UGANDA DELIVERY OF IMPROVED SERVICES FOR HEALTH (DISH II)

LESSONS LEARNED

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The Delivery of Improved Services for Health (DISH) II project ended in October 2002. For this reason, the team assigned in January 2003 to evaluate its work wondered whether contacts would be disinclined to talk about what they might see as a closed chapter in Ugandan health care. In fact, the opposite proved to be true. Everyone to whom we spoke was willing to share observations on the DISH experience. They were also eager to see the project's accomplishments serve as a springboard for greater progress in the near future, when two new projects will concurrently serve as the vehicles for USAID funding of HIV/AIDS, reproductive health, and child health services and systems. As the title of this report suggests, the preparation of this report was not a typical evaluation but rather an effort to discern and assess the key lessons learned from DISH II and, on the basis of those lessons, to formulate recommendations for the new projects.

The assessment team was especially grateful for the time that Professor Omaswa, Director General of the Ministry of Health (MOH), and many other senior MOH officials took to frankly and liberally share their observations, ideas, and concerns with us. We also greatly appreciated the willingness of district health teams in the seven "DISH districts" we visited, as well as the staffs of numerous health facilities at all levels, to meet and talk with us at length, often on very short notice.

Former DISH II staff persons gave generously of their time to share with the team their observations on the strengths and weaknesses of a project that was clearly, to them, a labor of love. We specifically want to thank former Chief of Party Souleymane Barry and his colleague Cheryl Lettenmaier for the many hours they spent talking with us. We also appreciated the unfailing encouragement and support given to us by Suzzane McQueen of USAID/Uganda. We wish her and her colleagues success in capturing the essence of DISH II in the launch of the ambitious new "Systems" and "Services" projects mentioned above.

Finally, we want to warmly thank Christie Billingsley and Jaime Teahen of the Monitoring, Evaluation and Design Support (MEDS) project for their support and attention to detail in putting this assignment together and seeing it through, even while Christie had other, more delightfully maternal, things on her mind.

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ACRONYMS

AIC	AIDS Information Centre
AMREF	Africa Medical Research Foundation
AFRHS	Adolescent-friendly reproductive health services
BCC	Behavior change communication
CAO	Chief Administrative Officer
CDFU	Communication for Development Foundation, Uganda
CHW	Community health worker
CYP	Couple years of protection
DDHS	District Director of Health Services
DHMT	District Health Management Team
DISH	Delivery of Improved Services for Health
DTST	District Training and Supervisory Team
EDF	European Development Fund
EU	European Union
FLEP	Family Life Education Program
FP	Family planning
FY	Fiscal or financial year
HC	Health center
HMIS	Health management information system
HPED	Health Promotion and Education Department (MOH)
HPD	Health Planning Department (MOH)
HRD	Human Resource Development Department (MOH)
HSD	Health sub-district
HSSP	Health Sector Strategic Plan
HUMC	Health Unit Management Committee (community and sub-district level)
IMCI	Integrated management of childhood illness
INTRAH	University of North Carolina, Program for International Training in Health
IEC	Information, education, communication
IPC	Interpersonal communication
IRH	Integrated reproductive health
IST	Inservice training
JHU/CCP	Johns Hopkins University Center for Communication Programs
LTPM	Long-term and permanent (family planning) methods
MCH	Maternal and child health
MOFPED	Ministry of Finance, Planning, and Economic Development
MOH	Ministry of Health
MOLG	Ministry of Local Government
MSH	Management Sciences for Health
NGO	Nongovernmental organization
PAC	Postabortion care
PHC	Primary health care
QA	Quality assurance
RH	Reproductive health

STI	Sexually transmitted infection
SYSTIMS	Supervision, Yellow Star, Training Information and Management System
SWAP	Sector-wide approach (to health care financing)
TA	Technical assistance
UNEPI	Uganda National Expanded Program of Immunization
VCT	Voluntary counseling and testing
VHT	Village health team
VHW	Village health worker

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EXECUTIVE SUMMARY

In January and February 2003, at the request of USAID/Uganda, a team of five Ugandan and expatriate public health professionals undertook a review of the performance and impact of the second Delivery of Improved Services for Health project. Known as DISH II, this was a three-year, USAID–funded program of support for strengthening reproductive, child, and maternal health services. Because the review occurred three months after the conclusion of DISH II, it took the form of an assessment of lessons learned from the project rather than a standard evaluation The goal was to help ensure the positive launch of two new USAID–funded procurements, the "Systems" and "Services" programs, that will continue support to the Ugandan health sector begun under DISH.

DISH II expanded on its predecessor, DISH I, with a broad mandate to provide technical and material assistance to 12 of Uganda's 56 health districts, in the process contributing to strengthening systems at the central Ministry of Health (MOH) level. Through the mechanism of grants to the 12 "DISH districts," accompanied by technical assistance provided by DISH branch offices, the project made possible significant improvements in access to and quality of reproductive, child, and maternal health services at all levels. Despite its short duration, DISH II substantially strengthened the capacity of DISH districts to plan, manage, and supervise health services. Representatives of district health teams who were interviewed during the preparation of this report repeatedly expressed their appreciation for this support.

Reinforcing national policy, DISH II successfully promoted the integration of services in health facilities through a combination of training in a range of clinical skills and enhanced support supervision. Its Yellow Star program signaled a new approach to quality assurance that was universally appreciated and has been adopted by the MOH for national application. Through design of new health management information system software, training, and provision of computer equipment, the project demonstrated to its district health teams the value of using health service data for management decision-making and contributed to the MOH's drive to create a "culture of information" throughout the system.

In a country where the sector-wide approach to health sector funding predominates, DISH II showed that the project approach still has its place. It did so by communicating and collaborating closely with the central MOH even as it focused on the specifics of technical assistance and capacity building in its focus districts. It thus paved the way for helping the MOH plan for national application of innovations, such as Yellow Star, that had proved their worth. At the same time, it is important to note that the word "fragile" is used more than once to describe those innovations in the report that follows. The project was far too short to fully achieve its ambitious goals, and there were signs that its relatively abrupt termination led in some cases to a distinct fall-off in performance and left some of its most significant products in a precarious state between success and failure, dependent on future care and feeding.

The report singles out areas in which DISH II had significant impact, looks in detail at the strengths and weaknesses of its inputs, and summarizes what the review team sees as the key lessons that emerged in each area. In a concluding section, it restates those lessons in the form of recommendations as to how DISH successors might best build on DISH II's admirable contributions to Ugandan health systems. It is a goal well worth pursuing.

I. INTRODUCTION

BACKGROUND

The second Delivery of Improved Services for Health project (DISH II) was a three-year effort (November 1999–September 2002) to strengthen reproductive, child, and maternal health services, and to increase demand for such services, in 12 districts of Uganda. DISH II was funded via a $17.4-million cooperative agreement between USAID/Uganda and the Johns Hopkins University Center for Communication Programs (JHU/CCP), leader of a consortium that also included Management Services for Health (MSH), the University of North Carolina Program for International Training in Health (INTRAH), and JHPIEGO. The project followed on DISH I (1994–1999), which operated in the same districts[1] but focused only on reproductive and maternal health services.

Despite being of unusually short duration for a project of its importance, DISH II had a broader mandate than DISH I. It added a child health component to the scope of assistance offered to districts and placed increased emphasis on systems strengthening at the national level. In doing so, it sought to support the Ugandan Ministry of Health's (MOH's) strategy, articulated in its Health Sector Strategic Plan (HSSP), to provide a National Minimum Health Care Package to all citizens within the context of a recently decentralized health system.

Like its predecessor, DISH II provided "project-type" assistance, rather than contributing to the "common-basket" approach to budgetary support favored by other donors. At the same time, DISH II's goals were very much in line with those of the HSSP, and it fully embraced the partnership principles of the MOH's sector-wide approach (SWAP) to health system strengthening, as evidenced, for example, by its contributions to establishing national health management information and supervision systems. In speaking with the assessment team, senior MOH officials complimented DISH II management for this support, for the project's contributions to national health policy development, and for its efforts to establish and maintain transparent partnerships in its dealings at both district and central levels. One official could have been speaking for many when he said that DISH II had been "the most collaborative partner that we have had."[2]

PURPOSE OF THE ASSESSMENT

Because this review took place more than three months after the DISH II project ended, it has been approached as an assessment of lessons learned from the project rather than as a standard evaluation of performance against specific programmatic targets. While the report comments substantively on the project's accomplishments and impact and

[1] The 12 DISH districts were Jinja, Kampala, Kamuli, Kasese, Luwero, Masaka, Masindi, Mbarara, Nakasongola, Ntungamo, Rakai, and Ssembabule.

[2] Background and details of DISH II's project interventions are available from many sources, notably the Final Project Report prepared by the DISH II team and circulated in draft in January 2003.

summarizes achievements against anticipated results in Appendix A, it places primary emphasis on using the lessons of DISH II as a basis for formulating recommendations for the immediate future.

The assessment team was told that USAID support for health programming in Uganda will be carried forward over the next five years through two new procurements--one focusing on strengthening systems within the central MOH (the "Systems" program), the other on services at the district level (the "Services" program). Activities are projected in 20 districts. In the team's view, the decision to separate systems and services is a wise one, permitting clarity of focus in each of these two critical arenas. At the same time, this decision will require increased effort to harmonize interventions. The team hopes that its recommendations will contribute to this harmonization process and will help the country regain the momentum for better health and strengthened capacity that has flagged since the end of DISH II.

METHODOLOGY

The assessment team reviewed an array of documentation pertaining to DISH design and outputs, USAID priorities, and MOH policies and strategies. It spoke at length with MOH and USAID officials, former DISH II staff, and representatives of other programs and organizations in a position to comment on the DISH experience. Team members also met with the Chief of Party and staff of the team that will implement the new Services project in order to share observations with the people who will be most directly involved in using the lessons of DISH as its successor unfolds. Names and titles of all the individuals contacted by the assessment team appear in Appendix B.

The team spent seven days in the field, meeting with District Health Management Teams (DHMTs) and others in the Kampala, Luwero, Jinja, Nakasongola, Ssembabule, Rakai, and Mbarara districts. The assessment team did not have time to visit all 12 DISH districts; therefore, with help from the DISH II team it selected seven districts that would provide a varied picture in terms of district size, program maturity, and relative strength of health services, and devoted a full day to each. In each district visited, the team first held round-table discussions with the full DHMT, explaining the purpose of the assessment and inviting frank observations about the strengths and weaknesses of their partnership with DISH, from its basic grant support to its various technical and logistical inputs.

Team members then dispersed to talk in more depth with individual members of the DHMT. For example, one team member spoke with the District Health Educator about outreach and behavior change communication (BCC) initiatives, another with the District Health Visitor about community-based activities, and a third with those responsible for receiving and entering data into the health management information system (HMIS). Finally, the team, either as a whole or in subgroups, visited a wide range of health facilities—Health Centers (HC) II, III, and IV, and hospitals. It visited both public and private sector facilities, including, in Rakai, the one facility that had been awarded a Yellow Star. It spoke with health subdistrict (HSD) medical officers, clinical officers,

nurses, midwives, and other providers, and, where possible, with clients and with members of HC management committees.

The team’s findings, lessons learned, and recommendations are presented in the following pages. Chapters are generally sequenced according to the evaluation questions contained in the assessment's Scope of Work Appendix C. Appendix A provides a statistical summary of achievement of DISH II's expected results.

II. ORGANIZATIONAL SYNERGY IN ACHIEVING RESULTS

DISH II PARTNERSHIP WITH THE UGANDAN MINISTRY OF HEALTH

The DISH II project team was successful in establishing partnerships with key MOH departments at the national level. In this respect, the project contrasted with DISH I, which focused more on district-based objectives and activities. DISH II MOH partners included the Departments of Quality Assurance, Reproductive Health, Sexually Transmitted Infection (STI)/AIDS Control, Health Promotion and Education, Planning/HMIS, Malaria Control, Child Health/Integrated Management of Childhood Illness (IMCI), Nutrition, and the Ugandan National Expanded Program of Immunization (UNEPI). The project team collaborated with these partners to identify common priorities within the scope of DISH project objectives and to develop strategies for training, quality assurance (QA), and IEC /BCC in project component areas.

