UPHOLD'S INTERGRATED HEALTH STRATEGY

Uganda Programme for Human and Holistic Development

Draft Document

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TABLE OF CONTENTS

Appendices

List of Abbreviations

AIM	- The HIV/AIDS Integrated Model District Programme
AIC	- AIDS Information Centre
ANC	- Ante-Natal Care
BCC	- Behaviour Change Communication
CBOs	- Community Based Organisations
CB-TB DOTs	- Community Based TB Directly Observed Treatments
CDC	- Centres for Disease Prevention & Control
C-IMCI	- Community Integrated Management of Childhood Illnesses
CVs	- Community Volunteers
CMS	- Commercial Marketing Strategies
DBL	- Danish Bilharziasis Laboratory
DFID	- Department For International Development
DOTS	- Directly Observed Treatment
EPI	- Expanded Programme for Immunization
GLRA	- German Leprosy Relief Agency
HA	- Health Assistant
HBMF	- Home Based Management of Fever
HSSP	- Health Sector Strategic Plan
HU	- Health Unit
HWs	- Health Workers
ICCM	- Inter-Agency Coordination Committee for Malaria
IEC	- Information Education and Communication
IMCI	- Integrated Management of Childhood Illnesses
IR	- Intermediate Result
ITNs	- Insecticide Treated Nets
IPT	- Intermittent Presumptive Treatment of malaria
IRS	- Indoor Residual spraying
MOH	- Ministry of Health
NCRL	- Natural Chemotherapeutics Research Laboratory
NGO	- Non Governmental Organisation
NTLP	- National TB & Leprosy Programme
PHWs	- Public Health Workers
PPP	- Public-Private Partnership
QA	- Quality Assurance
QC	-Quality Chemicals
RBM	- Roll Back Malaria
RCQHC	- Regional Centre for Quality of Health Care
SCI	- Schistosomiasis Control Initiative
SS	- Support Supervision
SWOT	- Strengths, Weaknesses, Opportunities and Threats
TASO	- The AIDS Support Organisation
TB- DOTs	- TB Directly Observed Treatment
UNICEF	- United Nations' Children's Emergency Fund

UPE	- Universal Primary Education
UPHOLD	- Uganda Program for Human and Holistic Development
UPMA	- Uganda Private Midwives Association
UPMB	- Uganda Protestant Medical Bureau
USAID	- United States Agency for International Development
VHT	- Village Health Team
WHO	-World Health Organisation

1. INTRODUCTION

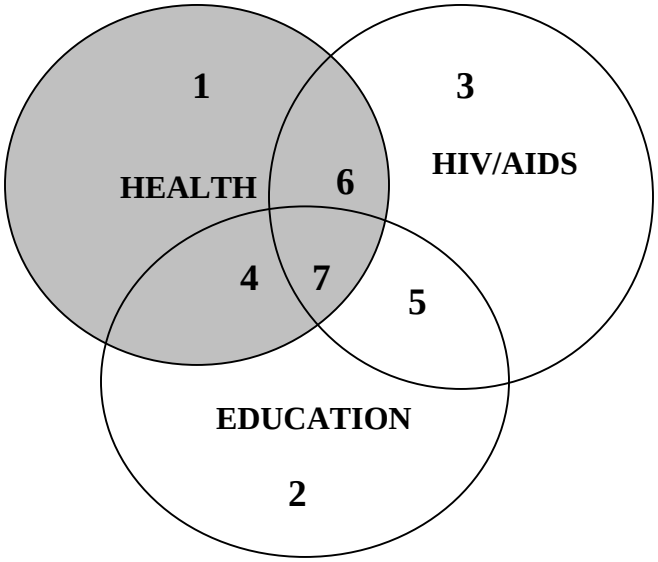
The Uganda Programme for Human and Holistic Development (UPHOLD) is a five-year program funded by the United States Agency for International Development (USAID) and supported by the Government of Uganda. The Programme works to strengthen capacity at decentralized levels for the improved delivery, planning, management, monitoring and effective use of social services in three main sectors: 1) Health; 2) Primary School Education; and 3) HIV/AIDS prevention and mitigation. UPHOLD supports twenty districts in Uganda to achieve results within the life of the program by fostering efficient synergies and effective partnerships leading to a strategic integration of social services.

This document contains nine sections. Section 1 provides an introduction to UPHOLD's integrated health strategy. Sections 2 – 8 describe UPHOLD's approach for each core intervention in health, which is based upon an analysis of key national policies and priorities, and the strengths, weaknesses, opportunities and threats (SWOT) of current strategies and interventions, as well as its interventions in cross-cutting technical areas and plans for limited Action Research where there are significant information gaps that constrain the design and implementation of effective strategies. Section 9, the Appendixes, provides a detailed matrix presenting the "SMART" (Specific, Measurable, Achievable, Relevant and Time-Bound) Objectives, Annual Targets, Key Interventions and Selected Indicators for each core intervention.

1.1 UPHOLD's Integrated Health Component

Figure 1 below shows the seven domains of UPHOLD's integrated approach to supporting core interventions in the three sectors. As an integrated social services program, UPHOLD's interventions in health services entail those interventions that lie solely within the health sector (domain 1) as well as those interventions that are strategically integrated with the Education sector (domain 4), with the HIV/AIDS sector (domain 6) or with both the Education and HIV/AIDS sectors (domain 7).

Figure 1: UPHOLD's Seven Domains of Intervention in Integrated Social Services



UPHOLD's core areas in the integrated health component are:

- Child & Adolescent Health;
- Communicable Disease Control (particularly malaria control, tuberculosis control, and schistosomiasis control);
- Integrated Reproductive Health; and
- School Health and Nutrition.

Four cross-cutting technical areas that are components of all of the core health areas are:

- Quality Assurance;
- Strengthening the Private Sector and Public-Private Partnerships;
- Behaviour-Change Communication; and
- Community Involvement.

1.2 KEY OBJECTIVES

UPHOLD's integrated health strategy is results-oriented and based upon approach to achieving intermediate results in its integrated health component in three broad areas:

1. Improved quality of integrated health services through their increased access and availability, and their effective use through the promotion of positive behaviours.

2. Increased capacity to sustain integrated health services through improved decentralized planning, management and monitoring of integrated health services and the strengthened role of the private sector in their delivery.

3. Strengthened enabling environment for the delivery and use of sustainable quality integrated health services through the implementation of effective policies and increased community involvement.

UPHOLD's strategy focuses on *Intermediate Results* ("IRs"): those results that can be achieved during the five year life-span of the Program.

1.3 UPHOLD's Behavior-Centered Approach

UPHOLD will use a behaviour-centered approach in many of its interventions to promote the delivery and effective use of quality health services. A behaviour-centered approach is based on the understanding that people's behaviors often have the most direct influence on their health and learning, as well as on the quality of services. UPHOLD will therefore strategically focus on the behaviours of different actors' (e.g. elected officials, opinion leaders, health program managers, health care service providers, social workers, teachers, clients, patients, parents, primary school students, family members, and communities) by:

- identifying behaviours that are beneficial to the effective use of health services, the improved quality of health services, and the improved planning, management and monitoring of health services-- as well as behaviours that may be detrimental;

- identifying motivations and barriers to adopt and sustain these behaviours, and

- strategically promoting the adoption of new beneficial behaviours or strengthening the practice of existing beneficial behaviours.

Key behaviours are identified in each of the following sections describing the core interventions in UPHOLD's integrated health component.

2. CHILD AND ADOLESCENT HEALTH

2.1 Overview of National Policies

The Ministry of Health, in its National Health Policy and Health Sector Strategic Plan (2000/01-2004/05) documents focuses on those health services that have demonstrable efficiency, cost-effectiveness and significant impact on reducing morbidity and mortality. The burden of disease study (Ministry of Health, 1995) found that the biggest contributors to ill health include Malaria, STI/HIV/AIDS, diarrhoeal diseases, acute respiratory tract infections, vaccine-preventable childhood illnesses and perinatal conditions. The most vulnerable groups to these conditions and illnesses are the children, adolescents and women. Malnutrition underlies more than half of the child deaths. The Demographic and Health Survey (UDHS) 2001-2002 shows that most children become malnourished between birth and 20 months, which period coincides with the period of rapid growth of the body and the brain.

2.1.1 Ministry Of Health Priorities

The Ministry of Health priority areas are contained in the Uganda National Minimum Health Care Package (UNMHCP) whose components include the following:

i. *Immunisation*

The Ministry of Health plans to attain and sustain high immunisation coverage during this period such that the EPI target diseases don't pose a significant public health concern. This is to be achieved through the development of strategies aimed at reversing the declining trends in immunisation coverage and achieving a high full (complete) immunisation coverage of children 12-23 months from 44% (1999), to 70% by 2005, a DPT3 coverage of 70% from 55% in 1999, and TT2 coverage in pregnant women from 50% to 80%.

ii. *Integrated Management Of Childhood Illnesses*

Infant mortality and under –five mortality rates are high in Uganda at 97 and 147 per 1,000 live births, respectively. The objective of the Ministry of Health is to reduce morbidity and mortality due to the common childhood illnesses, among the under- fives. IMCI as a strategy is intended to integrate control of diarrhoeal diseases, acute respiratory infections, immunisation, malaria case management and nutrition. Since these diseases/conditions constitute 70% of all the childhood illnesses, addressing them through the IMCI strategy will contribute to the reduction of morbidity and mortality in children under 5 years. The strategy is to be implemented under three components: Components I and II are health facility–based and include improved case management of childhood illnesses,

improved health worker performance at first and referral facilities and improved availability of drugs and supplies at the health facilities.

Component III (Household and community component) of IMCI focuses on the participation of the households and the community in sixteen key behaviours that are broadly classified under four objectives:

- Prevention of common childhood illnesses, injuries, and abuse at the household and community level
- Appropriate and timely care seeking behaviours of caretakers
- Compliance to the treatment and advice on care of the children and,
- Provision of a supportive and enabling environment at household and community level for childcare, survival, growth and development

The Ministry hopes to use these strategies to achieve the following targets by the end of the end of the Health Sector Strategic plan (HSSP):

- Achieve 100% coverage with components I and II
- Achieve 50% coverage with component III
- Reduce case fatality rate from diarrhoeal diseases of epidemic potential from 6% to 1%, and
- To reduce annual diarrhoeal disease incidence from 30 per 1000 to 15 per 1000 population

iii. *Nutrition*

The most recent demographic Health Survey (UDHS 2000/1) showed that 39% of the children below 5 years of age are stunted (with 15 % severely stunted), 4% suffer from wasting and 23% are underweight. It also revealed that 64% of the under-fives are anaemic and 28% of children under five years suffer from vitamin A deficiency. To control diseases due to nutritional anaemia, protein-energy malnutrition, iodine deficiency disorders and vitamin A deficiency, the Ministry is to use a combination of strategies that will include exclusive breastfeeding for the first six months of life, introduction of complementary feeding at six months with continued breastfeeding up to at least two years, growth promotion and monitoring activities in a multi-sectoral approach , food supplementation (including vitamin A supplementation) and case management of severe malnutrition.

The objectives of the Ministry of Health as stated in the five- year Health Sector Strategic Plan (HSSP) basing on the UDHS1995 results, are as follows:

- To reduce stunting in the under five year olds from 38% to 28%
- To reduce underweight in the under five year olds from 26% to 20%
- To increase exclusive breastfeeding at six months from 68% to 75%
- To increase and sustain vitamin A supplementation coverage for children 6-59 months from 80% to 95%
- To increase the proportion of households consuming iodated salt from 69% to 100%

- To increase public awareness on appropriate nutrition practices from the baseline to 95%

iv. *Adolescent Health*

Adolescent health forms an important component of sexual and reproductive health as outlined by the Ministry of Health. Adolescents, defined as those between 10-19 years of age comprise 24% of the total population and those defined as 'youths', aged between 15 -24 years, comprise 33% of the total population. 'Young people' is a term that is used to cover both age groups i.e. those between 10 and 24 years, and for purposes of the Ministry of Health's strategic framework, this is the targeted age group. Sexual activity among the young people is high (Nearly 50% of women become mothers before the age of 18 years-UDHS 2000/1) which exposes them to a tremendous risk of contracting sexually transmitted infections, (including HIV), early, unwanted and risky pregnancies, high infant mortality, unsafe abortions, and high school drop-out leading to reduced women's access to education, employment and high level of poverty. The Ministry's objective is to contribute to the reduction of neonatal, infant and maternal morbidity and mortality through the implementation of a set of strategies that address these problems through provision of information, education, life skills training and access to youth- –friendly services.

The objectives of the Ministry of Health include:

- To provide policy-makers and other stakeholders with reference guidelines for addressing the adolescent health concerns.
- To promote the involvement of adolescents in planning, implementation, monitoring and evaluation of adolescent health programmes.
- To provide legal and social protections of young people especially the girl child against harmful traditional practices and all forms of abuse including sexual abuse, exploitation and violence.
- To train and re-orient health workers at all levels to better focus and meet the special needs of adolescents.
- To improve the capacity of local institutions in research, monitoring and evaluation of adolescent health needs and programmes and to promote dissemination and utilisation of relevant information to create awareness that influence positive behaviour change amongst individuals, communities, providers and leaders concerning adolescent health.
- To promote coordination and networking between different sectors and nongovernmental organisations working in the field of adolescent health.
- To advocate for increased resource commitment for the health of adolescents in conformity with their numbers and requirements.

v. *School Health*

The Ministry of Health in collaboration with the Ministry of Education and Sports seeks to improve the health status of the school children, their families and teachers and to inculcate timely health-seeking behaviour among the targeted population. The aim is to attain the twin goals of providing education and health for all pupils/students and staff through integration of life skills-based health education, including sex education; improved access and utilisation of adolescent friendly health services and HIV/AIDS, STDs and provision of information on teenage pregnancy prevention in schools. Other services will include, improved provision of school-based medical care and nutrition/feeding services as well as the improved provision and utilisation of safe water, hygiene and sanitation facilities in the schools.

The objectives of the Ministry of Health together with the Ministry of Education and Sports during the planned period include:

- All primary schools (public and private) implementing the national School Health Programme
- All primary schools (public and private) having adequate pit latrine stance per pupil population in accordance with national standards, and to have different stances for girls separate from those for boys.
- All secondary schools (public and private) with adolescent health services.

vi. *Out Of School Health*

Similar facilities for those out of school to be provided in the health facilities with adolescent friendly health services clinics, peer educators and programmes targeting parents and community leaders.

SWOT analysis of the priority areas

i. *Immunisation*

Strengths	**Weaknesses**
Revitalisation policy in place including the communication strategy. Developed structure for the delivery of immunisation services down to the community level. Regular delivery of vaccines and other supplies to the district stores. Protected funds at the district and lower levels through the PHC conditional grant.	Facilitation of the services delivery at facility and community level. Poor micro planning at the health unit and sub district level. Relegation of immunisation activities to the no-qualified workers on the staff. Inadequate knowledge in the community about immunisation. Community involvement in planning immunisation activities.
Opportunities	**Threats**
Involvement of the private for profit and private not for profit health providers. Involvement of schools through the School Health Programme for advocacy and social mobilisation. Decentralisation and political structure conducive for community participation. Community-Based Growth Promotion as an integrated framework under which all child health interventions will fit.	Resistance to immunisation on political grounds and negative propaganda on immunisation. Immunisation campaigns that divert resources from routine immunisation programme and prime volunteers to payment for services rendered.

ii. *IMCI with special focus on Household and Community IMCI*

Strengths	**Weaknesses**
Policy in place for the implementation of community IMCI. Strategies for implementing household and community IMCI in advanced stages in some districts. Rapid scale up for components I and II. Availability of training materials, curriculum and trainers. Protected funds at the district and lower levels through the PHC conditional grant.	Performance at the facility level still poor despite the training of the health workers in IMCI. Low supervision by the trainers. Linkages between the Household and community IMCI with components I and II weak. Facilitation of the services delivery generally but especially at the community level.
Opportunities	**Threats**
Community structures in place for the implementation of HH and c-IMCI Decentralisation policies that empower communities in place. Favourable political environment that empowers women and the youth. Involvement of the private sector in the delivery of clinical component of IMCI. Community-Based Growth Promotion as an integrated framework under which all child health interventions will fit. Lessons and materials from progress in developing Community-Based Growth Promotion in several districts.	Household and community IMCI dependant on voluntarism. High attrition rate of the volunteers.

iii. *Nutrition*

Strengths	**Weaknesses**
Nutrition policy in place. Biannual vitamin A supplementation strategy in place. Availability of materials, and curriculum. Protected funds at the district and lower levels through the PHC conditional grant.	Growth promotions activities hardly carried out in the facilities. Linkages between the community growth promoters and the health facilities poor. Private providers not doing much in this field.
Opportunities	**Threats**
Community IMCI strategies as an opening for community based growth promotion and monitoring activities Immunisation strategy. IMCI Strategy Community structure conducive. Community-Based Growth Promotion as an integrated framework under which all child health interventions will fit. Lessons and materials from progress in developing Community-Based Growth Promotion in several districts available.	Voluntarism.

iv. Adolescent Health Services

Strengths	**Weaknesses**
Adolescent health policy in place. A number of adolescent reproductive? health initiatives in place. School health policy in place. Protected funds at the district and lower levels through the PHC conditional grant.	Performance at the facility level inadequate despite some training in the provision of adolescent – friendly health services. Facilitation of the service delivery system. Co-ordination of the various groups involved in the adolescent health programmes.
Opportunities	**Threats**
High enrolment in schools due to UPE and the involvement of the private sector in education mean increased access to children and adolescents for services (Immunisation, nutrition, hygiene, malaria…, HIV/AIDS, AFHS etc.). Expansion of the existing initiatives (AYA-African Youth Alliance, straight talk, Peer	Culture and religious barriers to adolescent health services. External factors that influence the adolescents' decision making process e.g. films, the internet etc Teachers often spread Sexually Transmitted Infections including HIV/AIDS to female pupils.

group initiatives, etc). Enabling policies (School health policy, Adolescent health policy, child statutes etc). Community and political structures. Involvement of the private schools and health facilities in the provision of AFHS. Involvement of peer groups and parents in adolescent health in schools and out of schools.	

2.1.3 Priority Activities For UPHOLD

The objective of UPHOLD is to establish an effective and efficient delivery of core interventions to achieve USAID's Strategic Objective number 8 (SO8) through the following intermediate result:

To increase access to key child health services at the community level, that will include promoting a healthy newborn, growth of the young child, early detection of sick children before they can become severely ill and care-seeking for the severely ill children, improved home management of diarrhoea and fever, as well as increased immunisation and improved nutrition.

The UPHOLD Child Health strategy will use IMCI and growth promotion as the framework through which to operationalize and anchor all other child health activities. This approach will fully integrate all child health interventions into a child health package that focuses on preventing problems while maintaining a system to refer and treat illness.

Community-Based Growth Promotion (CBGP) is a preventive health and nutrition program model that actively engages families of children under two and their communities in maintaining the adequate growth of young children. For sick children under five years, the program extends its treatment and referral services.

