QuIP Report on GUSO Flex in Uganda

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THE NATIONAL FORUM OF PLHA NETWORKS IN UGANDA
THE UGANDA HIV/AIDS PARTNERSHIP
NAFOPHANU

RESTLESS DEVELOPMENT
THE YOUTH-LED DEVELOPMENT AGENCY

Reach a hand
young people for young people

Straight TALK FOUNDATION

Healthy Entrepreneurs

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GLOSSARY OF QUIP TERMS

QuIP studies employ the following terms as described below:

Attribution[1]: Evidence that an action (X) of a named organisation or project is contributing to change in an *outcome* (Y) in the presence of other *drivers of change* (Z).

Attribution code: a code that indicates whether a *causal claim* (a) is having either a positive, negative or neutral effect on a specified *outcome*, and (b) explicitly identifies a selected organisation as the *driver of change*, is implicitly consistent with its *theory of change*, or is unrelated/incidental to it actions.

Blindfolding: The process of deliberately restricting what interviewers and/or interviewees know about an activity or actor in order to reduce the potential bias in favour of emphasising the importance of this activity or actor relative to other drivers of change.

Causal claim: A proposition that a specified *outcome* (Y) was a direct consequence of a specified action (X) or (Z). Note that an outcome in one causal claim can be a driver in another causal claim. Consider one narrative where X leads to Y_1 and another narrative where Y_1 leads to Y_2; then Y_1 is an outcome in the first claim, but a driver in the second. the outcome of X and the driver of Y_2. Similarly, Y_2 is both the outcome of Y_1 and the driver of Y_3

Causal chain: A series of connected causal claims, for example in a narrative where X leads to Y_1 leading to Y_2 leading to Y_3.

Causal driver: See *driver of change*.

Commissioner: The organisation contracting a QuIP study, and the primary user of the evidence to be collected. Responsibility rests with the Commissioner to decide what sort of evidence they want and why, as well as when, where, and how to collect it.

Credibility: How believable a particular finding or conclusion is to a particular person or audience. It acknowledges that their capacity to assess the validity and reliability of findings depends upon their own independent knowledge, experience and opportunity for cross-checking or triangulation against other sources. This contrasts with the quest to establish universal truths that are valid and reliable independently of the perceiver. In aspiring to produce reasonable or 'good enough' evidence the success of the QuIP ultimately hinges on the credibility of findings.

Count: the number of times a theme is mentioned in interviews and focus group discussions

a) **Respondent Count:** The number of respondents who mention a given theme ('driver of change', 'outcome' or 'attribution') when answering a given question. By definition, the maximum respondent count for a given theme in a QuIP with 24 respondents is 24.

[1] The QuIP has a strong affinity to Contribution Analysis as described by Mayne (2012). Mayne (2012:273) also distinguishes between attribution ("… used to identify both with finding the cause of an effect and with estimating quantitatively how much of the effect is due to the intervention") and with contribution, that asks whether "… in light of the multiple factors influencing a result, has the intervention made a noticeable difference to an observed result and in what way?" Taking "observed results" to refer to changes measured through routine monitoring, the QuIP conforms to this definition of contribution. But as the basis for identification of causal chains it also conforms to the first part of Mayne's definition of attribution.

b) **Citation Count:** The number of times a theme is mentioned, with a maximum of one count per respondent per domain. By definition, if a QuIP questionnaire has six domains and 24 respondents, then the maximum citation count for a given theme is 24 x 6 = 144.

Domain: An area of respondents' lives, or category of outcomes (e.g. Income, Health, Education) agreed in advance with the commissioner and used to structure interviews and focus group discussions. Most studies address a number of domains that are consistent with a *theory of change*. For example, they may refer to different aspects of the wellbeing of individual intended beneficiaries.

Driver of change: An action or state (X or Z) behind an outcome (Y). These are generally self-reported by respondents, in answer to questions like *'why did that happen?' or 'what was the reason for that?'* This term is synonymous with *causal driver*. Thematic coding is used to identify drivers of change, and to group similar drivers into groups or clusters.

Intended beneficiary: Those people that a specified organisation is aiming to benefit, by achieving *outcomes* specified in its *theory of change*. Sometimes the intended beneficiaries are organisations or associations of people, as is the case with capacity building projects.

Impact: Evidence that a specified project *credibly caused* a specified set of outcomes. In some cases the term impact may refer specifically to final or *tertiary outcomes*. X *credibly causes* Y in a particular context if (a) there is strong evidence that X and Y happened, (b) several stakeholders independently assert that X was a cause of Y, with minimal prompting, (c) there is no more credible counter-explanation for why they might have said this, (d) their account of how X caused Y is consistent with a plausible *theory of change*.

Outcomes: Changes (positive or negative) reported by respondents, often in answer to a question in the form of: *'during this time period has anything changed in this domain of your life?'*

Project or Programme: A specified set of activities, interventions, or investments over a given period of time aimed at achieving a specified set of intended outcomes for a specified group of intended beneficiaries. This is the object of a specified QuIP study. It is the responsibility of the commissioner to define it, as well as the theory of change behind it, as precisely as possible. Others may refer to a project as a 'treatment,' but in QuIP studies this term is generally avoided.

Respondents: Interviewees and focus group discussion participants. Their narratives are the source of causal claims, linking drivers of change (including but not limited to project activities) to outcomes, both intended and unintended. Respondents are usually a sample of intended beneficiaries, and data is collected form them through a mix of semi-structured interviews and focus group discussions.

Theory of change: The causal processes by which the commissioner of QuIP study expects a specified project to achieve intended outcomes and impact. Not all causal drivers originate with the project. Theories of change also identify incidental drivers of change and may also assess the risks associated with their occurrence or non-occurrence.

GLOSSARY OF TERMS AND ABBREVIATIONS

Bath SDR – Bath Social and Development Research

CHE – Community Health Entrepreneur

FGD – Focus Group Discussion

FLEP – Family Life Education Programme

GUSO – Get Up Speak Out

GUSO Flex – Get Up Speak Out Flexibility Fund

HE – Healthy Entrepreneurs

NAFOPHANU – National Forum of People Living with HIV/AIDs Networks in Uganda

QuIP – Qualitative Impact Protocol

RD – Restless Development

RHU – Reproductive Health Uganda

SRHR – Sexual and Reproductive Health and Rights

STF – Straight Talk Foundation

ToC – Theory of Change

UNYPA – Uganda Network of Young People Living with HIV

VSLA – Village Savings and Loans Association

EXECUTIVE SUMMARY

Background

'Get Up Speak Out - Flexibility Fund' (GUSO Flex) is a collaboration between the GUSO consortium, the Sexual and Reproductive Health and Rights (SRHR) Alliance Uganda, and Dutch social enterprise Healthy Entrepreneurs (HE). GUSO Flex is a project within the larger GUSO programme, and was implemented in four districts in Uganda (Bugiri, Iganga, Jinja and Mayuge) between March 2018 and 31 August 2019. Through an innovative community service delivery model that combined peer educator and peer provider models, GUSO Flex empowered young people to generate an income while accessing and disseminating SRHR and HIV information and services.

The project equipped youth between the ages of 18 and 24 to become Community Health Entrepreneurs (CHEs). The CHEs were trained in health and entrepreneurship; supplied with a basket of over-the-counter health products (including SRH items like condoms and sanitary pads), as well as a phone or tablet loaded with health information (e.g. videos on health topics); and equipped to make referrals to local medical centres (for health issues that were beyond their competencies). The CHEs could earn an income by selling health products in their communities.

A qualitative study using the Qualitative Impact Protocol (QuIP) was conducted to evaluate the health and income impacts of GUSO Flex on the CHEs near the end of the project. Fieldwork was carried out in two districts (Iganga and Mayuge) between June and July 2019. 24 individual CHEs were interviewed, and four focus group discussions were conducted, to answer the following evaluation questions:

1. Have there been any changes (positive or negative) in respondents' lives over the past year and a half?
2. What do respondents perceive to be the drivers behind these changes?
3. Are these changes in any way linked to GUSO Flex, or are they incidental to it?

The QuIP approach employs open-ended questions structured into domains based on the commissioner's theory of change. The questionnaire aims to explore changes and uncover the broad range of potential drivers leading to them. The domains used in the interviews with CHEs were:

- Health and living conditions
- Education (including training)
- Earning money
- Spending, saving and borrowing money
- Personal relationships
- Community relationships
- Overall wellbeing
- Aspirations for the future

Findings

This study found that GUSO Flex is having a markedly positive effect on those who are participating in the project as CHEs. They reported that their lives have been improved due to increased income, greater knowledge of health topics through training, having direct access to medicines and health tests, and increased confidence and social standing in their communities.

The biggest drivers of change mentioned by respondents were **working as a health entrepreneur** and **receiving training or sensitisation**. Both of these drivers were explicitly attributed to GUSO Flex via reference to Healthy Entrepreneurs and organisations that are part of the SRHR Alliance Uganda.

The **positive financial impact of working as a CHE** was a key finding. Working as a CHE improved respondents' incomes by allowing them either to abandon less profitable earning activities, or to diversify their income generating activities. This was particularly notable given a challenging economic context, with respondents mentioning drought and poor economic conditions at the national level.

Receiving **sensitisation and training** on health, access to HIV testing and family planning was linked by both male and female respondents to **improved relationships** with romantic or sexual partners, a change reported by two thirds of respondents. These changes included being able to discuss sexual health, to ensure that both partners were tested, and having more cooperative and equal relationships. Another driver of improved relationships, cited in both the male and female focus group discussions, was being seen as a **role model** and having **increased respect** in the community. Being seen as a role model also led some to give greater consideration to what kind of partner they wanted to be associated with.

Improved **access to health services**, medicine and products; and improved ability to treat people and make referrals to health centres; were other key findings. CHEs reported being better able to treat themselves and sick family members without having to go to hospital, because of the medicine they were supplied with by HE and the knowledge they had gained in training. CHEs reported **increased testing for HIV and STIs and increased condom use**, both by themselves and in their communities, particularly among young people. The communities CHEs served benefited from having a local point of contact for health services, assistance and referrals. The positive impact on health outcomes of working as a CHE extended beyond the entrepreneur themselves and into their communities.

There were some gender differences in positive outcomes. Men were more likely to mention the respect they received because of being a CHE, connecting working as a CHE to **improved social status**. Women focused more on the **financial benefits** of their participation in GUSO Flex, as well as emphasising the positive impact of working as a CHE on **improved confidence and self-belief.** For Women associated improved confidence with a number of positive changes including a wider range of friends, higher ambitions and improved wellbeing. These positive social consequences flowed from female CHEs going out to speak to new people and widening their range of connections in the community.

There were some minor differences in changes between the two districts where the QuIP was undertaken. Respondents in Iganga were more likely to mention improvements in the domain of *Health* relative to respondents in Mayuge. CHEs in Mayuge were more likely to mention positive outcomes in the domains of *Earning Money*, and *Spending, Saving and Borrowing Money*, with almost all citing an improved standard of living.

When asked about aspirations for the future, most individual respondents reported having **higher ambitions** now, based on their increased incomes but also on the value they now attached to knowledge as a way of forging ahead in life. However, in practice this often translated into sending relatives to school, rather than planning to pursue further education themselves. Some respondents felt that it was too expensive or that their responsibilities to their families would not allow them to go back to school, although they valued the training they had received through GUSO and GUSO Flex.

Evaluation questions

The QuIP approach directs respondents to identify significant *changes* in pre-defined areas of their lives, and to reflect on what they believe to be the *drivers* behind these changes. Respondent narratives collected during the interviews include chains of causation, where respondents will mention a driver which leads to an outcome, which in turn may function as the driver of an outcome further along the causal chain. The first two evaluation questions pertaining to changes and drivers of change can be answered by purely by analysing interview data. The QuIP then identifies which of these stories of change can be *attributed* to the commissioner's project (based on an in-depth knowledge of the project) and which proceed from other influences. This analysis is a key distinguishing characteristic of the QuIP and provides answers to the third evaluation question.

1: Have there been any changes (positive or negative) in respondents' lives over the past year and a half?

The lives of CHEs have improved in a number of ways over the past year. CHEs reported:

- Increasing their incomes
- Improved health outcomes
- Becoming a role model and more respected in their communities
- Increased condom and family planning use
- Higher ambitions and increased saving

2: What do respondents perceive to be the drivers behind these changes?

The drivers identified by CHEs show how GUSO Flex is helping to create positive outcomes for CHEs. The top two drivers, mentioned by all individual respondents and across all focus groups, were **working as a CHE** and **receiving training or sensitisation**. Other key drivers included **improved accessibility of health services, medications & products**; **increased income;** and **higher ambitions**. Where there is an overlap between key changes and key drivers of change, this indicates that themes appeared both as drivers and outcomes in respondent narratives.

3: Are these changes in any way linked to GUSO Flex, or are they incidental to it?

There is a strong relationship between GUSO Flex and the positive changes identified by CHEs. Changes linked to GUSO Flex had knock-on effects across domains, particularly in relation to increased income which was reported as leading to outcomes such as increased savings, an improved ability to take care of others, being able to send family members to school, improved nutrition and investing in one's own businesses to diversify income sources.

Working as a CHE, which was explicitly attributable to GUSO Flex, led to improved access to health services and health products, leading to improved health outcomes, more use of family planning and condoms and more communication about health within communities. Receiving training and sensitisation as part of GUSO Flex led to improved nutrition, business knowledge, knowledge about health, taking better care of health, testing for HIV and STIs, improved intimate relationships, and improved sanitation and hygiene. These all led to improved health outcomes, improved wellbeing and

improved standard of living. Improved knowledge about health also led to being able to treat people and make referrals to other services.

Working as a CHE also led to respondents being seen as role models and being more respected in the community, helping their own social integration but also improving community relations.

GUSO Flex training and sensitisation also had positive impacts on CHEs' perspectives on their own lives and what they could do in the future. This driver is linked to having higher ambitions, improved confidence and self-belief, and improved access to opportunities and networks for personal development. Having higher ambitions and access to opportunities and networks leads to more planning for the future, saving money and sending family members to school.

Having improved confidence and knowledge leads to engaging youth and encouraging/advising others. This again feeds back into better health outcomes.

The positive changes mentioned by respondents in this study were predominantly linked to GUSO Flex. Some other positive influences were described in addition to GUSO Flex, for example earning income from sources other than working as a CHE or investing in other business ventures. There were no negative changes explicitly linked to GUSO Flex. Any negative experiences were related to misperceptions in the wider community about CHEs, for example about what products the CHEs had access to, or the CHE business model and level of earnings.

The full report considers the detail behind the main reported changes, looking at the causal connections and any apparent differences between different types of respondents. The report also contains numerous quotes from respondents, enabling the reader to take a deeper dive into the stories of change.

Study limitations

QuIP studies mitigate confirmation bias by posing goal-free questions and encouraging respondents to focus on their lived experiences (rather than on a particular project or event). Respondents first identify important changes in their lives, and then work backwards to what caused those changes. QuIP studies further mitigate confirmation bias by "blindfolding" researchers and respondents, i.e. limiting what they know about the commissioner and the aims of the study. In this QuIP study logistics were such that the focus group discussions were conducted in a setting where CHEs met as a group. This may have engendered a tendency for FGD participants to refer to their role as a CHE more than they might otherwise have. Individual interviews were double-blindfolded, and it is felt that the bulk of data underpinning this report provides a well-rounded reflection of the recent experiences and changes in the lives of the respondents.

Acknowledgements

The authors acknowledge all participants in this study for their willingness to cooperate. We thank the research team for their efforts and we also thank Healthy Entrepreneurs and the Ugandan SRHR Alliance partners and in particular the Flex Fund project coordinator for their contributions to the study.

1. INTRODUCTION

1.1 Study objectives

This report summarises the findings from the Qualitative Impact Protocol (QuIP) study conducted between June and July 2019 in Uganda. The study was commissioned by Rutgers on behalf of the Get Up Speak Out (GUSO) consortium to assess the impact of its Flexibility Fund project (GUSO Flex). GUSO Flex was coordinated by Aidsfonds and implemented by the Sexual and Reproductive Health and Rights (SRHR) Alliance Uganda in partnership with Dutch social enterprise Healthy Entrepreneurs (HE). It was implemented in four districts in Uganda (Bugiri, Iganga, Jinja, Mayuge) starting in the spring of 2018 and ending on 31 August 2019. At the time of this evaluation the project had been running for a little over one year.

The QuIP study assessed the economic empowerment and health outcomes experienced by Community Health Entrepreneurs (CHEs) enrolled in GUSO Flex, and the extent to which they attributed any changes in their lives to GUSO Flex. It furthermore sought to explore any links that might exist *between* economic empowerment and health outcomes. This was prompted by a consideration of the rationale and assumptions underpinning GUSO Flex: being a CHE increases income and better knowledge about health; then together these two drivers help a CHE make better choices about their health and hence have improved health outcomes. The study also asked about changes in wellbeing and future aspirations that may have been influenced by improvements in income, as well as improvements in knowledge, volunteer opportunities, and mentoring.

The study addressed the following questions:

1. Have there been any changes (positive or negative) in respondents' lives over the past year and a half?
2. What do respondents perceive to be the drivers behind these changes?
3. Are these changes in any way linked to GUSO Flex, or are they incidental to it?

The report is divided into six sections:

- **Section 1** provides an overview of GUSO Flex in the context of the country and evaluation commissioner
- **Section 2** outlines the specific research methods used in this QuIP study, including sampling strategy, questionnaire structure, and data collection approach
- **Section 3** presents the study findings, providing an overview of the changes reported by CHEs, the drivers leading to them, and attribution of the changes
- **Section 4** identifies the organisations CHEs interacted with and the importance accorded to them
- **Section 5** provides a summary snapshot of change in different areas of CHEs' lives, based on responses to closed questions
- **Section 6** summarises the key findings

1.2 GUSO Flex background

Country context and scope of the challenge

Research in East Central Uganda on SRHR topics has revealed room for improvement. The area has a high teenage pregnancy rate (30.3%) with the median age of first marriage being 17.3 years of age. Only 39% of young people between 15 and 24 have comprehensive knowledge of HIV, and young women in this age group are 2.5 times more likely to have HIV than their male peers[2]. Social norms in Uganda, in particular regarding transactional sex, consent, and violence within couples, make girls particularly vulnerable to poor sexual and reproductive health outcomes[3].