DISH II's collaboration with the MOH Human Resource Development Department (HRD), which is responsible for inservice training (IST) of health service personnel, was limited and could have been improved, from the MOH's point of view. There is considerable overlap in responsibilities between the HRD and technical departments with regard to IST, and until recently individual technical departments have taken the lead in development of IST modules and programs. At district level, this approach has resulted in uncoordinated and often duplicative IST activities supported by MOH and various donor-funded programs. HRD has now developed an integrated national IST strategy to rationalize efforts at all levels while adhering to the continuing process of decentralization. The new Systems and Services programs will need to work in close partnership with MOH/HRD over the next five years, as well as coordinate closely with the EU Human Resources for Health program, which is expected to be launched later this year.

Although DISH II inputs and activities were focused on its 12 districts, the project's collaboration with the central MOH also contributed to building capacity within departments and to developing strategies and materials that will be of use to other government- and donor-supported projects in districts country-wide. Examples include the following:

- the Yellow Star program for quality assurance
- new Integrated Reproductive Health and Life-Saving Skills training curricula
- IMCI training materials for private providers
- distance-learning curricula for family planning and malaria
- training curricula and service delivery guidelines for long-term and permanent methods of contraception (LTPM)

- a variety of training and educational videos and other IEC/BCC materials

- district-based information management software packages that can be adapted for use at national and HSD levels

DISH II team members also participated actively in national forums, including biannual government of Uganda–donor joint review missions and MOH reproductive health stakeholders' conferences, to share information and contribute to policy discussions and formulation.

With the current shift toward sector-wide approaches and a central funding basket, there is considerable concern at the national level about donor programs that continue to use the project-based approach in selected districts. While continuing to support such an approach, USAID/Uganda must present its Systems and Services programs as clear opportunities to help the MOH achieve national objectives. Maintaining and strengthening the close collaborative relationships developed under DISH II with key MOH departments, as well as with other development partners, will be crucial to securing the acceptability and success of these new initiatives.

PARTNERSHIPS WITH DISH DISTRICTS

DISH II was successful in establishing collaborative partnerships with District Health Management Teams in the 12 project districts. DHMTs appreciated the DISH team's hands-on support for joint planning of project activities and for ensuring that inputs addressed priorities set out in district strategic plans. With a few exceptions, DHMTs also appreciated the project's flexibility in responding to changing district needs and priorities. Joint planning and implementation contributed significantly to building of capacity within DHMTs to plan for and utilize funds from a variety of sources.

Central to building capacity was provision, through DISH II's district grant mechanism, of equipment (vehicles, computers, printers, etc.) as well as of support for recurrent costs of DHMTs and HSDs. The district grants program is discussed in detail in chapter VIII. Beginning in the next fiscal year (FY), the Ministry of Finance, Planning, and Economic Development (MOFPED) will institute changes in the allocation of funds to districts, so that all direct project funds will be included in district budget ceilings. Although detailed parameters have not yet been set out for this process, USAID will need to ensure that project inputs to districts are carefully planned and used to directly or indirectly support delivery of a comprehensive range of quality health services, irrespective of specific project focus.

DISH II provided technical and logistical assistance to districts through four regionally dispersed "branch offices." Each office was staffed by a Planning and Management Coordinator (with Medical Officer qualifications), an IEC/BCC Coordinator, and four to five Training and Supervision Coordinators, plus support staff. Branch offices worked directly with DHMTs on planning and implementing project-supported activities and

monitored achievement of work plans and objectives supported by the project. The DHMTs saw this mechanism as very helpful, and the level of assistance provided was regarded as appropriate in most instances. Due in part to this success, MOH and donor partners are considering ways to improve the provision of technical assistance (TA) to districts and HSDs through strengthened MOH area teams. The new programs should work closely with MOH to determine how USAID resources can most effectively help this process.

Unfortunately, branch offices were not able to facilitate regular experience-sharing and problem-solving exchanges between DHMTs of different DISH districts. The experiences of other projects and programs have shown that such exchanges can be an effective tool in building district capacity and encouraging networking. The new programs may wish to take advantage of this heretofore missed opportunity.

Beyond district health teams, DISH II involvement with other stakeholders was less extensive. District Chief Administrative Officers (CAOs), Assistant CAOs for Health, and relevant local council representatives (for example, Secretary for Health, District Health Committee Chairman) were invited to project functions, but other collaborative efforts were few. Experiences from other projects and programs indicate that involving these key stakeholders more actively in project planning and implementation, as well as providing capacity-building support, can contribute significantly to an enabling environment for better health services.

USAID–FUNDED AND OTHER DEVELOPMENT PARTNERS

DISH II worked directly with a number of partners in developing and implementing project activities. These included AMREF (for distance-learning components), AIC (promotion of voluntary counseling and testing [VCT] services), the Straight Talk Foundation (production of IEC/BCC materials, notably for adolescent health), Uganda Private Midwives Association (training of private providers), YWCA (IEC/BCC implementation), Group Africa (IEC/BCC promotion), and BAVA Studios and Semat Productions (production of IEC/BCC programs). In most cases DISH support enabled these organizations and agencies to expand the range of their own activities as well as to build their capacity to plan and manage new types of programs.

DISH II also collaborated effectively with other USAID–funded projects, including BASICS II for IMCI, the MOST project for micronutrient services, and the Regional Center for Quality of Health Care at Makerere University. Details of this work may be found in the project's Final Report. Despite many challenges, DISH II coordinated successfully with the EDF -funded Rural Health Project, which overlapped in six DISH districts in southwest Uganda, and collaborated with the DFID-funded Family Health Project in eastern Uganda to develop tools for the Yellow Star program.

The team also found examples of confusion and duplication of effort that can be attributed to poor coordination. These included simultaneous development of HMIS software packages by DISH and at least two other donor-supported programs; concurrent

implementation of district management capacity-building programs by DISH and at least four other donor-supported programs; and concurrent development of reproductive health (RH) clinical training modules by both DISH and the MOH. Though in practice effective collaboration usually comes about informally, at the initiation of individual partners, overall responsibility rests with the MOH, from which all donors should take the lead in harmonizing inputs and programs.

DISH PROJECT MANAGEMENT

The DISH II project team comprised four collaborating partners: JHU/CCP, INTRAH, JHPIEGO, and MSH. From all reports received by the assessment team, the DISH II Chief of Party did a commendable job in building a unified team that worked well together in achieving project objectives using integrated and synergistic approaches. This view is shared by the MOH, former DISH II staff, and other development partners.

Decentralization of project management to the branch offices made a considerable difference to district partners, as field teams had more time to spend with each district in planning and implementing project activities. This strategy also enabled centrally based team members to work more closely with MOH and other national partners on systems-level priorities and initiatives.

LESSONS LEARNED

- Maintaining close relationships with MOH departments and other development partners is crucial to USAID–funded initiatives, because if provides a means to compensate for their project-based orientation and focus on selected districts.

- DISH II developed a number of valuable systems, tools, and materials that can be institutionalized within the central MOH and applied to districts country-wide.

- In light of new guidelines for allocation of resources to districts, project-supported inputs to districts must be planned for and utilized so as to support delivery of the National Minimum Health Care Package.

- Capacity-building needs are still considerable, even in many DISH districts, particularly at the HSD level.

- Regional forums that bring together different DHMTs for experience sharing and problem-solving are invaluable for capacity building and networking.

- Involving stakeholders from administrative and political structures at district, HSD, and subcounty levels in project planning creates a enabling environment for more effective district health services.

- Consistency in support to strengthening of health systems and services is greatly enhanced by effective coordination with the MOH by implementing partners and donor agencies.

III. QUALITY ASSURANCE

While the overall quality of health services in Uganda is still low, service quality in the 12 focus districts improved measurably under the DISH II project. Maintaining acceptable standards in these districts and achieving them elsewhere will require correction of complex systemic issues and sustained, intensive effort on the part of all partners.

EXPANSION OF CLINICAL SERVICES UNDER DISH II

The team visited facilities in seven of the twelve DISH districts in an effort to assess the extent to which the quality of services had evolved under the project. The team's most significant overarching observation was that the concept of integration of services, although applied with varying degrees of comprehensiveness (see below), had been enthusiastically embraced in virtually every health facility visited. While integration has been national policy in Uganda for nearly 10 years, DISH training and support clearly facilitated the districts' implementation of that policy. Clearly, health providers have come to understand that integration of services and training effectively increases access for clients on a day-to-day basis while reducing the impact of provider absence.

Assessment team observations on key clinical services, garnered from visits to health facilities as well as from key person interviews and literature review, are presented below.

Integrated reproductive health (IRH). Family planning (FP), STI, and safe motherhood are all covered in a well-designed modular training curriculum that the MOH has adopted for national use. In keeping with guidelines in this training, all clients (adults and children, sick and well) in small health centers are seen in the out-patient department. Larger facilities separate services when client load is high and sufficient staff is available. Although provider knowledge of IRH services seemed good and personnel frequently noted that the concept had been a revelation to them, its application was sporadic. Most providers still tended to focus on a client's chief complaint and thereby missed opportunities that the IRH approach is designed to catch.

Critical practices, such as use of the partograph in labor or of birth plans as part of antenatal care, were in use in only about half of sites visited. Given the low rate of utilization of fixed facilities for delivery, USAID–funded projects should make a concerted effort to reinforce use of these tested practices. In interviews, most providers praised the safe motherhood birth plans and community perception exercises as particularly effective in increasing facility-based delivery—findings that have been echoed in other analyses. The value of these and other tools for improving quality of IRH services needs to be constantly reinforced through IST and support supervision.

Clinical procedures. Clinical procedures introduced under the DISH project—for example, manual vacuum aspiration, taught as part of postabortion care (PAC) training;

life-saving skills for pregnancy and delivery; Norplant® insertion and removal; tubal ligation; and vasectomy—have been practiced sporadically, if at all, since the close of DISH II. Reasons cited or observed included absence of trained personnel or equipment, depleted supplies of Norplant, and lack of training in the use of the vacuum extractor (used for women in prolonged labor) for nurses and midwives. (See below for further discussion of LTPM.) New projects should make strengthening of on-site skills a priority and should integrate content into IRH training wherever possible.

Integrated management of childhood illnesses. Since nurses or nurse aides are often the only providers at health facilities, IMCI training provided by DISH II has been the key factor in improving child health services. As the "in-charge" at a busy Health Center IV in Kampala, whose waiting room was overflowing with mothers, babies, and children, noted, "These nurses wouldn't be able to handle those patients without IMCI guidelines. We would have had to refer them if the doctor wasn't here." In most health facilities visited, IMCI guidelines were present in the consultation area, although providers were not seen referring to them. Providers seemed to know the protocol but, as in other areas, they did not consistently apply it. As a relatively new approach to child health care, the IMCI concept and its algorithms must be the subject of intensive training and retraining of health workers.

Adolescent-friendly reproductive health services (AFRHS). While this innovative approach to increasing adolescent use of RH services was shown to be effective during pilot testing (66 percent of adolescents in pilot centers used FP as compared with 47 percent of adolescents in other HCs), the DHMTs generally thought it to be unsustainably expensive. Indeed, the assessment team observed only a few adolescents in each of two AFRHS sites visited, and none were females. Health facility staff said attendance had dropped radically since termination of DISH II, when materials (especially videos and games) had become less available. A review of registers in the two sites showed that only 3 to 6 percent of FP clients were adolescents, while 14 to 18 percent of antenatal clients were adolescents. In short, while the AFRHS approach clearly increases adolescents' knowledge and of comfort with HCs, it is not yet translating into increased use of center-based FP services.

