under Cooperative Agreement No. GHS-A-00-09-00012. The views expressed in this material do not necessarily reflect the views of USAID or the United States Government.

For more information about Lira District Child Survival Project in Uganda, visit: www.medicalteams.org

EVALUATION PURPOSE AND EVALUATION QUESTIONS

EVALUATION PURPOSE

The Final Evaluation (FE) provides an opportunity for all project stakeholders to take stock of accomplishments and lessons learned to date and to listen to beneficiaries at all levels. The FE Report will be used by the following audiences as a source of evidence to help inform decisions about future program designs and policies:

- The Lira District Health Office (DHO), health facility (HF) staff, and Health Unit Management Committees (HUMC)
- Uganda Ministry of Health
- Village Health Teams (VHT) and Mother Leader Group (MLG) volunteers
- Hands to Hearts International (HHI)
- The USAID CSHGP and the Uganda USAID Mission
- Medical Teams International (MTI) HQ and field staff

The evaluation is the FE for this four-year entry grant child survival project. There will be no follow-on programming implemented by MTI, therefore the results of the FE will be used by the DHO, the Sub-County leadership, HF staff and HUMCs, and village leadership and volunteers to develop strategies for continuing and/or adjusting the Child Survival Project (CSP) programming as appropriate. In addition:

- MTI is considering integrating lessons learned into their other programming in Uganda, especially in the Northern region;
- HHI will integrate lessons learned into their other world-wide programming;
- USAID mission may consider replicating successful program approaches in other programs in Uganda.

The evaluator was hired with project funds with specific approval from USAID. In addition, MTI worked with the Child Survival and Health Grants Program (CSHGP) to develop the Scope of Work (SOW), which received final approval from USAID. The draft and final reports are being submitted to CSHGP and MTI simultaneously. Because the evaluator is residing outside of the US, the final report will be submitted simultaneously electronically to both CSHGP and to MTI. MTI will complete publication of the document and submit the hard and CD copies to the various USAID agencies as described in the guidelines.

EVALUATION QUESTIONS

1) To what extent did the project accomplish objectives stated in the DIP?

   Objective No.1: Communities assume responsibility for their own health through strengthened community capacity

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

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

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

2) To what extent was the project implemented as planned? What changes were made to the planned implementation, and why those changes were made?
3) How were gender considerations addressed through the project? Are there any specific gender-related outcomes?
4) Which elements of the project have been or are likely to be sustained or expanded?

PROJECT BACKGROUND

RESULTS FRAMEWORK

GOAL	Reduce child morbidity and mortality in Uganda.			
STRATEGIC OBJECTIVE	Sustainable improvements in preventive maternal and child health behaviors and use of strengthened health services in Erute North Sub-District of Lira District.			
RESULTS / OBJECTIVES	Communities assume responsibility for their own health through strengthened community capacity (Village Health Teams, Parish Development Councils, and Health Unit Management Committees).	Improved health (C–IMCI) and child care (Early Childhood Development) behaviors among mothers of children under 5 years of age.	Improved quality of Health Center services through strengthened capacity for Integrated Management of Childhood Illness and Maternal Newborn Care.	Strengthened institutional capacity of Medical Teams International and the District Health Office to implement effective and efficient child survival activities.
KEY ACTIVITIES	Strengthen capacity of Village Health Teams in C-IMCI using a social and behavior change approach. Establish structured referral system between VHTs and local health facilities. Facilitate collaboration between VHTs and PDCs and HUMCs to benefit MCH.	Village Health Teams promote social and behavior change through existing channels (women's groups, church groups, community meetings) and through home visits.	Support IMCI training for health facility staff. On-the-job mentoring of health facility staff. Joint supportive supervision with DHO and partners.	HQ support for MTI Uganda capacity through structured plan based on Organizational Capacity Assessment and technical assistance in social and behavior change and monitoring and evaluation. MTI/DHO joint activities for planning, training, implementation, and evaluation.

HISTORY AND DEMOGRAPHICS

Context:

The Northern region of Uganda is one of the poorest parts of the country, (DHS 2011 found 40% of the population in the lowest wealth quintile) was marginalized from development benefits, and has suffered the effects of roughly 20 years of conflict and displacement brought about by the atrocities of the Lord's Resistance Army. By the time of the onset of the project, the population was returning to their homes and the internally displaced persons camps closed in December 2010. The project was implemented in the three sub-counties of Aromo, Ogur, and Lira. Of the three, Aromo was the most affected by the conflict with a larger proportion of families displaced and returning to their homes through the first year of the project; its infrastructure was also destroyed to a greater degree. The prolonged conflict resulted in numerous orphans throughout the three sub-counties, many of whom have been absorbed into households, further stretching existing resources. The three sub-counties continued to progress toward peace and stability through the life of the project and no further episodes of conflict occurred.

The 2011 DHS found a national infant mortality rate (IMR) of 54 per 1,000 live births while in Northern region the rate was 66, a child mortality rate (U5MR) of 90 per 1,000 live births with a rate of 105 in the North and a maternal mortality ratio (MMR) of 438 per 100,000 live births for the mid-2004 to mid-2011 period. This is higher than the MMR of 418 in the 2006 DHS.

MTI collaborated with the Lira DHO team for operation in Erute North Sub-District (Lira, Ogur and Aromo sub-counties) to revitalize the capacity for maternal, newborn and child primary health care.

MTI's Development Hypothesis and beneficiaries:

If we involve and educate community resource people/structures (VHTs, mothers groups, PDCs and HUMCs) to build their capacity to improve health at the household and community levels through promotion of key family health and child development practices, referrals, and community case management, as a result, key family health practices and referrals will improve.

VHTs were trained in integrated community case management (iCCM), however are not providing CCM services, as the drug supply in the district is insufficient for distribution at the community level.

CSP directly benefited 25,498 children under age five (U5) and 25,498 women of reproductive age for a total of 50,996 direct beneficiaries, including: 5,348 infants 0-11 months, 5,400 children 12-23 months, and 14,750 children 24-59 months. The total population of the project area is 124,379.

PROJECT DESIGN AND PARTNERS

Project Goal and Strategy:

The project overall goal was to reduce child morbidity and mortality in Erute North Sub-district of Lira District in northern Uganda.

MTI used a two-pronged strategy to improve the health and nutrition status of women and children under age five: a) to promote behavior change and community mobilization to take appropriate responsibility for health; and b) through training and mentoring, to build the DHO capacity to provide sustainable, quality service delivery at the facility and community levels.

Key Partners – Lira District Health Office and Government Structures:

The primary project partner was the Lira DHO of the Ministry of Health and the HUMCs and clinics in the sub-counties the project served. All project interventions supported the District's five-year development plan. Secondary, but very closely related, partners were the sub-county governments and their extensions, the Parish Development Committees (PDC) and Local Council Is (LC1). All programming was in collaboration with the DHO and the Sub-county chiefs of the three sub-counties.

HUMCs were reestablished according to government regulations at each of the four new health facilities and strengthened at the four original facilities.

Because the Ugandan governmental system is decentralized, structures with authority were in place for the project to work with and through. Two VHTs, chosen by the community, were in place as the community link to the HF although their training was minimal; LCIs were politically elected in each village and mandated to oversee its wellbeing; PDCs, the next level up, include LC1s from each community, a VHT representative, and are responsible for developing plans incorporating community needs. These plans are sent on up to the Sub-county level. The Sub-county is responsible for all activities within their area and liaises between their HFs and the DHO to address health issues. Each HF has a HUMC, made up of "people of integrity" who are responsible for ongoing operations of the HF; the HF in-charges are appointed as secretaries to the committee. The DHO is primarily responsible for clinical issues. In the project areas, the PDCs and HUMCs worked together to address HF management issues (counting drugs on arrival, protecting the HF property, staff housing, advocating for improvements/ expansions of the physical plant and/or staff and services.)

Supporting Partner – Hands to Hearts International (HHI):
HHI, an Oregon-based NGO specializing in early childhood development (ECD) for infants and very young children, was contracted to provide a training of trainers for MTI and HF staff on ECD. HHI first adapted their model in another Ugandan population, using the resulting modifications and trainers to conduct the training in Lira. They also provided some monitoring/mentoring for the project intervention. The training consisted of eight modules, delivered approximately weekly to parents and caregivers by two community identified Peer Educators (PE), a man and a woman. The modules include information on: the role of parenting; physical, cognitive, language, and social and emotional development; baby cues and massage; and health, hygiene, nutrition and sanitation. The intervention was originally implemented in selected communities across the three sub-counties however, in response to the mid-term evaluation (MTE); the implementation strategy was altered to focus on all of the communities in Aromo sub-county with no further formal work being done in Ogur and Lira.

Health Facilities in project area:
By the end of the project there were eight HFs in the target area. One Level IV HF in Ogur functioning as a sub-county referral center for the three sub-counties, in addition Ogur has two HF IIs providing basic services, Lira has two HF IIIs, one providing delivery services and Aromo has one HF III with delivery services as well as two HF IIs. Since the MTE four HF IIs that had been closed during the conflict were reopened with staff housing, two in Aromo, and two in Ogur.

Level of Effort (LOE:)
Even though the project was entry level, MTI chose to focus on five technical areas in addition to ECD. They planned to devote 10% LOE to strengthen Immunization, 20% for Control of Diarrheal Disease, 25% for Pneumonia Case Management, 20% for Infant and Young Child Feeding (IYCF), and 25% for Maternal and Newborn Care (MNC). No LOE was devoted to the ECD activities funded out of the match. In actuality at midterm the project was devoting 55% of their effort to immunizations, with not enough attention to IYCF and MNC. The MTE recommended the project scale back on immunization activities and confine them to the original 10% LOE.

Training:
At the community level VHTs, 75% of whom are men, were trained in technical areas of the project intervention, iCCM and some in ECD. Mother Leader Groups (MLG) were formed with members chosen by the communities and expanded from 300 to 1428 in response to the MTE recommendation to improve household (HH) coverage. A group of 96 were trained as trainers and all members were trained on key maternal and newborn care (MNC) and nutrition issues. Both VHTs and MLG members received information, education, and communication (IEC) materials. The Training of Trainer Mother Leaders (ML), as the 96 were called, provided first line mentoring for MLGs in their areas. PEs, and

selected VHTs received ECD training. PEs and MLGs generally conducted HH and small group health education (HE) while VHTs generally provided back up support to both groups, were responsible for community mobilization and were the primary liaison between the community and the clinic on clinical matters. A structured referral system was developed and both VHTs and MLGs referred patients to the clinic. LC1s were not specifically trained, however were welcome and eager to attend VHT, MLG, and PE training and refreshers.

Health providers (HP) in the original four HFs and in the four which opened in April 2012, received IMCI training and refresher training with guidelines and wall charts for the clinic. They also received on-the-job mentoring and joint supportive supervision with the DHO, and training in ECD, MNC, supportive supervision and the referral system. HUMCs and PDCs were not directly trained in technical issues, however, were encouraged to join the VHT, MLG and PE training and refresher training. The PDCs were however trained in developing emergency (ER) transport systems in their communities. Quarterly meetings were also held for VHTs and MLGs to problem solve and upgrade their skills. MLs met bi-weekly with MLG members to identify and resolve any issues. Health Providers, HUMCs and PDCs were invited to the quarterly meetings to ensure all stakeholders heard consistent messages and to help resolve problems that arose between the community and the HF.

Gender:
Gender norms in the project area often preclude women from deciding on their own when to seek health services or participate in outreach or HE activities. Men often still make decisions about how women use their time and access family resources. This was addressed in a number of ways. Because 75% of the VHTs are men and the turnover was very low, a cadre of MLG members was added to the community volunteer resources to ensure young mothers had a comfortable resource for HE. VHT contacts provided men with more information on health concerns, especially on maternal health and danger signs, encouraging them to be more involved in the health of their families and attend antenatal care (ANC) with their wives.

The village PE team consisted of a man and a woman to ensure both men and women would be reached with the ECD messages. Both the PEs and the MLGs addressed domestic violence in their health messages as well as male involvement in health issues in the family. The focus groups indicated both that domestic violence had decreased and men were attending more ANC visits with their wives.

Technical Package:
The technical package and activities were clear and, after modifying the implementation in accordance with the MTE recommendations, were well implemented and documented.

ADDITIONAL PARTNERSHIPS

Collaborations:
The Malaria Communities Program, also implemented by MTI, served an overlapping geographic area and provided opportunities to collaborate on project surveys, community feedback sessions, staff training and, where the actual projects overlapped, on project activities.

A Program Associate from MCHIP Washington provided CSP staff training on sustainability. UNICEF supports the Child Health Days as did the CSP.

USAID Uganda Health Objectives:
The project focused at a community and sub-county level on each of USAID Uganda's health objectives. HF staff were trained in MNC; DHO and HF staff were trained in supportive supervision; and the new health facilities were provided with basic equipment. The primary project focus was at the community level where three cadres of volunteers were trained in basic health messages including the need for ANC visits and HF deliveries. Strong links were forged between the HFs and the communities with communication between the two groups improving as described by each group during focus group

discussions. PDCs and HUMCs honed their advocacy skills resulting in four HFs being refurbished, staffed and equipped with the basics. These groups are currently planning their next advocacy efforts for the health needs of their communities.

MTI Relationship with USAID Uganda:
MTI kept the USAID mission informed about activities and constraints throughout the project. The DIP and annual reports were shared with the Mission Health Team. Debriefings were held during DIP development and after the midterm and final evaluations. The Lira team also attended coordination meetings at the USAID Gulu office.

Annex IV, with additional information regarding achievements, additions and changes is found in the Annex section of this submission.

EVALUATION METHODS AND LIMITATIONS

The Final Evaluation consisted of a combination of quantitative and qualitative methods using participatory techniques. The preparation began with alerting all partners to the future evaluation and gaining their commitment to be involved in the process.

A 30 cluster Knowledge, Practice and Coverage survey (KPC) and a Rapid Health Facility Assessment (RHFA) was conducted in mid August, two weeks prior to the qualitative evaluation, guided by MTIs Senior Advisor, Monitoring and Evaluation. A 30-cluster stratified sampling design was utilized to select the mothers of children aged 0-23 months. A total of thirty clusters were sampled, with twelve households from each cluster being selected for interviews. With eight functioning HFs in the project area no sample size selection was necessary and all eight HFs were surveyed for the RHFA. Preliminary data reports were provided to the evaluation team for use in finalizing the interview guides. (*Final KPC and RHFA reports are included in* ***Annexes VI and X A****)*

The consultant, Director of Hands to Hearts International, HQ Senior Advisor, Maternal and Child Health, and the CSP Project Manager prepared qualitative interview guides and planned the evaluation process in accordance with USAID's Evaluation Guidelines. *(see* ***Annex XI*** *for a list of the documents reviewed)*

A one-day orientation and training was conducted for evaluation team members to review focus group interview techniques and the interview guides, and make necessary revisions to the evaluation logistics. Focus group discussions were held in each of the sub-counties with representatives from each target population group to gather qualitative information. Comparatively low performing communities, as well as high performing communities were identified by project staff prior to the evaluation. Groups of mothers and, separately, groups of fathers were interviewed in those communities using identical questionnaires. In addition, groups of VHTs within a Parish were interviewed as were MLGs. HF staff, HUMCs, PDCs and Sub-county chiefs were interviewed to gain a non-community perspective on the community interventions and to gain a health system perspective on the project. To limit bias, project staff participated in interviews in geographic areas where they were not working. A list of all those interviewed are included in ***Annex XI***. Qualitative data collection followed the interview guides that were designed to triangulate the results of the RHFA and the KPC as well as assess the effectiveness of project processes and ascertain projections concerning project sustainability. The complete packet of interview guides is included in ***Annex X B.***

The External Consultant led evaluation team members through a participatory analysis of the findings from focus group interviews and of the KPC and RHFA findings.

Results were triangulated using the following tools:

- Quantitative 30 cluster KPC survey of mothers of children age 0-23 months,
- Quantitative Rapid-Health Facility Services Assessment,
- Comparison of data with available national and regional data from 2011 DHS,
- Triangulation of perspectives of qualitative interviews with community volunteers, project beneficiaries, community leaders, health facility staff, sub-county leadership and district health staff.

Evaluation Participants were:

- External consultant,
- MTI Uganda project staff,
- Lira District Health Office and health facility staff,
- Sub-County and Community leaders and volunteers,
- MTI Senior Advisor, Monitoring and Evaluation and Senior Advisor, Maternal and Child Health.

Finalization of Key Findings, Recommendations, and Action Planning

- Debriefing on key findings and recommendations with representatives from community volunteers, health facility staff, sub-county leadership and district health staff. (*see* ***Annex XVI C*** *for FE Results Meeting Agenda*)
- Debriefing with USAID Uganda Mission (*see* ***Annex XVII*** *for debrief PowerPoint*)
- Debriefing with MTI Uganda and MTI Africa Regional staff

Evaluation Limitations

Because four new HF were opened in April 2012 just after the MTE, it left very little time for improvements to be made. This meant that in order to report on RHFA data in a meaningful way, only data from the original four clinics is included in the narrative of this report. The entire RHFA report is included in ***Annex X A.*** An issue for the ECD portion of the qualitative evaluation was that some communities from the comparison areas in Lira and Ogur were included in the ECD interviews, resulting in some of the communities chosen for interviews being ECD non-intervention communities. This limited the qualitative information available from intervention communities two years after the direct project support concluded.

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

FINDINGS

EVALUATION QUESTION #1: To what extent did the project accomplish objectives stated in the DIP?

Summary Table of Inputs, Activities, and Outputs That Contributed to Key Outcomes

Project Objective No. 1: Communities assume responsibility for their own health through strengthened community capacity			
Project Inputs	***Activities***	***Outputs***	***Outcome***
Five year Lira District Development Plan Trainers MTI staff mentors Referral forms for VHTs and MLGs	Strengthen capacity of VHTs and MLGs in C-IMCI with a social and behavior change (SBC) approach Establish a structured referral system for VHTs & MLGs to local HFs by providing training to HF staff, VHTs and MLGs and developing forms. Trained HF staff in supportive supervision for VHTs Quarterly Refresher meetings for VHTs and MLGs with help of HF staff, PDCs and HUMCs Trained PDCs in establishing ER transport systems in their parishes	HF staff supervising VHTs in conjunction with PDCs and HUMCs VHTs and MLGs making appropriate referrals to HFs Problem solving during quarterly meetings with volunteers and HF staff concerning community and clinic issues	75% of the 560 VHTs received a supervisory visit during the last 6 months; 0% at baseline (BL). The majority of PDCs are initiating monthly meetings with VHTs, MLGs and HF staff in their parishes without MTI involvement to discuss clinic and referral issues 29 emergency transport systems established and are being used to transport community people to the HF; BL 0%. 100% of HFs received at least one referral from VHTs in the last month; BL 75%. *(for complete list of indicators, see M&E Matrix,* ***Annex XVI B)***
Project Objective No. 2: Improved health (Community-based Integrated Management of Childhood Illness) and child care (Early Childhood Development) behaviors among mothers of children under five years of age.			
Project Inputs	***Activities***	***Outputs***	***Outcomes***
C-IMCI Baseline and final KPC Trainers MTI staff mentors SBC strategy iCCM curriculum, handouts and VHT manuals IEC and SBC materials Monitoring and	Together with HF staff, train VHTs in iCCM Identify and train MLG members in IYCF and MNC messages Strengthen capacity of VHTs and MLGs to use SBC approach through existing channels Supportive supervision and mentoring for community volunteers Quarterly refresher	560 VHTs trained and supported in iCCM 1428 MLG members trained and supported in IYCF and MNC VHTs and MLGs delivering health messages and promoting SBC in communities (home visits, community meetings, church groups, immunization	88.2% of children 0-5 months were exclusively breastfed during the last 24 hours; BL 73.6%. *DHS: for Uganda, 41% of children are EBF.* 79.8% of children 0-23 months are <u>not</u> under weight; BL 72.3%. *DHS: 87.7% are <u>not</u> underweight in Northern Uganda.* 56.0% of children aged 12-23 months were fully vaccinated (BCG, DPT3,

evaluation tools Non-monetary incentives for VHTs and MLGs (t-shirts, name tags, umbrellas)	meetings for VHTs and MLs on technical issues provided by HF staff; PDCs and HUMCs included in meetings Organized drama group largely of MLG members, in project area	sessions) VHTs case finding and referring patients to clinics Drama performances throughout the 3 sub-counties with MNC and child health messages	OPV3 and measles) by 12 months of age, card verified; BL 15.5%. *DHS: 49% fully immunized by 23 months in Northern Uganda.* 83.9% of children aged 0-23 months were attended by skilled personnel at birth; BL 35.3%. *DHS: 51.9% attended by skilled personnel in Northern Uganda.* 69% of children with chest-related cough were treated with an antibiotic; BL 34.7%. *DHS: 43.6% received antibiotic in Northern Uganda* 88% of mothers report washing hands with soap at least 2 times in 24 hours; BL 54%.
ECD HHI trainers HHI ECD Training Materials MTI staff mentors Monitoring and evaluation tools Non-monetary incentives for PEs (t-shirts, nametags)	Train PEs, VHTs and HF staff in ECD messages and techniques Supportive supervision and mentoring for ECD PEs	452 PEs trained and supported in ECD messaging 19 HF staff trained as trainers in ECD	76.3% of mothers of children aged 0-23 months provide cognitive stimulation to their child in the form of games; BL 38%. 83.6% of mothers of children aged 0-23 months report they talk or sing to the child while feeding the child; BL 57.7%.
Project Objective No. 3: Improved quality of health facility services through strengthened Integrated Management of Childhood Illnesses and Maternal and Newborn Care capacity.			
Project Inputs	***Activities***	***Outputs***	***Outcome***
Baseline and Final Rapid Health Facility Assessment Ugandan IMCI materials Ministry of Health (MoH) IMCI trainers Home-based	Support IMCI and MNC training for HF staff On-the-Job mentoring of HF staff Involved HF staff, HUMCs and PDCs in meetings and training for community volunteers Encouraged HUMCs and	IMCI training for 34 health workers in HFs MNC training for 46 health workers at HF level Refresher and supportive supervision training for 40 health workers	In 100% of HFs, treatment was routinely appropriate to the diagnosis; BL 25%. In 100% of HFs, caretakers could correctly describe how to administer all prescribed drugs; BL 0%. All of the health workers except for one, completed all assessment tasks at least

maternal and newborn care materials IMCI Job Aids (wall charts, guidelines)	PDCs to perform their mandated activities Conduct Joint supportive supervision visits with DHO and partners	HUMCs and PDCs count drugs with HF staff upon delivery to HF; communicate results to communities HUMC and PDCs spot check for appropriate drug use & instructions at HH level	80% of the time; BL 21%. Reduction in complaints from community that HF staff are stealing drugs Reports from all community groups interviewed indicated that HF staff are "friendly and do not harass anymore."
Project Objective No. 4: Strengthened institutional capacity of MTI and the Lira District Health Office to implement effective and efficient child survival activities.			
Project inputs	***Activities***	***Outputs***	***Outcome***
Supportive Supervision check lists from Ministry of Health Organizational Capacity Assessment (OCA) Action plans for 6 MTI Uganda priority areas	MTI/DHO joint activities for planning, training, implementation and evaluation HQ technical assistance in social and behavior change, and monitoring and evaluation HQ and Africa Regional team support for MTI Uganda capacity through structured plan based on OCA	Joint supervision for HFs and VHTs together with DHO and health staff Support HF staff to arrange and facilitate coordination meetings with VHTs and MLGs Africa Regional team facilitated OCA update workshop in Nov 2012 to update action plans for priority areas	All 4 of the original HFs and 3 of the new ones received joint DHO/MTI supervision visits in the previous 3 months; BL 1 of original 4. Progress has been made in implementing action plans for all six priority areas with strategic planning, communication & decision making being completed.

CONTRIBUTIONS TO KEY OUTCOMES

EVALUATION QUESTION #1: To what extent did the project accomplish objectives stated in the DIP?

Objective 1: Communities assume responsibility for their own health through strengthened community capacity

Training, support, and supervision for VHTs and MLGs:
As documented in the Training Matrix ***(Annex VI),*** both VHTs and MLGs received training and refresher training in IYCF and MNC and the VHTs received iCCM training in addition to other topics throughout the project. CSP staff closely monitored the quality of home visits and community education sessions; supervision/ mentoring systems were established and monitored. *(see* ***Annex XIX E*** *for project documents)* VHTs supported MLGs in the community technically and helped them mobilize other necessary resources e.g. LC1 to encourage a family to comply with community by-laws or ER transport to the HF. VHTs were supervised technically by HF staff in the community and in the HF when a patient was referred. HF staff participated in the quarterly meetings organized by CSP, usually providing the technical refresher training for both the VHTs and the MLGs. LC1s, PDCs, HUMCs and HF staff all spoke of the critical work of the community volunteers and of the positive behavior changes being made

in the communities as a result of their work. Tangible support for about half of the VHTs came as bicycles from the government; these were given to the women VHTs and to some of the men.

Community volunteers' perception of project benefits to them and impact of their work: Both VHTs and MLGs described significant changes in behaviors of community members they attribute to their work. They see the increase in their knowledge and skills regarding Maternal and Child health issues as a direct result of the project activities. The changes they describe are confirmed by the KPC results, and by interviews with beneficiaries and HF staff. A few of their perceptions are:

Change	Observations and Triangulation
Decrease to near extinction the extraction of "false teeth." "False teeth" are actually a baby or small child's permanent teeth made visible by dehydration and traditionally thought to be the cause of illness	VHTs, MLGs and HF staff report seeing cases of extraction only rarely now
Dramatic increase in immunization completion by 1 year	KPC documented an increase in immunization completion by 12 months from 15.5 to 56.0%
"No more polio"	Polio was prevalent in the area only 10 years ago and now few cases are reported
More women are attending ANC for 4 visits, receiving TT, men are going with them to the HF and women are delivering at the HF	KPC documented 57.8% of women attend 4 ANC visits, up from 35.3%, 89.4% receive TT and 83.9% are delivering at the HF up from 35.3% at baseline.
Increase in understanding "balanced diet" for adults and children	The KPC indicates that more children from 6 months receive a minimum appropriate feeding now at 48%, up from 23.1%.
Caregivers are providing proper care for the cord of the newborn	Previously there were frequent cord infections, now HF staff report they are uncommon
Increased availability and use of latrines with hand washing resources	Local Councils are passing by-laws requiring improved health practices especially digging latrines. The KPC showed good hand-washing practices increased from 54% to 87.8%.
Now mothers give colostrum to their babies and exclusively breast feed (EBF)	At BL, colostrum was seen as bad and dirty so was discarded. Final KPC results for EBF were 88.2%; Immediate BF was 78.9% and 87.2% received no pre-lacteal feeds.
Massage for babies not walking on time	It is unclear why so many babies are not walking on time – perhaps because they are carried on the mother's back for extended periods especially during farming seasons. Baby massage was taught in the ECD classes and parents report it eliminates this problem.
Use of the HF has increased, parents are taking children in for care; women are delivering there.	Community volunteers are more comfortable with the HF and think the community is also. They describe an improved relationship between the community and HF staff.

***Community and HF staff perception of impact of volunteers**:*
Community people described the volunteers as their source of quality health information, and as the first person they go to if there is a health problem. HF staff were pleased with the referrals they received; saw more families seeking timely care for children; felt there were positive changes occurring in family health practices due to the work of volunteers, decreasing the incidence of diarrhea and malnutrition. Sub-county chiefs described the volunteers as the first line health services in their areas.

Sustainability:
The VHTs and MLGs both see community norms are changing and feel the above changes will continue. They are saying: "we can't go back to the old behaviors"; "we will keep making home visits and talk with families." The indicator concerning ER transport was achieved with all 29 PDCs establishing transport systems in their parishes with contacts to help find drivers during emergencies, directing them to the best facilities to handle the emergency and mobilizing and encouraging the community to save money for use during emergencies. However, those systems generally involve the patient sitting on the back of a motorcycle or bicycle, adequate most of the time. If the patient is acutely ill or has complications of labor, it is a less effective method of transport. Because there are very limited community resources, developing a way to transport these patients probably will require financial assistance from the sub-county or DHO level.

Community volunteers are concerned that referrals will be difficult as the forms were developed by MTI. In addition they know there are few transportation resources at the sub-county level and almost none at the lower level HFs perhaps impacting supervision visits and transport of patients.

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

***Improvements in KPC data and strategies**:*
All indicators showed improvement. *(for complete list of indicators see M&E Matrix**, Annex XIX B**)* The results were discussed during the FE Results Meeting. DHO and HF staff, and community volunteers are aware however that there is more work to do, as several indicators are lower than targeted. A variety of strategies seemed to contribute to the improvements:

1. Project interventions supported the Five-Year District Development Plan,
2. Improvement in HH coverage through development of the mothers group cadre of community volunteers and the MLs trainers/mentors,
3. Well-trained and supervised community volunteers with ongoing refresher training and review meetings,
4. Continuous mentoring by CSP staff, of MLs and VHTs and HF staff; collaboration with community leaders for supportive supervision and mentoring,
5. Strong partnerships with government structures and strong links between HFs and communities,
6. Motivational incentives and job aids: IEC materials, nametags, t/shirts, umbrellas and torches and acknowledgement from the HF staff and community leaders.

Key practices with lesser improvement on KPC and lessons learned:
Again, all indicators improved from baseline and all but one improved from mid-term. That indicator was: Children with chest–related cough taken to HP went from 86.1% at mid-term to 74.2% at final. The incidence of acute respiratory illness was down therefore the sample sizes were smaller. Four, although improving from mid-term, did not reach the target set by the project.

Indicator	BL	MTE	FE	Target	Considerations/Lessons Learned
EBF	73.6%	67.7%	88.2%	95%	Mothers work in the fields and caregivers may begin early weaning to soothe the child. Breast milk expression is not a common practice. It was covered in the IYCF cards but without emphasis or details.
Post-partum Visit	16.3%	22.2%	40.8%	50%	The increase in attendance at HFs increases the waiting times and may discourage mothers from going. VHTs are able to provide post-partum checks for uncomplicated deliveries and refer women with danger signs – refresher may be needed. More women VHTs would be an advantage.
Child with pneumonia danger signs to HF	57.8%	86.1%	74.2%	80%	Stock outs of medication means mothers often go directly to the drug shop for meds when children are sick.
Zinc for diarrhea	0.9%	2.6%	17.6%	30%	The project requested this indicator be dropped at mid-term, as there were no consistent supplies. The results were significantly increased at final. HF staff report they received zinc in one drug shipment, used it for diarrheal cases, saw improvements and now recommend mothers buy it from the drug shop, and some do.

Strategies for Lira DHO, and Lira, Ogur and Aromo Sub-County Chiefs for continuing progress:

1. Support the technical team to do continuous support supervision and mentoring of HF staff and community volunteers;
2. Ensure HF staff are able to stay current with the latest health interventions and refresher education;
3. Support/encourage HUMCs and PDCs to continue supporting the HFs and communities including continuing to develop methods of ER transport for acutely ill people;
4. Mobilize the resources of other partners, such as Northern Uganda–Health Integration to Enhance Services (NU-Heights), to focus on those geographic and programmatic areas needing additional support that are consistent with their plans;
5. Ensure VHTs, PEs and MLGs members are supported with attention, technical updates, refresher training, job aids, referral forms, modest in-kind incentives, and continued respect. Target refresher training especially to those indicators needing more improvement such as post-partum visits;
6. Integrate Mother's Group and Peer Education volunteers into the community health structure. Because they are not officially part of the health system, they could easily be lost even though they were key to the community gains made by the project.
7. Consider linking village volunteers to other government support programs to provide some "payment" for their services to the community.

ECD implementation and impact:

The project originally planned to conduct operations research to measure the impact of ECD training on health indicators. Intervention and comparison areas were mapped with the plan to compare the results in implementation communities with comparison communities. At midterm, however, it was

discovered that PEs, health staff and parents in the intervention area were so enthusiastic about the ECD skills they learned that they shared them with caregivers in the comparison areas. This sharing of information made it impossible to compare the impact of ECD training between the two areas.

To have a greater impact on a smaller area, formal ECD activities were targeted to Aroma sub-district for the last 18 months of the project. Aromo was selected for special attention as this sub-district was more affected by the conflict than either Lira or Ogur sub-districts, had the largest portion of displaced families returning at the beginning of project and had greater infrastructure damage. One hundred and fifty additional PEs were trained. During this phase, PEs delivered ECD lessons directly to caregivers in their homes. Because training was aimed at the HH, they were able to reach both parents and other caregivers. The widespread enthusiasm from Phase 1 undoubtedly contributed, however, to the remarkable FE results seen in non-intervention sub-counties in the KPC after two years of no project support in this population with a recent history of experiencing prolonged extreme violence.

Indicator	Lira	Ogur	Aromo
Cognitive Stimulation: % of mothers of children 6-23 months who report playing a game like "where is your nose." *Project wide BL data: 38%*	83.3%	72.1%	76.1%
Linguistic Learning: % of mothers of children 6-23 months who told a story, sang a song or named objects. *Project wide BL data: 22.7%*	63.9%	63.0%	67.0%
% of mothers of children 6-23 months who report talking or singing to their child while feeding them. *Project wide BL data: 57.7%*	83.5%	83.8%	83.5%

The focus group results from VHTs and from parents and caregivers indicate some interesting findings in addition to the above project indicators. In addition to child growth and development messages, PEs reinforced health messages including: immunizations, breastfeeding, nutrition, hygiene, sanitation, and safety while learning to use the toilet.

Change	Description
Relationship with the child	• Parents are playing with the child, singing and dancing with them, teaching them things, teaching them how to talk, making them toys, spending more time with them; • "My child is not afraid of me anymore; he is happy to see me," "I have permission to play with my child"; • Children no longer fear their parents; parents now love their children more; • Children learn faster, are more interested, understand instructions better; • "Discipline is talking and encouraging but not harassing like before"; • Children are attending school.
Relationship between parents	• Less violence in the home because have knowledge of social and emotional development; • "My wife likes me better"; wives love husbands more because they help with the children; • Men involved with family health care, going to clinic with pregnant wives, with mothers taking children in for care; • Parents feel accountable to neighbors.
Health behaviors	• Baby massage: helps babies walk on time, sleep, and not be so fussy; • Using nappies for babies, keeping them clean; • Toilet training easier; proper disposal of child feces.

Decreased family violence is an unexpected finding in this FE, and community members and volunteers attributed it to the ECD interventions. Conversations with parents revealed that the ECD program gave parents specific behaviors they could do to understand and correct a child's behavior without violence; and these behaviors worked in a population emerging from 20 years of sustained violent conflict.

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

Impact evident from RHFA data and strategies:
A major CSP strategy was to support the HUMCs and PDCs in their efforts to refurbish and reopen the HFs closed during the conflict. All four of the new facilities are level IIs and therefore do not offer delivery services. They were reopened after the MTE, and each is working to achieve the level of quality care as outlined in the Ministry of Health *Guidelines for Designation, Establishment and Upgrading of Health Units*. New HFs were provided with adult and child weighing scales and weighing pants, exam tables and screens, blood pressure machines, stethoscopes, fetoscopes, thermometers and gas cylinders, IMCI wall charts and guidelines. CSP staff trained staff in IMCI and mentored them to assist them in providing quality MNC and IMCI care.

The following chart is limited to the findings in the four original HFs to better capture the results of project interventions as the four new facilities have been in operation for a year and a half. Data on all eight HF can be found in the RHFA**. *(Annex X A)***

Indicator	BL Index Value	FE Index Value	Strategy/Activity
% HF maintaining up-to-date records of sick U5 children & HF has report in last 3 months and evidence of data use	25%	80%	IMCI training, mentoring and supportive supervision for HF staff
% HF maintaining up-to-date records of ANC and deliveries	25%	100%	MNC training, mentoring and supportive supervision for HF staff
% U5 patients for whom all 5 assessment tasks were done at least 80% of the time	21%	98%	IMCI training, mentoring and supportive supervision for HF staff
% HF: treatment for U5 children is routinely appropriate to diagnosis	25%	100%	IMCI training, mentoring and supportive supervision for HF staff
% HF: caretakers correctly describe how to administer all prescribed drugs	0%	100%	IMCI training, mentoring and supportive supervision for HF staff
% HF receiving external supervision at least once in last 3 months	25%	100%	Supportive supervision training and mentoring for DHO and higher level HF staff

HF staff perceived benefits of CSP:
At each HF, staff first mentioned the community level assistance they are getting from VHTs and MLGs when asked about the benefits of CSP.

Change	Description
Quality of Care	• VHTs promptly referring children and mothers with danger signs into HF • Improved skills through training and mentoring - see above RHFA data • Equipment made work easier. • Records at HF are better - see above RHFA data • Improvement in immunization, IMCI and ANC services – see above RHFA data • Growth Monitoring • Quality of monthly meetings at HF

***Role of HUMCs and PDCs with* HFs:** HUMCs were reestablished according to government regulations at each of the HFs. They are working with the PDCs, who represent the communities the HF serves. HF staff report they care for the physical plant, protecting it from intruders, supervising construction of improvements; advocate on behalf of the HF to the sub-county and DHO for equipment and supplies, additional staff, upgrades to the facility and staff housing, approval to drill bore holes; and they assist with staff management focusing on punctuality, attendance and efficiency of work. The HUMCs and PDCs also count the drugs with the HF staff as they come into the facility and report their status to the communities. They mobilize community members for EPI and other programs and generally keep the lines of communication open between communities and the HF. HUMCs and PDCs have clear plans for the upcoming year with strategies for how they will continue with their advocacy to improve both services e.g. immunization points, and resources e.g. bore holes.

Community perception of HF services: Focus group discussions in communities with mothers, fathers, and community volunteers gave the following descriptions of the changes in HF services. Some were issues addressed by the RHFA and are consistent with the results.

Change	Description
Quality of Care	• Children tested before treatment – RHFA confirmed, finding 99% of patients were seen in a facility completing all 5 assessment tasks at least 80% of the time. • Fewer maternal deaths, fewer baby deaths
Medication	• Better drug control; LCI now participating in counting drugs • Right prescriptions with clear instructions – RHFA confirmed, found 100% of the time caregivers correctly described how to administer all prescribed drugs
Health Education	• Health talks at the HF before treatment • Good explanation of how to prepare ORS • Support birth plans • Explain growth monitoring
Relationship with HF staff	• HF staff honor referrals from VHTs, good coordination with VHTs • No more harassment, staff are friendly • Staff are encouraging, spend more time with parents • Staff are at the HF
Services	• Family Planning services available • Better Immunization coverage • Enough beds in the ward • Sometimes provide mama kits for delivery • Good hygiene and sanitation at HF – confirmed by RHFA which found that 100% of HF had essential infrastructure present and functioning

Sustainability: HF staff, HUMCs and PDCs all thought the improvements in the HF would continue for two reasons 1) staff and community volunteers had been trained and mentored, and are using those skills in their work; and 2) the lines of communication are strong between the community and the HF. They think problems especially around transportation, and drug and equipment supply issues will probably continue. Both the HUMCs and PDCs had well defined strategies in place for advocating with the sub-county and DHO to accomplish their goals.

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

Impact of DHO/MTI joint supervision to HFs and communities:

The KPC and RHFA results both demonstrate the improvement in care provided and community level behaviors changed. Facility and community level providers attribute the improvements in their practice to the quality of supportive supervision they received from MTI staff and through the DHO. Supervision is decentralized so that although there is supervision from the DHOs office quarterly, mentoring and supportive supervision is also the responsibility of the higher level HFs for the lower level ones; helping to decrease the transportation challenges.

There was an additional level of supervision encouraged by CSP. HUMCs and PCDs, often involving HF staff, traveled to communities to provide supervision to community volunteers. Occasionally the Sub-county chief would also be involved. That level of attention and oversight for volunteers was described as essential for them to function well in their jobs. The HF staff and the community volunteers spoke of how important it is for someone to come to supervise their work and of how they hope this will continue now that CSP is finished.

MTI Uganda progress on organizational assessment low-scoring areas:
MTI originally used JSI developed materials to assess the capacity of MTI Uganda to provide support to the project. After the MTE, it was decided that a newly published Catholic Relief Services (CRS) Organizational Capacity Assessment (OCA) materials were more appropriate for MTI Uganda's situation. *(see **Annex XIX A** for the complete end of project OCA matrix)* In the baseline OCA there were six areas prioritized for improvement; two of those, Communication and Decision-making were combined in the final OCA. The areas of concern are: Succession Planning, Staff Salary and Benefits Policy, Strategic Planning, Communication and Decision-making, and Monitoring and Evaluation.

The MTI Africa Region team facilitated an OCA and planning process in November of 2012 and reported on the implementation results as of August 2013. MTI Uganda had made considerable progress in all five areas of concern. They completed implementation of the action plans for Strategic Planning and Communication and Decision-making and are continuing to identify next steps in those areas; in addition they are making significant progress toward completing the remaining three. The Africa Regional team is monitoring and facilitating further progress toward continued improvement in the original weak areas.

The Program Manager, who joined the team in November 2011, has been receiving project financial information on a monthly basis to assist with project planning. She has proved to be a strong force in assisting the project to make the adjustments recommended in the MTE and bring it to a successful conclusion.

EVALUATION QUESTION #2: To what extent was the project implemented as planned? What changes were made to the planned implementation, and why those changes were made?

Essentially the project was implemented as planned, however changes were made in response to the MTE recommendations.

Immunization: By the time of the MTE, staff were spending an estimated 55% of their time assisting HF personnel in immunization implementation although the CSP LOE was planned at 10%. After the MTE that LOE was scaled back to the original 10% with the project only continuing to support the Child Health Days.

Mothers Groups: Originally 300 Mothers Group members were trained. During the MTE it became clear that they were an excellent compliment to the VHTs, who are 75% men, making it possible for the project to reach women in the HH. After the MTE, their number was increased to 1428; they were organized by PDC; and they visited women in their HHs, easing the workload for the VHTs and ensuring pregnant women and mothers of children under two received timely MNC and IYCF information. In the last year of the program a drama group was organized by CSP made up largely of

MLG members who performed dramas on maternal and child health issues throughout the three sub-counties in order to reach a broader and larger portion of the population.

ECD: The ECD intervention was originally implemented in selected communities in the three sub-counties. The MTE recommended scarce resources be concentrated in Aromo, the most severely conflict affected of the three, to serve all Aromo communities. 152 additional PEs were trained and delivered ECD training to HHs, instead of through group settings. *(see **Annex I** – Program Learning Brief for more information)*

PDC: PDCs became more involved in monitoring and supervising project activities to strengthen community ownership and involvement in project management, and to increase the possibility that project activities would be sustainable after the end of CSP.

Nutrition: VHTs and MLGs were trained on nutrition using the WHO/UNICEF curriculum for East Africa and supplied with MoH counseling materials as recommended in the MTE.

EVALUATION QUESTION #3: How were gender considerations addressed through the project? Are there any specific gender-related outcomes?