Compounding these challenges is poor access to sexual and reproductive health information and services. The stigma surrounding the use of services can prevent young people from attending facilities, and when they do attend, they risk being treated rudely and judgmentally by service providers. This deters young people living with HIV from accessing information about safe sex, getting emotional support, and receiving appropriate treatment. In rural areas, this issue is even more pronounced, as health facilities lack resources like medicines and supplies of SRHR products like condoms[4].

The consequences of these intersecting issues can be devastating for both young people's sexual and reproductive health outcomes and their socio-economic security. Indeed, there is a link between sexual health, HIV status and young people's economic standing; economically independent young people are more likely to assert and demand that their rights are recognised and met, and are more likely to function as role models and mentors for their peers. Yet the political environment in Uganda sees young people increasingly denied their sexual and reproductive health rights. School-based comprehensive sexuality education has also come under fire from conservative political elements[5].

Commissioner and project background

GUSO Flex is part of the larger multi-country multi-year GUSO programme. It has been implemented only in Uganda, and only since 2018.

'Get Up Speak Out' (GUSO) was established in 2016 to carry out a five-year programme in seven countries to address gaps in services and overcome barriers to young people's realisation of their sexual and reproductive health and rights (SRHR).[6] It is being run by the GUSO consortium, which is led by Rutgers and consists of five other international NGOs: Aidsfonds, CHOICE for Youth and Sexuality, Dance4Life, the International Planned Parenthood Federation, and Simavi. In each country, the consortium partners work with local organisations to implement the programme.

In Uganda, GUSO is being implemented by the SRHR Alliance Uganda. The Alliance consists of eight Ugandan organisations: Centre for Health Human Rights and Development (CEHURD), Family Life Education Programme (FLEP), National Forum of People Living with HIV/AIDs Networks in Uganda

2 Ministry of Health Uganda (2012). Uganda AIDS Indicator Survey 2011. Available at: https://dhsprogram.com/pubs/pdf/AIS10/AIS10.pdf
3 Santelli, et al (2013) Behavioural, Biological, and Demographic Risk and Protective Factors for New HIV Infections among Youth, Rakai, Uganda. Journal of Acquired Immune Deficiency Syndrome. 63 (3) pp393 – 400.
4 Rutaremwa, G, and Kabagenyi, A. (2016) Utilization of Integrated HIV and Sexual and Reproductive Health Services among Women in Uganda. BMC Health Services Research 16 (1) pp1-9.
5 Iyer, P., & Aggleton, P. (2013) 'Sex Education Should Be Taught, Fine ... but We Make Sure They Control Themselves': Teachers' Beliefs and Attitudes towards Young People's Sexual and Reproductive Health in a Ugandan Secondary School." Sex Education. 13 (1) pp40 – 53.
6 A QuIP study in 2018 assessed the impact of the GUSO programme in Kenya

(NAFOPHANU), Reach a Hand Uganda (RAHU), Restless Development (RD), Reproductive Health Uganda (RHU), Straight Talk Foundation (STF), and Uganda Network of Young People Living with HIV (UNYPA). These organisations all work with youth volunteers between the ages of 18 and 24. The GUSO programme's theory of change (ToC)[7] is presented in Figure 1.

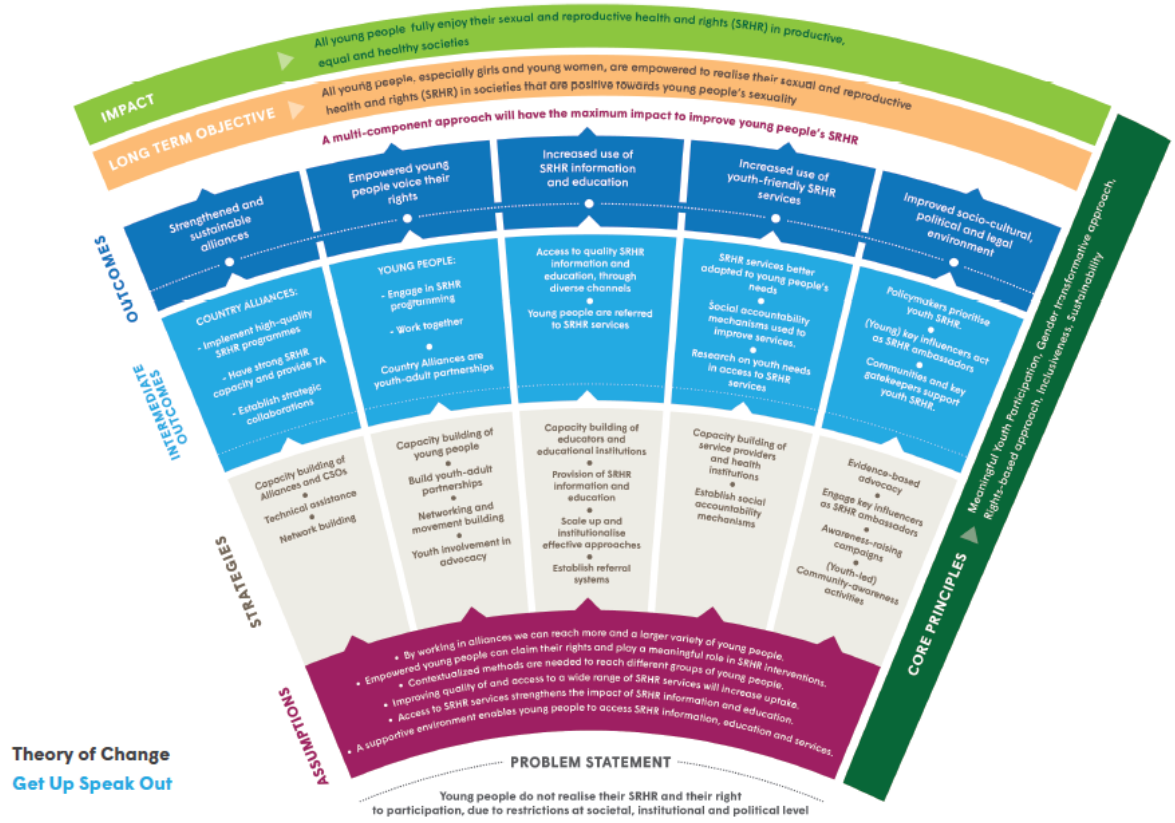


Figure 1: GUSO Theory of Change

In 2018, the GUSO consortium and six of the SRHR Alliance Uganda organisations partnered with Dutch social enterprise Healthy Entrepreneurs (HE) to deliver a new project: GUSO Flex. HE is a Dutch social enterprise dedicated to supporting last-mile delivery of health products in remote areas, and to date has trained and managed 4,000 entrepreneurs in four countries in Africa. GUSO Flex was designed to operate alongside the GUSO programme as an innovative way to extend and deepen access for young people to SRHR services, products and information and to add an economic empowerment component to the programme. GUSO Flex therefore targeted youth volunteers already enrolled in the GUSO programme in four districts in East Central Uganda: Bugiri, Iganga, Jinja and Mayuge.

7 Source: Get Up Speak Out Programme Document 2016-2020

Project description

Recognising the inter-linkage between health and economic challenges, especially in rural communities, the GUSO consortium embraced GUSO Flex as a way to combine the peer education model advanced by GUSO, and the last mile delivery model embraced by HE.

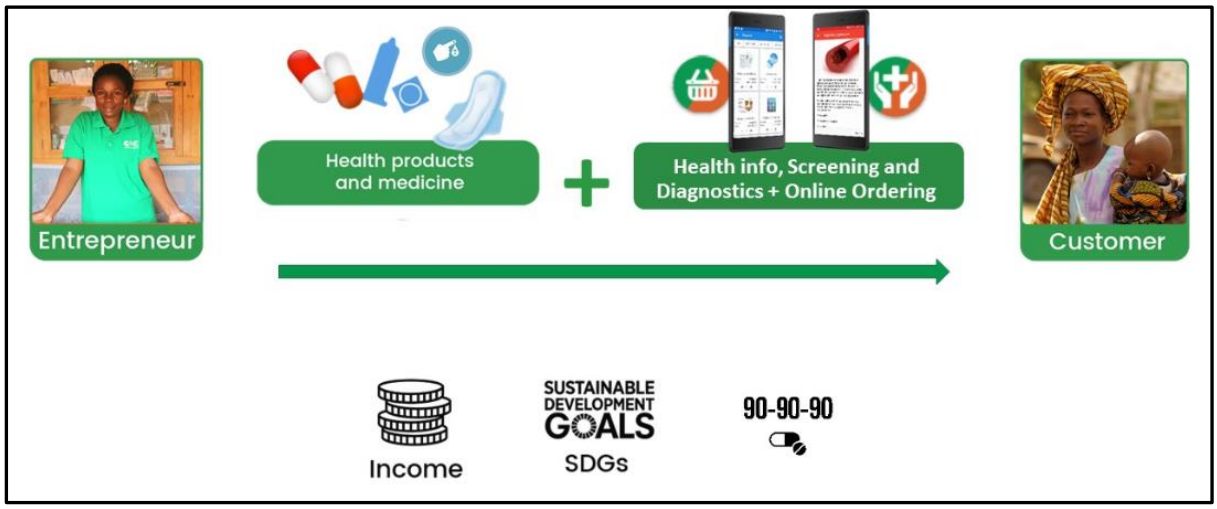


Figure 2: Healthy Entrepreneur model

Youth participating in GUSO Flex received training in entrepreneurship and health education from HE and the SRHR alliance partners, on top of the training in peer education and community health outreach they had already received as part of GUSO. In this way GUSO Flex's objectives aligned closely with and expanded upon those of GUSO. Two ways in which GUSO Flex went beyond GUSO were first, to combine health product and service provision with economic empowerment for the GUSO Flex participants; and second, to better integrate knowledge of, access to, and use of both sexual and reproductive health and HIV services and information.

GUSO Flex was launched in March 2018. In the first 5 months (between April and August 2018), 762 existing GUSO volunteers in the contiguous districts of Bugiri, Iganga, Jinja and Mayuge were trained as Community Health Entrepreneurs (CHEs). They were given five days of health training and two days of entrepreneurship training. In addition, they received an additional four days of further SRHR/HIV training some two months after the initial trainings.

To register as a CHE, candidates paid a 'commitment fee' of UGX 70,000 (about EUR 14). For this fee, they were provided with a tablet or a mobile phone loaded with videos and information on SRHR, family planning, HIV and other health topics like water, sanitation and hygiene (WASH) and basic healthcare. The CHEs were trained in how to use the tablet or phone to provide health information to their communities, and also received a t-shirt and cap so as to be identifiable as CHEs.

In addition, CHEs were instructed in how to refer patients to the local health centres. The purpose of this was to strengthen the current referral system to link remote communities more effectively to medical services. CHEs would be responsible for referring anyone who came to them with a health problem that required a consultation with a health worker, and were provided with a booklet to keep track of referrals.

Following successful completion of the training, CHEs were provided a basket of health-related items (e.g. soap, petroleum jelly, vitamins, reusable menstrual pads, contraceptives, and lubricants) and

over the counter medicine (including paracetamol, antimalarial tablets, antifungal creams, amoxycillin syrup for children, and clotrimazole). This basket of products was sold to CHEs 'on loan' at a steep discount, such that CHEs could make a profit straight away on any products sold (the market value of the goods in the basket was around UGX 500,000 or about EUR 100, but sold to CHEs for UGX 240,000 or about EUR 48). CHEs did not pay for the basket up-front, but effectively took out a zero-interest loan for the discounted value of the basket. This loan was to be repaid in full within a year, and the CHEs were required to make repayments every month, though no monthly repayment amount was specified. CHEs were able to re-order products on a monthly basis to re-stock their baskets.

Both the loan repayments and basket re-stocking took place at monthly "cluster meetings" hosted by HE at multiple venues in each of the districts. CHEs were expected but not obliged to attend these meetings. These meetings were also an opportunity for CHEs to discuss any issues that might have arisen during the past month with fellow CHEs and HE staff.

CHEs were free to leave the project at any time, in which case their commitment fee would be reimbursed. However, if the CHE failed to make monthly repayments, they would receive a warning letter; if non-payment continued they would eventually be released from the project and the CHE would be required to return their tablet/phone, hat, t-shirt and any unsold products.

HE provided the initial CHE training; managed the ongoing loan repayments, product re-stocking, and referrals; and supported CHEs through monthly "cluster meetings" over the course of 2018-2019. The health curriculum during this training was provided by SRHR Alliance Uganda partners RHU and STF. The additional integrated HIV and SRHR training was provided by FLEP and RAHU. Meanwhile, the CHEs continued their GUSO volunteer activities with whichever SRHR Alliance member they were affiliated with as part of the GUSO programme.

2. METHODOLOGY

2.1 QuIP background

This study was carried out using the Qualitative Impact Protocol (QuIP) evaluation approach[8]. QuIP studies are designed to collect credible evidence on the individual or household-level impacts of an intervention. This information is gathered directly from intended beneficiaries and based on their perceptions of what has changed in their lives over a set period of time and across a series of domains related to the project's theory of change (ToC). This is particularly useful in complex contexts where a variety of factors that are hard to disentangle influence the outcomes of an intervention.

The interview data is collected by a team of local researchers who are fluent in local dialects. They work completely independently of the QuIP analyst and the commissioning organisation. This enables them to be 'blindfolded' to both the identity of the study commissioner and to the theory of change being tested. This is an important aspect of the research approach, as it helps to reduce pro-project and confirmation bias.

The QuIP questionnaire consists in open-ended questions followed up by carefully defined closed questions. Questions are purposefully designed to be broad and open-ended to allow the respondents to speak freely about what they believe to be significant changes in their lives. The questionnaire is consciously designed to increase the potential to uncover unintended intervention outcomes or unexpected stories of change. Researchers are trained to use additional prompting questions to probe

[8] Further background and QuIP resources can be found at: www.bathsdr.org

further and establish what the perceived drivers of these changes are. Closed questions are used at the end of each questionnaire domain to capture overall perceptions of change in that specific area. Answers to these closed questions provide a useful set of snapshots of overall change. It is important to stress that these closed questions are limited in their scope as respondents are only given three choices of answer (better, worse, the same). The open questions provide a more detailed narrative shedding light on often complex and multiple drivers of the changes.

This interview approach, combined with blindfolding, increases the likelihood that field researchers will collect a broad range of information about changes in the community, as interviewers and interviewees are not limited to thinking about one intervention or project activity.

A final section of the questionnaire asks respondents about external organisations or programmes they engage with. Respondents are asked to rank external organisations and to detail their involvement with them. This element of the QuIP provides further information about which organisations and interventions are at work in the community and their relative importance to respondents.

The QuIP's rigorous analysis process involves coding only statements related to *changes* that the individual or focus group participants experienced and reported (i.e. any statements about the status quo are not coded, unless they are deemed significant enough to highlight to the commissioner). The standardised QuIP triple coding system identifies changes, drivers of change, and attribution of changes.

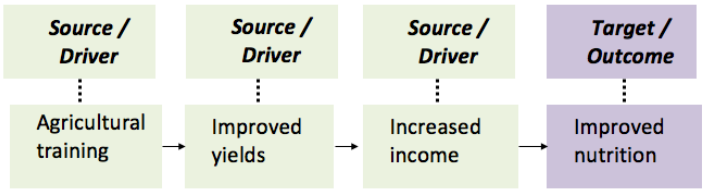
2.2 Understanding QuIP findings

The aim of carrying out a QuIP is to conduct a 'deep dive' assessment with a purposively selected group of people in the project target area to understand whether, and if so how, different aspects or 'domains' of their lives have changed in recent years. QuIP data is *not* intended to be statistically representative of the wider population, and findings cannot be extrapolated across the entire project area. Instead, responses are coded and counted for transparency and to highlight trends in the data. These coded findings remain 'representative' only of the particular population interviewed, but the value in this is that it provides an opportunity to learn from detailed perceptions of change in a carefully selected group. Where quotes are used, this is to help communicate more detail and give examples of the types of stories under discussion. However, the number of quotes used is not representative of any 'majority' or 'minority' view.

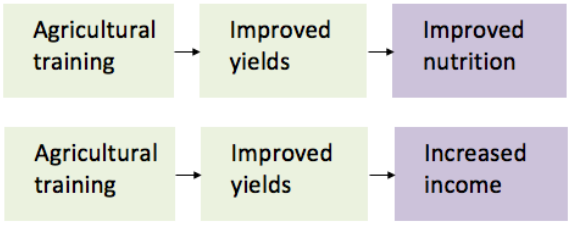
The QuIP approach to analysing data relies on creating and then counting 'thematic codes'. Descriptions of change and drivers of change are unique to each project, and the analyst creates coding tags *inductively* to reflect the content of the data, e.g. 'Increased income'. Coding tags designating drivers of change and the changes they produced are sequenced in a coding spreadsheet according to their order in the narratives provided by respondents. The QuIP coding spreadsheet allows for series of up to four causally linked sequential events – though many respondent narratives contain only two (at a minimum) or three causally connected events.

Whether a coding tag designates a 'driver of change' or an 'outcome' depends on its position in the sequence. Any tag in the first position is by definition a 'driver', while any tag with an empty position following it (i.e. no tag to its right in the sequence) is by definition an 'outcome.' A tag sandwiched between two other tags is both the outcome of the tag to its left in the sequence, and the driver of

the tag to its right in the sequence. In a long sequence the 'ultimate' outcome comes at the very end of a series of causal claims.



Note that different respondents may recount what are similar stories, differently: some stories will not be as detailed or complete as others, and some stories may stop short where others are elaborated on. Note that a similar story – or a story with similar elements – as told by two different respondents can end up producing different sequences:



The analyst uses a separate set of coding tags to denote attribution. These attribution tags are pre-determined rather than being inductively created by the analyst. There are nine pre-defined attribution tags that the analyst applies to the sequences of events they have coded inductively. The attribution tags are defined according to the relationship between the causal claim and the commissioner's intervention. The relationship is considered 'explicit' if the commissioner's intervention (or activities related to the intervention) is mentioned by name, and 'implicit' if the causal claim reflects the commissioner's theory of change. The table below describes the attribution coding tags in more detail:

	Positive code	Negative code	Explanation
Explicit project link	PE	NE	Positive or negative change explicitly attributed to the commissioner's project or project activities or project partners.
Implicit project theory of change link	PI	NI	Change confirming (positive) or refuting (negative) the specific mechanism by which the commissioner's project aimed to achieve impact, but with no explicit reference to the commissioner, the project or named project activities.
Other attributed	PO	NO	Change attributed to other forces not connected to the commissioner
Other not attributed	PN	NN	Change not attributed to any specific cause.