Given the critical reproductive health status of Ugandan adolescents (more than half the total population of the country is under age 15, only 7.5 percent of 15- to 19-year-olds use contraception, and 31 percent of females become pregnant before age 20), and absent newer ideas, the investment in AFRHS is probably justified. But follow-on activities must explore new ways to increase adolescents' use of services while decreasing costs.

Long-term and permanent contraceptive methods. DISH II outreach was singularly successful in increasing use of LTPM in its districts. The final report cites remarkable increases in couple years of venereal protection (CYP), and more than 70 percent of this increase was attributable to a LTPM "campaign" approach that proactively brought services to the population in their communities. Visits by outreach teams were preceded by intensive efforts using volunteer community health workers (CHWs) to inform and mobilize the population. Unfortunately, the initiative ground to a halt when DISH

support ended. Districts complained that providers trained in vasectomy and tubal ligation were no longer performing these procedures because of a lack of equipment and supplies. Perhaps even more distressing, the extremely high demand generated for Norplant had left the system, all the way up to the national medical stores, depleted of this commodity at the time of the assessment.

Almost no long-term methods (other than injectable contraceptives) are currently being provided in the DISH districts (or anywhere else in the country, for that matter). Although the DISH II LTPM outreach strategy was hugely successful while it was active, it has had little sustained impact. Some DHMTs suggested that LTPM campaigns had only short-term impact because most procedures were performed by outside teams and that on-site personnel were not adequately trained. Others felt that the intensity of the campaign approach "drained staff and created false expectations." Clearly, the depletion of Norplant stocks has also been damaging. USAID follow-on activities should make every effort to ensure dependability of stocks and possibly revisit use of the intrauterine device, which was supplanted by Norplant under DISH.

Immunization. Despite fairly high availability of immunization services at government and nongovernment sites, immunization rates show little improvement. The Systems and Services programs will need to give priority to strengthening a weak immunization program and drug distribution system.

DISTRICT TRAINING CAPACITY

DISH II helped develop a strong body of trainers within its own staff as well as within district health teams. The project trained nearly 450 trainers, most of whom have had some experience conducting training and follow-up for at least one of the clinical service areas discussed above. On the other hand, interviews with DHMTs and district trainers revealed that many of these individuals feel they have not had enough experience or mentoring in the different clinical trainings to initiate and organize trainings on their own.

That said, DISH II was a fast-learning and reactive project that improved its training approaches significantly as it progressed. Integrated trainings were appreciated for their comprehensiveness. Integrated orientations and use of the “whole-site approach” for the introduction of Yellow Star were considered highly effective and should be built upon for follow-on efforts. Expert DISH trainers, and perhaps some MOH staff, are considering forming a nongovernmental organization (NGO) that could provide specialized training services to the MOH when district cadres are not available or have not been developed. The team feels that this initiative is worthy of support.

Finally, most MOH representatives and DHMTs interviewed expressed the opinion that there was actually “too much training”, especially off-site (as opposed to facility-based) training, under the DISH projects. The effect of the many trainings offered was often to deplete health facility staffs for extended and uncoordinated periods and a consequent drop in service quality. While future projects will want to ensure the training and

refresher training of personnel, they should emphasize on-site approaches to health worker skill development and retention.

THE YELLOW STAR PROGRAM

The Yellow Star program was the signature innovation for quality improvement developed with DISH II support. The program recognizes facilities that meet and maintain 35 basic standards of quality. Based on the Minimum Health Care Package and linked to the community, these standards are divided into six categories: Infrastructure and Equipment, HMIS, Infection Prevention, IEC/Interpersonal Communication (IPC), Clinical Services, and Client Services. Yellow Star assessment teams determine whether each standard has been achieved, help the facility develop a plan for improving quality, and grant facilities consistently meeting the standards the "Yellow Star Award" as a seal of approval.

Yellow Star was implemented in two phases. The first assessments were conducted in six districts (Kamuli, Jinja, Luwero, Nakasongola, Mbarara and Rakai) in October 2001. The remaining six DISH districts were oriented and assessed in May 2002.

The team found a high degree of engagement in the Yellow Star program at all levels, from the leadership of the MOH to workers at the lowest levels of the health system. Facilities knew their rankings and what they needed to do to improve. Although some complained that the ability to meet every standard was beyond their control, all agreed that the standards were fair and constituted a minimum standard of quality. Many praised the approach, saying that it highlighted strengths as well as weaknesses, gave individuals concrete guidance on how to improve as well as the motivation to do so, and created a healthy sense of competition.

The Yellow Star approach is improving quality. By the end of DISH II, quality assessments in 174 facilities showed a 23.4 percent improvement in quality. Average scores increased from 48.1 to 75.1 percent. At the time of their first Yellow Star assessment visit, only 10 facilities scored above 70, while at the second visit 64 facilities scored above 70. No facilities scored in the high (91–100) range at the first visit; 13 did so at the second visit.

Table 1 - Improvements under Yellow Star

Category	Rating at Visit 1	Rating at Visit 2	Percentage Increase Between Visits
Infrastructure and equipment	42.2	61.3	45%
HMIS	44.1	55.2	25%
Infection prevention	36.9	60.0	63%
IEC/IPC	39.2	55.8	42%
Clinical services	51.9	66.1	27%
Client services	61.8	75.8	23%
Average score	**48.5**	**64.7**	**33%**

The assessment team analyzed a small sample of district Yellow Star scores to ascertain areas of greatest and least improvement. As shown in table 1, facilities had greatest improvement in infection prevention, followed by infrastructure and equipment, and IEC/IPC. More modest improvements were found in client services, clinical services, and HMIS. Almost all facilities improved over the baseline, although some units assessed after DISH II closed had declined, especially in clinical services and HMIS, indicating the ongoing need for strong support supervision.

The assessment team strongly recommends that USAID provide ongoing support to this creative approach to quality assurance. Yellow Star forms could be redesigned, to more clearly incorporate a specific plan for quality improvement in a given district and to identify who, or what level (for example, community, facility, supervision team, or HSD) is responsible for each particular element. Efforts should be made to ensure that all facilities have a good supply of forms so that the lack of forms would no longer be a valid excuse for failure to maintain the assessment cycle (a reason that the team encountered more than once). To further increase the opportunity for recognition and motivation, interim awards might be considered for facilities achieving a certain degree of improvement. Finally, the MOH could use cumulative Yellow Star scores to improve effectiveness of management teams at the HSD and district levels.

YELLOW STAR AND SUPERVISION LINKS

As described in chapter VII, if the Yellow Star approach is to succeed and the quality of care to improve in Uganda, assessments must be linked to supervision, and supervisory systems must be strengthened. Yellow Star assessments at the HSD level are designed to be conducted quarterly, during the third of each quarter's monthly support supervision visits. Although quite functional in many districts, the approach was not fully understood by all levels and needs to be reinforced. Assessment of HC IVs and hospitals, which is designed to be conducted by district-level assessment teams, seems even more problematic, with assessments not completed as regularly. Attention must be given to clarifying and reinforcing the role of district supervision teams.

LESSONS LEARNED

- The concept of integrated RH services has been effectively introduced and is widely appreciated by providers; however, it must be constantly reinforced through basic and IST and support supervision.

- AFRHS have been found to be effective, although the DISH II model has not been sustained. Given the size of the adolescent population of Uganda, such services must be an integral part of any ongoing program.

- The campaign approach to provision of LTPM achieved immediate impact, but left little behind except unmet demand. Such an approach must include

comprehensive training of local providers and the assurance of continued availability of supplies (for example, Norplant).

Training under DISH II was extensive and appreciated, but future programs need to achieve a better balance between off- and on-site training.

- The Yellow Star program is a success. Its potential as a tool for improving quality of care is so promising that the MOH is committed to applying it nationwide. Nonetheless, the program is still fragile. Only one facility has to date been awarded a Yellow Star, and others are discouraged about failing to get such recognition for reasons out of their control. In supporting the program, interim awards might be considered. A supply of assessment forms should always be available.

- Full integration of Yellow Star assessments with regular support supervision cycles is key to strengthening both activities and, ultimately, to enhancing quality.

IV. COMMUNITY-BASED SERVICES

THE FLEP/DISH EXPERIENCE

DISH II's involvement in supporting community-based RH services was most prominent in its assistance to the Family Life Education Project (FLEP). A project of the Busoga Diocese of the Anglican Church of Uganda, FLEP is a Jinja-based NGO that for many years has offered RH services through a network of 48 church-based rural health units (mostly at the HC II level) in Jinja, Kamuli, and Iganga districts. Interface between health units and the community is through a cadre of roughly 200 trained volunteer Village Health Workers (VHWs) who serve as the primary contact points for FP/STI/HIV education and counseling, contraceptive sales, and clinic referral.

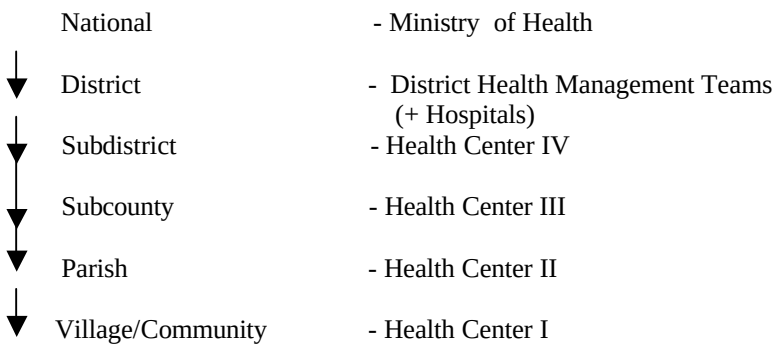
FLEP served as an early, significant model for community-based outreach and services in Uganda. With USAID funding, first through Pathfinder International and later under DISH I and II, FLEP provided logistical and material support to its VHWs. The rural health units to which they were linked charged modest users' fees that were used to pay staff salaries. FLEP also operated fee-based clinics in Jinja and Kamuli that provided LTPM services. Although this system did not prove to be independently sustainable, its use of VHWs was the first of its kind in the country. It demonstrated the impact that community-level, person-to-person contact can have in creating awareness of health issues and trust in health services.

A 2000 DISH II review highlighted chronic weaknesses in FLEP's financial management and administrative systems, as well as in the performance of its Board of Directors. At DISH's request, MSH and the Centre for African Family Studies undertook a comprehensive strategic planning exercise that led to the restructuring of internal management systems and retraining of the Board in their roles and responsibilities. For a period of time DISH even took over management of FLEP funds. To put FLEP in position to once again attract funding and ensure service quality, DISH also invested in retraining of VHWs and development of community-based HMIS. FLEP is now operating under its new structure with an interim director. For the moment, it has no significant donor support.

FLEP's management and Board weaknesses were highlighted as far back as 1996, in an evaluation for USAID ("Evaluation of the Busoga and East Ankole Diocese Community Family Planning Projects", POPTECH, October 1996). DISH II operated responsibly and creatively in bringing the issues to a head. The assessment team does not see justification for continued funding of FLEP. However, if FLEP is able to maintain its outreach program, a detailed evaluation thereof would be instructive to the development of sustainable community-based service approaches elsewhere. The FLEP/DISH experience is also illustrative of the advantages and pitfalls of working through NGOs. On the one hand, such arrangements can offer far more opportunity for innovation than programs funded by the public sector can. On the other hand, flawed leadership can seriously jeopardize a project's accomplishments.

OTHER COMMUNITY-BASED ACTIVITIES UNDER DISH II

Community-based health services (referred to as "Health Center I" although they are not offered from fixed facilities) constitute the most basic level in the hierarchy of health service delivery points that characterizes the Ugandan national delivery system:



The MOH's Health Sector Strategic Plan provides guidelines for action at the community level aimed at making people aware of health issues so that they can become informed consumers. In the seven districts visited by the assessment team, the DISH II project, working through DHMTs, employed various outreach strategies to increase community awareness of and demand for quality service. These included the following:

- Use of trained CHWs to promote safe motherhood, family planning, and other services;

- Use of CHWs to inform, generate demand, and prepare communities for LTPM campaign visits;

- Training and use of adolescent peer educators to transmit STI/HIV prevention messages to young people at community gathering places and events; and

- Organizing community mobilization activities, such as Child Health Days, where information, counseling, and services are available at a central location.