Existing gender norms in the project area often preclude women from deciding on their own when to seek health services or participate in outreach or health education activities. Men often still make decisions about how women use their time or access family resources. This was addressed in a number of ways. Because 75% of the VHTs are men and the turnover was very low, which prevented adding more female VHTs as originally planned, a cadre of MLGs were added to the community volunteer resources ensuring young mothers had a comfortable resource for HE. VHT contacts also provided men with more information on health concerns, especially information on maternal health and danger signs encouraging them to be more involved in the health of their families and attend ANC with their wives.

The village PE team consisted of a man and a woman, again chosen by the community, to ensure both men and women would be reached with the ECD messages, generally together. Both the PEs and the MLGs addressed domestic violence in their health messages as well as male involvement in health issues in the family. The focus groups indicated both that domestic violence had decreased and men were attending more ANC visits with their wives and even assisting with immunizations for their children.

Many of the members of the PDCs and HUMCs were men and by involving them in the supervision of community volunteers, CSP encouraged men in leadership positions to also communicate the project's basic MNC and child health messages.

EVALUATION QUESTION #4: which elements of the project have been or are likely to be sustained or expanded?

The program was built on the Lira District Five Year Plan and worked in close collaboration with the District Health Office and all of the DHO and governmental structures in the three sub-counties where it was implemented. Both the health personnel and the community volunteers see the health messages as part of their lives and cannot imagine "going back." The governmental structures from the sub-county chiefs through to the LC1s are engaged in making the systems work.

Community level focus groups identified a "better relationship with the HF" as a positive outcome of the program; HF staff discussed how much they appreciated the work of the VHTs and MLGs. Improving the relationships was a significant contribution of the program and one that CSP deliberately addressed. Communication mechanisms were in place with the refresher trainings/quarterly meetings for VHTs. CSP recognized that community people only were disturbed about one or two HP behaviors. The project worked with HF staff towards clearly identifying those negative behaviors and making them feel able and confident they could change them. CSP remained neutral focused only on behaviors. The project chose the time and place for giving feedback to HPs carefully and involved only those from the

district in whose presence HPs would feel comfortable discussing issues. The HF staff also had realistic concerns about community members and those concerns were taken back to communities by the VHTs and also resulted in positive change. Survey findings indicate more women are delivering at the HF and attendance at ANC is also up, reinforcing comments in the focus groups about the improved attitudes of HPs.

Continue	Mechanism	Needs
Community Volunteers Promoting SBC	DHO recommends absorbing MLG members and PEs into the Village Health Team. Current oversight mechanisms intend to continue. DHO indicates current referral form will be provided until the DHO completes development of an alternative.	Transport resources
HUMCs and PDCs	Both groups see their roles as vital to the functioning of the HFs and both are government mandated. Sub-county requires PDC level plans for their planning exercise.	Transport resources
Health Worker Performance	Health workers are proud of what they have accomplished and are asking for continued education; DHO/MoH have a continuing education mechanisms in place. Both DHO and Health Providers see from survey results there is more work to be done.	Continued Support and Supervision
ECD Behaviors	The KPC demonstrates that ECD behaviors are continuing in Sub-counties with no further project inputs for past two years.	View PEs as volunteers

NEW PARTNER GRANTEES: CHANGES IN GRANTEE ORGANIZATION CAPACITY

MTI HQ used the CSHGP grant as an opportunity to strengthen MTI Uganda institutionally. Prior to this grant, MTI Uganda was primarily implementing relief programming. At the onset of the grant HQ facilitated an organizational capacity assessment that identified six priority areas needing further work. Before the MTE, a minimum of attention was paid to the assessment results, however, a review of the OCA status was conducted immediately prior to the MTE by the Africa Regional team. The Africa Regional Director position was moved from HQ to Kampala in January 2012 and since then the Regional team has monitored and encouraged progress on OCA issues. An in-depth reassessment was conducted in November 2012 using the CRS assessment tool and combining two of the six areas. It was felt this tool was more appropriate for MTI to identify those areas requiring further interventions.

A follow-up review was done in August 2013. MTI Uganda had made considerable progress in all five areas of concern. They completed implementation of the action plans for Strategic Planning, and Communication and Decision-making and are continuing to identify next steps in those areas; in addition they are making significant progress toward completing the remaining three areas: Succession Planning, Staff Salary and Benefits Policy, and Monitoring and Evaluation. The Africa Regional team is monitoring and facilitating further progress toward continued improvement in the original weak areas.

Programmatically, MTI has made extensive use of and contributed to CORE technical resources, and built relationships with CORE members to benefit from their greater experience in implementing child survival programming. The USAID mandated MTE proved invaluable in providing very necessary guidance for project improvement. MTI incorporated the MTE recommendations throughout the project. The successful project conclusion is a result of the lessons learned from the MTE, HQ technical assistance to implement the MTE recommendations, and the leadership provided by the Project Manager hired shortly before the MTE.

CONCLUSIONS

MTI implemented a solid child survival program with many statistically significant results: HH/community level indicators improved significantly as did HP quality of care indicators. Delivery mechanisms and management at HF and community levels also dramatically improved.

District and Local Government are assuming responsibility for continuing interventions: Because the program chose to work through existing, though minimally trained, government structures and to contribute to the District five-year plan, the various government entities were picking up responsibility for program interventions before the project closed, improving the chances for sustaining the improved behaviors in HHs and HFs. CSP reconstituted or reactivated mandated structures, as with the HUMCs and PDCs and, with the MLGs and PEs, they added in a level keeping the structures and players connected, and continually strengthening their communications. This enabled existing bodies to provide support to HFs and community volunteers in the last months of the project. One of the program strengths was to ensure consistent messages were delivered through all interventions and at all levels. The project sponsored FE Results Meeting for the Lira DHO engaged representatives from all levels – volunteers through the District Chief Administrative Officer in a dialogue regarding the project outcomes and programmatic sustainability. *(see **Annex XIX C** for agenda)*

Positive relationship between HFs and communities: The often contentious relationship changed to collaboration by the end of the project. This relationship, working with the strong commitment of community volunteers and HPs, increases the possibilities for sustained program interventions and continued progress toward improving community health outcomes.

Community Volunteers: VHTs, MLG members and PEs all are described by the community and the HF staff as vital to changing behaviors in HHs. There is a level of respect for them not often seen in programs. The KPC survey results also point to significant improvements in HH behaviors. The MLG members and PEs are not currently a part of the official health structure and may be lost if not incorporated in some way even though they were key to changing behaviors at the HH level.

ECD: The ECD program produced more impact that originally envisioned. HPs and parents enthusiastically implemented it, and community members and volunteers attributed decreased family violence and improved relationships between parents and children to the interventions. This was in addition to the significant improvements to the measured indicators.

Project Management and OCA: As mentioned in the MTE, this was an ambitious project for a new agency. The country office had no experience with child survival programs and there were gaps in management oversight and support. This was overcome with the arrival of a new Project Manager shortly before the MTE. The project responded rigorously to the MTE recommendations and produced the above noteworthy results. *(see **Annex XIX D** for MTE Recommendation Response)* It was originally planned that MTI Uganda leadership would provide management oversight to the CSP. After the MTE, when the gap in management support became apparent, the Africa Regional team became more involved in providing the support needed. They also assumed responsibility for overseeing institutional strengthening for the MTI Uganda office.

RECOMMENDATIONS

This project always intended to operate for the duration of the grant and then close with the interventions continuing under the existing government structures. That has now happened and the DHO and Sub-county chiefs are assuming responsibility for project interventions and for continuing to strengthen the mandated health structures.

The following are strategies suggested to the DHO and Sub-county chiefs to assist with continued progress toward district health objectives:

1. Support the technical team to do continuous supportive supervision and mentoring of HF staff and community volunteers;
2. Ensure HF staff are able to stay current with the latest health interventions and refresher education;
3. Support/encourage HUMCs and PDCs to continue supporting the HFs and communities including continuing to develop methods of ER transport for acutely ill people;
4. Mobilize the resources of other partners, such as Northern Uganda–Health Integration to Enhance Services (NU-Heights), to focus on those geographic and programmatic areas needing additional support that are consistent with their plans;
5. Ensure VHTs, MLs and PEs are supported with attention, technical updates, refresher training, job aids, referral forms, modest in-kind incentives, and continued respect. Target refresher training especially to those indicators needing more improvement such as post-partum visits;
6. Integrate Mother's Group volunteers into the community health structure. Because they are not officially part of the health system, they could easily be lost even though they were key to the community gains made by the project.
7. Consider linking village volunteers to other government support programs to provide some "payment" for their services to the community

A number of project interventions are remarkable and worthy of replication in future projects while the larger MTI Uganda management issues will need continued attention.

It is recommended that close government collaboration be replicated whenever possible, along with strategies to build positive relationships between health workers and the communities they serve. As many other programs across the world have discovered, volunteer cadres of mothers delivering health messages to HHs is an extremely effective way to effect behavior change; this needs to be replicated both in future programming by MTI and also within the DHO mechanism in Northern Uganda whenever possible.

The success of the ECD programming was remarkable and the cost was minimal. The intervention changed its form over the life of the project in response to challenges and now needs to develop a strategy for replication at scale. The direct and indirect results are also worthy of considerable attention. The possible ECD effect on reducing family violence needs to be examined more closely to determine the extent to which it influenced that reduction.

TABLE OF RECOMMENDATIONS

Finding	*Conclusion*	*Recommenda-tion*	*Action*	*Who Is Respon-sible*
Collaboration with DHO and Governmental system strong; Government assuming responsibility	Project strategy to work closely with DHO and government structures effective and increases sustainability	Implement projects in close collaboration with governmental systems, especially in decentralized countries	Assess country's commitment to decentralization and design project around that commitment	MTI HQ

Mandated governmental structures are in place, trained and functioning	Current functioning is admirable, continued improvement will require sustained attention	Continue to support HPs, HUMCs, PDCs and community volunteer cadres	Provide technical updates & supportive supervision for HPs & community volunteers; continue engaging PDC & HUMCs and in local health management	DHO and Sub County Administra-tion
MLGs and PEs are providing quality HE at HH level	MLGs and PEs are an effective mechanism for communicating behavior change information to HHs	Formally integrate MLGs & PEs into DHOs community volunteer cadre & replicate model in other areas of the District	Officially consider MLG members and PEs as part of the Village Health Team	DHO
HH behaviors changed significantly after MTE & the expansion of MLGs	MLGs were effective communicators of MNC and IYCF messages to HHs	Replicate the strategy in all HH behavior change projects	Include HH level mother volunteers in future behavior change project designs	MTI HQ/ Technical team
Relationships between health workers and communities improved	Project strategy for addressing health provider/ community relationships effective	Replicate the strategy in all health projects	Include strategies for improving working relationships in future health project designs	MTI HQ/ Technical team
ECD behaviors continue without program inputs for 18 months	ECD messages effective and behaviors sustainable	Include ECD programming in future child survival projects	Collaborate with HHI to design effective strategy for implementation at scale	MTI HQ and HHI
OCA findings were not acted upon until after the MTE	Country office was not able to address issues until leadership was provided by Africa Regional team	Continue to address outstanding OCA issues and maintain successes achieved	Africa Regional Team continue to monitor OCA progress and support MTI Uganda staff	MTI HQ/ Africa Regional team

Integrating Early Childhood Development Activities with Child Survival Interventions

ECD Peer Educator Tonny Anyang of Apua Parish teaches a mother about baby cues

A child's early years are a critical period of development during which the foundations for children's emotional, social, intellectual and physical wellbeing are developed. The Lira Child Survival Project educated health workers and caregivers about early childhood development and simple actions they can take daily to support their infants was integrated as a key strategy.

This project was funded by the U.S. Agency for International Development through the Child Survival and Health Grants Program.

December 2013

Key Findings:

After training in early childhood development

- *76% of mothers played games that provided cognitive stimulation for their child increased from 38% at baseline.*
- *78% of mothers told a story, sang a song or named objects for their child to encourage linguistic learning increased from 23% at baseline.*
- *84% of mothers helped their child walk, massaged them, or played a game to encourage physical development increased from 63% at baseline.*

Background

Uganda's Early Childhood Development (ECD) policy was established in 2007. While the Government of Uganda recognizes that ECD is important and considers it as the first level of education (Education Act 2008), investment in ECD is low. ECD services are primarily sector based. Health, education and social services are provided in different settings. Pre-school services in urban areas are provided by private providers and by NGO's in rural areas. The Early Childhood Learning Framework was developed for ages 3-6 years and is a curriculum reference for implementers of ECD but is not mandated. As of yet, there is no framework for the ages of 0-3 years.

Project Design

The post-conflict period is often characterized by food insecurity, unreliable infrastructure, and a fragile family unit. It is an important time to rebuild community resilience by strengthening the parent-child bond, developing and reinforcing positive caregiving practices to improve long term child health and well-being. This can ameliorate the negative effects of the compromised environment, and build the foundation for physical and emotional health. In the Northern Uganda, post-conflict context, service provision is continually improving as the Ministry of Health and NGOs re-construct health facilities and provide health services at the community level.

The Lira Child Survival Project implemented by Medical Teams International and the Lira District Health Office served a population of 124,379 and operated in Lira, Aromo and Ogur sub-counties of Lira District in Northern Uganda. The project used a two-pronged approach to improve the health and nutrition status of women and children under age five: a) promoting behavior change and community mobilization to take appropriate responsibility for health; and b) building District Health Office (DHO) capacity to provide sustainable, quality service delivery at the facility and community levels. Educating health workers and caregivers about ECD and simple actions they can take daily to support their infants was integrated as a key strategy.

PROGRAM LEARNING BRIEF

Methodology

Hands to Hearts International (HHI), an international NGO based in Portland, Oregon, provided technical support for the ECD component of the project. The HHI's *A Curriculum for the Study of Early Childhood Development Trainer's Manual* was adapted to the local context and integrated available Uganda resources in the training design. The training was composed of eight modules: 1) Importance of the Role of Parents, 2)Physical Development, 3) Cognitive Development, 4) Language Development, 5)Social and Emotional Development, 6) Baby Cues, 7) Baby Massage and 8) Basic Health, Hygiene & Nutrition and Sanitation.

HHI master trainers provided training of trainers in ECD for health facility staff and MTI Child Survival Project staff. These staff in turn recruited and trained 300 volunteer Peer Educators to provide education on both ECD and health issues to families in their communities. Peer Educators working in female/male pairs led group trainings in their communities to reach both men and women caregivers.

The project originally planned to conduct operations research to measure the impact of ECD training on health indicators. Intervention and comparison areas were mapped with the plan to compare the results in implementation communities with comparison communities. At midterm, however, it was discovered that Peer Educators, health staff and parents in the intervention area were so enthusiastic about the ECD skills they learned that they shared them with caregivers in the comparison areas. This sharing of information made it impossible to compare the impact of ECD training between the two areas.

To have a greater impact on a smaller area, formal ECD activities were targeted to Aroma sub-district for the last 18 months of the project. Aromo was selected for special attention as this sub-district was more affected by the conflict than either Lira or Ogur sub-districts, had the largest portion of displaced families returning at the beginning of project and had greater infrastructure damage. One hundred fifty two additional Peer Educators were trained. During this phase, Peer Educators delivered ECD lessons directly to caregivers in their homes.

Findings

To measure impact of the ECD intervention, questions were included in the baseline, midterm and final Knowledge, Practice and Coverage surveys to measure household practices encouraging cognitive, linguistic and physical development. Focus group interviews were also conducted with parents, community volunteers and health staff to provide information on project participants' perspective of their participation in the ECD component and its impact.

Quantitative data collected during the final survey showed a remarkable increase in key ECD indicators. After training in early childhood development, the percentage of mothers who played games which provided cognitive stimulation increased from 38% at baseline to 76% at final. The percentage of mothers who told a story, sang a song, or named objects for their child to encourage linguistic learning increased from 23% to 78% and the percentage of mothers who helped their child walk, massaged them, or played a game to challenge physical development increased from 63% to 84%.

When broken down by sub-district, the data indicated that families in Lira and Ogur continued ECD practices after 18 months of no active ECD interventions, demonstrating impressive sustainability.

Indicator	Lira	Ogur	Aromo
Linguistic Learning: % of mothers of children 6-23 months who told a story, sang a song or named objects for their child (linguistic learning) at least 2 times per week	83.3	72.1	76.1
Active Feeding: % of mothers of children 6-23 months who report talking or singing to their child while feeding them	63.9	63.0	67.0
Physical Development: % of mothers of children aged 0-23 months who report helping their child walk, playing a lap game with their child, massaging or rubbing them gently, or by giving them objects with which to play	83.5	83.8	83.5

Qualitative interviews with parents and Peer Educators conducted during the project final evaluation indicated a widespread enthusiasm for ECD promotion and an understanding of the importance of supporting a young

child's development. Parents reported spending more time with their children playing, teaching them how to talk, and making toys for them. They also felt their relationships with their children improved and the parent – child bond was stronger. One parent comment *"My child is not afraid of me anymore; he is happy to see me," and another "I have permission to play with my child."* Discipline was achieved by taking and encouragement rather than physical punishment which had previously been the norm. Parents felt baby massage helps babies walk on time, sleep better, and not be so fussy.

Mothers, fathers and Peer Educators reported a decrease in domestic violence. It is difficult to pinpoint the elements of ECD or other outside efforts that might have contributed to these observations. Community members reported hearing radio messages about family violence and mentioned interventions by community leaders and churches to mitigate domestic violence in their communities. The change was most likely due to the impact of improving household ECD skills coupled with government and church and community leader efforts to decrease levels of violence in post-conflict Lira District.

Conclusions and Lessons Learned

Post conflict is an important time to rebuild community resilience by strengthening the parent-child bond, developing and reinforcing positive caregiving practices to improve long term child health and well-being. Integrating early childhood development with child survival interventions in Lira District has led to improvements in parent-child relationships and has encouraged caregivers to spend greater and more meaningful time with children reading, singing, and playing games that encourage physical, cognitive and language development. Community members also report it has facilitated better relationships between spouses. By helping parents better understand and interact with their children, it also seems to be a contributing factor to reducing household violence.

Because of the spillover of ECD messages between intervention and comparison communities, it is not possible to attribute gains the project made in health practices to the integration of early childhood development messages.

Recommendations and Use of Findings

The findings of this project are extremely encouraging and demonstrate the ability of HHI's ECD model to be replicated at scale. As evidenced by qualitative and quantitative data, the approach promotes a wide variety of positive behavior changes. The fact that families in Lira and Ogur are practicing the ECD skills they learned 18 months after activities ceased suggests the approach is sustainable as well.. The greatest learning for HHI was the model MTI used of training a male and female Peer Educator in each village of more than 220 villages, this encouraged the local communities to feel ownership of the information and created lasting local resources in the PEs who remain long after the end of this project, additionally it encouraged men to participate and thereby increase their involvement in caregiving and likely was a factor in decreasing domestic violence.

Given the significant and positive outcomes in child-caregiver relations, the decrease in domestic violence and the overall implications for child health and development, it would be wise for the Lira District Health Office to continue to support the existing PEs with once a year refreshers and small incentives to carry on the ECD messages. Lira has shown a simple, impactful and successful model to promote ECD, it could act as a model for the country and not allow the power of this intervention to fade and be forgotten.

The Lira Child Survival Project in Erute North Sub-District, Northern Uganda is supported by the American people through the United States Agency for International Development (USAID) through its Child Survival and Health Grants Program. The Lira Child Survival Project is managed by Medical Teams International under Cooperative Agreement No. GSH-A-00-09-00012. The views expressed in this material do not necessarily reflect the views of USAID or the United States Government.

For more information about The Lira Child Survival Project, visit: www.medicalteams.org

ANNEX II. LIST OF PUBLICATIONS AND PRESENTATIONS RELATED TO THE PROJECT

A presentation on the Lira Child Survival Project final evaluation and lessons learned was facilitated for Medical Teams International headquarters technical and management staff on November 19th, 2013.

ANNEX III. PROJECT MANAGEMENT EVALUATION

Prior to this grant, MTI Uganda was primarily implementing relief programming. Simultaneously with the award of the CSP, MTI was awarded a grant for a Malaria Communities Project also implemented in Northern Uganda.

MTI HQ used the CSHGP grant as an opportunity to strengthen MTI Uganda institutionally. At the onset of the work, HQ facilitated an organizational capacity assessment that identified six priority areas needing further attention. They originally used JSI developed materials to assess the capacity of MTI Uganda to provide support to the project. Prior to the MTE, a minimum of attention was paid to the assessment results, however, a review of the OCA status was conducted immediately prior to the MTE by the Africa Regional team. Since the Africa Regional Director position was moved from HQ to Kampala in January 2012, the Regional team has monitored and encouraged progress on the OCA issues. After the MTE, it was decided that the newly published Catholic Relief Services OCA materials were more appropriate for MTI Uganda's situation. In the baseline OCA there were six areas prioritized for improvement. Two of those, Communication and Decision-making were combined in the final OCA. The areas of concern were: Succession Planning, Staff Salary and Benefits Policy, Strategic Planning, Communication and Decision-making, and Monitoring and Evaluation. The complete end of project OCA matrix follows this narrative.

The MTI Africa Region team facilitated an OCA and planning process in November of 2012, and reported on the implementation results as of August 2013. (see Annex X1X A) MTI Uganda had made considerable progress in all five areas of concern. They completed implementation of the action plans for Strategic Planning and Communication and Decision-making and are continuing to identify next steps in those areas; in addition they are making significant progress toward completing action plans in the remaining three areas. The Africa Regional team is monitoring and facilitating further progress toward continued improvement in the original weak areas.

It was originally planned that MTI Uganda leadership would provide management oversight to the CSP. After the MTE, when the gap in management support became apparent, the Africa Regional team became more involved in providing the support needed. The HQ technical team provided rigorous oversight and technical support to the project. The new Program Manager, who joined the team in November 2011, has proved to be a strong force in assisting the project in making the adjustments recommended in the MTE and bringing it to a successful conclusion. She provided a vision of the direction the program needed to go that, with the backstopping provided by the HQ technical advisors and Africa Regional team, enabled the project to produce KPC and RHFA results frequently significantly higher than the MTE results. The problem of no financial information being available to the Program Manager was resolved after the MTE; the last year of the project she received program financial information monthly.

Lessons Learned

1. As an organization new to Child Survival programming, the mid-term evaluation was invaluable to provide an outside assessment of program progress and allow sufficient time for needed course corrections.
2. HQ technical advisors and senior management need to very closely monitor program management in country offices unfamiliar with Child Survival programming to ensure recommendations are followed.
3. Opportunities for strengthening an organization and country office are rare and need to be acted upon promptly by those with authority to make changes.

ANNEX IV. WORK PLAN TABLE

Activity		Activities Achieved, Dropped, Changed, or Added
Start Up and Planning	*Recruit project staff*	*All start up and planning activities were achieved*
	Orientation training for staff	
	Introductory visits and discussions with DHO at the district, sub-county and health facility level	
	Planning Meeting with DHO	
	Develop BCC strategy ➢ *focus groups* ➢ *community feedback* ➢ *doer/ non-doer surveys*	
	Preparation of DIP with consultant and DIP workshop	
	Meeting with USAID in Kampala	
	DIP meeting with DHO	
	Cross visit to HealthPartners Child Survival and MCP projects in Bushenyi District	
	Revise budget to be submitted with DIP	
	Mapping health facilities and VHTs	
	Meet USAID in Gulu – James Okello	
IMCI/ Support	*Identify local/country materials*	*34 health staff from four facilities were trained in IMCI in May 2010. Four new health Centre IIs opened in Ogur and Aromo sub-counties in April 2012. Supportive supervision and mentoring was expanded to cover all eight facilities. The project supported the newly opened facilities to establish HUMCs and take responsibly for supporting the CHWs in their catchment areas. Forty health workers at the 8 facilities were provided with IMCI refresher training in June 2013.* *Mentoring for health facility staff was provided on a monthly basis. DHO and MTI staff provided joint supportive supervision on a quarterly basis.*
	Plan IMCI training with DHO	
	Provide IMCI training	
	Conduct clinical IMCI mentoring	
	Conduct joint supervision of IMCI services	
C-IMCI and Community Case Management	*Plan C-IMCI training with DHO*	*560 VHTs were trained and provided community mobilization, community education, household visits, and referrals with support from project mobilizers.*
	Identify local/country materials	
	Train VHTs on C-IMCI	
	VHTs provide community education with support from mobilizers	
	Strengthen referral system from community to health facility by providing training to VHTs and providing referral forms	

Activity		Activities Achieved, Dropped, Changed, or Added
Maternal and Newborn Care	*Identify local materials and tools*	*Originally 300 Mothers Group members were trained. During the MTE it became clear that they were an excellent complement to the VHTs, who are 75% men, making it possible for the project to reach women in the HH. After the MTE their number was increased to 1148; they were organized by PDC; and they visited women in their HHs, easing the workload for the VHTs and ensuring pregnant women and mothers of children under two received timely MCN and IYCF information.* *During Year 3, the MLGs and VHTs were trained using the WHO/UNICEF* Community Based Infant and Young Child Feeding Counseling Package. *. MoH* IYCF National Counseling Cards for Community Volunteers *and* Safe Motherhood Flip Charts *for both facility staff and community volunteers were reproduced to support them during the health education* *In the last year of the program a drama group was organized by CSP made up largely of MG members who performed dramas on maternal and child health issues throughout the three sub-counties in order to reach a broader and larger portion of the population.* *Facility staff was provided with refresher training in MNC and follow up supportive supervision by the project MNH Mentor.*
	Train VHTs on MNC	
	VHTs provide community education with support from mobilizers	
	Conduct MNC refresher training at HF level	
	Supportive Supervision of perinatal services	
EPI	*Train VHTs on EPI*	*By the time of the MTE, staff were spending an estimated 55% of their time assisting HF personnel in immunization implementation although the CSP LOE was planned at 10%. After the MTE that LOE was scaled back to the original 10% with the project only continuing to support the Child Health Days.*
	VHTs provide community education with support from mobilizers	
	Support Child Health Days / national immunization days.	
Early Childhood Development	*Hands to Hearts hires local trainers*	*The ECD intervention was originally implemented in selected communities in the three sub-counties. The MTE recommended scarce resources be concentrated in Aromo, the most severely conflict affected of the three, to serve all Aromo communities. 152 additional PEs were trained and delivered ECD training to HHs, instead of through group settings. See Annex I – Program Learning Brief for more information.*
	Training of Trainers in ECD	
	ECD Trainers train Peer Educators in ECD in intervention areas	
	ECD Trainers train VHTs in ECD in control areas	
	Peer Educators train community members in intervention areas	
	VHT Trainers train community members in control areas	
	Follow up & Refresher TOT; gather lessons learned	
	Coordinate, support and supervise Peer	

Activity		Activities Achieved, Dropped, Changed, or Added
	Educators	
	Conduct ECD Review Meeting	
	Conduct ECD Forum	
VHT Support	*Collect information on VHT membership and status*	*During the first two year of project implementation MTI and health facility staff met quarterly with the VHTs at the sub-county level for an all-day session which included reviewing reports, discussing issues faced by the VHTs, coordinating work, and imparting some training. To provide more effective support, after midterm sessions were held monthly at the parish rather than sub-county level with smaller groups.* *PDCs became more involved in monitoring and supervising project activities to strengthen community ownership and involvement in project management, and to increase the possibility that project activities would be sustainable after the end of CSP.*
	Provide joint supportive supervision	
	Support health facility staff to arrange and facilitate coordination meetings with VHTs	
	Health Unit Management Committee members attend VHT – health facility coordination meetings on a quarterly basis	
M&E	*Conduct baseline and final KPC Surveys*	*M and E activities took place as planned.*
	Solicit community feedback of KPC results	
	Conduct focus groups discussions, and doer/ non-doer surveys	
	LQAS Surveys	
	Conduct HFA	
	Midterm and Final Evaluations	

ANNEX V. RAPID CATCH TABLE

Rapid CATCH Table

Indicator	*Baseline Estimate (%)*	*MTE Estimate (%)*	*Final Estimate (%)*
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to WHO/HCHS reference population)	27.7%	16.2%	20.2%
Percent of infants and young children aged 6-23 months fed according to a minimum of appropriate feeding practices.	23.1%	41.9%	48.9%*
Percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child	35.3%	50.0%	57.8%*
Percentage of mothers with children age 0-23 months who were protected against Tetanus before the birth of the youngest child.	75.7%	73.7%	89.4%*
Percentage of children age 0-23 months whose births were attended by skilled personnel	35.3%	50.5%	83.9%*
Percent of children 0-23 months who received a post - partum visit by an appropriate trained health worker within three days after birth	16.3%	22.2%	40.8%*
Percentage of children 0-5 months who were exclusively breastfed during the last 24 hours	73.6%	66.2%	88.2%
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months (Mother's recall).	70.1%	57.6%	85.3%*
Percentage of children 12-23 months who received DPT1 according to the vaccination card or mother's recall by the time of the survey	87.0%	89.4%	97.0%*
Percentage of children 12-23 months who received DPT3 according to the vaccination card or mother's recall by the time of the survey	85.1%	72.7%	91.7%
Percentage of children 12-23 months who received a measles vaccination	77.0%	80.8%	82.1%
Percentage of children 0-23 months who slept under an insecticide-treated bed net (in malaria risk areas, where bed net use is effective) the previous night.	51.3%	44.4%	58.3%
Percentage of children 0-23 months with a febrile episode that ended during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began.	25.0%	68.7%	51.5%*

Percentage of children 0-23 months with diarrhea in the last two weeks who received Oral Rehydration Solution (ORS) and/or recommended home fluids.	47.2%	52.5%	61.2%
Percentage of children age 0-23 months with chest-related cough and fast/difficult breathing in the last two weeks who were taken to an appropriate health provider.	57.8%	84.8%	74.2%
Percentage of households of children 0-23 months that treat water effectively.	11.3%	10.1%	41.4%*
Percentage of mothers of children 0-23 months who live in households with soap at the place for hand washing	85.0%	87.4%	96.4%*
Percentage of mothers of children age 0-23 months who are using a modern contraceptive method	33.3%	30.3%	28.1%

*** -** Statistically Significant

Annex VI:

Lira District Child Survival Project in Uganda

Child Health and Development in a Transitional Region

Erute North Sub-District, Uganda
October 2009 – September 2013

In Partnership with

Uganda Ministry of Health
Lira District Health Office

Final Knowledge, Practice, and Coverage Report

September 2013

Acknowledgements

The FE survey of Lira District, Uganda is the result of a cooperative effort between many dedicated people living in Uganda, Medical Teams International Uganda, the Lira DHO, and MTI HQ. I am thankful to the staff of Medical Teams International Uganda for providing the opportunity to produce the FE KPC survey in Lira District. Thanks go to the Uganda Country Director Felix Omodi for oversight of the evaluation., Also, special thanks go to MTI Uganda Child Survival Program Manager Lydia Akulo, Africa Health Program Advisor Michael O'Brien, and MTI Monitoring and Evaluation Officer George Aguze, for their support, assistance, and collaboration in every aspect of the evaluation, including the design and development of the survey tools, hiring and training the survey staff, and managing every aspect of the data collection.

Finally, I would like to express my gratitude and respect to each of the team members of the survey. Their tireless work and wonderful attitude made this survey possible. The Supervisors, staff members, and enumerators were a collaborative group consisting of members of MTI Uganda and the DHO and were essential in the completion of the survey. The supervisors and staff members of Medical Teams International Uganda will be essential in continuing the programs to assist the people of Lira district.

Dr. Todd A. Nitkin, DPM, FACFAS, MPH
Sr. Advisor in Monitoring and Evaluation
Representative, Washington, DC
Medical Teams International

Table of Contents

ACRONYMS

ACT	Artemisinin-based Combination Therapies
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
BL	Baseline Assessment
CATCH	Core Assessment Tool on Child Health
CDD	Control of Diarrheal Diseases
CHW	Community Health Workers
C-HIS	Community Health Information System
C-IMCI	Community IMCI
CI	Confidence Interval
CL	Confidence Limits
CMR	Crude Mortality Rate
CS	Child Survival
CORE	Collaborations and Resources Group
CSHGP	Child Survival and Health Grant Program
CSP	Child Survival Project
D	Precision
DHO	District Health Office
DHS	Demographic and Health Survey
EBF	Exclusive Breastfeeding
EPI	Expanded Program of Immunizations
FE	Final Evaluation
HHI	Hands to Hearts International
HC	Health Center
HF	Health Facility
HIV/AIDS	Human Immune Deficiency Virus/ Acquired Immune Deficiency Syndrome
HQ	Headquarters of MTI located in Portland, Oregon
IDP	Internally Displaced Person
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IPTp	Intermittent Preventive Treatment during pregnancy
ITN	Insecticide Treated Net
IYCF	Infant and Young Child Feeding
KPC	Knowledge, Practice, and Coverage Survey
LLITN	Long Lasting Insecticide Treated Net
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MICS	Multiple Indicator Cluster Survey
MNC	Maternal Newborn Care
MOH	Ministry of Health
MT	Midterm
MTE	Midterm Evaluation
MTI	Medical Teams International
MTI Uganda	Medical Teams International Uganda
N	Sample size
NGO	Non-Governmental Organization
NMCP	National Malaria Control Program
NUMAT	Northern Uganda Malaria AIDS & Tuberculosis
ORS	Oral Rehydration Salts
PCM	Pneumonia Case Management
PDC	Parish Development Committee
PHC	Primary Health Care
POU	Point Of Use

Rapid CATCH	Core Assessment Tool on Child Health
R-HFA	Rapid Health Facility Assessment
SP	Sulfadoxine-Pyrimethamine
SS	Statistically Significant
SSD	Statistically Significant Decline
SSI	Statistically significant Improvement
SO	Strategic Objective
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TT	Tetanus Toxoid
U5MR	Under 5 Mortality Rate
USAID	United States Agency for International Development
VHT	Village Health Team
WFA	Weight for Age

Executive Summary

At the outset of the project Uganda was a priority country for child survival efforts, with an IMR estimated in 2006 of 78/1,000 live births, U5MR of 134/1,000 live births, and an MMR of 550/100,000 which had not declined during the past ten years. The leading causes of child morbidity in Lira District were (in rank order): malaria, anemia, diarrhea, respiratory infections, and pneumonia. Causes of child mortality were: pneumonia, anemia, malaria, diarrhea, and respiratory infection. Malnutrition was an important contributing factor to infant and child deaths. The targeted location was Erute North Sub-district in Lira District in Northern Uganda. Direct beneficiaries were 25,498 children <5 and 25,498 WRA for a total of 50,996 direct beneficiaries. Capacity building activities with the DHO were aimed to improve the quality of health care for three sub-districts of Lira, Ogur and Aromo with a total population of 124,379.

The project goal was to reduce child morbidity and mortality in Uganda. Objectives were: 1) Communities assume responsibility for their own health through strengthening community capacity (Village Health Team volunteers (VHTs), Parish Development Councils, and Health Sub-districts); 2) Improved health (C-IMCI) and child care (ECD) behaviors among mothers of children <5 years; 3) Improved quality of health facility services through strengthened IMCI and MNC capacity; 4) Strengthened institutional capacity of MTI and DHO to implement effective and efficient child survival activities. These objectives support MoH goals and strategies as well as those of USAID Uganda. MTI utilized a two-pronged strategy: a) promoting behavior change and community mobilization to take appropriate responsibility for health: and b) building DHO capacity to provide sustainable, quality service delivery at the facility and community levels. The levels of effort by intervention for this Child Survival Project (CSP) were: 25% MNC, 25% PCM, 20% IYCF, 20% CDD, and 10% EPI.

MTI incorporated Early Childhood Development (ECD) activities into its CS project to enhance the impact and sustainability of technical interventions. Past research confirmed that child survival is indivisible from ECD – including health, physical, social/emotional, and language/cognitive domains. The CSP, therefore, integrated ECD into community health activities in order to improve feeding, care giving, and care-seeking behaviors by increasing women's participation in CHW (VHT) structures and integrating ECD into C-IMCI and ANC/EPI outreaches.

The primary implementing partner for this project was the Lira DHO, which regularly met with the design team and committed human resources to the implementation of the proposal, in order to harmonize approaches and plan for sustainability. Hands to Hearts International (HHI) was a collaborate partner, providing ECD TOT trainings for Peer Educators, and HF and MTI staff, and working with MTI and DHO to adapt the HHI curriculum to the local context. The project also coordinated with other CS stakeholders in country.

This FE Knowledge, Practices, and Coverage (KPC) survey was performed in August, 2013. The overall objective of this FE survey was to estimate the current level of chosen indicators as per the monitoring and evaluation (M&E) Matrix of specific objectives and intervention logic in the areas of maternal newborn care (MNC), nutrition and Infant and Young Child Feeding (IYCF),

control of diarrheal disease (CDD), pneumonia case management (PCM), and Expanded Program of Immunization (EPI), along with the indicators of the Rapid Core Assessment Tool on Child Health (CATCH). A 30-cluster stratified sampling design was utilized to select the mothers of children aged 0-23 months. A total of thirty clusters were sampled in Lira District, with twelve households from each cluster being selected for interviews. The KPC FE survey was designed utilizing participatory principles of evaluation in the spirit of partnership and capacity building.[1] The main findings in the areas of MNC, nutrition and IYCF, control of diarrheal disease, pneumonia case management, EPI, and ECD are as follows:

MNC

Eleven of the 12 MNC indicators, including all 6 of the indicators in the project Logframe and all the Rapid CATCH indicators for MNC, were statistically significantly improved (SSI) through the life of the project. In fact, the only MNC indicator not SSI is the rate of use of modern contraception.

- The rate of mothers receiving at least 2 TT immunizations was already relatively high at baseline (BL) (73%), but still the project was able to sow a SSI in this indicator to 89%.
- Additionally the rate of mothers taking proper IPT medication while pregnant was SSI from only 35% at BL to 68% at FE, and the rate of mothers who received iron while pregnant was SSI from 59% at BL to 91% at FE.
- Also, regarding health messaging, there was a statistically significant improvement in the rate of mothers who are able to correctly identify at least 2 neonatal danger signs for which they should seek immediate care, from 2% at BL to 51% at FE.
- At FE, 84% of all childbirths occur under the supervision of a skilled birth attendant, which is SSI from a BL rate of 35%.
- There was a SSI in this the rates of both mothers and children who received a postnatal visit from a trained HW within 2 days after birth. Mothers received a visit at a rate of 50% at FE (up from only 17% at BL), and children received a postnatal visit at a rate of 41% at FE (up from 16% at BL).
- The number of mothers with children aged 0 – 23 months who use a modern method of contraception was 33% at BL and 28% at FE.

Anthropometry AND IYCF

- At FE, The percentage of children with a Z-score of <-2SD at FE was 20%, not significantly decreased from the BL rate of 28%. However, the IYCF indicator relating to the proper feeding frequency and food diversity for children aged 6-23m was SSI from only 23% at BL to 49% at FE.
- The % of children aged 0-5m who were exclusively breastfed during the 24 hours prior to the survey, while already high at 74% at BL, was SSI to 88% at FE.
- Immediate BF practices for newborns was dramatically and SSI from 29% at BL to 79% at FE. There was also a SSI in the rate of mothers who did not give their child prelacteal feeds (from 47% at BL to 87% at FE), and therefore the summary indicator of immediate and exclusive breastfeeding was SSI from only 16% at BL to 71% at FE.

[1] KPC 2000+ Field Guide, The Child Survival Technical Support Project and CORE, http://www.childsurvival.com/kpc2000/kpc2000.cfm, August 2001.

- There has been a SSI in the composite IYCF indicator (the rate at which children aged 6-23m are fed the proper frequency and food group variety in their diet dependant on their age and breastfeeding status) from 23% at BL to 49% at FE. There was a SSI in proper feeding frequency in breastfed children (31% at BL to 66% at FE) which was the driving factor behind this improvement.
- The % of children receiving Vitamin A in the past 6m at FE (85%) was SSI from BL (70%).

Pneumonia Case Management

- The % of children age 0-23 months with ARI who were treated with an antibiotic increased significantly form BL to FE (35% at BL to 69% at FE).
- The % of children with ARI who were taken to an appropriate health provider increased significantly over the first half of the project (58% at BL to 86% at MT, but the FE result of 74% was not a SSI from BL.

Control of Diarrheal Disease

- There was a SSD in the prevalence in the rate of diarrhea at FE (24.3%) from BL (36%), which highlights the gains made in hygiene and water and sanitation (see below in this paragraph).
- There has been a SSI in the % of children who received ORS when suffering from diarrhea since baseline (47% at BL to 62% at FE).
- Zinc usage in children to treat diarrhea, which was almost non-existent at BL (2.6%), was still low but SSI to 18% by FE.
- Hygiene was improved, with the % of mothers who have soap at the place for hand washing and reported washing their hands with soap at least 2 of the appropriate times during a 24 hour recall period (after defecation and at one of the following: before food preparation, before feeding children, or after attending to a child who has defecated) SSI from 54% at BL to 88% at FE.
- The rate of safe feces disposal was SSI from 13% at BL to 61% at FE.
- The % of households of children 0-23m that treat water effectively was SSI from28% to 38% from BL to FE.

Expanded Program of Immunization

The project drastically improved immunization coverage in the project area, with 9 of the 11 measured EPI indicators statistically significantly improved. These are excellent achievements that verify excellent gains in immunization at the HFs and through outreach, as well as IMCI, HF supervision, and drug chain management at the HF level.

- Full EPI Coverage (% of children aged 12-23 months who received a BCG, DPT3, OPV3, and measles vaccination before the age of 12 months, card verified) showed a SSI from16% at BL to 56% at FE.
- Card verified DPT1 was raised from 47% at BL to 91% at FE, and card verified DPT3 was raised from 35% at BL to 85% at FE.
- Card verified measles vaccination was raised from 11% at BL to 66% at FE.

Early Childhood Development

MTI incorporated ECD activities into its CS project to enhance the impact and sustainability of technical interventions. Research confirms that child survival is positively linked to ECD – including health, physical, social/emotional, and language/cognitive domains.

- Six of the 7 ECD indicators that pertain to ECD behaviors at least 2 times per week were SSI over the course of the project.
    - There has been a SSI from BL of mothers of children aged 0-23 months who report playing games with their child in which they have their child identify their body parts, imitate actions, pretend play, or name objects (38% at BL to 76% at FE).
    - There has been a significant increase from BL of mothers report engaging their children in linguistic learning activities such as telling their child stories, singing them songs, or naming objects for them at least twice weekly (23% at BL to 64% at FE).
- Beliefs regarding the importance of several ECD components were also SSI. All of the indicators measuring beliefs regarding the fundamental principles behind ECD were SSI, except for one which was already above 90% before ECD messaging began.
- There has been a SSI from BL in the rate of mothers who report that they talk or sing to the child while feeding the child (58% at BL to 84% at FE).

Malaria

The project did not have a malaria component but rates of malaria and malaria prevention and care seeking practices improved.

