PONT – Mbale Primary Health Care Links

Project Plan 2008

Background

PONT are working within RCT to develop RCT/Mbale Coalition Against Poverty – a major collaboration between Local Government and Non-Governmental Organisations in both communities aimed at delivering the Millennium Development Goals through long term sustainable Communities linking.
Primary health Care links between PONT / RCT tLHB and Mbale CAP through the work of the PHC committee, Mbale, and the Health links team in PONT Wales are beginning to show measurable impact in community health care in Mbale, with benefits to both communities. We have piloted projects which link NGOs and government health departments to develop provision of basic primary health care in the Mbale Manafwa and Bududa districts. Additional partners with common aims (Salem and JENGA) have been invited to join the partnership by unanimous agreement of all existing partners. They will contribute to a coordinated network of providers in extending the coverage of the project throughout the Greater Mbale region.

Project overview – our long term vision and purpose:

To develop strong working relationships networking RCT health care professionals, educators and students of the tLHB, Hospital Trust, University of Glamorgan, RCT council and PONT, to form a robust Coalition Against Poverty. This network will enable staff and students from all link organisations to become informed and involved in making personal and professional links to help build capacity and develop training and projects specifically aimed at delivering the Millennium Development Goals to the potential benefit of up to a million people within the Mbale region. Initial pilots by PONT and recent collaboration in supporting training have demonstrated positive impact
of local NGOs developing provision of basic health care at village / community level, in accordance with the Ugandan government's 5 year Health plan.

The Mbale Coalition Against Poverty effectively links all the regional Council Departments with a network impact in improving health care at village level, with monitoring showing decreased rates of malaria in children and reported improvements in uptake of preventative health care.
Evaluation of training of volunteer health workers by a visiting University of Glamorgan lecturer has been well accepted and change implemented in the light of recommendations, with proposals for regular review of the curriculum coming from the Primary Health Care committee (PHC).
Exchange visits from Uganda to UK have helped to improve mutual understanding and significantly strengthened working relationships and friendships as well as sharing best practice and ideas for service improvement.

Training of health worker volunteers has been enthusiastically embraced and used to significant positive impact on health at village level, with enthusiasm for further training and regular continuing professional development at all levels.
Initiatives for greater collaboration have been actively developing from both sides, with growing numbers of individuals volunteering to become actively involved.
Meetings between the University of Glamorgan, Primary health care staff and PONT have been particularly fruitful, with positive sharing of ideas and dissemination of enthusiasm into a wide range of disciplines within the University. Proposed collaborative projects, for example, in engineering, housing and tenure, water and sanitation, education, and carbon offsetting all have potential for impact on the Millennium Development Goals including direct and indirect further benefits on MDGs 4,5, and 6.

PHC Objectives for 2008 forwards

1) To complete modules of training for Community Health Workers from new partner NGO Salem to bring them up to a common standard examined and accredited to the level of Community Health Promoter [OPL Level 1] – achieved May 2008
2) To continue to develop and strengthen Primary Health Care through building capacity within NGOs and Village Health teams, working towards comprehensive coverage by volunteer Community Health Workers of all communities within the Mbale region.

Phase 1 process requires community sensitisation, identification of suitable capable volunteers supported by their communities; training, accreditation and equipping of volunteers as Community Health Promoters [OPL Level 1]. Candidates to be trained in cohorts of 40 by locality to achieve best value for money. Aspiration to train a total of 200 in 2008.

3) To enable delivery of health care and advice by provision of raincoat, gumboots, umbrella, medical manual (Where There is No Doctor), and bag to 200 accredited volunteers.
4) To facilitate record keeping, learning and rudimentary access to local epidemiological information by provision of personal Log book to accredited volunteers.
5) To build capacity of NGOs to train further OPL Level 1 and 2 volunteers, and to support continuing professional development (CPD) by training 30 Trainer of Trainers. – achieved April 2008
6) To select qualified and experienced OPL Level 1 volunteers showing aptitude and commitment to go forward for OPL level 2 training. (This level to be undertaken as funding permits) [Medium term objective to have in place one OPL2 heading each Village Health Team, which would also contain additional OPL level 1 volunteers].
7) To locally procure mosquito nets funded by charitable giving through PONT and other grants to be distributed through the network of trained volunteers as agreed by the PHC or a delegated group of officers in line with agreed prioritisation (children under 5 and pregnant mothers). Liaison with DDHS offices for re-treatment of nets.
8) To monitor and evaluate effectiveness of mosquito net distribution and community sensitisation to malaria prevention by data collection on bednet