Such activities were generally carried out in collaboration with local NGOs, with the modus operandi depending on the type of NGO and social characteristics of the community served. The general result was to increase, at least temporarily, community use of existing fixed health facilities. But in the seven DISH districts visited, the assessment team found few commonalities in the relationships between DISH, the DHMT, and NGOs involved in community-based approaches. Likewise, the team found no mechanism through which to capture data on community-based health care services and information. Training of CHWs was, by and large, vertical rather than integrated; for example, it was linked to a single campaign or service, such as LTPM or safe motherhood. The concept and role of Village Health Teams (VHT), a key element of national policy in relation to community-based services, had not been operationalized.

In districts visited, DHMTs and subdistricts could provide little information on whether community-based activities initiated under DISH II were still operational. No support supervision, training, or documentation of such activities had been done since DISH II closed, the main reason given being lack of funds. DHMTs were of the opinion that district managers did not put funding of community-based services high on their priority list. While the concept of community-based information and services had been consistently validated under DISH II, instances of successful implementation were episodic and uncoordinated, often tied to narrow agendas, and low on the priority list once outside funding became unavailable.

THE FUTURE OF COMMUNITY-BASED SERVICES.

Oversight of community-level health care structures and services rests with numerous, sometimes overlapping, political and administrative bodies. These groups include the following:

- Local Councils
- Health Subdistrict Committees
- Subcounty Health Committees
- Parish Development Committees
- Health Unit Management Committees
- Village Health Teams

In the districts assessed, these structures were at different levels of training and motivation. For example, while several districts had elected their Health Unit Management Committees (HUMCs), many did not have funds with which to train committee members and were depending on local voluntary contributions, with mixed success. Further, HUMC participation in facility oversight had significantly diminished with the abolition of user fees, an indication that members viewed themselves primarily as financial watchdogs rather than as promoters of service quality and community acceptance.

Apart from the fact that some of these structures participated in the bottom-up district planning process, DISH II did not have a formal relationship with them. If these entities are to have broad impact, future USAID–funded programs must adopt a more proactive, integrated involvement with the community, tailoring interventions to a community's particular characteristics and concerns. In so doing, USAID will be supporting a key priority of the MOH, which is drafting national guidelines for selection, training, and supervision of VHTs and is collaborating with the National Bureau of Statistics to design a system to collect health data at community level for integration into the HMIS.

LESSONS LEARNED

- Although ultimately not sustainable in and of itself, FLEP's approach to community-based service delivery had a significant positive impact in the rural

communities where it was active. Elements of this approach will be instructive as efforts move forward to develop more sustainable services elsewhere.

- In selecting an NGO as implementing partner, a program should carefully analyze the NGO's management strengths and weaknesses and the quality of its leadership.

- The MOH has determined that community-based care (the Health Center I) is a critical component of the national system of integrated health services, and it is developing guidelines and strategies to define its approach. To be fully supportive, the Systems and Services programs need to draw on all experiences to date to make the coordinated, integrated approach to community-based services a clear priority.

- Early and continuous involvement of existing community structures is essential to the success of this approach. Such involvement can help ensure that interventions are tailored to a community's particular characteristics and needs.

V. BEHAVIOR CHANGE COMMUNICATION

IMPACT OF DISH II BCC INITIATIVES

DISH II continued and expanded DISH I's approach to influencing behavior change and creating demand for services by combining community outreach with the creation of BCC/IEC messages, materials, and other products. For example, DISH II reached out to communities, families, couples and individuals through

- A radio magazine that focused on specific health issues, such as malaria prevention and control, immunization, male involvement in family planning, prevention of STIs, VCT, and infant nutrition and breastfeeding. The radio programs were timed to coincide with overall BCC campaigns. Follow-up studies showed that listenership for these programs was two or three times higher in DISH districts than in others.

- Publication in three languages of the quarterly newsletter *Health Matters*, which treated health topics of importance to specific audiences and was distributed as newspaper inserts, through health facilities, and at community events. (As noted below, circulation was far wider than it needed to be, because many Ugandans do not have the literacy skills needed to read the newsletter.)

- Publication of *The Health Worker*, a journal for health service providers distributed through private and public health facilities. Health workers found it informative, but only four issues were published before DISH II ended.

- Production of the acclaimed "Centre 4" video series, which presents stories about issues surrounding the work of the staff of a rural Health Center IV. The video is now available in four languages. (The assessment team was privileged to deliver copies of the videos to DHMTs in the DISH districts that it visited.)

Other products included best-practices guidelines, flyers, posters, flip charts, and the Yellow Star campaign. While detailed information on achievement of behavioral objectives is not available, data gathered through the project's sentinel surveillance system offer some significant indications of its impact. For example, at sentinel sites in DISH districts, CYP, which had declined steeply between 1998 and 2000, increased dramatically in 2001 and 2002. Targeted outreach campaigns resulted in a fourfold increase in LTPM CYP between late 2000 and early 2002. Attended deliveries, down 21 percent between 1998 and 2000, increased by 40 percent in 2001 and 23 percent in 2002.

BCC CAPACITY AT DISTRICT AND LOWER LEVELS

BCC/IEC activity under DISH II was district focused, through campaigns devoted to specific areas (for example, LTPM, safe motherhood), and overseen by IEC Coordinators in the four DISH branch offices. Materials and messages for each campaign were developed from data gathered through focus groups and other sources. IEC Coordinators

worked with District Health Educators and local organizations to develop work plans and budgets for campaign activities.

District health teams are experienced in organizing community mobilization activities such as Child Health Days, safe motherhood community meetings, and bicycle rallies. Such events were used as focal points for outreach campaigns. (In the post–DISH era, such activities are extremely limited.) DHMTs also spoke enthusiastically of working with local drama groups and brainstorming preventive health messages for scripts that the groups then performed for youth and community audiences. To encourage such outreach, DISH II trained hundreds of adolescent peer educators, safe motherhood and family planning CHWs, and other community resource persons. Capacity for materials development at district and lower levels was lacking, however, and remains so. In the future, District Health Educators and others would benefit from training in message and materials development, possibly through CDFU.

ACCEPTANCE AND UTILIZATION OF DISH BCC MATERIALS

MOH officials spoke in positive terms about the quality and impact of DISH II's BCC strategy and output. They praised the project for working so closely with districts in developing BCC strategies, for the effectiveness of its messages, and for the exposure DISH II gave to a wide range of media tools. They also noted that non–DISH districts were frustrated because they could not avail themselves of this resource.

On the other hand, the Ministry felt that DISH's analysis of the responses to different messages, especially in terms of increased service utilization, was inadequate. Such analyses are clearly the most difficult aspect of any BCC program. Some MOH personnel also expressed antipathy for the "campaign approach" to message dissemination, largely because of its tendency to "make a splash and then be over" and to create false expectations. This view was not universally shared, especially at the district level, where the campaigns provided opportunities for community mobilization around health issues.

Mirroring opinions expressed to the team in most DISH districts, one DHMT prioritized BCC/media approaches, in terms of impact and community response, as follows:

1. Mass media—radio, television, and video—are the single most effective methods of reaching a large rural audience with health messages on a repeat basis.

2. Dance and drama, using theatrical troupes that are found throughout the country, can generate enthusiastic response and questions in the community, especially among young people.

3. Print materials can be helpful, especially well-illustrated posters and leaflets that do not contain excessive verbiage.

The fact that print material ranked as the third priority is a useful piece of information for future reference. In sum, there is a receptive but limited audience for newsletters and

newspapers, even when published in local languages. For example, the team noted that most of the copies of *Health Matters*, widely and plentifully distributed in three languages throughout DISH districts and beyond, went uncirculated and unused (or at least not used for their intended purpose). District offices and health facilities had large stocks of back issues of the newsletter in storage at the time of the team's visits.

Health workers and administrators, especially at district and health subdistrict levels, as well as some community leaders, found *Health Matters* informative and valuable, and they regretted its demise. But the great majority of people did not take the time to read it, preferring simpler, more interactive presentations of information. If *Health Matters* is reincarnated, as the team hopes it will be, a more targeted circulation is recommended, along with follow-up through reader surveys and other mechanisms to gauge response and further refine the audience.

Such follow-up is one of many tasks that might be taken up by the Communication for Development Foundation, Uganda (CDFU). An offspring of the DISH II IEC/BCC initiative, founded by DISH II staffers and others as the project was coming to a close, CDFU is a private-sector NGO that seeks to fill a market gap in Uganda in the capacity to design and implement IEC/BCC programs and campaigns. CDFU has sold its services to a number of programs in the health sector, and it is hoping to play an integral part in the new Systems and Services programs. The review team found it to be a promising young organization, worthy of serious consideration as a program partner.

LESSONS LEARNED

- Audience responses to BCC approaches are as varied as the approaches themselves. Both audiences and approaches should be constantly evaluated.

- BCC initiatives should be developed with sustainability in mind.

- CDFU is worthy of continued support, as a "think tank" and technical resource for development of use of different media to transmit messages, training of district IEC/BCC specialists, and analysis of the impact of BCC messages and activities.

- Especially at the community level, mass media and interactive activities find a greater response than print materials, which have a relatively limited (if essential) audience.

VI. CAPACITY OF DISH DISTRICTS TO SUSTAIN SERVICES

KEYS TO SUSTAINABILITY OF SERVICES

DISH II strengthened service capacity and effectiveness in its 12 districts, helped by its emphasis on integration and on the initiation of Yellow Star assessments that focused on achievement of 35 basic quality standards for health facilities. In the process, several keys to the sustaining of high-quality RH/maternal and child health (MCH) services were made clear.

Training follow-up and supervision. DISH II supported a great deal of training of health workers at all levels and in a wide range of skills. Most trainings were residential, that is, they took place away from the trainees' assigned posts. Training facilitators were drawn from District Training and Supervision Teams (DTSTs), led by project "Master Trainers." Follow-up visits by DTSTs to trainees at their work sites were scheduled for four and eight weeks after each training session. Unfortunately, much of the training under DISH II was offered late in the project, and DTSTs report they have not been able to carry out assigned follow-ups due to lack of funds. Most DHMTs regard training follow-up as a distinct and separate activity; however, with good planning and record-keeping this function could and should be integrated into routine support supervision.

Deployment of staff. Despite the volume of training under DISH II, frequent and unpredictable transfers of health personnel often left facilities with staff who had not been trained in key service areas. To maximize sustainability of DISH II inputs in strengthening health services, DHMTs need to be able to verify that facilities are staffed with appropriately trained health workers and to plan for additional trainings as gaps arise. An effective tool for this purpose is the Supervision, Yellow Star, Training Information and Management System (SYSTIMS) developed by DISH II, which is discussed in the HMIS section below.

Role of CHWs in sustaining services. CHWs play a key role as the interface between communities and health facilities. They do so by creating awareness of health issues at the village level and by generating demand for access and quality in health services. As an example, the project identified and trained CHWs to educate men and women on family planning and to refer clients interested in FP to health facilities for counseling and to register for periodic outreach services. Also, LTPM outreach campaigns were spearheaded by CHWs specially trained to explain the benefits of accepting long-term or permanent contraceptive methods.

The importance of continuity. While statistical analyses of the impact of these initiatives attest to the effectiveness of CHWs in creating demand, there were indications that they may have a negative impact if continued support is not ensured. For example, once community mobilization efforts ended and DISH II closed, districts no longer had the budgetary or technical capacity to support providers of LTPM services at outreach locations. Further, in the case of Norplant, national stock-outs meant that this product was

no longer available at any level. Demand had been created, but the system was no longer able to respond. In such situations, the population tends to lose motivation, and a negative impact on future mobilization campaigns can be expected.