- Over the course of the project, the rate of malaria in children under 2 was SSD from 75% at BL to 58% at FE.
- There has been a SSI in the use of bed nets in mothers of children under 2 since BL (41% at BL to 57% at FE), which is commendable considering there is a decrease in the availability of ITNs. However, the rate of children under 2 sleeping under a bed net was not statistically changed from 51% at BL to 58% at FE.
- The rate of households that contained at least 1 ITN was SSD from 82% at BL to 58% at FE. This correlates with the findings of the health facility assessment at final that should a lack of available nets for distribution in the entire project area.
- There has been a SSI in the rate of children treated with an antimalarial drug within 24 hours of the start of the fever, from 25% at BL to 52% at FE. The driving factor behind this increase is the fact that the rate of care seeking (mothers who sought care for their child with fever within24 hours) was SSI from only 22% at BL to 83% at FE.

Health Contacts

A great success of this project was the very significant increase in contact rates between mothers in the project area and qualified health workers orsources of accurate health information regarding MNC and mother and child health.

- Due to the projects strengthening of community capacity through VHTs, Parish Development Committees (PDCs), Mother Leader Groups, and Health sub-districts, the rate of mothers having contact with trained health personnel in the previous month was SSI from only 29% at BL to 92% at FE.
- Contact with VHTs led the SSI, with a rate of 81% by FE, up from only 10% at BL.

- Mothers now (at FE) attend a monthly meeting of some type in order to discuss their health or the health of their baby at a rate of 85%, a very large SSI from the baseline rate of 23%.
- There is a high saturation of health messaging in all villages from the VHTs, at 80% at FE, and also Health Educators, at 61% at FE.
- There is also high saturation of health messaging through the radio, which is shown by the high rate of mothers who report hearing health messaging from the radio, at 82% at FE.
- There are high rates of mothers hearing each important health topic (hand washing, treating water, danger signs/care seeking, diarrhea care, and SBA), with all rates above 75% (see the table for Health Contacts in the Results section).

Working in partnership with the DHO, MTI Uganda completed a project that improved the health of village communities in Lira District through building DHO capacity to provide sustainable, quality service delivery at the facility and community levels, and through promoting behavior change and community mobilization to take appropriate responsibility for health. This was accomplished through a combination of interventions, including providing supplementary training, supervision, and follow-up coaching of VHTs. The results of this FE KPC Survey reveal the many sustainable successes were accomplished in Lira District, as well as some continuing challenges of this project area that may be used in future projects as lessons learned.

CHAPTER 1

BACKGROUND, PROCESS AND PARTNERSHIP BUILDING, AND METHODS

1.1 Background

Program Strategy and Interventions

Goal and Objectives

The project goal was to reduce child morbidity and mortality in Uganda. These objectives supported MoH goals and strategies.

- **Objective 1:** Communities assume responsibility for their own health through strengthening community capacity (VHTs, Parish Development Councils, and Health Sub-districts).
- **Objective 2:** Improved health (C-IMCI) and child care (ECD) behaviors among mothers of children <5 years.
- **Objective 3:** Improved quality of HF services through strengthened IMCI and MNC capacity.
- **Objective 4:** Strengthened institutional capacity of MTI and DHO to implement effective and efficient child survival activities.

***Strategic Approaches*:** MTI utilized a two-pronged strategy: a) promoting behavior change and community mobilization to take appropriate responsibility for health: and b) building DHO capacity to provide sustainable, quality service delivery at the facility and community levels. The CSP implemented activities that strengthen community volunteer capacity to improve maternal and child health, based on the MoH policy prioritizing Village Health Teams (VHTs). Through the CSP, supplementary training, supervision, and follow-up coaching of VHTs was provided. The CSP worked hand-in-hand with DHO and HF staff that functions as support for VHTs. At present, the Senior Health Educator of the DHO oversees VHT activities.

At their request, the CSP assisted the DHO to build on previous training and strengthen the ***health facility staff skills*** through refresher trainings focused on selected topics within IMCI, such as CDD management with ORS+zinc and PCM.

***Technical Interventions*:** The level of effort by intervention for this CSP was: 25% Maternal and Newborn Care, 25% Pneumonia Case Management, 20% Infant and Young Child Feeding, 20% Control of Diarrheal Disease, and 10% Immunization. The CSP coordinated with the DHO and other actors in support of programs directed towards malaria control and HIV/AIDS. ECD supported the proposed technical interventions through cross-sectoral collaboration, focused on reinforcing positive early child care practices and interaction.

Objectives of the KPC Survey

The FE KPC survey was conducted in September of 2013. The objectives of the KPC survey were as follows:

- Appropriately collect data on the major areas of child and maternal health, including: maternal and newborn care, infant and young child feeding (IYCF), anthropometry, immunization coverage, diarrhea, acute respiratory infection (ARI), fever and malaria, water and sanitation, and hygiene. The survey collected the appropriate data by interviewing 33 mothers of children aged from 0-23m of each age and previous illness category needed to obtain 33 answers to each question in each of 6 SAs. Therefore, this produced a sample size of 198 for each question/indicator. This data will be used to determine progress of all indicators in the Project Design and, combined with qualitative studies, will determine areas of success and challenges, and direct the project in its second half.
- Promote capacity building: staff members were trained in the use of survey training methodology in order to facilitate future monitoring and evaluation.
- Train staff members in data analysis through the use of LQAS hand tabulation and training sessions following data collection.
- Train staff members in making changes to the monitoring and evaluation plan and health information system by relating the indicators used to the projects objectives, outputs, and activities during the data analysis training.
- Promote community awareness and acceptance through follow up Community Feedback Sessions.
- Partnership building: The survey utilized the concept of partnership building in all phases of training, data collection, and data analysis by involving all key stakeholders in all phases of the survey process.

1.2 Process and Partnership Building

MTI had two principal implementing partners in the project, the DHO and Hands to Hearts International. The project was coordinated with other CS stakeholders in country as well. The DHO is the local representative of the MOH, and therefore was a critical partner for long-term strengthening of county health services. An inclusive process was followed to involve all stakeholders in the design, training, implementation, and analysis of the KPC survey. The DHO, HHI, and USAID were all invited to participate in all aspects of the survey via letters and personal contact that outlined the exact process and dates of the training and survey. The DHO was interested all phases of the survey, and helped in areas where they were able, including, getting the word out to all villages via radio and personal visits, and reviewing and discussing results. They were also helpful during the baseline in adapting the survey to the local context and ensuring that the survey was performed in a culturally appropriate manner. Permission to conduct the survey was obtained from the MOH. The survey team was comprised to be as inclusive as possible in order to foster partnership. . Six supervisors and twenty four enumerators were chosen from members of MTI Uganda and the communities of Lira District.

1.3 Methods

The overall objective of this FE survey was to estimate the current level of chosen indicators as per the M&E Matrix of specific objectives and intervention logic in the areas of nutrition, immunization, pneumonia case management, and control of diarrheal disease, along with the indicators of the Rapid CATCH. In addition to this, questions and indicators were chosen to measure areas of Early Childhood Development. The survey was designed using LQAS methodology so that the project area may be divided into 6 management areas (Supervision Areas), and each of these areas monitored along with the project area as a whole. This provides the project with MT results for the entire project as well as a breakdown by SA so that actions based on the results may be targeted not only by indicator but also by management area. The KPC FE survey was designed utilizing participatory principles of evaluation in the spirit of partnership and capacity building.[2] The Core Team consisted of members of MTI Uganda, with backstopping by the Sr. Advisor in M&E from HQ. The survey team was comprised of 6 supervisors, who were members of MTI Uganda, and the communities of Lira. The enumerators were devised of members of MTI Uganda, , and local survey takers (enumerators) chosen from Lira District. Selection of the team members was based on their skills and their future role in the project and thus provided ownership of the survey and the project itself. The Sr. Advisor in M&E HQ, Africa Health Program Advisor, MTI Uganda Child Survival Program Manager, MTI Monitoring and Evaluation Officer George Aguze, , and MTI Uganda country office staff were involved in the evaluation planning process, including the development of the questionnaires and the recruitment of various team members. The trainings for the KPC Survey, data entry, and data analysis were directed by the Sr. Advisor in M&E HQ. Data analysis was performed utilizing Epi Info by the Sr. Advisor in M&E HQ and shared back with the MTI Uganda Core staff for discussions so that the results could be shared with the country staff and then the communities of Lira District through Community Feedback sessions. Final data analysis was performed in MTI HQ.

a. Development of the Questionnaire

The evaluation team reviewed the project documents including the detailed M&E Matrix with the project's goal, objectives, and activities. Key indicators were then chosen based on these parameters in conjunction with the newly revised Rapid CATCH (2008) and KPC 2000+ modules.[3] The initial draft questionnaire was developed and shared with the MTI Uganda staff for comments, suggestions, and feedback. Local and regional translators then translated the finalized version of the questionnaire into Luo. Separate translators then translated the questionnaires back into English to ensure that the wording of the questions and answer choices were accurate. Any changes necessary were made at that time. Additional changes important to the local context were made throughout the

[2] KPC 2000+ Field Guide, The Child Survival Technical Support Project and CORE, http://www.childsurvival.com/kpc2000/kpc2000.cfm, August 2001.

[3] ibid.

training, and the final questionnaire was completed following the fourth day of the training which included a field test of the questionnaire.

In addition to the questionnaires, anthropometric measurements consisting of age, gender, and weight of the eligible children aged 0-23 months were taken at the time of the survey from those children randomly chosen for the main questionnaire. Salter hanging scales were used for the weight measurement, which were calibrated prior to each weighing to ensure accuracy. The measurements were taken in order to calculate the child's weight for age and corresponding Z-scores.

b. Sampling design

A 30-cluster stratified sampling design was utilized to select the mothers of children aged 0-23 months. A total of thirty clusters were sampled in Lira district, with twelve households with children under the age of 24 months from each cluster being selected for interviews. The overall sample size of 360 households was derived from modifying the simple random sampling design. In a simple random sampling design, a sample size (n) of 96 is derived based on the formula:

$$\mathbf{n=z^2\,(pq)/d^2}$$

With a desired precision of d=0 .5:

The estimated proportion p=0.5 (chosen as it requires the largest sample size, thus ensuring that an adequate sample size is chosen), and q=1-p.

The desired Confidence Interval=95% leads to a $z^2 = 1.96$

The required sample size (n) = 96.

A cluster sample introduces bias in the form of the design effect into the sampling frame, meaning that households in close proximity have more in common than households that are from different areas of the same community, which decreases their possible variation. Therefore, the number of households should be doubled to at least 192. Taking into account that KPC surveys are used to estimate coverage for many different interventions at the same time, which requires looking at sub-samples (such as children less than 6 months old in order to estimate rates of exclusive breastfeeding), it is recommended that the sample size be increased even further, and therefore a sample size of 360 was chosen. Consequently, a 30-cluster stratified sampling design was adapted for the catchment area, with ten households interviewed in each cluster. The true estimate of the survey results include a margin of error as derived using the formula of 95% confidence limits:

$$\mathbf{P=}\ p + \mathbf{z}\ \sqrt{\ \mathbf{(pq/n)}}$$

P = the actual rate or proportion

p = the survey estimate

p = prevalence

q = 1-p

z = the confidence level (1.96 for a confidence level of 95%)

n = sample size

Choosing 30 clusters of 12 mothers, for a total sample size of 360, was done to ensure that the 95% confidence interval of each estimate would be narrow enough to distinguish differences in indicators over time in a meaningful way. The number of mothers per cluster was raised slightly, from the average KPC Survey that utilizes 10 mothers, to 12 mothers, so that a certain number of ECD related indicators would have a sample size large enough to be able to effectively compare certain health related outcomes between Aromo sub county, which continued to implement ECD in the second half of the project, and Ogur and Lira sub counties, which did not continue to implement ECD in the second half of the project.

c. The Selection Process:

The MTI Africa Health Program Advisor, MTI Uganda Child Survival Program Manager, MTI Monitoring and Evaluation Officer, along with other country office staff, met with the DHO and various local leaders and community personnel to determine the respective populations of each of the villages included in the survey sampling frame. Population figures obtained from MOH Lira district statistics for 2011 were used in conjunction with mapping techniques and visualization of the areas by MTI Uganda staff. Each village in the project area was listed randomly, with its population beside it. When the list was complete, the cumulative population of each village was determined by summing the total population of that village with the combined population of all the preceding villages on the list. The total cumulative population of the villages in the catchment area was then divided by 30 (corresponding to the 30 clusters needed) to obtain the sampling interval for that region. A random number was then chosen, with the stipulation being that the number had to be less than or equal to the sampling interval. The cumulative population of each village was then consulted, and the village containing the random number (the village whose cumulative population is equal to or larger than the random number, and whose preceding village had a cumulative population less than the random number) was chosen as cluster number 1. The second cluster was then identified by adding the sampling interval to the random number. The village whose cumulative population contained this number was chosen as the location of cluster number 2. The remaining clusters were then identified by continuing to add the sampling interval to the number that identified the previous cluster. In this way, each cluster was randomly chosen, with proper weight assigned to each village based on its population size. The larger the size of a population of a village, the greater the chance of having one or more clusters assigned to it.

The center of each cluster was determined by allowing the supervisors and enumerators local to these villages enlist the help of the Village Chief or elders to determine the spot where they felt that an equal number of households were on each side. The survey team then chose a random starting direction by spinning a bottle in the physical center of the cluster. The team would then walk in the direction the bottle pointed, and count the number of households in that direction until they reached the end of the households in that cluster. The survey team would return to the center and then choose a random number from a random number table, with the requirement that it had to be less than the number of homes in that direction. They then counted the doorways in the direction the bottle was pointing until they reached the doorway that corresponded to the random number chosen. This was deemed the first house. A protocol was established and written during the training sessions, prior to the survey, that determined which households, children, and thus mothers would be eligible for the survey. If the chosen household contained a child aged 0-23 months that was present and sleeps in the house at night, and a mother that was present and sleeps in the house at night, the survey would be taken at this household. If there was no child under two present, or the mother was not available for the interview, the survey team would move to the household that had the closest door relative to the doorway of the household just eliminated. This procedure was then repeated until 12 successful interviews with eligible mothers were conducted in that cluster.

d. Training of Supervisors and Enumerators

The training of supervisors and enumerators required 4 days in total. The training curriculum was adapted from the CORE Group's Knowledge, Practice, and Coverage (KPC) Survey Training Curriculum. The training curriculum was shared with the Core team prior to the training, and the Core team was fully involved with all aspects of the training in order to strengthen the local capacity to conduct future small-sample surveys.

Six supervisors were chosen for the FE survey from MTI Uganda staff. The training regimen of the supervisors included: the objective of the evaluation, the sampling process of a 30-cluster sampling frame, proper selection of the clusters, households, children, and mothers, accepted technique and protocol regarding data collection, and an in-depth review of the questionnaires to be used. Measurement of weight was first demonstrated, and then performed, to ensure proper technique. Training methods used included several days of mini lecture followed by discussions, demonstrations, role-play, group work, and pre-testing of the questionnaires. Their responsibilities included supervising twenty-four local enumerators, taking part in every aspect of the data collection, and taking the lead in choosing each cluster's center, the household chosen, the eligible infant, and then the eligible mother. The training of the enumerators took place with the training of the supervisors and consisted of a several day process that was similar in nature to the training regimen of the supervisors. It included the same several days of mini lecture followed by discussions, demonstrations, role-play, and group work including the measurement of weight, using several children under two for practice. Repeated practice administering the questionnaires and completing each set of 8 questionnaires properly was performed on local volunteer mothers who were not eligible for inclusion in the

actual survey. The survey teams then performed a field test of the questionnaire in nearby Lira district villages that had not been randomly selected for the survey, under the watchful eyes of the Core team. Following the field test the training concluded with a meeting to discuss any issues that arose during the field test and make final changes or adjustments of the questionnaire so that it would be as accurate and context appropriate as possible for the survey. These changes were then made to the questionnaire prior to making copies for the survey.

e. Data Collection

Each supervisor was assigned four enumerators for a total of six groups, each consisting of four enumerators and one supervisor. A supervisor went to the first chosen house, with two of the enumerators in his/her team, to determine the eligibility of that household, choose the eligible child aged 0-23 months, choose the eligible mother, and weigh the child chosen, using the protocol developed previously. The supervisor would then help determine which questionnaires in the set of 8 questionnaires could be asked at that household (always beginning with the main questionnaire). As the 2 enumerators conducted the rest of the interview with the appropriate questionnaires, the supervisor would then take the other two enumerators in the team to the next eligible household and repeat this process, and would therefore alternate between the two groups of two enumerators. The supervisor would then help each group find the remaining eligible children to complete the set of questionnaires. This allowed the supervisor to take the lead role in determining the eligibility of the household, the weighing process, and immediately checking and correcting any problems with each finished questionnaire while the mother was still available. Each evening the supervisors and Core team met and discussed any issues that arose during the day in order to ensure consistency in the data collection process. The data collection process required 5 days in total, with an average length of interview of approximately 35 minutes.

f. Data Analysis

A preliminary analysis of the data was performed by calculating frequency distributions of major indicators were prepared using the Epi-info 3.5.3 database, so that MTI Uganda staff had some immediate results to guide programmatic decisions and guide community feedback sessions . These results were then used in discussing the Project design in detail with the MTI Uganda staff in order to increase their capacity in developing project designs and formulating monitoring plans from the objectives, outputs, activities, and indicators chosen.

The final analysis was then performed, also using the Epi-info 3.5.3 database. All Rapid CATCH indicators, indicators from the M&E Matrix, several indicators chosen from the KPC 2000+ modules, and indicators dealing with ECD and Health Contacts were presented in the analysis. A 95% confidence interval and a precision of 0.5 were used for each indicator, and 95% confidence limits were calculated for each.

g. Results and Discussion

The results are organized into sections that represent each area of the different study indicators. The following chapters represent the program intervention areas, as per the M&E Matrix. Each table contains the indicators measured for that intervention area, with the M&E Matrix indicators denoted with a red box. Also, all Rapid CATCH Indicators are highlighted with orange font. All indicators that have shown a statistically significant improvement at FE have the FE data in red font, and any indicators showing a statistically significant decline are highlighted with a yellow font.

CHAPTER 2

MATERNAL AND NEWBORN CARE

Project Matrix Indicators Are Denoted with Red Boxes
Rapid CATCH Indicators Highlighted in Orange Font
Data at FE that show a SSI are indicated with a red font
Data at FE that show a SSD are indicated with a yellow font

MATERNAL AND NEWBORN CARE						
• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
10. % of mothers of children age 0-23m who had one or more antenatal visits when they were pregnant with the youngest child	85.7	81.2-89.4			96.1	93.4-97.8
11. % of mothers of children age 0-23m who had four or more antenatal visits when they were pregnant with the youngest child	35.3	29.9-41.0	49.6	42.6-56.4	57.8	52.5-62.9
12. % of mothers of children aged 0-23m who received at least 2 TT vaccinations before the birth of their youngest child	75.7	70.4-80.4	73.5	67.3-79.6	89.4	85.8-92.4
13. % of mothers with children age 0-23 months who received at least 2 doses of IPT during the pregnancy with this youngest child.	35.0	29.6-40.7	59.1	52.3-66.0	68.3	63.3-73.1
14. % of mothers of children aged 0-23m who received iron tablets/syrup while pregnant	58.6	52.3-64.6			91.0	87.6-93.8
15. % of mothers who took iron tablets/syrup for at least 12 weeks	0.0	0.0-0.0			51.4	46.1-56.6
16. % of children aged 0-23m whose births were attended by skilled personnel	35.3	29.9-41.0	53.3	46.4-60.2	83.9	79.7-87.5
17. % of children aged 0-23m whose births were attended by a traditional birth attendant	48.3	42.6-54.1			11.9	8.9-15.9
18. % of mothers of children aged 0-23m who received a post-natal visit from an appropriate trained health worker within two days after birth	16.7	12.5-20.9	30.0	23.7-36.4	50.3	45.0-55.5
19. % of mothers of children aged 0-23m who know at least 2 maternal danger signs	2.0	0.7-4.3	20.0	14.4-25.6	51.1	45.8-56.4
20. % of children aged 0-23m who received a post-natal visit from an appropriate trained health worker within two days after birth	16.3	12.2-20.5	18.8	13.3-24.2	40.8	35.7-46.1
21. % of mothers of children aged 0-23m who are currently using modern contraception	33.3	28.0-39.0	30.0	23.6-36.4	28.1	23.5-33.1

Every MNC indicator measured, except for modern contraception, was statistically significantly improved (SSI) over the life of this project. All project indicators were SSI, including the following:

- **Tetanus Toxoid:** The percentage of mothers receiving at least two tetanus toxoid immunizations in Lira District was SSI from BL (73%) to FE (89%), despite the fact that there was no SSI at MTE. This increase indicates excellent improvement of antenatal care services and tetanus immunizations being performed by antenatal health care staff, as well as increased utilization of these services.

- **IPT:** At baseline only 35% of mothers took proper anti-malarial medication at least 2 times during pregnancy with their youngest child. By FE this was SSI to 68%, which speaks to the utilization of ANC services as well as improved HF Supervision and drug chain improvements.
- **Iron While Pregnant:** The percentage of mothers who received iron while pregnant was SSI from 59% at BL to 91% at FE, which again shows the excellent increase in utilization of ANC services, supportive supervision at the HF level, and drug chain improvements.
- **Skilled Birth Attendant:** At FE 84% of all childbirths now occur under the supervision of a skilled birth attendant, which is SSI from BL (35%). MTI has accomplished this through focus on increasing the use of health facilities and skilled birth attendants through VHTs, and mothers groups who are being trained in health promotion. This training also included the importance of ensuring that both mother and child receive follow up care including a post partum visit with a trained health professional within 3 days of birth.
- **Danger Signs:** There was a SSI in the rate of mothers who are able to report at least 2 maternal danger signs from 2% at BL to 51% at FE. This is due to extensive health messaging performed throughout the project.
- **Mother Postnatal Visit:** There was a SSI in this indicator, from 16.7% at BL to 28% at FE, also due to increased activity of VHTs and mothers groups.

CHAPTER 3

ANTHROPOMETRY AND INFANT AND YOUNG CHILD NUTRITION

4.1 Anthropometry-Nutritional status of children aged 0-23 months

Malnutrition and under-nutrition are major determinants in the increased vulnerability of children to many infectious diseases, including diarrhea, ARI, and febrile illness. Inversely, many infectious diseases may be the cause under-nutrition in children. In addition, the nutritional status of children indirectly reflects the health and nutrition status of mothers. Therefore, the nutritional status of children aged 0-23 months is an important indicator in relation to child survival and community health programs.

In this survey, nutritional status was assessed through the anthropometric measurement of weight-for-age in children aged 0-23 months. The weight of each child was taken and combined with the age and gender of the child to calculate the weight-for-age indicator. The indicator is expressed in standard deviations (Z-score) from the median values of weight-for-age of the CDC reference population from the year 2000.

ANTHROPOMETRY
Project Matrix Indicators Are Denoted with Red Boxes
Rapid CATCH Indicators Highlighted in Orange Font
Data at FE that show a SSI are indicated with a red font
Data at FE that show a SSD are indicated with a yellow font

ANTHROPOMETRY						
WFA Children 0-23m (Undernutrition)						
• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
22. % distribution of moderately malnourished children (-3< Z-score >-2)	17.0	12.9-21.7			10.1	7.3-13.8
23. % distribution of moderately malnourished female children (-3< Z-score >-2)	15.5	10.2-22.2			7.4	4.2-11.8
24. % distribution of moderately malnourished male children (-3< Z-score >-2)	18.6	12.6-25.9			13.8	8.8-20.3
25. % distribution of severely malnourished children (Z-score <-3)	10.7	7.4-14.7			10.1	7.3-13.8
26. % distribution of severely malnourished female children (Z-score <-3)	9.0	5.0-14.7			10.3	6.5-15.3
27. % distribution of severely malnourished male children (Z-score <-3)	12.4	7.5-18.9			9.9	5.6-15.8
28. % of children classified as being Underweight (Z-score <-2)	27.7	22.7-33.1	17.6	12.3-22.9	20.2	16.3-24.9
29. % of female children classified as being Underweight (Z-score <-2)	24.5	18.0-32.1			17.6	12.7-23.6
30. % of male children classified as being Underweight (Z-score <-2)	31.0	23.6-39.2			23.7	17.2-31.3

- **Undernutrition:** The % of children with a Z-score of <-2SD at FE is 20%, not significantly decreased (SSI) from the BL rate of 28%. However, the IYCF indicator (see the next section on IYCF) was SSI from only 23% at BL to 49% at FE.

4.2 Infant and Young Child Feeding (IYCF)-Nutrition

Health promotion and education regarding nutrition and breastfeeding was one of the interventions of MTI Uganda. The project worked to improve the nutritional status of children through the promotion of correct breastfeeding and complimentary feeding practices, including immediate breastfeeding following childbirth, exclusive breastfeeding of children under 6 months of age, and the introduction of digestible and nutritional complimentary foods in children 6 months and greater.

BREAST FEEDING AND INFANT AND YOUNG CHILD FEEDING (IYCF)
Project Matrix Indicators Are Denoted with Red Boxes
Rapid CATCH Indicators Highlighted in Orange Font
Data at FE that show a SSI are indicated with a red font
Data at FE that show a SSD are indicated with a yellow font

BREAST FEEDING AND INFANT AND YOUNG CHILD FEEDING (IYCF)						
• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
31. % of children aged 0-23m who were ever breastfed	96.6	93.8-98.4			99.2	97.4-99.8
32. % of mothers of children aged 0-23m practicing immediate initiation of breastfeeding (within 1 hour of birth)	29.0	23.9-34.5	22.7	16.9-28.6	78.9	74.3-83.0
33. % of mothers of children aged 0-23m who did NOT give prelacteal feeds during the first 3 days after delivery	46.6	40.8-52.5	56.0	48.1-62.0	87.2	9.6-16.8
34. % of mothers of children aged 0-23m practicing immediate and exclusive breastfeeding of newborns	16.3	12.3-21.0			71.1	66.1-75.7
35. % of children aged 0-5m who were exclusively breastfed in the last 24h	73.6	59.7-84.7	67.7	61.2-74.2	88.2	79.8-93.9
36. % of infants aged 6-9m who receiving breast milk and complementary foods	69.8	55.7-81.7	84.1	79.1-89.2	85.5	74.2-93.1
37. % of mothers of children aged 0-23m who continue to breastfeed their child aged 6-11m	97.5	91.4-99.7			97.9	92.7-99.7
38. % of mothers of children aged 0-23m who continue to breastfeed their child aged 12-17m	87.8	79.6-93.5			87.7	78.5-93.9
39. % of mothers of children aged 0-23m who continue to breastfeed their child aged 18-23m	68.3	55.3-79.4			78.2	68.0-86.3

- **Exclusive Breastfeeding:** The % of children aged 0-5m who were exclusively breastfed during the 24 hours prior to the survey was SSI at FE (88%) from MTE (68%), but not from BL (73.6). This could be due to the fact that the Confidence Intervals (CIs) are larger due to the lower sample size of mothers with children aged 0-5m.
- **Immediate Breastfeeding:** There was a very large and SSI of Immediate BF practices for newborns, which was only 29% at BL and 23% at MTE. By FE this was increased to 79%.
- **No Prelacteal Feeding:** there was also a very large and SSI in the % of mothers who do not give their infant prelacteal feeds, rising from 47% at BL to 87% at FE.
- **Complimentary feeding:** Complimentary feeding was relatively high at BL, at 70%, and was also high but not SSI at FE (86%). This is not significantly higher than at BL because the sample size of mothers of children aged 6-9m was small (n=53) due to 30 cluster methodology. However, a complimentary feeding rate of 86% is quite high.
- **Continued BF in children to 23m:** Continued BF is statistically unchanged in all categories, which were already high

IYCF INDICATORS
Project Matrix Indicators Are Denoted with Red Boxes
Rapid CATCH Indicators Highlighted in Orange Font
Data at FE that show a SSI are indicated with a red font
Data at FE that show a SSD are indicated with a yellow font

IYCF Indicator and Tabulation Plan Indicators						
• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
47. Minimum frequency of feeding (FF) for breastfed children 6-23m: % of breastfed children aged 6-23m who ate solid or semi-solid foods at least the minimum recommended number of times in the 24 hours preceding the survey	31.3	25.0-38.0			66.5	60.1-72.6
48. Minimum frequency of feeding (FF) for non-breastfed children 6-23m: % of non-breastfed children aged 6-23m who ate solid or semi-solid foods at least the minimum recommended number of times in the 24 hours preceding the survey	14.7	5.0-31.1			6.5	0.8-21.4
49. Minimum frequency of feeding (FF): % of children aged 6-23m who ate solid or semi-solid foods at least the minimum recommended number of times in the 24 hours preceding the survey	28.8	23.1-34.5			59.5	53.3-65.4
50. Minimum dietary (food group) diversity for breastfed children 6-23m: % of breastfed children aged 6-23m who received minimum dietary (food group) diversity in the 24 hours preceding the survey	65.4	58.5-71.8			79.4	73.6-84.4
51. Minimum dietary (food group) diversity for non-breastfed children 6-23m: % of non-breastfed children aged 6-23m who received minimum dietary (food group) diversity in the 24 hours preceding the survey	50.0	32.4-67.6			16.1	5.5-33.7
52. Minimum dietary (food group) diversity for children 6-23m: % of children aged 6-23m who received minimum dietary (food group) diversity in the 24 hours preceding the survey	63.2	57.1-69.3			72.0	66.1-77.3
53. IYCF Indicator: % of children age 6-23m fed according to a minimum of appropriate feeding practices	23.1	18.4-27.9	42.3	36.4-49.1	48.9	42.7-55.1
Vitamin A Supplementation						
54. % of children aged 0-23m who received Vitamin A supplementation in the 6m preceding the survey	70.1	63.3-76.4	55.5	48.6-62.4	85.3	80.1-89.5

- **IYCF Indicator:** There has been a significant improvement in this indicator, increasing from 23% at BL to 49% at FE. There was a SSI in proper feeding frequency in breastfed children (31% at BL to 66% at FE) which was the driving factor in this improvement.

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The results reveal that feeding practices for children aged 6-23m have improved significantly, particularly with the immediate and exclusive BF of newborns and children aged 0-5m, respectively, as has proper infant and young child feeding.

- **Vitamin A:** The % of children receiving Vitamin A in the past 6m at FE (85%) was SSI from BL (70%).

CHAPTER 4

PNEUMONIA CASE MANAGEMENT

Project Matrix Indicators Are Denoted with Red Boxes
Rapid CATCH Indicators Highlighted in Orange Font
Data at FE that show a SSI are indicated with a red font
Data at FE that show a SSD are indicated with a yellow font

PNEUMONIA CASE MANAGEMENT						
• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
75. % mothers of children 0-23m who report that their child had a cough and difficulty breathing/fast breaths in the 2 weeks prior to the survey	49.0	43.2-54.8			24.7	20.4-29.6
76. % of children age 0-23m with chest-related cough and fast/difficult breathing in the last two weeks who were taken to an appropriate health provider	57.8	49.4-65.9	86.1	81.3-90.9	74.2	63.8-82.9
77. % of children age 0-23m with chest-related cough and fast/difficult breathing in the last two weeks who were taken to an appropriate health provider within 2 days of the start of symptoms	41.5	33.4-49.9			61.8	50.9-71.9
78. % of children age 0-23m with chest-related cough and fast/difficult breathing in the last two weeks who received antibiotics	34.7	27.0-43.0	64.4	57.7-71.0	68.5	57.8-78.0
79. % of children age 0-23m with chest-related cough and fast/difficult breathing in the last two weeks who were taken to a health facility or who received antibiotics from an alternative source.	78.2	70.7-84.6			87.6	79.0-93.7
HYGIENE						

Acute Respiratory Infection is recognized as one of the major public health problems in Uganda. Most children were given symptom relieving not curative medicines in the form of cough syrups or country medicines. Objectives of the project included the recognition of the danger signs of pneumonia, improved access to quality care, and the promotion of optimal and timely health seeking behaviors among mothers/caretakers. The present evaluation estimates the prevalence of ARI among children aged 0-23 months, the mother's knowledge concerning ARI, the mother's management of ARI, and timely health seeking behaviors in relation to ARI.

- **Rate of ARI:** The rate of ARI was SSD from 49% at BL to 25% at FE, indicating improved hygiene (see the hygiene section, below).
- **Health Seeking for ARI**: The % of children with ARI who were taken to an appropriate health provider increased significantly over the first half of the project (58% t BL to 86% at MT), but there was not a SSI from BL to FE (74%). The sample sizes were smaller at FE (n=89) due to lower rates of pneumonia, which is good, but this increased the CI and therefore the result at FE was not SSI.
- **Antibiotics for ARI**: The % of children aged 0-23 months with ARI who were treated with an antibiotic also increased significantly form BL to MT (35% to 64%), and this remained SSI at FE (69%).
- **Timely care seeking for ARI:** There was a SSI in timely care seeking behaviors for ARI, rising from 42% at BL to 62% at FE. This corresponds with a SSI in timely care seeking for fever/malaria as well (see the Malaria section for details).

CHAPTER 5

CONTROL OF DIARRHEA

Project Matrix Indicators Are Denoted with Red Boxes
Rapid CATCH Indicators Highlighted in Orange Font
Data at FE that show a SSI are indicated with a red font
Data at FE that show a SSD are indicated with a yellow font

DIARRHEA						
• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
66. % of mothers of children 0-23m who report that their child had a diarrhea in the 2 weeks prior to the survey	37.5	31.9-43.4			24.3	20.0-29.2
67. % of children 0-23m with diarrhea in the last two weeks who received Oral Rehydration Therapy (ORT) and/or recommended home fluids.	47.2	37.5-57.1	53.5	46.6-60.5	61.2	50.0-71.6
68. % of children 0-23m with diarrhea in the last two weeks who were treated with Zinc	0.9	0.0-5.1	2.6	0.4-4.8	17.6	10.2-27.4
69. % of children 0-23m with diarrhea in the last two weeks who were treated with antidiarrheals or antibiotics, which is incorrect treatment for watery diarrhea	22.2	14.8-31.2			40.0	29.5-51.2
70. % of children 0-23m with diarrhea in the last two weeks who were offered more fluids during the illness (more fluid and/or more breast milk if exclusively breastfeeding)	9.3	4.5-16.4			27.1	18.0-37.8
71. % of children 0-23m with diarrhea in the last two weeks who were offered the same amount or more food during the illness	21.0	13.5-30.3			11.4	7.6-15.2
72. % of children aged 0-23m with diarrhea in the last two weeks who were offered increased fluids and the same amount or more food during the illness.	2.0	0.2-7.0			5.3	3.3-8.3

Diarrhea was a common cause of childhood morbidity and mortality in Lira District and, and Uganda as a whole. It is well proven that diarrhea is one of the major contributors to malnutrition in children. MTI Uganda made a high priority the reduction of childhood diarrhea prevalence and morbidity through preventive and curative measures. This diarrhea management initiative was an intervention aimed at raising the awareness of mothers/caretakers about the necessary steps required to both prevent and treat diarrheal disease. Interventions aimed at the prevention of diarrhea included instruction in the importance of appropriate hand washing behaviors as well as the promotion of the use of latrines. Diarrhea case management at the household level included proper feeding and fluid management during diarrhea episodes, including the proper preparation and use of Oral Rehydration Salts (ORS).

- **Incidence of Diarrhea:** The rate of diarrhea was SSD from 38% at BL to 24% at FE, which highlights the improvements in hygiene and the treatment of water in the household (see these sections for greater detail).
- **ORS Use:** At MTE there was no SSI (47% at BL to 54% at MTE), but by FE a SSI was shown, with a rate of 61%. This SSI from BL is due to health messaging and availability and proper treatment at the HFs.

- **Zinc:** Zinc usage was SSI from only 1% at BL to 18% at FE, when there was no change at MTE, so this shows increased effect of health messaging, IMCI, HF supervision, and drug chain management in the last half of the project.
- **Increased Fluids with Diarrhea:** The rate of mothers who offer their child more to drink with diarrhea was SSI from 9% at BL to 27% at FE. However, because the amount of food offered was not SSI, the overall indicator of increased fluids and the same or More Food offered was not SSI (2% at BL and 5% at FE).

HYGIENE

Project Matrix Indicators Are Denoted with Red Boxes
Rapid CATCH Indicators Highlighted in Orange Font
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Data at FE that show a SSD are indicated with a yellow font

HYGIENE						
• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
82. % of households with that has soap at the place for hand washing	85.0	80.4-88.8			96.4	93.7-98.0
83. % of mothers of children 0-23m who live in households with soap at the place for hand washing that washed their hands with soap at least 2 of the appropriate times during a 24 hour recall period(after defecation and at one of the following: before food preparation, before feeding children, or after attending to a child who has defecated).	54.0	48.2-59.7	75.3	69.3-81.4	87.8	83.9-91.0

- **Soap at the Place for Hand washing:** This indicator, despite being high at BL (85%), was still SSI through the project's health messaging, to 96% at FE.
- **Appropriate hand washing with soap:** There has been a significant increase from 45% at BL to 88% at FE, which effectively contributed to a lower rate of diarrhea at FE (see the diarrhea section, above).

WATER AND SANITATION

Project Matrix Indicators Are Denoted with Red Boxes
Rapid CATCH Indicators Highlighted in Orange Font
Data at FE that show a SSI are indicated with a red font
Data at FE that show a SSD are indicated with a yellow font

WATER AND SANITATION						
84. % of households with an improved source for drinking water	91.0	87.2-94.0			89.4	85.8-92.4
85. % of households of children 0-23m that treat water effectively	11.3	8.0-15.5	10.7	6.4-15.0	41.4	36.3-46.7
86. % of households using an improved toilet facility	27.7	22.7-33.1			38.1	33.1-43.3
87. % of households who safely disposed of their child's feces the last time s/he passed stool	13.0	9.4-17.3				
88. % of households using a traditional latrine						

- **Point of Use water treatment:** There had been no significant change in the rate at BL (11%) to MTE (11%). Investigation following the midterm revealed that most households did not feel that they needed to treat water because they had access to an improved water source (91.0% of households in Lira District have access to an improved water source). However, health messaging around the importance of treating water was increased and at FE there was a SSI increase at FE to 41%.

CHAPTER 6

IMMUNIZATION

Project Matrix Indicators Are Denoted with Red Boxes
Rapid CATCH Indicators Highlighted in Orange Font
Data at FE that show a SSI are indicated with a red font
Data at FE that show a SSD are indicated with a yellow font

In this survey Expanded Program of Immunization (EPI) Access is measured by the percentage of children aged 12-23 months who received a DPT1 vaccination before the age of 12 months as verified by a vaccination card, and EPI Coverage is measured by the percentage of children aged 12-23 months who received a BCG, DPT3, OPV3, and measles vaccination before the age of 12 months verified by an immunization card, meaning that they received full vaccination coverage. Added to these measurements is the drop-out rate which measures the number of children aged 12-23 months who received a DPT1 vaccination by card verification or mothers recall but who were not continued in a vaccination program and therefore did not receive a DPT3 vaccination. These indicators provide an excellent picture of immunization services with regard to access, coverage, and completion of immunizations. Since MTE four additional health facilities were opened in the project area and immunization outreach was expanded. As a result immunization services access, performance and coverage has improved.

IMMUNIZATION						
• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
56. % of mothers of children 0-23m who were ever given a vaccination card for their youngest child 0-23m	78.0	72.9-82.6			90.8	87.4-93.6
57. % of children 0-23m that currently have a vaccination card (verified)	50.9	42.9-58.9			84.5	78.2-89.6
Vaccination Card verified by 12m of age						
58. % of children aged 12-23m who are fully vaccinated (received BCG, DPT3, OPV3, and measles vaccines) by 12 months of age, card verified	15.5	10.3-22.1	37.9	31.1-44.6	56.0	48.1-63.6
59. % of children aged 12-23m that received a DPT1 vaccine, as verified by a vaccination card, by 12m of age.	42.2	34.5-50.3			87.5	81.5-92.1
60. % of children aged 12-23m that received a DPT3 vaccine, as verified by a vaccination card, by 12m of age.	30.4	23.4-38.2			79.2	72.2-85.0
61. Drop-out Rate by 12m of age (DPT1-DPT3)/DPT1: % of children aged 12-23m who received DPT1 but did not receive follow up card verified immunization and therefore did not receive DPT3, vaccination	14.3	9.3-20.7			11.3	6.9-17.1
62. % of children aged 12-23m that received a measles vaccine, as verified by a vaccination card, by 12m of age.	26.1	19.5-33.6			61.9	54.1-69.3

- **Vaccination Card:** The % of children with a vaccination card was SSI from only 51%at BL to 85% at FE due to health messaging and IMCI in the HFs
- **Vaccinations, Card Verified, by 12m:** Every indicator regarding the immunization of children by 12m of age was SSI, because all health units were supplied with cards, fridges and vaccines, and mothers now have cards. Mother leader groups were trained to teach mothers not to lose cards, and were going house to house and bringing children to HFs for immunization. Also, because more cards were present at survey, a higher % of children could be verified as having

been vaccinated. This resulted in a DPT1 vaccination rate of 88%, a DPT3 vaccination rate of 79%, and a measles immunization rate of 62% at FE. This measles rate, which was 62% at FE, was the limiting factor, which culminated in a full vaccination rate of 56% at FE.

Vaccination Card Verified						
• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
63. % of children aged 12-23m that received a DPT1 vaccine, as verified by a vaccination card	47.2	39.3-55.2			90.5	85.0-94.5
64. % of children aged 12-23m that received a DPT3 vaccine, as verified by a vaccination card	34.8	27.5-42.7			85.1	78.8-90.1
65. % of children aged 12-23m that received a measles vaccine, as verified by a vaccination card	33.5	26.3-41.4			73.2	65.8-79.7
66. % of children aged 12-23m that received a Vitamin A injection, as verified by a vaccination card	10.6	6.3-16.4			66.1	58.4-73.2

- Again, all card verified vaccination rates were SSI by FE, with a DPT1 rate of 91% and a DPT3 rate of 85% at FE. The limiting factor was measles vaccination, which was SSI from 34% at BL to 73% at FE. This excellent SSI in immunization rates shows an increased availability of vaccines and IMCI at the HFs as well as outreach and access to immunization days.

- **Vitamin A:** The Vitamin A rate was SSI from 11% at BL to 66% at FE, also showing increased drug availability, IMCI, immunization outreach and immunization access through immunization days.

Vaccination Card or Mothers Recall						
• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
65. % of children aged 12-23m that received a DPT1 vaccine, as verified by a vaccination card or by mothers recall	87.0	80.8-91.7	88.9	84.5-93.3	97.0	93.2-99.0
66. % of children aged 12-23m that received a DPT3 vaccine, as verified by a vaccination card or by mothers recall	85.1	78.6-90.2	73.2	67.1-79.4	91.7	86.4-95.4
67. % of children aged 12-23m that received a measles vaccine, as verified by a vaccination card or by mothers recall	77.0	69.7-83.3	79.7	74.1-85.3	82.1	75.5-87.6

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- **DPT1:** There was a SSI in DPT1 immunization, both card verified and card or mother's recall. DPT1 immunization by card or mother recall was SSI from 87% at BL, which was already quite high, to 97%at FE, which is almost universal coverage.
- **Measles vaccination (card verified or mother's recall):** There has been no significant change in measles vaccination coverage (82% at FE), as coverage was already quite high (77% at BL).