use and incidence of malaria in children under 5 in cohorts of 25 homesteads per OPL2 over a 12 month period following provision of the net. Data to be collected by OPL2s, collated by NGO supervisors and available to all partners. [OPL2s qualified Nov 06 and April 07]

9) To collect additional quarterly data on key health care indicators: immunisation uptake, births (including level of care at delivery) and deaths (including age of death and cause where possible), latrine provision, health education activities and referral rates to Government Health Facilities. Data to be collected by OPL2s, collated by NGO supervisors and available to all partners.
10) To provide laptop computers to each NGO and administrative funds to support collection and collation of data and timely reporting to Mbale PHC and to Wales.

Methods to reach these objectives

We will actively seek out key skills within our partner organisations to develop projects of high quality and best practice, whilst also including a wide range of enthusiasts and channelling their skills in appropriate and innovative ways.
We will use approved local training provision and accreditation, with regular evaluation and advice from expert trainers and teachers. Regular review of curriculum and delivery of training, including input from students and graduates of the course, incorporating new and pertinent topics and training methods by agreement of PHC team and local government health directorate.

Project manage delivery of training in an ordered and timely manner within the agreed strategy towards achieving full coverage and supported by adequate and timely funding streams.

Regular monitoring and evaluation of interventions through data collection on sample cohorts following net distribution, and through quarterly returns and monitoring of Log books (information gathering). Timely reporting of findings and proposed improvements, with feedback of analysed data to OPLs (information giving and learning opportunities).

We will continue to communicate regularly. Clear lines of communication between key personnel are in place, most frequently by email, but texting and phone calls are also used for speed of communication.
Reports of meetings to be shared internationally via email.
Periodic planned visits will continue in both directions as these facilitate significant progress in the planning and development of our work together.

Our longer term goals

Active involvement of staff and students working in Wales NHS organisations and organisations providing education in the health care professions. Raised awareness and sense of ownership and participation in international health care links for both individuals who make exchange visits and those who contribute to the link through

their efforts within Wales. Raised public awareness of issues, links work done, and opportunities to get involved.
Inter-organisational networking, collaboration and sharing of expertise and best practice both in–country and internationally.

Phased rollout of training of sufficient numbers of Village Health Teams [OPLlevels 1 and 2], locally supported by Trainers of Trainers (ToTs), supervisors and Core Facilitators to complete full coverage of 10 subcounties, with further subcounties thereafter until full coverage throughout the region is achieved.

Maintain longterm provision for updating and continual personal development of individual health workers, with opportunities for those with aptitude and personal interest to progress further on into paid government health care work.

An efficient and effective referral system, improved accessing of government health facilities by communities, and strengthened working relationships between community volunteers and government health staff.

Broadening of training to include support and development of approved training for traditional birth attendants (TBAs) and other community care providers along similar lines and principles, where needs have been appropriately identified and assessed.

Excellence in monitoring and evaluation with publication of important findings. Learning and implementation of good ideas and best practice from other Wales health links with Africa.

Benefits in Mbale:

Capacity building in Primary Health Care:
Training and equipping of CHPs (OPL Level 1) and supporting organisational supervisors and trainers, providing a network of volunteers to deliver health promotion, public health initiatives and basic health care advice and simple interventions.
Integrated working, Government – Non-government collaboration in line with Ugandan 5 year health care plan.
Development of rudimentary returns of Key Heath Indicator data from villages and communities beyond the reach of Health facility data returns with potential to inform health care planning.
Interest from a linked NGO in Kampala suggests the possibility of rolling out the programme to other regions.
Improved uptake of and access to health care
Reduced burden of mortality and morbidity in targeted communities.
(MDGs 4,5,6)

Benefits in Wales:

A joint approach from NHS organisations and staff and academic institutions within a Welsh district builds capacity by strengthening relationships through a

multidisciplinary, multi-professional, multi-agency team approach to facilitate working together.