Neutral	O	Responses that were felt to be of interest, not related to change.

Once the whole dataset has been coded (both inductively and with attribution tags), the QuIP analyst can run queries to establish how many times different coding tags have been used in different ways, and the relationships between them.

Figures and tables in this QuIP report use two different types of 'count' in relation to the coding tags:

a) **Respondent Count**: The number of respondents who mention a given tag (driver of change, outcome, or attribution tag) when answering a given question. The maximum respondent count will always be equal to the number of people interviewed, plus the number of FGDs in the study. For example, in a study with 24 individual respondents and four FGDs, a given change can be mentioned a maximum of 24 + 4 = 28 times. (Usually the 'count' is lower than the maximum since not everyone mentions a given change).

b) **Citation Count:** The number of times a tag is mentioned, with a maximum of one count per respondent per domain. This gives an indication of whether a given change is mentioned in more than one life area by the same respondent. For example, does a respondent mention improved health only in their answer to questions in the health domain, or also in other domains such as income and relationships? In a study with 8 domains (and 24 individual respondents + 4 FGDs), the maximum potential number of citations for a given change tag (or driver tag, or attribution tag) is 8 x (24+4) = 224

c) **Note on FGD Counts:** Focus groups are assigned a single 'count', even though there are typically between six and eight participants in a given FGD. In this study there were four FGDs, so the maximum 'respondent count' for the FGDs is four and the maximum 'citation count' for the FGDs is 24 (4 FGDs x 8 domains = 24).

This analysis method allows the rich narrative information gathered from interviews to be coded and displayed in the tables and visualisations contained in this report. This coding process enables the analyst to look for patterns and trends across the dataset, and to understand which stories of change are common across the sample, and which are specific to certain individuals, or to a particular group of respondents.

A note on respondent voice

As respondent voice is central to QuIP's methodology and philosophy, quotations from the narrative accounts are presented throughout this report. Furthermore, the respondent codes presented in the tables, figures, and quotations, allow the reader to trace data back from the charts to the original underlying quotes (available in the accompanying Dashboard file).

Note that QuIP interviews and focus group discussions were carried out in person and in the local language by a local research team. Summary rather than verbatim responses were then translated into English and written up by these same researchers. Any quotations used in the report reflect the wording and English language used by the data collection team. Translations or clarifications are

provided where necessary, but where possible the English has been deliberately left as written by the field researchers, in order to maintain as much transparency as possible.

All the respondent data is anonymised by allocating a code to each respondent and focus group discussion. Any quotation used in the report is tagged with the code of the source of the quote.

Data in the form of audio recordings of interviews and notes taken by the local researchers are stored securely by the research team for a maximum of one year, at which point they are deleted.

2.3 Data collection

In all, 24 individual interviews and four focus group discussions (FGDs) with CHEs were conducted by two local researchers over the course of one week. Each interview lasted between 30 minutes and one hour, while the FGDs took between one-and-a-half and two hours each. The individual interviews were arranged by appointment and were held one-on-one at a location of the respondent's choosing. The FGDs were conducted immediately following HE's monthly district-level cluster meetings in June, held on June 19th in Bukoyo Village in Iganga, and on June 20th and 22nd in Mayuge. The FGDs took place prior to the 24 individual interviews.

2.4 Blindfolding

Double blindfolding of interviewers and respondents, which the QuIP approach endorses as a way to reduce pro-project and confirmation bias, had to be modified for this QuIP. Because the timing and location of the FGDs coincided with the HE cluster meetings, it was impossible to avoid interviewers and respondents making some connection between the research and the respondents' identities as CHEs – and by extension, to avoid assumptions that the research was related in some way to HE, GUSO Flex, GUSO, and/or SRHR Alliance organisations.

The researchers and respondents did remain partially blindfolded, however, as they were not informed of the underlying theory of change being tested nor the specific outcomes of key interest to the commissioner. Moreover, the open-ended nature of the questions and the QuIP approach to interviewing meant that respondents were actively encouraged to think broadly about change and drivers of change, and interviewers were able to probe for a wide range of information not just narratives linked directly to activities as a CHE. The QuIP approach is consciously designed to increase the potential of uncovering unintended outcomes of an intervention and unexpected stories of change.

2.5 Questionnaire and domains

The QuIP questionnaire for this study explored changes in eight areas of CHEs' lives based on the areas of impact targeted by GUSO Flex:

- Health and living conditions
- Education (including training)
- Earning money
- Spending, saving and borrowing money
- Personal relationships
- Community relationships
- Overall wellbeing
- Aspirations for the future

Respondents were also asked to rank any external organisations in these domains which they felt had played an important role in their lives. This provided information on CHEs' perceptions of organisations involved in GUSO Flex, as well as of other organisations GUSO Flex might benefit from knowing about.

The questionnaire was semi-structured and the bulk of the questions in each domain were open-ended. The researchers were trained to probe respondents with follow up questions to establish what they perceived to be the reasons for the changes mentioned.

At the end of each domain, one or two closed questions captured a respondent's *overall* perception regarding change in that area of their life. This allowed respondents to provide their own summary judgement of the direction of change, given that the narratives elicited by the open and probing questions typically included a mixture of positive and negative elements.

2.6 Sampling

QuIP sample selection combines purposive and random approaches. In this study the purposive sampling aimed to capture the potentially differential impact of GUSO Flex based on attributes of CHEs. Through careful consideration with the commissioner, CHE attributes were identified which were likely to enhance commonality or homogeneity of experiences of the project. The attributes used in the purposive sampling phase were: the district where the CHEs operated, their affiliations with GUSO partners, financial performance as a CHE, and gender.

The QuIP was conducted in two of the four districts where GUSO Flex was implemented, and with CHEs affiliated with three of the six SRHR Alliance Uganda partners involved in GUSO Flex. The decision was made to focus the evaluation on CHEs with a background in SRHR, which is why respondents were selected on the basis of affiliation with FLEP, RHU, and STF. The evaluation was conducted in Iganga and Mayuge Districts because this is where most of the CHEs affiliated with the selected SRHR Alliance partners were located. Jinja District was excluded from the body of the study because the launch of GUSO Flex had been delayed there, and the CHEs in Jinja would not have had as much exposure to the project as CHEs in the other districts.

The pool of potential respondents that resulted from this purposive sampling based on partner affiliation and district consisted in CHEs affiliated with STF in Mayuge; and in Iganga, about two thirds were affiliated with RHU and about one third with FLEP.

Finally, the financial performance of CHEs was considered and only CHEs in sound financial standing per May 2019 were included in the sampling pool. Although the commissioner initially wanted to include non-performers in the sample, this would have been at the expense of learning about CHEs for whom the project seemed to be working better. Non-performers would also have been difficult to reach as they most likely would not attend the cluster meetings, which were used as an entry point for data collection.

In summary, *purposive* sampling narrowed the original pool of 767 CHEs across four districts and six GUSO partners, down to 131 CHEs across two districts and three GUSO partners. CHE numbers were then cross tabulated with gender.

Table 1: Purposive sample frame

District	**Female**	**Male**	Total
Iganga	6	10	16
	21	29	50
Mayuge	32	33	65
	59	**72**	**131**

12 male and 12 female respondents were then *randomly* selected from these pre-determined pools, for a final set of 24 respondents, as shown in Table 2. These 24 respondents were assigned alpha-numeric codes to anonymise the data collected; these codes are shown in Table 3.

Table 2: QuIP study sample frame

District	**Female**	**Male**	Total
Iganga	1	2	3
	5	4	9
Mayuge	6	6	12
	12	**12**	**24**

Table 3: Respondent codes

District	**Female**	**Male**	Total
Iganga	ILF-17	ILM-15, ILM-17	3
	IRF-1, IRF-4, IRF-7, IRF-11, IRF-13	IRM-1, IRM-2, IRM-9, IRM-11	9
Mayuge	MSF-2, MSF-4, MSF-5, MSF-10, MSF-11, MSF-16	MSM-4, MSM-7, MSM-8, MSM-10, MSM-16, MSM-17	12
	12	**12**	**24**

Separate focus group discussions were held with male and female respondents in each of the two districts. Each focus group had between six and eight participants. FGD participants were drawn from the CHEs who participated in the June cluster meetings hosted by HE in the respective districts, which were open to CHEs regardless of their GUSO partner affiliation. Hence some FGD participants were not affiliated with the purposively selected organisations FLEP, RHU, and STF.

Table 4: Focus group codes

District	**Female** (# participants)	**Male** (# participants)	Total
Iganga	IGF-2 (6)	IGM-1 (6)	2
Mayuge	MGF-4 (7)	MGM-3 (8)	2
	2	**2**	**4**

2.7 Data analysis

A QuIP analyst thematically coded the narrative data for causal claims. Responses to open-ended questions were analysed for sequences of 'drivers of change' and 'outcomes'. Only statements related to change were coded. Answers to closed questions were collated to provide an overall 'snapshot' of changes by domain.

Once the analyst had inductively identified causal claims, these were then analysed for attribution. Pre-defined attribution codes were used to indicate whether the claim was positive or negative, and whether it was attributable to GUSO Flex. Attribution is considered 'explicit' if the respondent linked the outcome to any of GUSO Flex's activities or partners by name; and 'implicit' if the connection reflected the project's rationale but did not mention the project by name.

3. MAIN FINDINGS

This section explores respondent narratives through the lens of change: what changes did respondents highlight in each domain? What activities or influences did they consider drove these changes? Did they attribute these drivers to any particular organisations or projects – in particular, how did GUSO Flex appear in respondent narratives?

In this report, key findings based on the *individual interviews* are considered separately from those that emerged in the *focus group discussions*. In each section, the following dimensions are considered in turn:

- Changes: understanding the main changes happening in people's lives across domains
- Variations in reported changes by sample characteristics (i.e. by sex and district): Congruent with the sampling strategy, findings were considered through the lenses of respondent sex (did themes reported by males differ substantially from those reported by females?) and district (did Mayuge-based respondents mention or emphasise different things from Iganga-based respondents)?
- Drivers of change: the reported causes of these changes
- Attribution of change: whether changes were attributed to GUSO Flex or to another source
- Causal claims: exploring the ways in which drivers and outcomes are linked in respondent narratives

Finally, findings which were considered 'of interest' in either the individual interviews or FGDs, but which are not directly related to the project's rationale, are considered.

3.1 Individual interviews

Key changes

Comparing *counts* of outcomes by respondent count (i.e. the number of respondents who mentioned the change) and citation count (i.e. mentioned by respondents across different domains) show the findings to be largely congruent.

The top 14 changes by *respondent* count are shown in Figure 3. Topping the list were **improved health outcomes** (mentioned by all 24 individual respondents); **being a role model and respected within the community** (mentioned by 23 out of 24 individual respondents); and **increased income** (mentioned by 22 individual respondents).

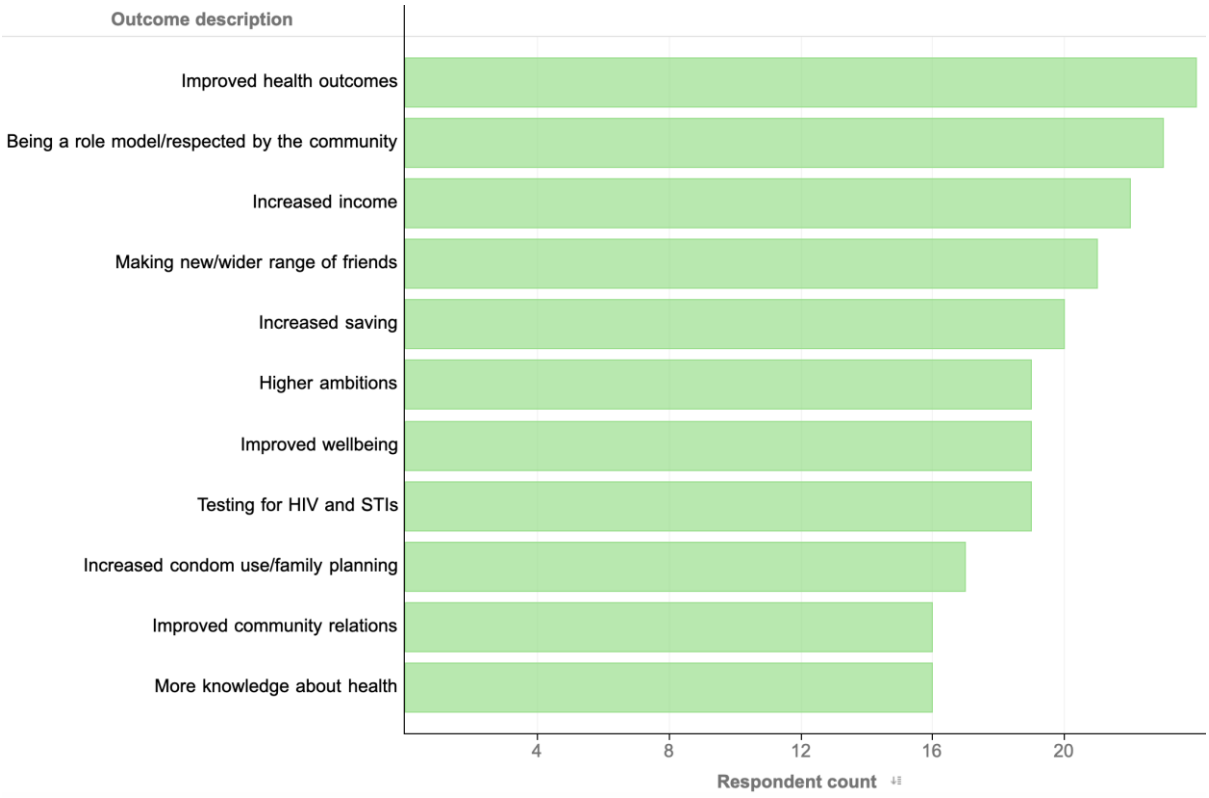


Figure 3: Changes by respondent count

The top 12 changes by *citation* count reflect the three changes mentioned by the greatest numbers of respondents, just in a slightly different order, with the emphasis here on **increased income**. As shown in Figure 4, **increased income** was mentioned 44 times, followed by **improved health outcomes** (mentioned 41 times) and **making a new and wider range of friends** (mentioned 32 times) – closely followed by **being a role model/respected in the community** (mentioned 31 times).

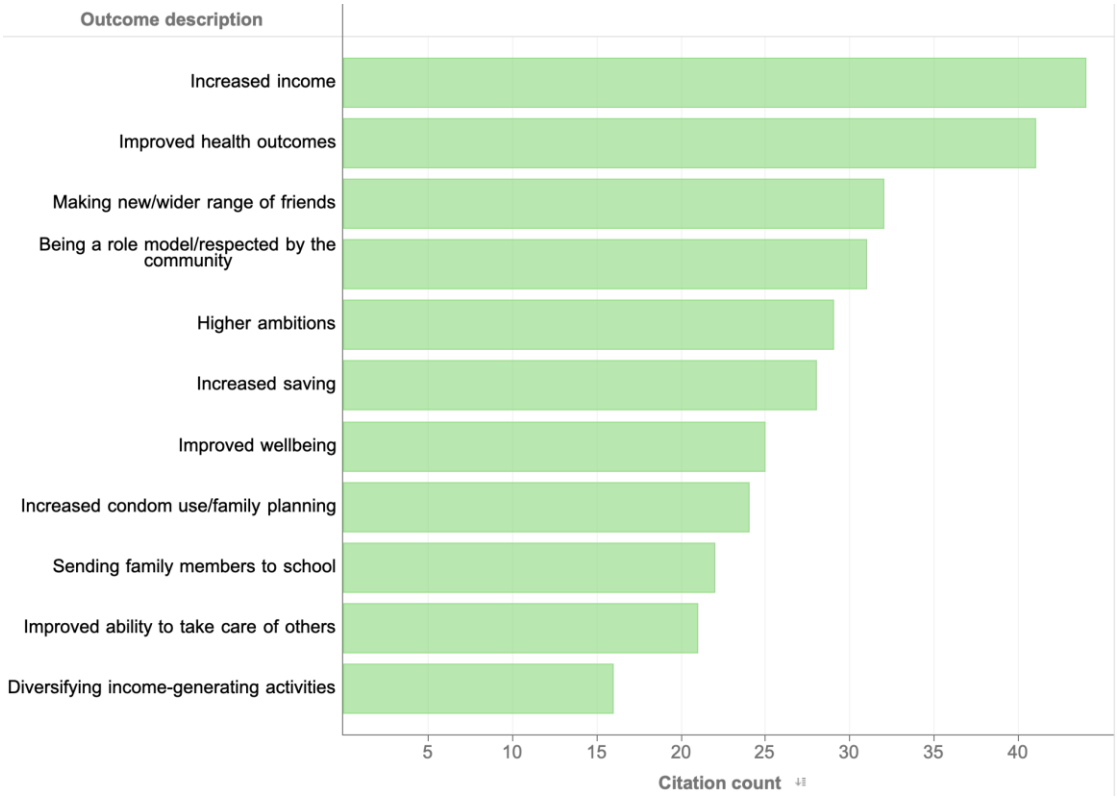


Figure 4: Changes by citation count

Variations by respondent attributes

Variation by district

There was some slight variation between Iganga and Mayuge, the two districts where fieldwork took place. Whilst all respondents across both sites reported improvements in the *Health* domain, ten respondents in Iganga mentioned improved accessibility of healthcare, but just five in Mayuge.

In contrast, in Mayuge there was more emphasis by respondents on positive financial outcomes across the two domains of *Earning Money*, and *Spending, Saving and Borrowing Money*. Similar numbers of respondents in Mayuge mentioned financial stability and independence (eight in Mayuge and six in Iganga) but more respondents in Mayuge mentioned an improved standard of living (ten in Mayuge compared to four in Iganga).

Variations by sex

The data highlights some interesting differences between the outcomes that men and women mentioned. The citation counts reveal women were much more likely than men to mention having **increased income** (29 citations by women, in contrast to 15 citations by men). Whilst both men and women cited **improved health outcomes** in their top 2 changes, there was an interesting difference in the types of services that they valued. Women were much more likely to report **increased condom and family planning usage** (15 mentions compared to 9 by men); whereas men were much more likely to mention increased **HIV and STI testing** (16 times compared to 10 for women).