Support supervision. A strength of DISH II was its work to improve the capacity of districts and subdistricts to supervise services and providers. In so doing, the project was guided by the Ministry of Health's enlightened philosophy of "support supervision," that is, supervision that is used as an opportunity to train and encourage as much as to oversee. The project collaborated with the MOH and other partners in finalizing National Supervision Guidelines and distributing them in DISH districts. This was followed by training of district and HSD supervisory teams and provision of funds through district grants to carry out monthly support supervision activities.

Despite the closing of DISH II, most DHMTs and HSD teams have been able to continue supervision activities, although often on a much-reduced basis. It has sometimes been difficult to maintain a regular monthly supervision routine, and many teams now must visit several health facilities on a single day rather than make full-day visits. Nonetheless, the concept of support supervision has been embedded in the system, and in several DISH districts Yellow Star assessments have been integrated into the routine sequence of supervisory visits (see below).

Yellow Star program. Yellow Star was DISH II's principal tool for enhancing the health system's capacity to ensure the quality of integrated services. Its cost was covered by project funding and subgrants to districts. Since the close of DISH II, continuation of Yellow Star activities has depended on funds provided through central MOH mechanisms. Principal recurrent costs are public information (radio and other media), supervision to carry out assessments, printing and distribution of assessment forms, and holding award ceremonies. As an example, the Rakai District has budgeted 10 million Uganda shillings (Ushs), or about US$5,500, for these expenses in 2002–2003.

The key element of the Yellow Star process is the quarterly visit to each facility, when assessment and scoring are carried out. The team noted that several districts regard Yellow Star activities as distinct from regular support supervision; each activity is covered separately in district budgets. Other districts have integrated Yellow Star assessments into the monthly sequence of support supervision visits, with one visit per quarter devoted to a Yellow Star assessment. Although the visits are different (a Yellow Star assessment focuses specifically on 35 standards of quality while a regular support supervision visit concerns itself with all health facility operations), they are also complementary, since both focus on strengthening services The MOH intends to promote this integration as Yellow Star is rolled out to new districts, which will be critical to sustaining both of these essential tools.

LOGISTICS SYSTEMS

In collaboration with the MOH, the DANIDA District Drug Management Program, and the DELIVER Project DISH II developed a joint work plan for improving district-level

drug management. Assistance included drug needs quantification training in the 12 project districts and reinforcement of stock management procedures during supervision visits. The project also supported refurbishment and equipping of district medical stores and provided basic supplies and stock cards to health centers.

The outcomes of project efforts were positive. The DISH II 2002 Facility Survey found that stock-outs of oral contraceptives occurred in 23 percent of facilities in 1999 compared with only 7.6 percent in 2002. Over the same period, the facilities' stock shortages for injectable contraceptives declined from 18 percent to 10.5 percent and for condoms from 58 percent to 9.5 percent. DHMTs also noted that drug supply orders coming from lower-level health units were more precise and contained more of the needed information.

Unfortunately, DISH II ended before new logistics systems were fully operational. Apart from the supportive interventions described above, the project itself had little control over supply of drugs and contraceptive commodities to health centers; instead, it had to rely on existing and emerging national systems to ensure that necessary items were in place to support quality services. As already noted, periodic national stock outages and delays in delivery at times compromised project activities. To compensate, DISH II personnel often obtained and distributed drugs and supplies from their own alternative sources. While this ensured that project activities moved forward as planned, it also created a false sense of security by covering up inefficiencies in systems that must be remedied now that project support has ended.

The USAID–supported DELIVER project has been working at national level to strengthen procurement and distribution systems for drugs and commodities, and will continue to do so over the next several years. The Systems and Services programs will need to work closely with DELIVER to help develop and put in place more efficient and responsive systems at district, HSD, and health facility levels. There is no more fundamental prerequisite to building confidence in the responsiveness and quality of a health system than the assurance of a ready supply of drugs and other commodities.

HEALTH MANAGEMENT INFORMATION SYSTEMS

To collect and track data and facilitate more efficient planning and management of district health services, DISH II developed a district-level HMIS software program based on the MOH HMIS. It introduced reporting formats, trained HMIS officers in all project districts, and trained DHMTs, HSD managers, and HC in-charges in analysis and use of data for decision-making. Although the project established a selected number of facilities to serve as sentinel sites for monitoring purposes, systems and training activities covered all health facilities in the 12 project districts. A second software package, known as SYSTIMS, was introduced to track supervision, Yellow Star, and IST information at the district level. Computer hardware was also provided to each district and to selected HSDs.

HMIS reporting from lower-level health units to DHMTs and the central MOH clearly improved over time. By 2002, DISH districts showed an average HMIS reporting rate of 95 percent compared with a national average of 86 percent. Sixty-eight percent of reports in DISH II districts were submitted on time compared with 56 percent nationally. The assessment team observed that all DHMTs and HC IVs visited, plus a number of lower-level health units, had charts and graphs on display showing trends in certain indicators over time. The team was unable to assess how well this information was actually used to make management decisions, particularly at lower levels, but all health unit staff and supervisors interviewed said that the project had given them a new appreciation of the value and utility of such information.

Nevertheless, there is a long way to go before this appreciation is fully translated into practice. The assessment team observed that DHMTs were not fully utilizing the software provided them. Most districts were entering data from the monthly HMIS-105 forms, but few were able to generate reports using the program. Instead, HMIS officers were transferring data by hand into Excel to generate charts and graphs. Some districts had experienced computer problems and were therefore not using their HMIS at the time of the assessment team's visit, and no HMIS officers had back-up data. No district visited was using the SYSTIMS software program to collect data on supervision, Yellow Star, and training. Most did not even know that the program was installed on their computers.

A key reason for low levels of utilization of new software was that systems were introduced and HMIS officers trained very late in the project, allowing no time for post-training follow-up. DHMT staff frequently mentioned to the team that, in this regard, they felt somewhat cast adrift, unable to fully operationalize their new knowledge and resources. The team also observed that district HMIS officers were often selected from lower-level staff, such as records clerks and assistants. Such staff tend to have limited experience with computers and often lack the training and background to be able to assess the accuracy of data or undertake basic analysis. While such personnel can be effective as data entry clerks, future programs should encourage selection of higher-level officers to actually manage data collection and analysis. The new Ministry of Local Government (MOLG) structure for DHMTs includes a position of HMIS Officer at the U5 level. Ideally, this should be a U3 level position, one that could be filled by trained statisticians. The Systems and Services programs should work with MOH and MOLG to see whether this level can be adjusted. Another option would be to assist districts to identify alternatives to ensure that HMIS data are well managed and used.

While HMIS reporting rates have improved significantly, the accuracy of data collected remains a concern. The DISH II project team, together with DHMTs, undertook periodic data validation exercises to cross-check HMIS summary data submitted to the DDHS against records kept in health facilities. Results indicate that there is still a significant amount of error in data generated as a consequence of poor reporting at health facility level. Since MOH systems have eliminated most incentives for under- or over-reporting, simple transcription error is the most likely reason for the majority of inaccuracies. DHMTs found such validation exercises to be of considerable value and they intend to continue them in future. Basic data validation is also included in the Yellow Star

process, so it should be possible for MOH and DHMTs to track trends toward improvement in this area over time.

DISH II was successful in improving collection and utilization of data for decision-making at district, HSD, and health unit levels. Future programs should be able to build on this foundation to continue improving skills at all levels in using data in routine planning, management, and monitoring. To this end, much remains to be done to enable MOH and lower-level managers to make full use of information in continuing to develop a responsive, high-quality health system.

FINANCIAL SUSTAINABILITY

Initially DISH II planned to address the issue of the financial sustainability of health districts by strengthening management of cost-sharing mechanisms at the facility level and by exploring opportunities for community health insurance or prepayment schemes. The March 2001 abolition of user fees in government health facilities made this strategy no longer operative. Consequently, DISH II focused on strengthening capacity at district and HSD levels to budget, plan for, and manage finances provided through government and donor funding mechanisms. District management of DISH II subgrants provided the project with a hands-on opportunity to work with DHMTs and HSD managers on integrated planning, implementation, and reporting.

Building good financial and resource planning and management skills will be increasingly important, particularly at lower levels (HSDs, subcounties, and individual health facilities) as Uganda's decentralization process moves forward. The Systems and Services programs can work with MOH, MOLG, and other partners to develop financial and resource-management tools appropriate to lower-level structure, and to provide integrated, coordinated management training programs for lower-level managers and providers.

LESSONS LEARNED

- Exit strategies should be planned well in advance of the final stages of a project. Implementation of new activities should be phased out at least three months before the end of the project to ensure that new systems and skills can be fully understood, appropriately used, and effectively applied after a project comes to a close.

- A project must make sure that new skills given in training sessions, such as for HMIS, are being used in the worksite. Sustainability of training activities requires follow-up at the workplace for several months. Without follow-up, training may be a waste of time and money.

- Assisting the MOH to integrate Yellow Star assessments into its support supervision system should be a primary objective of any new USAID–funded programs.

- No single factor can contribute more to the dependability, and thus the sustainability, of a health system than the assurance that health units at all levels have a ready supply of drugs and commodities when needed and requested.

VII. DISH II CONTRIBUTIONS TO NATIONAL SYSTEMS

YELLOW STAR PROGRAM

Yellow Star, perhaps DISH II's most significant innovation, has been fully embraced by the Ministry of Health, and plans are in place to introduce the program country-wide. First-phase introduction in 20 identified districts is scheduled to take place in FY2002–2003, although funds have not yet been fully secured. (These 20 districts should not be confused with those to be selected for coverage by the Services program, although there may be overlap.) Districts are expected to fund a significant proportion of roll-out costs from primary health care (PHC) conditional grant funds, with additional funds to be made available from MOH and yet-to-be-identified donors. Given the short timeframe, combined with multiple competing priorities for limited MOH and district funds, it appears unlikely that the target of 20 districts will be achieved this year. Nonetheless, the MOH remains fully committed to incorporating Yellow Star as a central tool for promoting and monitoring service quality throughout the system.

Now that Yellow Star has been in use for 12 to 18 months in DISH II districts, it is clear that a number of adjustments may need to be made in some of its tools before the program is implemented nationwide. To be prepared to fully support MOH priorities, the Systems and Services programs will need to undertake a detailed assessment of Yellow Star program implementation and determine what changes are required.

CLINICAL TRAINING

Training curricula and materials developed with DISH II support have been fully taken up by MOH as national standards. These include self-instruction manuals, BCC (see below) and distance-learning materials, and curricula and supervision guidelines for the clinical, MCH, and QA interventions (Integrated Reproductive Health and Life-Saving Skills, Emergency Obstetric Care, IMCI, PAC, HMIS, Yellow Star, LTPM, and Control of Malaria in Pregnancy, among others) on which the project has focused. While copies of these materials have been distributed to MOH and other development partners and programs, they have not yet been disseminated to all DHMTs. The Systems and Services programs should consider providing whatever assistance they can to make this dissemination a reality, and thus gain maximum advantage from the many DISH II inputs that have met with MOH approval and acceptance.

TRAINING CAPACITY

DISH II employed 18 Master Trainers to implement training and supervision activities in the 12 project districts. The goal was to develop a 10- to 12-member district training and supervision team in each DISH district. The DTST teams would, in turn, train service providers in basic clinical skills components. The project also established four regional teams to provide LTPM outreach services and training. This training structure remains largely in place and can continue to function if sufficient funding is made available.

Given their relative newness, the teams will require regular supervision over the medium term as they gain experience in providing quality training.

There is no formal pool of qualified trainers at the national level to further develop and oversee the district teams. A number of Master Trainers who have worked with DISH, MOH, and other programs have discussed setting up a private-sector NGO or consulting group so that qualified trainers could be contracted by MOH, districts, and various donor-funded programs to present training-of-trainers and other training programs countrywide. Providing TA and support to this group through USAID–funded programs would help fill a critical gap in national training capacity.