Individuals actively involved benefit from continuing professional development and expanding networks of professional colleagues gaining knowledge and experience in Tropical diseases expertise and understanding through the process of data collection and analysis, and diseases of poverty and valuable knowledge gained through the findings of the analyses.

Building expertise in Wales in health links. Already different links are beginning to share experience, information and expertise with one another, enthusiastic to collaborate to achieve best practice in international health links.

Involvement in international links creates and promotes Global Citizenship with heightened awareness of issues such as Fair Trade, Climate change, Carbon impact, Environmental Conservation and Convergence, which drives changes in behaviour towards more responsible Global Citizenship of individuals and communities.

Dr Cath Taylor, Health Links Lead, PONT / RCT tLHB

December 2007

Appendix 1 Heallth links partners

PONT health links committee: Health links lead Dr Cath Taylor, GP, RCT
Dr Geoff Lloyd, GP, RCT; Dr Sally Venn, NPHS Wales; GP. Dr Carl Venn, GP
Drs Simon & Sian Gray, GPs, Mr Chris Cruise, RCT tLHB

PHC committee in Mbale: Chairman Mr Fred Chemuko
Government institution partners: Dr Francis Abwaimo, DDHS; Dr Gideon Wamasebu, DDHS Manafwa; Dr Godfrey Mulekwa, DDHS, Bududa, Uganda.
NGO partners: Share An Opportunity (Eastern Uganda), Uganda Women's Concern Ministries, Foundation for Development of Needy Communities, Salem (Uganda), JENGA, Mbale, Uganda

Appendix 2: Addressing The Millennium Development Goals

Health links_ objectives address a number of the MDGs directly and indirectly:

1) Eradicating extreme poverty and hunger. Funding costs of purchasing medicines and inability to work whilst sick are a major financial burden for poor families. Better health reduces this burden. Health Promoters include advice on Income Generating Activities (IGAs) in their work.
2) Achieve universal primary education. Teachers in schools in Mbale region report improved attendance in children who have less sickness or responsibility for care of ill relatives.
3) Promote gender equality and empower women. About half of those trained are women and provide good local role models, having equal standing with their male colleagues. Increased uptake of Family planning and reduction in domestic violence through reductions in drunkenness advocated by OPL2s.
4) Reduce child mortality by preventing malaria, improved health promotion and healthcare advice including encouraging uptake of immunisations and more timely referral of appropriate cases for medical help.
5) Improve maternal health by promotion of mosquito net use for pregnant mothers; encouraging delivery assisted by health professional in Health Facilities, family planning advice and health promotion.
6) Combat HIV/AIDS, malaria and other diseases. Health workers promote and encourage HIV testing, give advice, encourage PMTCT (Prevention of Mother to Child Transmission) and ARV compliance; prevention of malaria sensitisation programmes and advice; distribution of nets and reinforcing advice at visits. Supervision treatment including TB DOTS. Hygiene advice / latrine use / promotion / provision ORS to address diarrhoeal illnesses.
7) Ensure environmental sustainability – some volunteers also actively involved in development of low energy wood burning stoves, tree planting projects and agriculture with additional expertise within NGOs which can be shared and promoted through the OPL network.
8) Developing a global partnership for development – the key to the whole programme is developing partnerships between health providers and volunteers in both communities with the express purpose of building capacity within the health services in Mbale. It has already demonstrated a remarkably committed partnership of government and NGO health providers in Mbale forming a single effective coalition operating through the Primary Health Team Committee. Partnerships within Wales are developing with a strong focus on addressing the MDGs and there is increasing dialogue and exchange between Wales and Uganda within the partnership.

Appendix 3: **Mbale PHC / PONT –RCT tLHB* Planning meeting**
Saturday 1st December 2007 at Mount Elgon Hotel

Present: Dr Francis Abwaimo (Mbale), Sr Jennifer Wandawa (Mbale), Fred (SAO), Richard (FDNC), Sandra (FDNC), Robert (UWCM), Micross (Salem).
Dr Cath Taylor (Health links coordinator, PONT); Drs Carl & Sally Venn (PONT)
Apologies: received from JENGA and Manafwa and Bududa districts.