The outcomes mentioned most frequently by women were:

- Increased income (29 citations)

- Improved health outcomes (16)
- Increased condom/family planning use (15)
- Increased saving (15)
- Improved wellbeing (14)

The outcomes mentioned most frequently by men were:

- Improved health outcomes (25 citations)
- Making a new and wider range of friends (20)
- Being a role model/respected by the community (18)
- Higher ambitions (18)
- Testing for HIV and STIs (16)
- Increased income (15)

Disaggregating these outcomes by sex shows that men possibly place a higher value on the social status and networks associated with working as a CHE. Indeed, men mentioned the outcome of **improved access to opportunities and networks for personal development** much more frequently than women (seven times compared to one mention by women). In comparison, as noted above, women prioritised the financial benefits associated with this role. **Investing in business** however was mentioned with equal frequency by both women and men (five citations each).

Another difference was that double or more the number of women as men reported **improved nutrition** and **increased physical activity** as a positive change (13 women compared to four men, and eight compared to four, respectively). Women also were more likely to report **improvements to their romantic relationships** in the past year than men: there were nine citations by female respondents compared to three by men.

Drivers of change

Analysis of the changes described in the previous section revealed that they were linked to certain key drivers of change strongly association overall to GUSO Flex. The top two drivers of change were **working as a CHE** and **receiving training or sensitisation**, which were both mentioned by all 24 individual respondents. Working as a CHE was cited 181 times (i.e. by every respondent in almost each domain), and receiving training or sensitisation 116 times. While working as a CHE can be explicitly attributed to GUSO Flex, not enough detail was provided about the content of 'training and sensitisation' to make attribution of this driver explicit. Training and sensitisation, while aligning with the theory of change of GUSO Flex, might have been delivered as part of GUSO Flex, or by another GUSO partner, or by another organisation entirely.

Figure 5 shows the top drivers of change by respondent count. It shows the top ten drivers across the data. The three drivers following the top two were **Improved accessibility of services and products and medication**; **increased income;** and **having higher ambitions**. These were all identified by the vast majority of respondents as significant drivers of change in their lives (mentioned by 23, 23, and 22 respondents respectively).

Note that **increased income** appears here as a driver of change, but also in the previous section on outcomes. This indicates that it was mentioned at various points in respondent narratives, sometimes as the result of some other event or change, and sometimes as the driver of further change. For example, many respondents mentioned increased income as a result of working as a CHE, income which then enabled them to pay for family members to go to school.

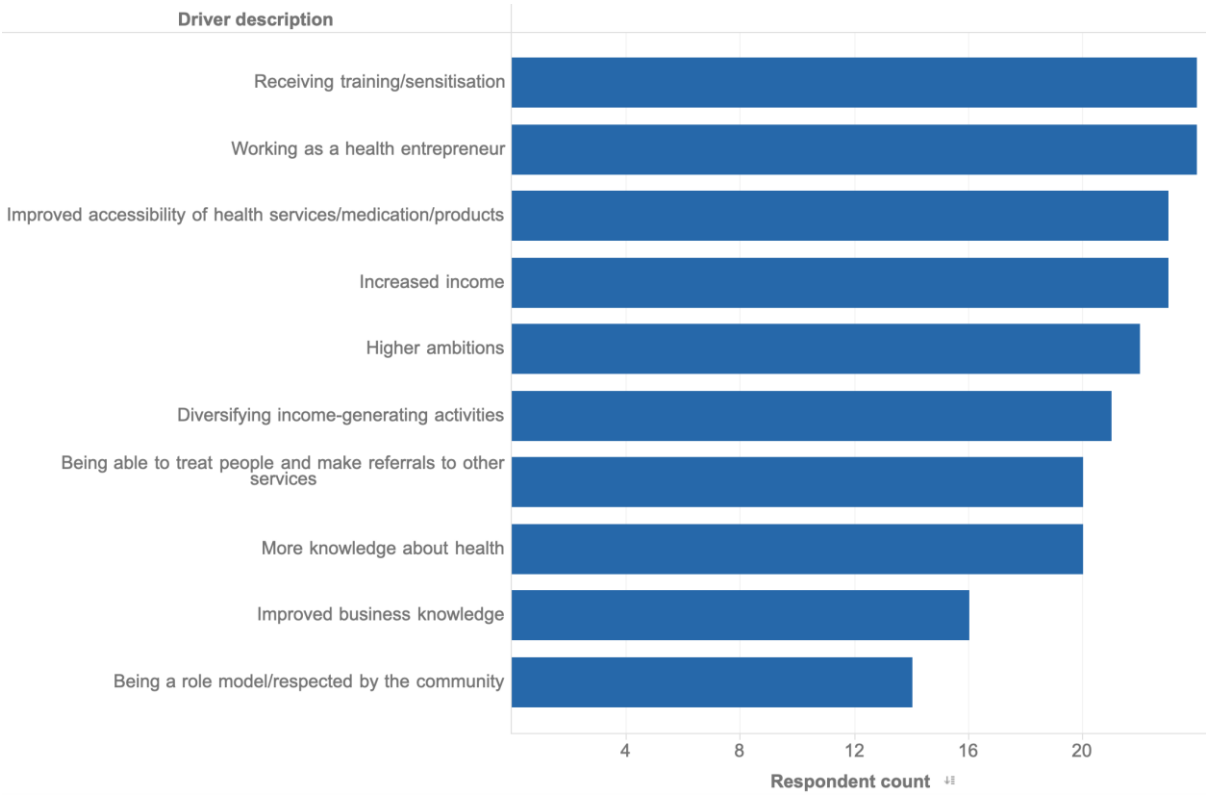


Figure 5: Drivers of change by respondent count

Drivers of change by domain

Table 6 shows the top drivers of change by respondent count, across each domain of the interview. It indicates the huge positive impact that working as a CHE has had on the lives of respondents over the last year, especially in the domains of health and living conditions; earning money; and social dynamics such as personal relationships, community relationships and overall wellbeing.

Health and living conditions	**Education**
• Working as a CHE (2) • Receiving training/sensitisation (21) • Improved accessibility of health services, medication and information (18) • More knowledge about health (11)	• Receiving training/sensitisation (21) • Having higher ambitions (14) • Working as a CHE (9) • Access to opportunities and networks for personal development (5)

Earning money • Working as a CHE (23) • Diversifying income-generating activities (17) • Increased income (12) • Improved business knowledge (9)	**Spending, saving and borrowing money** • Increased income (21) • Working as a CHE (22) • Diversifying income-generating activities (17) • Improved business knowledge (8)
Personal relationships • Working as a CHE (24) • Receiving training/sensitisation (21) • More knowledge about health (13) • Being able to treat people and make referrals to other services (10)	**Community relationships** • Working as a CHE (24) • Being able to treat people and make referrals to other services (17) • More communication about health within communities (11) • Being a role model/respected by the community (10)
Overall wellbeing • Working as a CHE (10) • Increased income (10) • Receiving training/sensitisation (8) • Improved accessibility of health services, medication and information (4)	**Aspirations for the future** • Having higher ambitions (17) • Working as a CHE (16) • Receiving training/sensitisation (18) • Access to opportunities and networks for personal development (6)

Table 6: Drivers of change by domain

In the domain of *Earning money*, respondents spoke in positive terms both of diversifying their earnings stream (they could earn more money because they had more jobs), but also of reducing the number of jobs they held (because working as a CHE earned them more money, they were able to dispense with lower-paying jobs). For example, twelve respondents mentioned reducing or stopping other forms of income-generating activities, of which four specified that this was because they made more money from selling health products. These respondents had previously been a teacher, a porter, and a bricklayer, and another had plaited hair for a living.

While discussing *Community relationships*, the status accorded to CHEs was a significant positive outcome for respondents, many of whom described how previously in the community they were not respected or known.

Professional or educational opportunities, and access to networks for development that being a CHE enabled, was linked to increased ambition in the domain *Aspirations for the future*. Many CHEs were eager to make sure future generations of family members would attend school. Where respondents did not feel they themselves could return to full-time education, this was in part be due to social norms which make it more difficult for adults with children or younger siblings to stop working. Nonetheless, respondents were positive about the opportunities for training they had experienced in the past year and mentioned wanting more training in future in order to expand their knowledge and the services they could offer to their communities.

Attribution of changes

This section focuses on whether the changes noted above can be attributed explicitly or implicitly to GUSO Flex, or to other sources. Figure 6 summarises the attribution of changes across domains, and shows that across all domains, the project is both explicitly and implicitly linked to positive change by the vast majority of the respondents.

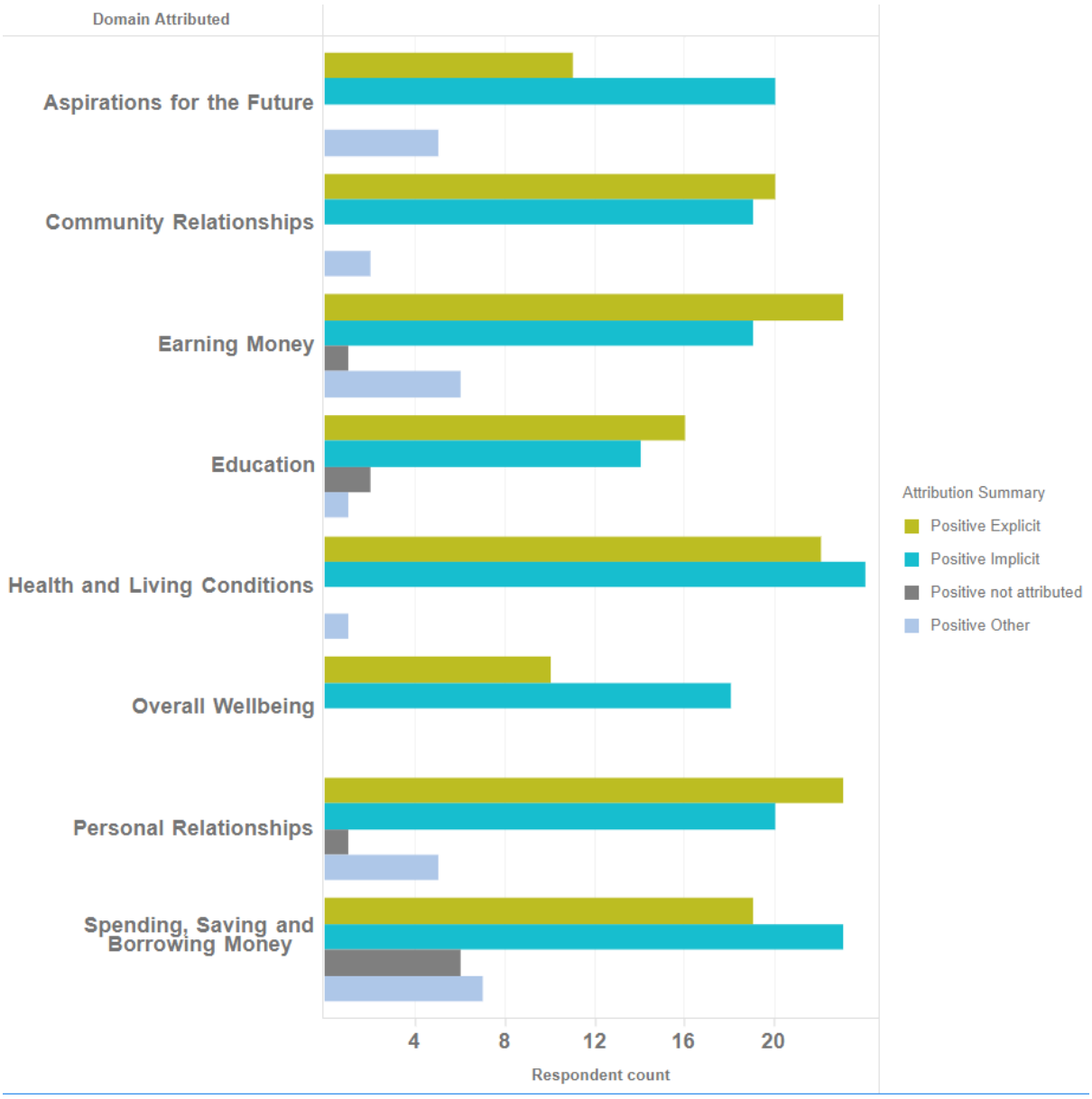


Figure 6: Attribution of changes by domain, by respondent count

Changes attributed to GUSO Flex

Figure 7 shows the top 15 changes that were explicitly attributed to GUSO Flex (by citation count). The top four explicitly attributed changes were **increased income** (cited 30 times), **making a new/wider range of friends** (cited 24 times), **being a role model and respected by the community** (cited 21

times), and **improved health outcomes** (cited 20 times). Some examples of these positive outcomes from respondents are quoted below:

MSF-11: 'I work as a health worker. Previously I had low income but now I took up health entrepreneurship I have stopped receiving money from other people. The reason for the change is that I am involved in Health Entrepreneurship.'

IGM-1: 'Now the community listen to me because I am a health worker.'

MSM-8: 'I have many different friends in the community irrespective of the gender because of all my clients that I provide health products to.'

A number of quite specific health-related changes were attributed to the project, including **testing for HIV and STIs** and **increased family planning and condom use** (cited 18 and 16 times respectively).

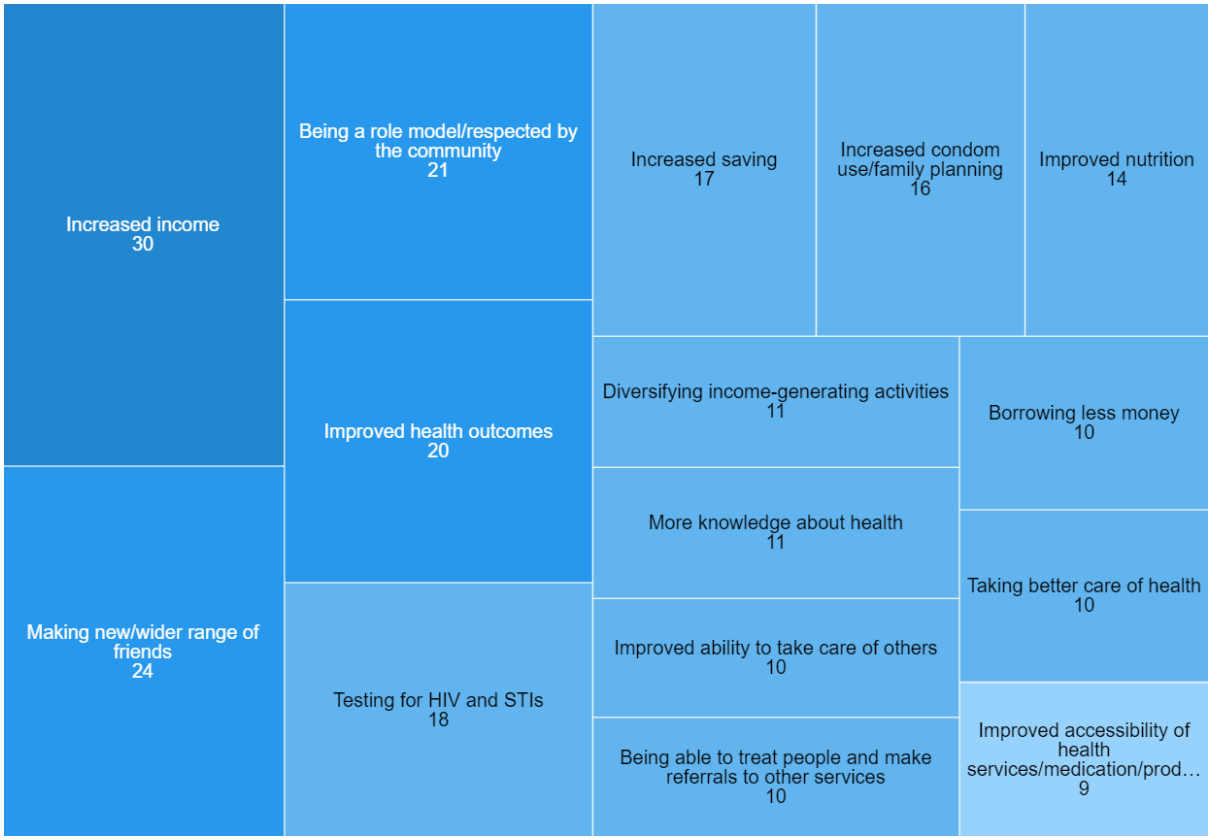


Figure 7: Changes explicitly attributed to GUSO Flex, by citation count

Causal claims

This section looks at the links between the drivers reported by respondents and the changes that were most widely reported. Of all the top drivers discussed above, **working as a CHE** was most frequently linked to **increased income**, mentioned 71 times. The second most frequently cited change linked to

working as a CHE was **improved accessibility of health services, medicines and products,** mentioned 47 times.

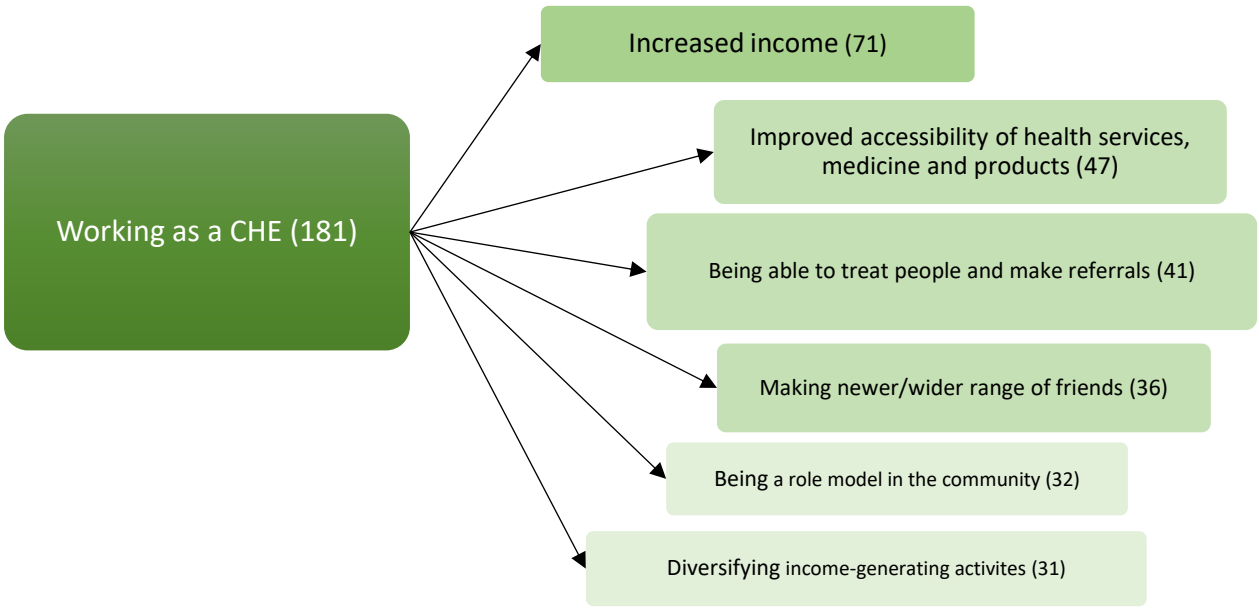


Figure 8: Changes directly linked to 'Working as a CHE' by citation count

The chain does not stop here however: **improved accessibility**, for example, had a variety of other consequences, creating a causal chain starting with working as a CHE and spreading out into numerous further positive outcomes. These can be seen in Figure 9, which shows how **improved accessibility of healthcare, products and services** leads to **improved health outcomes**, **increased condom and family planning use**, and other outcomes.