CBGP promotes improved child growth with the goals of reducing mild and moderate malnutrition (stunting and underweight) and the severity and duration of illness. The model centres upon adequate monthly weight gain as a dynamic and visible measure of progress; frequent contact with the family, with weighing and tailored program action; counselling, tailored to meet family needs, focusing on care-seeking practices and household practices such as young child feeding and immunisation; feedback to the community as a tool for action; and, disease detection, treatment and referral for all children under five years through use of a modified IMCI protocol by trained growth promoters.

Growth is an effective indicator for monitoring the health and development of all young children. As a range of problems can cause growth faltering, the tailored inquiry that follows the first sign of growth faltering will touch on all of the key family practices of IMCI. Referral and support will be extended to all sick children under five years.

The priority activities in Child and Adolescent health will include:

i. Child Health Package and Operational Guidelines

- Hold a review meeting with all Ugandan groups currently implementing growth promotion (BASICS II, World Bank supported NECD, MOH etc) and C-IMCI activities to discuss and understand lessons;
- Conduct an orientation training for all UPHOLD health staff on C-IMCI/Growth Promotion;
- Incorporate the concept of growth promotion into the work of the National NGO Steering Committee;
- Support the use of child growth as an indicator of development and poverty reduction;
- Conduct formative research to understand current practices related to home treatment, care-seeking, and adherence to treatment recommendations for pneumonia, diarrhoeal disease, malaria, nutrition and immunization, feasible practices and the barriers and motivations to each;
- Develop comprehensive behaviour-change strategies for each component that promote feasible behaviours and address barriers and supports to those feasible behaviours;
- Review and produce guidelines and materials for C-IMCI/community-based growth promotion and how it serves as a framework for all other child health actions;
- Review materials developed by BASICS on community based growth promotion (CBGP), C-IMCI and immunisation, including the training of trainers guide, training guide for growth promoters, the handbook for growth promoters and counselling cards, and initiate the process of training community growth promoters;
- Review the community problem-solving and strategy development approach started by BASICS for use in linking communities to the health units in order to adopt it in UPHOLD (broader beyond immunization to growth data as well);
- Review and produce the tools developed by the MOH and other partners for monitoring immunisation performance at the health unit level;
- Assist districts to set criteria for selecting communities in collaboration with NGOs; and
- Conduct formative studies in the UPHOLD districts on the key child health behaviours.

ii. Increased access to child health services at the health facility level

- Train health workers in HC II-IV (in public and private sector) in the IMCI components I and II and support training of health workers (both in public and private sector) on supervision for growth promotion;
- Train health workers in the referral hospitals in IMCI to be able to manage referred severely ill children
- Support the training of health workers (both in public and private sector) on nutrition and micronutrients including vitamin a and iron supplementation;
- Support private health practitioners to carry out immunisation activities;
- Support the supervision of C-IMCI/Growth promotion activities from central to district to health units to communities;
- Establish clear referral and counter referral systems with community support for referral;
- Support districts, health sub-districts and sub-counties to carry out micro planning activities with the health units to establish their catchment and target population;
- Support districts, HSDs and Sub counties to carry out whole site support supervision activities using materials developed by DISH II Project;
- Support districts to carry out advocacy and actual implementation and supervision of activities for the biannual vitamin A supplementation;
- Support NGOs, CBOs and PDCs, where they exist to mobilise immunisation services and link them with community growth promotion / child health activities;
- Support the collaboration of DHTS with the NGOs, CBOs and the private sector working in their districts, through meetings and identification of each organisation's area of work; and
- At the National level, support the National NGO Steering Committee to strengthen its support of IMCI.

iii. Increased access to services at the community level

- Hold discussions with the communities on growth promotion and child health;
- Support communities to conduct mapping exercises to determine the optimum number of growth promoters in communities that need to be trained;
- Support districts to foster linkages between the community growth promoters, other community resource persons and the health units through meetings and joint community activities;

iv. Improved household level practices

- Use formative research findings to draft comprehensive strategies to support good practices at the household level;
- Design intervention-specific strategies and workplans starting with key priorities and phasing in both different media and messages over time, in coordination with the overarching UPHOLD communications strategy.

v. Improved access to quality Adolescent Health Services (AHS)

Safe sex practices and contraceptive use are not universal among the adolescent population of Uganda for a variety of reasons. These include; unavailability of services, various myths about contraceptive methods and lack of control on the part of the adolescents to access the services. However, even where the services are available, the adolescents are reluctant to use the services for fear of their concerns getting revealed to their families resulting in punishment, other barriers include inability to pay for the services, lack of interest or training of health staff regarding adolescent health concerns. Other factors that contribute to poor health services among adolescents include poverty, lack of parental guidance, lack of information regarding reproductive and sexual health care, over-reliance on uninformed or poorly informed peers for information, lack of community services and poor attitude amongst parents and service providers regarding adolescent reproductive health needs.

UPHOLD's objective is therefore to contribute to the improvement of access and utilisation of quality adolescent reproductive health services through the following strategies:

- Develop a comprehensive program including the key behavioural elements to address adolescent needs – this may need to include formative research with adolescents on feasible behaviours related to use of services and the main barriers and supports to each feasible behaviour;
- Work with districts to support district-level adoption and implementation of these strategies;
- Support the establishment of adolescent-friendly health clinics in the public and private health units;
- Support various organisations involved in adolescent health services provision;
- Support peer groups in schools and out of schools to provide information and counselling services;
- Provide support to the teachers and PTAs in schools to provide information through the school health programme;

- Expand the provision of AFHS to include indoor/outdoor activities;
- Strengthen the logistics, supplies and equipment for provision of quality AFHS; and
- Create a supportive environment at the community level for AFHS through the involvement of community leaders and parents.

vi. Adolescent School Health Services

- Disseminate the national School Health policy;
- Conduct formative research to understand current practices related to prevention and care-seeking for the main health problems affecting school-aged adolescents; and
- Develop behaviour-change strategies to identify feasible practices and address the barriers and supports to each for pupils and the people who must support their practices;
- With the Ministry of Health and Ministry of Education and Sports, agree on a few key services to be provided such as malaria treatment, iron supplementation, and tetanus toxoid vaccination.

vii. Monitoring and Evaluation

- Develop monitoring tools from program objectives and behaviour-change strategies;
- Support districts, HSDs and Sub counties to train health workers in the use of the monitoring tools;
- Support districts to carry out Performance Improvement activities for the services above;
- Support districts to carry out supervision, monitoring and evaluation of the activities carried out.
- Support districts to involve the private sector, NGOs and CBOs in the provision of the services identified above.
- Support the strengthening of the Health Management Information System (HMIS).

2.1.4 Expected outputs by the end of the first year of implementation

i. Child Health Package and Operational Guidelines

- Review meeting held with others implementing growth promotion;
- Orientation training for staff on C-IMCI/Growth Promotion conducted;
- Meeting with National NGO Steering Committee held to incorporate the concept of growth promotion;
- An integrated C-IMCI/ Growth Promotion strategy developed;
- Guidelines and tools for C-IMCI/ Growth Promotion produced and disseminated to the districts;

- Work in those districts with C-IMCI/Growth Promotion already being implemented continued and work in one or two new districts initiated; and
- Plans for formative research on key child health practices developed.

ii. Increased access to services at the health facility level

- Training plans for health providers developed;
- Referral systems established;
- Plans for supporting districts to improve services developed;
- Monitoring tools for coverage and drop out produced and introduced in the districts;
- Advocacy for Vitamin A supplementation carried out;
- Support of the implementation of the bi-annual vitamin A supplementation; and
- Plans for iron supplementation.

iii. Increased access to services at the community level

- Communities in one or two new districts sensitised to C-IMCI/Growth Promotion; and
- Mapping of catchment's population and targets for immunisation set by all the health units.

iv. Improved household practices

- BCC interventions to improve provider-client relationships and to increase household communication.

v. Adolescent Health

- Comprehensive behaviour-change strategies designed with partners, including adolescents themselves;
- Plans for establishing adolescent –friendly clinics established in most of the districts;
- Peer group associations for information sharing and counselling initiated;
- The beginning of a cadre formed of teachers, parents and community members who are supportive of adolescent-friendly health activities;
- National School Health policy disseminated to districts; and
- District planning meetings held on program strategies for in school and out of school adolescent health services.

2.1.5 Key Behaviors

Using a behaviour-centered approach, UPHOLD will focus on promoting the following behaviours in interventions for Child and Adolescent Health:

Community IMCI

i. Nutrition/Hygiene:

Mothers of babies up to 6 months old

1. Breastfeed exclusively until the 5th month: this implies giving the baby no other food or liquid (including water), feeding at least 10X per day and night; using both breasts; feeding each time until the baby's hunger is satisfied; the mother herself eating more than normal and drinking much more.
2. HIV+ mothers seek individualized counselling (how do mothers know if they are HIV+? is testing routinely done in ANC?).
3. Continue breastfeeding sick child even more often than normally.

Mothers of babies 6 to 23 months old

1. Continue at least 6 to 8 daily breastfeeds per day until 1 year.
2. At 6 months begin introducing soft foods, introducing them one at a time, twice a day until 8 months, then 3 to times a day until 12 months. Food should not be too watery and should include fruits and vegetables and by one year oil and ground nuts. (Note: program should recommend specific foods and combinations—this advice is too general. Recommend specific foods rich in vitamin A and iron).
3. Each time, feed the baby until you are sure he or she is satisfied.
4. Encourage the baby to eat if he or she seems distracted.
5. Give all foods and liquids (other than breast milk) by spoon or cup, not by baby bottle.
6. If cooked food sits for more than 30 minutes without being eaten, re-heat it and let it cool a bit before feeding it to the baby
7. Eat and drink more than normal.
8. When the child is sick, continue breastfeeding and giving complementary food. If the child seems reluctant to eat and drink, be persistent, give smaller quantities more often, give favorite foods.
9. Do the same for a child recovering from illness (first 10 days after sick). Also add extra high-energy foods such as oil and ground nuts.
10. Take advantage of all opportunities for child to receive vitamin A drops every 6 months.

(Clarify policy on iron supplementation for children)

Mothers of children 12 to 23 months old

1. Continue breastfeeding 4 to 6 times per day.
2. Feed the child the family foods.
3. Feed 3 meals plus two snacks twice a day

4. Watch your child eat. Be certain that child is getting enough food and that older siblings are not taking his or her food.
5. Be certain that the child's diet includes fruits and vegetables, oil and ground nuts, and meat if possible.
6. If cooked food sits for more than 30 minutes without being eaten, re-heat it and let it cool a bit before feeding it to the baby
7. Continue breastfeeding and giving complementary food to a sick child. If the child seems reluctant to eat and drink, be persistent, give smaller quantities more often, give favorite foods.
8. Take advantage of all opportunities for child to receive vitamin A drops every 6 months.

(Clarify policy on iron supplementation for children)

Mothers of children 0 to 23 months old

1. Wash your hands with soap or another cleansing aid before contact with food or after contact with faeces.
2. Dispose of babies' faeces in a latrine.
3. Treat water that people will drink or cook with (chlorinate or treat by sunlight). (Program needs to research feasible alternatives.

Fathers and other family influentials

1. Encourage mothers to follow these practices.
2. Assist in preparing food and feeding.
3. Help the mother obtain sufficient food for her and the child.

Community and facility-based health volunteers and workers (public, private, and traditional)

1. Encourage mothers to follow all of the above practices.
2. Begin each contact by assessing current practices and then negotiate the best feasible improvements.

Malaria: (see also Control of Communicable Diseases and School Health and Nutrition)

Pregnant women

1. Go to ANC in the 4th and 7th months of pregnancy to obtain malaria treatment.
2. Take tablets as instructed.
3. Use the ITN voucher you receive at ANC to purchase an ITN.
4. Sleep under an ITN (every night, all year long).

Mothers or other caretakers of young children

1. Ensure that all children under 5 sleep under an ITN (every night, all year long).
2. Take (or ensure another family member takes) net for re-treatment every 6 (??) months OR retreat at home every 6 (??) months.

3. Obtain a Homapak as soon as you notice that a child under 5 has a fever.
4. Give the medicine all 3 days as per the instructions.
5. Take child immediately to a health facility if illness worsens or child is not improving after 2 days of medicine.

Fathers and other family influentials

1. Give money needed for ANC visits, purchasing ITN, and re-treatment.
2. Encourage the mother to carry out her recommended practices.

Health workers (public and private)

1. Treat mothers and children kindly and with respect.
2. Perform technical tasks correctly regarding IPT, treatment of malaria cases, handing out ITN vouchers.
3. Give clear explanations and instructions and confirm mothers' understanding.

Community and religious leaders

1. Encourage families to protect themselves and the community against malaria by carrying out recommended practices re: IPT, Homapak, and ITN.

Community volunteers

1. Give Homapaks to families that need them.
2. Give clear instructions and confirm understanding.
3. Advise families to obtain vouchers and ITNs, and explain proper use of ITN

[For ITN use: UPHOLD will need to find out if disposal of re-treatment solution is an issue. Need to research best ways of re-treatment (individual or mass)]

Immunization:

Health workers who immunize (public and private)

1. Store and administer vaccine properly.
2. Follow proper procedures to ensure vaccine safety.
3. Treat mothers and children kindly and with respect.
4. Tell each mother about side effects and the date and importance of returning for the next vaccinations, and then confirm that mothers understand.
5. Always write the return date clearly in the child's card (do not write a weekend or holiday date).

Mothers

1. Bring the baby to begin vaccinations in the first two weeks of life.
2. Be certain to understand the return date.
3. Bring the baby back each return date or as soon as possible after.

4. Treat side effects as instructed.

Community Volunteers

1. Help mothers understand when the baby needs to return for the next vaccination.
2. Urge her to do so.

Fathers

1. Encourage the mother to follow the scheduled dates.
2. Provide money for travel if needed.

Community and religious leaders

1. Urge all families to have their children fully immunized by the child's first birthday.
2. Publicly recognize families that have done so.

Danger sign recognition, care-seeking, and compliance (see Malaria also)

Mothers (and other family influentials)

1. Treat mild child illness appropriately at home (feeding and liquids, ORS, sooth the throat with tea or honey and lemon.
2. Recognize danger signs requiring a consultation with a trained health worker (bloody or excessive diarrhea and vomiting, fast/difficult breathing, disinterest in eating/drinking, lethargy, convulsions).
3. Take the child immediately to a trained health worker after noticing one of these signs.
4. Do not leave a consultation until you are sure you understand what the health worker has explained about the illness and treatment.
5. Purchase the full dose of any medicine needed.
6. Give the full dose as instructed.
7. Bring the baby back if he or she worsens.

Health workers (public and private)

1. Treat mothers and children kindly and with respect.
2. Diagnose carefully and treat correctly.
3. Explain what the caretaker should do and then confirm that mothers understand. Especially explain carefully how to take medicine and about side effects.

Community volunteers

1. When asked, help family make decision on need for a medicine consultation
2. Advise families on proper home care and treatment compliance.

Community and religious leaders

1. Work with community to establish means of emergency transportation.

2.1.6 Partners in Implementing Child & Adolescent Health Interventions

UPHOLD will collaborate with the Ministry of Health to implement effective policies at decentralized levels. Collaboration will be fostered particularly within a number of divisions and sections of the Ministry of Health, which include:

IMCI: To review the IMCI strategy, materials and tools and to scale up the approach to the 20 districts where UPHOLD will be working. UPHOLD will work with IMCI to develop strategies for integrating IMCI with Education and HIV/AIDS activities for all the three IMCI components but especially the household and community component.

Nutrition: To work with the Ministry of Health, Nutrition section to review and adopt the community-based growth promotion (CBGP) materials and to introduce CBGP activities in the districts.

UNEPI: UPHOLD will work with UNEPI to improve coverage through strengthening the linkages between health workers and the community, involvement of the health units in the monitoring of their performance (Coverage, drop-out, vaccine wastage, and data management) through micro planning at the sub district and health units level.

School Health: To liaise with the school health department to implement the school health activities that will include development of capacity among the teachers to effectively promote and deliver basics school health services, training of peer educators, provision of adolescent friendly health services and distribution of reading materials (e.g. straight talk, child talk etc) to the schools. Efforts will be made to involve the parents through establishment of appropriate for a for information exchange.

Reproductive Health: To review the life-skills based health education materials for adoption and use in the training of adolescents both in schools and out of schools. To work with the Department to develop BCC strategy for adolescent-friendly health services.

Ministry of Education: Tetanus toxoid immunisation in schools will be done in close collaboration with head teachers of schools. Together with the school health department and the department of reproductive health, of the ministry of health work with the school teachers to promote adolescent health services in the schools through training of peer educators and establishment of adolescent health clubs in schools. Schools will form an entry point for community and household IMCI.

AIDS Information centre (AIC): UPHOLD shall work with the AIC in the provision of voluntary counselling and testing services and the provision of

information on HIV/AIDS, as part of the Adolescent friendly health services at the health facilities that are designated to provide this service.

The AIDS Support Organisation (TASO): UPHOLD shall work with TASO in the mitigation of the effects of HIV/AIDS through support counselling and post-test care

BASICS: UPHOLD shall work with BASICS to scale up the Health worker – community linkages that where started on in improving and sustaining a high immunisation coverage, scale up the community and household IMCI activities and scale up the community based growth promotion and monitoring activities.

MOST: Micronutrient supplementation has been carried out by MOST project. UPHOLD will build on the lessons learned in this project and scale up its approach.

AIM: UPHOLD shall work with AIM in the area of provision of information and counselling services on HIV/AIDS.

PATH- AYA: In the provision of adolescent friendly health services, UPHOLD will collaborate with PATH-AYA who has experience in working with NGOS and private organisations to provide these services.

WHO: To work with WHO on the technical areas of immunisation, adolescent health, nutrition and IMCI for purposes of strengthening the approaches and scaling them up.

UNICEF: To work with UNICEF on the community dialogue, an approach that is being developed and is close to the health worker- community linkages strengthening that BASICS has been working on. In addition to this work with UNICEF on the immunisation, adolescent health services and nutrition and community IMCI.

DISTRICTS: Work with the districts in the initial planning and implementation of their work plan

AMREF: Work with AMREF in the areas of immunisation, nutrition and community IMCI, especially in districts where we overlap with them.

UGANDA RED CROSS: We shall work with the Red Cross in the area of community mobilisation for immunisation, community growth promotion and community IMCI.

3. COMMUNICABLE DISEASE CONTROL

UPHOLD will prioritize the control of malaria, tuberculosis and schistosomiasis in its communicable disease control component.

3.1 Overview of National Policies, Priorities and Current Interventions for Malaria Control

Malaria causes ill health and death in Uganda more than any other single disease and is responsible for more than 15% of the life years lost due to premature death. It accounts for 25-40% of outpatient attendances at health units and about 9-14% of in-patient deaths. The Government of Uganda recognises poor health as a major cause of poverty and malaria as one of the principal contributors to poor health and therefore to poverty. Government's commitment to address this problem and substantially reduce the burden is expressed in the Health Sector Strategic Plan which sets out specific targets to be attained by June 2005, and reflects the targets set by the African Heads of State in April 2000 in the "Abuja Declaration" and the objectives of Roll Back Malaria set out in 1998.

1. To increase the proportion of the population at risk of malaria, who receive
   effective treatment for malaria within 24 hours of onset of symptoms to 60% by end of 2005.