IEC/BCC

DISH-developed IEC/BCC materials have been provided to the MOH Health Promotion and Education Department (MOH-HPED) with the intention of making them available to districts and implementing partners country-wide. HPED does not have a budget to reproduce these materials; production, dissemination, and continued use will depend on external funding. Implementing partners should take their lead from HPED to ensure that the messages conveyed in this materials are consistent and to promote coordination and collaboration in testing and dissemination of messages and materials. This is essential to making maximum use of experience and resources.

One such resource is the Communication for Development Foundation Uganda (CDFU), described earlier. CDFU has solid experience and strong links with a variety of media production companies, and with the right opportunities has the potential to provide high-quality technical assistance to the MOH and its partners in helping them expand from traditional IEC to new BCC approaches. Systems and Services would do well to support this fledgling initiative and thus sustain an important legacy of DISH II.

MANAGEMENT INFORMATION SYSTEMS

The DISH II-developed HMIS and SYSTIMS software are more fully discussed in chapter VI. These tools were finalized and introduced to the 12 DISH districts shortly before the project closed, but are not being fully utilized by all districts. More training and, especially, follow-up are required at district level. These tools might be better managed by higher-level DHMT officers than by the individuals who currently are responsible for their use (that is, records clerks who have limited experience with computer systems and lack the analytical skills needed to fully use the information generated). Both systems have been handed over to MOH, and both have the potential to serve as much-needed national and district-level information management systems. The MOH HPD is assessing the DISH HMIS system, as well as two similar systems developed by other programs, to determine the proper configuration for a national HMIS system. To assist this process, both DISH systems should be assessed to determine what further adjustment and development are needed to take them to HSD and national levels, should the MOH decide to go with one or both of the DISH II packages.

LESSONS LEARNED

- DISH II made substantial contributions, refined in the course of its close involvement with 12 health districts, to development of national systems, including QA (through Yellow Star), HMIS, training, and BCC. These contributions have been positively acknowledged by the Ministry of Health. USAID and its new programs are urged to maintain close collaboration with the MOH and other partners, continuing to strengthen these and other systems and expanding their capacity for national application.

VIII. DISH II DISTRICT GRANTS PROGRAM

STRENGTHS AND WEAKNESSES

Much of DISH II's support to the 12 DISH districts was provided in the form of grants, each signed by the project's prime contractor, JHU/CCP, and the respective DDHS. Grants totaling roughly US$1.4 million were awarded over two fiscal years; the amount of individual grants varied according to the size of the district and its demonstrated capacity to manage funds.

Activities covered by the grants were fairly consistent across districts and were directly linked to annual district plans. About half the funds were spent on training, with the remainder spent on recurrent costs (that is, field allowances, fuel, and transport) to support BCC, management, and QA activities, including Yellow Star and support supervision.

DISH II provided TA to each DHMT's annual planning process, using MOH planning and budgeting guidelines. This helped build planning capacity at district level while ensuring that project-supported activities fit with district priorities and were included in annual work plans. District subgrant amounts were established at the time of planning, so that each district knew in advance the level of funding to be expected for each fiscal year.

DHMTs gave high ratings to the DISH II district grant approach, contrasting it with other donor-supported projects that implement activities directly with project staff and thereby compromise the role of district managers. Although DISH II objectives did not cover the full range of district priorities, DHMTs appreciated the reliability of approved funding and the ability of the project to respond, albeit with limitations, to changing district and HSD priorities. With TA from DISH II branch offices, districts gained the capacity to track subgrant activities, monitor achievements against targets, and prepare project and donor reports.

To gauge the impact of project closure, the assessment team looked at the health budgets for several districts. Among them was the Jinja District, in which DISH II grant funds represented 13 percent of the total health budget for FY 2001–02 (see following table). If development funds and NGO facility grants are excluded from the total (because they do not cover recurrent costs for districts and HSDs), DISH II grant funding was 20 percent of all funding available for recurrent costs and activities in the years for which it was awarded. As World Bank health funding also ended in late 2002, the Jinja District experienced a total decrease in FY 2002–03 of 35% of funds previously available for district health activities. Similar situations were to be found in other DISH districts. The six DISH districts in southwestern Uganda were additionally affected by the conclusion of the EDF Rural Health Project in December 2002.

For FY 2002–03, districts expected a significant increase in PHC non–wage grants from the MOH that would help offset the loss of project funds in DISH districts. But districts

and HSDs report that they are receiving only about 75 percent of funds expected so far this year. (The team was unable to quantify this in the time given, but data on district budgets and actual releases can be obtained from MOH-HPD.)

Table 2 - Jinja District Health Budget--FY2001–02

Budget Allocation	Agency	Budgeted Ushs (in millions)	Percentage of Budget
PHC non-wage	MOH	289,345	36
Medical development*	MOH	168,924	21
DHSP–KFW	World Bank	112,000	14
DISH II	USAID	104,066	13
NGO health units*	MOH	101,326	13
Other	District	24,523	3
Total		800,184	100

*These line items are earmarked for specific purposes and do not include funds to cover current expenditures at district or HSD level.

DISH II district grants appear to have been more accessible, reliable, and relevant to districts than other funding, as evidenced by levels of expenditure against budget. 100% of DISH grant funds were expended by the Jinja District in FY 2001–02, in contrast to development fund expenditures (85% of amount budgeted) and World Bank fund expenditures (less than 10% of amount budgeted). Similar patterns occurred in other districts. The assessment team did not explore reasons for the failure to expend all funds from these other sources.

The transition from DISH II district grants at the end of the project differed from district to district. Some districts used funds from other sources to continue DISH-supported activities. They started scaling down activities in advance in anticipation of decreased funding. Other districts are still struggling to fit former project-supported activities into already-allocated budget lines. Now that funding is more limited, most districts and HSDs said they were undertaking fewer supervision activities than planned. No district had carried out any training, IEC/BCC activities, or LTPM outreach since the close of DISH II.

LESSONS LEARNED

- Providing direct grants to districts ensured that project activities were carried out and targets achieved.

- The district grants mechanism allowed DHMTs to be the principal implementers of project-supported activities. This contributed significantly to capacity building in such key areas as management, planning, and implementation skills.

- Sustainability, implementation, and exit strategies need to be carefully planned from the beginning to minimize the impact of closure of a major project grant such as DISH II.

- Future MOFPED guidelines will include all project-based donor resources in MOH and district budget frameworks, which means that equivalent amounts will be deducted from central funding allocations to MOH and districts. Donor-funded projects will therefore need to work with MOH and district partners to ensure that project resources support district needs and priorities, contribute to capacity building, and do not compromise the provision of a full range of basic health services at lower levels.

IX. COMMENTS FOR DISH II SUCCESSORS

The Lessons Learned sections at the end of chapters II through VIII provide detailed summaries of the assessment team's conclusions. This chapter summarizes the team's findings and recommendations for managers of subsequent USAID–funded programs of support to the Ugandan health sector.

PARTNERSHIPS

Findings. Even though its support for implementation was district-specific, DISH II, in contrast to DISH I, proved the value of maintaining a close working relationship with the central MOH. While Ugandan health systems are decentralized, they can be sustained only through a standardized, nationwide approach. DISH II worked diligently to achieve the organizational synergy necessary to make this possible and, in the process, to support the MOH's HSSP. The development of HMIS, immunization, IMCI, Yellow Star, training, and other systems helped operationalize a sector-wide approach to health system strengthening. However, the partnerships between districts, health subdistricts, and lower levels are still of uneven quality, and sharing of ideas and accomplishments across districts is limited.

Recommendation. Follow-on programs must maintain a balance between district-focused and central MOH support and information sharing. Systems developed under DISH II are still fragile, and close collaboration with the MOH is essential to their growth. Full implementation of a national HMIS, combined with the harmonization of support supervision and Yellow Star assessment cycles, will help solidify working relationships between districts, HSDs, and lower levels. Equally important will be a more transparent, collaborative approach to involving administrative and political structures in program planning, from CAOs to subcounty administrators, health committees, and community groups.

QUALITY ASSURANCE

Findings. DISH II's concentration on improving quality and access in RH services through training, financial, and logistical support, as well as its intensive focus on support supervision, have had a significant impact in DISH districts, even though serious problems of service quality remain. Outreach activities, notably for LTPM, were successful in the short term, although local capacity to maintain such services is still lacking. While drug and contraceptive supplies are still problematic, the concept of integrated services has been widely embraced. Yellow Star, DISH II's signature innovation, is proving to be an effective supervisory and QA tool that has substantially raised service quality in DISH districts over its short life span.

Recommendation. The most effective way to improve quality of services in Uganda is through regular, comprehensive support supervision of health facilities. Ensuring uniform application of the Yellow Star program through full integration into support supervision

cycles will strengthen the program's potential impact on quality. More prosaically, making sure that all facilities have ready supplies of Yellow Star assessment forms will eliminate a common reason for delay. In addition, no effort should be spared in making new logistics systems operational, so that stock-outs of drugs and supplies, another critical impediment to quality, no longer occur at any level.

COMMUNITY-BASED SERVICES

Findings. Involvement of communities and community agents in health service delivery varies widely in Uganda. Few models have proved sustainable, especially since the abolition of public sector user fees. FLEP's use of VHWs, supported by DISH II, demonstrated a dynamic approach to community-based services, but one that was ultimately unsustainable. Other DISH II-supported community-based efforts consisted of outreach initiatives for LTPM, Child Health Days, safe motherhood, and the like, using CHWs to prepare the ground. Their objective was to expand community awareness of and demand for service quality and to increase utilization of fixed health facilities.

Recommendation. Mobilizing community resources to provide basic services (the designated "Health Center I" of the national health system) and to strengthen links with and trust in health facilities and providers is key to ensuring full coverage, especially in rural areas. A survey and analysis of projects that use CHWs, VHWs (the FLEP experience), and other agents to provide RH information and services would provide a basis for determining the most functional and sustainable approaches. Political and administrative structures at local and subdistrict levels must also be involved.

BEHAVIOR CHANGE COMMUNICATION

Findings. DISH II developed an approach to behavior change and demand creation that integrated community outreach with a wide range of BCC/IEC materials and initiatives, such as the Yellow Star campaign, best-practices guidelines, a newspaper and newsletter, radio programming linked to community-based services, and the acclaimed "Centre 4" video series. Statistics from DISH sentinel sites indicate that this effort resulted in substantial increases in service utilization; however, much of it was unsustainable, and some dissemination plans proved to have limited benefit. *Health Matters* and *The Health Worker* are no longer published, and the former was too widely distributed to audiences with limited literacy. Radio programming had to be discontinued for budgetary reasons, despite the fact that it is the most appreciated of the mass media in rural areas. Follow-up data on the use and impact of the videos are uncertain. Yellow Star is the most visible remaining evidence of DISH II, but its materials need to be reinvigorated. Overall, the DISH BCC effort left a significant legacy, creating demand for messages and materials that is waiting to be met once more, and leading to the launch of CDFU, a new NGO with potential to be an important technical resource.

Recommendation. Future BCC initiatives should be developed with sustainability and a discerning eye as to audiences foremost in mind. It is better to have fewer products , with a reasonable expectation of being continued after external funding expires, than to whet

and then disappoint appetites. It is also essential that publications and broadcasts designed for general audiences be available in local languages, as they were under DISH. Follow-on projects are also encouraged to support and work with the CDFU.

HEALTH MANAGEMENT INFORMATION SYSTEMS

Findings. Through training, establishment of sentinel sites, provision of hardware, and development of a comprehensive computerized database, DISH was instrumental in demonstrating the value to the health system of decision-making based on timely health facility data. While still young, an "information culture" is rapidly gaining acceptance in Uganda, and this phenomenon has positive implications for future decision-making. DISH II ended too soon to adequately support those trained in HMIS systems use. Capacity for recording and using data at all levels needs further strengthening, as does central database management.