Interestingly, it also leads to reduced spending. A number of respondents mentioned that because they have health products in the home, they did not need to spend money when relatives or they themselves became unwell. This is illustrated in the following quotations:

IRM-2 (E1): 'I also spend less on health care because I get drugs at a very cheap price from Healthy Entrepreneurs.'

IGF-2 (E1) 'Sanitary pads have done great things for me, because every month I was spending over 2000 on pads, but now I no longer spend any money on buying pads because I have them at home.'

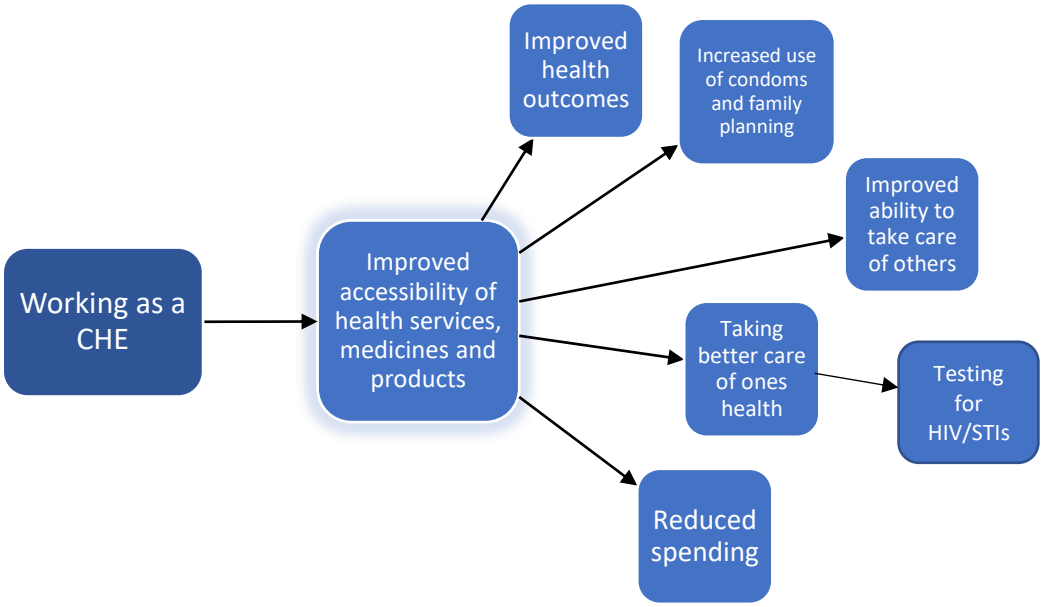


Figure 9: Effects of 'Working as a CHE' via 'Improved accessibility of health services medicines and products'

Receiving training or sensitisation was also linked to a broad range of changes. The top changes by citation count associated with receiving training or sensitisation are shown in Figure 10.

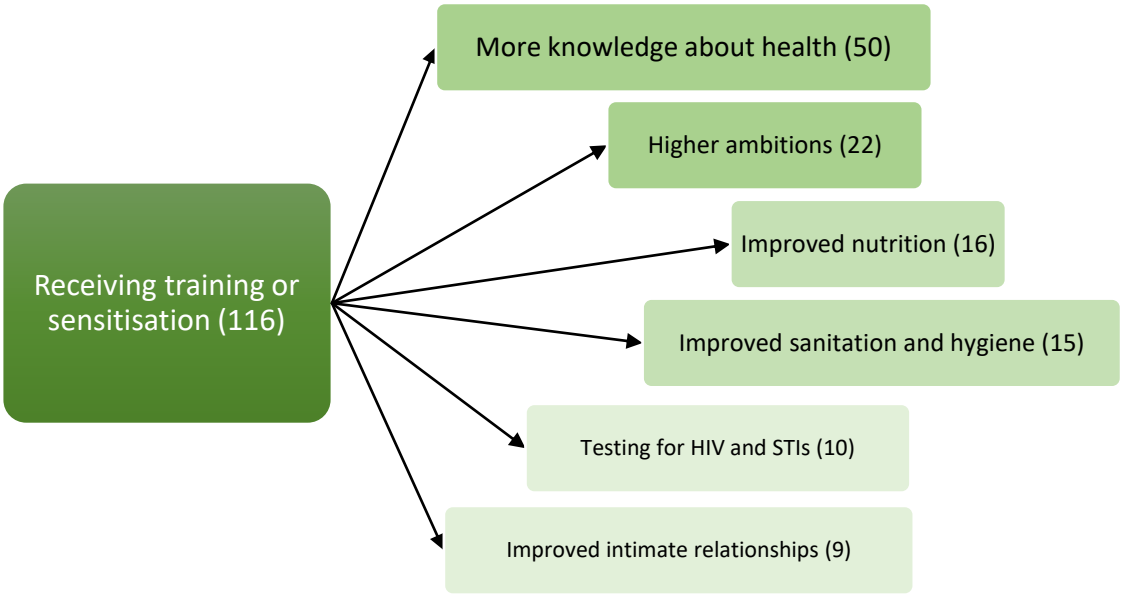


Figure 10: Changes directly linked to 'Receiving training or sensitisation' by citation count

The top change here, cited 50 times, is having **more knowledge about health**. This in turn was associated with a number of further changes, as shown by the casual chain below. **Receiving training**

and sensitisation is a major driver in respondents having more knowledge about health, as is working as a CHE. Having more knowledge about health enables respondents to **take better care of their health** which together lead to **improved health outcomes**; it also leads to **less spending on healthcare**. This is shown in the causal chain diagram in Figure 11.

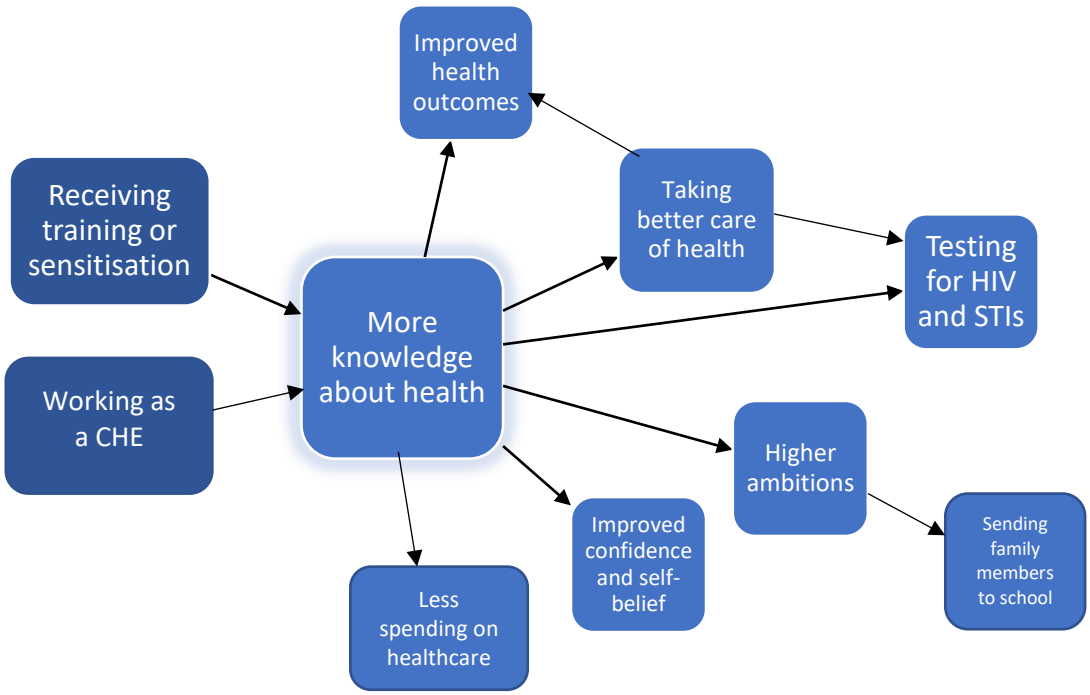


Figure 11: Effects of 'Working as a CHE' and 'Receiving training or sensitisation' via 'More knowledge about health'

The relationship between more **knowledge about health, working as a CHE**, and **improved access to healthcare** is illustrated in the quotations below:

MSF-2: 'I can access the medicine in time when I want it since Healthy Entrepreneurs brings us First Aid medicines. Now for diseases like malaria which is a problem for us in the village we have medicine which we buy from Healthy Entrepreneurs. When you go to the health facility you sit in a long waiting line, but here you know you have the RDT and Coartem in the house, and your neighbours can come and test with you. Even you and your children can test for malaria there and then without going to the health facility.'

MGM-3: 'I no longer spend a lot of money on buying drugs for my children and myself because I now can manage simple diseases like fever and malaria. This has really saved me from spending on health.'

Another change flowing from having **more knowledge about health**, is that some CHEs started to develop **higher ambitions**. This was in part due to realising how useful further knowledge can be for improving one's life in various ways, as illustrated by the quotes below:

IGF-2 (C1) 'I see that schooling is very important. Most people where I live think that I am still going to school, because they see me with the health products. They ask me 'where are you studying' and I tell them that I am at some nearby campus, even though I don't go to school. I see that schooling is very important and when I get an opportunity, I feel that I need to go back and study.'

MGF-4 (H2) 'One of the things that has improved my wellbeing is being close to the health workers and being seen in my community as a health worker. This has changed the way I view the world because I feel I should be exemplary to others in the community.'

MSF-10 (C1) 'I have put my sibling into school and my child is in primary one. My ideas have changed because I have realised when you are not educated, you can't reason like a person who has been at school.'

However, as the last respondent indicates, **higher ambitions** did not necessarily lead to CHEs going back to school themselves, but it did lead to their helping to **send their own children or young relatives to school**. CHEs often felt that going back to school themselves was not an option for them personally:

IRM-2 (I1) 'I have aspired to educate my children up to higher levels because as their father I have missed a lot of opportunities over the past years because I did not attain enough education. So, when I see people like you and other people that I have met within this period of a year I admire you, but it is now late for me to go back to school. So I aspire to take my children to school.'

MGM-3 (C1) 'I have a new attitude towards going to school and I would love to go to school, it's only that I now have a family and cannot go. In many places that I go to, they ask me for the level of education, so that makes me feel the great value of education. So I pay school fees for my children and other sisters.'

IRF-11 (C3) 'I have now seen the value of education and I want to educate my children up to a higher level than I have attained.'

IGF-2 (C1) 'There are some of my uncle's children who were not in school, but after obtaining training by Healthy Entrepreneurs, I went and talked to them and showed them the advantages of education. So, because they were not so clever, I encouraged them to join skills training instead. One of them is undergoing a tailoring course, another one is in hairdressing training.'

One of the top positive drivers of change cited was **increased income**. Increased income was linked by respondents to various other outcomes that remain significant to the GUSO Flex theory of change and objectives. Figure 12 shows the link between increased income and a number of positive outcomes.

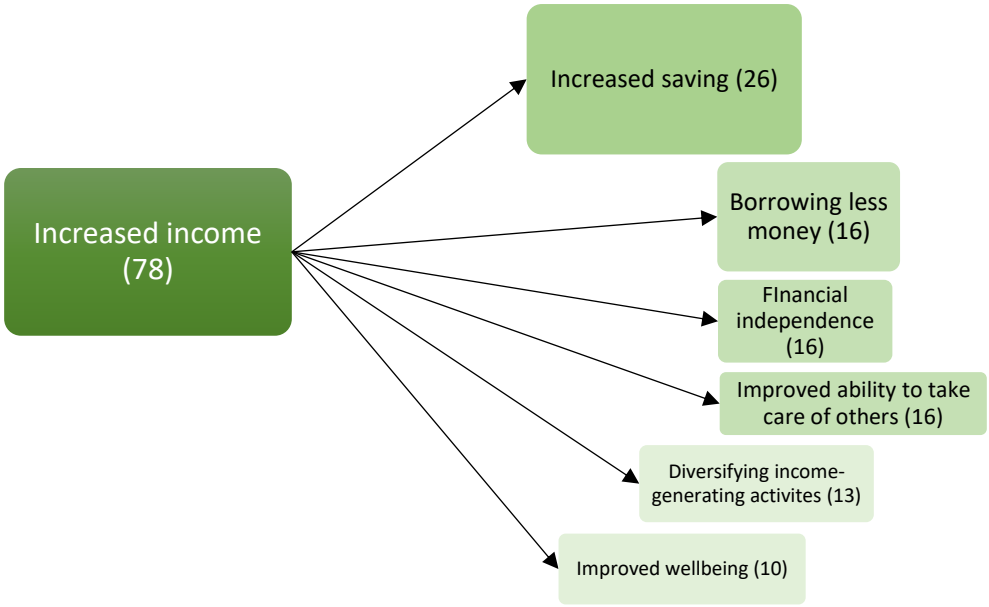


Figure 12: Changes directly linked to 'Increased income' by citation count

Increased income was both a driver of change *and* a top positive outcome, as discussed earlier. The top drivers which fed into increased income as an outcome are shown below in Figure 13. The direction of the arrows indicates the ways in which respondents described some of these drivers and outcomes feeding into each other, as illustrated by these quotes:

IGF-2: (E1) 'I have earned from those products. I normally buy porridge and sell it and earn some profits. I normally buy it at 2500 and go and sell it at 4000. So, I earn some profits and out of those profits I bought a pig and now I plan to buy a male pig.'

MSF-11: (E6) 'My earnings have increased because now I am able to reinvest my profits from health products in my other business.'

MSF-2: (E9) 'The choice I make is to run my businesses as I want and now my choices are expanded because I can access a loan because of my involvement in Health Entrepreneurship.'

In both of the financial domains (*Earning Money;* and *Saving, Spending and Borrowing Money*), **diversification of income generating activities** was mentioned by 17 out of 24 individual respondents. Diversification of income was driven by several factors and forms part of the causal diagram shown in Figure 13. Income source diversification is triggered by **increased income** (which enables investment in other businesses) but also feeds back into increased income because of the dividends that it pays. The same cycle is true for **increased saving.**

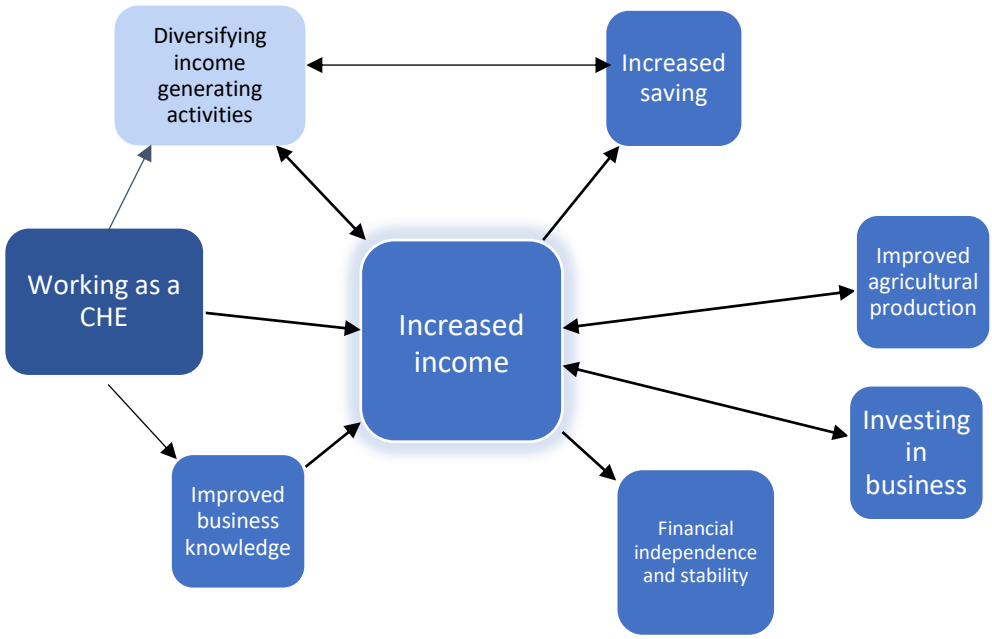


Figure 13: Changes linked to 'Diversifying income-generating activities' in relation to other top drivers and changes

Working as a CHE is directly linked to **diversifying income-generating activities** because it offers an alternative form of work that can fit around other work people do:

MSM-4 (D1) 'I now earn from at least three sources and this is because I was trained by Healthy Entrepreneurs on how to diversify business to improve my earnings. So, I now earn from a retail shop, mobile money and agriculture.'

MGF-4 (D1) 'In the past I never used to make this money until I joined Health Entrepreneurship. Now I can move in the community selling products and make some money. On average I get 40000/= of which I can use some of it to pay my product loan then some of it I can buy more products and maybe buy a chicken. During this year the chickens I bought have hatched more chickens so I hope I will have more than what I started with. I believe I will buy a goat in future. I will no longer find it a challenge to pay my loan for the products, so my money is able to make more profits and I will have some money all the time and will be able to pay for basic things like sugar, salt and other things.'

A widely reported change related to working as a CHE was **making new/wider range of friends** within the community, as shown in Figure 14. This is a notable outcome given the objective of GUSO Flex to expand access to healthcare for both young people and the community at large. **Making a wider range of friends** was cited as an outcome of being a CHE 37 times. This was sometimes mentioned as a direct outcome of working as a CHE, and sometimes later on in a causal chain with interim steps including **being able to make referrals and treat people**, and **being a role model**. This last *driver* was also simultaneously cited as an *outcome* of **making a wider range of friends**. **Engaging with youth** was also cited as an outcome that flowed from **working as a CHE** via other intermediary steps.