It was agreed the PHC should constitute members from all three districts and all 5 NGOs involved in the PONT – RCT tLHB link. [see attached]

CHPs training (OPL level 1) needs of each NGO were listed:

Salem have 36 community based health workers who need completion of training to achieve standard to pass accreditation exam.

JENGA have 45 CHPs who have completed training. They will need some to be identified to progress to OPL2. CHPs currently travel from Namatala into the local villages, ie are not drawn from the villages. Future CHPs should come from the local communities rather than commute.

UWCM have all their CHPs now trained to OPL2 level (15 in total), so need further CHPs trained to improve coverage.

FDNC have 5 CHPs and 15 OPL2s. Need more CHPs

SAO have over 100 CHPs and 30 OPL2s. They need more CHPs.

The Process of expanding the CHPs cadre
SENSITISATION COMMUNITIES – SELECTION CANDIDATES FOR TRAINING – TRAINING – EXAM - CERTIFICATION -> selection about one third to progress to future OPL2 training. [VHT – OPL2 + 1 - 3 CHWs]

It has been previously agreed by PHC and in discussions this week that the priority is to train more CHPs, but to achieve optimal effectiveness, the process of selection should be preceded by careful sensitisation of communities and particularly their leaders as a priority.
Both SAO and Salem have expertise in needs assessment and sensitisation. It was agreed the other 3 NGOs should draw on their expertise to build the capacity of their organisations through initially 2 selected volunteers (drawn from the OPL2 cadre). SAO/Salem personnel will accompany chosen volunteers to receive this training, by teaching them in the field, setting assignments, etc. *[are these to be ToTs??]*
Sensitisation of communities would take one day; further training one week.
Identification of CHPs candidates a further 2 weeks. *Action: costings - Fred*

Each CHP would cover around 100 homesteads / households (with an average of 8 individuals per homestead).
Need to identify and select a cohort of 40 per locality to be trained locally (subcounty level).
If begun immediately the time to start of training would be around one month, with training Jan – June. By September, OPL2 candidates could be selected from that cohort for training in, say, November 2008 if funds allow. *Action: costings – Fred*

Equipment: T shirt; WTIND book; gumboots; raincoat; umbrella; bag.

CPD training.
It was agreed to provide 3 monthly training centrally for OPLs.
This allows efficient use of human resources and offers a forum for not only teaching on subjects requested or of current importance, but a regular exchange of ideas and peer support, with "cross fertilisation" of ideas from the different NGOs.
3 monthly CPD for CHPs would be provided locally (efficiency cost and time)

Data collection
Changes agreed through deliberations this week:

Quarterly returns [OPL2s] – as per suggested data sets, with PHC to refine before commencing in January.
Quarterly reports compiled by supervisors by end April / July / Oct / Jan to be forwarded to Wales, with response within 2 weeks.

Malaria net data forms – refined to simpler form (quarterly return captures births, deaths) 25 per OPL2. Starting with 25 new homesteads with next issue of nets. This cohort of 25 to be followed monthly, with NGO supervisors collating and returning quarterly figures for 12 months.

Lap top computers to support data processing and admin to be provided to each NGO for use by supervisor. *Estimated costs: £750 + £300 x 4 = £1950*
Admin budget
stationery, transport, log books, referral forms *Action: costings – Fred*

Referral forms: requested and designed at conference by OPL2s (confers credibility, facilitates learning). To include Reply slip. *Action: Jennifer*

Log book – every CHP / OPL to keep a simple log in a sturdy book.
[Quarterly returns collected by OPL2s to include information from CHPs]

Appreciation – nil at present. Sustainability issues. Subject to be kept on the agenda.