2. To increase the proportion of pregnant women receiving IPT to 60% by end of 2005.

3. To increase the proportion of children aged less than 5 years, regularly sleeping under Insecticide Treated Nets (ITNs) to 50% by the end of 2005.

4. To reduce malaria case fatality rate at hospital level to 3% by end of 2005.

3.1.2 SWOT Analysis

The analysis of the strengths, weaknesses, opportunities and strengths (SWOT) of current interventions in malaria control is derived from the HSSP.

SWOT ANALYSIS (Malaria)

Strengths	**Opportunities**
1. Government commitment as expressed in the enabling policies & strategies. 2. Guidelines are in place for ITNs, IPT, HBM and some IEC materials are available). 2. Community IMCI is targeting behaviour change relevant to malaria prevention & control. 3. Good collaboration between partners at the centre (MOH, WHO, UNICEF, DFID, Ireland AID) (collaboration mechanism ICCM & sub committees)	1. Communities already perceive malaria as a major health problem and are eager to find a solution. 2. Information on care seeking practices exists(RBM 2001, CMS 2000) 3. High ANC attendance. 4. Private sector involvement in the planned interventions is already initiated (e.g. CMS for ITNs, UPMA for IPT) 5. School children (UPE) can be used to disseminate information (ITNs, HBM & IPT) 6. Boarding schools are a good opportunity for IRS 7. Heavily populated institutions like barracks (police, prisons, army) are an opportunity for IRS.
Weaknesses	**Threats**
1. Lack of IEC materials in local languages (IPT, ITN, HBM) 2. Inadequate community mobilization and Sensitization for malaria control activities. 3. Inadequate participation of non-health sectors in malaria control activities, yet malaria consequences include other sectors. 4.Coordination of actors at lower level is poor 5. Low ITNs coverage. 6. Low awareness of new initiatives (HBM, IPT) 7. Inadequate involvement of the private sector in malaria prevention & control activities.	1. Inappropriate self medication is a rampant practice. 2. Use of herbs for treatment of malaria is a common practice & delays appropriate treatment seeking. 3. Some cultural beliefs about pregnancy and childhood illnesses can interfere with uptake of interventions (some severe conditions may be attributed to factors requiring use of herbs rather than modern medicine e.g. convulsions). 4. Cost of ITNs & insecticide is still high for the rural poor.

3.2 Overview of National Policies, Priorities and Current Interventions for Tuberculosis Control

Uganda is among the 22 countries with a high burden of tuberculosis which endorsed the Amsterdam declaration in March 2000 and has a high TB notification rate of about 146 cases per 100,000 population (1999), with an annual increase of about 10% each year. The prevalence of TB infection among adults is 50-70% and 50% of TB patients are HIV sero-positive. This association

between TB and HIV/AIDS has accelerated the problem of TB in this country. Currently the annual notification of TB cases is approximately 30,000 cases. This is a public health emergency and requires effective processes for diagnosis and management of all TB cases, as well as accurate monitoring systems for the evaluation of treatment outcomes.

A combined National TB/Leprosy Programme (NTLP) was instituted in 1990 and gained national coverage in 1995. The NTLP piloted the "Community Based TB Care with DOT" in Kiboga district in 1997 – 1998. A WHO supported study in 1998 showed that this approach achieved the WHO recommended target of 70% detection of smear positives cases and 80% cure rate of those detected and was 63% cost-effective. It resulted in savings for the health system and the family. The DOTs strategy is aimed at; ensuring a high cure rate of TB patients, rapidly decreasing the spread of disease and preventing the emergence of multi-drug resistant tuberculosis. It relieves the challenge of health facility overcrowding, understaffing & inadequate infrastructure, solicits community participation and mobilizes additional resources. This approach has since been expanded to 36 out the 56 districts. ***The key to success of this intervention hinges on the partnerships between the formal health services and the communities.***

The National TB control programme of the MOH has the short term objective of implementing community based TB care in all districts in Uganda by the end of 2003 so as to achieve; treatment success rate of 85% and case detection efficiency of 70% of all smear positive cases. UPHOLD will aim at attaining these targets in the programme districts. The current case detection rate is 53% (WHO target is 70%) of the estimated case load of 60,000 -70,000 new cases per year. The treatment success rate is 66% (2000/2001), (WHO target is 85%). At present, 36 (20 complete coverage, 16 partial coverage) out of 56 districts are implementing Community Based TB Directly Observed Treatment (CB- TB DOTs)

Priority activities spelt out by the National TB control Programme are:

1. Expansion of community TB care to all districts in Uganda by end of 2003
2. Strengthen case management for TB to achieve higher success rate of 85%
3. Increasing case detection to 70%
4. Strengthen TB care activities at the district and sub-district levels.
5. Integrate TB care within voluntary counseling and testing centers and the general health system.
6. Assess & explore modalities for private sector role in TB care.

SWOT ANALYSIS (TB)

Strengths	**Opportunities**
1. Enabling policies & guidelines are in place. 2. Collaborated efforts of central level stakeholders, MOH, WHO, GRLA, AIM, CDC, AIC, Mildmay, CUAMM, RCQHC, UPMB	1. Community based DOTs approach 2. DOTs 3. Zonal & district supervisors for support of district activities
Weaknesses	**Threats**
1. Inadequate diagnosis facilities (lab, supplies, personnel). 2. Poor flow of drug supplies (purchasing is the problem, lack of **funds**, many steps in the purchasing process) 3. Low human resource capacity (centre)	1. Stigma 2. HIV escalating TB prevalence 3. Drug resistance 4. Purchase of drugs is a long process, leading to expiry of drugs before use sometimes.

3.3 Overview of National Policies, Priorities and Current Interventions for Schistosomiasis Control

The prevalence of schistosomiasis in Uganda is one of the highest in Sub-Saharan Africa. The infections are mainly due to S. Mansoni and are found in 38 out of the 56 districts. The intensities of S. Mansoni are particularly high close to large water bodies (lakes & rivers) and are mainly associated with fishing. Many of the fishing communities experience infection prevalences ranging from 60%-100%. It is estimated that 2 million people in Uganda are infected with S. Mansoni and 13% of the population are at risk of infection.

The current government priority for schistosomiasis control is to deliver mass treatment consisting of praziquantel to populations with a prevalence rate of over 50% and mass treatment to school children in populations with prevalence rates between 20% -50%. This will be combined with mass treatment for intestinal worms using a single dose albendazole administered at 6-monthly intervals. Modalities are being worked out (spearheaded by MOH) for integration of schistosomiasis control activities with other programme activities namely; filariasis treatment, onchocerciasis treatment, malaria control activities, school health activities, health promotion and Education and environmental sanitation.

Strengths	**Opportunities**
1. Government commitment to schistosomiasis control expressed in the recent high profile launch. 2. Committed partners already embarking on activities (Schistosomiasis Control Initiative, WHO,DBL DFID & others)	1. Community systems that have been used for onchocerciasis & filariasis can be used for Schistosomiasis. 2. Sufficient quantities of drugs for mass treatment are already donated by Bill & Melinda Gates Foundation 3. The Schistosomiasis Control Initiative will be distributing the drug praziquantal to primary school children in 8 UPHOLD-supported districts, thus great opportunities for effective and efficient partnership

Weaknesses	Threats
1. Inadequate knowledge about transmission of schistosomiasis among the affected communities. 2. Inappropriate feacal disposal practices leading to contamination of water bodies and subsequent sustained transmission	1. Transmission of schistosomiasis is associated with an economic activity (fishing) which can not be avoided.

3.3 UPHOLD's Priorities in the Control of Malaria, Tuberculosis and Schistosomiasis

Malaria control priorities: UPHOLD will support the implementation of malaria prevention and control interventions aimed at quick attainment of the HSSP targets. The goal will be to prevent and control morbidity and mortality and to minimise social effects and economic losses attributable to malaria. This will be achieved through; provision of prompt effective treatment for malaria, use of preventive measures such as insecticide treated nets and intermittent presumptive treatment of malaria in pregnancy.

Stakeholders at different levels will contribute to malaria prevention and control in the 20 districts in accordance with their comparative advantages.

i. **Improving Case Management** through scaling up known best practices such as home based management of fever, supported by behaviour change interventions, improved quality of services at health facilities and research to explore appropriate options for prompt effective treatment for severe malaria and combined malaria-ARI at community level.

In this regard, UPHOLD will support the scaling up of Home Based Management of Fevers (HBM) in the 20 districts, to increase access to effective treatment of uncomplicated malaria at household level. This will be done in collaboration with MOH, WHO and other partners, by supporting activities for selecting, training & supervising community volunteers to provide first line antimalarial drugs at community level. Working in close collaboration/consultation with WHO, MOH (HPE) & C-IMCI, UPHOLD will support development of communication strategies, aimed at behaviour change for improved treatment seeking practices, so that patients and/or caretakers recognise the signs and symptoms early, know what appropriate actions to take, where to seek for appropriate treatment and to comply with treatment and referral instructions.

UPHOLD will support dissemination of clinical guidelines, refresher training and support supervision of health workers to improve the quality of case management in health facilities (public & private).

Action research will be supported to assess the impact, safety and best delivery options for combined malaria-ARI treatment at home, community level and peripheral HUs. In addition action research will be supported to explore further community innovations for delivery of effective treatment (rectal artesunate) for severe malaria at community level. Rectal artesunate is a potentially life saving antimalarial drug which has been formulated for rectal administration to patients who are severely ill, can no longer swallow anything, including drugs and yet are not able to get injectable treatment urgently. The results/outputs from this research will contribute to innovative best practices for home & community management of malaria & ARI.

ii. Intermittent Presumptive Treatment during pregnancy extended to all ANCs possibility of community IPT explored.

Provision of Intermittent Presumptive Treatment in ANC services, will be supported and will involve , dissemination of guidelines on IPT, orientation of ANC staff to the value and correct use of IPT, IEC activities for creating demand for IPT, integration of IPT information into HIMS and support supervision to promote quality IPT services. Exploration of the possibility of delivering IPT at community level will be supported, through action research.

iii. Vector Control is one of main strategies against malaria. The key intervention under this strategy will be promotion of Insecticide Treated Nets (ITNs). Promotion of ITNs use will be supported in line with MOH ITNs policy of minimising as much as possible, by all partners, the distribution of free nets to the public except in special circumstances (e.g. emergencies). Private sector involvement will be crucial to the success and sustainability of the ITNs strategy. UPHOLD will support districts to build private sector capacity and increase ITNs coverage, through the National Voucher Scheme for ITNs distribution.

iv. Epidemic Prevention, Preparedness and Response: Districts will be supported through facilitating training and support supervision; to compile, analyse & utilise data for early detection of epidemics. The epidemic prone districts will be the focus for building capacity for epidemic preparedness and response.

All priority malaria control interventions will be implemented in the Internally Displaced Persons(IDPs) camps in the 2 Northern Uganda districts included in the UPHOLD programme.

Malaria prevention and control activities will be promoted in schools (ITNs, IRS, and appropriate case management). In addition schools will be used as vessels for information dissemination. Appropriate options for doing this will be explored to include drama, songs and art & crafts, child to child and parent to child activities. Makerere University, Department of Music Dance & Drama and Local drama groups will be supported to compose appropriate songs and plays for

intended audiences. Working in collaboration with partners (MOH, HEP, CHANGE), FM radio stations' producers will be trained to produce messages for behaviour change for improved health seeking practices.

Tuberculosis control: UPHOLD will collaborate with other stakeholders to scale up community based TB Directly Observed Treatments (TB DOTs), through improving diagnostic systems (e.g. training microscopists), supporting behaviour change communication interventions for TB (prevention, treatment & control), supporting coordinated private sector involvement in TB control activities, exploring potential collaboration & involvement of schools in TB control activities and supporting communities to embrace TB DOTs. This will be done through support to the district health services, NGOs and CBOs.

UPHOLD will support the strengthening and improving of the following areas in the TB programme activities:

i. Training and supervision of the key HWs (Drs, nurses, lab personnel, field staff) in the National TB Leprosy Programme (NTLP) activities (promotion of support supervision (SS) at all levels & feed back to maintain interest & competence).

ii. Strengthen activities at the focal unit of operation the Sub-County (using existing staff: HA, PHWs staff of peripheral HUs & CVs)

iii. Build human capacity to:
    a. Support activities for case detection
    b. Achieve high treatment success rate
    c. Promote good record keeping & reporting for TB cases
    d. Support supervision

iv. Empowerment (training/orientation seminars, mobilisation, etc.) of communities for planning, implementing & supervising Community Volunteers (CVs).

v. Support the integration of TB testing & treatment in TASO & AIC activities to subsequently increase VCT coverage & integration of TB /HIV care.

vi. Enhance behaviour change communication interventions for TB (prevention & treatment)

vii. Support coordinated involvement of the private sector (e.g. traditional healers) in TB activities.

viii. Explore the extent of involvement of schools (children; child to child, child to parent, teachers; school curriculum) in TB control activities.

ix. Support action research to explore the role of the private sector in TB control activities, factors influencing TB treatment & outcomes in women, development & evaluation of an IEC strategy for TB and causes of delay in care seeking for TB and non compliance with treatment.

Schistosomiasis control:

i. Prevalence surveys: to map out areas of high concentration of schistosomiasis. This exercise has already been undertaken by MOH (Division of Vector Borne Diseases) in the 21 districts targeted for schistosomiasis activities over the next four years.

ii. Mass treatment for schistosomiasis for all communities where the prevalence of schistosomiasis is above 50% and mass treatment for school age children in communities where prevalence is between 20% - 50%. When the prevalence of infection is below 20%, the drugs are made available at the health units in the affected communities and supplemented with IEC strategies advising communities to seek treatment.

Working in close collaboration, with Schistosomiasis Control Initiative(SCI) and other partners, UPHOLD will support activities for community capacity building for mass treatment of schistosomiasis through sensitization of communities, selection of community volunteers, training and supervision of volunteers and the training of teachers to effect mass treatment in schools and conduct supervisory activities. Support will be provided for the development of a communication strategy for community mobilization and sensitization for schistosomiasis control activities.

Schistosomiasis Control Initiative (SCI) is an initiative of the Imperial College, London, which receives funds from the Bill & Merinda Gates Foundation and has already donated sufficient quantities of drugs (praziquantel) (estimated to last for the next 4-5 years), for mass treatment of schistosomiasis in the selected 21 districts. Eight (8) out of the 20 UPHOLD supported districts are included in the districts targeted for schistosomiasis control activities under the above arrangement. The 8 districts are; Arua, Bugiri, Bundibugyo, Lira, Gulu Kitgum, Mayuge and Wakiso.

3.4 Communicable Diseases Control for Internally Displaced Person's (IDP)

The World Health Organization (WHO) estimates that 30% of the world's annual burden of malaria mortality occurs in countries affected by complex emergencies. Uganda currently has an on going complex emergency situation in the North involving armed insurgency by rebels, namely the Lord's resistance Army (LRA). Refugees from neighbouring countries are also resident in Uganda. In the recent past government of Uganda has instructed communities living in the districts

most affected by the insurgency namely; Gulu Kitgum and Pader to evaluate to internally displaced populations camps (IDP), enabling large scale movement of troops without endangering civilian populations. This directive has resulted into large population movements into already overwhelmed IPD camps. As a result, there is overcrowding, poor shelter and poor sanitation, therefore primary Health care facilities are overwhelming and communicable diseases are rampant.

A national task force on Emergency in the North has been established, coordinated by UNOCHA/ Ministry of Emergency preparedness. However coordination of a health response has not been strong to date. Through Ireland AID support, The Malaria Consortium (MC) is currently providing technical support to Gulu district in respect of malaria prevention and control interventions. Namely HBM, IPT & ITNs.

3.4.1 Priority Interviews for communicable diseases control for IDPs

i. To enable the Health facilities (public and private) in the districts affected by internal displacement to deliver prompt quality services for treatment of malaria & TB, through orientation of health workers, provision of guidelines & regular support supervision.

ii. To undertake training of community health workers in Home Based Management of fever (HBM) in all accessible IDP camps to enable them to provide prompt treat of fever using Homapak.

iii. To implement behavior change communication interventions for creating demand for IPT among pregnant women, so that they attend (ANC and receive IPT among pregnant women so that they attend ANC and receive IPT.

iv. To distribute free ITNs at ANC for pregnant women and <5s in the IDP communities.

v. To establish sustainable systems for re treatment of ITNs twice a year.

vi. To work out modalities for diagnosis & treatment of TB in IDP communities and integrate this into other activities that involve use of community volunteers, namely; HBM, schistosomiasis mass treatment 7 intestinal worms mass treatment.

vii. Work with the district health services to implement behavior change communication strategies related to prevention and control of malaria, TB, schistosomiasis, intestinal worms and other communicable diseases.

3.4.2 SWOT analysis for communicable Diseases for IDPs

Strengths	**Opportunities** 1. Several development partners are already supporting programmes in the insurgency districts (Ireland AID (Homapak), WB (NUSAF),) 2. There are a number of agencies (local & international) already working in these districts and offering services in different fields who can be partners in communicable diseases control (MC, WV, URC, CRS, save the children- Norway, Save the children- den mark and others, GUSCO) 3. Coordination mechanisms exist for partners working in the e.g. Contact Group on the North, UNOCHA & others.) 4. People aggregated together in camps are easy to access with services to attain high coverage.
Weaknesses 1. Although coordination mechanism exists, there have not been regular coordination meetings.	**Threats** 1. The insurgent might continue for some I the future 2. Insurgency sometimes limits access to the IDPs 3. Infrastructure for delivery of services is at a very low ebb.

3.4.3 Priority activities for work in areas with Internally Displaced Persons

1. Undertake a rapid assessment of health needs in the 2 UPHOOLD supported Northern districts with special emphasis on malaria, TB, schistosomiasis, intestinal worms & other Education & HIV/AIDS issues relevant to UPHOLD

2. Quality needs for drugs & supplies for the affected districts.

3. Training for community identified volunteers in each IDP on the HBM strategy and completion of the record forms. Formal Health workers will be involved in these activities to establish a referral pathway for severe febrile illnesses.

4. Establish a mechanism for targeting pregnant women for the distribution of pre- treated ITNs & IPT

5. Conduct behavior change interventions to promote; prompt & appropriate treatment of fevers, ITNs & IPT during pregnancy.

As much as is feasible, activities for communicable diseases control will be integrated with other activities in health, education and HIV/AIDS.

3.5 Key behaviours for Infectious Disease Control

i. **Malaria** (see Community IMCI and SHN)

ii. **Tuberculosis**

Population in General

1. Accept, understand, and support people with TB.
2. Encourage people with cough for 3 weeks or longer to be tested.

People with TB

1. Go for and complete testing if you have had a cough for 3 weeks.
2. Comply with treatment.

Treatment supporters (volunteers)

1. Supervise the full treatment correctly.
2. Encourage compliance and give emotional support.
3. Orient community on TB and its treatment.

Facility-based health staff (public and private)

1. Test competently (to confirm or reject the TB diagnosis).
2. Counsel effectively.

Family members

1. Accept, understand, and support people with TB.
2. Encourage people with cough for 3 weeks or longer to be tested.
3. Encourage compliance and give emotional support during treatment.