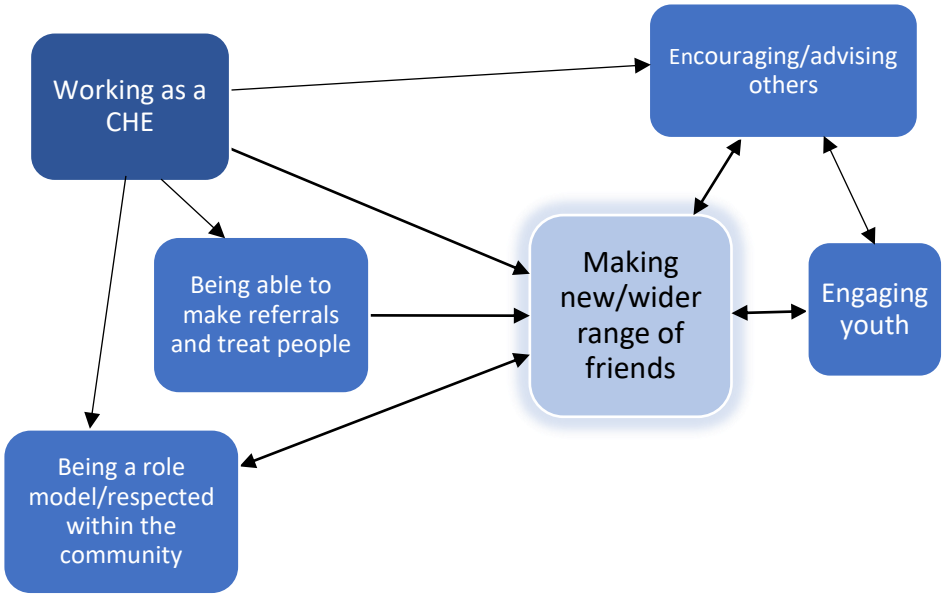


Figure 14: Changes linked to 'Making a new and wider range of friends'

IGF-2 (F1) 'If my fellow youth come in need of them (condoms), I can give them condoms in secret. It is easy to access them because if they have come here, they just have to inform me and I give them.'

IRM-7 (F1) 'My friends are mostly the youths aged 10-25 years of age. This is because I have what they want and they come to me for youth friendly services like condoms and we tell them about issues like reducing gender-based violence. I also have different friends with different ages, educational levels, gender and other things. These come to consult me about their health issues and some come for advice about how to solve gender-based violence among themselves. Overall I now have many more friends than before.'

MSM-8 (F1) 'I have gained so many friends within the past one year, especially other youths, because I educate them about health and provide condoms to them.'

3.2. Focus group discussions

The QuIP methodology uses FGDs to triangulate findings from the interviews with individual respondents. The same open questions are used but the closed questions are omitted. The data generated by enlarging the sample size in this way makes it possible to see where the same issues emerge as in individual interviews.

For this study, FGDs were organised by sex of respondent, in order to allow freer discussion of topics such as romantic relationships and HIV status which might be difficult to discuss with members of the opposite sex present. The FGDs were held to coincide with the June cluster meetings organised by HE, so as to facilitate access to a large number of CHEs at the same time. In Iganga, the male-only FGD was held in Bukoyo village; and in Mayuge it was held in in Busakira village. The female-only FGDs were held in Bukoyo village, under a tree, and in Mayuge Health Centre 3 Mission Facility.

The focus groups generated data which largely corroborated the findings from interviews with individuals, but further emphasized particular issues. The subsequent sections explore the key outcomes and drivers identified by FGD participants, and draw some comparisons between this data and that generated by the individual interviews.

Key changes

Figure 15 shows the ten changes most frequently cited in the focus groups. To compare these to the changes most frequently cited in the individual interviews, refer to Figure 4 above. What can be seen is that **being a role model** and **being a role model/respected by the community** was mentioned frequently both in FGDs and by individual respondents, as was **increased income.**

Increased condom use and family planning was mentioned far more frequently in the FGDs than in individual interviews. For individual respondents condom use and family planning was the sixth most cited change, but in the FGDs it was top of the list along with the two other key changes. There were no significant differences between the changes that were most frequently mentioned by men and by women in the context of the FGDs.

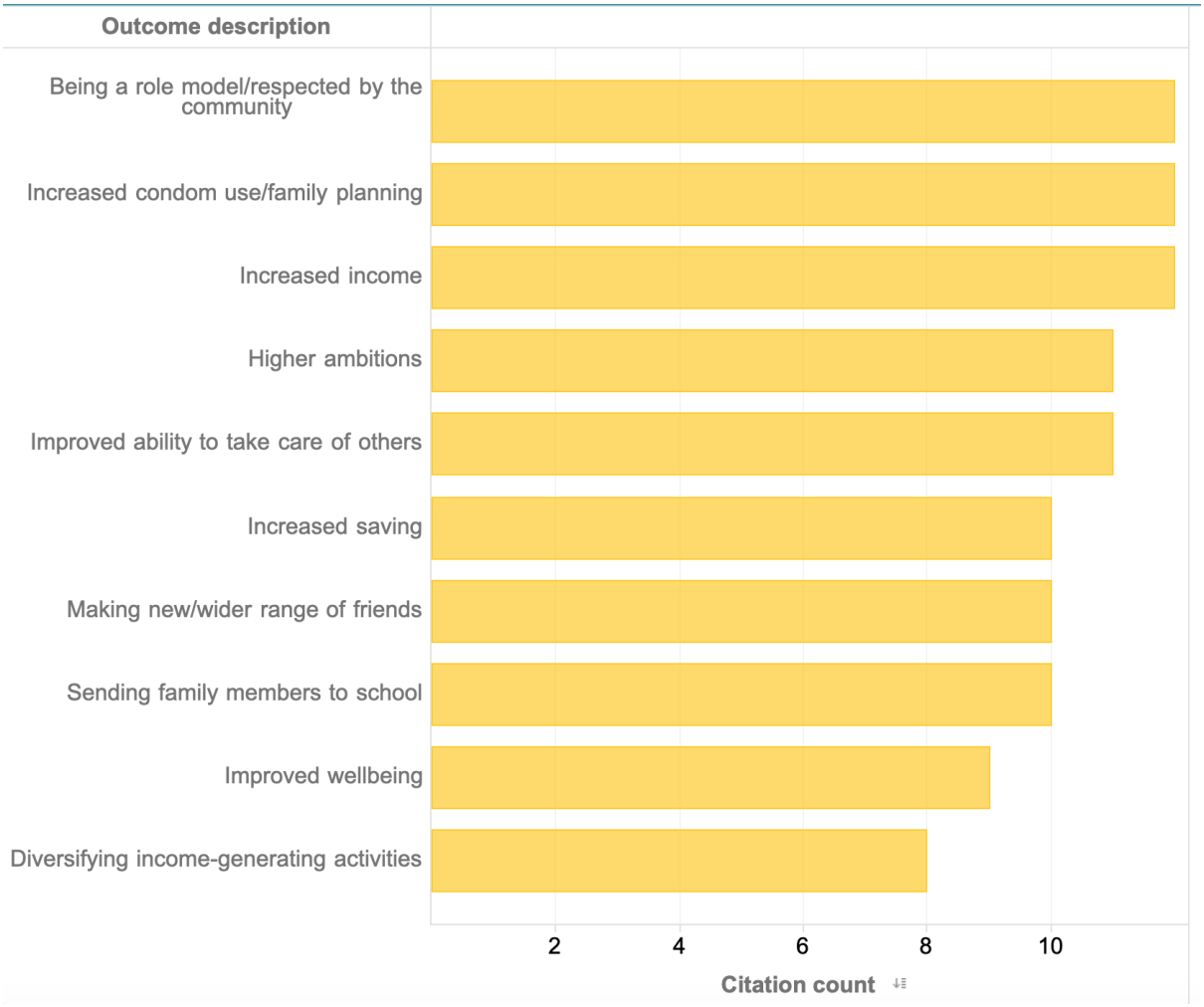


Figure 15: Changes mentioned in FGDs by citation count

The below quote is from the women's FGD in Iganga. It illustrates how increased condom and family planning use spread in this community:

IGF-2: 'What changed is that people have understood family planning and not producing children whom you cannot afford. In case of any kind of problem like famine, that's when they can know that having many children, they cannot afford them. People they understand that, ''let me go to this health care provider". So, I gained some trust by some women who are there. They come and explain to you their problems and whatever concerns their lives as a family and they ask, "what kind of family planning method can we use?" So, I give them some advice.'

Drivers of change

The top ten drivers of change by citation count that were identified in the FGDs (as shown in Figure 16) were the same as those identified in the individual interviews. The top drivers of change were **working as a CHE** (30 citations), **receiving training/sensitisation** (14 citations) and **increased income** (15 citations). This is consistent with the findings from the individual interviews, where these were also the top three drivers, although increased income was cited less frequently by individuals than training.

However, the disparity in the number of men and women mentioning **increased confidence and self-belief** as a driver is notable: it was mentioned 9 times by women, and only 2 times by men in the FGDs. Quotations from the women-only FGDs illustrate the importance of self-confidence to them:

IGF-2 I3: For me what has changed my views is the self-esteem that I gained. I believe I can be a leader now in my own community. I didn't think I could stand before the community before.'

MGF-4 I1: 'We are prepared for any challenge. Even before a brick is considered to be a brick, it has to first be burnt. So, we are prepared to face challenges to be what we want to be.'

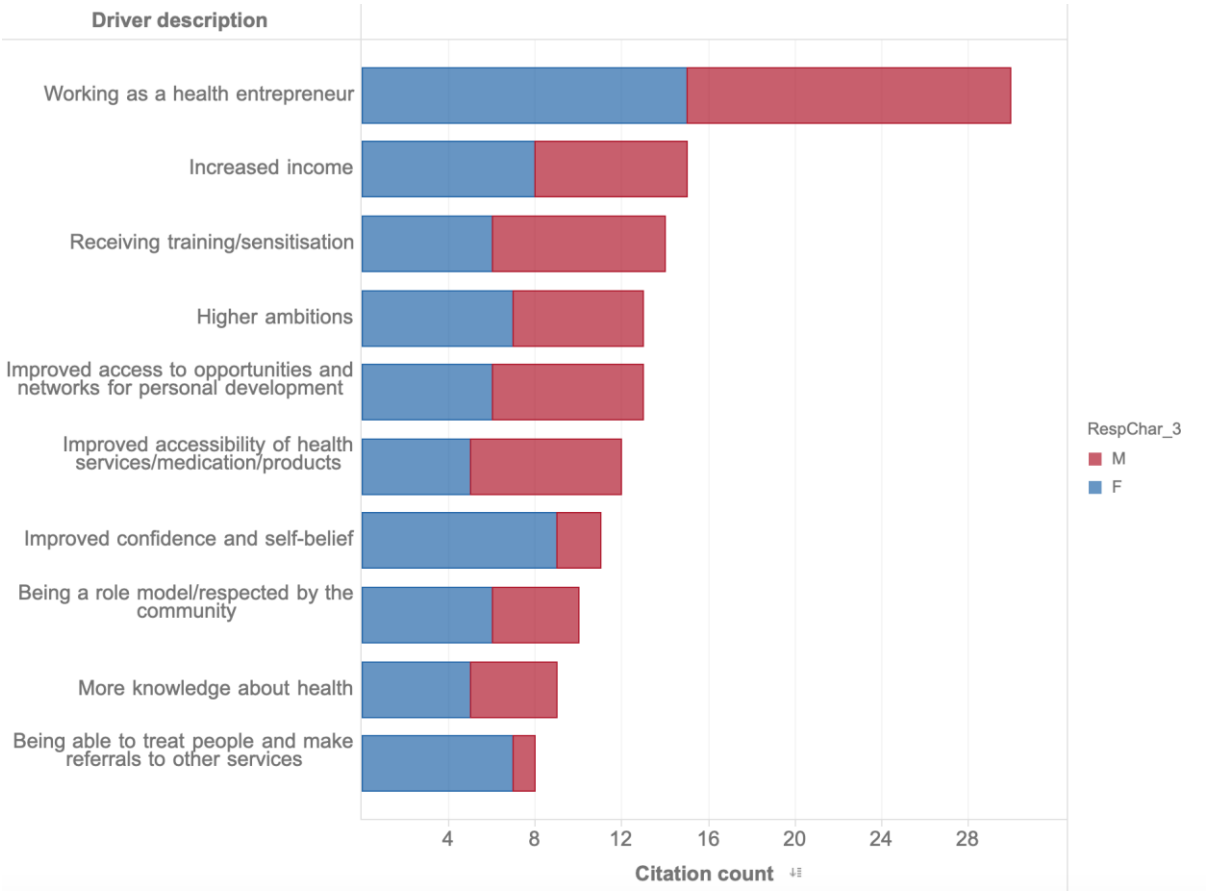


Figure 16: Drivers of change by sex by citation count (red=male FGDs, blue=female FGDs)

Causal claims

This emphasis by women on **improved confidence and self-belief** in the FGDs is interesting to explore further because of its pertinence to the objectives of GUSO Flex. This driver was associated with a number of positive changes by female FGD respondents, including a wider range of friends, higher ambitions and improved wellbeing, as shown in Figure 17. These positive social consequences flowed from female CHEs going out to speak to new people and widening their range of connections in the community.

Improved confidence and self-belief was also mentioned as an outcome, with the main drivers leading to it being **working as a CHE** and having **more knowledge about health**. These connections are illustrated in the causal diagram below:

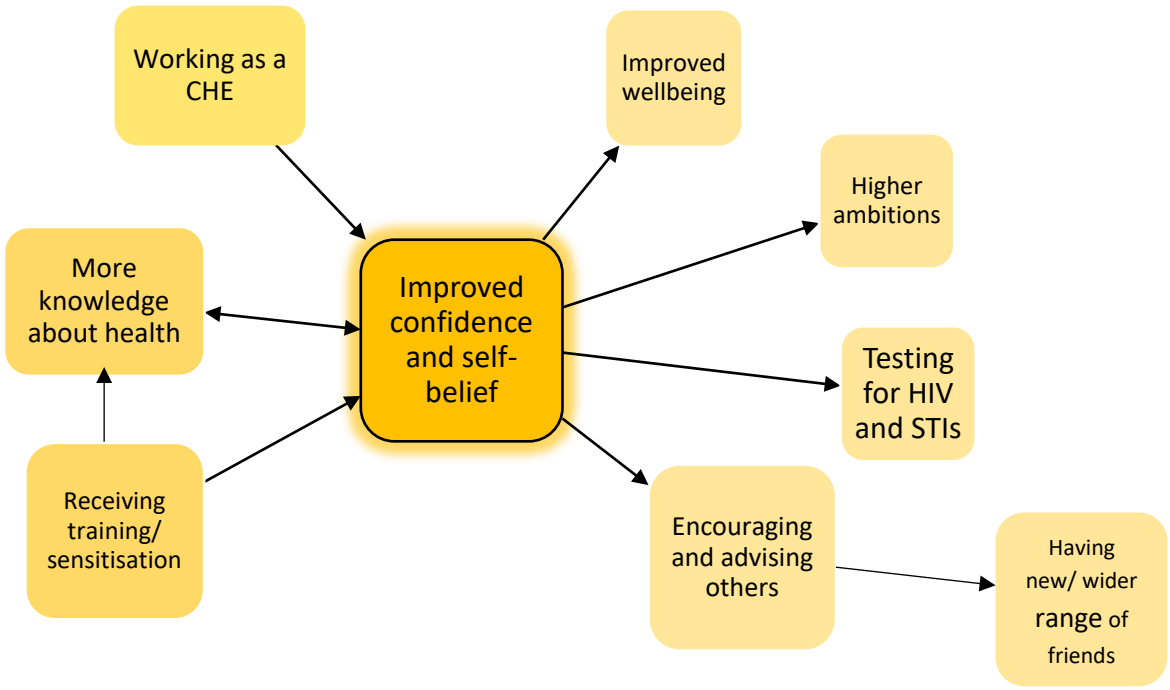


Figure 17: Changes linked to 'Improved confidence and self-belief'

IGF-2 B1: 'They took away my boredom. For example during this vacation, I could sit at home lacking anything to do - but now that I have these products, I can walk around and visit my friends and explain to them about the products.'

IGF-2 G1: 'During the week I make follow-up visits to patients and mothers who are pregnant, telling them the importance of going to the health facility. Why is it that am concerned about women who are pregnant? When I found out my own HIV status, and discovered that am HIV positive, I gave birth to a girl who is right now in primary three. I also have twins which are HIV negative. I feel so good when a mother has told me about her status, and when she is pregnant, I make sure that I come with a gift for the baby who is negative. I relate so much to those mothers.'

3.3. Summary of key changes

Individual and FGD respondents alike reported a number of positive changes in their lives over the past year, from improved intimate relationships and increased self-confidence, to increased financial stability and diversification of income generating activities. The positive outcomes that were mentioned with the most frequency across domains were improved health outcomes, increased income, and higher ambitions; the positive outcomes mentioned by the most respondents were increased income, improved health outcomes and being a role model in the community.

Whilst **improved health outcomes** is one of the top outcomes by both citation count and respondent count that is attributed explicitly to GUSO Flex. However, explicit attribution is not is not as high for it as for some of the other positive outcomes. The reason for this is that often the links to improved health outcomes were 'training and sensitisation', which was not always explicitly linked with being a

CHE. If implicit links are counted as well, the project can be seen as playing a significant role across these outcomes too.

The outcomes most frequently attributed explicitly to GUSO Flex were increased income, a broadening of connections in the community and increased social status and respectability. This indicates the high regard that the communities where CHEs are active have for the project and its activities.

The major positive stories of change emerging from respondents are:

1) Working as a CHE was frequently reported as improving both community and personal access to healthcare products and services.
2) The income generation associated with being a CHE has a variety of positive knock-on financial effects, including increased savings behaviours, reduced spending on healthcare, income diversification and investment in business.
3) The training and sensitisation received by those working as CHEs led them to having better nutrition, sanitation, use of family planning and other sexual and reproductive health services like HIV testing, and better health outcomes.
4) The social opportunities associated with being a CHE, such as improved respectability and access to networks of educated people, has improved respondents' wellbeing in the here and now and encouraged them to raise their aspirations for the future.
5) CHEs engage with their communities across gender and age lines, meaning that access to healthcare, products and referrals is being expanded.

3.4. Challenges

Respondents reported a number of challenging dynamics which may be of interest to GUSO Flex. Even though they were not mentioned often or by very many people, they might signal areas for further exploration. This section draws attention to certain challenges facing CHEs by illuminating the CHE context and how it may affect CHEs' experiences of GUSO Flex.