CHAPTER 7
EARLY CHILDHOOD DEVELOPMENT

Project Matrix Indicators Are Denoted with Red Boxes
Rapid CATCH Indicators Highlighted in Orange Font
Data at FE that show a SSI are indicated with a red font
Data at FE that show a SSD are indicated with a yellow font

EARLY CHILDHOOD DEVELOPMENT						
• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
87. % of mothers of children aged 0-23 months who report helping their child walk, playing a lap game with their child, massaging or rubbing them gently, or by giving them objects with which to play	63.2	56.6-67.8			84.2	80.0-87.8
88. Cognitive Stimulation: % of mothers of children aged 6-23 months who report playing a game like "Where is your nose? or Where are your eyes?..."), or by encouraging imitation (making different faces) or by encouraging pretend play or by showing them common objects and asking them to name them	38.0	31.9-44.5	68.5	62.0-74.9	76.3	71.6-80.6
89. % of mothers of children aged 0-23 months who report teaching their child new words, telling stories, singing a song, or saying prayers to their child	34.8	29.4-40.5			78.8	74.2-82.9
90. Linguistic Learning % of mothers of children aged 0-23 months who told their child a story, sang a song to the child or named objects for their child (linguistic learning) at least 2 times per week	22.7	18.1-27.8	40.1	33.2-46.9	64.4	59.3-69.4
91. % of mothers of children aged 0-23 months who played with their child at least 2 times per week	61.0	55.2-66.6			88.3	84.6-91.5
92. % of mothers of children aged 0-23 months who sang or played music for their child at least 2 times per week	40.0	34.4-45.8			72.2	67.3-76.7
93. % of mothers of children aged 0-23 months who massaged, hugged, or cuddled with their child at least 2 times per week	64.3	58.6-69.8			74.2	69.3-78.6

- All ECD indicators that pertain to ECD behaviors at least 2 times per week, except for 1, were SSI over the course of the project, including: physical interaction (playing, massaging, etc.) cognitive stimulation, teaching, linguistic learning, and singing/music. The indicator "The percentage of mothers aged children 0 – 23 months who massaged, hugged, or cuddled with their child at least 2 times per week" increased but not significantly. This indicates excellent saturation of ECD messaging to mothers as well as excellent adaption of ECD behaviors by the mothers in the project area.
- **Cognitive Stimulation:** There was a significant increase from 38% at BL to 76% at FE, with all SAs meeting the DR.
- **Linguistic development:** There has been a significant increase from 23% at BL to 64% at FE, indicating a substantial increase in mothers teaching children linguistics.

BELIEFS REGARDING ECD

• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
94. % of mothers of children aged 0-23 months who believe that playing with a child helps a young child to learn and think well	94.0	90.7-96.4			98.6	96.6-99.5
95. % of mothers of children aged 0-23 months who believe Parents should find or make things with which young children may play	72.0	66.6-77.0			98.3	96.2-99.3
96. % of mothers of children aged 0-23 months who believe playing helps young children learn	78.3	73.2-82.9			98.1	95.9-99.1
97. % of mothers of children aged 0-23 months who believe Making toys and play things for children under 6 helps them get ready for school	88.3	84.1-91.7			95.8	93.1-97.6

- Likewise, all beliefs regarding the efficacy of the fundamental principles behind ECD were SSI, except for one which was already above 90% before ECD messaging began. This again relates to excellent saturation and uptake of ECD messaging.
- The % mothers who believe that they should provide things for their child with which to play was SSI from 72% at BL to 98% at FE, and those who feel that playing helps the child learn was SSI from 78% at BL to 98% at FE. Also, the rate of mothers who believe playing with toys helps the child prepare for school was SSI from 88% at BL to 96% at FE.

ECD ACTIVITIES

• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
98. % of mothers of children aged 0-23 months who report playing with their child by chatting with the child	40.3	34.7-46.1			42.8	37.6-48.1
99. % of mothers of children aged 0-23 months who report playing with their child by dancing before the child	37.3	31.8-43.1			44.4	39.3-49.7
100. % of mothers of children aged 0-23 months who report playing with their child by telling stories to the child	21.0	16.5-26.1			29.4	24.8-34.5
101. % of mothers of children aged 0-23 months who report playing with their child by singing songs to the child	34.8	29.4-40.5			78.6	74.0-82.7
102. % of mothers of children aged 0-23 months who report playing with their child by putting the child on her belly and playing with the child	79.3	74.3-83.8			81.1	76.7-85.0
103. % of mothers of children aged 0-23 months who report playing with their child by playing with toys with them	28.3	23.3-33.8			32.2	27.5-37.4
104. % of mothers of children aged 0-23 months who report looking into their child's eyes while feeding them	87.3	83.0-90.9			93.6	90.4-95.8
105. % of mothers of children aged 0-23 months who report talking or singing to their child while feeding them	57.7	51.9-63.3	65.4	58.7-72.0	83.6	79.4-87.3
106. % of mothers of children aged 0-23 months who report showing them affection in some other way while feeding them	53.7	47.8-59.4			91.3	87.7-93.8
107. % of mothers of children aged 0-23 months who report holding their child close to their body while feeding them	71.7	66.2-76.7			95.6	92.7-97.4

- **Increased verbal stimulation**: Verbal Stimulation through singing was SSI from 35% at BL to 79% at FE.
- **Stimulation while feeding:** There has been a SSI in all of the ECD feeding indicators, except for looking into the child's eyes while feeding, which was already at 87%. Talking to the child while feeding was SSI from 58% at BL to 84% at FE.

ECD INDICATORS BY SUBCOUNTY

INDICATORS BROKEN DOWN BY SUBCOUNTY TO REVIEW THE EFFECTS OF ECD						
INDICATOR	LIRA		OGUR		AROMO	
1. Cognitive Stimulation: % of mothers of children aged 6-23 months who report playing a game like "Where is your nose? or Where are your eyes?..."), or by encouraging imitation (making different faces) or by encouraging pretend play or by showing them common objects and asking them to name them	83.3	74.4-90.2	72.1	64.3-79.0	76.1	67.0-83.8
2. Linguistic Learning % of mothers of children aged 0-23 months who told their child a story, sang a song to the child or named objects for their child (linguistic learning) at least 2 times per week	63.9	53.5-73.4	63.0	54.8-70.6	67.0	57.3-75.7
3. % of mothers of children aged 0-23 months who report talking or singing to their child while feeding them	83.5	74.6-90.3	83.8	77.0-89.2	83.5	75.2-89.9
4. IYCF Indicator: % of children age 6-23m fed according to a minimum of appropriate feeding practices	33.0	23.8-43.3	38.3	30.6-46.5	34.9	26.0-44.6
5. % of mothers of children 0-23m who live in households with soap at the place for hand washing that washed their hands with soap at least 2 of the appropriate times during a 24 hour recall period(after defecation and at one of the following: before food preparation, before feeding children, or after attending to a child who has defecated).	86.6	78.2-92.7	83.8	77.0-89.2	94.5	88.4-98.0
6. % of children age 0-23m with chest-related cough and fast/difficult breathing in the last two weeks who were taken to an appropriate health provider	80.0	59.3-93.2	83.3	67.2-93.6	89.3	71.8-97.7

- There are no statistically significant differences in the uptake of ECD between the counties, and therefore, likewise, there are no statistically significant differences in health outcomes measured due to ECD.

CHAPTER 8

MALARIA AND THE MANAGEMENT OF FEBRILE ILLNESS

Lira District is a malaria endemic area and the incidence of fever in children less than 24 months is quite high in these areas. Malaria is highly endemic in Uganda (90-98% *P. falciparum*) and is the leading cause of morbidity and mortality nearly country-wide.[4] In Lira District, malaria accounts for 34% of the disease burden. The present evaluation estimates the prevalence of febrile illness (a proxy for malaria) among children aged 0-23 months, the mother's knowledge concerning malaria and health seeking behaviors in relation to malaria.

Project Matrix Indicators Are Denoted with Red Boxes
Rapid CATCH Indicators Highlighted in Orange Font
Data at FE that show a SSI are indicated with a red font
Data at FE that show a SSD are indicated with a yellow font

MALARIA						
• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
108. % of households that contain at least 1 insecticide treated bed net	82.0	76.3-86.9			58.3	53.0-63.4
109. % of children aged 0-23 months that slept under an insecticide treated mosquito net the previous night.	51.3	45.5-57.1	43.3	36.4-50.2	58.3	53.0-63.4
110. % of mothers of children aged 0-23 months that slept under an insecticide treated mosquito net the previous night.	41.7	36.0-47.5			56.7	51.4-61.8
111. % of mothers of children 0-23m who report that their child had a fever in the 2 weeks prior to the survey	74.8	69.5-79.7			58.4	53.0-63.5
112. % of children 0-23m who had a fever in the 2 weeks prior to the survey that were brought to a health facility within 24 hours of the start of symptoms	22.3	17.0-28.4			82.5	76.6-87.4
113. % of children 0-23m who had a fever in the 2 weeks prior to the survey that were treated with an antimalarial medication within 24 hours of the start of symptoms	25.0	19.4-31.3	69.2	62.8-75.7	51.5	44.4-58.5
114. % of mothers who know the cause of malaria	85.0	81.0-89.0			84.7	80.6-88.3

- **ITN in home:** There has been a SSD in the rate of households that have an ITN, from 82% at BL to on 58% at FE. This correlates with the findings of the health facility assessment at final that show a lack of available nets for distribution in the entire project area.
- **ITN use (mothers and Children under 2:** There has been a SSI in the use of bed nets in mothers of children under 2 since BL (41% at BL to 57% at FE), which is commendable considering there is a decrease in the availability of ITNs. However, the rate of children under 2 sleeping under a bed net was not statistically changed from 51% at BL to 58% at FE.
- **Treatment of malaria:** There has been a significant increase in the proper treatment of malaria (25% at BL to 52% at FE). This was not an intervention area of this project, so this SSI is

[4] Uganda Malaria Control Strategic Plan: 2005-6 – 2009-10.

indicative of the increased awareness of mothers of the importance of immediate care seeking through our other health messaging, and our efforts at the HF level that have caused an increased effectiveness of the HFs in IMCI, supervision, and increased availability of medications at the HF.

CHAPTER 9
HEALTH CONTACTS

Project Matrix Indicators Are Denoted with Red Boxes
Rapid CATCH Indicators Highlighted in Orange Font
Data at FE that show a SSI are indicated with a red font
Data at FE that show a SSD are indicated with a yellow font

CONTACT WITH TRAINED HEALTH PERSONNEL

HEALTH CONTACTS

*"Trained health personnel" refers to: Doctor, Nurse/Midwife, Auxiliary Midwife, TBA, CHW, Health Educator (VHT or CHP), or Growth Monitoring Person
***"Any type of meeting" refers to: Mother's Group, Care Group, Breastfeeding Group, Health Education Group, Village Development Committee, Savings/Finance Group

- Key to comments on the right:
  - SS=Statistically Significant
  - SSI=Statistically Significant Increase
  - SSD= Statistically Significant Decrease
- RED BACKGROUND INDICATES PROJECT INDICATOR
- ORANGE FONT INDICATES Rapid CATCH INDICATOR

	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
115.Percentage of mothers of children aged 0-23 months who reported having a trained health personnel contact them or to talk to them about their health or the health of their child at least 1 time in the last month*	29.3	24.2-34.5			92.5	89.1-94.9
116.Percentage of mothers of children aged 0-23 months who reported having a TBA contact them or to talk to them about their health or the health of their child at least 1 time in the last month	8.3	5.5-12.1			22.2	18.1-26.9
117.Percentage of mothers of children aged 0-23 months who reported having a CHW/VHT contact them or to talk to them about their health or the health of their child at least 1 time in the last month	10.3	7.1-14.3			81.4	77.0-85.3
118. Percentage of mothers of children aged 0-23 months who reported having a Health Educator contact them or to talk to them about their health or the health of their child at least 1 time in the last month	6.0	3.6-9.3			56.9	51.6-62.1
119.Percentage of mothers of children aged 0-23 months who reported having a Growth Monitoring Person contact them or to talk to them about their health or the health of their child at least 1 time in the last month	6.3	3.9-9.7			42.8	37.6-48.1

- Due to the projects ability to strengthen community capacity through VHTs, Peer Educators, PDCs, Mother Leader Groups, and Health sub-districts, the rate of mothers having contact with trained health personnel in the previous month was SSI from only 29% at BL to 92% at FE. This is a noteworthy achievement, and the breakdown of this contact may be seen in the table, above. Contact with VHTs was SSI the greatest, with a rate of 81% by FE, up from only 10% at BL.

HEALTH MEETNG ATTENDANCE

• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
120.Percentage of mothers of children aged 0-23 months who reported having attended any type of meeting in the community in the past month in which their health or the health of their child was discussed**	22.7	18.0-27.4			84.7	80.6-88.3
121.Percentage of mothers of children aged 0-23 months who reported having attended a Mother's Group meeting in the community in the past month in which their health or the health of their child was discussed	7.3	4.7-10.9			62.5	57.3-67.5
122.Percentage of mothers of children aged 0-23 months who reported having attended a Care Group meeting in the community in the past month in which their health or the health of their child was discussed	3.3	1.6-6.0			31.9	27.2-37.1
123.Percentage of mothers of children aged 0-23 months who reported having attended a Breast Feeding Group meeting in the community in the past month in which their health or the health of their child was discussed	2.3	0.9-4.7			38.9	33.9-44.2
124.Percentage of mothers of children aged 0-23 months who reported having attended a Health Education Group meeting in the community in the past month in which their health or the health of their child was discussed	8.3	5.5-12.1			56.7	51.4-61.8
125.Percentage of mothers of children aged 0-23 months who reported having attended a Health Village Development Meeting in the community in the past month in which their health or the health of their child was discussed	7.0	4.4-10.5			43.3	38.2-48.6
126.Percentage of mothers of children aged 0-23 months who reported having attended a Savings Finance Group Meeting in the community in which their health or the health of their child was discussed	8.0	5.2-11.7			53.3	48.0-58.6
127.Percentage of mothers of children aged 0-23 months who reported having attended a another type of meeting in the community in the past month in which their health or the health of their child was discussed	4.0	2.1-6.9			5.6	3.5-8.6

- At FE mothers were attending a monthly meeting of some type on order to discuss their health or the health of their baby at a rate of 85%. This is a very large SSI from the baseline rate of 23%. Meeting facilitated by VHTs, Mother Group Leaders and Peer Educators allows this accessibility and created the demand for these groups, and this is another sustainable change in the community. The rate of attendance of each type of group is indicated in the table, above, with the largest SSI noted in Mother's Groups (63% at FE), which is excellent. There is a SSI in the rate of attendance in each type of specific group.

HEALTH MESSAGING BY SOURCE

• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
128.Percentage of mothers of children aged 0-23 months who reported having received health messages from radio in the past month	NA	NA			82.4	78.0-86.2
129.Percentage of mothers of children aged 0-23 months who reported having received health messages from the newspaper in the past month	NA	NA			8.9	6.3-12.5
130.Percentage of mothers of children aged 0-23 months who reported having received health messages from television in the past month	NA	NA			5.9	3.8-9.0
131.Percentage of mothers of children aged 0-23 months who reported having received health messages from a health educator in the past month	NA	NA			61.3	56.1-66.4
132.Percentage of mothers of children aged 0-23 months who reported having received health messages from a CHW/VHT in the past month	NA	NA			80.3	75.8-84.3
133.Percentage of mothers of children aged 0-23 months who reported having received health messages from another source in the past month	NA	NA			15.7	11.5-20.8

- There is high saturation of health messaging from the VHTs, 80% at FE, and also Health Educators, 61% at FE. This excellent saturation of the community with health messaging from the VHTs and health educators was a major factor in the many health indicators that showed a SSI over the course of the project.
- There is a very high saturation of health messaging through the radio in all villages of the project area, which is shown by the high rate of mothers who report hearing health messaging from the radio, 82% at FE.

TOPICS OF HEALTH MESSAGING

• Key to comments on the right: ➢ SS=Statistically Significant ➢ SSI=Statistically Significant Increase ➢ SSD= Statistically Significant Decrease • RED BACKGROUND INDICATES PROJECT INDICATOR • ORANGE FONT INDICATES Rapid CATCH INDICATOR	BL		MTE* *LQAS measured all Project Indicators and Rapid CATCH Indicators		FE	
	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)	PERCENT (%)	95% CONFIDENCE INTERVAL (%-%)
132.Percentage of mothers of children aged 0-23 months who reported having heard any messages about hand washing in the last month	NA	NA			88.2	84.3-91.3
133.Percentage of mothers of children aged 0-23 months who reported having heard any messages about treating of drinking water in the last month	NA	NA			89.1	85.4-92.2
134.Percentage of mothers of children aged 0-23 months who reported having heard any messages about danger signs of diarrhea and seek timely health care in the last month	NA	NA			87.7	83.9-90.9
135.Percentage of mothers of children aged 0-23 months who reported having heard any messages about home care for children with diarrhea in the last month	NA	NA			79.9	75.4-83.9
136.Percentage of mothers of children aged 0-23 months who reported having heard any messages about the importance of antenatal and postnatal care in the last month	NA	NA			90.0	86.4-92.9
137.Percentage of mothers of children aged 0-23 months who reported having heard any messages about care seeking for danger signs in the last month	NA	NA			78.2	73.6-82.4
138.Percentage of mothers of children aged 0-23 months who reported having heard any messages about skilled birth attendance at delivery and birth preparedness in the last month	NA	NA			91.8	88.4-94.4

- The high rate of mothers hearing each messages on key health topic again reveals the excellent saturation of this project area with health messages through community volunteers and health staff. Improvement in many key health practices can be attributed to the solid coverage of health messages. Each topic is broken down in the table, above, and all rates are quite high. These were not measured at BL, so no determination of SSI was possible.

CHAPTER 10

SUMMARY

The goal of the Lira District Child Survival Project was to reduce child morbidity and mortality in Uganda. Objectives were: 1) Communities assume responsibility for their own health through strengthening community capacity (VHTs, Parish Development Councils, and Health Sub-districts); 2) Improved health (C-IMCI) and child care (ECD) behaviors among mothers of children <5 years; 3) Improved quality of health facility services through strengthened IMCI and MNC capacity; and 4) Strengthened institutional capacity of MTI and DHO to implement effective and efficient child survival activities. These objectives support MoH goals and strategies as well as those of USAID Uganda. MTI used a two-pronged strategy that included promoting behavior change and community mobilization to take appropriate responsibility for health and building DHO capacity to provide sustainable, quality service delivery at the facility and community levels. The level of effort by intervention for this Child Survival Project (CSP) was as follows:

1. 25% MNC
2. 25% PCM
3. 20% IYCF
4. 20% CDD
5. 10% EPI.

MNC

11 of the 12 MNC indicators, including all 6 of the indicators in the project Logframe and all the Rapid CATCH indicators for MNC, were SSI through the life of the project. In fact, the only MNC indicator not SSI is the rate of use of modern contraception. The rate of mothers receiving at least 2 TT immunizations was already relatively high at BL (73%), but still the project was able to sow a SSI in this indicator to 89% at FE. Additionally the rate of mothers taking proper IPT medication while pregnant was SSI from only 35% at BL to 68% at FE, and the rate of mothers who received iron while pregnant was SSI from 59% at BL to 91% at FE. These statistically significant increases highlight the gains made in health messaging regarding the importance of ANC, HF support and supervision, and drug chain improvements. Also, regarding health messaging, there was a statistically significant improvement in the rate of mothers who are able to correctly identify at least 2 neonatal danger signs for which they should seek immediate care, from 2% at BL to 51% at FE. This is due to extensive health messaging performed throughout the project. Also, at FE 84% of all childbirths now occur under the supervision of a skilled birth attendant, which is SSI from BL (35%). MTI accomplished this through focus on increasing the use of health facilities and skilled birth attendants through VHTs, and mothers groups who trained in health promotion. This training also included the importance of ensuring that both mother and child receive follow up care including a post partum visit with a trained health professional within 3 days of birth, which is why there was a SSI in this the rates of both mothers and children who received a postnatal visit from a trained HW within 2 days after birth. Mothers received a visit at a

rate of 50% at FE (up from only 17% at BL), and children received a postnatal visit at a rate of 41% at FE (up from 16% at BL).

Anthropometry AND IYCF

The nutritional status of children aged 0-23 months was of major concern in Lira District. The overall rate of under-nutrition at BL was 27.7%, with 17.0% moderately underweight and 10.7% severely underweight. This is similar to the results found by a DHS study in 2006 which revealed the overall rate of under-nutrition to be 21.8% in the Northern region of Uganda. At FE, The percentage of children with a Z-score of <-2SD at FE is 20%, not significantly decreased from the BL rate of 28%. However, the IYCF indicator relating to the proper feeding frequency and food diversity for children aged 6-23m was SSI from only 23% at BL to 49% at FE

The percentage of children aged 0-5m who were exclusively breastfed during the 24 hours prior to the survey, while already at 74% at BL, was SSI to 88% at FE. Immediate BF practices for newborns was dramatically and SSI from 29% at BL to 79% at FE. There was also a SSI in the rate of mothers who did not give their child prelacteal feeds (from 47% at BL to 87% at FE), so the summary indicator of immediate and exclusive breastfeeding was SSI from only 16% at BL to 71% at FE. The complementary feeding rate for 6-9m old children was already high at BL (70%), and this was not SSI, but was 88% at FE. This is not significantly higher than at BL because the sample size of mothers of children aged 6-9m was small (n=53) due to 30 cluster methodology. However, a complimentary feeding rate of 88% is quite high.

There has been a significant improvement in the composite IYCF indicator, which determines the rate at which children aged 6-23m are fed the proper frequency and food group variety in their diet dependant on their age and breastfeeding status. There was a SSI in this indicator from 23% at BL to 49% at FE. There was a SSI in proper feeding frequency in breastfed children (31% at BL to 66% at FE) which was the driving factor behind this improvement, and was stressed in health messaging throughout the project. Also, the % of children receiving Vitamin A in the past 6m at FE (85%) was SSI from BL (70%). This is excellent, particularly since the indicator was SSD at midterm. Efforts were made by the project to work with the facilities and mothers to ensure both a high supply and demand of Vitamin A.

Pneumonia Case Management

Pneumonia is the fifth-highest contributor to Lira District's burden of disease, but is the primary cause of child mortality.[5] Objectives of the project were the recognition of the danger signs of pneumonia, improving the access to quality care, and promoting optimal and timely health seeking behavior among mothers/caretakers. The % of children age 0-23 months with ARI who were treated with an antibiotic increased significantly form BL to FE (35% at BL to 69% at FE).This again speaks to the project interventions of improving care seeking behaviors, IMCI and supervision at the HFs, and drug supply chain management. The % of children with ARI who were taken to an appropriate health provider increased significantly over the first half of the project (58% at BL to 86% at

[5] Lira District Health Office Annual Report, July 2008

MT, but the FE result of 74% was not a SSI from BL.

Control of Diarrheal Disease

MTI Uganda made a high priority the reduction of childhood diarrhea prevalence and morbidity through preventive and curative measures. This diarrhea management initiative was an intervention aimed at raising the awareness of mothers/caretakers about the necessary steps required to both prevent and treat diarrheal disease. Interventions aimed at the prevention of diarrhea included instruction in the importance of appropriate hand washing behaviors as well as the promotion of the use of sanitary latrines. Diarrhea case management at the household level includes proper feeding and fluid management during diarrhea episodes, including the proper preparation and use of Oral Rehydration Salts (ORS).

There was a SSD in the prevalence in the rate of diarrhea at FE (24.3%) from BL (36%), which highlights the gains made in hygiene and water and sanitation (see the hygiene and water and sanitation paragraphs below.) There has been a SSI in the % of children who received ORS when suffering from diarrhea since baseline (47% at BL to 62% at FE), which is impressive as there was no SSI at MT (54%). This reveals that continuing efforts in health messaging created results over time. In addition, zinc usage in children to treat diarrhea, which was almost non-existent at BL (2.6%), was SSI to 18% by FE. This again highlights gains in both drug chain management and supervision at the HFs as well as IMCI.

Hygiene was improved, with the percentage of mothers who have soap at the place for hand washing that washed their hands with soap at least 2 of the appropriate times during a 24 hour recall period (after defecation and at one of the following: before food preparation, before feeding children, or after attending to a child who has defecated) SSI from 54% at BL to 88% at FE. Also, the % of households with soap present at the place for washing was SSI from an already high 85% at BL to 96% at FE. Likewise, the rate of safe feces disposal was SSI from 13% at BL to 61% at FE. These results are due to excellent saturation of health messaging by the project, which resulted in a SS lower rate of diarrhea and better treatment of diarrhea cases that did occur.

With regards to Water and Sanitation, the % of households of children 0-23m that treat water effectively was SSI from28% to 38% from BL to FE.

Expanded Program of Immunization

Immunization coverage improved in the project area, with 9 of the 11 measured EPI indicators statistically significantly improved. This can be attributed to the opening of four additional health facilities, expansion of immunization outreach and the CSP's efforts to support immunization services. EPI Coverage is measured by the percentage of children aged 12-23 months who received a BCG, DPT3, OPV3, and measles vaccination before the age of 12 months verified by an immunization card, meaning that they received full vaccination coverage. The project showed a significant increase in EPI coverage from BL (16% at BL to 56% at FE). In addition, there has been a SSI in the coverage of DPT1, DPT3, and measles immunization, both card verified and card

verified to be by 12m of age. Card verified DPT1 was raised from 47% at BL to 91% at FE, and card verified DPT3 was raised from 35% at BL to 85% at FE. Also, card verified measles vaccination was raised from 11% at BL to 66% at FE. These are excellent achievements that verify excellent gains in immunization at the HFs and through outreach, as well as IMCI, HF supervision, and drug chain management at the HF level. While measles coverage was SSI by both card verified and card verified by 12m, it was not SSI by card or mothers recall (82% at FE) as coverage was already quite high (77% at BL).

Early Childhood Development

MTI incorporated ECD activities into its CS project to enhance the impact and sustainability of technical interventions. Research confirms that child survival is positively linked to ECD – including health, physical, social/emotional, and language/cognitive domains. Six of the 7 ECD indicators that pertain to ECD behaviors at least 2 times per week were SSI over the course of the project, including: physical interaction (playing, massaging) cognitive stimulation, teaching, linguistic learning, and singing/music. This indicates excellent saturation of ECD messaging to mothers as well as excellent adoption of ECD behaviors by the mothers in the project area. There has been a SSI from BL of mothers of children aged 0-23 months who report playing games with their child in which they have their child identify their body parts, imitate actions, pretend play, or name objects (38% at BL to 76% at FE). These are important builders of cognitive, motor, or linguistic functions. In addition, there has been a significant increase from BL of mothers report engaging their children in linguistic learning activities such as telling their child stories, singing them songs, or naming objects for them at least twice weekly (23% at BL to 64% at FE).

Beliefs regarding the importance and efficacy of several ECD components were also SSI. All of the indicators measuring beliefs regarding the fundamental principles behind ECD were SSI, except for one which was already above 90% before ECD messaging began. The % mothers who believe that they should provide things for their child with which to play was raised from 72% at BL to 98% at FE, and those who feel that playing helps the child learn was SSI from 78% at BL to 98% at FE. Also, the % of mothers who believe playing with toys helps the child prepare for school was SSI from 88% at BL to 96% at FE. This again relates to excellent saturation and uptake of ECD messaging. All 3 indicators measuring interaction with their child during feeding were SSI. There has been a SSI from BL in the rate of mothers who provide report that they talk or sing to the child while feeding the child (58% at BL to 84% at FE).

Malaria

The prevalence of fever in children aged 0-23 months in Lira District was found to be quite high in the baseline KPC Survey at 74.8%. Malaria is highly endemic in Uganda (90-98% *P. falciparum*) and is the leading cause of morbidity and mortality nearly country-wide.[6] In Lira District, malaria accounted for 34% of the disease burden at the start of the project. Over the course of the project, the rate of malaria in children under 2

[6] Uganda Malaria Control Strategic Plan: 2005-6 – 2009-10.

was SSD from 75% at BL to 58% at FE. There has been a SSI in the use of bed nets in mothers of children under 2 since BL (41% at BL to 57% at FE), which is commendable considering there is a decrease in the availability of ITNs. However, the rate of children under 2 sleeping under a bed net was not statistically changed from 51% at BL to 58% at FE. The rate of households that contained at least 1 ITN was SSD from 82% at BL to 58% at FE. This correlates with the findings of the health facility assessment at final that should a lack of available nets for distribution in the entire project area.

Of the children who had a fever in the 2 weeks prior to the survey, at BL only 25% were treated with an antimalarial drug within 24 hours of the start of the fever. There has been a significant increase in the proper treatment of malaria to 52% at FE. The driving factor behind this increase is the fact that the rate of care seeking (mothers who sought care for their child with fever within24 hours) was SSI from only 22% at BL to 83% at FE.

Health Contacts

One of the greatest successes of this project was the very significant increase in contact rates between mothers in the project area and qualified health workers or accurate health information regarding MNC and mother and child health. Due to the project's strengthening of community capacity through VHTs, PDCs, Peer Educators, Mother Leader Groups, and Health sub-districts, the rate of mothers having contact with trained health personnel in the previous month was SSI from only 29% at BL to 92% at FE. Contact with VHTs led the SSI, with a rate of 81% by FE, up from only 10% at BL. Also, mothers now (at FE) attend a monthly meeting of some type on order to discuss their health or the health of their baby at a rate of 85%. This is a very large SSI from the baseline rate of 23%. The structure and function of these groups, supported by the CSP, allows this accessibility and created the demand for these groups, and this is another sustainable change in the community. The rate of attendance of each type of group in indicated in the table, above, with the largest rates noted in Mother's Groups (63%), which is excellent.

In addition, the saturation of the project area with health messaging on important MNC topics was excellent throughout the project. There is a high saturation of health messaging in all villages from the VHTs, with a rate of 80% at FE, and also Health Educators, with a rate of 61% at FE, due to the project initiatives utilizing VHTs and Health educators to reach mothers. Good saturation of the community with VHTs and health educators is evidenced by the many improved health indicators indicating changes in health behaviors in this project. There is a very high saturation of health messaging through the radio in all villages of the project area, which is shown by the high rate of mothers who report hearing health messaging from the radio, with a rate of 82% at FE. Finally, there is a very high rate of mothers hearing messages on each key health topic (hand washing, treating water, danger signs/care seeking, diarrhea care, and SBA) again reveals the excellent saturation of this project area with health messages through our project sources, which related to the high SSI achieved with health outcomes.

In conclusion, by working in partnership with the DHO, MTI Uganda implemented a project that improved the health of village communities in Lira District through building DHO capacity to provide sustainable, quality service delivery at the facility and community levels, and through promoting behavior change and community mobilization to take appropriate responsibility for health. This was accomplished through a combination of interventions, including providing supplementary training, supervision, and follow-up coaching of VHTs. The results of this FE KPC Survey reveal the many sustainable successes that were accomplished in Lira District, as well as a few continuing challenges of this project area that may be used in future projects as lessons learned.

ANNEX VII. COMMUNITY HEALTH WORKER TRAINING MATRIX

Project Area (Name of District Or Community)	Type of CHW	Official Government CHW or Grantee-Developed Cadre	Paid or Volunteer	Number Trained Over Life of Project		Focus of Training	Number of Days
				Male	Female		
Health Centres	Health Workers	Government staff	Paid	8	26	IMCI	11 days
Health Centres	Health workers	Government	Paid	10	30	Refresher on IMCI	3 days
Health Centres	Health Workers	Government staff	Paid	3	16	ToT in ECD	5 days
Health Centres	Health Workers	Government staff	Paid	8	38	Maternal Newborn Care	3 days
Health Centre	Health workers	Government	Paid	16	29	Refresher on MNC	3 day
Community (Lira, Aromo and Ogur sub-counties) and Health Centres	Health Workers and Community Leaders	Government staff	Paid/ Volunteer	5 Community Leaders 21 Health Workers	7 Community Leaders 7 Health Workers	Referral Systems	2 days
Health Centres	Health Workers	Government staff	Paid/ Volunteer	17	23	Joint Support Supervision	2 days
Health workers/community vaccinators	Health workers/community vaccinators	Government staff	Paid/ Volunteer	14 Community Vaccinators 11 Health Workers	10 Community Vaccinators 42 Health Workers	Refreshed on EPI	1 Day
Community (Lira, Aromo and Ogur sub-counties)	VHTs	Government	Volunteer	420	140	ICCM	5 days
Community (Lira, Aromo and Ogur sub-counties)	VHTs	Government	Volunteers	420	140	Refresher on ICCM	2 days
Community (Lira, Aromo and Ogur sub-counties)	VHTs and Peer Educators	Government CHWs and Grantee developed Cadre(CSP)	Volunteer	150	150	ECD	3 days
Community	Peer educators	Grantee developed	volunteers	64	88	ECD	5 Days

(Aromo sub-county)		*Cadre(CSP)*					
Community (Aromo sub-county)	*Peer educators*	*Grantee developed Cadre(CSP)*	*volunteers*	*114*	*138*	*Refresher training on ECD*	*2 Days*
Community (Lira, Aromo and Ogur sub-counties)	*Mothers Group Volunteers*	*Grantee developed Cadre(CSP)*	*Volunteer*	*00*	*1428*	*MNC and IYCF*	*5 days*
Community (Lira, Aromo and Ogur sub-counties)	*VHTs*	*Government CHWs*	*Volunteer*	*420*	*140*	• *Referral Systems Reporting and Record Keeping* • *Maternal danger signs* • *Early health care seeking behavior* • *Immunization* • *Health Hygiene and sanitation* • *The importance of home visits* • *Emergency Transport* • *Nutrition*	*Half-day trainings provided during quarterly meetings*
Community (Lira, Aromo and Ogur sub-counties)	*Mothers Group Volunteers*	*Grantee developed Cadre(CSP)*	*Volunteer*	*00*	*1248*	*MNC and IYCF*	*Half-day trainings provided during quarterly meetings*

ANNEX VIII. EVALUATION SCOPE OF WORK

Terms of Reference for
Final Evaluator External Consultant for the
Lira Child Survival Project
in Lira, Uganda
September 4 – December 19, 2013

I. Introduction

Medical Teams International will hire Sue Leonard as an independent consultant to conduct a final performance evaluation (FE) for the Lira Child Survival Project funded by USAID's Child Survival and Health Grants Program (CSHGP) Cooperative Agreement No. GSH-A-00-09-00012, September 30, 2009 – September 30, 2013. USAID's CSHGP supports community-oriented projects implemented by U.S. private voluntary organizations (PVOs) and nongovernmental organizations (NGOs) and their local partners. The purpose of this program is to contribute to sustained improvements in child survival and health outcomes by supporting the innovations of PVOs/NGOs and their in-country partners in reaching vulnerable populations.

This document describes the Final Evaluator's SOW for the Lira Child Survival Project FE.

II. Background

The project overall goal is to reduce child morbidity and mortality in Uganda, in support of Uganda Ministry of Health goals, objectives and strategies. The project has four key results/objectives:

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

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

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

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

The Lira CSP has five child survival interventions (pneumonia, diarrhea, nutrition, immunizations and maternal newborn care) along with a sixth intervention Early Childhood Development (ECD) which has been implemented with match funding. The

CSP postulated that the addition of ECD would enhance child survival impact as documented in the Lancet "Child Development in Developing Countries" meta-analysis (2007).

III. Project Population

Beneficiaries*	Total
Total Population	125,000
Total Neonates	5625 live births per year
Infants aged 0–11 Months	5,375
Children aged <5 Years	25,000
Women of Reproductive Age (15–49 years)	25,250
Total Beneficiaries	50,250
Expected Pregnancies	6468 expected pregnancies per year
Community Health Workers or Volunteers (CHWs), Disaggregated by Sex	140 women and 420 men Village Health Team volunteers 150 female Peer Educators for Early Childhood Development 1428 Mother Group volunteers
Health Facilities (Hospital to Sub Health Post)	4 Health Center II 3 Health Center III 1 Health Center IX
Community-Based Structures (e.g., Village Development Committees [VDCs])	8 Health Unit Management Committees and 29 Community Emergency Transport Committees

*Source: *National census in 2002, projections for 2013, 3.4% growth rate.*

IV. Partners

The key partner is the Lira District Health Office (DHO) team and Ministry of Health (MoH) staff at eight health facilities. MTI has worked with the MoH to train Maternal Child Health staff, Village Health Teams, and Mother Leader Groups and provide joint follow-up supportive supervision. MTI has supported outreach and immunization activities.

Hands to Hearts International (HHI), an international NGO based in Portland, Oregon, has been a consulting partner for the ECD component of the project. HHI worked with MTI and the DHO to adapt existing curriculum to the local context and provided ECD TOT trainings for MTI and health facility staff. On-going technical assistance focused on monitoring and evaluation.

V. Key Activities

Key activities for Objective No. 1 include training and follow-up to strengthen the capacity of Village Health Teams in integrated Community Case Management (iCCM); establishing a structured referral system between Village Health Teams (VHTs) and local health facilities; and facilitating collaboration between VHTs and Parish Development Committees and Health Unit Management Committees to benefit maternal and child health.

To achieve Objective No. 2, Village Health Teams and Mother Groups promote social and behavior change through community meetings and home visits. Under Objective 2, MTI also introduced early child development (ECD) for children under two with an operations research plan to assess whether the ECD training would enhance child survival outcomes in intervention versus control areas. Since this is a CSHGP entry grant, the innovation was not required. To have a greater impact on a small area, after the Midterm evaluation, ECD activities were confined to Aromo sub-county.

For Objectives Nos. 3 and 4, MTI and the Lira DHO conduct joint activities for planning, training, implementation and evaluation. The project supported training in Integrated Management of Childhood Illness (IMCI) for health facility staff, followed by on-the-job mentoring of health facility staff and joint supportive supervision with the District Health Office partners.

For Objective 4, as part of entry grant requirements, MTI Uganda receives support from MTI head office to sustainably build MTI Uganda capacity through a structured Action Plan based on results from the use of an Organizational Capacity Assessment tool adapted from the Organizational Capacity Tool developed by John Snow, Inc.

VI. Purpose of the Final Evaluation

The FE provides an opportunity for all project stakeholders to take stock of accomplishments and lessons learned to date and to listen to beneficiaries at all levels. The FE Report will be used by the following audiences as a source of evidence to help inform decisions about future program designs and policies:

- The Lira District Health Office, health facility staff, and Health Unit Management Committees
- Uganda Ministry of Health
- Village Health Team and Mothers Group volunteers
- Hands to Hearts International
- The USAID CSHGP and the Uganda USAID Mission
- Medical Teams International HQ and field staff

VII. Methodology

The evaluation approach comprises both a desk review of secondary data sources and collection of qualitative quantitative data to complement existing data. Medical Teams International will facilitate this sharing and feedback.

Secondary Data: The final evaluator will review project reports including the Detailed Implementation Plan, annual reports and midterm evaluation report to assess the quality of quantitative and qualitative data and make assessments of project results in relation to the project design and targets set. The final evaluator will also review the USAID Global Health Initiative Uganda *A Strategy for Accelerating Reductions in Maternal and*

Neonatal Mortality, 2011, the Uganda Ministry of Health *Road Map to accelerate Reduction of Maternal and Neonatal Morbidity and Mortality (2007), Operational Framework for Nutrition in the National Child Survival Strategy, IYCF National Counseling Cards for Community Volunteers and Safe Motherhood Flip Charts* and Village Health Team Strategy and Operational Guidelines and training materials.

Qualitative Data: Interviews with community volunteers, project beneficiaries, health staff, and District Health Team members will provide information on project participants' perspective of their participation in the project and its impact. The external consultant Team Leader, Hands to Hearts consultant and MTI's Senior Advisor, Maternal and Child Health will develop the interview guides with input from the Lira team. A sample of high performing and low performing communities will be selected.

Quantitative Data: MTI's Senior Advisor, Monitoring and Evaluation, will travel to Lira in August to support the team to implement a Health Facility Assessment and household Knowledge, Practice and Coverage (KPC) survey.

Data Analysis: Quantitative and qualitative findings will be analyzed jointly by the external consultant, MTI field and HQ staff, District Health Team members, and health facility staff. Facilitation of the review workshops will be shared by the External Consultant and MTI HQ and project staff.

Limitations: The evaluation report will include a discussion of the methodological limitations of the evaluation.

VIII. Evaluation Questions

1) To what extent did the project accomplish objectives stated in the DIP?

   Objective No.1: Communities assume responsibility for their own health through strengthened community capacity
   a) What training, support and supervision were provided by the project to Village Health Teams and Mothers Groups?
   b) What do VHTs and Mothers Groups feel they have gained from the CSP's support? What do they feel has been the impact of their work?
   c) What do beneficiaries and health staff feel has been the impact of the work of community volunteers?
   d) How will the VHTs and Mothers Groups continue to work after the project closes? What support will they need?

   Objective No.2: Improved health (Community-based Integrated Management of Childhood Illness) and child care (Early Childhood Development) behaviors among mothers of children under five years of age.
   a) As evidenced by KPC data, what key maternal, newborn and child health practices have improved? What strategies and activities contributed to the improvement?

b) What key maternal, newborn and child health practices have not improved? What are lessons lesson learned from indicators that did not improved?
c) What can the Lira, Ogur and Aromo DHOs do to address the gaps that still exist?

d) What are parents and VHT perspectives on the implementation of early childhood development and its impact on families?

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

a) As evidenced by HFA findings, what has been the impact of project support on implementation of IMCI and MNC services at health facilities? What strategies and activities contributed to the improvement?
b) How do health staff feel they have benefited from the support the project has provided?
c) How have HUMCs supported the health facilities?
d) Do families feel health facility services have improved?
e) In what ways will improvements in services continue?

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

a) What has been the impact of DHO/MTI joint supervision visits to health facilities and communities?
b) What progress has MTI Uganda made in improving low-scoring areas identified during the baseline organizational assessment?
   - Strategic Planning
   - Staff Salaries and Benefits policies
   - Communication
   - Decision-making
   - Succession Planning
   - Monitoring and Evaluation

2) To what extent was the project implemented as planned? What changes were made to the planned implementation, and why those changes were made?

3) How were gender considerations addressed through the project? Are there any specific gender-related outcomes?

4) Which elements of the project have been or are likely to be sustained or expanded?

IX. Final Evaluator Characteristics and Expected Timeline

The consultant will serve as the evaluation team leader and is welcome to propose additional evaluation team members to round out the evaluation team's skill set in order to ensure adequate representation of evaluation, technical, geographic, cultural and language skills. Team members, their affiliations, and disclosure of conflicts of interest

will be listed in an annex to the evaluation report. The consultant will coordinate closely with the Medical Teams International team regarding tool finalization, evaluation methodology, timeline, and draft report finalization.