Sub-country level health worker

1. Bring medicine to volunteers every two weeks.
2. Assess and support volunteers and patients.

iii. **Schistosomiasis (see also SHN)**

Children 6-15 years old

1. Never urinate or defecate in water (do it before entering or come out).
2. Attend all mass treatments for shisto.
3. Eat before taking the medicine.
4. Encourage non-school attending children to go to mass treatments.
5. Take medicine in front of a teacher or health worker.

Parents and caretakers of those children

1. Encourage children never to urinate or defecate in water.
2. Accompany children to mass treatments.
3. Feed children before treatment or ensure that they eat food available at place of treatment.

Persons who regularly spend a lot of time in water

1. Wear boots in water (is this FEASIBLE?).
2. Attend available mass treatments for shisto (??) or go annually to a health facility for treatment.
3. Eat before treatment.
4. Take medicine in front of health worker.

School teachers

1. Encourage children never to urinate or defecate in water
2. Encourage all children to attend mass treatments.
3. Organize the mass treatment at your school (food, recording, administering medicine, advising on side effects).
4. Carry out assigned tasks during the mass treatment.

Health workers (public and private)

1. Organize the mass treatment at your schools.
2. Carry out your assigned tasks during the mass treatment (food, recording, administering medicine, advising on side effects).
3. Treat other high-risk persons at health facilities.

Community and religious leaders

1. Encourage all parents to bring their children to mass treatment and ensure they eat first.

4. INTEGRATED REPRODUCTIVE HEALTH

4.1 Background

Reproductive health is defined as a state of complete physical, mental, emotional, and social well being in all matters relating to the reproductive system, its functions and processes (ICPD,Cairo,1994).It includes sexual health, the enhancement of life and personal relations, counselling and care related to reproduction and sexually transmitted diseases.

The National Health Policy(September 1999) and the Health Sector Strategic Plan(2000/01-2004/05) identify the Uganda National Minimum Health Care Package as the cornerstone for fulfilment of the health sector Mission of attaining a good standard of health by all people in Uganda in order to promote a health and productive life.

One of the 12 elements of the Uganda National Minimum Health Care Package is the Sexual and Reproductive Health and Rights. The Element addresses four main components namely:

- Essential Antenatal and Obstetric Care.
- Family Planning
- Adolescent Reproductive Health
- Violence against Women

The Mission of the Reproductive Health Division is to attain the highest possible level of health for women, men, children and adolescents in Uganda through the development of appropriate Reproductive Health policies, objectives and Strategies, and to ensure accessibility to high quality affordable and integrated sexual and reproductive health services. In fulfilment of this Mission, the Division formulated a 5 year strategic Framework (1999 – 2004) focussing on the following strategies:

- Provision of Quality, Integrated services
- Human Resource Development for effective services delivery
- Strengthening advocacy and community participation in Reproductive Health
- Effective Supervision, Monitoring and Evaluation

The Reproductive Health Division further developed a package that provides a national guide for the operationalisation of Reproductive Health policy with an overall output of increased accessibility and utilisation of services. This is the “Sexual and Reproductive Health Minimum package for Uganda”. The package focuses on the following key areas:

- Safe Motherhood and breast feeding
- Family planning
- Adolescent Sexual and Reproductive Health
- Sexually transmitted Diseases and HIV/AIDS
- Reproductive Health Cancers(cervix, prostate and Breast)
- Gender issues(domestic violence, female genital cutting and male participation
  and involvement)

Although there has been a high level of policy commitment by GOU and MOH to address reproductive health concerns and improve services, these efforts have not translated into action and results on the ground as yet.

Maternal mortality, which is the death of a woman in pregnancy or within 42 days of the termination of a pregnancy stands at 505/100,000 live births(UDHS,2000/01).A similar survey, UDHS 1995 showed that in 1995,the maternal mortality ratio(MMR) was 506/100,000 live births. Some sources indicate that |MMR in Uganda could be as high as 1,200 per 100,000 live births(WHO,1996).Uganda has been rated as one of the 8 countries having the highest MMRs in the world.
The direct obstetric leading causes of maternal death in Uganda include bleeding (Haemorrhage), unsafe abortion, sepsis, eclampsia and obstructed labour. HIV/AIDS, Malaria and anaemia contribute greatly to the indirect causes of death.

Although the Antenatal care (ANC) attendance stands at 94% for single attendance, much needs to be desired in terms of quality. There is minimal or non existent provider-client interaction and 42% of the pregnant women are reported to receive two or more doses of tetanus toxoid. Most of these women receive care from medical professionals, the majority of whom are in public facilities (71 %).

The MOH recommends that a woman attend ANC at least four times during pregnancy. Overall only 42 percent of women make four visits and majority of them attend late when it is sometimes late to identify complications.

Overall, 37% of births occur at health facilities while 62 percent of the mothers are delivered at home. Delivery under skilled attendance is 38%.

The infant mortality rate (IMR) is currently 88 per 1,000 live births. Perinatal mortality contributes 30-40 % of infant mortality. The common causes of perinatal mortality are closely linked to poorly managed pregnancy, childbirth and puerperium. IMR and MMR are usually linked. In low resource countries, the pattern is that MMR is about one-fifth of IMR (Lijestrand, 2000).
Postnatal attendance/check-up is reported to be as low as 10% (UDHS, 2000/01) and yet about 60% of all the causes of maternal death are said to occur within

the first 2 days of childbirth. The WHO recommended schedule of postnatal checkups is within 6 hours, 6 days and 6 weeks after childbirth.

Uganda has one of the highest fertility rates in eastern and central Africa currently standing at 6.9 as compared to Kenya 4.7 and Zimbabwe 4.0.The contraceptive prevalence rate (CPR) is still very low, and yet the unmet demand for family planning services is 35 % with 21 percent for spacing and 14 percent for limiting. The CPR for all methods is 23% and 18% for modern methods.

Uganda's population is very young with youth (10-24 years) constituting 31.9% of the total population of 24.6 million people. Although the overall TRF has remained stagnant for the last decade or so, adolescent fertility is on the rise due mainly to low contraceptive prevalence in this age group. The current teenage pregnancy rate is 31% and many of these pregnancies end up in unsafe abortions.

The prevalence of STDs and HIV is also high among Uganda adolescents. It is estimated that youth comprise about 50% of those infected with HIV. Young girls are particularly at risk for STDs and HIV as many trade sex for material needs.

The HIV infection prevalence rate from antenatal sentinel surveillance sites although declining stands at 6.5 %.The Health Sector Strategic Plan targets a national average of 5 % by the year 2004/05.

The current policy on HIV/AIDS emphasis prevention of STI including HIV focuses on the more vulnerable adolescents, youths and women.

VCCT and PMCT services are being scaled up while a few centres have started providing Anteretrovirals (ARVs)

Although a lot of effort in terms of policy and pressure groups activities has been put in place to address reproductive health needs of women and girls through the lifecycle approach, gender equity at the community and in some levels of reproductive health care provision remains a big issue of concern**.**

STI/HIV/AIDS and unwanted pregnancies have been cited as the common problems affecting school children. STIs coupled with menstrual problems and lack of sanitary wear are key factors leading to absenteeism of girls from school (School Health Policy, draft, Jan 2003). Less than 10% of girls aged 15 years and above were able to define safe period correctly .In the same study, it was revealed that children above the age of 15 years,25% of the boys and 16 % of the girls had sexual partners. Life education is offered in less than 10 % of the schools and in most cases only to girls.

According to the School Health Policy, a number of interventions have been pioneered by government and other stakeholders to foster health in schools. Some of these include:

- Adolescent reproductive health guidance and counselling(1997-2000)
- Life Skills Initiative

Although these interventions have had some positive impact on school health gaps still remain. Effectiveness of these interventions has been compromised by a lack of a policy framework to guide the planning and implementation of school health activities. As a result, the implementation of these interventions has been piecemeal and not effectively co-ordinated.

Among the school Health policy objectives, the following clearly address the IRH issues.

- To integrate life skills based health education including sex education, into the curricular at all levels of education
- To improve access and utilisation of Adolescent Sexual and reproductive Health including HIV/AIDS/STDs and teenage pregnancy prevention information in schools.
- To mainstream gender and disability concerns in the provision of school health services especially sanitation and hygiene

Basing on the aforesaid therefore, there is a dire need to intensify collaborative efforts involving all stakeholders in RH including the communities and families in order to improve the reproductive health status for longer and productive lives of Ugandans.

4.2 Overview of National Policies and Priorities

According to the National Health Policy and the Health Sector strategic Plan, the following were identified as the priority areas and targets for RH, to be achieved by 2005.

- to reduce Maternal mortality rates from 506 to 354 / 100,000 live births
- to increase the % of deliveries taking place in a health facility from 25.2 to 35%
- to contribute to a reduction of IMR by 30% from 97 per 1,000 live births by reducing perinatal mortality
- to reduce total fertility rates from 6.9 to 5.4
- to increase contraceptive prevalence rate from 15% to 30%
- to provide 20% of adolescents with appropriate, accessible, affordable and acceptable RH services
- to increase the proportion of deliveries by skilled assistants from 38% to 50%
- to increase attendance of at least 4 ANC visits per pregnancy
- to increase tetanus toxoid coverage among pregnant women receiving at least 8 doses from 50% to 80%

- to integrate management of STIs and screening for RH cancers into existing RH services
- to increase health facility specific number of caesarean sections per 1000 deliveries within the catchment areas of the health facility from 14 to 25 -30%

In June 2003, a national RH Symposium was held and after long deliberations, the RH stakeholders narrowed down the priorities to the following:

- increasing access to and use of family planning services
- improving the quality and increasing the frequency of utilisation of ANC services
- increasing access to and use of adolescent friendly RH services
- increasing the proportion of deliveries supervised by qualified health workers
- increasing access to and use of basic and comprehensive emergency obstetric care services

4.3 SWOT ANALYSIS OF IRH SERVICES

Over the past few years, MOH has put together a package of activities from the sexual and reproductive health minimum package for use at the various levels of health service delivery, from the referral hospital to the community level. A lot of resources have also been put in by various partners to strengthen delivery of RH services. However, there are still major weaknesses. Below is the SWOT analysis of the current National reproductive Health Services in Uganda:-.

STRENGTHS	**WEAKNESSES**
• Policy guidelines and Service Standards in place • Training Manuals available for priority training areas • HSDs as a source of EOS closer to the people • High accessibility coverage for Obstetric services (ANC attendance – 94 %) • Development of many HMIS materials on pregnancy, labour and the newborn.	• Low levels of service utilisation • Very few HC4s providing EOS • A weak referral system including community responsive referral system • Very few facilities offering effective AFRHS • Insufficient equipment in many facilities • Poor quality services(inadequate supplies, drugs) • Poor Indicators (except ANC coverage) • Low levels of community involvement. • Poverty of Interpersonal Skills among service providers • Inequitable distribution of services • Poorly explored cultural beliefs and practices • Weak support supervision including performance improvement analysis • monitoring of labour; and weak record-keeping and data collection. • Minimal dissemination of policy guidelines and service standards. • Minimal private sector involvement • Data collection from the private sector is difficult
OPPORTUNITIES	**THREATS**
• The HSD structure to provide technical support • Existing organisational structures e.g. FBO/CBO conducive for community involvement • Presence of CORPs that supplement the service providers • YSP for quality improvement is being scaled-up. • In health, there is a wide coverage by the private sector.	• Prolonged lack of confidence in public facilities will be difficult to reverse. • Resorting to unattended deliveries aggravates maternal mortality • Natural and man made disasters. • Low staffing levels in some districts

4.4 Priority activities for UPHOLD

Within the framework of the National health Policy and priorities for RH, UPHOLD will work with districts and other collaborating partners to establish and efficient, effective and sustainable delivery of interventions aimed at achieving USAID's Strategic Objective 8 (SO8). This will be done through several intermediate results:

- IR 8.1 Effective use of Reproductive Health Services
- IR 8.2 Increased Capacity to Sustain Reproductive Health Services
- IR 8.3 Strengthened enabling environment for RH services.

The UPHOLD Strategy will focus on the following key areas:

- Improving quality of RH services at all levels
- Improving access to and availability of RH services
- Supporting the adaptation of positive RH behaviours
- Improving decentralised planning, management and monitoring systems for RH
- Promoting private sector role in service delivery
- Increasing community participation and advocacy for RH services.

The objectives, targets, key activities and indicators for UPHOLD interventions are outlined in the table below.

4.4.1 Improving quality of RH services

UPHOLD plans to introduce the Yellow Star Program to all the 20 districts and the Yellow Star standards will be used to assess and monitor the quality of RH services being provided.

UPHOLD will work with partners to introduce and promote approaches such as Partnership Defined Quality (PDQ) and Making Pregnancy Safer (MPS) which promotes involvement of communities in assessing the services, designing and implementing interventions to ensure that the service meet client needs.

Although the proportion of pregnant women attending ANC at least once is high, currently, only 42% of pregnant women attend ANC at least 4 times as is recommended if the ANC objective of identifying and preventing problems during pregnancy is to be achieved. UPHOLD will promote the goal oriented ANC approach with a profile of at least 4 visits at 16, 20 –24, 28 – 32 and 36 weeks, attended to by service providers with the knowledge and skills to provide the expected services which will include:

- Adequate information on pregnancy risk factors and danger signs
- Birth and emergency readiness planning

- Screening and management of medical, surgical and obstetric conditions and complications (e.g. for STIs, urine protein, anaemia, blood group etc).
- Advice on nutrition and provision of micronutrient supplementation (iron and folic acid)
- Tetanus toxoid
- Deworming
- Voluntary confidential counselling and testing for HIV, advice and referral for prevention of mother to child transmission of HIV services if required (PMTCT).
- Intermittent presumptive treatment (IPT) for malaria and promoting the use of insecticide treated nets (ITNS)

The main activities to be undertaken to promote quality of RH services will include:

4.4.2 Carrying out a needs assessment of available RH services. This will include assessing the human resource capacity to provide the services as well as the ability of the facilities to provide them. Of particular concern is the capacity of the service delivery points to provide basic and comprehensive essential obstetric care. Essential obstetric care (EOC) refers to a minimum of services that can save lives of the majority of women with obstetric complications.

<table>
<tr><td colspan="2">Signal function used to identify Basic and Comprehensive EOC</td></tr>
<tr><td>Basic EOC Services

1. Administer parenteral* antibiotics
2. Administer parenteral oxytocic drugs
3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia
4. Perform manual removal of placenta
5. Perform removal or retained products (e.g., manual vacuum aspiration)
6. Perform assisted vaginal delivery</td><td>Comprehensive Services

(1-6) All of those included in basic EOC
(7) Perform surgery (Caeserian section)
(8) Perform blood transfusion</td></tr>
<tr><td colspan="2">A Basic EOC facility is one that is performing all functions 1-6

A Comprehensive EOC facility is that performing all functions 1-8</td></tr>
<tr><td colspan="2">*Parenteral administration of drugs means by injection or intravenous infusion (‘drip’)</td></tr>
</table>

The assessment will be done early in the first year and the findings used to guide district specific interventions in subsequent years. Where necessary, basic RH equipment will be provided.

4.4.3 Improving the technical competence of service providers through training and supervision. Whole site training and support will be preferred. The use of simple tools that can contribute to improved quality of RH services e.g. use of a partograph to monitor labour will be supported. In addition to one –time technical training for individual providers in specific RH service areas, HSD will be supported to conduct refresher trainings for their RH service providers in form of quarterly or biannual “grand rounds”.

4.4.4 Action research will be carried out to guide UPHOLD interventions. In the first year, research will be carried out regarding the design, cost and utilisation of the “mama kit”.

4.4.5 Improving the management of drugs & supplies for RH through working with health facilities managers to improve their skills in forecasting needs, especially for FP supplies and monitoring utilisations to ensure that there are no stock outs at any time.

4.5 Improving access & availability of RH services

In order to improve access and availability of RH services, UPHOLD will focus on strengthening referral systems from community level to hospital level. Interventions will build on lessons learnt from existing community mechanisms for referral and from the RESCUER final evaluation. A functioning referral system requires the ability to recognise early danger signs at initial point of service, the availability of appropriate skills and supportive attitude of service providers at referral points, an appropriate transport system and the readiness of the referral facility to manage the complications in terms of surgical facilities, intravenous fluids and blood transfusion.

UPHOLD will support the setting up of new service delivery points for Voluntary Surgical Contraception / long term contraception and PMTCT services in all HSD. UPHOLD will work closely with district condom focal persons to identify and establish new non-traditional outlets for condom distribution and will strengthen linkage between NGOs and the condom focal persons.

UPHOLD will strengthen provision of post natal care services at all HCIII and IV levels, including post natal FP and post abortion care.

RH outreach programs will be supported and a communication program designed and implemented to encourage utilisation of available services. The design of the communication program will be informed by action research on

socio-cultural influences to utilisation of services, including communication between partners.

In districts with conflict areas, UPHOLD will work with the district and partners to design and implement innovative ways to bring RH services to IDPs and to other vulnerable groups such as the night commuters in Gulu.

4.6 Promoting positive behaviour change

Activities to promote positive RH behaviours will build on those that will improve quality and access to services. A two pronged approach will be used and action research will provide guidance on district / ethnic specific areas of focus.

The first approach will involve working with service providers to improve not just their technical skills but their communications skill as well e.g. interpersonal communication skills so as to provide adolescent friendly services, to carry out outreaches and to reach out to community leaders.

The second approach will focus on the communities through a variety of communication channels such as advocacy meetings, pamphlets and brochures for community leaders; use of interactive radio programs that take advantage of the numerous FM radio stations in the country, drama, songs, local dances etc and exploring ways to include RH issues into other community level activities such as functional adult literacy where they exist. For adolescents the use of peer groups and peer counsellors will be supported.

4.7 Improving decentralised planning, management and monitoring of RH services.

In order to have sustainability of services, it is important that local governments at district and sub-county levels get involved in planning and managing RH services.

In partnership with other stakeholder such as the Population Secretariat, advocacy for RH will be carried out targeting district, cultural, religious and sub-county leaders in order to create an understanding of RH services, address fears and misconceptions about RH and generate local support for activities.

UPHOLD will equip district and health facility managers with the knowledge and skills to extract RH data from service statistics and use it for advocacy purposes.

UPHOLD will also provide grants to support local government initiatives from promoting RH.

4.8 Promoting private sector role in RH

In order to have improved quality, access to and utilisation of RH services, it is important that DHS work with the private sector, both the private for profit and private, not for profit sectors.

During the first year, UPHOLD will conduct a mapping exercise to identify the various groups of RH private providers operating in each district and arrange for an initial meeting between the extended DHT and the private providers to identify roles possible avenues of collaboration.

UPHOLD will ensure that training and materials for RH provided to districts are extended to the private providers as well and will support biannual meetings between DHTs and private providers.