Changes which fall into this category and were mentioned enough to merit looking at in more depth were **increased spending** (mentioned by 11 respondents); earning **inadequate income** (mentioned by seven respondents) and **being unable to afford something** (mentioned by five respondents). These are shown in Figure 18:

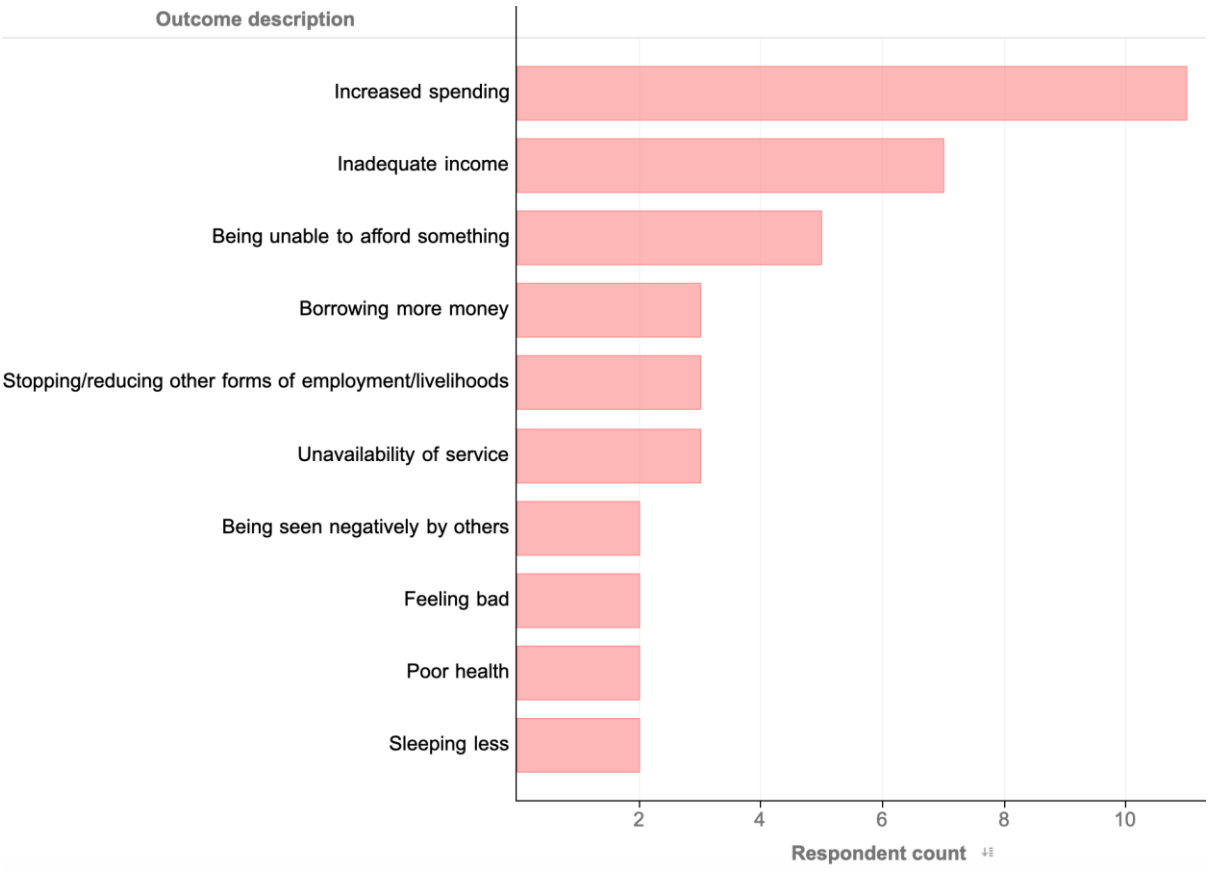


Figure 18: Challenges by respondent count

Variations across respondent attributes

While the differences are very small, respondents from Iganga were more likely to mention challenges than those in Mayuge. Iganga respondents mentioned inadequate income eight times compared to only three citations in Mayuge; and being seen negatively by others in the community twice compared to no citations in Mayuge. There was very little difference between men and women's reporting of these types of change, except that all those who reported stopping or reducing alternative livelihoods and employment were women living in Mayuge.

Working as a CHE was the most widely cited driver of changes across all domains, and this included being a driver of certain challenges such as increased spending and inadequate income. Figure 19 shows the five challenges that were mentioned by the most respondents.

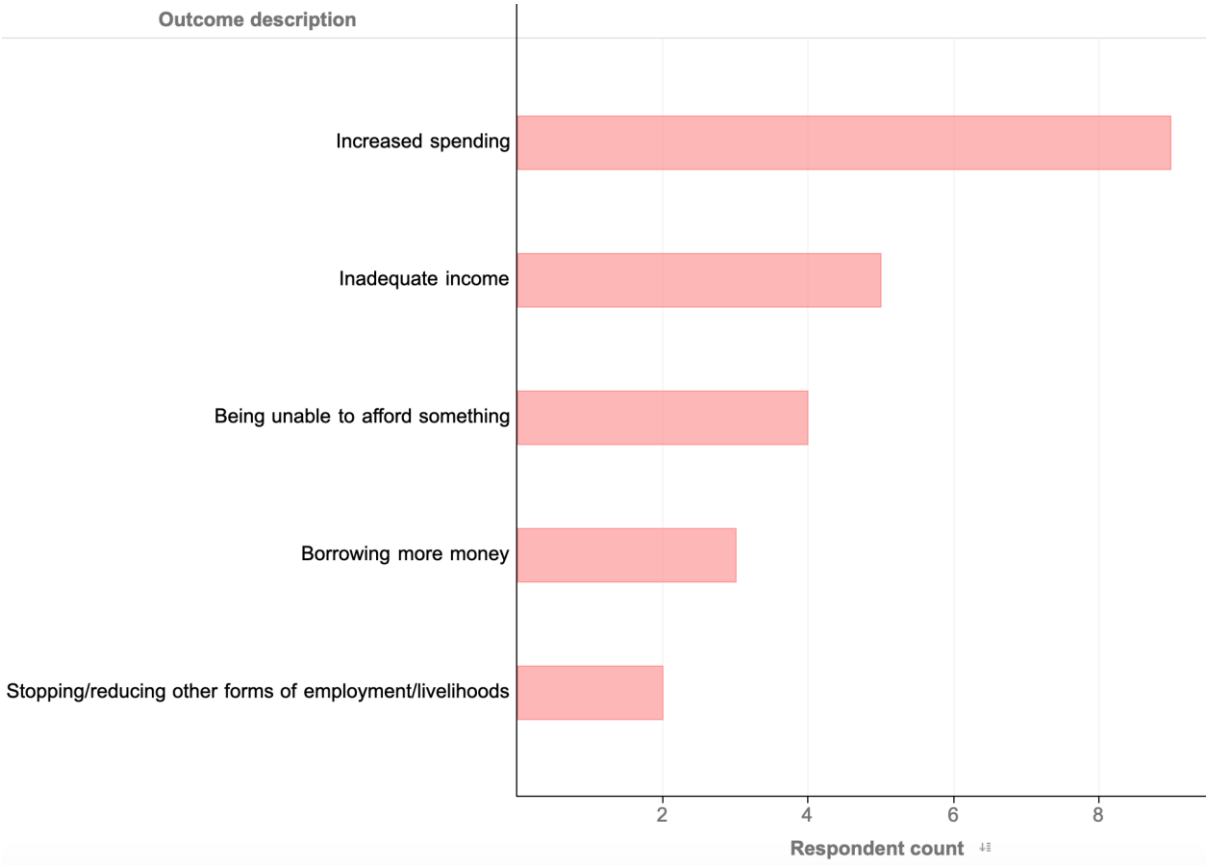


Figure 19: Top challenges by respondent count

There are several reasons why **working as a CHE** was mentioned in this context. Some of the issues that CHEs had experienced included having to stop other forms of income generation because their work as a CHE occupied all their time and energy. This is not necessarily a negative outcome; indeed, some respondents were explicitly positive about the fact they had been able to give up other forms of work which paid less. However, some answers indicated negative associations with CHE work:

MGF-4 (D1) 'In the past I used to sell second hand clothes but since I started the entrepreneurship I stopped because I didn't have enough time'

ILM-15 (D3) 'I move with health products and at times I don't get clients to take the health products.'

IRF-1 (D1) 'I was selling foodstuffs but I stopped, I could not move anymore'

In the domain *Health and living conditions*, female FGD respondents in the Iganga stated that they were sometimes accused by the community of overpricing products (relative to Living Goods for example, a competitor to HE), or of being **unable to provide services** which community members wanted:

IGF-2 (B1) 'There are some prices, not all of them but there are some medicines, which are a little bit expensive. When someone finds you selling Panadol which costs 300 but when you are selling it at 500, they will complain that you are a bit expensive and the one who is complaining about it are the other

people who sell the products to us. There are certain things which are quite expensive and the competition is high because we are near others who have the same products like us, such as Living Goods. They have porridge and we also have it; they sell it at a different price and we also sell it at a different price, and ours is higher than theirs.'

Attribution of challenges

Challenges attributed to GUSO Flex

The data shows that there were some changes that appeared to be attributed to the GUSO Flex project which were experienced as negative. Digging further into the narratives, however, shows that this presentation of change is complicated. Whilst the vast majority of respondents did not mention **increased borrowing** as a negative change, two respondents mentioned having some difficult experiences with the loan received to set up as a CHE:

IRM-9: 'GUSO Flex gave us products in the form of a loan and therefore they gave us two loans one of 130000= and the other of 110000=. The loan affected me because as I was trying to repay, they usually increased my balance without giving me a genuine reason why it has increased.'

IRM-1: For borrowing I only have a loan from health entrepreneurship of 240,000= which I am struggling to pay. I really don't take loans from anywhere. In fact, that loan has affected me because I keep taking back the profits that I would have used for other things.

Two other respondents cited the **availability of products and services** creating some problems in the domain of earning money:

IGF-2: 'We are able to get medicines because they bring them to us. But the biggest challenge is that sometimes the time they bring it we are not financially stable and have no money to buy them. This is because there are times when they tell us that the cluster meeting is for a certain day, but some members may not have the money that day to buy products. There are some who will get the money the next day - but the only day on which they have to come back is a month later, and again, if on that day they have come on a day when you don't have money, you cannot access medicines. So, you again have to wait until the month ends when they will come back. In so doing you lack products to sell.'

IGF-2: 'We really appreciate that we get the medicines in plenty, but like what my colleague has said, it comes sometimes when we are lacking money.'

MSF-2 'We the health entrepreneurs were given simple drugs - but for strong medication you have to go to the hospital. Healthy Entrepreneurs give us clotrimazole, feminine wash; but they don't give us the strong medication. So, the medications we have, we use them as First Aid.'

Another respondent explained that **being unable to offer a service** to the community made them see him negatively, and this affected his wellbeing. Yet this may be due to misinformation about what CHEs are able to provide to the community, as shown in the quotation that follows:

IGM-1: 'Over the past year we have experienced some positive health changes but on the other hand we also have challenges. People in the community expect us to provide services beyond what we are

able to give them. For example, the community expects us to test them for malaria, yet we have not been trained to do that. So people think badly of me if I can't help them.'

CHEs sometimes are called on to work unsociable hours. One female respondent in Iganga mentioned experiencing **reduced sleep**, but the issue at the heart of this was that people would come to her house late at night and ask for condoms and this made her feel uncomfortable. Yet getting less sleep was reported by other respondents in a more positive way: they felt they had something to get out of bed for now they had work to keep them busy. These two quotes illustrate the contrasting picture around reduced sleep:

IGF-2: 'Condoms can be obtained for free, and people have to be able to access them easily. If a person needs them at any time of day or night he can access them from me. But there are some people whom we don't allow to come to our homes at night.'

IRF-13 B1: 'I now don't sleep for long hours the way I used to, as now I have to wake up early and walk around to sell the health products to get money.'

Challenges associated with other influences

Most of the challenges that were mentioned by CHEs were due to factors and conditions beyond the scope of GUSO Flex. However, these are still worth looking at because of their implications for the outcomes of GUSO Flex.

Some CHEs cited an inability to sell health products in their communities as causing them to have **inadequate income**. Often, these factors were not linked with anything more specific than simply being unable to find a market, though sometimes this was due to broader economic conditions:

IGF-2 (E4) 'My saving has not been constant. It depends on the ability of the community to buy. Whenever people have food, they have some money; when they are lacking food, they are lacking money.'

IGF-2 (D3) 'The beginning was good, but in the last year, let me say in the last six months, there was a lot of drought - so we struggled so much with marketing these products we are selling. People never had money, so we faced a challenge in selling the products. I think some of us wanted to give up because we could spend a week without selling anything. The truth is that someone can have malaria and need Coartem, but doesn't have the money to buy it. Then some people could borrow and fail to pay us.'

Increased spending was also cited by some respondents as a problem. This was also due to a combination of factors beyond the scope of the project itself. A key reason mentioned by respondents in both regions was drought, but increased expenditure on school fees was also widely cited. One respondent reported that his living costs had risen because he had moved to a bigger town.

MSM-17 (E1) 'My spending has increased. Previously I used not to buy food but now, I buy it. This is because of the drought and because much of the land is covered by sugar cane plantations.'

IGM-1 (E1) 'Because of the prolonged drought that hit the area I now spend more on buying food. I also spend more money on paying for school fees since I committed myself to marry at an early age and I have school going children. So generally over the year I spend a lot of money buying food, paying school fees and paying medical bills for diseases that I am not able to treat by myself.'

IRF-4 (E3) 'My spending has increased because every time the child goes in a higher class, school fees increase.'

MGM-3 (E1) 'I work from Mayuge town and I now spend more money on rent, food and taking care of my family.'

Causal claims

This section looks at the links between the drivers respondents described and the challenges that were most widely reported. Broader structural and contextual factors beyond the scope of the project were mentioned in relation to negative changes. These negative changes included the **drought** and the **difficult economic conditions** over the past year in Uganda, which have led to **inadequate income**, as well as more spending and having to **diversify livelihoods**, as seen in Figure 20.

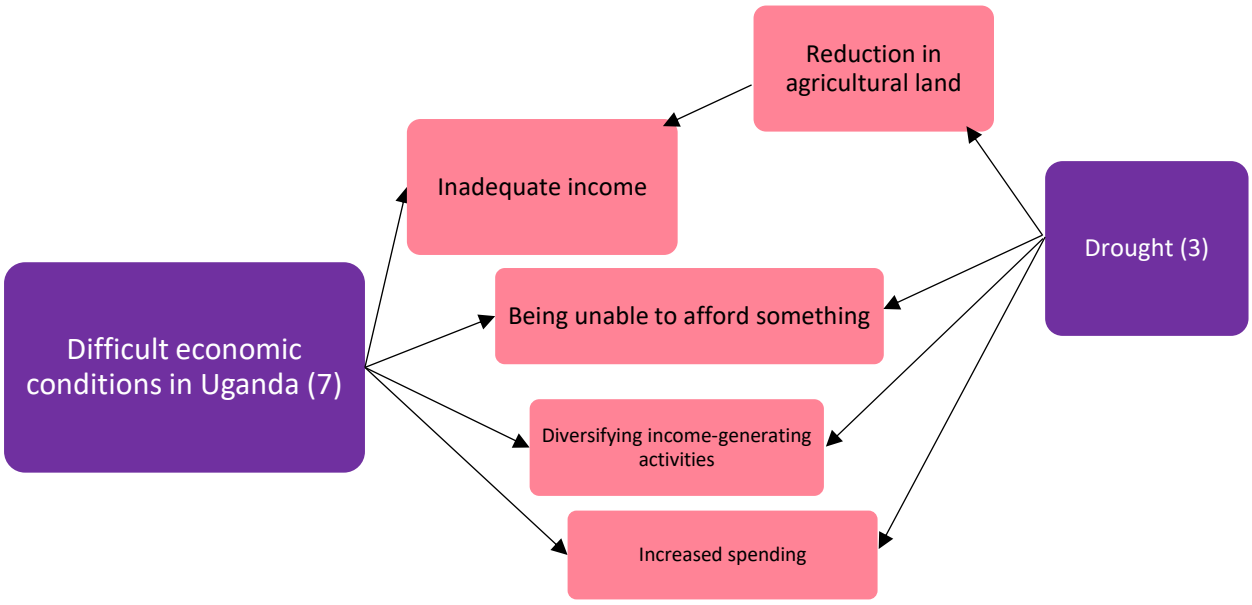


Figure 20: Drivers attributed to influences other than GUSO Flex by citation count

Difficult economic conditions and **drought** have been mentioned in earlier sections of this report; in the quotes below respondents describe how they have sought to offset these challenges. As part of the training that CHEs receive, they are encouraged to save money in order to pay back their loans. However, a respondent in Mayuge mentioned problems with Village Savings and Loans Associations (VSLAs) which put her off taking this route for saving money:

MGF-4 (D1) 'We had a savings group but when the one who used to keep the money disappeared with it, I gave up on that. I no longer ask for money or support from anyone.'

As shown in Figure 21, **working as a CHE** was linked directly to **being seen negatively by others** four times. Respondent explanations included how being seen earning money can cause others to be less willing to help you, and how working with the opposite sex can lead to accusations of lax morals:

IGF-2 (D1) 'I had two sisters who are educated and acquired good jobs, and they would support me because I disclosed my HIV status to them. When they heard anything about me, they got very concerned. But since that time, they have heard about my status as a healthcare provider, and when we meet in the village they see me with the tablets to sell. Now when we are going to the village if there is a function, my sisters no longer give me a lift because they know that I have money. They used to pass by my home to pick me in their cars to go. They know that I have money, yet I don't have a lot, and I still need their help. But because they know that I now have a job, they no longer feel sorry about me.'

IGF-2 (E1) 'Most people, the moment they see that you have started working, they stop giving you help.'

IGM-1 (G1) 'Some community members think badly of us when we are advising women because they may think we are being intimate with them.'

Two respondents mentioned **unavailability of a service** being a negative outcome resulting from being a CHE. By this they meant that the community expected certain things from them as CHEs that they were not able to provide. This then had various further consequences, including being seen negatively by others.