Requirements:

The consultant must be approved by USAID CSHGP and should meet the following minimum requirements:

- Proven expertise and leadership in
  - integrated community-oriented reproductive, maternal, newborn, and child health projects
  - conduct of evaluations (baseline, endline) using mixed methods
- Experience with design, collection, and analysis using applied research methods in a program implementation context
- Familiarity with public health system in Uganda
- Demonstrated ability to communicate with and lead a team of stakeholders, staff, and national experts in participatory evaluation
- Familiarity with USAID programming
- Skill or familiarity with cost analysis methods for program assessments
- Excellent analytical and writing skills (English)
- Signed statement explaining any conflict of interest

Key Tasks of the Evaluation Team Leader:

- Review project documents and resources to understand the project
- Refine the evaluation objectives and key questions based on the CSHGP guidelines in coordination with Medical Teams International Teams and its partners
- Provide input to developing the field evaluation schedule and assessment tools
- Lead the team to complete the collection, analysis, and synthesis of supplemental information regarding the program performance
- With the team, interpret both quantitative and qualitative results and draw conclusions, lessons learned, and recommendations regarding project outcome
- Lead an in-country debriefing meeting with key stakeholders, with a PowerPoint slideshow deliverable, no longer than 20 slides (with USAID/Washington, DC, participation remotely, as able)
- Prepare draft report in line with the CSHGP guidelines and submit to CSHGP and Medical Teams International simultaneously on or before October 16th.
- Prepare and submit the final report, which is due at the USAID CSHGP GH/HIDN/NUT office on or before 90 days after the end of the project

Timeline:

August 18 - 31	September 4 -5	September 7 - 8	September 9 - 20	September 21 - 22	October 16	December 19
KPC survey and HFA implemented with support	Preparation to travel	Travel to Uganda	Field Work	Travel back to the US	Draft report submitted to CSHGP and MTI by	Report finalized based on feedback from CSHGP

from M and Advisor					external consultant	and MTI. Soft version submitted by external consultant and hard copies posted by MTI HQ.

X. Final Evaluation Report

The FE report should follow the outline in USAID CSHGP's Guidelines for Final Evaluations. A draft and final report, written by the final evaluator, must be submitted directly to the CSHGP. Draft and final reports should be submitted according to the submission instructions as indicated in the guidelines.

XI. Estimated Budget

	Unit cost	***Number of Units***	***Total***
External Consultant's time (Team Leader) Preparation - 2 Travel days – 2 Days in country - 12 Writing FE report - 4 Editing FE report - 1	$450	21	$9,450
Hands to Hearts Consultant time 2 days	$500	2	$1,000
KPC Survey	$4,100	1	$4,100
Health Facility Assessment	$4,000	1	$4,000
Review meeting	$3,500	1	$3,500
Focus group interviews	$1,400	1	$1,400
Total			$23,450

XII. Deliverables

At the conclusion of the consultancy period, the consultant is expected to complete the following deliverables:

- Lead an in-country debriefing meeting with key stakeholders (and remote participation by USAID/Washington, DC) with a PowerPoint presentation no longer than 20 slides for distribution
- Prepare a draft report in line with the CSHGP guidelines and submit to CSHGP and Medical Teams International simultaneously on or before October 16

- Prepare and submit the final report, which is due at the USAID CSHGP GH/HIDN/NUT office on or before 90 days after the end of the project.

ANNEX IX. EVALUATION METHODS AND LIMITATIONS

The Final Evaluation consisted of a combination of quantitative and qualitative methods using participatory techniques.

Preparation

The preparation began with alerting all partners to the future evaluation and gaining their commitment to be involved in the process. Joint planning then began with the external consultant, Director of Hands to Hearts International, MTI HQ, MTI Uganda, and the Lira DHO in accordance with USAID's Evaluation Guidelines.

Documents Review

1. Project DIP
2. Annual Reports from Years 1 and 3
3. Mid Term Evaluation Report
4. USAID Global Health Initiative Uganda *A Strategy for Accelerating Reductions in Maternal and Neonatal Mortality, 2011*
5. Uganda Ministry of Health *Road Map to accelerate reduction of Maternal and Neonatal Morbidity and Mortality (2007)*
6. *Operational Framework for Nutrition in the National Child Survival Strategy*
7. *IYCF National Counseling Cards for Community Volunteers and Safe Motherhood flip Charts*
8. Village Health Team Strategy and Operational Guidelines and training materials

Surveys and Interview Guides

A 30 cluster KPC and a R-HFA was conducted in mid August, two weeks prior to the qualitative evaluation, guided by MTIs Senior Advisor, Monitoring and Evaluation. A 30-cluster stratified sampling design was utilized to select the mothers of children aged 0-23 months. A total of thirty clusters were sampled in Lira District, with twelve households from each cluster being selected for interviews. There are only eight functioning HFs in the project area therefore no sample size selection was necessary as all eight HFs were surveyed for the RHFA.

Preliminary data reports were provided to the evaluation team for use in preparing the interview guides. Final KPC and RHFA reports are included in ***Annexes VI and X A***. The consultant, Director of Hands to Hearts International, HQ Senior Advisor, Maternal and Child Health and the CSP Project Manager, prepared qualitative interview guides. Criteria were established for selection of the communities for qualitative final evaluation field visits.

In Country

A one-day orientation and training was conducted for evaluation team members to review focus group interview techniques, to review the interview guides, and make necessary revisions to the evaluation logistics. Focus group discussions were held in each of the sub-counties with representatives from each target population group to gather qualitative information. Comparatively low performing communities, as well as high performing communities were identified by project staff prior to the evaluation. Groups of mothers and, separately, groups of fathers were interviewed in those communities using identical questionnaires. In addition, groups of VHTs within a Parish were interviewed and Mother Groups were also interviewed. Health facility staff, HUMCs, PDCs and Sub-county chiefs were interviewed to gain a non-community perspective on the community interventions and to gain a health system perspective on the project. Project staff participated in interviews in geographic areas where they were not working. A list of all those interviewed are included in ***Annex XIV***. Qualitative data collection followed the interview guides that were designed to triangulate the results of the RHFA and the KPC as well as to assess the effectiveness of project processes and ascertain projections

concerning project sustainability. The complete packet of interview guides is included in ***Annex X B.***

Evaluation Question	Information Source	Survey Data
1) To what extent did the project accomplish objectives stated in the DIP? 4) Which elements of the project have been or are likely to be sustained or expanded?	• Mothers with children 0-23 months in high performing communities • Fathers with children 0-23 months in high performing communities • Mothers with children 0-23 months in low performing communities • Fathers with children 0-23 months in low performing communities • Village Health Teams • Peer Educators • Mother Groups • Health Unit Management Committees • Parish Development Committees • Health Facility Staff • Senior Assistant Secretary of Sub-Counties (Sub-County Chiefs) • MTI Senior Advisor, M&E	• Quantitative 30 cluster KPC survey of mothers of children age 0-23 months • Quantitative Rapid-Health Facility Services Assessment
2) To what extent was the project implemented as planned? What changes were made to the planned implementation, and why those changes were made?	• CSP Program Manager • Project Staff • MTI Senior Advisor Maternal Child Health • MTE Report • Project Annual Reports	
3) How were gender considerations addressed through the project? Are there any specific gender-related outcomes?	• CSP Program Manager • MTI Senior Advisor Maternal Child Health • Program Staff	
Question1) Objective 4, b) What progress has MTI Uganda made in improving low-scoring areas identified during the baseline organizational assessment?	• MTI Regional Director Africa • MTI Africa Health Programs Advisor • MTI Uganda, Human Resources • Organizational Capacity Assessment	

The External Consultant led evaluation team members through a participatory analysis of the findings from focus group interviews and of the KPC and RHFA findings.

Results were triangulated using the following tools:

- Quantitative 30 cluster KPC survey of mothers of children age 0-23 months

- Quantitative Rapid-Health Facility Services Assessment
- Comparison of data with available national and regional data from 2011 DHS
- Triangulation of perspectives of qualitative interviews with community volunteers, project beneficiaries, community leaders, HF staff, sub-county leadership and district health staff.

Participation by:

- External consultant
- MTI Uganda project staff
- Lira District Health Office and health facility staff
- Sub-County and Community leaders and volunteers
- MTI Senior Advisor, Monitoring and Evaluation and Senior Advisor, Maternal and Child Health

Finalization of Key Findings, Recommendations, and Action Planning

- FE Results Meeting on key findings and recommendations with representatives of DHO, community volunteers, health facility staff, and sub-county leadership. *(see **Annex XIX C** for FE Results Meeting Agenda)*
- Debriefing with USAID Uganda Mission (*see **Annex XVII** for debrief PowerPoint*)
- Debriefing with MTI Uganda and MTI Africa Regional staff

Evaluation Limitations

Because four new HF were opened in April 2012 just after the MTE, it left very little time for improvements to be made especially in the physical plants. This meant that in order to report on RHFA data in a meaningful way, only data from the original four clinics is included in the narrative of this report. The entire report is included in ***Annex X A***. An issue for the ECD portion of the qualitative evaluation was that the decision was made also to include communities in Lira and Ogur in the ECD interviews. Except for the ECD interventions, all project interventions were implemented across all communities in the three sub-counties, resulting in some of the communities chosen for interviews being ECD non-intervention communities. This limited the qualitative information available from intervention communities two years after the direct project support concluded.

Annex X A

Lira District Child Survival Project in Uganda
Child Health and Development in a Transitional Region

Erute North Sub-District, Uganda
October 2009 – September 2013

In Partnership with

Uganda Ministry of Health
Lira District Health Office

Final Evaluation Rapid Health Facility Assessment
Erute North Sub-District
Uganda

September 2013

Table of Contents

ACRONYMS

ANC	Antenatal Care
ARI	Acute Respiratory Infection
CHP	Community Health Promoter
CHW	Community Health Workers
C-IMCI	Community IMCI
CS	Child Survival
CORE	Collaborations and Resources Group
CSHGP	Child Survival and Health Grant Program
CSP	Child Survival Project
DHO	District Health Office
EPI	Expanded Program of Immunizations
HF	Health Facility
HFA	Health Facility Assessment
HS	Health services
HW	Health Worker
IMCI	Integrated Management of Childhood Illnesses
M&E	Monitoring and Evaluation
MNC	Maternal Newborn Care
MOH	Ministry of Health
MTI	Medical Teams International
MTI/Uganda	Medical Teams International/Uganda
N	Sample size
ORS	Oral Rehydration Salts
PHC	Primary Health Care
RHFA	Rapid Health Facility Assessment
USAID	United States Agency for International Development
VHT	Village Health Team

I. Executive Summary

In October 2009, Medical Teams International began the Lira District Child Survival Project in Uganda: Child Health and Development in a Transitional Region aimed at reducing child and maternal mortality and morbidity in Erute North Sub-District, Uganda.

In September 2013, the Child Survival team carried out a Rapid Health Facility Assessment (R-HFA) as part of the Final Evaluation process to assess the capacity of the 8 health facilities presently functioning in Erute North Sub-District. The assessment measured capacity in the areas of access, inputs, processes, and performance. The team utilized 4 teams of three individuals, consisting of one supervisor and two enumerators, which included members of the same staff that performed the baseline and midterm KPC survey and RHFA. This staff was comprised of MTI Supervisors and DHO members. Each team contained at least two members with extensive experience in health. All 8 HFs were scheduled to be surveyed in 4 days. At BL and MTE there were 4 HF that were assessed: Aromo (HF level 3), Barapwo (HF level 3), Amuca (HF level 3), and Ogur (HF level 4). This evaluation has also added Abala (HF level 2), Akangi (HF level 2), Apuce (HF level 2), and Walela (HF level 2). Therefore, the results are presented in 2 ways, first a comparison of the rates of the 4 HF that were surveyed at BL and MT, as well as FE, and then the rate of all 8 HFs.

At baseline (BL) and midterm evaluation (MTE) the R-HFA brought to light several areas of needed improvement at the HFs in the project area. At BL the HFs did not perform well in any of the major areas of analysis, including: access (service availability), inputs (staffing and supplies), processes (training and supervision, and Information systems) and HW performance. Some areas continued to struggle even at the MTE, but the second half of the project focused on these challenges and by this FE there were major improvements in several areas since BL, most notably:

- Service availability-Growth Monitoring: 2/4 HF at BL to 8/8 HF at FE
- Infrastructure: 1/4 HF at BL to 8/8 HF at FE
- Supplies for child services:1/4 HF at BL to 3/4 original and 3/4 new HF (6/8 total) at FE
- Drugs for Child health: 1/4 HF at BL to 8/8 HF at MT
- Training: 1/4 HF at BL to 8/8 HF at FE
- Supervision: 1/4 HF at BL to 8/8 HF at FE
- HW Performance (Assessment): 0/4 HF at BL to 7/8 HF at FE
- HW Performance (treatment): 1/4 HF at BL to 8/8 HF at FE
- HW Performance (counseling): 0/4 HF at BL to 8/8 HF at FE
- Optional indicator for availability of immunizations: 1/4 HF at BL to 8/8 HF at FE
- Optional indicator for HF community participation: 3/4 HF at BL to 8/8 HF at FE
- Optional indicator for community referral: 3/4 HF at BL to 8/8 HF at FE

A complete discussion of the 12 Core Indicators and optional indicators measured in the RHFA is available in the Summary Section (Chapter 4).

CHAPTER 1

Program Overview

Project Area and Description:

Medical Teams International implemented the Lira District Child Survival Project (LDCSP) in the Erute North Sub-District of Northern Uganda. The goal of the project was to reduce morbidity and mortality of children under five and women of reproductive age in Erute North Sub-District, Uganda. Direct beneficiaries were 25,498 children <5 25,498 WRA for a total of 50,996 direct beneficiaries. The level of effort by intervention for this Child Survival Project (CSP) was: 1/4 MNC, 1/4 PCM, 20% IYCF, 20% CDD, and 10% EPI. Capacity building activities with the DHO included improving the quality of health care for the sub-district population of 113,400. The primary implementing partner for this project was the DHO. Hands to Hearts International (HHI) was a collaborative partner, providing Early Childhood Development TOT trainings for VHTs, Peer Educators, and HF staff, and working with MTI and DHO to adapt the HHI ECD curriculum to the local context.

Health Care Services:

The Ugandan MoH is decentralized with district teams responsible for planning, budgeting, and monitoring performance. Each district is divided into Health Sub-Districts which are responsible for delivering a basic package of health services, including control of communicable disease, Integrated Management of Childhood Illness (IMCI), reproductive health, immunization, environmental health, health education and promotion, epidemics, and nutrition.[1] Successful implementation largely reflects district management priorities, capacities, and resources for training and supervision. A recent follow-up study of 10 districts in 2009 (none in the North) had mixed results. Staff turnover following the training was low, but only about half of clinic visits incorporated IMCI.

At baseline there were a total of 4 functioning government health facilities in the project area. During 2007-08, DHO reported 93% of HCs had no stock out for first-line malaria, 78% quinine, 90% Fansidar, 97% measles vaccine, 93% Oral Rehydration Salts (ORS) sachets, and 91% Cotrimoxizole tablets. According to DHS 2006, 56% of children with diarrhea in Northern Region were treated with ORS packets and there was negligible access to zinc. Utilization of health services is low, according to MTI's Knowledge, Practices & Coverage (KPC) survey (conducted in Aug. 2007): 30% of mothers took their child to an appropriate provider for fever, and 58% for pneumonia symptoms. When asked about their impression of services at Health Facilities (HFs), focus group participants expressed dissatisfaction, citing inadequate manpower, unqualified personnel rendering services, harsh treatment from some HF personnel, late arrival or absenteeism

[1] Uganda MoH: National Health Policy, 1999.

of HF personnel causing patients to wait, and overwhelming numbers of patients at the HF. According to the district Biostatistician, approximately 54% of the Sub-district population lived within 5 km of a HF. The farthest distance from a sub-district referral center (HC IV) was 25 km, and 45 km to the regional referral center in Lira Town.

Project Goals, Objectives and Strategy

The project goal was to reduce child morbidity and mortality in Uganda. Objectives were: 1) Communities assume responsibility for their own health through strengthening community capacity (VHTs, Parish Development Councils, and Health Sub-districts); 2) Improved health (C-IMCI) and child care (ECD) behaviors among mothers of children <5 years; 3) Improved quality of health facility services through strengthened IMCI and MNC capacity; 4) Strengthened institutional capacity of MTI and DHO to implement effective and efficient child survival activities. These objectives supported MoH goals and strategies as well as those of USAID Uganda. MTI used a two-pronged strategy: a) promoting behavior change and community mobilization to take appropriate responsibility for health: and b) building DHO capacity to provide sustainable, quality service delivery at the facility and community levels. The level of effort by intervention for this Child Survival Project (CSP) was: 1/4 MNC, 1/4 PCM, 20% IYCF, 20% CDD, and 10% EPI.

CHAPTER 2

Purpose of the Rapid Health Facility Assessment and Methodology

The objective of this Health Facility Assessment was to collect quantitative data regarding the health system in the project area, particularly the primary health care (PHC) facilities providing maternal, neonatal, and child health (MNCH) services. The new Rapid Health Facility Assessment (RHFA) used to collect this data had been designed and recently upgraded by CSTS, and is now called RHFA Version 2.1. [2]

The CSTS RHFA tool is designed to be rapid and cost effective, and is designed to be used at the local level to devise strategies, with the MOH entity present in the project area, and to improve the delivery of integrated child health services.[3] The BL assessment was conducted before IMCI training had begun and prior to any interventions aimed at health facilities so that an integrated strategy to improve the quality of health care could be implemented. This FE RHFA measured the progress made in the 12 core areas of HF capacity.

The R-HFA version 2.1 tool utilizes as its subjects the first six children, under the age of five, entering the health facility on the day of the survey with diarrhea, fever, or cough and examines three major areas of health care delivery[4]:

- Case management: Does the healthcare worker (HW) assess, diagnose, and treat children with diarrhea, fever (malaria), and ARI properly? Does the HW explain follow up care to the caretaker well?
- Health facility infrastructure: Does the health facility have the necessary equipment, supplies, medications, and privacy to perform adequate MCH services?
- Management (Processes): Are the proper management processes being followed in the health facility (supervision, record keeping, and continuation of training)?

This R-HFA tool focuses on the delivery of care for the most important causes of infant and child morbidity and mortality, which include: diarrhea, acute respiratory infections (ARI), malaria, measles, and malnutrition. The purpose of collecting this data is to allow the project, in conjunction with the MOH, DHO, and other health workers in the project area, to determine gaps in service and prioritize their response in order to provide essential, integrated health services. There are four main modules in the R-HFA, with a fifth optional module. All are formatted in Excel for ease of use[5]:

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[2] R-HFA Version 2.1; CSTS 2007; http://www.childsurvival.com/rhfa_1.cfm

[3] BASICS II Health Facility Assessment; BASICS 1999; http://www.basics.org/Publications/pubs/hfa/hfa_apdxc.htm

[4] Ibid.

[5] R-HFA Version 2.1; CSTS 2007; http://www.childsurvival.com/rhfa_1.cfm.

a. Observation Checklist for sick child care: To observe the HW in the assessment, diagnosis, and treatment of six consecutive cases of care of children under the age of five with fever, diarrhea, or breathing difficulty. The HW is assessed for adherence to the national (IMCI) protocol for assessment, classification, and treatment of childhood illness.
b. Client (Caretaker) Exit Interview: To assess whether the caretaker has the correct knowledge of how to administer drugs given for diarrhea, malaria, and/or breathing difficulty (used a proxy for adequate counseling), and whether the caretaker knows under what circumstances the child is to return to the clinic.
c. Health Facility Checklist: To assess the presence of a minimal level of infrastructure, equipment, supplies, and medications.
d. Health Worker Interview and Record Review: To assess the staffing, MNCH services offered, and also assess the frequency of training, supervision, and other key processes.
e. CHW Survey and Checklist (optional): To collect data on CHWs regarding six of the twelve health facility core indicators (through examination of registers).

Selecting the Sampling Frame

The sampling methodology was revised by CSTS to use a quality assurance type approach similar, but not identical, to that used in LQAS. The new methodology dictates that at least 80% of the health facilities perform adequately, according to the indicators chosen in the HFA, for the project area to pass. This is called the performance benchmark. Also, an unacceptable level of 4/6 is chosen as the level that should not go undetected in determining that the health facilities are not performing adequately in regard to a given indicator[6]. The alpha and beta errors have been placed at 10%. The new R-HFA software automatically calculates the sample size needed, and calculates the results following the survey. Because there are only 8 functioning HFs in the project area, no sample size selection was necessary as all 8 HFs were surveyed.

Selecting the Survey Teams

Four teams of three individuals, one supervisor and two enumerators were formed using the same staff that participated in the baseline KPC Survey and community Feedback sessions. This staff was comprised of MTI Supervisors and DHO members. Each team contained at least two members with experience in health. Therefore, all 8 HFs were scheduled to be surveyed in 4 days.

Each element of the R-HFA was administered by the following members of the R-HFA survey team:

a. Observation Checklist for sick child care: Enumerator with experience in health
b. Client (Caretaker) Exit Interview: Enumerator, with guidance from Enumerator with experience in health
c. Health Facility Checklist: Supervisor

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[6] R-HFA Version 2.1; CSTS 2007; http://www.childsurvival.com/rhfa_1.cfm

d. Health Worker Survey: Supervisor of Enumerator with experience in health; should be performed by whichever team member has completed their other duties.
e. CHW Survey and Checklist (optional): Enumerator with guidance from Supervisor or Enumerator with experience

Training the Survey Team

The refreshment training of the survey team required two days and was facilitated by the MTI HQ Sr. Advisor in M&E who directed the FE survey. The main objectives of the training were to discuss the purpose of the survey and the resulting information; discuss the logistics of the survey; review and practice each of the forms; and practice administering these forms in the facility setting. A health facility that was near the training site but not part of the project in Erute North Sub-District was chosen for the HFA was used for the field test.

The Survey Process

Observation of Clinical Care and Caretaker Exit Interview

The first six children under the age of five presenting to the facility during the survey period whose caretakers describe them as having diarrhea/vomiting, fever/malaria, or cough/difficulty breathing/pneumonia were included in the sample. The caretakers were met as they entered the clinic, and if they agreed to take part in the survey they were followed throughout the facility. If the caretaker brought more than one sick child under the age of five, one child was randomly chosen to be the index child. The enumerator with experience in health observed the clinical encounter between the HW and the caretaker and child. The second enumerator conducted the Exit Interview with the caretakers of sick children outside of the facility as they exited, following receiving the child's medications.

Health Facility Checklist

After ensuring that these interviews were proceeding well, the supervisor completed the Health Facility Checklist with an available HW at the facility. A HW was present because determining the conditions in the consultation room and of some of the equipment required some discussion with the HW.

Health Worker Survey

Following completion of the observation of six consultations between the HW and the caretaker/child, the enumerator with experience or the supervisor, whichever was available, performed the HW Survey.

Providing Feedback to the Staff

Surveyors were instructed to provide some feedback to staff on the day of the assessment. The feedback on positive points was provided to alleviate any anxiety the staff may have felt due to the survey, but also included constructive comments to improve clinical treatment and management techniques. It was recommended during the training that feedback regarding the following items be given[7]:

- Strengths and problems in case management, particularly in the assessment and treatment of sick children
- Quality of home-care advice and communication between health workers and caretakers
- Inappropriate use of medications
- Problems in record keeping
- Ways to improve clinic organization
- Major barriers to effective practice

Checking the Completed Questionnaires

Completed questionnaires were checked by the supervisor and enumerators administering the questionnaire immediately at the conclusion of the interview so that any discrepancies or missed questions could be discussed with the person being interviewed. At the end of each facility session, the Supervisor reviewed all forms with the enumerators before leaving the facility. The completed forms were then brought to the central point chosen for data entry and given to the data entry staff. This was done nightly so that data entry could be performed during the data collection period. The data entry staff reviewed the completed questionnaires for accuracy while the survey team was there, in order to clarify or correct any unclear or incorrect items noticed in the forms.

Data Entry

During the data collection phase of the survey, data was entered into the R-HFA Excel program provided in the R-HFA zip file available on the CSTS website[8]. Data was entered daily throughout the survey so that any discrepancies could be discussed with the supervisors as soon as possible. Cleaning of the survey data was accomplished by the data entry staff as the data was presented. Following data entry for the final assessment, all data was then combined in the single Excel file, provided by CSTS, and analyzed by the HQ Senior Advisor in M&E and was shared immediately with the team in Uganda.

[7] R-HFA short instruction 12-09-07; R-HFA Version 2.1; CSTS 2007; http://www.childsurvival.com/rhfa_1.cfm

[8] R-HFA Version 2.1; CSTS 2007; http://www.childsurvival.com/rhfa_1.cfm

CHAPTER 3

Main Findings

ACCESS (INPUTS)

1. Service Availability

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Indic. #	Domain	Indicator	% HF with all elements		
			BL	MTE	FE
1 CHILD	Service Availability - Child	% HF that offer all three basic child health services (growth monitoring, immunization, sick child care)	0/4	1/4	3/4
1 ANC	Service Availability - ANC	% HF that offer ANC at least once a week	4/4	4/4	4/4
1 NEO	Service Availability - Delivery	% HF that offer delivery services on all days	2/4	1/4	3/4

FE OF ALL 8 HFS

Indic. #	Domain	Indicator	% HF with all elements	
			4 NEW HF	ALL 8 HF
1 CHILD	Service Availability - Child	% HF that offer all three basic child health services (growth monitoring, immunization, sick child care)	2/4	5/8
1 ANC	Service Availability - ANC	% HF that offer ANC at least once a week	1/4	5/8
1 NEO	Service Availability - Delivery	% HF that offer delivery services on all days	0/4	3/8

- At baseline, 0/4 of the HFs offered all 3 basic child health services
    - This was due to the fact that no facilities saw patients 30 days per month (including outreach). However, all of the facilities provided sick child services at a minimum of Monday-Friday, for a total of 20 hours per week
    - At FE, 3/4 of the original HFs, all except Barapwo, offered child health services (HS) 30 days per month (including outreach), and 5/8 of the total HFs provided HS 30 days per month. In addition to Barapwo, Akangi and Walela did not provide HS 30 days per month.
    - Growth Monitoring:
        - At BL only 2 of the 4 HFs (Ogur and Amuca) offered growth monitoring.

- At FE, all 8 HFs offered GM. At MTE it was discovered that mothers did not bring their health cards to the other facilities so they were not able to be checked. Activities were put in place at all HFs to encourage all mothers to bring their children's health card with them to every visit. As part of the IMCI protocol, growth monitoring was introduced to all HFs so that all HFs provided growth monitoring services in the facility and/or through outreach.

- Immunization:
  - At baseline all 4 HFs offered immunization services through the facility and/or outreach.
  - At FE all 8 HFs offered immunization services
- ANC Services:
  - At baseline and MTE all HFs in Lira District offered ANC services and at final all the original HFs still offered ANC. Of the 4 new HFs, only Abala offered ANC.

- Delivery Services:
  - At FE, Barapwo, one of the original HFs, and each of the new HFs did not provide delivery services. In 2008, Barapwo was upgraded from a level 2 facility to a level 3 facility and therefore had no maternity unit, and the new facilities are all level 2 and therefore had no maternity unit.

2. Staffing

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Indic. #	Domain	Indicator	% HF with all elements			Index Value (% avg. HF attainment		
			BL	MTE	FE	BL	MTE	FE
2	Staffing	% HF with all staff who provide clinical services working on the day of survey	0/4	1/4	1/4	48%	68%	66%

FE RESULTS OF ALL 8 HFS

Indic. #	Domain	Indicator	% HF with all elements		Index Value (% avg. HF attainment	
			4 new HF	ALL 8 HF	4 new HF	ALL 8 HF
2	Staffing	% HF with all staff who provide clinical services working on the day of survey	4/4	5/8	100%	83%

This indicator has been changed from the original RHFA staffing indicator, which was: "% of HFs with at least one provider meeting the country definition as qualified to provide curative care for children is present on day of survey". All HFs would have met the old indicator, both at BL and MTE, because at least one qualified

provider was present at each facility. However, the new indicator determines the number of each type of staff, and determines if they are all present on the day of the survey.

- Therefore, at BL, 0/4 of the HFs met this requirement, with the average HF attainment at 48% (meaning the average HF had 48% of its qualified staff present).
- At FE 1/4 (Amuca) of the original HFs had all staff present, and all of the new facilities had all staff present, for a total of 5/8 HFs.

The project worked with the DHO to continue to improve staff attendance since MTE so that treatment of patients could be as effective as possible and refresher training in IMCI was as effective as possible by ensuring that all HW treating patients were present to benefit from project follow-up mentoring and supportive supervision activities after IMCI topic training is provided.

3. Infrastructure

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Ind #	Domain	Indicator	% HF with all elements			Index Value (% avg. HF attainment		
			BL	MTE	FE	BL	MTE	FE
3	Infrastructure	% HF in which all essential infrastructure is present and functioning on day of the survey (**improved water source; functional latrine for clients**; **setting allowing auditory and visual privacy**)	**1/4**	**4/4**	**4/4**	**63%**	**72%**	**100%**

FACTORS	BL	MTE	FE
Has at least one bed	3/4	3/4	3/4
Has 24 hour staff coverage	3/4	4/4	3/4
Has functioning emergency communication	3/4	3/4	0/4
Has emergency transportation usable today	0/4	0/4	0/4
Has electricity from the grid or a generator with fuel	3/4	1/4	1/4
Has a usable client latrine	**4/4**	**4/4**	**4/4**
Has water from protected water source on or near grounds	**2/4**	**4/4**	**4/4**
Has auditory and visual privacy	**2/4**	**4/4**	**4/4**

FE RESULTS OF ALL 8 HFS

Indic. #	Domain	Indicator	% HF with all elements		Index Value (% avg. HF attainment	
			4 New HF	ALL 8 HF	4 New HF	ALL 8 HF
3	Infrastructure	% HF in which all essential infrastructure is present and functioning on day of the survey (**improved water source; functional latrine for clients**; **setting allowing auditory and visual privacy**)	**4/4**	**8/8**	**100%**	**100%**

FACTORS	4 NEW HF	ALL 8 HF
Has at least one bed	0/4	3/8
Has 24 hour staff coverage	1/4	4/8
Has functioning emergency communication	2/4	4/8
Has emergency transportation usable today	0/4	0/8
Has electricity from the grid or a generator with fuel	0/4	1/8
Has a usable client latrine	**4/4**	**8/8**
Has water from protected water source on or near grounds	**4/4**	**8/8**
Has auditory and visual privacy	**4/4**	**8/8**

- At BL, all essential health infrastructure was present on the day of the survey in only 1/4 of the HFs (Ogur), with the average HF attainment at 63%.
    - The limiting factors were: emergency transportation, which was not available in any of the HFs, an improved, protected water source, which was only available in 2/4 of the HFs (Ogur and Amuca), and auditory and visual privacy, which was also only available in 2/4 of the HFs (Ogur and Aromo).
    - However, there was 24 hour staff coverage in 3/4 of the original HFs (Aromo, Barapwo, and Ogur).
    - However, 3/4 of the HFs had electricity from the grid or a generator with fuel and functioning emergency communication (Aromo, Barapwo, and Ogur).
    - All of the HFs had a useable client latrine.
- At FE, all essential health infrastructure was present on the day of the survey in all 4 of the original HFs and all 4 of the new HFs as well.
    - All 8 facilities had water from a protected water source and auditory and visual privacy (both up from 2/4 at BL).
    - Also, 24 hour staff coverage was available in 3/4 of the original HFs and only 1 of the new facilities (Walela)
    - However, electricity from the grid or a generator with fuel was down from 3/4 at BL (all HFs except Aromo), to only 1/8 at FE (Amuca).

4. Supplies – Child

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Indic. #	Domain	Indicator	% HF with all elements			Index Value (% avg. HF attainment		
			BL	MTE	FE	BL	MTE	FE
4 CHILD	Supplies - Child	% HF with all essential supplies to support child health on day of the survey (accessible and working scale for child, accessible and working scale for infant, timing device for diagnosis of pneumonia, spoon/cup/jug to administer ORS)	1/4	3/4	3/4	40%	95%	95%

FACTORS	BL	MTE	FE
Has functioning and accessible infant scale	2/4	4/4	4/4
Has functioning and accessible scale for children/adults	2/4	3/4	4/4
Has functioning timer or watch	2/4	4/4	3/4
Has pitcher for ORS	1/4	4/4	4/4
Has cup or spoon for ORS	1/4	4/4	4/4

FE RESULTS OF ALL 8 HFS

Indic. #	Domain	Indicator	% HF with all elements		Index Value (% avg. HF attainment	
			4 New HF	ALL 8 HF	4 New HF	ALL 8 HF
4 CHILD	Supplies - Child	% HF with all essential supplies to support child health on day of the survey (accessible and working scale for child, accessible and working scale for infant, timing device for diagnosis of pneumonia, spoon/cup/jug to administer ORS)	3/4	6/8	85%	90%

FACTORS	4 NEW HF	ALL 8 HF
Has functioning and accessible infant scale	3/4	7/8
Has functioning and accessible scale for children/adults	4/4	8/8
Has functioning timer or watch	4/4	7/8
Has pitcher for ORS	3/4	7/8
Has cup or spoon for ORS	3/4	7/8

- At BL only 1/4 of HFs (Barapwo) had all of the essential supplies to support child health, and the average HF attainment was 40% of these essential supplies.
    - ORS pitchers and spoons were only available in Barapwo, and scales and timers were available in only 2/4 (Barapwo and Amuca) of the facilities.
- At FE 3/4 of the original HFs (Aromo, Barapwo, and Ogur) and 3/4 new HFs (all but Abala) had all of the essential supplies to support child health, and the average HF attainment was 90% of these essential supplies.

Supplies – MNC

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Indic. #	Domain	Indicator	% HF with all elements			Index Value (% avg. HF attainment		
			BL	MTE	FE	BL	MTE	FE
4 Neo	Supplies – HF	% HF with all essential supplies to support maternal-newborn health present on day of the survey (partograph, vacuum extractor, resuscitation device, weighing scale, antibiotics and baby wraps)	0/4	0/4	1/4	25%	30%	65%

FACTORS	BL	MTE	FE
Has functioning neonatal resuscitation equipment	0/4	3/4	3/4
Has functioning and accessible infant scale	3/4	3/4	4/4
Has functioning vacuum extractor	0/4	0/4	1/4
Has neonatal wraps for warming	0/4	0/4	1/4
Has partographs	2/4	0/4	4/4

Supplies – MNC

FE RESULTS OF ALL 8 HFS

Indic. #	Domain	Indicator	% HF with all elements		Index Value (% avg. HF attainment	
			4 New HF	ALL 8 HF	4 New HF	ALL 8 HF
4 Neo	Supplies – HF	% HF with all essential supplies to support maternal-newborn health present on day of the survey (partograph, vacuum extractor, resuscitation device, weighing scale, antibiotics and baby wraps)	0/4	1/8	0%	13%

FACTORS	4 New HF	ALL 8 HF
Has functioning neonatal resuscitation equipment	0/4	3/8
Has functioning and accessible infant scale	0/4	4/8
Has functioning vacuum extractor	0/4	1/8
Has neonatal wraps for warming	0/4	1/8
Has partographs	0/4	4/8

- At BL, none (0/4) of the HFs had all of the essential supplies to support maternal-newborn health available and the average HF attainment was only 25% of these essential supplies.
    - None of the facilities had neonatal resuscitation equipment, functioning vacuum extractors, or neonatal wraps for warming.
    - Only 2/4 of facilities (Aromo and Amuca) had partographs.
- At FE, only Amuca (1/4) of the original HFs had all of the essential supplies to support maternal-newborn health available and the average HF attainment was at only 65% for these essential supplies. Also, none of the new HFs had all essential MNC supplies, for a total of only 1/8 HFs and only a 13% average HF attainment.
    - Aromo, Amuca, and Ogur had neonatal resuscitation equipment and infant scales.
    - Only Amuca had functioning vacuum extractors or neonatal wraps for warming.
    - All 4 of the original HFs had functioning partographs, and none of the new HFs had functioning partographs, for a total of 4/8.

Supplies – ANC

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Indic. #	Domain	Indicator	% HF with all elements			Index Value (% avg. HF attainment		
			BL	MTE	FE	BL	MTE	FE
4 ANC	Supplies - ANC	% HF with all essential supplies to support antenatal care present on day of survey (blood pressure machine, tetanus toxoid vaccine, hemoglobin reagents, syphilis testing kit, and albastix for protein)	0/4	0/4	0/4	42%	54%	75%

FACTORS	BL	MTE	FE
Has functioning blood pressure equipment	2/4	4/4	3/4
Has hemoglobin testing reagents	1/4	3/4	2/4
Has syphilis testing kits	2/4	1/4	3/4
Has malaria test kits	2/4	2/4	4/4
Has urine albumin test strips	0/4	1/4	2/4
Has tetanus toxoid	3/4	2/4	4/4

Supplies – ANC

FE RESULTS OF ALL 8 HFS

Indic. #	Domain	Indicator	% HF with all elements		Index Value (% avg. HF attainment	
			4 New HF	ALL 8 HF	4 New HF	ALL 8 HF
4 ANC	Supplies - ANC	% HF with all essential supplies to support antenatal care present on day of survey (blood pressure machine, tetanus toxoid vaccine, hemoglobin reagents, syphilis testing kit, and albastix for protein)	0/4	0/4	13%	44%

FACTORS	4 New HF	ALL 8 HF
Has functioning blood pressure equipment	1/4	4/8
Has hemoglobin testing reagents	0/4	2/8
Has syphilis testing kits	0/4	3/8
Has malaria test kits	1/4	3/8
Has urine albumin test strips	0/4	2/8
Has tetanus toxoid	3/4	7/8

- At BL 0/4 of the HFs had all of the essential supplies to support antenatal care.

- No facilities had albumin test strips, and only 1/4 of the HFs (Aromo) had syphilis testing kits and hemoglobin testing kits available.
- Also, malaria test kits (Aromo and Amuca), blood pressure equipment (Ogur and Aromo), and syphilis testing kits were available in only 2/4 (Aromo and Amuca) of the facilities.
- All HFs other than Barapwo had tetanus toxoid available.

- At FE none of the HFs had all of the essential supplies to support antenatal care, with a 75% attainment at the original HFs and only a 44% attainment at all 8 HFs.
    - Only Aromo and Ogur had hemoglobin testing reagents or malaria test kits.
    - Ogur had all equipment except functional BP equipment.

5. a. Drugs - CHILD

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Indic. #	Domain	Indicator	% HF with all elements			Index Value (% avg. HF attainment		
			BL	MTE	FE	BL	MTE	FE
5 CHILD	Drugs - CHILD	% HF with all first line medications for child health present on day of the survey (ORS, oral antibiotic for pneumonia, first line oral antibiotic for dysentery, first line antimalarial, vitamin A)	1/4	1/4	4/4	40%	75%	100%

FACTORS	BL	MTE	FE
Has ORS packets	3/4	4/4	4/4
Has first line child pneumonia drug	1/4	1/4	4/4
Has first line dysentery drug	1/4	2/4	4/4
Has first line antimalarial	1/4	4/4	4/4
Has vitamin A	2/4	4/4	4/4

FE RESULTS OF ALL 8 HFS

Indic. #	Domain	Indicator	% HF with all elements		Index Value (% avg. HF attainment	
			4 NEW HF	ALL 8 HF	4 New HF	ALL 8 HF
5 MNC	Drugs - MNC	% HF with all essential delivery & neonatal drugs present on day of survey (i.e., Oxytocin, antibiotics for newborn sepsis and eye infections)	4/4	8/8	100%	100%

FACTORS	4 NEW HF	ALL 8 HF
Has ORS packets	4/4	8/8
Has first line child pneumonia drug	4/4	8/8
Has first line dysentery drug	4/4	8/8
Has first line antimalarial	4/4	8/8
Has vitamin A	4/4	8/8

- At baseline, 1/4 of HFs (Amuca) had all first line medications available, which is defined as: ORS, a first line oral antibiotic for pneumonia, a first line drug for dysentery, a first line antimalarial, and Vitamin A.
    - This is due to the fact that while 1/4 of facilities had first line drugs for pneumonia (Barapwo) and 50 % of HFs had Vitamin A (Aromo and Amuca), only 1/4 of HFs (Amuca) had first line medications also available for malaria and dysentery.
- At FE, all HFs had all first line medications available, the average HF attainment rose from 40% to 100%

5. b. Drugs – MNC

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Indic. #	Domain	Indicator	% HF with all elements			Index Value (% avg. HF attainment		
			BL	MTE	FE	BL	MTE	FE
5 MNC	Drugs - MNC	% HF with all essential delivery & neonatal drugs present on day of survey (i.e., Oxytocin, antibiotics for newborn sepsis and eye infections)	0/4	0/4	3/4	25%	42%	92%

FACTORS	BL	MTE	FE
Has antibiotics for newborn sepsis/pneumonia	1/4	1/4	4/4
Has neonatal eye ointment	1/4	2/4	3/4
Has Oxytocin	1/4	2/4	4/4
Has Nevirapine (in high HIV prevalence areas only)- OPTIONAL	2/4	2/4	3/4

FE RESULTS OF ALL 8 HFS

Indic. #	Domain	Indicator	% HF with all elements		Index Value (% avg. HF attainment	
			4 NEW HF	ALL 8 HF	4 New HF	ALL 8 HF
5 MNC	Drugs - MNC	% HF with all essential delivery & neonatal drugs present on day of survey (i.e., Oxytocin, antibiotics for newborn sepsis and eye infections)	0/4	3/8	34%	63%

FACTORS	4 NEW HF	ALL 8 HF
Has antibiotics for newborn sepsis/pneumonia	2/4	6/8
Has neonatal eye ointment	2/4	5/8
Has Oxytocin	0/4	4/8
Has Nevirapine (in high HIV prevalence areas only)	0/4	3/8

- At BL, none of the HFs had all of the essential delivery and neonatal drugs present on the day of the survey. In fact, all 3 essential MNC drugs were available in only 1 out of the four HFs each (antibiotics-Amuca; neonatal eye ointment-Ogur; and Oxytocin-Ogur).
- At FE 3/4 of the HFs had all of the essential delivery and neonatal drugs present on the day of the survey, with a 92% attainment rate. Only Ogur did not have eye ointment. None of the new HFs had MNC drugs as they are not performing deliveries and are level 2 HFs.

5. c. Drugs – ANC

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Indic. #	Domain	Indicator	% HF with all elements			Index Value (% avg. HF attainment		
			BL	MTE	FE	BL	MTE	FE
5 ANC	Drugs – ANC	% HF with all essential ANC drugs (Tetanus toxoid, iron/folate, IPT, ITNs)	1/4	4/4	0/4	69%	100%	69%

FACTORS	BL	MTE	FE
Has tetanus toxoid	3/4	4/4	4/4
Has iron / folate	3/4	4/4	3/4
Has antimalarial IPT	3/4	4/4	4/4
Has ITNs	2/4	4/4	0/4

Drugs – ANC

FE RESULTS OF ALL 8 HFS

Indic. #	Domain	Indicator	% HF with all elements		Index Value (% avg. HF attainment	
			4 NEW HF	ALL 8 HF	4 New HF	ALL 8 HF
5 ANC	Drugs – ANC	% HF with all essential ANC drugs (Tetanus toxoid, iron/folate, IPT, ITNs)	0/4	0/8	56%	63%

FACTORS	4 NEW HF	ALL 8 HF
Has tetanus toxoid	3/4	7/8
Has iron / folate	3/4	6/8
Has antimalarial IPT	3/4	7/8
Has ITNs	0/4	0/8

- At BL, only 2/4 HFs had all of the ANC drugs present on the day of the survey. Barapwo was missing 3 of the 4 drugs (Tetanus toxoid, Iron, and ITNs). Amuca was missing antimalarials. Only half of the HFs had ITNs (Aromo and Amuca).
- At FE, none of the HFs had all the essential ANC drugs, because there were no ITNs available at any HF. Three out of 4 of the original HFs had all other ANC drugs, with Aromo only missing Iron. Three out of 4 of the new HFs had all other drugs, with Apuce missing Tetanus toxoid, Iron, and Fansidar for IPT.