4.9 Increasing community participation

In addition to activities outlined in sections 4.1, to 4.4 above that will promote community participation in RH, UPHOLD will also provide training to Village Health Teams and other Community Resource persons on RH

4.10 Key **Behaviors for Reproductive Health**

ANC:

Pregnant women

1. Go for a first ANC visit as soon as you're sure you are pregnant (to be sure that the pregnancy seems fine).
2. Go for a second ANC visit in the 4th month (to receive TT, IPT, iron tablets (??))
3. Go for a third ANC visit in the 7th month (to receive TT, IPT, iron tablets (??))
4. 4. Go for a 4th ANC visit in the last month to learn how the baby is lying.
5. Take the malaria and iron tablets as instructed.
6. Keep taking the iron tablets as instructed (most side effects go away after a few days; you still need more iron even after the pills have helped you feel better and have more energy).
7. Seek help from a community health volunteer or health worker if side effects are bothering you a lot.
8. Suggest and participate in birth preparedness planning with other key family members.

Pregnant Women (plus husbands and other family influentials)

1. Participate in birth preparedness planning (decide where, who will attend, and in case of emergency, transport, money, who will accompany, who will give blood (?), who will watch children (??)

2. Encourage mother to attend ANC (accompany her if possible).
3. Provide needed transport money.

Health workers (public and private) (current KAP and program actions will be somewhat different for each group)

1. Treat mothers and children kindly and with respect.
2. Carry out tests, evaluation, and counselling correctly.
3. Explain what the mother should do and then confirm that mothers understand. Especially explain carefully how to take medicine and about side effects.
4. Explain and motivate pregnant women to engage husband and other key family influentials in birth preparedness planning.

Other Reproductive Health Concerns:

Pregnant women

1. Use a skilled care provider to attend your deliveries.
2. If a danger sign occurs during pregnancy, labor, delivery, or after delivery, urge your family to take you immediately to a health facility with Comprehensive Essential Obstetric Care services.

Couples

1. Abstain from sexual activity until marriage.
2. If already sexually active: be faithful to one partner and consistently and correctly use a condom or begin to abstain (substitute other ways of showing intimacy).
3. Obtain and use a reliable method to delay at least two years between pregnancies.
4. Use long-term permanent methods of family planning.

Public and private providers

1. Improve your reproductive health skills and resources.
2. Treat mothers and children kindly and with respect.
3. Diagnose and treat competently and according to quality standards.
4. Counsel clearly and adequately and confirm understanding.

Community leaders and organized groups

1. Establish a community transportation plan for medical emergencies.

5. SCHOOL HEALTH AND NUTRITION

5.1 Background

School Health and Nutrition (SHN) makes contributions to primary school education, health and HIV/AIDS programs. SHN can improve the educational performance of school children, the health of school children and the health of their communities. SHN is quite possibly the most strategic area of UPHOLD's results-oriented approach to improving the quality, use, planning, management and monitoring of social services because of its holistic and integrated approach of building effective synergies between improving health and improving learning and performance in primary schools.

Despite recognition of its importance, comprehensive program implementation generally remains limited to pilot programs, select districts, or specific topics. UPHOLD's commitment to support a comprehensive SHN program at decentralized levels should help Uganda to develop one of the first large-scale initiatives in Africa.

Success in reducing child mortality has resulted in increased numbers of children who reach school age. Due to Universal Primary Education in Uganda, seven and one-half million people, 30 percent of the population, are now enrolled in primary school.[1] Children of school age continue to face serious health problems. These problems can keep them from school altogether, decrease their attendance, and even hold back their performance by forcing them to miss school or lose concentration. SHN interventions have proven to improve their academic performance, enrollment, retention and absenteeism.[2]

SHN interventions also improve the health status of children, teachers and communities. Schools provide structures to easily access and bring services to a majority of school-age children. Interventions such as iron supplementation, immunization and nutrition education can improve their current health status and future health. Teachers can benefit from some of services and the reduction in illnesses among pupils. Treating school children for communicable illnesses helps to lower the level of disease in the entire community, particularly for intestinal worms and schistosomiasis. In addition, children can act as change agents for their families and peers.

Finally, SHN has long-term benefits for children. SHN can prepare children to make responsible and healthy life choices through life skills education. In addition, SHN can help girls to stay in school. It is now well established that better educated girls grow up to raise healthier children and families.

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[1] School Health Programme and the Role of Health Promotion and Education Department presentation by Dr. J.M. Twa-Twa, Principal Medical Officer, MOH, August 26, 2003.

[2] World Education Forum Education for All 2000 Assessment. School Health and Nutrition. UNESCO, 2000.

International organizations have developed several frameworks for implementing SHN:

- WHO has a health-promoting school framework that is characterized by schools that are constantly strengthening their capacity as health settings for living, learning and working;
- UNICEF has child-friendly school framework that are characterized by being healthy for children, effective with children, protective of children, and involved with families and communities and children;
- The World Bank has a FRESH framework: a concerted effort to Focus Resources on Effective School Health that includes health-related policies in schools, safe water and sanitation facilities, skills-based health education and school-based health and nutrition services.

International organizations adopted the FRESH framework at the Education For All conference in Dakar in 1997.

5.2 Overview of National Policies, Priorities and Current Interventions

The ultimate goal of Government of Uganda is to reduce mass poverty. To this aim, the Government has a National Health Policy, a Health Sector Service Policy and an Education Policy among others.

To address the inter-sectoral issue of school health and nutrition, the Ministry of Health and the Ministry of Education & Sports have drafted a School Health Policy that lays out the full range of interventions that can improve the education and health status of school-age children, including physical, psychological and emotional aspects. The vision of the Government is to promote healthy minds in healthy bodies for better school performance.

The package of interventions listed by the policy includes health education, physical education, medical and dental care services, nutrition services, water and sanitation, adolescent reproductive health, promotion of safety and good lifestyles, promotion of immunization, management and control of communicable diseases and epidemics in schools, health promotion for staff and school-parent-community partnerships.

The policy calls for multi-sectoral committees at every level, from the national level to the school level.

The implementation mandate lies mainly with the Ministry of Education & Sports with participation of the Ministry of Health. The Ministry of Health will provide technical input on health content and help to monitor and evaluate implementation of the policy.

To date, the policy has been approved by the Ministry of Health and is under consideration by the Ministry of Education & Sports.

5.2.1 SWOT Analysis of SHN interventions and programs

Strengths	**Weaknesses**
▪ A committed national government ▪ Large percentage of children enrolled in primary school ▪ A draft SHN policy developed with multi-sectoral stakeholders, particularly MOH and MOES ▪ Experience in Uganda working in primary schools on health education, HIV/AIDS prevention, hygiene ▪ Experience and commitment in Uganda to the child-to-child approach	▪ Lack of district-level scientific data on health problems ▪ Lack of qualitative information about primary school pupils and their families
Opportunities	**Threats**
▪ Chance to bring health and education sectors together for a common goal ▪ Ability to integrate health education into education materials development ▪ Build on existing activities and interest in HIV/AIDS prevention for pupils ▪ Strong national support and mobilization for PIASCY ▪ Revision of the PIASCY Manual	▪ The MOES may not approve the school health policy in the near future

5.2.2 Assumptions & Risks

- There will be sufficient funding for implementing partners to service 1,600 schools.

- The MOH will be able to train partners in basic SHN service provision.

- Partners without prior experience in areas of school health will work to develop strengths and expertise in these areas just as they have in more familiar topics.

- Partners will be able to procure medicines and drugs that are fundamental to providing SHN services. Partners will ask for medicines and drugs from other donors or work directly with district health units to procure and distribute necessary amounts.
- Partners will be able to mobilize commitment from and partnership with district education and health teams.

- The PIASCY initiative will continue to be the governments' focus for responsible sexuality education.

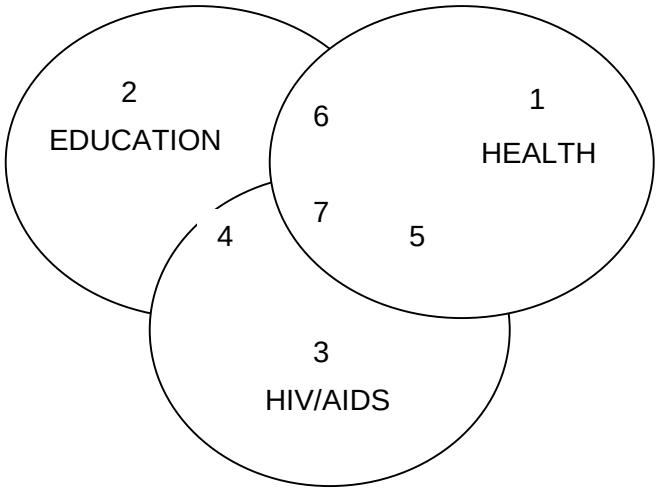
5.3 UPHOLD's Goals, Objectives and Priorities for SHN

Goals: UPHOLD is working to contribute to the Government of Uganda's goal of reduction of mass poverty through the USAID Intermediate Result (IR) 8.1: Effective Use of Social Services, IR 8.2: Increased Capacity to Sustain Social Services and IR 8.3: Strengthened Enabling Environment for Social Services. The goals of School Health and Nutrition (SHN) activities are to:

1. Contribute to improved educational outcomes of primary school children;

2. Contribute to improved health outcomes among the primary school-aged population;
3. Prepare school-age children to make healthy and responsible life choices; and

4. Support integration of health, education and HIV/AIDS at every level.



UPHOLD is mandated to bring the sectors of health, education and HIV/AIDS together. Many SHN activities sit at the intersection of all three sectors – section 7 in the UPHOLD diagram-- such as responsible sexuality, life skills, and HIV/AIDS education and mitigation-- while others represent section 6, such as health education and treatment of common illnesses and injures.

PIASCY and SHN: While the Presidential Initiative for the AIDS Strategy for Communication to Youth (PIASCY) was conceptualized independently of the SHN Policy, there is a strong strategic link between the two. Where ever strategic analysis indicates the potential for efficient and effective synergies between PIASCY and the SHN interventions promoting responsible sexuality and

life skills, UPHOLD will support the integration of PIASCY within its SHN component.

SHN will directly contribute to the following indicators:

- *Primary School daily attendance at target facilities*: Average daily attendance of children enrolled in primary school at target facilities, by gender and by grade improved (P1-P7);

- *Retention rate to form four*: Improved retention rates to primary four disaggregated by gender; and

- *Quality learning*: Increased proportion of pupils achieving at least 75% of set of quality learning education standards.

SHN will also contribute to:

- *Number of higher risk sex partners*: Decreased percentage of respondents aged 15-49 who have had sex with a non-marital, non-cohabiting partner in the last 6 months

- *Individuals treated in STI program*: Increased number of individuals who present for and receive STI treatment at target facilities.

Objectives: The objectives of UPHOLD's interventions in SHN by 2007 include:

- By the end of 2007, 1/3 of primary school children in the 20 UPHOLD-supported districts will receive at least 3 of the 4 components (including anemia) of the high impact package of SHN services.

- By the end of 2007, 60% of primary school pupils in private schools in the 5 target districts will receive the high-impact package of SHN interventions.

- By the end of 2006, at least 1 district wide or national level business / association will support SHN activities in each of the 5 target districts.

- By the end of 2007, 60% of schools and their communities in the 5 target districts will incorporate SHN into their annual school development plans.

- By the end of 2007, 100% of schools in all 20 UPHOLD-supported districts will have access to the SHN policy and information.

Priority Approaches

SHN activities will follow each of the UPHOLD principles. In addition, UPHOLD SHN activities will pay particular attention to innovative approaches specific to success:

1. Integrate sectors at every level:

The SHN policy calls for multi-sectoral committees at the national level, the district level and the sub-county level. The policy also recommends that each school and class form an SHN committee. UPHOLD will support implementation of the policy and effective programs by brining together health, education, agriculture, community development, water and other related sectors at each level.

2. Emphasize parent/guardian and community participation:

Parents/guardians are critically important to pupils' success in schools. For children to take certain health actions, parents/guardians need to take actions themselves, such as accompany children to medicine distributions, set up hand washing facilities with cleansing agents at home and pack or prepare lunches. For other health actions, parents need to support and children and schools. SHN programs will start by forming SHN committees made up of parent, school official and pupil representatives. Then input from parents/guardians will be necessary to design strategies to reach and work with them. Finally, each activity will need to involve parents at some level.

In UPE schools, programs need to work with parents need to change their perception of responsibility – to promote the idea of teachers and parents working together to make education effective. This will be done through image/branding as well as by actively engaging parents in each activity.

3. Use innovative approaches to ensure adolescent participation:

In addition to promoting parent and community participation, SHN activities will promote children's participation at every stage. Programs will start by forming SHN committees in schools – that will include pupil representatives – and SHN groups in each class.

Programs will then gather input from pupils of all ages on their perceptions, beliefs, needs and options for improved practices. Special techniques can be used to gather input from younger adolescents whose voices are often not heard regarding program design.

During implementation, activities will ensure adolescent participation through child-to-child, peer education and collaboration with SHN groups in each classroom to implement and monitor activities.

4. Provide information as well as support to healthful practices:

Studies show that knowledge and attitudes are easiest to change, but behaviors are much more challenging.[3] Behavior change often requires information and skills-based education as well as other inputs to develop internal will and external support. Designing program strategies around behaviors, or behavior-centered programming, will ensure some impact.

Negotiation will be a key element in the content design as well as activity implementation. Negotiation will be the central approach in materials for counseling and guidance for pupils (e.g. risk reduction plans or goal-setting plans) and counseling for parents or relatives. This will help to make actions realistic and meaningful to participants.

5. Consider teacher motivation at the school level:

As teachers will be the primary change agents and service delivery force for each of the activities – in addition to their teaching responsibilities -- will be critical to assess and address their motivation through non-monetary incentives.

Wherever possible, implementing partners will use alternative delivery mechanisms when they seem effective and sustainable. When teachers are used, their motivations need to be considered.

Priority Activities:

UPHOLD has prioritized activities that will have the largest impact in the shortest amount of time, using the criteria of magnitude of the problem, impact on educational outcomes, ability to impact and building on best practices. Each of these will be supported with health education in the curriculum and sensitization and activities for communities.

The emphasis will be on primary schools – the focus of the Education Sector of UPHOLD and where the majority of school-age children can be reached, both public and private schools. Pre-primary services will be done wherever possible given limited facilities for children in preprimary years. Secondary school services will be limited to key elements and only in districts where implementing partners already work with secondary schools or if the districts particularly emphasize secondary schools.

[3] Gallant, Melanie and Eleanor Maticka-Tyndale. School-based HIV prevention programmes for African Youth. Social Science and Medicine, August 2003.

These activities will be linked with district health systems and services by training health workers to supervise teachers in health service delivery from the beginning of activities. In addition, a strong referral component will be part of the services at school.

The districts that choose to work on SHN will then prioritize based on these areas and their pressing local needs, within the national SHN policy. UPHOLD will support districts to:

1) Orient district officials and below on SHN;

2) Collect local data on the key health problems that affect school-age children and their educational performance;

3) Gather input from pupils, parents, teachers and health workers where needed;

4) Develop strategies for school health and nutrition that reflect local needs and describe how to phase in activities; and

5) Implement in partnership with national ministries and/or local organizations.

Pre-Primary Years

Since the World Bank-sponsored CHILD Project is ending in December 2003, few activities are being implemented in terms of health and nutrition for pre-primary children. The CHILD Project helped communities to develop and implement action plans that could include food security initiatives, day care centers for pre-primary children and child health days every six months with deworming, among other services.

UPHOLD will work with local organizations and the Ministry of Education and Sports (MOES) and the Ministry of Health (MOH) to pilot activities in a small area. The pilot will provide lessons to replicate activities more widely.

The goal will be to prepare children to attend school by improving their health and nutritional status. SHN activities for pre-primary children will include:

- Hand washing promotion in day care centers and to parents;

- Nutritional supplements with fortified snacks in centers that are providing food;

- Nutrition education of parents (in coordination with community-based growth promotion);

- Deworming for intestinal worms and schistosomiasis where needed (in coordination with community-based growth promotion); and

- Immunization promotion to parents (in coordination with community-based growth promotion).

Primary Schools

High Impact Package of Activities	Additional Activities
Anemia prevention: • Malaria treatment and prevention • Helminth treatment and prevention • Micronutrient supplementation	School feeding: • Information on packed lunches • Community organized snacks or lunches • (*boarding*) Policies and support for diversified diet
Responsible sexuality: • Training on PIASCY & life skills • Peer education • Guidance and counseling • Community/adult involvement	Vision & hearing screening: • Screening and remedial measures for pupils with vision or hearing problems
Promotion of girls' retention & completion: • Sanitary materials • Separate latrines for girls with washing facilities • Protection from abuse	Immunization promotion & safety: • Support for routine vaccinations and immunization campaigns • Injection safety
Hygiene: • Handwashing promotion • Safe drinking water promotion • Water source & latrine construction • Latrine cleanliness	HIV/AIDS stigma reduction and OVC support: • Education and communications to address stigma of infected and affected people for schools and communities • Protection of orphans • Memory books

ANEMIA PREVENTION

Malaria treatment and prevention:

Key Behaviors:
- Seek treatment from teacher when sick with fever
- Adhere to treatment schedule
- Sleep under or next to a treated net every night

Key Behaviors for Teachers:
- Use diagnosis chart to assess and treat pupils with fever
- Give children clean drinking water to take medicine
- Observe children swallowing medicine
- Send note home to parents that explains what and how child was treated, specifying treatment schedule
- Refer cases of fever that do not improve within 36 hours
- Refer complicated cases to health facility without delay

Approach:
Malaria is the most common health problem in school age children throughout the country. It contributes to absenteeism, poor performance and high rates of anemia.

Service delivery through Homapaks or first aid kits at school: National protocol recommends a one-time dose of Fansidar (SP) and three doses of chloroquine to treat malaria.

Due to success in a pilot area, the Government, with the support of WHO, UNICEF and USAID, is expanding Homapaks for home-based treatment of fever. Schools are a natural extension of community-based delivery of malaria treatment. The Homapak initiative can train teachers as dispensers of the medicine at the same time community agents are trained. If expansion of Homapaks is not feasible, first aid kits can be established according to the SHN policy.

Schools can nominate two to three teachers per school to be trained. Districts might add other medicines to treat minor injuries and illnesses at school such as gauze, bandages and panadol. Panadol will serve the extra benefit of relieving girls' menstrual cramps when needed.

The medicines in the First Aid Kits can be offered to teachers as well as pupils in order to keep teachers motivated and healthy so they can continue teaching in school.

Links with net delivery programs: Although UPHOLD is not able to provide bednets to pupils, the program and partners can work with those projects distributing nets to promote at least one treated net and preferably two nets in households with school age and younger children.

Retreatment of bed nets (mosquito nets) at schools: Malaria programs around the world have recommended using schools as centers for retreatment. Many communities in Uganda traditionally operated treatment centers for cattle. These are now defunct but the concept could be reinstated with nets through schools or communities each quarter.

Education in the curriculum: Where possible, UPHOLD will support partners to supplement the curriculum to support inquiry and participatory teaching related to malaria treatment and prevention.

Helminth treatment and prevention:

Key Behaviors:

- Go to school health day for treatment
- Take medicine
- Bring all non-enrolled siblings and friends for treatment
- Avoid urinating and defecating in water (river or lakes)
- Wear shoes or slippers outside the house and classroom
- Wash hands with water and a cleansing agent after using the toilet and before eating

Approach:

The Ministry of Health states that helminth infections are another leading health problem of preprimary and primary school children.