Recommendation. Notwithstanding decentralization of the health system, ensuring HMIS capacity at the MOH level, including selecting database software sufficiently robust to analyze and disseminate data on a national scale, is in everyone's interest. Technical and logistical support to this end are urged, in order to regain lost momentum. Equal attention should be given to developing HMIS capacity at all health facility levels.

DONOR STRATEGY

Findings. All would agree that DISH II lasted too short a time to enable it to fully implement and nurture its many innovations. Probably the most significant of these, Yellow Star and HMIS, remain fragile; they could founder without sustained support. The impact of many DISH II outreach initiatives, all well received, was nonetheless limited. Three years is too brief a time for a project that is ambitious in scope, under new management (with a prime contractor unfamiliar with its management role), and given more to do than its immediate predecessor. A daunting task was further complicated by periodic suggestions on the part of USAID that the project might be extended, for anywhere from two to six years. Not surprisingly, there was too little time for a proper project phase-out, as activities continued full bore until the end and then were summarily cut off. Funds available to many districts were drastically reduced. A recipient of less flexibility and resilience than the Uganda MOH could have been seriously disillusioned by such circumstances.

Recommendation. Investments as ambitious as DISH II must be given an appropriate amount of time to bear lasting fruit and to be clear on their timetables. Planning for the sustaining of initiatives after external funding ceases must be started at the outset. Strategies might include "front-end loading" of financial and logistical inputs and gradually diminishing them over time as national resources take up the slack. The excellent rapport developed by DISH II with the central MOH, if it is maintained, will be of enormous value to this strategic planning process, not least because two new programs—Systems and Services—are being simultaneously introduced, and their harmonization will be critical to future success. The assessment team also urges that

USAID seriously consider building on its DISH investments by maintaining support to some DISH districts, notably those where motivation and energy are high, but capacity still fragile.

APPENDICES

A. Achievement of Expected DISH II Results

B. Persons Contacted

C. Scope of Work

APPENDIX A

ACHIEVEMENT OF EXPECTED DISH II RESULTS

ACHIEVEMENT OF EXPECTED DISH II RESULTS

DISH II was developed to assist USAID/Uganda achieve its Strategic Objective (1997-2001) of "increased service utilization and changed behaviors related to reproductive, maternal and child health". The project was designed to achieve four intermediate results set forth below. Statistical success in doing so has been analyzed in several documents. These include the *DISH Final Project* report, January 2003; the 2002 *DISH Facility Survey* (the assessment team used the December 2002 draft version); and a case study review entitled *Evaluation of DISH Special Interventions,* conducted by Makerere University. The team did not conduct extensive data collection of its own, but rather sought to clarify and confirm findings reported in these and other documents.

FINDINGS

Ninety percent of appropriate health facilities in the 12 DISH districts will provide reproductive and child health services.

The table below presents data from three consecutive DISH project facility surveys. The 2002 Facility Survey confirms that, in the 12 DISH districts, access to core services has been steadily increasing since 1997, with most now available in more than 90 percent of government facilities. VCT, still in its relative infancy, has also become more available, although at a lower overall level. Services showing declines include family planning (in the NGO sector) and delivery care. But the survey report suggests this may be due to the vagaries of sampling. Because of rapid increases in private, for-profit health facilities since 1997, the composition of samples differs radically, with such facilities representing only 15 percent of the sample in 1997 and 71 percent in 2002. Hospitals and HC IV's (where most deliveries are performed) were relatively underrepresented. The document states "...while percents of facilities offering services may have remained the same or declined, the actual number of facilities may have increased".

Table 1: Availability of Services in DISH Districts

		Percent of Facilities Offering Service (by Operating Authority)								
	Type of Service	**Government**			**NGO**			**Private**		
		1997	**1999**	**2002**[3]	**1997**	**1999**	**2002**	**1997**	**1999**	**2002**
a	Family Planning	96	100	100	78	81	62	NA	76	76
b	STI Treatment	82	96	94	97	100	100	NA	97	97
c	VCT	12	27	35	25	26	35	NA	15	30
d	ANC	89	92	92	83	94	94	NA	56	NA
e	Delivery Care	78	77	69	64	74	71	NA	42	34
f	Immunization services	96	97	99	83	84	86	NA	10	13

[3] 2002 figures based on DRAFT version "Uganda Dish Facility Survey" December 2002, by ORC Macro. The draft has no tables so some figures may not be exact, but are based on narrative such as "remains virtually unchanged".

In general, evidence points to the fact that DISH II, through training, technical assistance and other support, successfully increased overall access to services in DISH districts. Issues of quality and sustainability of these services are addressed under the following intermediate results, and in the body of this report.

Eighty percent of health facilities in the 12 districts will provide services that meet the basic standards of quality as outlined by the MOH.

The assessment team found that, despite considerable progress, there is still room for substantial improvement in basic standards of quality in Uganda's health system. Although DISH district facilities may be closer to that goal than those of other districts, the project's target - 80 percent of facilities meeting basic standards - was unrealistic. In fact, by the end of DISH II, only one health facility out of more than 1,000 in DISH districts had achieved minimum standards for three consecutive quarters, as required to earn the Yellow Star designation.

The 2002 *DISH Facility Survey* was based on visits to over 300 health facilities and 850 client interactions. Overall, it rated only 40 percent of visits for antenatal care (ANC) and 16 percent of sick child visits to be of acceptable quality. While the table below indicates such deficiencies in these and other areas, it does at the same time reflect the fact that the DISH II investment in training resulted in significant improvements.

Table 2: Quality of Care[4, 5]

	Facility Survey: Antenatal Care (ANC) and Sick Child (SC) Visit Observations	Trained Provider	Untrained Provider	Overall
a	Handwashing before examining client (ANC)	77%	37%	
b	Provider discussed Birth Plan (ANC)	71%	36%	
c	Tetanus Toxoid given (ANC)	74%	62%	
d	First ANC visit rated acceptable overall	NA	NA	40%
e	Assessed child's immunization status (SC)	63%	38%	
f	Sick child consultation rated acceptable overall	21%	4%	16%

Perhaps the most useful, certainly the most visible, measure of DISH II impact on quality of care can be found in the record of Yellow Star assessments. The project's final report cites an analysis of Yellow Star scores for 174 "first phase" facilities that shows an average 23 percent improvement between first and third assessments. In the first visit only 10 facilities scored above 70, while in the second visit 64 facilities scored above 70, and 13 reached the 91-100 range. During its site visits, the assessment team was also able to confirm facilities' continued engagement in and commitment to Yellow Star, even after the end of DISH II, and to steady improvement in quality scores.

[4] Data from Draft *Uganda DISH Facility Survey* assessed 30 of 35 Yellow Star standards as described in that document's Appendix C.

[5] Data from the Facility Survey on Quality Standard that disaggregate providers according to training may be biased by "service delivery environment,.. (especially) existence of support-supervision…"

The capacity of the 12 districts to sustain good quality reproductive and child health services will be strengthened.

As noted in the DISH II Final Report, the project's original emphasis, for the purposes of this result, was on financial sustainability of district health services. The abolition of user fees by the Ugandan Ministry of Health rendered this objective unattainable, and the project focus switched to "programmatic sustainability through increased local capacity". In the absence of defined statistical targets for this indicator on which it could comment, the assessment team refers the reader to Chapter VI of this report.

Increases in specific behavior change indicators for the 12 DISH districts will be achieved.

As the DISH II Final Report describes, statistics on the use of reproductive health services began to decline in 1998. DISH II was able to reverse these trends starting in 2000, and in most cases had brought indicators above the baseline by project's end. Analysis of sentinel site data for the period between the first quarter of 1999 and the first quarter of 2002 shows that use of all targeted services (except STI) has increased steadily since early 2000.

The only population-based data available to confirm these findings is found in the 2001 Uganda Demographic and Health Survey (DHS). A summary of the status of DISH II indicators at the project's midpoint is provided in the table below.

Table 3: Summary of impact of DISH behavior change communication (BCC)

DISH II BCC Indicators				**2000-01 DHS Data**	
		1999 Baseline	**2002 Target**	**National**	**DISH Districts**
a	CPR among women of reproductive age	21.9	25.4	20.1	28.1
b	Condom use by women during their last sex act with a non-regular partner	47	53	37.8	45.3
c	Percent of infants exclusively breast fed for six months	24.5	32.8	63.2	NA
d	Percent of children immunized with three doses of DPT	25	60	46.1	38.8
e	Percent of children fully immunized	36	50	36.7	30.1
f	Percent of deliveries taking place in a health facility	54	58.5	36.6	48.8
g	Percent of mothers who know at least three signs of complicated pregnancy	17.9	25.4	NA	NA

These findings indicate that, by 2001, the project had achieved its targets for changed behavior with respect to CPR and breast feeding, but not for other services. However, DISH districts showed levels higher than the national average in all areas except immunization. (The DHS did not have data on mothers' knowledge of complicated pregnancy.)

The assessment team attempted to obtain service statistics for the DISH II project period from the MOH Health Management Information System (HMIS) in order to confirm findings and trends for the period after the DHS. It was unable to access any data after June 2001 because system software had changed and the data was on a different computer that was not functional on the days of the team's visits to the MOH. Annual data through June 2001 was provided but proved to have little comparative utility, since it provided no percentages or target population figures. These frustrations highlighted for the team the importance of strengthening and streamlining HMIS at central and district levels (see Chapter VI).

APPENDIX B

PERSONS CONTACTED

PERSONS CONTACTED

KAMPALA

Ministry Of Health

Professor Omaswa, Director General
Paul Kagwa, Assistant Commissioner, Health Promotion and Education
Dr. E.K. Kanyesigye, Ass't Commissioner, Human Resource Development
Dr. Anthony Mbonye, Ass't Commissioner, Reproductive Health
Dr. Henry G. Mwebesa, Ass't Commissioner (QA)/Quality Assurance Specialist
Eddie Mukooyo, Ass't Commissioner, HMIS; Head, MOH Resource Center
Dr. Florence Ebanyat, former Ass't Commissioner, Reproductive Health

Kampala City Council

Dr. Mubiru, DDHS
Geoffrey Mmiro, HMIS
Rita Nahwada, District Health Educator (DHE)
Sr. Daisy Okware, District Health Visitor (DHV); DISH Focal Person
Dr. Wayira, Deputy DDHS
Staff of Mawende Health Center IV

Delivery of Improved Services for Health II (DISH II)

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Rebecca Kakooza, Trainer, Jinja
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Geoffrey Olupot, HMIS Specialist

UPHOLD (USAID Services Program)

Dr. Nosa Orobaton, Chief of Party (JSI)
Barbara Durr, Deputy

USAID/Uganda

Rob Cunnane, Head, Health, HIV/AIDS and Education Office
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JSI/Deliver Project

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Commercial Market Strategies

Beth Fischer, Privatising Health Services Advisor

LUWERO

Luwero District Health Services

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JINJA

Jinja District Health Services

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Family Life Education Project (FLEP)

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Nakasongola District Health Services

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Save the Children RH Project

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SSEMBABULE

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RAKAI

Rakai District Health Services

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Staff of Health Center II…
Dr. Vincent Bwete, Kalisizo Hospital

John Tumusiime, Senior Nursing Officer, Kalisizo Hospital
Edward Kabuye, Administrator, Kalisizo Hospital

MBARARA

Mbarara District Health Services

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Simon Isuba, District Drug Inspector
Lubega Kazooba, District Health Educator
Edward Muganwa, District Health Inspector
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APPENDIX C

SCOPE OF WORK

SCOPE OF WORK
UGANDA DELIVERY OF IMPROVED SERVICES FOR HEALTH (DISH II) EVALUATION

Background

The Uganda Delivery of Improved Services for Health (DISH) II project is a three year project (November 1999-September 2002) funded through a cooperative agreement awarded to the Johns Hopkins University and its partners, the University of North Carolina and Management Sciences for Health. DISH II followed DISH I (1994-1999), which was implemented through a contract with Pathfinder International. DISH I provided assistance in reproductive and maternal health, including family planning, STD prevention and management, antenatal care, safe deliveries and post abortion care. DISH I also addressed maternal and infant nutrition, health education, district level implementation of the MOH's Health Management Information System (HMIS) and cost recovery by health facilities. The project was implemented in 12 districts: Masindi, Nakasongola, Luwero, Kampala, Jinja, Kamuli, Masaka, Sembabule, Rakai, Mbarara, Ntungamo and Kasese. The project trained and equipped more than 1,000 health workers to provide reproductive and maternal health services; renovated 56 health facilities; and organized seven (7) multi-media communication campaigns to educate the public about improved health.