PROCESSES

6. Information Systems

Information System – Child

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Indic. #	Domain	Indicator	% HF with all elements			Index Value (% avg. HF attainment		
			BL	MTE	FE	BL	MTE	FE
6 CHILD	Information System - Child	% HF that maintain up-to-date records of sick U5 children (age, diagnosis, treatment) and for HF: have report in last 3 months and evidence of data use	0/4	0/4	0/4	25%	80%	80%

Information System – Child

FE RESULTS OF ALL 8 HFS

Indic. #	Domain	Indicator	% HF with all elements		Index Value (% avg. HF attainment	
			4 NEW HF	ALL 8 HF	4 New HF	ALL 8 HF
6 CHILD	Information System - Child	% HF that maintain up-to-date records of sick U5 children (age, diagnosis, treatment) and for HF: have report in last 3 months and evidence of data use	0/4	0/8	80%	80%

- At BL, none of the HFs maintained up to date records on sick children under 5 years of age, or up-to-date monthly service data.
    - The average facility had only 25% of the elements required for having up-to-date records and monthly service data.
    - Ogur performed best with 80% of the elements in place.
    - Aromo and Barapwo HFs did not have any of the elements in place, while Amuca had only 20% of the elements in place.
    - Barapwo and Amuca used the data to create a wall chart, and Barapwo used the data to create a graph and in discussions, but the other HFs did not use the data at all.
- At FE, still 0/4 of the original HFs and also 0/4 of the new HFs maintained up to date records on sick children under 5 years of age, or up-to-date monthly service data.
    - However, at FE each facility had 80% of the elements required for having up-to-date records and monthly service data, up from 25% at BL.
    - All facilities (8/8) had complete information in the sick child register, but no HF was using the monthly service data (MSR) which, therefore, is the limiting factor.

Information System – ANC

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Indic. #	Domain	Indicator	% HF with all elements			Index Value (% avg. HF attainment		
			BL	MTE	FE	BL	MTE	FE
6 MNC	Information System - ANC	% HF that maintain up-to-date records of antenatal care (TT, blood pressure, expected date of delivery) & deliveries (present & up to date)	2/4	1/4	2/4	63%	75%	75%

FACTORS	BL	MTE	FE
An ANC register was observed	3/4	4/4	4/4
ANC register with complete delivery information, last 3 months	2/4	3/4	4/4
ANC register with complete TT information, last 3 months	2/4	3/4	4/4
ANC register with complete BP information, last 3 months	2/4	0/4	3/4
ANC register with entry in last 7 days	3/4	4/4	4/4
Delivery register was observed	3/4	4/4	3/4
Delivery register was up to date (entry in last 30 days)	3/4	4/4	3/4

FE RESULTS OF ALL 8 HFS

Indic. #	Domain	Indicator	% HF with all elements		Index Value (% avg. HF attainment	
			4 NEW HF	ALL 8 HF	4 New HF	ALL 8 HF
6 MNC	Information System - ANC	% HF that maintain up-to-date records of antenatal care (TT, blood pressure, expected date of delivery) & deliveries (present & up to date)	0/4	2/8	14%	45%

FACTORS	4 NEW HF	ALL 8 HF
An ANC register was observed	1/4	5/8
ANC register with complete delivery information, last 3 months	1/4	5/8
ANC register with complete TT information, last 3 months	1/4	5/8
ANC register with complete BP information, last 3 months	1/4	4/8
ANC register with entry in last 7 days	1/4	5/8
Delivery register was observed	0/4	3/8
Delivery register was up to date (entry in last 30 days)	0/4	3/8

- At BL, 2/4 HFs (Aromo and Amuca) had up to date records on antenatal care. Aromo and Amuca had all of the elements in place, and Ogur had 2/4 of the elements in place, while Barapwo had none of the elements in place.
- At FE, all original HFs had up to date records on antenatal care. Amuca was missing BP information, and Barapwo did not have the delivery register up to

date. Of the new HFs, none had delivery information as they do not perform deliveries, and only Abala had an ANC register with complete information.

7. Training

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Indic. #	Domain	Indicator	% HF with all elements		
			BL	MTE	FE
7 CHILD	Training - Child Health	% HF in which interviewed HW reported receiving in-service or pre-service training in child health in last 12 months	1/4	3/4	4/4
7 MNC	Training - Maternal-Neonatal Care	% HF in which interviewed HW reported receiving in-service or pre-service training in maternal neonatal care in last 12 months	1/4	3/4	4/4

FACTORS			
CHILD HEALTH	**BL**	**MTE**	**FE**
Immunization training	0/4	2/4	4/4
Pneumonia case management training	0/4	3/4	4/4
Diarrhea case management training	1/4	3/4	4/4
Malaria case management training	0/4	3/4	4/4
ACT use training	0/4	3/4	4/4
ITN use training	0/4	3/4	4/4
Nutrition training	1/4	3/4	4/4
Breastfeeding promotion training	0/4	3/4	4/4
IMCI training	0/4	3/4	4/4
MNC	**BL**	**MTE**	**FE**
IPT use training	1/4	3/4	4/4
Newborn care training	0/4	2/4	4/4
Post-partum care training	0/4	1/4	4/4
ANC training	0/4	2/4	4/4
Infection control training	0/4	1/4	4/4
AMTSL training	0/4	1/4	4/4
Ob / neonatal emergencies referral training	0/4	1/4	4/4

Training

FE RESULTS OF ALL 8 HFS

Indic. #	Domain	Indicator	% HF with all elements	
			4 NEW HF	ALL 8 HF
7 CHILD	Training - Child Health	% HF in which interviewed HW reported receiving in-service or pre-service training in child health in last 12 months	4/4	8/8

7 MNC	**Training - Maternal-Neonatal Care**	**% HF in which interviewed HW reported receiving in-service or pre-service training in maternal neonatal care in last 12 months**	**4/4**	**8/8**

FACTORS		
CHILD HEALTH	**4 NEW HF**	**ALL 8 HF**
Immunization training	4/4	8/8
Pneumonia case management training	3/4	7/8
Diarrhea case management training	3/4	7/8
Malaria case management training	3/4	7/8
ACT use training	3/4	7/8
ITN use training	3/4	7/8
Nutrition training	2/4	6/8
Breastfeeding promotion training	3/4	7/8
IMCI training	3/4	7/8
MNC		
IPT use training	2/4	6/8
Newborn care training	4/4	8/8
Post-partum care training	3/4	7/8
ANC training	3/4	7/8
Infection control training	3/4	7/8
AMTSL training	3/4	7/8
Ob / neonatal emergencies referral training	3/4	7/8

- At BL. only1/4 of the HFs (Ogur) had HWs who reported receiving in-service or pre-service training in both maternal neonatal care and child health in the last 12 months. Training in MNC consists of: training in MNC and at least one other of the trainings listed above in the MNC section. Training in child health consists of: training in Child Health and at least one other of the trainings listed above in the child health section. Ogur received training in diarrhea case management, nutrition, and IPT use.
- At FE, all of the original and new HFs had HWs who reported receiving in-service or pre-service training in both maternal neonatal care and child health within the last 12 months. The various trainings are broken down in the above table. The child health trainings in pneumonia, diarrhea, malaria, ACT, ITN, BF, and IMCI were not received in Abala HF, and Abala and Apuce did not receive nutrition training.

8. Supervision

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Indic. #	Domain	Indicator	% HF with all elements		
			BL	MTE	FE
8	Supervision	% HF that received external supervision at least once in the last 3 months (supervision included one or more of the following: checked records or reports, observed work, provided feedback, gave praise, provided updates, discussed problems))	1/4	3/4	4/4

FE RESULTS OF ALL 8 HFS

Indic. #	Domain	Indicator	% HF with all elements	
			4 NEW HF	ALL 8 HF
8	Supervision	% HF that received external supervision at least once in the last 3 months (supervision included one or more of the following: checked records or reports, observed work, provided feedback, gave praise, provided updates, discussed problems))	3/4	7/8

- At BL, only 1/4 of the HFs (Ogur) received any type of external supervision at least once in the 3 months prior to the survey. During this visit, the supervisor observed work in the HF, discussed problems, and checked drug supplies.
- At FE, all 4 original HFs and 3/4 new HFs received supervision (Abala did not).

PERFORMANCE

9. Utilization of Curative services

The percentage of HF with > 1 sick child encounters per child under the age of 5 in Lira District was not able to be calculated, because no facilities had complete sick child registries available at the time of survey.

10. HW Performance (Assessment)

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Indic. #	Domain	Indicator	% HF with all elements			Index Value (% avg. HF attainment		
			BL	MTE	FE	BL	MTE	FE
10 CHILD	HW Performance (Assessment)	% patients in a facility for whom all 5 assessment tasks were done at least 80% of the time (check presence of general danger signs (including both vomiting and convulsions), assess feeding practices, assess nutritional status, check vaccination status)	0/4	0/4	3/4	21%	68%	98%

FE RESULTS OF ALL 8 HFS

Indic. #	Domain	Indicator	% HF with all elements		Index Value (% avg. HF attainment	
			4 NEW HF	ALL 8 HF	4 NEW HF	ALL 8 HF
10 CHILD	HW Performance (Assessment)	% patients in a facility for whom all 5 assessment tasks were done at least 80% of the time (check presence of general danger signs (including both vomiting and convulsions), assess feeding practices, assess nutritional status, check vaccination status)	4/4	7/8	100%	99%

In order for a HF to be considered as having key assessment tasks routinely performed, in greater than 80% (5 or 6 out of the 6 cases observed) of the encounters the HW must perform all of the key assessment tasks.

- The baseline found that no facilities (0/4) contained HWs who were routinely performing all 5 key assessment tasks.
    - Furthermore, the average facility was performing only 21% of the key assessment tasks.
    - Ogur performed best by performing 63% of the assessment tasks, followed by Barapwo, which performed 21% of their assessment tasks.

Aromo and Amuca performed the worst, performing only 4% and 8% of their assessment tasks, respectively.

- Assessment tasks which were assessed most frequently were: the ability to feed or breastfeed, asking if the child had been vomiting everything, and checking for the presence of convulsions, which were each asked 29% of the time.
- Assessment tasks which were assessed least frequently were: checking the nutritional status and checking for immunizations on the child health card, which were each performed only 4% of the time.

- At FE, 3/4 original facilities and all new HFs contained HWs who were routinely performing all 5 key assessment tasks.
  - Furthermore, at FE the average facility performed 98% of the key assessment tasks, with only Ogur not passing, only because 1 HW did not ask about convulsions in 2/6 children observed. All other performance was acceptable, thus the 98% attainment level.

10. HW Performance (Treatment)

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Indic. #	Domain	Indicator	% HF with all elements		
			BL	MTE	FE
11 CHILD	HW Performance (Treatment)	% HF where treatment is routinely appropriate(at least 80% of the time) to the diagnosis (for encounters in which at least one of the presenting problems was fever, breathing problem, or diarrhea)	1/4	4/4	4/4

HW Performance (Treatment)

FE RESULTS OF ALL 8 HFS

Indic. #	Domain	Indicator	% HF with all elements	
			4 NEW HF	ALL 8 HF
11 CHILD	HW Performance (Treatment)	% HF where treatment is routinely appropriate(at least 80% of the time) to the diagnosis (for encounters in which at least one of the presenting problems was fever, breathing problem, or diarrhea)	4/4	8/8

- At BL, only 1/4 of the HFs (Aromo) provided treatment that was routinely appropriate to the diagnosis. A HW must diagnose and treat the sick child correctly in greater than 80% (5 or 6 out of the 6 cases observed) of the encounters observed in order for a HF to be considered as providing correct treatment.

- At FE, all 8 facilities provided correct treatment appropriate to the diagnosis.

10. HW Performance (Counseling)

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Indic. #	Domain	Indicator	% HF with all elements		
			BL	MTE	FE
12 CHILD	HW Performance (Counseling)	% HF where caretakers whose child was prescribed an antibiotic, antimalarial, or ORS, correctly describe how to administer all prescribed drugs	0/4	0/4	4/4

FE RESULTS OF ALL 8 HFS

Indic. #	Domain	Indicator	% HF with all elements	
			4 NEW HF	ALL 8 HF
12 CHILD	HW Performance (Counseling)	% HF where caretakers whose child was prescribed an antibiotic, antimalarial, or ORS, correctly describe how to administer all prescribed drugs	4/4	8/8

- AT BL, a very weak area in regards to HW performance was in the area of counseling the caretaker regarding the proper method of administering the medicines prescribed. None (0/4) of the HFs were routinely properly instructing caretakers in how to correctly administer drugs prescribed for their child.
- At MTE, despite training in IMCI, this continued to be a challenge. It was determined that the HW was instructing the caretakers too quickly, and the dispensers were not aiding the caretakers by reiterating the instructions to them. In addition, many mothers were illiterate, and the dispensers were writing the instructions on the medication bag instead of drawing pictures to illustrate the instructions. The project worked on these 3 areas to improve the communication between the HWs and the caretakers, and at FE all 8 HFs were counseling caretakers properly regarding medication directions.

OPTIONAL INDICATORS

COMPARISON OF THE 4 HF AT BL TO MTE TO FE

Area of Analysis	Indic. #	Domain	Indicator	% HF with all elements			Index Value (% avg. HF attainment)		
				BL	MTE	FE	BL	MTE	FE
INPUTS	Opt1	Availability of Immunizations	% HF with all nationally-mandated immunizations in stock on day of survey	1/4	4/4	4/4	44%	100%	100%
	Opt2	Availability of Guidelines	% HF with all nationally-mandated guidelines for care of children available and accessible on day of survey	1/4	2/4	4/4	46%	83%	100%
	Opt3	Infection Control	% HF with all infection control supplies and equipment on day of survey	0/4	0/4	1/4	68%	65%	85%
PROCESSES	Opt4	HF-Community Participation	% HF with at least one method for community participation **and** at least one way to incorporate information	3/4	4/4	4/4			
	Opt5	Community Referral	% HF that received at least one referral from CHW (VHT) in the last month	3/4	4/4	4/4			

FE RESULTS OF ALL 8 HFS

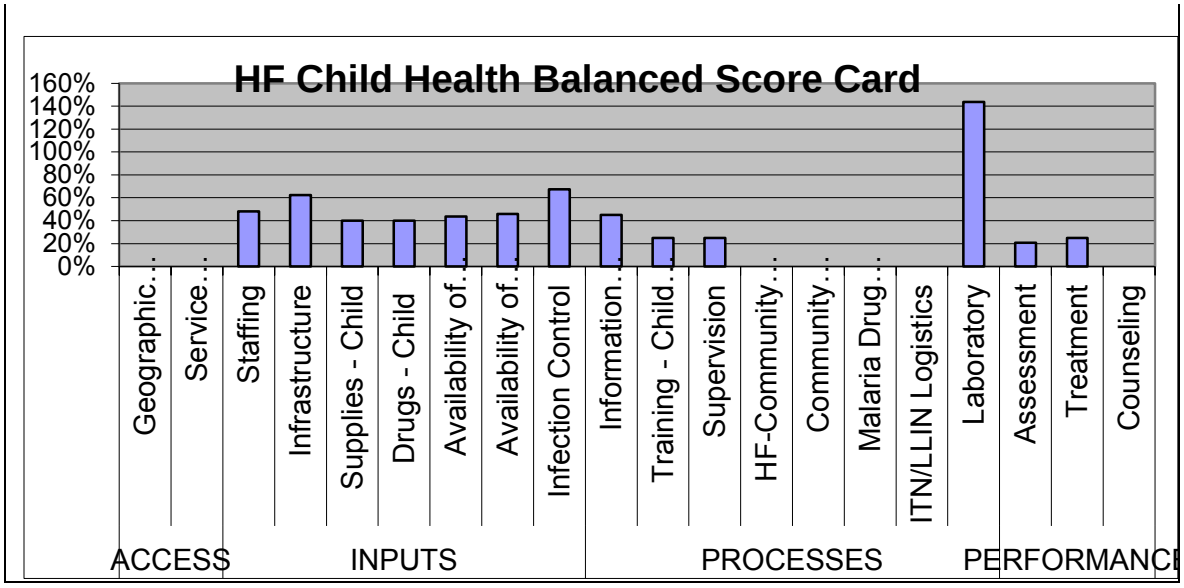
Area of Analysis	Indic. #	Domain	Indicator	% HF with all elements		Index Value (% avg. HF attainment)	
				4 new HF	ALL 8 HF	4 new HF	ALL 8 HF
INPUTS	Opt1	Availability of Immunizations	% HF with all nationally-mandated immunizations in stock on day of survey	4/4	8/8	100%	100%
	Opt2	Availability of Guidelines	% HF with all nationally-mandated guidelines for care of children available and accessible on day of survey	1/4	5/8	54%	77%
	Opt3	Infection Control	% HF with all infection control supplies and equipment on day of survey	0/4	1/8	83%	84%
PROCESSES	Opt4	HF-Community Participation	% HF with at least one method for community participation **and** at least one way to incorporate information	4/4	8/8		
	Opt5	Community Referral	% HF that received at least one referral from CHW (VHT) in the last month	4/4	8/8		

- At BL, Only 1/4 of the HFs (Amuca) had all of the required immunizations in stock (BCG, OPV, DPT, and MMR), and had all of the guidelines regarding the care of children available and accessible on the day of the survey. At FE all 8 HFs had all required immunizations and all required guidelines present on the day of the survey.
- At BL, no facilities had all of the requisite infection control supplies. This was due to the fact that no facility had an adequate infectious waste disposal area. Also, chlorine or other disinfectants were present in only 2/4 of the HFs (Ogur and Barapwo), and only 2/4 of the facilities had evidence of adequate sharps disposal and infectious waste disposal practices (Aromo and Amuca). In addition, Ogur did not have gloves or needles present, and Aromo did not have syringes available. At FE this continued, with only 1 original HF (Aromo) having the requisite infection control supplies because it was the only facility having an adequate infectious waste disposal areas and evidence of adequate infectious waste disposal practices.
- At baseline, 3/4 of the facilities (Ogur, Aromo, and Amuca) had the combination of at least 1 method for community participation and at least one way to incorporate community information. At FE this had improved to all 8 facilities.
- At BL, 3/4 (Ogur, Aromo, and Barapwo) of the HFs reported that they had received at least one referral from VHTs in the last month. At FE this had improved to all 8 of the HFs.

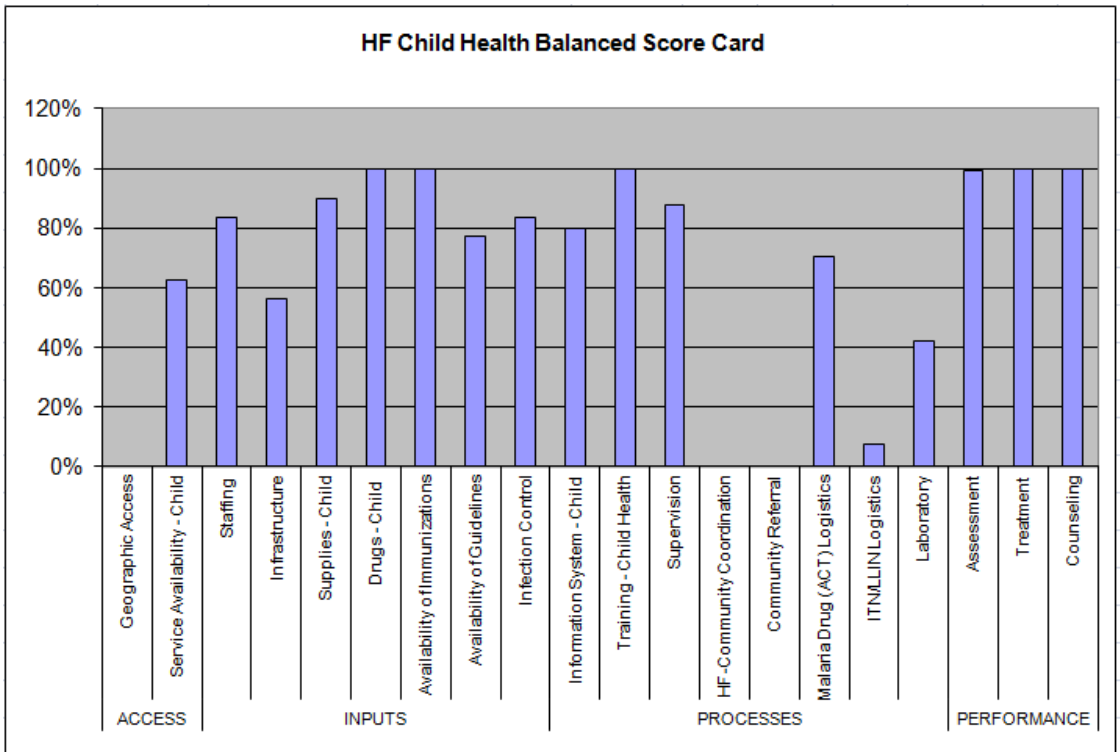
CHAPTER 4

Conclusions/Summary

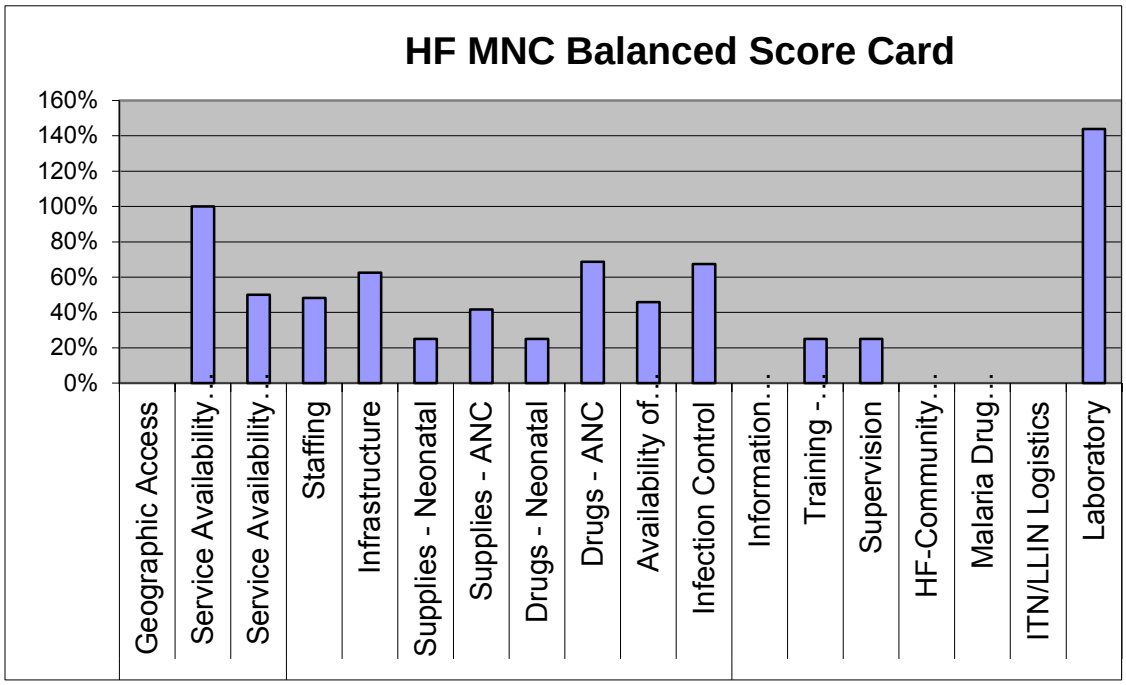
BASELINE



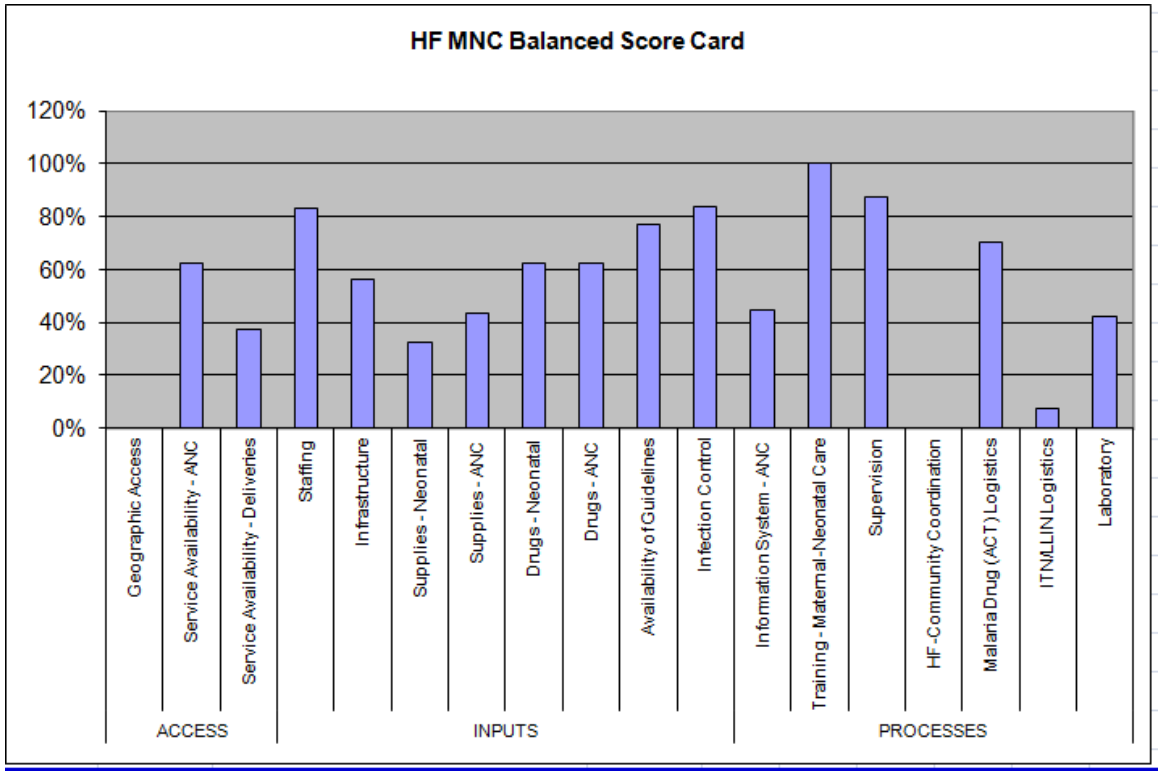
FE



BASELINE


HF MNC Balanced Score Card
160%
140%
120%
100%
80%
60%
40%
20%
0%
Geographic Access
Service Availability…
Service Availability…
Staffing
Infrastructure
Supplies - Neonatal
Supplies - ANC
Drugs - Neonatal
Drugs - ANC
Availability of…
Infection Control
Information…
Training -…
Supervision
HF-Community…
Malaria Drug…
ITN/LLIN Logistics
Laboratory

FE


HF MNC Balanced Score Card
120%
100%
80%
60%
40%
20%
0%
Geographic Access
Service Availability - ANC
Service Availability - Deliveries
Staffing
Infrastructure
Supplies - Neonatal
Supplies - ANC
Drugs - Neonatal
Drugs - ANC
Availability of Guidelines
Infection Control
Information System - ANC
Training - Maternal-Neonatal Care
Supervision
HF-Community Coordination
Malaria Drug (ACT) Logistics
ITN/LLIN Logistics
Laboratory
ACCESS
INPUTS
PROCESSES

The following is a summary and discussion of each of the 12 core indicators, along with a comparison to BL. The graphs above provide a visual summary of each of these areas, with a comparison of BL to MT.

ACCESS (INPUTS)

1. **Service Availability:**

At baseline, 0/4 of the HFs offered all 3 basic child health services

- This was due to the fact that no facilities saw patients 30 days per month (including outreach). However, all of the facilities provided sick child services at a minimum of Monday-Friday, for a total of 20 hours per week
- At FE, 3/4 of the original HFs, all except Barapwo, offered child health services (HS) 30 days per month (including outreach), and 5/8 of the total HFs provided HS 30 days per month. In addition to Barapwo, Akangi and Walela did not provide HS 30 days per month.
- Growth Monitoring:
    - At BL only 2 of the 4 HFs (Ogur and Amuca) offered growth monitoring.
    - At FE, all 8 HFs offered GM. At MTE it was discovered that mothers did not bring their health cards to the other facilities so they were not able to be checked. Activities were put in place at all HFs to encourage all mothers to bring their children's health card with them to every visit. As part of the IMCI protocol, growth monitoring was introduced to all HFs so that all HFs provided growth monitoring services in the facility and/or through outreach.
- Immunization:
    - At baseline all 4 HFs offered immunization services through the facility and/or outreach.
    - At FE all 8 HFs offer immunization services
- ANC Services:
    - At baseline and MTE all HFs in Lira District offered ANC services, and at final all the original HFs still offered ANC. Of the 4 new HFs, only Abala offered ANC.
- Delivery Services:
    - At FE, Barapwo, of the original HFs, and each of the new HFs did not provide delivery services. In 2008, Barapwo was upgraded from a level 2 facility to a level 3 facility and therefore had no maternity unit, and the new facilities are all level 2 and therefore had no maternity unit.

2. **Staffing**:

This indicator has been changed from the original RHFA staffing indicator, which was: "% of HFs with at least one provider meeting the country definition as qualified to provide curative care for children is present on day of survey". All HFs would have met the old indicator, both at BL and MTE, because at least one qualified

provider was present at each facility. However, the new indicator determines the number of each type of staff, and determines if they are all present on the day of the survey.

- Therefore, at BL, 0/4 of the HFs met this requirement, with the average HF attainment at 48% (meaning the average HF had 48% of its qualified staff present).
- At FE 1/4 (Amuca) of the original HFs had all staff present, and all of the new facilities had all staff present, for a total of 5/8 HFs.

The project worked with the DHO to continue to improve staff attendance since MTE so that treatment of patients could be as effective as possible and refresher training in IMCI was as effective as possible by ensuring that all HW treating patients were present to benefit from project follow-up mentoring and supportive supervision activities after IMCI topic training is provided.

3. **Infrastructure:**

- At BL, all essential health infrastructure was present on the day of the survey in only 1/4 of the HFs (Ogur), with the average HF attainment at 63%.
  - The limiting factors were: emergency transportation, which was not available in any of the HFs, an improved, protected water source, which was only available in 2/4 of the HFs (Ogur and Amuca), and auditory and visual privacy, which was also only available in 2/4 of the HFs (Ogur and Aromo).
  - However, there was 24 hour staff coverage in 3/4 of the original HFs (Aromo, Barapwo, and Ogur).
  - However, 3/4 of the HFs had electricity from the grid or a generator with fuel and functioning emergency communication (Aromo, Barapwo, and Ogur).
  - All of the HFs had a useable client latrine.
- At FE, all essential health infrastructure was present on the day of the survey in all 4 of the original HFs and all 4 of the new HFs as well.
  - All 8 facilities had water from a protected water source and auditory and visual privacy (both up from 2/4 at BL).
  - Also, 24 hour staff coverage was available in 3/4 of the original HFs and only 1 of the new facilities (Walela)
  - However, electricity from the grid or a generator with fuel was down from 3/4 at BL (all HFs except Aromo), to only 1/8 at FE (Amuca).

4. **Supplies**:
   a. **Supplies – Child:**

- At BL only 1/4 of HFs (Barapwo) had all of the essential supplies to support child health, and the average HF attainment was 40% of these essential supplies.

        - ORS pitchers and spoons were only available in Barapwo, and scales and timers were available in only 2/4 (Barapwo and Amuca) of the facilities.
    - At FE 3/4 of the original HFs (Aromo, Barapwo, and Ogur) and 3/4 new HFs (all but Abala) had all of the essential supplies to support child health, and the average HF attainment was 90% of these essential supplies.

b. **Supplies-MNC:**

- At BL, none (0/4) of the HFs had all of the essential supplies to support maternal-newborn health available and the average HF attainment was only 25% of these essential supplies.
    - None of the facilities had neonatal resuscitation equipment, functioning vacuum extractors, or neonatal wraps for warming.
    - Only 2/4 of facilities (Aromo and Amuca) had partographs.
- At FE, only Amuca (1/4) of the original HFs had all of the essential supplies to support maternal-newborn health available and the average HF attainment was at only 65% for these essential supplies. Also, none of the new HFs had all essential MNC supplies, for a total of only 1/8 HFs and only a 13% average HF attainment.
    - Aromo, Amuca, and Ogur had neonatal resuscitation equipment and infant scales.
    - Only Amuca had functioning vacuum extractors or neonatal wraps for warming.
    - All 4 of the original HFs had functioning partographs, and none of the new HFs had functioning partographs, for a total of 4/8.

c. **Supplies-ANC:**

- At BL 0/4 of the HFs had all of the essential supplies to support antenatal care.
    - No facilities had albumin test strips, and only 1/4 of the HFs (Aromo) had syphilis testing kits and hemoglobin testing kits available.
    - Also, malaria test kits (Aromo and Amuca), blood pressure equipment (Ogur and Aromo), and syphilis testing kits were available in only 2/4 (Aromo and Amuca) of the facilities.
    - All HFs other than Barapwo had tetanus toxoid available.
- At FE none of the HFs had all of the essential supplies to support antenatal care, with a 75% attainment at the original HFs and only a 44% attainment at all 8 HFs.
    - Only Aromo and Ogur had hemoglobin testing reagents or malaria test kits.
    - Ogur had all equipment except functional BP equipment.

5. **Drugs**:

a. **Child**:

- At baseline, 1/4 of HFs (Amuca) had all first line medications available, which is defined as: ORS, a first line oral antibiotic for pneumonia, a first line drug for dysentery, a first line antimalarial, and Vitamin A.
    - This is due to the fact that while 1/4 of facilities had first line drugs for pneumonia (Barapwo) and 50 % of HFs had Vitamin A (Aromo and Amuca), only 1/4 of HFs (Amuca) had first line medications also available for malaria and dysentery.
- At FE, all HFs had all first line medications available, the average HF attainment rose from 40% to 100%

b. **MNC**:

- At BL, none of the HFs had all of the essential delivery and neonatal drugs present on the day of the survey. In fact, all 3 essential MNC drugs were available in only 1 out of the four HFs each (antibiotics-Amuca; neonatal eye ointment-Ogur; and Oxytocin-Ogur).
- At FE 3/4 of the original HFs had all of the essential delivery and neonatal drugs present on the day of the survey, with a 92% attainment rate. Only Ogur did not have eye ointment. None of the new HFs had MNC drugs as they are not performing deliveries and are level 2 HFs.

c. ANC:

- At BL, only 2/4 HFs had all of the ANC drugs present on the day of the survey. Barapwo was missing 3 of the 4 drugs (Tetanus toxoid, Iron, and ITNs). Amuca was missing antimalarials. Only half of the HFs had ITNs (Aromo and Amuca).
- At FE, none of the HFs had all the essential ANC drugs, because there were no ITNs available at any HF. Three out of 4 of the original HFs had all other ANC drugs, with Aromo only missing Iron. Three out of 4 of the new HFs had all other drugs, with Apuce missing Tetanus toxoid, Iron, and Fansidar for IPT.

PROCESSES

6. **Information Systems**

a. **Child:**

- At BL, none of the HFs maintained up to date records on sick children under 5 years of age, or up-to-date monthly service data.

- The average facility had only 25% of the elements required for having up-to-date records and monthly service data.
- Ogur performed best with 80% of the elements in place.
- Aromo and Barapwo HFs did not have any of the elements in place, while Amuca had only 20% of the elements in place.
- Barapwo and Amuca used the data to create a wall chart, and Barapwo used the data to create a graph and in discussions, but the other HFs did not use the data at all.

- At FE, still 0/4 of the original HFs and also 0/4 of the new HFs maintained up to date records on sick children under 5 years of age, or up-to-date monthly service data.
    - However, at FE each facility had 80% of the elements required for having up-to-date records and monthly service data, up from 25% at BL.
    - All facilities (8/8) had complete information in the sick child register, but no HF was using the monthly service data (MSR) which, therefore, is the limiting factor.

b. **ANC:**

- At BL, 2/4 HFs (Aromo and Amuca) had up to date records on antenatal care. Aromo and Amuca had all of the elements in place, and Ogur had 2/4 of the elements in place, while Barapwo had none of the elements in place.
- At FE, all original HFs had up to date records on antenatal care. Amuca was missing BP information, and Barapwo did not have the delivery register up to date. Of the new HFs, none had delivery information as they do not perform deliveries, and only Abala had an ANC register with complete information.

7. **Training:**
    - At BL. only1/4 of the HFs (Ogur) had HWs who reported receiving in-service or pre-service training in both maternal neonatal care and child health in the last 12 months. Training in MNC consists of: training in MNC and at least one other of the trainings listed above in the MNC section. Training in child health consists of: training in Child Health and at least one other of the trainings listed above in the child health section. Ogur received training in diarrhea case management, nutrition, and IPT use.
    - At FE, all of the original and new HFs had HWs who reported receiving in-service or pre-service training in both maternal neonatal care and child health within the last 12 months. The various trainings are broken down in the above table. The child health trainings in pneumonia, diarrhea, malaria, ACT, ITN, BF, and IMCI were not received in Abala HF, and Abala and Apuce did not receive nutrition training.

8. **Supervision**:

- At BL, only 1/4 of the HFs (Ogur) received any type of external supervision at least once in the 3 months prior to the survey. During this visit, the supervisor observed work in the HF, discussed problems, and checked drug supplies.
- At FE, all 4 original HFs and 3/4 new HFs received supervision (Abala did not).

PERFORMANCE

9. **Utilization of Curative services**: The percentage of HF with > 1 sick child encounters per child under the age of 5 in Lira District was not able to be calculated, because no facilities had complete sick child registries available at the time of survey.

10. **HW Performance** (**Assessment):**

In order for a HF to be considered as having key assessment tasks routinely performed, in greater than 80% (5 or 6 out of the 6 cases observed) of the encounters the HW must perform all of the key assessment tasks.

- The baseline found that no facilities (0/4) contained HWs who were routinely performing all 5 key assessment tasks.
    - Furthermore, the average facility was performing only 21% of the key assessment tasks.
    - Ogur performed best by performing 63% of the assessment tasks, followed by Barapwo, which performed 21% of their assessment tasks. Aromo and Amuca performed the worst, performing only 4% and 8% of their assessment tasks, respectively.
    - Assessment tasks which were assessed most frequently were: the ability to feed or breastfeed, asking if the child had been vomiting everything, and checking for the presence of convulsions, which were each asked 29% of the time.
    - Assessment tasks which were assessed least frequently were: checking the nutritional status and checking for immunizations on the child health card, which were each performed only 4% of the time.
- At FE, 3/4 original facilities and all new HFs contained HWs who were routinely performing all 5 key assessment tasks.
    - Furthermore, at FE the average facility performed 98% of the key assessment tasks, with only Ogur not passing, only because 1 HW did not ask about convulsions in 2/6 children observed. All other performance was acceptable, thus the 98% attainment level.

11. **HW Performance** (**Treatment):**

12. At BL, only 1/4 of the HFs (Aromo) provided treatment that was routinely appropriate to the diagnosis. A HW must diagnose and treat the sick child correctly in greater than 80% (5 or 6 out of the 6 cases observed) of the encounters observed in order for a HF to be considered as providing correct treatment.

13. At FE, all 8 facilities provided correct treatment appropriate to the diagnosis.

14. **HW Performance (Counseling):**
    15. AT BL, a very weak area in regards to HW performance was in the area of counseling the caretaker regarding the proper method of administering the medicines prescribed. None (0/4) of the HFs were routinely properly instructing caretakers in how to correctly administer drugs prescribed for their child.
    16. At MTE, despite training in IMCI, this continued to be a challenge. It was determined that the HW was instructing the caretakers too quickly, and the dispensers were not aiding the caretakers by reiterating the instructions to them. In addition, many mothers were illiterate, and the dispensers were writing the instructions on the medication bag instead of drawing pictures to illustrate the instructions. The project worked on these 3 areas to improve the communication between the HWs and the caretakers, and at FE all 8 HFs were counseling caretakers properly regarding medication directions.

ANNEX X B DATA COLLECTION INSTRUMENTS

FOCUS GROUP QUESTIONNAIRES

Guide for Interviews with Beneficiaries
(Mothers and fathers with children younger than 5 years)

Date: _____ Interviewer: _____
Nino dwe Apeny apeny
Community: _____ Sub-County: _____
Wang tic Gomola
Number of Women/Men: W____/ M___
Wel mon/ coo M C

1. **What activities have you participated in with VHTs and mothers groups?**
   Kodi tic ango ame ibedo wunu iye karacel kede VHT kede gurup a toto?

Receive home visits	
Attended community education sessions by VHT Pwonyere me yot kom me kin paco ame VHT oyubu	
Referrals to health facility by VHT Nwongo balo me wot idakatal ibot VHT	
Any other contact with VHT Kit rwate okene kede VHT?	

2. **Does anyone have an example of how the VHT and mothers groups helped this community?**
   Nyo ngatoro tye kede apor ikom kit ame VHT kede group a toto okonyo kede jo me kan?

_____
_____

3. **What have you learned from the VHTs or mothers group in the community about how to have a healthy pregnancy? Have you tried any of the practices discussed?**

Ngo ame VHT kede opwonye amon me kin paco opwonyo wu kede akwako kite me bedo kede yotkom ikare me yac?Kong itemo keto itic ngo ame opwonyo?

_____
_____

4. **What have you learned about taking care of newborns? Have you tried any of the practices discussed?**
   Ngo ame opwonyowu kede ite nyango akwako gwoko otino ame pwod onywalo anywala?Kong itemo keto itic ngo ame opwonyo?

_____
_____

5. **What new information about feeding infants and young children have you learned? Have you tried any of the practices discussed?**
   Ngec ango anyen akwako pito otino ame inwongo?Kong itemo keto moro kiken itic kit ame opwonyi kede?

_____
_____

6. **How do you know if a child is not growing well?**
   Ingeo ningo ka atin pet ye adongo aber?

_____
_____

7. **Why do some children not grow well? What do children who are not growing well need?**
   Pingo otino okene pe dongo aber? Ngo ame otino ame pet ye adongo aber mito?