Service delivery: BILHARZIA: In schools with prevalence of bilharzia over 30%, mass treatment is recommended on an annual basis. In schools with prevalence under 30% but over 10%, mass treatment is recommended for each child in grade 1 and in grade 7 (upon entry and exit). 40-milligram per kilogram of body weight of Praziquantel each year is effective, safe and inexpensive. Prevalence can be assessed by teachers administering selective treatment questionnaires to their pupils. INTESTINAL WORMS: In schools with more than 70% prevalence or more than 10% heavy infections, WHO recommends treatment of school-age children 2 to 3 times each year. In places where more than 50% but fewer than 70% are infected, treatment of school-age children once a year is recommended. Selective treatment is sufficient when fewer than 50% of school-age children are infected. The treatment is Mebendazole (500 milligram single dose) or Albendazole (400 milligram single dose).

Schools are ideal centers to deliver mass treatment since WHO has found that treating 75% of all school aged children between 6 and 15 years will reduce the

level of parasites in the entire community.[4] This requires outreach to out of school children through peers and parents but teachers can treat all children at school.

Vitamin A can be distributed at the same time to children under 10 years of age. Children under 10 receive the greatest benefit from vitamin A supplements.[5] In addition, pregnant girls and women should not receive vitamin A; children 10 and under will not risk any danger from taking vitamin A.

Programs can organize school health days or open days to deliver helminth medicines as well as provide education, dramas, awards for health contests and/or sports to attract pupils, out of school children, parents and other community members. Alternatively, programs can deliver medicine on one day of the school year.

Education in the curriculum: Where possible, UPHOLD will support partners to supplement the curriculum to support inquiry and participatory teaching related to helminth treatment and prevention.

BCC:

To supplement information and education in the curriculum about worms, including bilharzia, behavior-centered communications can be used to support children to take medicine and practice preventive behaviors. Programs can gather basic input from pupils, non-enrolled children and parents regarding their beliefs, perceptions, current practices and alternative practices about helminth treatment and prevention.

Micronutrient Supplementation:

Key Behaviors:

- Take iron supplements at school
- Take vitamin A supplements during school health days
- In areas of iodine deficiency, test salt at home for iodine
- Eat iron and vitamin A-rich foods

Approach:

It is generally acknowledged that malnutrition is a serious problem in school pupils, anemia, vitamin and undernutrition. In addition, pupils in day schools often stay hungry during the school day and go without lunches or snacks. The current political climate is not conducive to supporting schools to prepare lunches.

[4] Prevention and Control of Schistosomiasis and Soil-transmitted Helminthiasis: report of a WHO Expert Committee. WHO Technical Report Series: 912. Geneva 2002.

[5] Personal communication with Dr. Keith West, Johns Hopkins University, 2001.

Service delivery: To combat anemia, UPHOLD SHN activities will supplement primary school boys and girls with iron each year-- once a week for 10 weeks. Teachers are able to distribute the iron supplements after reading motivating messages to the pupils.

Vitamin A can be distributed at the same time as deworming medicine to children under 10 years of age. Children under 10 receive the greatest benefit from vitamin A supplements and face no risk of pregnancy.[6]

Education in the curriculum: Where necessary, UPHOLD will work with the Ministries and partners to modify or supplement the curriculum to make the life skills specific to developmentally appropriate behaviors and contextual needs.

BCC: UPHOLD SHN activities will include working with partners in mass communication such as Straight Talk, to add behavior-centered communication about anemia prevention, iron and vitamin A diet diversification.

RESPONSIBLE SEXUALITY

Key Behaviors:

- Delay sexual debut until physically and mentally ready
- If sexually active, use condoms or abstain
- Seek services from a senior teacher or health worker with any questions or problems
- Report sexual abuse to senior teacher or head teacher

Approach:

Responsible sexuality promotion is critical to preventing HIV/AIDS and developing healthful attitudes and practices related to reproductive and sexual health. Studies around the world have demonstrated how much more effective it is to help younger adolescents develop healthy practices than to change older adolescents' practices. This is particularly relevant for sexual activity and shows the unique opportunity SHN can play in HIV/AIDS prevention.

Life skills to supplement PIASCY: The presidential initiative to provide age-appropriate messages regarding HIV/AIDS prevention to primary school children during assemblies twice a month provides an excellent basis for classroom lessons after school clubs. Discussions can build upon the themes presented during assemblies with discussions and skill-building exercises.

International evaluations of skills-based education have shown that life skills can effective in forming or changing behaviors when specifically linked to certain

[6] Personal communication with Dr. Keith West, Johns Hopkins University, 2001.

behaviors or health decisions, and when pupils learn by doing.[7] UPHOLD should work with partners to develop a training course for teachers in how to use and teach from the PIASCY manual with a focus on life skills.

The topic of stigma will be addressed through the PIASCY manual and supplement, both stigma against HIV infected persons and HIV affected persons.

Peer education: Older school children often prefer to learn from their peers. Peer education provides this channel of information and empowers the peer educators themselves to take initiative and leadership. However, international evaluations have shown that peer educators themselves often benefit more than others who participate in the programs.[8] In addition, evaluations have identified close supervision of the peer educators as a critical component. Peer educators need adults to support and guide them, as well as to answer sensitive and complex questions that can arise. Peer educators also need locally appropriate materials that address the specific needs of their context.

UPHOLD will build on lesson learned in Uganda and elsewhere and use peer education programs to provide information and create positive images among upper primary and secondary school pupils.

Parent /adult involvement: Younger adolescents often trust their parents or relatives (aunts and uncles in the Buganda culture) and want their input most. Parents, relatives or other concerned adults are in the unique position to provide support and guidance to younger adolescents as they grow. To do this, adults often need to clarify their own values and expectations for children. Then, adults need to learn the skills to counsel and guide children through adolescent years. This can be done through Parent Teacher Associations (PTAs) / School Management Committees (SMCs) or other community-based organizations or individuals. Parents will need specific materials to support communication with their younger adolescent children.

For all adolescents, the program may want to work with parents and community groups to discuss issues about sexuality and generate solutions to collective problems adolescents face such as abuse by teachers or other older men and lack of use of health center services.

Counselling: Boys and girls need counselling for particular difficulties and general concerns as they grow. UPHOLD and partners will support training in guidance and counselling of Senior Men and Senior Women teachers or other concerned adults in the areas of puberty, menstruation, abuse and responsible

[7] WHO Information Series on School Health Document 9, Skills for Health: Skills-based Health Education including Life Skills: An Important Component of a Child Friendly / Health Promoting School, 2003

[8] Intervention Strategies that Work for Youth: Summary of FOCUS on Young Adults End of Program Report. YouthNet Youth Issues Paper 1, Family Health International for USAID, 2002

sexuality: delaying and abstaining from sex, condom use, partner reduction and care-seeking. Materials will assist teachers to tailor their advice to individuals' needs.

Alternatively, an internship program to place and support new college graduates as guidance counsellors in primary schools could support pupils and build the capacity of Senior teachers in counselling at the same time.

As part of the action research recommendations (see attached), power dynamics between girls and boys will be explored with the aim of developing materials and activities that address this important factor in sexual relationships.

PROMOTION OF GIRLS' RETENTION AND COMPLETION

Sanitary materials:

Key Behaviors:

- Ask Senior Woman Teacher for sanitary materials or toilet paper each month
- OR make alternative materials for menstrual periods
- Ask teacher or nurse for Panadol when cramps are severe
- In boarding schools, allow girls to carry bags for sanitary materials or put pockets in uniforms

Approach:

Without good practices, UPHOLD partners will work with select SHN committees to test feasible and appropriate options. Options could include provision of toilet paper and a piece of soap to each girl every month, banana fiber made into pads or other local solutions. UPHOLD is in dialogue with a private sector specialist regarding the possibility of collaborating with toilet paper production companies to package toilet paper and soap together and lower prices for schools.

Construction of separate latrines with washing facilities:

Key Behaviors for School Officials:

- Construct separate latrines for girls with doors that lock, water source and incinerators

Approach:

Although UPHOLD cannot fund construction, partners can ask for assistance from other donors or provide basic solutions. SHN committees could explore options such as a bucket with water, soap or another cleansing agent such as laundry soap or local alternatives and a bucket with a lid for waste. If possible and necessary, committees could construct simple thatch walls around a stall for girls.

Protection from abuse:

Key Behaviors for Girls:

- Take a friend or "buddy" whenever around a teacher
- Refuse overtures by teachers
- Report abuse immediately to a friend, Senior Woman Teacher or SHN committee
- Seek health care from an adolescent friendly provider if abused

Approach:
Without best practices in this area, UPHOLD will work with select communities and SHN committees to feasible test options. Options to test include contracts between pupils and schools that specify never being with a teacher alone, committees to investigate misconduct by teachers, and fining teachers who have relations with a pupil.

Community mobilization:
SHN committees will be sensitized on girls' education and the importance of community involvement to increase enrollment and attendance. They will be asked to consider what actions to take to mobilize their communities to send girls to school and to include these actions in the annual school plans.

Education in the curriculum: Awareness about abuse by teachers and key behaviors to take will be included in the supplement to PIASCY Message 23.

HYGIENE

Key Behaviors:

- Wash hands with water and a cleansing agent before eating and after using the toilet at school and at home
- Drink clean water at school and at home
- Use a toilet to defecate at school and at home
- Keep nails clipped short
- Eat cooked and heated foods and wash fruits and vegetables

Approach:
The Ministry of Health has determined that diarrheal disease also significantly contributes to illness in preprimary and primary school pupils.

Education in curriculum: Where possible, UPHOLD will support partners to supplement the curriculum to support inquiry and participatory teaching related to hygiene, particularly hand washing, toilet use, water cleanliness and wearing slippers. In addition, the benefits of adequate washing and cleanliness will be

included to promote good practices. Pupils will be encouraged to share the information and possible actions to take with their families.

District level policies: UPHOLD will support districts to develop and enforce policies in schools regarding toilets, hand washing facilities and drinking water at schools. School administration will also be encouraged to monitor food hygiene in schools were vendors sell food on school grounds.

Coordination with school & community health work: In terms of hygiene, the key participants are often the teachers at school and parents at home. Providing the facilities and support to drink clean water, use toilets and wash hands with a cleansing agent is often the most important action.

School Management Committees (SMCs) will be encouraged to include hygiene activities in their annual plans on school quality through PTAs and/or SHN team.

In addition, UPHOLD SHN activities will link with community-based hygiene promotion by mobilizing families to boil their drinking water, set up hand washing facilities, provide cleansing agents for hand washing, constructing and maintaining toilets, and disposing of young children's feces appropriately. SHN may link with CORPS or Community Development Assistants to monitor hygiene issues in communities and schools.

BCC: In addition to information and education, behavior-centered communication to support improved practices for families and pupils may be needed for certain hygiene practices such as treating drinking water, using alternative cleansing agents for hand washing, and ensuring that children wear slippers or shoes. These can be shared through community theatre, school drama and arts, radio and community meetings.

ADDITIONAL SHN ACTIVITIES

SCHOOL FEEDING

Guidelines on packed lunches

Key Behaviors for Parents:

- Send a snack from home of groundnuts, fruit, cassava or other food that will not spoil

Approach:

UPHOLD and partners can develop basic guidelines to assist parents to pack foods that will not spoil. Parents may need to be encouraged to think about types of food they can send for snacks or lunch other than staple foods. To

support this dissemination, teachers and community health workers will convene community meetings to discuss options with parents.

Community-based organization of snacks or lunches

Key Behaviors for Parents:
- Contribute food and/or money and time to the school for communal preparation of snacks

Approach:
Without best practices in the new political environment, UPHOLD will work with select communities in districts that include SHN in their plans to test options for parents and schools.

Policies and support for diversified diet

Key Behaviors for Boarding School Officials:
- Prepare and serve animal protein to pupils at least once a week
- Prepare and serve fruit to pupils at least three times a week

Key Behaviors for District and Farm School Officials:
- Provide farm equipment to school farms and farm schools during planting and harvesting time

Approach:
Without best practices in this area, UPHOLD can work with select boarding schools in districts that include SHN in their plans to test feasible options.

For farm schools, without best practices in this area, UPHOLD can work with select farm schools in districts that include SHN in their plans to test feasible options.

IMMUNIZATION PROMOTION & SAFETY

Key Behaviors:
- Ask parents to take younger siblings to health center for immunizations
- Girls: Attend immunization day at schools or health centers for tetanus toxoid (TT)
- Avoid sharing needles with family members
- Avoid playing with needles

Approach:
UPHOLD SHN will promote immunization in schools for pupils and through pupils to their families and siblings at home. The program will also provide

communications support to delivery of TT immunizations for girls to protect them from maternal neonatal tetanus in the future. In addition, education and communication for injection safety is also needed.

Education in curriculum: Pupils will be informed and encouraged through inquiry teaching to mobilize their families to take all children for routine immunizations and to use injections safely. UPHOLD will work with partners to supplement the curriculum where possible.

Coordination with community health work: To avoid misconceptions about immunizing only girls with tetanus toxoid, the program will work with local government, community groups and community health workers to inform, educate and discuss the benefits and side effects of the vaccine.

BCC: Injection safety needs to be addressed in schools and in communities: to reduce the demand for injections, to use needles safely (not to share with family members) and to dispose of them properly (not to play with needles). Pupils will be encouraged to share these points with their families and siblings. Comic books that address commons perceptions and practices could be used for this purpose.

VISION & HEARING SCREENING

Key Behaviors:

- Participate in vision and hearing screenings
- If found to have deficiencies, sit at the front of the classroom

Approach:

SHN activities can include training teachers to conduct basic vision and hearing screening at the same time they are trained to dispense medicines. This can be done during the first term for P1 pupils to start. Pupils with any problems can be seated in the front of the classroom. Teachers can discuss the deficiencies and appropriate care with their parents.

HIV/AIDS STIGMA REDUCTION & OVC SUPPORT

Key Behaviors for Pupils and Parents:

- Accept HIV infected teachers and pupils at school
- Show kindness and caring toward HIV infected teachers and pupils
- Show kindness to pupils affected by AIDS
- Protect orphans and vulnerable children if abused or taken advantage of
- Make a memory book with parents or guardians

(These need to be made more specific according to local needs and contexts)

Approach:
These behaviors and their context will be incorporated into teaching materials and community mobilization efforts.

Secondary Schools

ANEMIA PREVENTION

Malaria treatment and prevention:

Key Behaviors:
- Seek treatment from teacher or nurse when sick with fever
- Adhere to treatment schedule

Approach:
Malaria is the most common health problem in school age children throughout the country. It contributes to absenteeism, poor performance and high rates of anemia.

Service delivery through Homapaks at school: National protocol recommends a one-time dose of Fansidar and three doses of chloroquine to treat malaria.

Due to success in a pilot area, the Government, with the support of WHO, UNICEF and USAID, is expanding Homapacks for home-based treatment of fever. Schools are a natural extension of community-based delivery of malaria treatment. The Homapak initiative can train teachers as dispensers of the medicine at the same time community agents are trained. Schools can nominate two to three teachers per school to be trained. Schools might add other medicines to the Homapaks to treat minor injuries and illnesses at school such as gauze, bandages and panadol. Panadol will serve the extra benefit of relieving girls' menstrual cramps when needed.

Indoor Residual Spraying (IRS): In boarding schools, UPHOLD and partners will promote spraying indoors at the start of each term. Private schools will be encouraged to organize and fund this activity without outside financial support.

Education in the curriculum: Where possible, UPHOLD will support partners to supplement the curriculum to support inquiry and participatory teaching related to malaria treatment and prevention.

Iron Supplementation and Nutrition:

Key Behaviors:
- Take iron supplements at school
- Eat iron and vitamin A-rich foods

Approach:
It is generally acknowledged that malnutrition is a serious problem in school pupils, anemia, vitamin and undernutrition.

Service delivery: To help combat anemia, particularly in older adolescent girls, UPHOLD SHN activities will supplement primary school girls and boys with iron each year-- once a week for 10 weeks. Teachers are able to distribute the iron supplements after reading motivating messages to the pupils.

Education in the curriculum: Where necessary, UPHOLD will work with the Ministries and partners to modify or supplement the curriculum to make the life skills specific to developmentally appropriate behaviors and contextual needs.

BCC: UPHOLD SHN activities will include working with partners in mass communication such as Straight Talk, to add behavior-centered communication about anemia prevention, iron and vitamin A diet diversification.

Policies and support for diversified diet: Without best practices in this area, UPHOLD will work with select boarding schools in districts that include SHN in their plans to test feasible options.

Support for large-scale cultivation of foods for lunches: Without best practices in this area, UPHOLD will work with select farm schools and school farms in districts that include SHN in their plans to test feasible options.

RESPONSIBLE SEXUALITY

Key Behaviors:
- Abstain until mentally and physically ready
- Use dual protection if sexually active, particularly condoms
- Practice “zero grazing” if sexually active
- Seek immediate treatment for STIs from an adolescent friendly health worker
- Report sexual abuse to head teachers or SHN committee

Approach:

Peer education: Older school children often prefer to learn from their peers. Peer education also empowers the peer educators to take initiative and leadership. However, international evaluations have shown that peer educators themselves often benefit more than others who participate in the programs. In addition, evaluations have identified close supervision of the peer educators as a critical component. Peer educators need adults to support and guide them, as well as to answer sensitive and complex questions that can arise. Peer educators also need locally appropriate materials that address the specific needs of their context.

UPHOLD will build on lesson learned in Uganda and elsewhere and use peer education programs to provide information and create positive images among upper primary and secondary school pupils.

Community involvement: Adults – parents, relatives or guardians-- need to learn the skills to counsel and support adolescents through adolescent years. In particular, adults need to support adolescents to use health services. This can be done through adult peer educators, Parent Teacher Associations (PTAs), CORPS or other community-based agents. Adults will need specific materials to support communication with adolescents.

For all adolescents, the program may want to work with community groups to raise issues about sexuality and generate solutions to collective problems they identify such as abuse by teachers or other older men or promote health center services for adolescents.

Counselling:

Boys and girls need counselling for particular difficulties and general
Concerns as they grow. UPHOLD and partners will support training in guidance and counselling of Senior Men and Senior Women teachers in the areas of puberty, menstruation, abuse and responsible sexuality: delaying and abstaining from sex, condom use, partner reduction and care-seeking. Materials developed by the Uganda Counselling Association will assist teachers to tailor their advice to individuals' needs.

Timeline of interventions for SHN

During the first year, UPHOLD and partners will orient district teams to SHN, develop plans, help support the formation of SHN committees at the district level and below, train teachers, parents and peer educators sub-county by sub-country. At this point, input gathering, behavior change strategy development, material development and supply procurement will be done for all sub-counties. During the second year, partners will begin implementation.

At the end of 2007, at least one-third of the primary schools in the 20 UPHOLD-supported districts, or 1,600 schools out of the total 4,800 schools, will provide the high-impact package of school health and nutrition services. It is likely that at least five districts will become strong partners in SHN in year one of the grants: Katakwi, Luwero, Rukungiri, Pallisa and Wakiso. Special strategies will be developed for Gulu and Kitgum.

These districts have been targeted for SHN activities from the first year of grants because potential implementing partners are active and interested in scaling up their activities there.