Nets: Beyond current commitment, which will be met ASAP, nets to be supplied as funds allow. No set number of nets per CHP or OPL (though aim for at least one per household with under 5s eventually; polygamous or those with large numbers children may need two nets). PHC / supervisors to decide how to allocate. *[Not discussed at meeting but please consider LAMPS project and interaction 2 projects may have. CT].*

*Note: Rhondda Cynon Taff [Pontypridd district] teaching Local Health Board [counterpart to DDHS office]
**Fred and Cath discussed further to this meeting the need for provision of ToTs (trainer of trainers) training, suggested 3 per subcounty ie 30 in total, which would enable facilitation of training CHPs at local level. Agreed in principle.
Action: further discussion / recommendation of PHC. Fred to give costings please

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Appendix 4:

RCT / Mbale Coalition Against Poverty

Long term sustainable joint working through community partnerships

Healthcare partners

RCT, Wales: RCT tLHB; HESAS, Uni Glam; PONT; Pontypridd&Rhondda NHS Trust;
Mbale, Uganda: District Directorates Health Services of Mbale, Manafwa and Bududa;
NGOs: SAO(Uganda), UWCM, FDNC, Salem, Uganda, Jenga;
Mbale Regional Referral Hospital

Collaborative Development of Sustainable Community Health Care in Mbale

Aim: Comprehensive coverage basic health care at community level Mbale Region

- trained volunteer health workers in Village Health Teams
- integrated into existing system with clinical attachment to rural Health Centres
- in line with Uganda Government 5 year health plan.
- addresses MDGs by targeting poorer communities for low cost intervention

Existing partnership has demonstrated health care improvements through pilot phase

- project data
- central Ugandan govt. data

Coverage: Key structure, mechanisms in place to plan and implement phased roll out.

- robust stakeholder management team
- training and supervision system

Quality training

- accreditation
- annual review, modification course
- quarterly CPD.

NGO capacity building

- Trainer of trainers
- IT support

Research

- quarterly key indicator data; log books
- Public health
- University healthcare training division

Monitoring & Evaluation

- data collection on sample families with nets
- reports
- interval visits

RCT Community commitment:

- charitable funding of training through PONT
- personnel self-funded / PDP release

Feedback

- email; interim and annual reports

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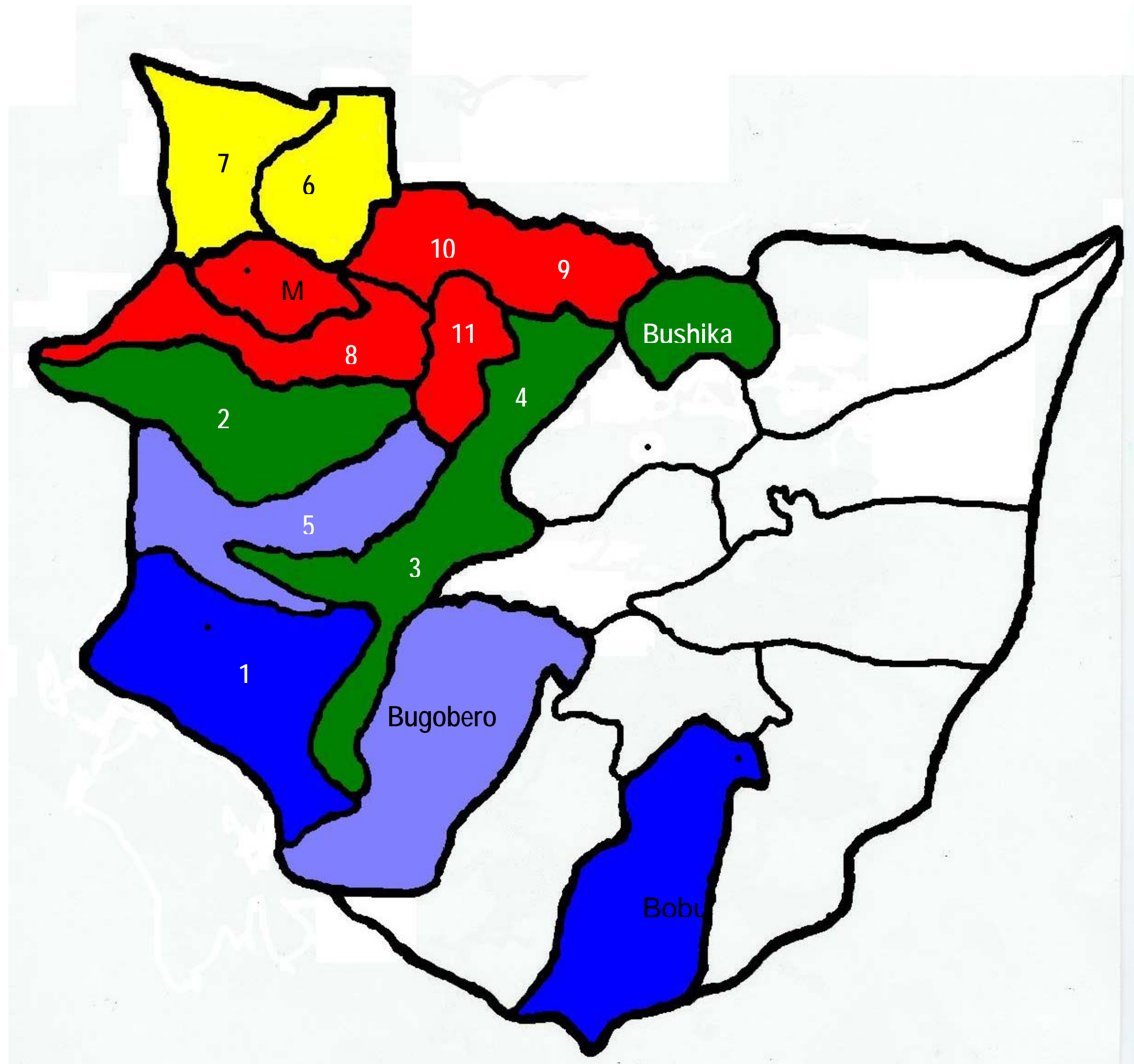
Appendix 5:

Assignment of Subcounties by NGO - Mbale, Baduda & Manafwa
as agreed at PHC meeting 15 Nov 2007



District	SAO	FDNC	UWCM	Salem	JENGA
Mbale	1. Busiu	2. Bunghoko	5. Busoba	6. Namanyonyi	Mbale municipality
Mbale		3. Bukiende		7. Nakaloke	8. Bunghoko Mutoto
Mbale		4. Busano			9. Bufumbo
					10. Bukonde
					11. Wanale
Manafwa	Bobutu S/C		Bugobero S/C		
Baduda		Bushika S/C			

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Appendix 6:
Projected Training costs
Operational Level OPL1 and OPL2 and CPD Village Health Teams Phase 1 – 4

2008 onwards

Phase 1		Phase 2		Phase 3				Phase 4				Total
200OPL1s		200OPL1s		200OPL1s		200OPL1s		200OPL1s		200OPL1s		1200
£15,000		£15,000		£15,000		£15,000		£15,000		£15,000		£90K
	60OPL2s		60OPL2s		60OPL2s		60OPL2s		60OPL2s		60OPL2s	400
	£20,000		£20,000		£20,000		£20,000		£20,000		£20,000	£120K
CPD L1												
£1500		£3000		£4500		£6000		£7500		£9000		£31.5K
CPD L2												
£2000	£4000		£6000		£8000		£10,000		£12,000		£14,000	£56K
ToTs												
£6,000												£6K
£2,000 IT								£2,000 IT				£4K
Supervision												
£2,300		£4,600		£5,100		£6,000		£7,000		£8,000		£33K
£28,800	£24,000	£22,600	£26,000	£24,600	£28,000	£27,000	£30,000	£31,500	£32,000	£32,000	£34,000	£340.5K

OPL1 Operational level 1 / Community Health Promoter Volunteer
OPL2 Operational Level 2 "Dispenser" Volunteer (drawn from more able OPL1 candidates)
ToT Trainer of Trainers (drawn from OPL2 candidates)

CPD Quarterly educational updates – locally for OPL1s, centrally for OPL2s
Supervision Costs of transport, subsistence for supervising Core Facilitator

Village Health Team (OPL Volunteers): Training and Supervision System