_____
_____

8. **If your child has diarrhea what do you do?**

What signs do you look for to know you need to go the health center? Anyutene ame ineno me miyi ngeyo ni myero iter atin idakatal?	
Continue breast feeding, and maintain or increase feeding. Mede kede doto atin, kede mede kede mie cem aromaroma onyo adit akato	
Treat with ORS/ increase fluids. Mie yat kadukadu ame orubu kede pii/mie gin amata adit	
Other (En okene?)	

9. **How can you prevent diarrhea?**
   Yore ango ame itwero gengo kede two cado?

_____
_____
_____

10. **If your child has a cough or difficulty breathing what do you do?**
    Ka atini tye kede aola nyo peko iweo mere,myero itim ngo?

Early recognition of danger signs Neno con anyut areco ame aola kelo ikom atin	
Appropriate careseeking Moyo kony me dakatal con	
Other En okene	

11. **How can you prevent coughs and difficulty breathing?**
    Yore ango ame iromo gengo kede two aola kede peko me weo atin?

_____
_____

12. **Think of the way the community was four years ago, are there any health practices that are different now?**

Nen kong imwaki angwen okato angec,nyo tye alokaloka amako yotkom ikin paci

_____

_____

13. **Over the past four years, have there been changes in the quality of health care at the Health Centers**

If there were improvements, what were they? If things are worse, why is that so? Why do you think the changes happened?

Ikare me mwaki angwen ame okato angec,kite me miyo kony me yot kom omede malo idakatal? Ka ee, ngo aber ame rwomere omede? Ka pe,pingo? Itamo ni alokaloka ni otimere pingo?

_____

_____

_____

14. **In this community, do you think families are caring for their children differently than they were 4 years ago? In what ways?**
Why?
Iwangtici, wun itamo ni onywal dong tye agwoko otinogi aber ikato imwaki angwen ame okato angec?Iyore mene? Kede pingo?

_____

_____

_____

15. **Do you think those changes will continue after the Project ends?**
Itamo ni alokaloka ni bino mede ameda kadi bedi project ogik?
Why? Pingo?

_____

_____

_____

---

16. **Now that the Child Survival Project is ending, do you think the changes in the community and at the health facility will continue?**

Aman ame dong project tye akik oko ni, itamo ni alokaloka aber ni bino mede ameda i kin paci kede i dakatal?

How will they continue?Iyore mene ame gin bino mede kede?

_____

_____

What problems will make that difficult?

Kit peki ango ame twero mio mede kede tic bedo atek?

_____

_____

How could those problems be resolved?

Kite ango ame kodi peki no twero cobere kede?

_____

_____

Guide for Interviews with Beneficiaries who received lessons on ECD (Mothers and fathers with children younger than 5 years)

Date: _____ Interviewer: _____
Nino dwe Apeny apeny
Community: _____ Sub-County: _____
Wangtic Gomola
Number of Women/Men: W____/ M___
Wel mon/coo M C

Remind the parents of the meaning of "ECD" – ECD stands for early childhood development, today we are referring to it as a set of caregiver actions and behaviors that support a child's first years of development, including feeding, clothing, helping the child learn to speak and learn about the world, seeking health care, providing love, among many other actions.
For and Ogur, do you remember attending ECD lessions?
Questions for Focus Groups

1. **What was the most useful thing you learned from the ECD lessons?**
Ngo apire tek ame inwongo i pwonyere anyen ikite me gwoko otino?

_____
_____

2. **Is there a difference in how you spend time with your child now compared to how you did before you attended ECD lessons? If yes, explain/describe.**
Nyo tye alokaloka moro ikite ame ibedo kede atini ikareni ka iporo kede ikare ame pwod pe opwonyi kede yore anyen me gwoko otino. Ka ee kong imi apor.

_____
_____

3. **Are the children responding differently to you now, e.g. after you attended the ECD lessons? If yes, explain/describe**.
Nyo itamo ni Otino ni dong aman winyi, ka iporo kede kare ame pwod pe inwongo kede pwony anyen ikite me gwoko gi?Ka ee, kop kit ame gin winyi kede?

_____
_____

4. **Have you implemented any changes in hygiene, nutrition or sanitation after you attended the ECD lessons? If yes, explain/describe.**
Nyo Iketo itic pwony anyen ame ibin inwongo akwako cilo me kom,kede kite me gwoko ka konyere aber iyonge nwongo pwonyere me yore anyen ikite me gwoko otino?Ka ee kobi

_____
_____

5. **How do you discipline your child ? Has this always been how you have disciplined? If it changed, why?**
Kite ango ame ipwonyo kede atin ka otimo bal ?Kit ame didik onwongo ipwonyo kede eno? Ka alokaloka tye iye ,pingo?

_____
_____

6. **Is there ever violence between you and your husband, such as hitting, smacking or pushing? Has this always been how you have interacted? If it changed, why?**
Anaka ni kong gero moro obedo ikin yin kede cwari,calo goyi, dongi, onyo cori? Kit ame didik wun ubedo kede eno?Ka alokaloka tye iye pingo?

_____

_____

7. **Have you noticed any changes in your child's health, growth or development after you attended the ECD lessons? If yes, what changes?**
   Nyo ineno alokaloka ikom atini iyore me dong, nyo kite me nyang piny iyonge yin inwongo pwonyere anyen ikite me gwoke? Ka ee,alokaloka ango?

_____
_____

8. **Is there anything else you wish to share?**
Onyo tyen cadenoro ame imito miyo wunu?

_____
_____

Guide for Interviews with Village Health Teams

Date: _____ Interviewer:_____
Nino dwe Apeny apeny
Community: _____ Sub-County: _____
Wangtic Gomola
Number of VHTs: Men ___ Women ___
Wel a VHT Coo Mon

1. **Intro: Why did you volunteer to work as a VHT? What have been the challenges?**
   Acaki me apeny; Pingo idyere me tic acalo atic me yot kom me kin paco? Peki mene ame inwongo wunu alubere kede ticwu?

_____
_____

2. **What topics did the trainings cover? Did you receive any refresher training? What topics did you received?**
   Ikin kare mene ame inwongo wunu kede pwonyere? Kit pwonyere mene me yot ame inwongo wunu?

Topics: Wipwony_____
_____

How often: Kare ame powonyo kede _____
Who provided the training_____
Nga ame opwonyowu?

3. **have you ever received any support from community leaders?**
   Kodi kony ango ame inwongo ibot otela wu?
   If yes, what support have you received?

_____
_____
_____

4. **What support have you received through visits from MTI staff? From the health staff or health assistants?**
   Kodi kony ango ame inwongo wunu ka otic me medical team olimo wu? Aya ibot dakatal nyo dakatal me cil paco?

	Frequency Tyen adii	What is done Ngo ame otimere?
MTI staff **Otic me medical team**		
Health facility staff **Otic me dakatal**		

5. **Have you seen changes in the communtiy as a result of your work?**

Nyo ineno alokaloka iwangtici kan, alubere kede tici?

Care practices during pregnancy Kite me gwokere ikare me yac	
Care of newborns Gwoko atin ame pwod onywalo anywala	
Feeding infants and young children Doto kede pito otino	
Preventing diarrhea and respiratory infections Gengo cado kede aola	
Caring for children with diarrhea and respiratory infections Gwoko atin atye acado kede two aola	

6. **What have been the most difficult family health practices to change?**
   Kodi tim me yot kom mene ame inwongo tek me loko ikin paci?

_____
_____
_____

7. **Do you have any success stories about improving the health care or nutrition of children in your community?**
   Nyo iye kede cadennoro aber akwako kite me rwom me yot kom kede pito otino oyito kede malo iwang tic wu ni?

_____
_____
_____

8. **Now that the Child Survival Project is ending, will you continue to work in your community? What activities will you continue to carry out? Who will support you?**
   Aman adong kony me project otum oko ni, pwod ibino mede kede tic iwang tici? Kodi ticene ame ibino mede kede? Nga ame bino konyo kuru wu iye?

_____
_____

Are there some activitries you will not be able to continue?
Kodi ticene ame itamu ni pe ibno twero mede kede?

_____
_____

Which ones? Why?
Ticene? Pingo?

_____
_____

Guide for Interviews with Village Health Teams & Peer Educators Who facilitated ECD lessons

Date: _____ Interviewer:_____
Nino dwe Apeny apeny
Community: _____ Sub-County: _____
Wang tic Gomola
Number of VHTs: Men ___ Women ___
Wel VHT Coo Mon
Number of PEs: Men ___ Women ___
Wel PEs Coo Mon

Questions:
Apeny

1. **Did you notice changes in caregiver's knowledge, attitudes or behaviors during the course of ECD lessons? If yes, please describe with some examples.**
   Nyo Ineno alokaloka ingec,tam kede kwo a jo a gwoko otino ikare ame ipwonyo gi kede yore anyen me gwoko otino? Ka ee, kong ikobiwa kede apor.

_____
_____
_____

Have you noticed changes in caregiver's attitudes or behaviors that have persisted since the ECD trainings? If yes, please describe some examples.
Nyo ineno alokloka me cuny kede kite me kwo ogwok otino ame pe olokere cakere ame opwonyogi?Ka eek kob kede apor

_____
_____

2. **Are there unhealthy attitudes or practices that have not changed? If so, what are these attitudes and practices and why do you think this is?**
   Nyo tye kit cuny nyo tim areco akwako yotkom ame pe olokere? Ka tye kodi cuny kede tic areco mene ame pe olokere kede itamo ni pingo pe olokere?

_____
_____
_____

-

3. **Have you personally made changes in your attitudes or behaviors because of your involvement with the ECD lessons? If yes, please describe.**
   Yin dang ikelo alokaloka itami kede ikwo ni pi bedoacalo apwony me yore anyen me gwoko otino? Ka ee kobi
   ---
   ---
4. **In regards to seeking health care when they notice IMCI danger signs, are caregivers now:**
   Akwako kite me yenyo kony me yot kom ka onywal oneno anyut arecu ikareni:
   Onywal bunyu tero atin, onyo ri kede tero atin, onyo pe tero atin.
   - **more likely _____(# who agree with this)**
   - **less likely _____(# who agree with this)**
   - **or have not changed _____(# who agree with this)**

   in their practices of seeking health care for their child?

_____
_____
_____

5. **If they are now "more likely" or "less likely" to seek health care for their child, what do you attribute the changes to?**

Ka gin dong aman otwero bunyere me moyo kony me yotkom otino gi idakatal, ngo ame itamo ni mio gin obunyere me moyo kony pi otino gi **?**

_____
_____

7. Is there anything else you would like to share?

Nyo itye kede cadenoro onyo tamoro ame itwero nywako kedwa?

_____
_____
_____

Guide for Interviews with Mother Group Leaders

Date: _____ **Interviewer: _____**
Nino dwe **Apeny apeny**
Community: _____ Sub-County: _____
Wangtic **Gombolola**
Number of Women Interviewed: _____
Wel mon ame openyo

1. **Why did you choose to work as a Mothers Group Leader? What have been the challenges?**
   Pingo idyere me bedo acalo atela atoto me pwonyo kop me yot kom ikin paco? Peki mene ame inwongo alubere kede dyere wu?

   _____
   _____

2. **What kind of health training did you receive over the past year as a Mothers Group Leader?**
   Kodi pwonyere mene me yot kom ame ibin inwongo wunu i mwaka okato angec acalo toto odyere me pwony ikin pacu?

   _____
   _____

3. **Did you receive any refresher training? If yes what topics?**

   ---

4. **Have you ever received support from community leaders? If so what support?**

   ---

5. **How have you shared health messages with the community?**
   Kit yore ango ame wun olalo kede ngec me yot kom ikin paci?

   ---**Have you seen changes in the communtiy over the past year and a half?**
   Nyo ineno wunu kit alokaloka moro aber akwako gwok me yotkom i akina pacu iyi mwaka acel kede nucu ame okato angec?

Care practices during pregnancy Kite me gwokere ikare me yac	
Care of newborns Gwoko atin ame pwod onywalo anywala	
Feeding infants and young children Doto kede pito atin	
Preventing diarrhea and respiratory infections	

Kite me gengo cado kede two aola	
Caring for children with diarrhea and respiratory infections Kite me gwoko otino ame tye kede two cado kede aola	

6. **What have been the most difficult family health practices to change?**
   Kodi tim me yotkom ango ame dong inwongo wunu loko obedo atek totwal ikin paco?
   _____
   _____

7. **Do you have any success stories about improving the health care or nutrition of children in your community?**
   Nyo itye kede cadenoro aber ame iromo mio akwako yore me dongo rwom me yotkom kede pit aber pi otino ikin pacu?
   _____
   _____

8. **Now that the Child Survival Project is ending, will you continue to work in your community? What activities will you continue to carry out? Who will support you?**
   Aman a dong projek agik oko ni,ibino wunu mede kede tic wu Iyi akina paco? Kodi ticene ame ibino mede kede tiyo? Itamo ni nga ame bino konyo korwu iye?

   Are there some activitries you will not be able to continue?
   Nyo tye tic mogo ame pe ibino romo tiyo wunu?
   _____
   _____

   Which ones? Why?
   Ticene kede pingo?
   _____

Guide for Interviews with Health Unit Staff

Health Facility:_____**Sub-County:**_____

Date: _____ **Interviewer:**_____

Staff Name:_____ **Position:**_____

Male (#) ____Female (#)_____Time in position at this health facility:_____

1. What was your greatest success at the health facility this last year?

_____

2. Pease tell us about the training you received through MTI CSP or any other source. What was good about the training and what could be improved?

Type of Training	Date of Training	Training Leader	Strengths of Training	Suggested Areas for Improvement

Have you received any refresher training? If yes what topics?

---

3. Are there positive changes in your work at this health unit due to MTI CSP project activities?

---

4. What have been your greatest challenges at the health facility this last year?

---

5. What are additional skills and capacities the facility still needs to implement quality maternal, newborn and child health services?

   Do you work with VHTs or MLGs? If yes, in what way?

_____

_____

6. What is your opinion of the work done by the VHTs and Mothers Groups in their communities?

_____

7. Have you seen any positive changes in health and nutrition practices by families that you think are due to the work of the VHTs and Mothers Groups?

_____

_____

8. Do VHTs refer patients to your health unit? Are these referrals appropriate? Can you describe a specific instance?

_____
_____
_____

9. Has your health facility received a supportive supervision visit during the past three months? If yes, by whom?

_____
_____

10. Has the HUMC supported your facility within the past year? Can you give specific instances of how they have or have not supported you?

---

11. Now that the Child Survival Project is ending, will the improvements continue? How?

_____

Guide for Interviews with PDCS

Health Facility:_____**Sub-County:**_____
Dakatal **Gombolola**
Date: _____ **Interviewer:**_____
Nino dwe **Apeny apeny**
Number of members interviewed and their positions:
Wel jo ame openyo kede rwom gi

---

1. What have you accomplished as the PDCs during the past four years?
   Ngo ame ityeko tiyo wunu aber a calo iryonget ame loo dakatal iyi mwaki angwen okato angec?

_____

_____

2. Have you received support from MTI staff? If so, what kind of support?
   Nyo Ibin inwongo wunu kony i bot otic me medical teams? Ka Ee, kodi konyene?

Is there support you did not receive that would have been helpful? If so, what kind of support?
Nyo tye kit konyoro ame pe ibin inwongo wunu ibot medical team ame itamuwunu ni onwongo romo bedo me kony totwal botwu? Ka ee, kodi konyene

3. Has the PDCs collaborated with the HUMCs to improve services? In what ways?
   Nyo iryonget wu ni obin okubere kede dakatal pi medo rwom me kony me yot kom idakatal kane? Iyore mene?

_____

_____

4. What is your opinion of the work done by the VHTs in their communities?
   Tamwu tye ni ngo alubere kede tica VHT ikin paci?

---

5. Do you support the VHTs in their work? (Yes or No) _____
   Ikonyo wunu kor VHT me tiyo tic gi?
   If yes, how do you support them? _____
   Ka ee ,I ikonyo kor gi iyore mene?
   If no, how could you support them?
   Ka pe, yore mene ame onwonongo myero ikony kor gi kede?
   _____

6. Have you seen any changes in health and nutrition practices by families that you think are due to the work of the VHTs? If so, what changes?
   Nyo ineno wunu alokaloka moro itim me yotkom kede kite me pit aber Iyi akina paci, ame itamo wunu ni obedo adwogi me tic aber a VHT? Ka ee, alokaloka mene

---

---

7. What is your opinion of the work of Mothers Groups?
   Wun Itamo ningo ikom tic a toto ame odyere me pwony ikin paci?

---

8. Do you support the Mothers Groups in their work? (Yes or No)
   Nyo ikonyo wunu kor toto ame odyere me pwony I akina pacu? (ee nyo pe)
   If yes, how do you support them?
   Ka ee iyore mene ame ikonyo kor gi **kede?**

   If no, how could you support them?
   Ka pe, yore mene ame iromo konyo kor gi kede?

Have the health services in parish changed in the last four years?
Onyo ineno alokaloka aber me yot kom I parish wu ni iyi akina mwaki angwen okato ni?

---

9. What is your PDC planning to do in this next year?
   Ngo ame iryonget wuni tye ayikere me timo imwaka abinoni?

How will you make those things happen?
Ibino keto wunu yika wu ni itic ningo?

What obstacles will you face?
Peki mene ame itamo wunu ni ibino rwate wunu kede?_

How will you solve those problems?
Kite ango ame ibino cobo wunu ked peki no?

How do you see the PDC working with the VHTs and Mother lead groups now that the project is ending?

Guide for Interviews with Health Unit Management Committees

Health Facility:_____**Sub-County:**_____
Dakatal **Gomola**
Date: _____ **Interviewer:**_____
Nino dwe **Apeny apeny**
Number of members interviewed and their positions:
Wel jo ame openyo kede rwom gi

1. What have you accomplished as the HUMC during the past four years?
   Ngo ame ityeko tiyo wunu aber a calo iryonget ame loo dakatal iyi mwaki angwen okato angec?

_____
_____

2. Have you received support from MTI staff? If so, what kind of support?
   Nyo Ibin inwongo wunu kony i bot otic me medical teams? Ka Ee, kodi konyene?

_____

Is there support you did not receive that would have been helpful? If so, what kind of support?
Nyo tye kit konyoro ame pe ibin inwongo wunu ibot medical team ame itamuwunu ni onwongo romo bedo me kony totwal botwu? Ka ee, kodi konyene

_____
---

3. Has the HUMC collaborated with the health facility to improve services? In what ways?
   Nyo iryonget wu ni obin okubere kede dakatal pi medo rwom me kony me yot kom idakatal kane? Iyore mene?

_____
_____

4. What is your opinion of the work done by the VHTs in their communities?
   Tamwu tye ni ngo alubere kede tica VHT ikin paci?

_____
---

5. Do you support the VHTs in their work? (Yes or No) _____
   Ikonyo wunu kor VHT me tiyo tic gi?
   If yes, how do you support them? _____
   Ka ee ,I ikonyo kor gi iyore mene?
   If no, how could you support them?
   Ka pe, yore mene ame onwonongo myero ikony kor gi kede?

_____
---

6. Have you seen any changes in health and nutrition practices by families that you think are due to the work of the VHTs? If so, what changes?
   Nyo ineno wunu alokaloka moro itim me yotkom kede kite me pit aber Iyi akina paci, ame itamo wunu ni obedo adwogi me tic aber a VHT? Ka ee, alokaloka mene

_____
---

7. What is your opinion of the work of Mothers Groups?
   Wun Itamo ningo ikom tic a toto ame odyere me pwony ikin paci?

_____
---

8. Do you support the Mothers Groups in their work? (Yes or No)
   Nyo ikonyo wunu kor toto ame odyere me pwony I akina pacu? (ee nyo pe)
   If yes, how do you support them?
   Ka ee iyore mene ame ikonyo kor gi **kede?**

   If no, how could you support them?
   Ka pe, yore mene ame iromo konyo kor gi kede?

_____

---

9. Have the services at this Health Center changed in the past 4 years?
   Nyo alokaloka moro me kony me yotkom onen I dakatal Ikine me mwaki mwaki angwen okato angec
   In what ways? **Iyore mene?**

   _____
   Why do you think they changed**? Itamo ni pingo olokere?**

_____

---

10. Do you think those changes will continue after the project ends?
    Itamo ni alokaloka ni bino mede ka projek ogik?

    _____
    How could they continue?
    Otwero mede iyore mene

    _____
    Or Why won't they continue?
    Nyo pe otwero mede pingo?

_____

---

11. What is your HUMC planning to do in this next year?
    Ngo ame iryonget wuni tye ayikere me timo imwaka abinoni?

_____

    How will you make those things happen?
    Ibino keto wunu yika wu ni itic ningo?

_____

    What obstacles will you face?
    Peki mene ame itamo wunu ni ibino rwate wunu kede?_

_____

    How will you solve those problems?
    Kite ango ame ibino cobo wunu ked peki no?

_____

Guide for Interviews with Sub-County Chief

Sub District:_____ **Sub-County:**_____

Date: _____ **Interviewer:**_____

Staff Name:_____ **Position:**_____

Male (#) ____Female (#)_____

1. What was the greatest success in your sub-district this last year?

_____

2. Please tell us about the training staff received through MTI CSP or any other source. What was good about the training and what could be improved?

Type of Training	Strengths of Training	Suggested Areas for Improvement

3. Are there positive changes in your work in this sub district due to MTI CSP project activities?

_____

_____

4. What have been your greatest challenges in the sub district this last year?

_____

5. What are additional skills and capacities the sub district still needs to implement quality maternal, newborn and child health services?

_____

_____

6. What is your opinion of the work done by the VHTs and Mothers Groups in their communities?

_____

_____

7. Have you seen any positive changes in health and nutrition practices by families that you think are due to the work of the VHTs and Mothers Groups?

_____

_____

8. Do VHTs refer patients to the health units? Are these referrals appropriate? Can you describe a specific instance? (use if seems appropriate)

_____

_____

_____

_____

9. Are you, or others in your office, involved in conducting Supportive Supervision visits to health facility staff? If yes, how many visits were conducted in this last quarter?

_____

Do you think these visits will continue after the project is complete? How can that happen?_____

_____

10. What do you see as the role of the HUMCs in relation to the health facilities? What are their advantages and disadvantages? Can you give specific instances of how they have or have not supported health facilities?

_____

_____

_____

10. Now that the Child Survival Project is ending, will the improvements continue? How?

_____

_____

_____

ANNEX XI. SOURCES OF INFORMATION

List of Documents Reviewed

1) ◦ Project Detailed Implementation Plan

2) ◦ Project annual and midterm evaluation reports

3) ◦ USAID and Ministry of Health background documents
   - USAID Global Health Initiative Uganda A Strategy for Accelerating Reductions in Maternal and Neonatal Mortality, 2011
   - the Uganda Ministry of Health Road Map to accelerate Reduction of Maternal and Neonatal Morbidity and Mortality (2007)
   - Operational Framework for Nutrition in the National Child Survival Strategy
   - Uganda Demographic and Health Survey 2011

4) Social and behavior change materials
   - IYCF National Counseling Cards for Community Volunteers
   - Safe Motherhood Flip Charts
   - Village Health Team Strategy and Operational Guidelines and training materials.

5) Final Rapid Health Facility Assessment

6) Final Household Knowledge, Practice and Coverage (KPC) Survey Report.

List of Persons Interviewed and Contacted during the Final Evaluation

Interviews with Mothers of Children 0 – 23 Months		
Sub-County	**Community**	**Participant's Name**
Aromo	High performing Community (Atapara dam-walela)	Alum Harriet
		Amongi Betty
		Auma Susan
		Mary Rose
		Joan Opio
		Adong Dokas
		Betty Eling
		Adong Evaline
		Betty Akello
		Aciro Scovia
	Low performing Community (Okio walela- teabolo)	Betresy
		Ipali Jesca
		Stella
		Dockas
		Sikobiya
		Susan
		Dorcus Agea
		Acceng Mirriam
		Akello Janet
		Apio Molly
Ogur	High performing Community (Baradanga Adwoa-coo rom ps)	Amoni Harriet
		Juspin Omara
		Adong Caroline
		Apio Teddy
		Aciro Christine
		Agness Ogwang
		Akello Sarah
		Esther ogwang
		Akite Betty
		Adong Susan
	Low performing Community (Angolocom- Ogur)	Atim Everly
		Adong Stella
		Aguti Semmy
		Acio Sarah
		Apio Eunice Hope
		Akullo Lillian
		Acheng Florence
		Agaba Faith
		Auma Joy
		Akello Parah
Lira	High performing Community (Telela A-Omito)	Akello Lucy
		Atala Susan
		Phoebe Anyii
		Susan Arwata

		Jenet Abeja
		Kilara Okila
		Agnes Akello
		Santa Opio
		Sarah Edonga
		Doris Oyuku
	Low performing Community (Olengobir -Amuca)	Ongom Francis
		Florence Adol
		Atim Jannet
		Claire Odongo
		Betty Arot
		Santa Ongola
		Joyce Orima
		Flow Adol
		Jenet Ojok
		Teddy Ebonga
		Christine Obot

Interviews with Fathers of Children 0 – 23 Months		
Sub-County	**Community**	**Participant's Name**
Aromo	High performing Community (Wigweng –Odoro)	Munu Denish
		Alobo Tom
		Oroc Dickens
		Odongo Bonny
		Okidi James
		Okello Geoffrey
		Oton Geoffrey
		Ogwang Jimmy
		Omara Jaspher
		Opio Jaspher
	Low performing Community (Ajuri – Apua)	Ongom Francis
		Ocen Bosco
		Omara Aloysious
		Odyek Alex
		Ojuka Bonny
		Obong Samson
		Opio James
		Olwa Tonny
		Otyang Jimmy
		Obol James
Ogur	High performing Community (Baradanga Adwoa-coorom ps)	Opio Peter
		Okullu Patrick
		Okello Sammuel
		Otyang Anjilo
		Obua Joel
		Omara Ambrose

		Atum Yubentino
		Ogwang Yubentino
		Adi Albino
		Atyang Martin
	Low performing Community (Angolocom)	Atim Kizito
		Omara Francis
		Anyima Felix
		Omara Alfred
		Apita Denish
		Ocen Alfred
		Opio Innocent
		Ekia Tom
		Okello Tom Lwak
		Otoro Nelson
Lira	High Peforming Community (Telela A)	Ongom Francis
		Oluk James
		Anena Sam
		Opio Alex
		Anyonga Vincent
		Ouni Emmanuel
		Okello Joel
		Elem Peter
		Olet Tonny
	Low performing men (Olengobir Amuca)	Orima Santo
		Opong George
		Opio Patrick
		Otim Fedinan
		Alobo Ceaser
		Emuna Maxuel
		Ogwang Tonny
		Okello Mike
		Etuke Ronny
		Ocim Jimmy

Interviews with Mother Group Leaders		
Sub-County	**Community**	**Participant's Name**
Aromo	Otara Parish	Sophia Okello
		Betty obonyo
		Amongi Christine
		Jenifer Omara
		Dorine Otim
		Amony Brenda
		Mary Ogwal
		Ketty Anam
		Acio Anna
		Colline Todo
		Acen Polly
Ogur	Acelela , Angolocom and Orit Parish	Judith Awio
		Dorine cong
		Costa oyom
		Betty Todi
		Apio Shara
		Evaline opeto
		Akullo Scovia
		Akello Esther
		Angom Grace
		Akullo Eunice
Lira	Barapwo Parish	Molly Omara
		Eunice Ocen
		Harriet Okaka
		Enesta Acili
		Kevin Ogwang
		Sarah Odur
		Monika Olwa
		Agness Okello
		Alit Betty
		Jane Ote

Interviews with VHTs/PEs		
Sub-County	**Community**	**Participant's Name**
Aromo	Owene	Omara Jimmy Aron
		Odic Tom
		Ojok Jaspher
		Agonga Charles
		Juspanti Omara
		Owot Moses
		Esther Aoka
		Celestiono Okodi
		Aleny Jimmy
		Opido Richard
		Tonny
Ogur	Orit	Acai Silvesto
		Todi Louis

		Egonga Geoffrey
		Ameny Linous
		Okello Alex
		Odongo Bosco
		Onyona C.P
		Ojok Joel
		Jenet Ocen
		Auma Flow
		Odongo Joel Bob
		Susan Okabo
		Hellen Omara
		Akullo Scovia
		Otim Lawrence
		Okello Francis
		Angom Eunice
		Atim Gloria
		Oluk George
		Opio Jaspher
Lira	Barapwo	Mido Aguma
		Esther oming
		Ogwok Alfred
		Lucy Awidi
		Collin Otim
		Grace Dengo
		Otit Charles
		Ongol Tonny
		Omondi Jimmy
		Ocen James
		Conny Onapa
		Apio Dorcus
		Jenet Onyinge
		Vicky Okello
		Sarah Odur
		Akello Betty
		Obua Amos

Interviews with HUMCs		
Sub-County	**Community**	**Participant's Name**
Aromo	Walela	Olinga Paskol
		Atala Rose
		Atula C.V
		Atim Christine
		Odic Tom
		Esther Aoko
		Okello Augustine
Ogur	Akangi H/C11	Okello Joe
		Toli A Eunice
		Adiro Judith
		Opio Tonny
		Okello Mary Francis
		R F Olello

		Egwali Fred
		Ogwang Patrick
		Obura Desmond
		Jacob Oweta
		Opio Patrick
		Amule Christine
		Okello Geoffrey
		Opio Richard
		Omara Bob
		Ojok Pious
		Odongo Moses
Lira	Barapwo	Otto Click
		Okany George
		Okello George
		Ochen James
		Ogwal Moses
		Ebila Jino
		Sophia Atyeno

Interviews with Health Facility Staff		
Sub-County	**Community**	**Participant's Name**
Aromo	Walela	Olinga Pascol
		Olwoc Jimmy
		Atim Christine
		Odich Tom
		Atworo James
		Esther Aoko
		Akullo Ketty
		Ogweng George
		Abonyo Dorothy
		Tino Beatrice
Ogur	Ogur	Okullo Geoffrey Agoro
		Acio Charity
		Nandudu Babra
		Amongi Susan
		Akello Dorcus
		Middy Sophia
		Akello Shphie
		Ogwang James
		Doris Amodo
		Anying Betty
Lira	Barapwo	Acio Catherine
		Ogang Moses
		Adong Agness
		Otyek Godtry
		Akullo Caroline
		Ejeng Sarah
		Atwongo Harriet

		Ojok Johnson
		Okello George
		Akun Beatrice

Interviews with Parish Development Council Members		
Sub-County	**Community**	**Participant's Name**
Aromo	Walela	Munu Denis
		Alele Filbert
		Odongo Gilbert
		Odongo Bonny
		Opio Lawrence
		Ajal Nelson
		Opio Jaspher
		Okello James
		Odoc Joe
		Ogwang Dicken
Ogur	Ogur	Obong Moris
		Okello Joseph
		Awio Thomas
		Opio Tonny
		Akedo Christine
		Oloo Willy
		Okello Moses
		Ojok Tonny

Interviews with Senior Assistant Secretaries of Sub-Counties (Sub-County Chief)	
Sub-County	**Name**
Aromo	Emmanuel Komakech
Ogur	Eunice A. Toli
Lira	George Okany (Acting Sub-County Chief)

Key Informant Interviews		
Name	**Title**	**Agency**
Laura Peterson	Executive Director	Hands to Hearts International
Lydia Akulo	Project Manager	Child Survival Program, MTI
George Aguze	Project M & E Officer	Child Survival Program, MTI
Dan Ward	Regional Director, Africa	MTI, Africa Region
Mike O'brien	Africa Health Programs Advisor	MTI, Africa Region
Allan Obore	Human Resources/ Administration	MTI, Uganda

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name SUE LEONARD	
Title EXTERNAL CONSULTANT	
Organization	
Evaluation Position EXTERNAL EVALUATOR	☒ Team Leader ☐ Team Member
Evaluation Award Number *(Contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Lusa Child Survival Project Medical Teams International GSH-A-00-09-00012
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to the following:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	Lue Leonard
Date	10 Sept 2013

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	Alfredo Hyder
Title	CSP Programme Manager
Organization	Medical Teams International
Evaluation Position	☐ Team Leader ☑ Team Member
Evaluation Award Number *(Contract or other instrument)*	GSH-A-00-09-00012
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Lira Child Survival Project Medical Teams International GSH-A-00-09-00012
I have real or potential conflicts of interest to disclose.	☑ Yes ☐ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to the following:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation*	✓ Managed the project for half of its life time ✓ Have very good experience with the project. ✓ Currently working with the project

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	10/09/2013

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	OZUNGU TOBIAS
Title	VHT MOBILISER
Organization	MEDICAL TEAMS INTERNATIONAL
Evaluation Position	☐ Team Leader ☑ Team Member
Evaluation Award Number *(Contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	CHILD SURVIVAL PROJECT-LIRA Medical Teams International GSH-A-00-09-00012
I have real or potential conflicts of interest to disclose.	☑ Yes ☐ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to the following:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation*	Am the VHT mobiliser in Ogur Sub-County

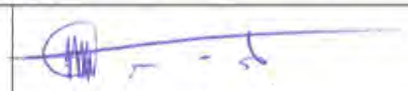
I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	10/09/2013

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	OLOBO DENIS
Title	ECN [ENROLLED COMPREHENSIVE NURSE]
Organization	MEDICAL TEAMS INTERNATIONAL
Evaluation Position	☐ Team Leader ☑ Team Member
Evaluation Award Number *(Contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Lira Child Survival Medical Teams International GSH-A-00-09-00012
I have real or potential conflicts of interest to disclose.	☐ Yes ☑ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to the following:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	10/09/2013

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	Apenyo Kennedy
Title	Medical Clinical Officer
Organization	Medical Teams International
Evaluation Position	☐ Team Leader ☑ Team Member
Evaluation Award Number *(Contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Lira Child Survival Project Medical Teams International GSH-A-00-07-00012
I have real or potential conflicts of interest to disclose.	☐ Yes ☑ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to the following:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	10/09/2013.

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	APIYO CHRISTINE
Title	MATERNAL CHILD HEALTH MENTOR
Organization	MEDICAL TEAMS INTERNATIONAL
Evaluation Position	☐ Team Leader ☑ Team Member
Evaluation Award Number *(Contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	CSP Lira Child Survival Project Medical Teams International Lam GSH-A-00-09-00012
I have real or potential conflicts of interest to disclose.	☑ Yes MATERNAL AND CHILD HEALTH ☐ No MENTOR
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to the following:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation*	MATERNAL ~~AND~~ CHILD ~~HEALTH~~ MENTOR (CSP)

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	 apiyo christine.
Date	10th / Sept. / 2013

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name ARAC	ARACH MARY
Title	COMMUNITY OUTREACH COORDINATOR
Organization	MEDICAL TEAMS INTERNATIONAL
Evaluation Position	☐ Team Leader ☒ Team Member
Evaluation Award Number *(Contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Medical Teams International LIRA CHILD SURVIVAL PROJECT GSH-A-00-09-00012
I have real or potential conflicts of interest to disclose.	☑ Yes WORK AS A COMMUNITY OUTREACH COORDINATOR FOR THE PROJECT ☐ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to the following:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	Arrahmany.
Date	10/09/2013

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	ACHAN DOREEN SUSAN
Title	VHT MOBILIZER
Organization	MEDICAL TEAMS INTERNATIONAL
Evaluation Position	☐ Team Leader ☒ Team Member
Evaluation Award Number *(Contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Medical Teams International LIRA CHILD SURVIVAL PROJECT GSH-A-00-09-00012
I have real or potential conflicts of interest to disclose.	☑ Yes WORKED AS VHT MOBILIZER ☐ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to the following:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	Achan Devanshan
Date	10th Oct 2013

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	AJOK SUSAN
Title	VHT MOBILIZOR
Organization	MTI
Evaluation Position	☐ Team Leader ☒ Team Member
Evaluation Award Number *(Contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	CHILD SURVIVAL PROJECT MIRA. Medical Teams Int'l GSH-A-00-09-00019
I have real or potential conflicts of interest to disclose.	☑ Yes ☐ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to the following:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation*	I am a VHT MOBILIZOR AT OGUR SUB COUNTY

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	10th/09/2013.

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	OMOBO JAMES
Title	VHT MOBILIZER
Organization	MEDICAL TEAMS INT
Evaluation Position	☐ Team Leader ☑ Team Member
Evaluation Award Number *(Contract or other instrument)*	Medical Teams International GSH-A-00-09-00012
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	CHILD SURVIVAL PROJECT - LIRA
I have real or potential conflicts of interest to disclose.	☑ Yes ☐ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to the following:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation*	I am a mobilizer

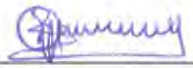
I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	10/09/2023

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	OJOK NIXON
Title	VHT MOBILISER
Organization	MEDICAL TEAMS INTERNATIONAL
Evaluation Position	☐ Team Leader ☑ Team Member
Evaluation Award Number *(Contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Lira Child Survival Project Medical Teams International GSH-A-00-09-00012
I have real or potential conflicts of interest to disclose.	☑ Yes ☐ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to the following:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation*	I am a VHT Mobiliser for Child Survival Project hits.

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	10/09/2013

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name AWAI Molly	
Title Store keeper	
Organization MTI	
Evaluation Position	☐ Team Leader ☑ Team Member
Evaluation Award Number *(Contract or other instrument)*	Lina Child Survival Project Medical Teams International GSH-A-00-09-00012
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Lina head office MTI
I have real or potential conflicts of interest to disclose.	☐ Yes ☑ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to the following:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation*	

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Signature	
Date	10/04/2013

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	ODUR JOEL
Title	MATERNAL & CHILD HEALTH COORDINATOR.
Organization	MEDICAL TEAMS INTERNATIONAL (MI).
Evaluation Position	☐ Team Leader ☑ Team Member
Evaluation Award Number *(Contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Medical Teams International GSH-A-00-09-00012 LIRA CHILD SURVIVAL PROJECT.
I have real or potential conflicts of interest to disclose.	☑ Yes ☐ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to the following:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation*	I am maternal and child health coordinator, Lira child survival Project.

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	10th - sept - 2013 .

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	Apili Harriet
Title	VHT Mobilizer
Organization	MTI
Evaluation Position	☐ Team Leader ☑ Team Member
Evaluation Award Number *(Contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	GSH-A-00-09-00012 Lira CSP - MTI
I have real or potential conflicts of interest to disclose.	☑ Yes ☐ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to the following:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation*	I am a VHT Mobilizer of Lira CSP.

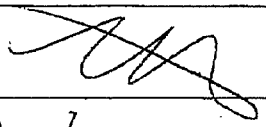
I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	10/09/2013

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	Dr. Todd Nitkin
Title	Sr. Advisor in M+E
Organization	Medical Teams International
Evaluation Position	☐ Team Leader ☒ Team Member
Evaluation Award Number *(Contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Liberia CSP Uganda CSP
I have real or potential conflicts of interest to disclose.	☒ Yes ☐ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to the following:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	9/26/13

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	Mary Helen Carruth
Title	MTI Senior Advisor, MCH
Organization	Medical Teams International
Evaluation Position	☐ Team Leader ☒ Team Member
Evaluation Award Number *(Contract or other instrument)*	
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Lira Child Survival Project Medical Teams International GSH-A-00-09-00012
I have real or potential conflicts of interest to disclose.	☒ Yes ☐ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to the following:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation*	I have provided technical support for the project, including the development of the DIP.

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	Mary Helen Carruth
Date	Sept 10, 2013

ANNEX XIII. STATEMENT OF DIFFERENCES

Medical Teams International does not wish to state any differences with the final evaluation report. We find that the report is comprehensive and constructive.

ANNEX XIV. EVALUATION TEAM MEMBERS, ROLES, AND THEIR TITLES

	Names of People who Participated in Qualitative Assessments September 9th -16th, 2013		
No	**Name**	**Title**	**Role in the Survey**
1.	Lydia Akulo	CSP Program Manager	Planning and Coordinating evaluation activities
2.	George Aguze	Monitoring and Evaluation Officer	Review of tools, data entry, technical support to team
3.	Arach Marry	CSP Community Outreach Coordinator	Data collector
4.	Odur Joel	CSP Maternal Child Health Coordinator	Data collector
5.	Apiyo Christine	CSP Maternal Child Health Mentor	Data Collector
6.	Achan Doreen	CSP Village Health Team Mobilizer	Data Collector
7.	Omodo James	CSP Village Health Team Mobilizer	Data Collector
8.	Apili Harriet	CSP Village Health Team Mobilizer	Data Collector
9.	Ojungu Tobias	CSP Village Health Team Mobilizer	Data Collector
10.	Ojok Nixson	CSP Village Health Team Mobilizer	Data Collector
11.	Ajik Susan	CSP Village Health Team Mobilizer	Data Collector
12.	Olobo Denis	Enrolled Comprehensive Nurse (MTI Pader)	Data Collector
13.	Apenyo Kenedy	Medical Clinical Officer (MTI Pader)	Data Collector
14.	Okwir Jasper	Enrolled Comprehensive Nurse (MTI Ogur)	Data Collector
15.	Acheng Teddy	Intern	Data Collector
16.	Awal Molly	Logistic Assistant	Data Collector
17.	Opio Peter	CSP Driver	Driver
18.	Okello Peter	MTI Driver	Driver
19.	Angulu Tonny	Hired Driver	Driver
20.	Mary Helen Carruth	MTI Senior Advisor Maternal Child Health	Evaluation Co-facilitator
21.	Sue Leonard	Independent Consultant	External Consultant

ANNEX XV. FINAL OPERATIONS RESEARCH REPORT

No Operations Research was conducted within the Lira Child Survival Project

ANNEX XVI. OPERATIONS RESEARCH BRIEF

No operations research was conducted within the Lira Child Survival Project

USAID
FROM THE AMERICAN PEOPLE

Lira Child Survival Project in Uganda

Final Evaluation

Stakeholder Debrief

Medical Teams International

Evaluation Purpose

The FE provides an opportunity for all project stakeholders to take stock of accomplishments and lessons learned to date and to listen to beneficiaries at all levels. The FE Report will be used by the following audiences as a source of evidence to help inform decisions about future program designs and policies:

- Lira DHO, health facility staff and Health Unit Management Committees
- Uganda Ministry of Health
- Village Health Teams and Mothers Group Volunteers
- Hands to Hearts International
- USAID CSHGP and Uganda USAID Mission
- Medical Teams International HQ and field staff

Evaluation Questions

1. To what extent did the project accomplish objectives stated in the DIP?
2. To what extent was the project implemented as planned? What changes were made to the planned implementation, and why were those changes made?
3. How were gender considerations addressed through the project? Are there any specific gender-related outcomes?
4. Which elements of the project have been or are likely to be sustained or expanded?

Project Background

- Four year Child Survival Project
- Implemented in Aromo, Ogur and Lira sub-counties of Lira District, Erute North Sub District
- Implemented in collaboration with Ministry of Health, Lira District Health Office; and Hands to Hearts International

Project Objectives

- Objective 1: Communities assume responsibility for their own health through strengthened community capacity.
- Objective 2: Improved health (C-IMCI) and child care (Early Childhood Development) behaviors among mothers of children under five years of age.
- Objective 3: Improved quality of health facility services through strengthened IMCI and MNC capacity.
- Objective 4: Strengthened institutional capacity of MTI and the Lira District Health Office to implement effective and efficient child survival activities.