Implementing Partners

UPHOLD will work with select NGOs and other partners to achieve SHN goals and objectives.

- AMREF will implement the package described below in three districts: Katakwi, Pallisa, and Rukungiri. This program will test feasible ways to provide girl pupils with sanitary materials each month and community-based interventions to protect pupils from abuse by teachers. AMREF will also submit plans for a basic set of SHN activities in Gulu and Kitgum.

- Africare will implement anemia prevention, hygiene and promotion of girls' retention in Rukungiri. They will partner with AMREF who will implement the responsible sexuality component in Rukungiri. Africare will also test feasible ways to mobilize communities to provide food for primary school pupils.

- Save the Children Federation/US (SCF) will implement the package in Wakiso and Luwero districts in the Central region. SCF will conduct qualitative research on feasible ways to support adolescents with a particular focus on gender socialization and younger adolescents' needs.

- Straight Talk Foundation (STF) will develop and implement a training course for the Primary Teaching Centers (PTCs) in the 20 UPHOLD-supported districts in adolescent reproductive and sexual health (ARSH). The training will include information and support for healthful behaviors among the pre-service teachers themselves and training in how to teach ARSH to pupils, including the revised PIASCY manual.

- The Ministry of Education & Sports and the Ministry of Health plan to support district implementation of the school health policy by orienting all 20 UPHOLD-supported districts in SHN, developing a training of trainers workshop for implementing partners and district staff in the five target districts and providing monitoring and supervision assistance.

- Madrasa will provide nutrition and hygiene education in their community-run day care centers for pre-primary children in Wakiso and Luwero Districts.

- Child-to-Child Uganda could develop a training of trainers program for implementing partners in the five target districts on appreciation of child participation, with particular emphasis on the Tippy Tap. This may also be incorporated into UPHOLD's inquiry teaching module which would reach all 20 UPHOLD-supported districts.

- The Ministry of Gender, Labour and Social Development's PEARL Project and Child-to-Child Uganda could train UPHOLD district officials and partners in adult peer education.

- The Uganda Counseling Association could develop a training of trainers program for guidance and counseling and material development related to responsible sexuality. In addition, the Association may support an internship program for recent college graduates to serve as guidance counselors in primary schools in select districts among the five target districts.

UPHOLD can support program activities in two ways: funding district plans that include SHN activities and giving grants directly to organizations that will work with districts.

It is expected that at least five districts will be partners in SHN from year two of the UPHOLD program (year one of the grants). Partners should at least implement the high-impact package and add additional activities based on needs and interest.

The remaining UPHOLD–supported districts will be encouraged to consider incorporating SHN in their annual plans. If these districts are not able to implement the full high-impact package, they can be supported to incorporate specific components based on needs, described below in the high-impact package and additional activities.

Creative solutions are required to provide some components of SHN to the North and other areas of conflict. Partners, including districts, will be encouraged to incorporate basic services in their programs wherever possible. AMREF now supports nighttime centers for children between 10 and 18 years. These offer the institutional structure to provide basic services.

6. QUALITY ASSURANCE

6.1 Definition

Quality Assurance (QA) can be simply defined as a system to support performance according to standards. It implies a systematic way of establishing and maintaining quality improvement activities as an integral and sustainable part of systems or organisations. In the education and health systems, this includes all activities that contribute to the design, assessment, monitoring of standards agreed upon by all stakeholders and improving quality of service delivery, client satisfaction and effective utilisation. In most cases, managers and supervisors tend to limit the standards to professional or technical ones, but in social services, client focused or "customer service" standards are very important determinants of utilisation of the services.

6.2 Overview of National Policies, Priorities and Interventions in Quality Assurance in the Health Sector

The current National Health Policy clearly spells out the role of the sector's stakeholders in ensuring the public has access to quality services. The Health Sector Strategic Plan mandates the Quality Assurance Department to ensure that: Guidelines are developed, disseminated and used for technical and support services; Supervision is strengthened; and QA capacity is built at all levels. To this effect, the Ministry of Health piloted and adopted the Yellow Star Programme (YSP) as a QA model to be strengthened and implemented in all districts of the country. The YSP aims to improve quality of health services through a system of supervision, certification of facilities that achieve basic standards and recognition of these facilities. Currently, there are 35 basic standards, which reflect interventions in all health services areas and address the Uganda Minimum Health Care Package. They include standards on infrastructure, health management, infection prevention, interpersonal communication/relationships with clients and patients, technical competence in key services areas (IMCI, reproductive health, malaria, TB and injury management) and those which are client-focused or termed "customer-service". The programme was initiated in 12 districts of Uganda with encouraging results and the MOH has planned to expand its dissemination and establishment in 22 districts for FY 2002/2003 and another 22 for FY 2003/2004.

There were some key lessons learned during the implementation of the Yellow Star Program which are outlined below:

- Each level of the health system must be committed to attaining and maintaining the basic standards and needs to play its part in supporting health facilities to do so. During dissemination of the program, teamwork was emphasised as key principle of QA and attaining Yellow Star status.
- Supervisors see the monitoring of the standards as a way to focus supervision efforts. The elements of skills development in supervision and

problem solving, which were inbuilt in their training helped them gain more confidence in initiating quality improvement activities.

- The Yellow Star tools were viewed by district and community leaders as a practical application to their constitutional role in monitoring social sector activities, therefore every effort should be made to increase their awareness and involvement in QA.
- To improve quality, the community must be involved in defining and participating in QA and more investment should be made to develop participatory approaches to engage the community in QA.
- To increase ownership of QA initiatives, information on achievements and quality gaps must flow freely between the different levels of the health system and all avenues to effect this communication should be sought.

HIV/AIDS: The National Policy Guidelines and Service Standards for RH (MOH, 2001) emphasise the need to integrate HIV/AIDS services into RH services at facility level, but do not indicate clear steps on how to do this. Over the last two years, the MOH has developed draft policies on VCT and PMCT and ARVT, with QA incorporated in varying degrees. In addition, there are guidelines for implementation of the policy for VCT services, but none for the implementation of PMTCT and other HIV/AIDS prevention or care and support services.

HIV/AIDS interventions in the country have mainly been spearheaded by the NGO and PFP sector. Voluntary Counselling and Testing (VCT) for example were initiated by AIC while counselling and social support were initiated by TASO. Initially, the health sector took the lead in coordinating HIV/AIDS interventions, but HIV/AIDS is no longer regarded as a health problem alone and a multis-sectoral approach has been adopted by the government. To this effect the Uganda AIDS Commission was placed under the President's Office and coordinates HIV/AIDS interventions across the sectors. At district level, the District HIV/AIDS Action Committees (DHAC) are comprised of members from all sectors and NGOs working in the district, but they are still weak and UPHOL will assist them to play their role in designing innovations, coordinating, monitoring and evaluating HIV/AIDS interventions.

There are many quality concerns in service delivery for HIV/AIDS prevention and mitigation of impact, which need to be addressed both at the point of delivery as well as from a systems perspective so that QA can be incorporated into the interventions. In addition, clients of HIV/AIDS interventions are usually in such dire need that they accept whatever they are given and their perspective or involvement in quality of care is often overlooked.

The demand for counselling services is high, yet the number of counsellors and counsellor assistants is inadequate. This leads to concerns about the quality of counselling due to heavy workloads and the need for a system to ensure that provider performance is monitored and continuously improved. Under VCT, laboratory protocols to ensure quality testing exist in AIC and TASO supported

centres and are routinely monitored, however in government facilities providing the services, monitoring is not as rigorously conducted and needs strengthening.

PMTCT interventions are still very dynamic in the country, but the MOH plans to establish PMTCT centres at all HC IV, while PMTCT+ is being piloted at Nsambya and Mulago Hospitals. PMTCT+ brings new dimensions into the quality of care of in this service area, because the amount of resources needed (human and otherwise) to ensure that an HIV+ mother and her family receive adequate and quality care and support to cope with HIV/AIDS is immense.

Home based care and support for HIV/AIDS infected and affected persons has traditionally been provided by the private sector i.e. NGOs and CBOs. In some districts, attempts have been made to coordinate their activities, but in most, the type, frequency and quality of the home-based care are not known. There is therefore a need to ensure that all HIV/AIDS interventions at different levels have elements of QA incorporated in them.

UPHOLD will therefore support action research in quality perspectives of clients and promote interventions which will incorporate these perspectives into standards being developed at district and national level. UPHOLD will also support activities to translate guidelines which have already been developed at central level into simplified forms which district level providers can use and design job aids to support activities to disseminate the guidelines.

6.3 Developing a Culture of Quality

There is need to inculcate a culture of quality at all levels of the education and health systems as well as in HIV/AIDS interventions. The concepts of QA are not yet known by most stakeholders and need to be disseminated at all levels. This will entail promoting institutional changes in systems to reward or sanction certain behaviour/practices and also promoting positive role models i.e. those who adhere to standards and have good work ethics. Improving the performance of service providers will be a key objective of UPHOLD and action research to establish the motivating factors for good performance will be carried out and the results used to determine incentives for better performance. In the health sector, although the Yellow Star Programme (YSP) was designed to have a strong community component, it is minimally felt at this level. The Yellow Star Programme has a lot of goodwill from stakeholders and can be strengthened in the health sector and adopted in other sectors once its effectiveness in improving quality is proven.

6.4 SWOT Analysis

The SWOT analysis of the existing QA systems below shows that although the policy environment in both sectors is good, the policy has not yet been fully translated to action.

SWOT Analysis of QA Systems

Strengths	**Weaknesses**
• Good policy environment. • Some standards exist in the health and education sectors. • Supervision systems which can be used as basis for QA design, control and improvement exist in education and health sectors	• Policies on QA are not well translated for implementation at decentralised levels. • Concept of QA not known/appreciated by stakeholders. • Standards are not fully owned by or shared with all stakeholders. • Supervision systems for monitoring standards are weak and not all stakeholders are involved. • Feedback and dissemination mechanisms for performance achievements are weak. • Weak incentive/disincentives system.
Opportunities	**Threats**
• YSP (as a better practice) can be scaled up and strengthened in both sectors. • Communities appreciate quality and can be mobilised to participate in QI activities. • Community structures (HUMC, SMC, PTA, PDC) and NGOs/CBOs can be utilised for promoting community participation in QI.	• Lack of motivation of service providers to change behaviours. • Behaviour change is a slow process. • Community may use standards to punish or threaten service providers. • Community demands may be inappropriate from technical quality perspective. • QI in services may lead to high client turnovers, which in turn may compromise technical quality.

UPHOLD (Services) is mandated to improve the quality and use of health, education and HIV/AIDS services and build capacity of stakeholders to sustain QA efforts. This will be done through building the capacity of the community and service providers to participate in quality improvement activities using the Yellow Star Programme as a better practice QA model. Other QA methods will also be adopted for use depending on their adaptability and utility at different levels of service delivery and for different sectors. The overall objective will be to change individual, community and institutional behaviours to effect improvement in the quality of services as well as the demand and utilisation of these services. This strategic framework for QA therefore focuses on: creating opportunities for dialogue and consensus building for a common understanding of what constitutes quality; disseminating QA concepts and performance standards agreed upon by stakeholders to all levels; and strengthening support systems for QA.

6.5 Priority Areas for UPHOLD's Interventions in Quality Assurance

i. Scaling up YSP implementation in the health sector to new districts.

This will entail introducing the YSP to 16 districts in a phased manner, starting with 10 districts in the first year. Dissemination activities will include meetings, seminars, training workshops and IEC materials in the print, radio and television media. UPHOLD will partner with organisations with a proven track record in designing training and IEC materials as well as training in QA whom UPHOLD, two of which are highlighted below:

- The Regional Centre for Quality of Health Care based in Uganda, which promotes better practices in 20 countries in East, Central and Southern Africa, providing technical assistance in QA training, designing of IEC materials and developing standards and guidelines.
- Health Training Consult, a local training consultancy firm composed of senior health trainers with experience in QA and technical health service areas.

ii. Building the Capacity of Districts to Sustain QA Initiatives

Existing community and organisational structures (including the private sector) will be an important focus of intervention to ensure consensus, ownership and sustainability of QA initiatives. Therefore interventions will be designed to increase the awareness and skills of managers and providers in QA methods in all sectors, as well as strengthen support systems to monitor performance according to standards and improve feedback mechanisms to inform stakeholders about achievements and quality gaps. Supervisors have poor supervisory skills and UPHOLD will support districts to strengthen their skills as well as increase the motivation for effective supervision. Quality review meetings for working groups of different stakeholders will be promoted at all levels to ensure the use of information for decision making. These working groups will be assisted to incorporate the private sector in all their activities and promote sharing of experiences to effect a balanced improvement of quality of services in both public and private sector.

The motivation for good performance is another area that needs to be explored by UPHOLD and an incentive system developed. There is a need to determine what motivates supervisors and providers to work effectively and promote it. Innovations in incentives/disincentives for providers to improve performance will be piloted in a few districts and scaled up accordingly to contribute to the development of an effective incentive system in the education and health sector.

iii. Strengthening Community Participation in QA

The existing structures for community involvement in social services (Health Unit Management Committees, School Management Committees and Parent Teachers Associations) are currently weak. In most districts these structures have disbanded because of poor motivation and many are not functional because they do not know their roles and responsibilities or are not facilitated to

perform them. UPHOLD will therefore strengthen them through training and provision of means to carry out their roles and responsibilities. UPHOLD will also use proven methods of arriving at partnership-defined quality (PDQ) for better social services. We will support work with through organisations in all sectors and community based organisations (CBO), to promote dialogue between communities and service providers. An important partner in the health sector is Uganda National Health Consumers Organisation (UNHCO), a NGO which advocates for patients rights to quality health services and has strong links at community level for the few districts it works in, facilitating dialogue between the community and service providers. These fora for dialogue will be used as a means of gathering and disseminating information about quality as well as gaining commitment to participate in quality improvement activities in social services.

District based NGOs and CBOs will be facilitated through the grant strategy to mobilise communities to participate in QA activities. CBOs will be encouraged to use PDC to mobilise communities for PDQ activities, and where they do not exist, UPHOLD will provide for their training. In addition, grant awardees will be provided with training in QA and management skills to ensure that interventions they implement are conducted effectively and will be sustained.

Within the first year, it is expected that the communities will be more involved in quality improvement activities. The YSP will be disseminated and established in the health sector for 10 of the 20 UPHOLD-supported districts. This will increase awareness of all stakeholders about issues pertaining to quality of care and gain their commitment to QA. Improving the supervision and information flow systems will increase the capacity of decentralised levels to monitor quality and initiate QI activities. Assessments results of service delivery points will be disseminated to all stakeholders and used as focal points of discussion with communities so that QI activities can be owned from grass root level and improved quality of service delivery for core interventions realised i.e. Child Health, Reproductive Health, Malaria, TB and HIV/AIDS control and Nutrition.

The planning and management capacities of decentralised levels and NGOs/CBOs will also be increased by providing support for management and QA skills development in the form of training, supervision, study trips and incentives.

6.6 Objectives in Quality Assurance (QA)

The overall purpose of QA is to improve the quality of social services in health, primary school education and HIV/AIDS in the 20 UPHOLD-supported districts of Uganda. Specific objectives of the QA component of UPHOLD's interventions in integrated health include the following, and are further developed in Appendix 4.

1. By the end of 2007, 60% of lower level health facilities (HC II-IV) achieve at least 75% of Yellow Star Programme standards.
2. By the end of 2007, 80% of facilities providing VCT and PMTCT services will meet at least 75% of a set of quality standards as defined by stakeholders.
3. BY the end of 2007, 50% of community based care and support services for HIV/AIDS will provide quality services as defined by stakeholders.
4. By the end of 2007 all UPHOLD supported districts will have established and functioning monitoring and evaluation systems at district and lower levels.
5. By the end of 2007, 60% of health facilities will have active community – facility partnerships.
6. By the end of 2007, an incentive system for better health provider performance will be established in at least 2 districts.

6.7 Monitoring Indicators for Quality of Care

Three sets of indicators will be used to monitor quality of care for integrated health services:

1. Indicators reflecting improved overall quality of health services with integration of QA principles and practices through the Yellow Star Programme, adapted versions and other QA models.
2. Indicators reflecting improved quality of service delivery for core interventions health.
3. Indicators reflecting systems strengthening for QA.
4. Indicators reflecting increased community participation in quality improvement and satisfaction with services.

Quality of health services	Number of health facilities awarded Yellow Star or equivalent status.	YSP assessment reports	Document review	DDHS	Annual
Quality of health services	Percentage improvement in Yellow Star scores for health facilities disaggregated appropriately.	YSP assessment reports	Document review	DDHS	Quarterly
Quality of health services	Percentage improvement in proportion of health facilities achieving 75% of set of core intervention health care standards.	YSP reports	Records review	DDHS DEO	Quarterly
Strength of quality assurance system	Percentage of health facilities with correctly completed supervision rounds conducted by HSD	Inspection/ supervision reports	Record review	UPHOLD	Quarterly
Quality of VCT/PMTCT/HBC services	Percentage improvement in quality standards for VCT/PMYCT/HBC services	UAC, AIC database, monitoring reports	Document review	UAC AIC	Annual

Community participation in quality improvement	Percentage increase in functioning community support systems for improving quality in education services	School/NGO /CBO supervision reports	Records review	DDHS DEO	Quarterly
Community participation in quality improvement	Percentage increase in functioning community support systems for improving quality in health services	NGO/CBO supervision reports	Records review	DDHS DEO	Quarterly

6.8 Key Behaviours for Quality Assurance (Based on Yellow Star Criteria)

Facility-based health workers

1. Keep key records and forms properly filled out and up to date: client registers, monthly Summary Report forms, stock cards.
2. Consistently follow correct aseptic techniques.
3. Use appropriate teaching aids during client counselling/education.
4. Encourage clients to actively discuss any problem or concern about their health and treatment.
5. Weigh and plot children's weight correctly.
6. Receive patients and their attendants in a friendly and respectful manner.
7. See clients on a first-come, first-serve basis (except for emergency cases).
8. Provide clear and appropriate information on treatment compliance.

7. PRIVATE SECTOR

7.1 Definition

The private sector includes all organisations, efforts and individuals other than Government. It includes Private For Profit (PFP) and Private Not For Profit (PNFP). The PFP now called Private Health Practitioners (PHP) include clinics, hospitals, pharmacies, drug shops, midwifery, diagnostic facilities, and dental facilities. Also included in the group are private schools. The PNFP can be non facility based (like Non Government Organisation -NGO, Civil Society Organisations -CSO and Community Based Organisations –CBO) or facility based like clinics, hospitals and faith based schools). Some are registered while the majority especially in the health sector are not registered. It also includes Traditional and Complementary Medicine Practitioners (TCMP). TCMP includes herbalists, spiritual healers, bone setters, Traditional Birth Attendants (TBA), traditional dentists. Individual community members become private providers when they carry out self-medication and education.