Survey data show that DISH I project activities contributed to improvements in health seeking behavior in a population of more than 7 million men, women and children in Uganda. In DISH I project districts, the proportion of women using modern family planning methods increased from 13 percent in 1995 to 21 percent in 1999; and the proportion of men using condoms to prevent sexually transmitted infections including HIV/AIDS increased from 7 percent in 1995 to 44 percent in 1999. More women in the project areas delivered with the assistance of a midwife or doctor—an increase from 55 percent in 1995 to 64 percent in 1999. Access to and use of voluntary counseling and testing (VCT) also increased.

DISH II was designed to support key components of the "minimum package" of reproductive and maternal health services largely in the twelve districts noted above by building on and expanding DISH I activities and incorporating other previously funded field support activities. While DISH I focused on reproductive health, DISH II includes child health and an increased emphasis on capacity building and systems strengthening. The project is implemented in collaboration with the central MOH and District leaders in the 12 districts. The total estimated cost of the program is $17,366,970 over three years. The completion date of the project is September 30, 2002.

The goal of DISH II is to increase service utilization and to change behavior related to reproductive, maternal, and child health in 12 of Uganda's 56 districts. This goal will be attained by:

- increasing availability of good quality reproductive, maternal and child health services through public, private and NGO facilities;

- improving the districts' capacity to manage, sustain and continuously improve health service performance; and

- Changing public health attitudes, beliefs and practices.

The DISH II project was developed in an effort to assist USAID/Uganda to achieve Strategic Objective (SO) 4 in the Country Strategic Plan (1997-2001), *Increase service utilization and change behaviors related to reproductive, maternal and child health*. To this end, DISH II has focused its approach on improving availability, integration, quality and sustainability of health services. Through an emphasis on this fourfold approach, DISH II has worked to reduce fertility and mortality, change behavior, build capacity, improve monitoring and evaluation, and facilitate expansion of the program beyond the 12 districts.

Anticipated Results

As articulated in the final work plan (July 2001-September 2002), by the activity completion date the project is expected to have achieved the following results:

1. Ninety percent of appropriate health facilities in the 12 districts will provide reproductive and child health services;
2. Eighty percent of the health facilities in the 12 districts will provide health services that meet the basic standards of quality as outlined by the MOH;
3. The capacity of 12 districts to sustain good quality reproductive and child health services will be strengthened; and
4. Increases in specific behavior change indicators for the 12 DISH-supported districts will be achieved (see Annex 1 for these targets and other benchmarks).

Purpose of the Evaluation

1. To assess the extent to which the DISH II project has directly contributed to increased service utilization and changed behavior related to reproductive and maternal and child health in the districts of implementation.

2. To identify and document best practices and lessons learned that can be applied in the implementation and management of activities under USAID/Uganda's new Integrated Strategic Plan (ISP) 2002-2007.

Evaluation Questions

1. Did DISH II achieve its expected results? For each result, document what was achieved and how achievement was measured. Document the factors that hindered

implementation and limited the achievement of expected results, and where possible, provide recommendations for avoiding these issues in the future.

2. How effectively did the organization and management of the project support achievement of results? In particular, focus on the relationships with other USAID–funded partners, the MOH, DISH districts, and USAID. In those instances where issues were identified, provide recommendations to avoid or mitigate these problems in the future.

3. What lessons have been learned from DISH's roll out of the Yellow Star program? What has been the long term impact of this program and how sustainable has it been in the DISH districts? How successful was DISH in getting the central MOH to have ownership of the program (i.e. are there issues that remain; has the roll out to non-DISH districts begun?) What other organizations have been involved and how viable might it be to partner with these entities as USAID/Uganda continues to work in this area?

4. Has DISH II been successful in developing effective and sustainable community based models for service delivery, including but not limited to their work with the Family Life Education Program (FLEP)? What lessons have been learned from the DISH experience in this area? Assessment should look at the strengths and weaknesses of DISH II support to FLEP, the effectiveness of community-based models implemented through FLEP, and the overall sustainability of the program.

5. How effectively has DISH II influenced behavior change related to reproductive and maternal and child health, thus contributing to reduction in fertility and mortality in the 12 districts? The evaluation should focus on the appropriateness of the materials developed; lessons learned about the process of developing these materials (i.e. collaboration issues); longevity of the use of DISH materials (i.e. are they still being used or just sitting on shelves); and use of the materials by the central MOH and non-DISH Districts. Provide recommendations for future work in IEC/BCC.

6. To what extent has the project strengthened the capacity of the 12 districts to sustain quality reproductive and child health services? What are the strengths, weaknesses, impact and lessons learned from the activities undertaken in the areas of: supervision and district-wide quality of care systems; drug management capabilities, in particular stock management; capacity to manage health information; financial sustainability; and client satisfaction.

7. To what extent have DISH models and materials been used by the central MOH and rolled out to non-DISH districts? Based on lessons learned from DISH, how could we more effectively work with the central MOH and districts in the current decentralized system?

8. What was the impact of the district grant program under DISH II? What were the lessons learned and how can we be more effective in the future?

Evaluation Methods

The team shall use a variety of methods for collecting information. These may include, but are not necessarily limited to, the methods listed below.

- Document Review. The team must possess a clear understanding of the program description, cooperative agreement, work plans, the context in which the project operates in Uganda, and project accomplishments. The team will have full access to all documents generated by DISH II, unclassified USAID reports, other donor reports and GOU reports.
- Key Informant and Stakeholder Interviews. The team will need to obtain the input of USAID/Uganda program and SO team staff; representatives of key Ministries (Health, Gender, Labor and Social Development, and Finance, Planning and Economic Development); bilateral and multilateral donors; key players in the 12 districts of implementation, (including District Health Team, elected and appointed district and sub-county local government officials, public and private service providers at all levels, FLEP staff and clients, and a full range of project beneficiaries). USAID/Uganda and the DISH II team will compile a preliminary list of key contacts.
- Site Visits. The team will be expected to visit service delivery points and other appropriate sites in the 12 districts. The sites will be selected in consultation with USAID/Uganda and the DISH II team.
- Rapid Appraisal. Methods such as focus group discussions with clients, service providers, and other stakeholders will be employed as appropriate.

Team Composition and Participation

The evaluation team will consist of four members: two expatriates and two locally recruited technical experts. One of the expatriates will function as the team leader and will be responsible for assembling and editing the final evaluation report, as well as providing technical expertise in one or more of the technical areas. One team member must have expertise in child survival/reproductive health and another team member must have expertise in systems strengthening. The team members must collectively provide evidence of expertise in the following areas: HIV/AIDS; quality of care; behavior change communication; training; adolescent health; and monitoring and evaluation. The team members must have demonstrated, significant previous experience in the evaluation of integrated health service delivery programs in Africa (preferably East Africa). All of the team members must demonstrate excellent written and oral communication skills in English and high levels of computer literacy. The proposal should be clear about the role of the local hire staff.

Representatives of USAID/Uganda (PPD, SO8) and the Ministry of Health will also collaborate closely with the team, participate in all of the evaluation activities, and provide assistance with identifying key stakeholders and arranging interviews and site visits. However, the evaluation team will be required to arrange for their own

transportation, computer equipment, and other logistical requirements for the duration of the evaluation.

Level of Effort

The evaluation is expected to require 152 person-days of effort from the evaluation team, 40 days for each of the expatriate members and 36 days each for the Ugandan technical experts. The expatriate members will spend two days in pre-departure preparations, including meetings or virtual consultations with key individuals in USAID and elsewhere (Rebecca Rohrer and Ruth Bessinger), and two days in travel status en route to and from Uganda. To save time the team leader will arrive several days ahead of the team to do the set up and organization.

The evaluation team will work together for five weeks (30 person-days each) in Uganda. This level of effort allows for document review, site visits, stakeholder interviews, focus group discussions and other rapid appraisals, data analysis, and preparation of the draft evaluation report. The team will be expected to submit a draft report and present an oral debriefing to Mission staff prior to the departure of the expatriate core team members. The team leader will have one additional week in which to revise the draft report after receiving written comments from USAID and the MOH. The comments will be submitted to and compiled by USAID/Uganda for transmission to the team leader.

Deliverables

Evaluation work plan: Within three days after arrival of the expatriate evaluation team members in Uganda.

Draft evaluation report: Prior to the departure of the expatriate team members from Uganda. The draft will be submitted in both hard and electronic versions and will be presented at an oral debriefing to concerned stakeholders.

Final evaluation report: Within 10 days from receipt of consolidated written comments from USAID/Uganda.

ANNEX 1

End of Project Targets

- Modern contraceptive prevalence rate (CPR) will increase from an average of 21.9 in 1999 to 25.4 in 2002 among women of reproductive age
- Condom use by women during their last sex act with a non-regular partner will increase from 47 percent in 1999 to 53 percent in 2002.
- Percent of infants exclusively breastfed for six months will increase from 24.5 percent in 1999 to 32.8 percent in 2002.
- Percent of children immunized with three doses of DPT will increase from 25 percent in 1999 to 60 percent in 2002.
- Percent of children fully immunized will increase from 36 percent in 1999 to 50 percent in 2002.
- Percent of deliveries taking place in a health facility will increase from 54 percent in 1999 to 58.5 percent in 2002
- Percent of mothers in DISH districts who know at least three signs of complicated pregnancy will increase from 17.9 percent to 25.4 percent

Project Interventions

The interventions as stated in the DISH II work plan are as follows:

- Increase the availability of key components of the minimum health care package and ensure basic standards of quality of care in 12 districts through training, expanding range of services and developing innovative learning approaches.

- Change critical behaviors related to reproductive, maternal and child health in 12 districts by improving male involvement in family planning, infant nutrition, HIV prevention among core transmitters and promotion of long term and permanent family planning methods

- Increase capacity to sustain services, by supporting the District Health management teams (DHMT) in planning, budgeting, health management information systems (HMIS), logistics, supervision, quality standards and financial sustainability.

- Provide specific support to the Family Life education Project (FLEP) in four critical areas: improved sustainability; community based maternal and child health; information, education and communication; and expanded service delivery capacity.

- Facilitate wider adoption of DISH strategies (best practices and materials) by disseminating DISH materials and facilitating technical networking among key partners.

- Conduct joint monitoring, research and evaluation of DISH interventions through routine collection of data, analysis of DISH survey data, and special focused research, assessing the quantity and quality of service delivery, detecting changes in attitudes, knowledge and behavior.

- Improve DISH project management and networking by developing common vision and broad consensus on expected results and implementation frameworks among DISH II, health districts and sub-districts, key departments at the MOH, and selected implementing and development partners

END OF PROJECT TARGETS

1. Curriculum materials for reproductive health/maternal health and child survival available to all DTSTs and 550 unit in-charges; integrated modular curricula disseminated nationally.
2. All 17 DISH trainers trained; all 12 DTSTs trained, 800 nurses and midwives trained, 52 clinical officers trained, and 194 nurse aides trained.
3. All midwives trained in post-abortion care (PAC).
4. 135 nurses, midwives, and clinical officers trained in adolescent reproductive health.