Evaluation Methods

- **Desk Review of Secondary Data**:
  - Detailed Implementation Plan
  - Program Reports
  - USAID and Ministry of Health background documents
  - Project IEC materials
- **Qualitative Data:**
  - Interviews with: community volunteers and project beneficiaries,
  - Health Unit Management Committees, Parish Development Committees, health staff, and District Health Team members and
  - Director of Hands to Hearts International
- **Quantitative Data:**
- Health Facility Assessment and
- Household Knowledge, Practice and Coverage (KPC) survey.
- **Data Analysis:**
- Quantitative and qualitative findings analyzed by MTI field and HQ staff, District Health Team members, and health facility staff

Findings

- **Objective 1:** Strengthened community capacity – significant improvement in indicators
- Supported the 5 year District Development Plan
- Worked through the established governmental system: Local Council (LC1), Parish Development Council (PDC), Sub-County, Health Unit Management Committees (HUMC), Health Facilities II, III, and IV and the District Health Office (DHO)
- VHTs – trained, before had limited skills. Communities have two VHTs; are the primary health person in the community; Mother Leader Groups (MLG) support them.

Findings

- **Objective 1:** Mother Leader Groups – Key to success of program

- Originally 300 were trained; after mid-term added 1128 more, total of 1428 in 282 villages
- 96 Mother Leaders received a TOT, then trained the remaining mothers
- Function like care groups – do HH level health education, group sessions, work closely with VHTs, HFs
- Developed Community Theater Groups to dramatize health messages throughout the project area

Findings

- **Objective 1:** Health Facility
- Routine meetings with VHTs, MLGs to discuss health technical issues e.g. appropriateness of referrals; communication and work flow problems e.g. mothers not bringing cards to clinic, health staff being rude to patients
- HUMCs closely monitor work of clinic (counting drugs when arrive, care for physical facility)
- PDCs may be 2-3 in HF area. Also participate in stock taking of incoming drugs; maintain communication between HF and community.

Findings

- **Objective 2:** Improved health (C-IMCI)

Indicator	Baseline	Final	DHS (North)
Underweight	27.7	20.0	12.3
EBF	73.6	88.2	Uganda 41.0
IBF – within 1 hour	29	78.9	38.4
Minimum Appropriate Feeding	23.1	48.9	38.4
ANC four or more visits	35.3	57.8	
Birth attended by skilled personnel	35.3	83.9	51.9
Maternal danger signs post natal	2.0	51.1	
Immunizations complete by 12 mo.	15.5	56.0	(23 m) 49.0
Chest related cough to health clinic	57.8	74.2	80.5

Findings

- **Objective 2:** Early Childhood Development (ECD)

Indicator	Baseline	Final
Mothers providing cognitive stimulation	38.0	76.3
Mothers telling a story, naming objects, singing a song	22.7	64.4
Mothers singing while feeding	57.7	83.6

- Peer Educator (PE) volunteers, 2 per village, provided basic child development information at HH level along with key health messages

Findings – EDC

- Gave parents "permission" to play with and relate to their children
- First half of the project, implementation was scattered; last half, it was more intense and concentrated in one sub-county;
- Results were impressive across all three sub-counties with 25-40% gains in specific EDC indicators;
- In addition to indicator changes, all community level focus groups reported:
  - Better relationship between spouses,
  - More love for the child,
  - Child responds more positively to parent,
  - Less domestic violence.

Findings

- Changes in implementation
  - Number of MLG members increased from 300 to 1148 after the MTE to better reach HHs with health education
  - PDCs began monitoring and supervision of project activities to increase community involvement in management
  - ECD interventions focus on one sub-county only after MTE
  - Immunization LOE returned to 10% from 55% before MTE
- Gender Issues Addressed
  - Man and woman team as peer educators for ECD to be sure to reach whole population with messages;
  - MLGs formed to reach mothers as peers as most VHTs are men;
  - Encouraging male involvement in ANC and PMTCT

Findings

- Integration of political and technical systems
  - LCs and PDCs attended VHT and MGL training sessions on their own initiative;
  - Representatives from each LC are on PDC;
  - PDCs work with HUMCs to monitor and support the health facility;
  - HF staff are on the HUMC;
  - PDCs and HUMCs lobby, plan and report to the Sub-County.
- LCs are now enacting "bylaws" in communities requiring improved health behaviors (digging pit latrines, attending immunization clinic)

Conclusions - Sustainability

- Parish Development Committees meet monthly with VHTs and also with MLGs along with HF staff to discuss issues/ problems and emerging health concerns;
- Sub-County Chiefs go to health facilities sometimes weekly and to communities with HF In-Charge or staff;
- Health planning starts with communities, through the LC1, contributing their issues/concerns to the PDCs who develop their priorities for the year and submit to the Sub-County who submit their plans to the District. All activities must fit into the plan;
- LC1s are involved in health issues in the community, working closely with VHTs and MLGs and serve on the PDC;

Conclusions - Sustainability

- Relationships between communities and HF staff have improved and routine PDC meetings help resolve new/continuing issues – HF staff are friendly and do not harass
- Indicators are improved from baseline and generally have met targets but need to be better according to HFs
- Volunteers are committed – concerned that may not have referral forms, worry they will not be "kept in the loop"
- District Health Officer assures they will continue to use the referral forms, that communication with them will continue, that they are the first line of health intervention and are critical to improvement of health in village.

Conclusions

- **Project Effect**
  - Strengthened the existing system,
  - Provided training where needed (HF staff, VHTs, MLGs); Welcomed other leaders to trainings
  - Developed and institutionalized lines of communication and monitoring systems from community to sub-county
  - Closely monitored and corrected technical competence from community to the HF

Recommendations

- Use ECD in future programming
- Use MLGs, or HH level health education and mentoring, in future programming
- Phase out of community level work at least in last 6 months of project. Project was not strong at mid-term therefore was still heavy into implementation toward the end of the project and could not phase out of communities earlier.

Child Survival and Health Grants Program Project Summary

Oct-15-2013

Medical Teams International (Uganda)

General Project Information

Cooperative Agreement Number:	GHS-A-00-09-00012
MTI Headquarters Technical Backstop:	Mary Helen Carruth
MTI Headquarters Technical Backstop Backup:	Janis Lindsteadt
Field Program Manager:	Lydia Akulo
Midterm Evaluator:	Judiann McNulty
Final Evaluator:	
Headquarter Financial Contact:	Pamela Blikstad
Project Dates:	9/30/2009 - 9/29/2013 (FY2009)
Project Type:	New Partner
USAID Mission Contact:	Janex Kabarangira
Project Web Site:	www.medicalteams.org

Field Program Manager

Name:	Lydia Akulo (Project Manager)
Address:	PO Box 1095 Lira Uganda
Phone:	011-256-0772-696665
Fax:	
E-mail:	lakulo@medicalteams.org
Skype Name:	

Alternate Field Contact

Name:	Micheal O'brien (Africa Health Advisor)
Address:	PO Box 26073 Kampala Uganda
Phone:	011-256-0789-817876
Fax:	
E-mail:	mobrien@medicalteams.org
Skype Name:	

Grant Funding Information

USAID Funding: $1,499,646

PVO Match: $511,133

General Project Description

Medical Teams International (MTI), a 2009 New Partner category grantee, is implementing the *Lira District Child Survival Project* in northern Uganda. The project goal is to reduce child morbidity and mortality through sustainable improvements in preventive maternal and child health behaviors and utilization of strengthened health services in Erute North Sub-District of Lira District.

The capacity of Village Health Teams (VHTs) in community integrated management of childhood illness (C-IMCI) will be strengthened using a social and behavior change approach, a structured referral system between VHTs and local health facilities will be established, and facility staff will be trained in IMCI and also receive on-the-job mentoring. The project will incorporate Early Childhood Development (ECD) activities to enhance the impact and sustainability of project interventions. Integration of ECD will further improve health status by promoting positive caregiving practices in the earliest years of life to affect all domains (cognitive, physical, language, and social/emotional).

Project Location

Latitude: 2.16	**Longitude:** 32.93
Project Location Types:	Rural
Levels of Intervention:	Health Center Health Post Level Community
Province(s):	Lango Sub-Region, Northern Region
District(s):	Lira District
Sub-District(s):	Lira, Aromo, and Ogur Sub-counties of North Erute County

Operations Research Information

There is no Operations Research (OR) component for this Project.

Partners

Lira District Health Office (Collaborating Partner)	$0
Project communities (Collaborating Partner)	$0

Strategies

Social and Behavioral Change Strategies:	Community Mobilization Interpersonal Communication
Health Services Access Strategies:	Implementation in a geographic area that the government has identified as poor and underserved
Health Systems Strengthening:	Supportive Supervision Referral-counterreferral system development for CHWs Review of clinical records (for quality assessment/feedback)
Strategies for Enabling Environment:	Building capacity of communities/CBOs to advocate to leaders for health
Tools/Methodologies:	BEHAVE Framework Rapid Health Facility Assessment LQAS

Capacity Building

Local Partners:	Dist. Health System Health Facility Staff

Interventions & Components

Control of Diarrheal Diseases (20%) - Hand Washing - ORS/Home Fluids - Feeding/Breastfeeding - Care Seeking - Case Management/Counseling	IMCI Integration	CHW Training HF Training
Immunizations (10%) - Classic 6 Vaccines - Mobilization	IMCI Integration	CHW Training HF Training
Infant & Young Child Feeding (20%) - ENA - Comp. Feed. from 6 mos. - Cont. BF up to 24 mos. - Maternal Nutrition - Promote Excl. BF to 6 Months	IMCI Integration	CHW Training HF Training
Maternal & Newborn Care (25%) - Recognition of Danger signs - Newborn Care - Post partum Care - Integation. with Iron & Folic Acid - Normal Delivery Care - Birth Plans - Emergency Transport - Neonatal Vitamin A - Kangaroo Mother Care (skin to skin care) - AMTSL	IMCI Integration	CHW Training HF Training
Pneumonia Case Management (25%) - Case Management Counseling - Recognition of Pneumonia Danger Signs	IMCI Integration	CHW Training HF Training

Operational Plan Indicators

Number of People Trained in Maternal/Newborn Health			
Gender	**Year**	**Target**	**Actual**
Female	2010	0	
Female	2010		148
Male	2010		478
Male	2010	0	
Female	2011	150	
Female	2011		474
Male	2011		462
Male	2011	480	
Female	2012	474	
Female	2012		1684
Male	2012		532
Male	2012	462	
Female	2013	1694	
Female	2013		1752
Male	2013		612
Male	2013	538	
Number of People Trained in Child Health & Nutrition			
Gender	**Year**	**Target**	**Actual**
Female	2010	0	
Female	2010		162
Male	2010		183
Male	2010	0	
Female	2011	160	
Female	2011		474
Male	2011		462
Male	2011	195	
Female	2012	474	
Female	2012		1684
Male	2012		532
Male	2012	462	
Female	2013	1694	
Female	2013		1752
Male	2013		612
Male	2013	538	
Number of People Trained in Malaria Treatment or Prevention			
Gender	**Year**	**Target**	**Actual**
Female	2010		134
Female	2010	0	
Male	2010		426
Male	2010	0	
Female	2011		0
Female	2011	0	
Male	2011		0
Male	2011	0	
Female	2012		0
Female	2012	0	
Male	2012		0
Male	2012	0	
Female	2013		0
Female	2013	0	
Male	2013		0

Male	2013	0	

Locations & Sub-Areas

Total Population: 124,379

Target Beneficiaries

	Uganda - MTI - FY2009
Children 0-59 months	25,498
Women 15-49 years	25,498
Beneficiaries Total	50,996

Rapid Catch Indicators: DIP Submission

Sample Type: 30 Cluster

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	**227**	**300**	**75.7%**	**11.0**
Percentage of children age 0-23 months whose births were attended by skilled personnel	**106**	**300**	**35.3%**	**8.6**
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	**39**	**53**	**73.6%**	**26.0**
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall	**141**	**201**	**70.1%**	**13.2**
Percentage of children age 12-23 months who received a measles vaccination	**124**	**161**	**77.0%**	**15.0**
Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey	**140**	**161**	**87.0%**	**15.3**
Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey	**137**	**161**	**85.1%**	**15.3**
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	**55**	**220**	**25.0%**	**8.7**
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids	**51**	**108**	**47.2%**	**16.0**
Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider	**85**	**147**	**57.8%**	**14.7**
Percentage of households of children age 0-23 months that treat water effectively	**34**	**300**	**11.3%**	**5.2**
Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing	**255**	**300**	**85.0%**	**11.2**
Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night	**154**	**300**	**51.3%**	**9.9**
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)	**83**	**300**	**27.7%**	**7.8**
Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	**56**	**242**	**23.1%**	**8.1**
Percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child	**106**	**300**	**35.3%**	**8.6**
Percentage of mothers of children age 0-23 months who are using a modern contraceptive method	**100**	**300**	**33.3%**	**8.4**
Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within two days after birth	**49**	**300**	**16.3%**	**6.2**

Rapid Catch Indicators: Mid-term

Sample Type: LQAS

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	**146**	**198**	**73.7%**	**6.1**
Percentage of children age 0-23 months whose births were attended by skilled personnel	**100**	**198**	**50.5%**	**7.0**
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	**131**	**198**	**66.2%**	**6.6**
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall	**110**	**198**	**55.6%**	**6.9**
Percentage of children age 12-23 months who received a measles vaccination	**160**	**198**	**80.8%**	**5.5**
Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey	**177**	**198**	**89.4%**	**4.3**
Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey	**144**	**198**	**72.7%**	**6.2**
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	**136**	**198**	**68.7%**	**6.5**
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids	**104**	**198**	**52.5%**	**7.0**
Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider	**168**	**198**	**84.8%**	**5.0**
Percentage of households of children age 0-23 months that treat water effectively	**20**	**198**	**10.1%**	**4.2**
Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing	**173**	**198**	**87.4%**	**4.6**
Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night	**88**	**198**	**44.4%**	**6.9**
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)	**32**	**198**	**16.2%**	**5.1**
Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	**83**	**198**	**41.9%**	**6.9**
Percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child	**99**	**198**	**50.0%**	**7.0**
Percentage of mothers of children age 0-23 months who are using a modern contraceptive method	**60**	**198**	**30.3%**	**6.4**
Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within two days after birth	**44**	**198**	**22.2%**	**5.8**

Rapid Catch Indicators: Final Evaluation

Sample Type: 30 Cluster

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	**322**	**360**	**89.4%**	**4.5**
Percentage of children age 0-23 months whose births were attended by skilled personnel	**302**	**360**	**83.9%**	**5.4**
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	**82**	**93**	**88.2%**	**9.3**
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall	**203**	**238**	**85.3%**	**6.4**
Percentage of children age 12-23 months who received a measles vaccination	**138**	**168**	**82.1%**	**8.2**
Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey	**163**	**168**	**97.0%**	**3.6**
Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey	**154**	**168**	**91.7%**	**5.9**
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	**106**	**206**	**51.5%**	**9.7**
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids	**52**	**85**	**61.2%**	**14.7**
Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider	**66**	**89**	**74.2%**	**12.9**
Percentage of households of children age 0-23 months that treat water effectively	**149**	**360**	**41.4%**	**7.2**
Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing	**347**	**360**	**96.4%**	**2.7**
Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night	**210**	**360**	**58.3%**	**7.2**
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)	**72**	**356**	**20.2%**	**5.9**
Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	**129**	**264**	**48.9%**	**8.5**
Percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child	**208**	**360**	**57.8%**	**7.2**
Percentage of mothers of children age 0-23 months who are using a modern contraceptive method	**101**	**360**	**28.1%**	**6.6**
Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within two days after birth	**147**	**360**	**40.8%**	**7.2**

Rapid Catch Indicator Comments

ANNEX XIX A. MTI UGANDA OCA ACTION PLAN

Issues	Action	Status at Mid-Term	Status at Final
Succession Planning	1. CD to bring member of management team to lobby and advocate for funding 2. Establish delegation policy 3. Provide equal opportunity for managers to serve as designated officer in charge 4. Create awareness among staff and ensure delegation is communicated to staff *5.* Build capacity of management team; invite/hire reputable consultants to present to and/or train the management team; managers attend short courses e.g. U.M.I. and L.D.C.	While delegation is practiced and an OIC is appointed as the situation arises, an overall plan and policy is yet to be developed.	Progress has been made in addressing three of the five actions planned for succession planning • *Member of management team is in place to lobby and advocate for funding.* • *Delegation policy is now in place. Delegation was practiced for 5 months in early 2013 when the MTI Country Director was out on sick leave.* • *Delegation plan communicated to all MTI staff.*

Staff Salary & Benefits Policy	1. Adopt a salary and benefits policy 2. Revise the annual salary increase policy 3. Make uniform health insurance policies in all project sites 4. Provide medical insurance for immediate family members 5. Streamline/ clarify sick and maternity leave policies 6. Set standards on bereavement support 7. Review and disseminate end of project or end of contract policy 8. Conduct assessments of staff capacity to identify gaps 9. Approve funding for staff development; utilize consultants for professional development activities.	MTI U drafted new policies that clarified benefits but due to a delay in a field visit by MTI HQ's HR manager, policies will be finalized during that visit in May 2012. An assessment of staff capacity by the MTI U HR manager is currently underway.	Progress has been made in addressing seven of the nine staff salary and benefits policy action items: • *A new salary and benefits policy was reviewed and adopted by MTI HR and MTI HQ team in May 2012.* • *The annual salary increase policy has been revised, but not yet implemented due to budget constraints.* • *A uniform health insurance policy is now in place for all MTI staff providing insurance for family members.* • *In October 2012 OCA, MTI Uganda identified additional policies to be reviewed and updated, including procurement, security, and HR. These policies were updated and implemented in August 2013. This included a revision of sick and maternity leave policy and bereavement.* • A full assessment of staff capacity and plan for funding for staff development has not yet been accomplished.

Strategic Planning	1. Request guidelines from HQ for developing SP 2. Develop a plan to develop a SP; identify external support needed from HQ or local consultant; gather information on funding sources and regional needs; meet with potential FBO partners; and conduct a SWOT analysis *3.* Complete an MTI-Uganda SP (an off-site workshop)	MTI U engaged in a strategic planning process facilitated by the Africa Region Deputy Director and led by the Country Director. The MTI U Strategic Plan, based on MTI's agency plan, was finalized in March 2011. The plan will be reviewed annually and used to guide program and organizational growth.	• Action items for developing a strategic plan were all completed: • *MTI U engaged in a strategic planning process facilitated by the Africa Region Deputy Director and led by the Country Director. The MTI U Strategic Plan, based on MTI's agency plan, was finalized in March 2011. The plan is reviewed annually and used to guide program and organizational growth.*

Communication & Decision-making	1. Finalize organizational structure with clearly defined channels of supervision and communication. 2. Organize regular staff meetings or other fora for staff to contribute ideas and improvement recommendations *3.* Ensure communication is copied to all pertinent staff	In July 2011 MTI U decentralized their structure, creating regional teams of projects in Northern Uganda and SW Uganda. This streamlined communication and reporting within MTI U. Project managers meet with their teams weekly, followed with monthly regional meetings and quarterly management team meetings which facilitate project reporting, sharing of upcoming key activities, and any constraints or obstacles are addressed. With the placement of the Africa Regional Health Advisor in Uganda, a regular system of communication and technical advising with project teams was developed.	Progress has been made in all three action items regarding communication and decision making: • *In July 2011 MTI U decentralized the organizational structure, creating regional teams of projects in Northern Uganda and SW Uganda. This streamlined supervision, communication, and reporting within MTI U.* • *Project managers meet with their teams weekly, followed with monthly regional meetings and quarterly management team meetings which facilitate project reporting, sharing of upcoming key activities, and any constraints or obstacles are addressed.* • *With the placement of the Africa Regional Health Advisor in Uganda, a regular system of communication and technical advising with project teams was developed.* • *In 2013, MTI Uganda is working to create a knowledge management system to more readily share information between staff. In the spring of 2013, MTI Uganda staff members were linked with the MTI HQ data system. Additionally, an information resource sharing system is now being developed.*

Monitoring and Evaluation	1. Conduct a Readiness Assessment for M&E (capacity, resources, tools etc) 2. Develop a comprehensive M&E plan 3. Adapt relevant M&E tools from MTI HQ and other partners 4. Provide M&E support to all MTI Uganda projects *5.* All M&E staff and PMs go through PCM	All MTI U projects carry out M&E, with new tools being adapted. A comprehensive M&E plan is to be developed in FY 13. All key management staff have completed MTI Project Cycle Management (PCM) training with the exception of new staff in SW Uganda. It is planned to roll out PCM training in the next year to non-management staff who demonstrate a readiness to learn and apply it in their work.	Two of the five action priorities for M&E were accomplished: • *A readiness assessment and a comprehensive M&E plan were not performed due to timing and budgetary constraints.* • *However, all MTI U projects carry out M&E, with new tools being adapted and with support from MTI HQ.* • *All key management staff have completed MTI Project Cycle Management (PCM) training.*

ANNEX XIX B. PROJECT M & E MATRIX

The Project Monitoring and Evaluation Matrix

Objectives	*Indicators*	*Baseline Values*	*EOP Target*	*Progress as of MTE*	*Progress as of FE*	*Comments*
Objective/ Result 1: Communities assume responsibility for their own health through the strengthening community capacity (Village Health Teams, Parish Development Councils, and Health Sub-districts).	% of VHTs who are women	5%	25%	24%	24%	There has been no turn-over of VHTs so no new women VHTs have been trained. All 1,428 MLGs are women and support the VHTs by providing information to the community. These women are not VHTs and therefore not factored into the calculation of this indicator. However, strengthening the MLG network is a notable step towards including women in the management of community health.
	% of VHTs who received a supervisory visit during the last 6 months	0%	50%	49.3%	75%	The CSP has intensified VHT supervision using the newly developed activity tracking tool. Mothers groups also received quarterly supportive supervision.
	% of communities with an emergency/referral transportation system	0%	70%	Data not available	29 Emergency transport committee formed and functional	Emergency transport committees have been established in each of the 29 parishes through the PDCs.

Objectives	*Indicators*	*Baseline Values*	*EOP Target*	*Progress as of MTE*	*Progress as of FE*	*Comments*
	% of PDCs and HUMCs using information from CHIS for decision making in the last year, with at least 1 concrete example of action taken	0%	70%	0%	90%	Project staff have mentored PDCs and HUMCs in using community level data from VHTs to make decisions. PDCs and HUMCs used information from VHT, MLG and PEs for planning both at the sub county and district, for example, to expand EPI outreaches, establish outreaches for Nodding Syndrome in Aromo, and the reopening of health units in Ogur and Aromo.
Objective/ Result 2 Improved health (C-IMCI and child care (ECD) behaviors among mothers of children <5 years	% of children 0-5 months who were exclusively breastfed during the last 24 hours	73.6%	95%	66.2%	88.2%	
	% of children aged 0-23 months who were put to the breast within one hour of delivery	29.0%	60%	22.7%	78.9%	
	% of children aged 0-23 months who **did not** receive prelacteal feeds during the first 3 days after delivery	46.6%	75%	55.0%	87.2%	
	IYCF: % of children 6-23 months fed according to a minimum of appropriate feeding practices	23.1%	50%	41.9%	48.9%	
	% of children 0-23 months with diarrhea in the last two weeks who received Oral Rehydration solution (ORS) and/or recommended home fluids.	47.2%	70%	52.5%	61.2%	A challenge to meeting this indicator is frequent stock out of ORS. Findings from focus group interviews indicated that knowledge about home fluids, with the exception of home fluids was limited.

Objectives	*Indicators*	*Baseline Values*	*EOP Target*	*Progress as of MTE*	*Progress as of FE*	*Comments*
	% of children 0-23 months with diarrhea in the last two weeks who were treated with Zinc.	0.9%	30%	2.6%	17.6%	The MTE recommended that because of unreliable supplies of zinc, this indicator has been dropped. Since MTE health facility staff have been encouraging parents to purchase zinc for their children with diarrhea from private pharmacies.
	% of mothers of children aged 0-23 months who live in households with soap at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during a 24 hour recall period	54.0%	80%	75.3%	87.8%	
	% of children aged 0-23 months with chest-related cough and fast/difficult breathing in the last two weeks who were taken to an appropriate health provider.	57.8%	80%	84.8%	74.2%	
	% of children aged 0-23 months with chest-related cough and fast/difficult breathing in the last two weeks who were treated with an antibiotic	34.7%	70%	64.4%	68.5%	
	ANTHROPOMETRICS % of children 0-23 months who are not underweight (-2 SD for the median weight for age, according to WHO/NCHS reference population)	72.3%	88%	82.36%	79.8%	
	MNC % of mothers with children aged 0-23	75.7%	90%	73.7%	89.4%	

Objectives	*Indicators*	*Baseline Values*	*EOP Target*	*Progress as of MTE*	*Progress as of FE*	*Comments*
	months who received at least two Tetanus Toxoid vaccinations before the birth of their youngest child.					
	% of mothers with children aged 0-23 months who received at least 2 doses of IPT during the pregnancy with this youngest child.	35.0%	60%	59.1%	68.3%	
	% of children age 0-23 months whose births were attended by skilled personnel	35.3%	50%	50.5%	83.9%	
	% of mothers of children 0-23 months who received a post-partum visit by an appropriate trained health worker within two days after the birth of the youngest child.	16.33%	50%	22.2%	40.8%	
	% of mothers of children 0-23 m are able to report at least two known maternal danger signs during the postpartum period	2.0%	80%	20.0%	51.1%	
	IMMUNIZATION % of children aged 12-23 months who received measles vaccine according to the vaccination card or mother's recall	77.0%	90%	80.0%	82.1%	
	% of children aged 12-23 months who are fully vaccinated (received BCG, DPT3, OPV3, and measles vaccines) by 12 months of age, card verified	15.5%	50%	37.9%	56.0%	The VHT and MLG are tracking children with incomplete vaccinations and referring them. The indicator is expected to improve by the EOP.
	ECD	38.0%	80%	68.5%	76.3%	An ECD forum was held in Aromo in

Objectives	*Indicators*	*Baseline Values*	*EOP Target*	*Progress as of MTE*	*Progress as of FE*	*Comments*
	% of mothers of children aged 0-23 months who provide cognitive stimulation to their child in the form of games such as "where are your eyes", etc.					March 2013. This was meant to further engage the community including sub county Health Facility in charges and the district leaders (health sub district in charge, DHO, RDC). This forum further created awareness about ECD.
	% of mothers of children aged 0-23 months who told their child a story, sang a song, or spent time naming objects for child at least 2 times in the past week	22.7%	75%	40.1%	64.4%	
	% of mothers of children aged 0-23 months who report that they talk or sing to the child while feeding the child	57.7%	80%	65.4%	83.6%	
Objective/ Result 3 Improved quality of care in health facilities through strengthened capacity in IMCI and MNC	% of HC have a passing score with regard to the assessment of sick children (> 80% of patients observed in each facility have all 5 assessment tasks performed on them by the HW)	0/4	3/4	0/4	7/8	All health workers except for one completed all assessment tasks at least 80% of the time.
	% of HC in which > 80% sick children treated according to protocol	1/4	3/4	4/4	8/8	
	% of HC staff received a supervisory visit within 3 months	1/4	3/4	3/4	7/8	
Objective/ Result 4: Strengthened institutional capacity of MTI	Demonstrate improvement in 6 low-scoring priority areas identified during the Organizational Capacity Assessment	0	6	2	6	MTI Uganda is now using the Holistic Organizational Capacity Assessment Instrument developed by Catholic Relief Services so has not updated the JSI Score Card used at baseline. The updated action plan

Objectives	*Indicators*	*Baseline Values*	*EOP Target*	*Progress as of MTE*	*Progress as of FE*	*Comments*
and DHO to implement effective and efficient child survival activities						indicates progress made in all six priority areas identified as low scoring at baseline.
	Action plans for 6 priority areas implemented and scores improved	0	6	2	6	Progress has been made in implementing action plans for all six priority areas. The action plans for addressing strategic planning, communication and decision making have been completed. Progress has been made in addressing succession planning, staff salary and benefits policy, and monitoring and evaluation**.**
	Lessons learned and best practices are disseminated utilizing at least three different media (program manual, presentations, web site, program guidance and meetings with stakeholders)	No	Yes	Yes		MTI has shared successes and lessons learned with the DHO and NGOs working in Lira during quarterly district level health coordination meetings and during meeting with PDCs and USAID in Kampala and Gulu. MTI shared lessons learned and best practices with USAID-funded SCHIPHA project in northern Uganda through a joint training on performance improvement as well as a meeting with the MCHIP Ethiopia focal person. The Africa Health Advisor made a presentation on midterm survey results at headquarters in Portland,

Objectives	*Indicators*	*Baseline Values*	*EOP Target*	*Progress as of MTE*	*Progress as of FE*	*Comments*
						Oregon as well in March, 2012.
	% of health facilities received joint DHO/MTI supervision visits once per quarter	0	75%	100%	87%	All eight health facilities received quarterly supportive supervision services.

ANNEX XIX C. FINAL EVALUATION RESULTS MEETING - LIRA

Final Child Survival Programme Evaluation Result Meeting -18/ 09/2013

Time	Activity	Responsible Person
9.00 AM-9.05	*Registration, Prayer, Introduction Agenda*	*CSP staff*
9.05-9.15 am	*Welcome Remarks*	*Regional Program Manager*
9.15.am -9.30 am	*Opening Remarks*	*District Chief Administrative Officer*
9.30. -9.45 am	*Programme Highlights*	*CSP Program Manager*
9. 45-10.00 am	*Break tea*	
10. 00 -11.00 am	*Project Achievement*	*District Planner/MTI M & E*
11. 00 am – 11.30 am	*Live Story*	*VHT & MLG*
11.30-11:45	*Preliminary Results*	*Evaluation Consultant*
11:45-12:15 pm	*Open Discussion*	*Led by Ogur Sub-County Chief -All Participants*
12.15-12.30 Pm	*Remarks from MTI Country Director*	*Country Director*
12.30-1.00 pm	*Handover of Certificates Closing Remarks*	*District Health Officer*
1.00 pm-2:00pm	*Lunch and Departure*	*All*

Participants

Village Health Teams	*PCD Members*	*Sub County Chiefs*	*District Chief Administrative Officer*
Mother Leader Groups	*HUMC Members*	*District Planner*	*CSP Project Manager and Staff*
Peer Educators	*Health Facility Staff*	*District Health Officer*	*FE Team*

ANNEX XIX D. RESPONSE TO MIDTERM RECOMMENDATIONS

Midterm Evaluation Recommendations	Progress as of September 2013
Recommendation 1: Triple the number of Mother Leader Groups to reach every household with a pregnant woman or children under two with key messages on maternal newborn care, complementary feeding, and optimal breastfeeding. While supporting behavior change in these interventions, the MLGs can also promote sanitation and monitor child health cards to minimize immunization drop-outs.	The number of Mother Leader Groups has been tripled to 1428. The number of MLGs recruited was based on population numbers, ensuring adequate coverage. The MLGs have been provided with t-shirts, name tags and MoH counseling materials and support the VHTs to promote health messages through household visits and community dramas on IYCF/MNC, and sanitation. They monitor Child health cards and refer patients to the health facilities.
Recommendation 2: Train VHTs and MLGs in nutrition using the WHO/UNICEF curriculum for East Africa which has been left with the project manager. This can be done for MLGs in two hour segments each month alternating with MNC training for a total of four hours of training per month. This may be supplemented with the Freedom from Hunger breastfeeding and complementary feeding modules that were previously sent to the project. The new CORE Group material on newborn care at home can serve as a basis for training in MNC.	VHTs are trained during quarterly review meetings at the parish levels for about four hours, using the recommended WHO/UNICEF curriculum for East Africa. The MLGs were also trained using the same curriculum. MoH counseling materials for both facility staff and community volunteers were reproduced to support them during the health education VHTs and MLGs are following a community education plan to ensure that nutrition and MNC messages are covered comprehensively and thoroughly.
Recommendation 3: Withdraw support to routine and outreach immunizations in order to free up staff time to focus on the other technical interventions, particularly maternal newborn care and nutrition, including breastfeeding, complementary feeding, and maternal nutrition. To improve complete coverage of immunizations, focus on identification of DPT and OPV drop-outs at the household level. Meet with District Health Office as soon as possible to share MTE results, review the MOU and explain the project's decision to reduce support for vaccine and staff transport for outreach and assistance with immunizations to a level consistent with the MOU (only for Child Health Days).	After the MTE, CSP staff time was refocused on supervision, monitoring and mentoring of both health workers and community volunteers to improve MNC/ IYCF and maternal nutrition services at the facility and community. Project support for EPI was limited to Child Health Days during which the MLG and VHTs go home to home to identify those children and pregnant mothers defaulters and give vitamin A and de-worming tablets

Midterm Evaluation Recommendations	Progress as of September 2013
Recommendation 4: Confine continuation of ECD to the available budget and to having a greater impact on a small area. The VHTs and PEs need more comprehensive training including the TOT aspects in order to better transmit learning to community members. The community groups must be kept to no more than 10-12 to ensure optimal learning. The sessions may be repeated twice for reinforcement.	ECD was confined in Aromo Sub county with a total 252 Peer Educators promoting ECD practices in the community. Each PE visits 20 to 26 households per month. The MTI ECD Focal Person provides the topic to be discussed uniformly for each month
Recommendation 5: Realign remaining budget (within USAID rules) to cover as many of the following priorities as possible: an additional staff member to have one person available to focus on ECD (match funding), reproduction of the quality IEC materials available from the MOH nutrition cluster, incentives for VHTs and MLGs, and training for VHTs and MLs.	One staff member, Harriet Apili, focuses mainly on ECD activities. She was not newly hired, but her job description was changed so that she can dedicate more effort to ECD. High quality bound IEC materials on IYCF and MNC were acquired from the MOH and produced for the Lead Mothers. Copies for the VHTs and were printed, laminated, and distributed to the VHTs and MLGs. A third realignment was was approved by USAID to cover printing of additional counseling material, incentives for Mothers Leaders and refresher training for the VHTs on ICCM.
Recommendation 6: Continue with plans for the equity study and for complete mapping of VHT coverage. The results may implicate coordination with the health centers to increase the number of VHTs and for CSP to train any new ones.	The MTE KPC revealed that Aromo sub-county performed much lower in reaching project indicators as compared to Lira and Ogur sub-counties. This raised concerned about equity and household coverage. New VHTs were not trained because two VHTs were already assigned per village by the MOH and had already been trained in a one-time CSP activity. However, CSP did map the population of the project area, which informed the process of selection and placement of MLGs to improve household coverage. To provide more intensive support to families, Aromo sub-county has also been targeted for ECD activities. Equity is also being reached in other ways. Due to advocacy from the HUMC of Aromo, a midwife was transferred to the health facility to address the needs of this area. The District provided maintenance to the refrigerator at Aromo HCIII which

Midterm Evaluation Recommendations	Progress as of September 2013
	has enabled the newly opened health centers to carry out EPI outreaches. There are now 11 EPI outreaches in Aromo as compared with 8 before the opening of the new facilities. In addition, the four newly-opened health facilities are improving access to health services for the respective communities by reducing distances to the service points**.**
Recommendation 7: Conduct quarterly VHT meetings and MLG bi-weekly meetings at the parish level to reduce group size for effective learning.	VHTs and MLGs meet quarterly as planned with MTI Supervisors. The TOT/Mother Leaders meet bi-weekly with the trained mothers. All meetings are now conducted at the parish levels as recommended
Recommendation 8: For M&E, the indicator for zinc treatment needs to be dropped. There are no zinc supplies and UNICEF is still working with the MOH at central level on a zinc protocol. The indicator for emergency transportation plans would be more useful for measuring project effort if the last phrase "with at least one use within the past three months" is dropped. MTI could report in the final survey the total number of transport plans, then, separately as an addendum, report whether any had been used in the last three months. We would prefer that communities not suffer emergencies requiring frequent use of the emergency transport system.	Zinc is not supplied in the health facilities, and the related project indicator has been dropped. There are committees set at the parishes whose roles include having an emergency plan or the community
Recommendation 9: MTI management should provide the project manager adequate financial information on a quarterly basis to enable her to adjust project activities appropriately.	Management provides financial information to the project Manager on a monthly basis.

ANNEX XIX. PROJECT CHECKLISTS AND REFERRAL FORMS

Selection Criteria for Community Volunteers

MTI would like to implement Early Childhood Development activities in Aromo Sub County through a network of community volunteers (Peer Educators).

Step I: MTI staff explains the role of Peer educators to the community leaders

1. The MTI Village Health Team Mobilisers visit the Parish Development Committee and the Chairperson Local Council One to explain the ECD activity and request him to organize community for a meeting.
2. At the end of this meeting, a date should be set for the meeting

Step II: MTI visits the community to explain the ECD in details and to ask them to nominate appropriate candidates.

1. MTI VHT Mobilisers accompanied by health facility staff and VHT Parish Mobilisers for that particular parish) visit the community on the agreed date.
2. The health facility staff and MTI ECD trainer explain to the community what ECD entails e.g.
   ECD involves a new way of caring for children less than 5 years by improving on the quality of their lives through providing support to their physical, mental, emotional/psychological development and proper nutrition, sanitation and a clean environment.
   Volunteers would need to be able to volunteer 6-8 hours a week .Volunteer must not be a VHT member. Priority is given to women with children less than 2 years of age.
   The incentive which will be provided by MTI in conjunction with the DHO will be training, technical support, and materials for training care givers and tracking activities in the community. Volunteers are not paid for their voluntary work and this role will not lead to a paid job
   A community volunteer is a person trusted and selected by the community and must currently be above 18 years, able to read and write at least in Luo, live in this community and is not local council chairperson I or Local Chairperson II (Check and balances)
   General qualities of good volunteers are:
   Kind and compassionate, trustworthy and respectful, good communication skills, Non-judgmental, live by example, have good support from their spouses, and wants to serve their community.

Step 3: the community to nominate 6 female and 6 male volunteers out of which 4 will be selected.(Nomination of three volunteers to every one needed is to avoid biasness and make the process more representative).

Step 4: Administer ECD volunteer questionnaire to all those nominated

Name----------

Date parish----------

Name of interviewer----------

No	Question	Answer	Answer given (Tick)	Rating	rationale
1	Where do you stay	Does not live within the parish		Discontinue the interview	PE must come from the parish
		Lives within the parish		20	Is essential
2	How many hours can you decide to do ECD Work in a week ?	6-8 hours		20	Should be able to volunteer at least 6 hours a week
		0-3 hours		0	Will not have time to volunteer
		4-5 hours		10	
		More than 8 hours		20	Will be able to volunteer at least 6 hours a week
3	How many days do you do your own work a week? (either paid or unpaid)	I do not work		20	Those who do not work may have more time to volunteer but may also have unpaid commitments
		7 days a week		Discontinue interview	Will not have time to volunteer
		6 full days a week		Discontinue the interview	Will not have time to volunteer
		5 full days a week		5	May not have enough time to volunteer
		Less than 5 full days a week		10	More likely to have time to volunteer
4	Why would you like to serve as a community volunteer(can give more than one response)	I am a mother/Father myself so I want to help my fellow mothers/Fathers		20	Able to identify with other parents/ care takers
		I want to gain experience in working in health activities and ECD work		10	Motivation may be good

		I enjoy voluntarism since God rewards me		20	Motivation Is good
		I am jobless and I want a job		Discontinue the interview	Inappropriate motivation
		Only because I have been selected by the community		Discontinue the interview	Inappropriate motivation
		I want to serve my people by involving in ECD WORK		10	Motivation may be good
		For political interest		Discontinue the interview	Inappropriate motivation
		To be recognized by the community		Discontinue the interview	Inappropriate motivation
		To be given a bicycle		Discontinue the interview	Inappropriate motivation

Signature of nominee: ----------

Signature of interviewer: ----------

Date: ----------

Step 5: Analysis is made and the best candidates are chosen and informed to come for the training.

Community Volunteer Activity Tracking Tool

Name:_____ Check one: PE_____ VHT_____ HF Staff____ MLG____ CSP staff___

Sub-County:_____ Parish:_____ Village:_____

	ECD Lesson Numbers: *Enter the lesson number(s) provided to the participant in form below.*			
	Lesson name	*Date(s) of Lesson*	*Lesson name*	*Date(s) of Lesson*
1=	*Introduction to Early Childhood Development*		*5 = Social, Emotional Development*	
2=	*Physical Development*		*6 = Baby Cues*	
3=	*Cognitive Development*		*7 = Baby Massage*	
4=	*Language Development*		*8 = Health, Hygiene, Nutrition & Sanitation*	

#	***Name of Caregiver***	***Male (M) Female (F)***	***# of children under 3 years old***	***Relationship of the caregiver to the child***	***Lesson #s given***							
					1	***2***	***3***	***4***	***5***	***6***	***7***	***8***
1)												
2)												
3)												
4)												
5)												
6)												

Community Learning Session: Community Volunteer Quality Improvement Checklist

Specify if Static Health Talk or Community Outreach: _____ Date:_____

Audience: _____ Venue: _____ Community: _____

Technical Content		
a) Presents technical information accurately	**Yes**	**No**
b) Answered participants' questions accurately or offered to find out answer if question was beyond technical knowledge	**Yes**	**No**
c) Corrected misinformation	**Yes**	**No**
Comments:		
Following the Education Plan		
a) Followed VHT guidelines	**Yes**	**No**
b) Had all necessary materials ready and organized	**Yes**	**No**
Comments:		
Facilitation Skills		
a) Spoke clearly and loudly	**Yes**	**No**
b) Praised and encouraged participants	**Yes**	**No**
c) Demonstrated respect to participants	**Yes**	**No**
d) Created a dialogue and limited lecture style	**Yes**	**No**
e) Used open questions to encourage discussion	**Yes**	**No**
f) Visual Aids (if applicable)	**Yes**	**No**

➢ Showed visual aids	**Yes**	**No**
➢ Displayed visual aids so that all participants could see	**Yes**	**No**
g) Used other teaching methods and facilitation skills (demonstrations, role plays, stories, games) If other methods used, indicate what was done here:	**Yes**	**No**
Comments and Follow up Needed :		

Record Keeping and Reporting	Yes or No	
a) The register is updated if a family moves away, if a baby is born or a family member dies	**Yes**	**No**
b) Referrals are correctly documented	**Yes**	**No**
c) The register covers all the families in the VHT's sector	**Yes**	**No**
d) Monthly reports are complete	**Yes**	**No**
e) Monthly reports are submitted on time	**Yes**	**No**
Actions to be Taken and Comments:		

CSP PROJECT

VHT REFERRAL FORM

Nying .....Mwaka.....

Awobi/Nyako, Nying Totere.....

Nino dwe me tin..... .....Nino dwe atwo ocakere iye.....

Cawa otunu kede bot VHT.....

Tye akoko/Tye kede.....

Danger signs.....

Acwalo idakatal anyinge .....

Nying VHT ocwalo.....

Nino Dwe kede Cawa Amwe Atwo Otunu Kede Idakatal ame ocwale iye.....