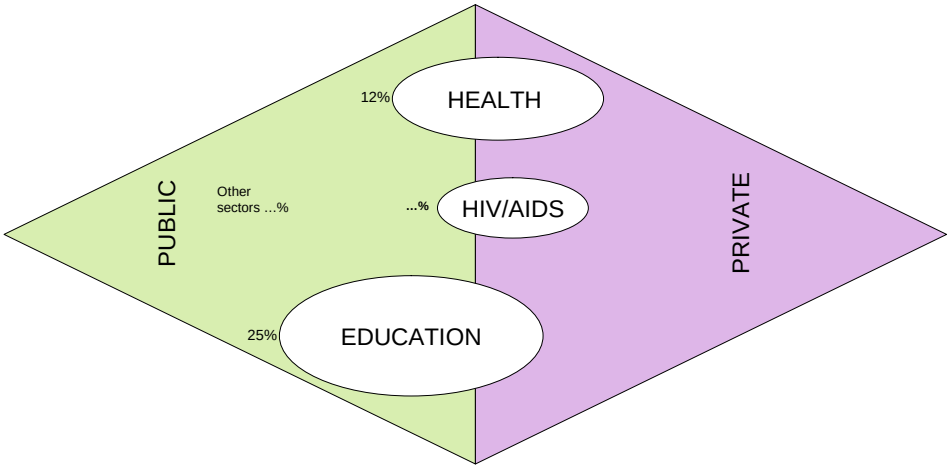
7.2 Background

The private sector plays a very significant role in the delivery of services in health, education and HIV. It is known that over 80% of sick children seek care in private facilities and over 60% of mother deliver their babies in places out side the public facilities, while the majority of services for HIV prevention and mitigation are offered by private facilities and organisations. Although Universal Primary Education provides for most of the education needs (through the public sector) for primary school going children, nevertheless the private sector particularly community schools and informal education initiatives are making very significant contribution. The early childhood development and education initiatives are entirely provide by the private sector.

The conceptual frame below schematically shows the importance of the private sector in health, HIV and education. The majority of service for health and HIV, and a significant proportion of education services are provided by the private sector. Arguably within the public sector education gets a bigger share (25%) of the national allocation than health (8%)[9] and HIV. It is therefore critical for UPHOLD to strategically target the private sector.

[9] Aide Memoir-Joint Review Mission of Government of Uganda and Development partners in Health Sector

Relative contribution of the public and private sector to health, education and HIV



7.3 Overview of National Policies, Priorities and Interventions

There are very favourable policies regarding the private sector in the overall Health Policy, Health Sector Strategic Plan (HSSP). There is also draft policy in the offing regarding Public Private Partnership. This shows that the private sector is a Ministry of Health Priority. A number of strategies (like the National Strategy for Utilising the Potential of Private Practitioners in Child Survival) and initiatives like Improving Child Health Care Practices of Private Providers have been developed and are due for scaling up.

The role of the private sector in health as spelt out in the draft in the Policy on the Private Partnership in Health include: providing priority services in line with the Uganda National Minimum Health Care Package (UNMHCP); health service not prioritized in the UNMHCP but demanded by the community; contributing to policy development, planning, monitoring; resource mobilization for health care, research and proper utilization/accountability of resources.

HIV:
There is a clear multi-sectoral policy for the control of HIV/AIDS in Uganda with the Uganda Aids Commission (UAC) at its helm. As a result of this policy there are different programs in line ministries like the Aids Control Program of the Ministry of Education and NGOs like TASO and AIC. The current policy emphasis is still prevention of sexually transmitted infection including HIV (focusing on the more vulnerable adolescents, youths and women) and mitigation of personal and social impact of AIDS

(including treatment of opportunistic infections, antiretroviral drugs, social support and care for orphans.

7.4 SWOT analysis of the private sector

Strengths	**Weaknesses**
• In health there is community perceived quality and confidence • In health there is wide coverage by the private sector • Wide access to the private sector • High quality education in some private schools • In education, strong models for providing quality education to children in remote and disadvantaged regions • In education, strong models for facilitating early childhood education program • Strong associations of private providers like UPMA, UMA • Early childhood education, provided exclusively by private sector • There are quite a number of schools for disabled children • Wide spread private initiatives for HIV control and mitigation services	• Coordination of several players/groups is very hard • Cost of the services prohibit access to PHP although wide spread • Weak associations of private providers in education that are needed to enforce quality • Quality of private facilities (health and education) is variable; however, in many the quality is poor. • Data about private services is incomplete in both education and health as many facilities aren't registered. • District capacity to monitor quality is weak especially in education • Early childhood education is in infant stages and does not exist in the majority of Uganda communities
Opportunities	**Threats**
• Perceived community confidence in private sector • Favourable policy environment for public-private partnerships exist in both health, education and HIV • For health, presence of organised groups and associations • Non-public organizations provide substantial experience and technical expertise in providing community-based education programs for disadvantaged populations. • Non-public organizations provide substantial experience and technical expertise in providing community-based integrated (health-education) services for pre-primary children • Non-public organizations provide substantial experience and technical	**1.** Quack/brief case organisations **2.** Public (LC1, LC3, LC5) interpretations of national policy may not allow for flexible solutions. **3.** Cultural constraints and/or convention biases against empowerment of community members in technical affairs (health and education). **4.** In education, early politics of UPE removed parental participation in education (i.e., disallowed parent contributions, yet parent response was to distance themselves from schools altogether) **5.** Entrepreneurship priorities of some private schools may threaten quality improvement initiatives

expertise in providing community-based programs for monitoring quality in health and education. • A proportion of the PAF provides for quality monitoring and evaluation.	

7.5 UPHOLD's objectives in the private sector

UPHOLD's interventions in the private sector will contribute to the achievement of intermediate results in three areas:

1. Private sector delivery of core interventions: Will be achieved through identifying, developing and scaling out best practices that will improve and expand private sector participation in integrated health core interventions.

The specific objectives within this intermediate result area are:

- To increase to *40%* the proportion of registered private health facilities that delivery a key core interventions by the year 2006
- By 2006 at least *50%* of UPHOLD supported districts will have activities that demonstrate participation of the traditional healers in activities for HIV prevention and AIDS care

2. Strengthen public private partnerships at district and sub county level: UPHOLD will implement an integrated approach to strengthen public private partnerships at district and sub-county level to plan and implement strategies and activities in integrated health.

The specific objectives within this intermediate result area are:

- By 2006 at least *50%* of UPHOLD supported districts will have activities that demonstrate Public Private partnerships in health

3. Pilot and explore options for improving quality standards in private facilities: Will be achieved through integrated approaches including target performance contracts and introducing yellow star like quality improvement initiatives in private facilities.

The specific objectives within this intermediate result area are:

- To increase by 30% by 2006 the proportion of registered private health facilities which meet a set of quality standards as defined by stakeholders

7.5.1 Priority interventions for UPHOLD

The following are the priority areas for integrated in which UPHOLD will focus over the next five years in the private sector:

Health

i. Building/strengthening private sector capacity for training and supervision in appropriate skill areas

ii. Support scaling out IMCI training for private providers

iii. Improve access to micronutrients (vitamin a) and regular de-worming by private provider

iv. Stimulate private providers' involvement in or carryout outreach programs for both curative and preventive services.

v. Institutionalise growth promotion and immunisation by private providers

vi. Scale out better practices in malaria prevention and control (e.g. Home based malaria management, ITN distribution and re-treatment)

vii. Strengthen integrated reproductive health (including family planning), adolescent friendly health services and safe motherhood (SM) services offered by the private sector.

viii. Strengthen the referral system between the private sector and public sector and vice versa and referral within the private sector

ix. Scale up quality assurance initiatives in the private sector

x. Explore and introduce health insurance and prepayment schemes. CMS has been involved in several health insurance initiatives and documented quite a number of projects in this area. Uphold will work in close collaboration with the Uganda Community Based Health Financing Association (UCBHFA) to scale up some of their initiatives.

xi. Work with traditional healers and private midwives to improve the quality of care provided

xii. Build *community-health provider* partnerships for identifying and addressing quality improvement priorities, including quality assurance initiatives (private and public). Engage the technical expertise and experiences of private sector to adapt existing best practices (e.g., save-us: *partnership defined quality* or *PDQ*). Enhance yellow star program with experience from the above community-based

quality assurance and in the long run integrate the two quality assurance initiatives (e.g., yellow star, facilities-based and PDQ, community-based).

xiii. Build/strengthen the distribution systems of materials and commodities (like condoms, ITNs, drugs) for the benefit of the private sector**.** The social marketing component of CMS under Population Services International (PSI) is to continue for the next five year marketing and distributing condoms, contraceptives and STI drugs. There two mainly areas where uphold should collaborate in social marketing. One is the behaviour change component of the social marketing within communities to increase awareness about availability of commodities and their utilisation. The second area is through support supervision and monitoring supported by UPHOLD to identify private facilities not having the supplies and linking to CMS supply chain. UPHOLD will also use experiences and learns learnt by deliver project in logistics management in the public sector.

HIV

i. Strength prevention strategies for HIV/STDs in the private facilities

ii. Institutionalise sex/HIV education in private schools

iii. Provide targeted grants for: training, equipment and support supervision to private providers (including PHP) in order to improve access to critical HIV services like VCT, PMTCT, DOTs, and adolescent friendly services. CMS has experience in this area working with Bushenyi Medical Centre in Bushenyi district and 22 clinics in a pilot project called PROFAM in Kampala, Mbarara and Bushenyi. Users pay a minimal fee for service. The issues/challenges arising so far include people's fear for VCT, non availability of ARVs and little community awareness of availability of services. UPHOLD would have to look at the communication aspect of this partnership to ensure community awareness and use of services and linking up with other services like ARVs.

iv. Work with Natural Chemotherapeutics Research Laboratories (NCRL) to access their initiatives to patients and traditional healers. NCRL is Government institution under MOH charged with research on biological resources for safety, efficacy, standardization and information dissemination. It deals with groups and individual traditional healers in providing safe and affordable remedies for HIV opportunistic infections like herpes zoster, diarrhoea, skin problems etc. Working with NCRL will enable UPHOLD access and disseminate valuable information to traditional healers and consumers affordable remedies for some HIV opportunistic infections and the much needed nutritional supplements. This collaboration will be exploited to link traditional healer for referral of HIV patient to AIC and TASO clinics.

v. Work with THETA and traditional healers to access better prevention and care for STI/HIV/AIDS.

Cross cutting

i. Develop an UPHOLD private sector strategy

ii. Support district and sub county plans to reflect the private sector involvement

iii. Carry out action research in the private sector (including to map out the distribution of the private sector at district and lower levels, identify and scale up best practices, market segmentation)

iv. Strengthen private sector associations at district and lower levels by providing resources for regular peer and stakeholders meetings and support supervision. This support should include attracting or incentive mechanisms for private providers to register.

v. Design a grant mechanism for the private sector to scale out best practices or partner with public sector to bring to scale best practices and core interventions

vi. Strengthen the capacity for grant management by the private sector. As part of grant management capacity UPHOLD could teach private providers business management skills. CMS has a curriculum for training private providers in business kills as a stepping stone for the loans management training and loans. A lesson will be borrowed from CMS experience and tools.

vii. Explore contractual arrangements with private providers to offer preventive services like immunisation and early identification of health/developmental related learning constraints which may not be a profitable venture

viii. Facilitate integrated community based strategies to address health/learning needs of young children

ix. Foster/build integrated community based models for quality assurance and facilitate their incorporation into existing QA programs like Yellow Star.

x. Develop and where there is already strengthen cross flow of information between and among the private and public sectors

7.5.2 List of collaborating partners in the private sector

The following list presents many of the partners with whom UPHOLD will work closely in scaling up best practices and identifying innovations in the private sector and the public-private partnerships.

- Line ministries of Health and Education
- Uganda Private Midwives Association: This is an umbrella organisation for qualified midwives working privately. It has been in existence for over 40 year. It has vast experience of building technical and managerial capacities over the decades. It has a national wide membership of over 600 midwives. It has been receiving and managing support from different funding agencies including USAID funded programs for a long time. UPHOLD plans to work with the association directly and through the grant mechanism to improve the quality of reproductive health, child and adolescent health services.
- Faith Based Medical Bureaus: These include Uganda Protestant Medical Bureau, Uganda Catholic Medical Bureau, and Uganda Muslim Medical Bureau. The importance of collaborating with these organisations is that they run or initiated a chain health institutions and programs. Government is already collaborating with them in matters of ensuring quality of services in the institutions affiliated to them.
- Uganda Medical Association: This is the umbrella association of Uganda doctors. Any interventions targeting doctors would best be introduced in collaboration with UMA.
- AIM Project is already piloting some very good innovations in giving grants to PHP to increase access to key services like VCT. UPHOLD will borrow they methodology and expertise in this area.
- DELIVER Project
- Natural Chemotherapeutic Research Laboratories
- The Family planning Association Of Uganda
- Uganda Private Practitioners' Association
- Uganda Women Doctors Association
- CMS/PSI
- Uganda Community Based Health Financing Association (UCBHFA)
- Uganda Private Midwives Association (UPMA)
- THETA
- TASO
- Young Men's Christian Association (YMCA) and Young Women Christian Association (YWCA) these two associations are important partners in early childhood development. They train nursery school teachers for private schools.
- Forum for Education NGOs in Uganda (FENU) is the umbrella organisation for NGOs dealing in the education sector. They supervise and monitor member NGOs.
- Aids Information Centre (AIC)

- The Agha Khan Foundation through Madarasa supports other schools in production of learning and instructional materials and learning methods for early childhood education.
- Districts
- Sub-counties

7.5.3 Expected output at the end of the first year of implementation

By the end of the first year the following key out puts will have been achieved. Some of them will be part of the continuous products and out puts that are expected throughout the life time of the project. Because the private sector is a relatively new, UPHOLD will not be able to reach all 20 districts in the first year, therefore we target 15 districts to start off. For different interventions the number of districts may be less than 15. Within district UPHOL is targeting sub-counties and lower levels. Even with the district it will only be possible to reach only a few of the sub- counties. The out puts therefore are expressed by the number of sub counties we hope to reach with each intervention, in the districts at the end of the first year.

Health

IMCI

- Trainer for private sector IMCI trained in 15 districts
- 60 private providers trained in improved child care per each of the 15 district (three course of 20 participants each, one course per sub county)
- All trained private providers followed up

Micronutrients

- 100 private clinics in each of the 15 districts distributing Vitamin A (at a rate of at least 20 clinic per each of five sub counties in each district)

Growth Promotion and immunisation

- 100 private clinics in each of the 15 districts carrying out growth promotion and immunisation counselling/administration (at a rate of at least 20 clinics per each of five sub counties in each district).

Malaria management and control

- 5 sub-counties per district in 10 districts implementing HBMF
- 100 clinics in each 15 districts selling ITNs (at a rate of at least 20 clinic per each of five sub counties in each district)

Reproductive health

- Trainer for private sector IRH trained in 15 districts
- 40 private midwives trained in IRH in each of the 15 district. 10 private midwives will be selected and trained in each of 4 sub counties per district.
- All trained private midwives followed up

Quality of care

- 60 private clinics implementing quality improvement activities in each district at rate of 10 private clinics per sub county in 6 sub-counties.

HIV

- 100 private clinics in each of 15 districts selling condoms and STD drugs (20 per sub county in at least 5 sub counties per district
- Partnership plan to support activities of traditional healers and Natural Chemotherapeutic Laboratories
- At least 10 clinics per district receiving grants, equipment, training and support supervision to improve access to VCT and DOTs. (2 per sub county in at least 5 sub counties per district)

Cross-cutting

- Private sector strategy in place
- 15 district work plans reflecting private sector
- Report o f the mapping of private sector done in 10 districts

8. ACTION RESEARCH FOR INTEGRATED HEALTH

UPHOLD will rely on baseline information and qualitative data on health-related behaviours where these exist, to develop effective strategies and interventions to promote the adoption and strengthening of beneficial behaviours. Where no data exists, rapid, small-scale, but in-depth research will be absolutely essential to assure the achievement of results through UPHOLD's Behavior-Centered programming. The focus of any action research by UPHOLD will be on refining and improving the understanding of feasible behaviors and the barriers, motivations or supports for people to adopt these behaviours. While UPHOLD has made an initial list of key behaviors for each core intervention in its integrated health component, the input of participant groups is needed before the list of key behaviours can be finalized.

Standard features of UPHOLD's action research initiatives are as follow:

- Conducted only when there are important gaps in information essential to the design of effective interventions for promoting beneficial behaviour change.
- Rapid, low-cost, in-depth and predominantly qualitative.
- When possible, there will be a stage of *Trials of Improved Practices* (TIPs), which is the key technique for being able to complete an analysis of behaviours that are not only ideal but *feasible* for target groups to adopt and maintain.
- In-depth interviews will be supplemented with direct observations when possible.
- Although the research must be focused, all question guides should start with general questions on perceptions and concepts, in order to provide the opportunity for respondents to have an input into discussion topics.
- UPHOLD will look for opportunities to combine research topics on various topics with the same type of respondents. This is essential given the breadth of areas that UPHOLD is covering (multiple areas of health, education, and HIV/AIDS).

UPHOLD's overall approach to information-gathering consists of three basic phases:

Phase 1: Review of existing information (locate, read and analyze existing studies; possibly interview a small number of experts such as anthropologists and other experienced qualitative researchers).

Phase 2: Conduct in-depth interviews with various participant groups, possibly with a few focus group discussions. Because of the incredible breadth of UPHOLD activities, it is not practical to do separate exploratory research on each technical topics (TB, ANC, etc.). Therefore, to the extent reasonable, this phase might be organized by type of respondent.

Phase 3: For selected areas, carry out *Trials of Improved Practices* (TIPs). Some appropriate areas would be provider treatment of clients, home treatment of fever, couples abstaining or having only protected sex, etc.

The table on the following page presents a preliminary list of health topics, participants groups and methods for Action Research.

Preliminary Topics, Participant Groups, Methods and Comments for Action Research

Health Topics	Participant Groups	Methods and Comments
Breastfeeding, young child feeding, including during illness	Mothers and other caretakers of children 0-5, 6-11, and 12–3 months old	Because the basic program recommendations have already been approved by the MOH, UPHOLD should limit research to a small number of in-depth interviews or TIPs in each new district to learn about specific foods and behavioral and cultural issues.
Child health topics: feeding during illness, fever, ARI, hand washing, clean water, child feces disposal	Primarily mothers of children under 2 and 2-4; some in-depth interviews with fathers and female family influentials	In-depth interviews, followed by TIPs
Perceptions of community health status and problems, health care alternatives, TB, schisto	Community leaders, male and female adults; school-age children on schisto and malaria	In-depth interviews
Reproductive health, family planning; for pregnant women ANC, IPT, anemia and iron tablets; newborn care	Women of childbearing age (with sub-samples of pregnant women and TBAs), husbands, adolescents	In-depth interviews, possibly followed by TIPs on inter-spousal discussions, information-gathering, beginning a new method
Reproductive health, adolescents	Adolescents (younger and older), their parents, teachers	In-depth interviews, possibly followed by TIPs
Provision of quality and friendly health services	MOH health care providers	In-depth interviews, followed by provider TIPs
Provision of quality and friendly health services; new roles for private providers	Private sector providers (MDs, midwives, traditional healers)	In-depth interviews, followed by provider TIPs
Exploring possible collaborative roles for traditional healers: current practices re: diagnosis and treatment (for fever, pneumonia, TB) and willingness and ability to collaborate	Traditional healers	In-depth interviews, possibly followed by TIPs