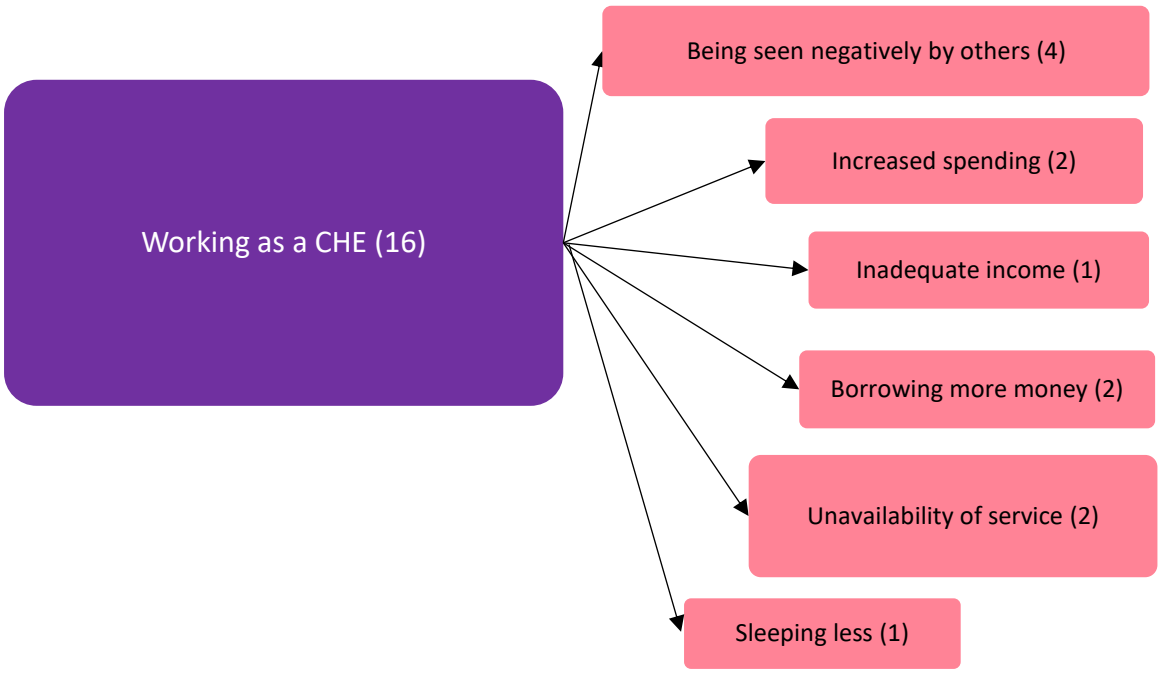


Figure 21: Challenges associated with 'Working as a CHE' by respondent count

Summary of challenges

Respondents reported facing a small number of challenges in their lives over the past year. Some of these were associated with the difficult economic and environmental changes in Uganda, which led some respondents to feel financially troubled. The outcomes that were mentioned most frequently across domains and by the most respondents in relation to these challenges were inadequate income, increased spending, and being unable to afford things. Overall, attribution of these difficulties to GUSO Flex was low.

Some ambiguous or neutral changes were attributed to GUSO Flex explicitly. These included spending more money, which was experienced negatively by some and positively by others. Even when reported negatively, spending more money was part of a causal chain that resulted in positive decisions and outcomes on the part of CHEs, and aligned with the objectives of the project, such as investing more in education or in business opportunities.

Some interesting and potentially relevant stories of change emerging from respondents are:

1) Drought and economic problems in Uganda have made income-generation more difficult, even for those who have a source of income like the CHEs.
2) Working as a CHE and relying on this source of income exposes respondents when there are problems in the system like being unable to deliver services desired by communities, being unable to invest in further products and experiencing trouble repaying loans. This resulted in some CHEs feeling bad or feeling that they were seen negatively by the community.
3) Spending more money than in previous years was frequently reported, but this should not be perceived as inherently a negative outcome as this money is sometimes being spent on business investments, schooling and planning for the future.

Overall, the interviews and FGDs both revealed interesting additional information about the experiences and perspectives of CHEs. Understanding how they see their work in their own words can help to identify areas where further training and additional support is needed from GUSO Flex.

3.5. Incidental observations of interest

The benefit of the QuIP approach is that it allows space for respondents to discuss things which may be missed by more directive interviewing. Both the interviews and FGDs produced some data which raised questions about the messages CHEs are taking away from the trainings they receive, either from GUSO Flex or other organisations.

Respondents reported selling a range of products, not all of which were strictly health-related. Some CHEs mentioned food items such as porridge flour and Lato (UHT/dried) milk, which they used at home and sold as being health-promoting. There was also repeated mention of feminine hygiene wash and its use to treat candida, which respondents described as a sexually transmitted infection. Aloe vera acne cream was also described as being a health product.

In the women's focus group discussions in both Iganga and Mayuge, CHEs mentioned receiving sensitisation about abortion. The advice they received was for women to keep unwanted babies because abortion is dangerous. It was not clear which trainings specifically had been the source of this message, or how it related to training received as a CHE.

4. RESPONDENTS' LINKS WITH EXTERNAL ORGANISATIONS

Respondents were asked to list and rank, without prompting, what they considered to be the most important organisations with which they had interacted over the last year. A wide variety of organisations was mentioned, including government ministries and international NGOs, but Healthy Entrepreneurs was ranked first by 19 of the 24 respondents, and second by another three. In total 23 respondents out of 24 mentioned Healthy Entrepreneurs explicitly by name (although in most cases the organisation was referred to as "Health" rather than "Healthy" Entrepreneurs). SRHR Alliance Uganda organisations also ranked frequently among respondents' top two.

Below are some quotations from respondents relating to organisations important to them:

IRF-4: 'Healthy Entrepreneurs brought us products closer. I am able to help myself. If it is a sickness I am able to treat myself. There is easy access to treatment in the community.'

MSF-2: 'FLEP has trained me in family planning methods.'

IRM-7: 'Healthy Entrepreneurs trained me in provision of community health care while getting some money out of selling the health products; gender-based violence solving; and decision making.'

MSM-17: 'NAFOPHANU trained us on health, how to improve our livelihoods, and general wellbeing.'

5. SNAPSHOTS OF CHANGE BY DOMAIN

At the end of each domain, individual respondents were asked closed questions with multiple-choice style responses to indicate if they considered overall change in that area of their life to be positive, negative, or absent. These closed questions allowed the respondent to provide their own judgement of the overall direction of change they had experienced in that domain over the previous year. Whilst the open-ended answers and narrative accounts that have been explored in previous sections of this report reveal the complexity and nuance of change over the past year for CHEs in Iganga and Mayuge, answers to the closed questions provide a useful snapshot of the overall perception of change by respondents. This is shown in Table 7 below.

Domain or sub-domain	Positive	No change	Negative
Health outcomes	24		
Educational involvement	24		
Status in community	24		
Personal friendships	24		
Overall wellbeing	23	1	
Aspirations for the future	23	1	
Knowledge of health in relationships	23	1	
Earning money	22	1	1
Community relationships	21	3	

Choice over how to earn	21	3	
Saving money	20	3	1
Quality of intimate relationships	16	8	
Spending money	16	1	7
Borrowing money	6	3	15

Table 7: Responses to closed questions by domain

The table shows a clearly positive picture of change in nearly all areas of respondents' lives. Every one of the 24 individual respondents noted improvements in their health outcomes, their involvement in education, their personal friendships and their status in the community. Almost all respondents noted improvements in their overall wellbeing, aspirations, and knowledge of health in romantic relationships, as well as in their ability to earn money.

Only in the area of borrowing money was there mention of any 'negative' change. However, this snapshot needs to be considered in the context of the questionnaire as well as of social stigma around borrowing. Borrowing did not get 'better' or 'worse', but rather 'increased' or 'decreased'. In 15 of the 24 interviews, respondents mentioned that their borrowing had increased. Since CHEs are effectively required to take out a loan as part of GUSO Flex to purchase their first basket of health products, this outcome was expected. Coding an increase in borrowing as negative reflects the negative sentiment expressed by respondents around being in debt. Having loans that need to be repaid was considered negative, while being free of debt was considered positive. The six respondents who reported a *positive* change in this area did so because they had successfully paid off some if not all of their loans.

Spending money is another area where the results need nuanced consideration. An increase in spending is in and of itself neither positive nor negative. In the responses, interviewees reported spending more money, but as noted earlier in this report, many of them were using their enhanced income to send children to school and invest in businesses. These were things respondents were happy to be able to spend more money on, and were thus considered positive.

In the area of the quality of romantic relationships, it might have been hoped that more than two thirds would have reported improvements, though it is reassuring that no respondents reported negative change. Further exploration is needed to fully understand the ways in which respondents judge the quality of relationships with romantic or intimate partners.

6. CONCLUSION

This QuIP study sought to provide independent evidence regarding the impact that GUSO Flex has had on the financial wellbeing and health of CHEs, who over the past year have been participating in the project in Uganda. Stories of change were collected from male and female CHEs in Mayuge and Iganga who had been recruited by SRHR Alliance Uganda members. Through individual interviews and focus group discussions the study sought to answer the following questions:

1. Have there been any changes (positive or negative) in respondents' lives over the past year and a half?
2. What do respondents perceive to be the drivers behind these changes?
3. Are these changes in any way linked to GUSO Flex, or are they incidental to it?

This final section provides a discussion of the main findings in relation to the evaluation questions, and considers the implications for GUSO Flex.

Evidence from CHE narratives shows GUSO Flex is having a positive impact on the lives of respondents. The main changes are increased income, increased access to health products and services, and improved status within the community. The biggest drivers of change in these areas were working as a CHE and receiving training or sensitisation, both of which were explicitly attributed to GUSO Flex by respondents via reference to Healthy Entrepreneurs and organisations that were part of the SRHR Alliance Uganda.

The positive financial impact of working as a CHE was a key finding. The section on 'other interesting findings' revealed issues relating to the economic context in which CHEs were having to operate. Whilst this was sometimes unfavourable, with mentions of drought and poor economic conditions at the national level, working as a CHE helped respondents. It improved their income by allowing them to either abandon less profitable activities, or diversify their income generating activities. This economic context also explains why making investments that involved spending money (e.g. by purchasing health care products on loan) made some respondents nervous in case they were unable to sell their products or repay their loans.

There were some interesting gender differences in positive outcomes, with women focusing more on the financial benefits of their participation in the GUSO Flex project, whereas men were more likely to mention the social outcomes of being a CHE. Women in the FGDs emphasized the positive impact of working as a CHE on their confidence and self-esteem. When it came to the financial strain of working as a CHE, it was only men in Iganga who mentioned worries about the loan repayments and the problem of getting people to buy products when the economy was struggling.

Receiving training and sensitisation (and thus having more knowledge about health, and accessing HIV testing and family planning) was linked to improved intimate relationships by both men and women. In the closed questions, seven male individual respondents and nine female respondents said that their romantic relationships had improved over the last year; the rest stated that they had stayed the same. Interestingly, being a role model and respected in the community was also cited as a driver for improved relationships in the male and female FGDs in Iganga, where respondents explained that being seen as a role model in the community had led them to consider more what kind of partner they wanted to be associated with.

Working as a CHE was connected to improved social status which was seen as a positive outcome by many respondents, in particular by men. However, working as a CHE could also cause negative

outcomes, as was reported by two female respondents who felt discouraged because family members or loved ones had withdrawn their financial support now they were seen to have a source of income. Meanwhile being a CHE did not provide them enough income to make up for this withdrawal of financial assistance. Another negative outcome reported by two respondents was that the community felt they didn't provide enough or the right products or services; this was based on a misunderstanding by the community of what the role of CHE consisted in, but it put the CHE in an awkward position.

Other key findings related to improved access to health services, medicine and products, and to being able to treat people and make referrals to health centres. CHEs reported being better able to treat themselves and sick family members without having to go to hospital; and their communities benefited from having a local point of contact for health services, assistance and referrals. The positive impact on health outcomes of working as a CHE extended beyond just the entrepreneur and into the community. CHEs reported increased testing for HIV and STIs, and increased condom use, both by themselves and amongst their communities, especially among young people.

There were some minor differences in changes reported by CHEs between the two different sites where the QuIP was undertaken. In Iganga, respondents were more likely to mention improvements in the domain of *Health*. For example, almost all (11 out of 12) respondents in Iganga reported increased testing for HIV and STIs (in Mayuge just 3 out of 12 reported improved accessibility of healthcare in the past year). CHEs in Mayuge, meanwhile, cited positive outcomes more frequently in the domains of *Earning Money*, and *Spending, Saving and Borrowing Money*. An improved standard of living was reported by ten respondents in Mayuge (compared to four in Iganga).

Regarding aspirations for the future, 19 out of 24 individual respondents reported having higher ambitions. However, over half of these (15 out of 24) used their increased income to send relatives to school rather than themselves. This was because often respondents felt that it was too expensive for them to retrain. However, they valued the training they received through GUSO and GUSO Flex, which allowed them to improve their knowledge without going back into formal education.

In conclusion, GUSO Flex is having a markedly positive effect on those who are participating in the project as CHEs. These improvements are happening due to their increased income, more knowledge through training, and having direct access to medicines and health tests. CHEs report that they have increased social status in their communities by virtue of providing health assistance, leading to improved wellbeing and confidence, especially amongst women.

7. APPENDICES

Appendix 1: QuIP Individual Questionnaire

Question Id	Question
A1	Respondent code
A2	Name of interviewer
A3	Location of interview
A4	Date of interview
A5	Start time of interview
A6	End time of interview
A7	Please can you give me some information about you?
B1	Please tell me about any changes to your health over the last year?
B2	Please tell me about any changes to your living situation over the last year?
B3	Overall how has your health changed over the last year?
B4	What are the main changes and main reasons for any changes, in order of importance?
C1	Please tell me about any changes to your involvement in education (school, university, training courses) over the last year?
C2	Overall, how has your involvement in education changed over the last year?
C3	What are the main changes and main reasons for any changes, in order of importance?
D1	Please tell me how earning money has changed over the last year?
D2	Overall, how has the amount you earn (in cash or in kind) changed over the past year?
D3	What are the main changes and the main reasons for any changes, in order of importance?
D4	Overall, do you have more choice about how you earn money now than before?
D5	What are the main reasons for any changes, in order of importance?
E1	Please tell me how your spending has changed over the last year?
E2	Overall, how has the amount of money you spend changed over the last year?
E3	What are the main reasons for any changes, in order of importance?
E4	Please tell me how your saving has changed over the last year?
E5	Overall, how has the amount of money you save changed over the last year?
E6	What are the main changes and main reasons for any changes, in order of importance?
E7	Please tell me how your borrowing has changed over the last year?
E8	Overall, how has the amount of money you borrow changed over the last year?
E9	What are the main reasons for any changes, in order of importance?
F1	Please tell me how your friendships have changed over the last year?
F2	Overall, do you have more or better friends now than you did a year ago?
F3	What are the main changes, and the main reasons for any changes, in order of importance?
F4	Please tell me how your intimate (love and/or sexual) relationships have changed over the last year?
F5	Overall, do you have better intimate (love and/or sexual) relationships now than you did before?
F6	What are the main changes, and the main reasons for any changes, in order of importance?
F7	Please tell me how your views or knowledge about personal health in intimate relationships have changed in the year?

F8	Overall, do you have better knowledge of personal health in intimate relationships now than you did before?
F9	What are the main changes, and the main reasons for any changes, in order of importance?
G1	Please tell me how your relationships with other people in your community (outside of your immediate friends and family) have changed over the last year?
G2	Overall, how has your position/ status within your community changed over the last year?
G3	What are the main changes, and the main reasons for any changes, in order of importance?
G4	Please tell me how overall relations in the community have changed over the last year?
G5	Overall, how have relationships in the community changed over the last year?
G6	What are the main reasons for any changes, in order of importance?
H1	If we consider wellbeing as including your physical, emotional, mental and spiritual health, overall, taking all things into account, how has your wellbeing changed over the last year?
H2	Please explain your answer. Are there specific things you can think of that have happened to improve/reduce your feeling of wellbeing during the period?
I1	Please tell me how your hopes and aspirations for the future have changed over the last year?
I2	Overall, how has your feeling about the future changed?
I3	What are the main changes and the main reasons for any changes, in order of importance?
J1	Please list the organisations/services/groups that have been most important to you across the different areas we have discussed (health, education, employment, finances, relationships) over the last year. For each organisation, please describe: - What have you done with them, how long have you had links with them, has anything changed over the last year?- What difference have your links with this organisation made in your life? Please rank the organisations, with "1" being the one you value most. Community interest groups, charities, religious groups or government representatives.
K1	Questions asked by the respondent
K2	Other observations

Appendix 2: Respondent Summary Details

Question:	Age	Sex	No. of school years	Current education status	Current employment status	Current relationship status	Current housing status
Resp ID							
ILF-17	20	Female	12	No - not studying or learning	2 sources of earnings	Yes - in a relationship (boyfriend/girl friend)	Living with parents or other family
ILM-15	24	Male	13	No - not studying or learning	2 sources of earnings	No - single (never been married)	Living with parents or other family
ILM-17	20	Male	13	No - not studying or learning	3 sources of earnings	Yes - in a relationship (boyfriend/girl friend)	Living with parents or other family
IRF-1	21	Female	11	No - not studying or learning	3 sources of earnings	Yes - in a relationship (boyfriend/girl friend)	Living with parents or other family
IRF-11	23	Female	8	No - not studying or learning	2 sources of earnings	Yes - married	Living with husband or wife
IRF-13	24	Female	13	No - not studying or learning	2 sources of earnings	Yes - married	Living with husband or wife
IRF-4	29	Female	13	No - not studying or learning	2 sources of earnings	Yes - married	Living with husband or wife
IRF-7	21	Female	11	No - not studying or learning	2 sources of earnings	Yes - married	Living with husband or wife
IRM-1	30	Male	8	No - not studying or learning	3 sources of earnings	Yes - married	Living with husband or wife
IRM-11	21	Male	11	No - not studying or learning	3 sources of earnings	Yes - married	Living with husband or wife
IRM-2	35	Male	11	No - not studying or learning	1 source of earnings	Yes - married	Living with husband or wife
IRM-9	24	Male	11	No - not studying or learning	2 sources of earnings	Yes - in a relationship (boyfriend/girl friend)	Living with parents or other family
MSF-10	24	Female	11	No - not studying or learning	2 sources of earnings	Yes - married	Living with husband or wife

MSF-11	26	Female	11	No - not studying or learning	2 sources of earnings	Yes - married	Living with husband or wife
MSF-16	26	Female	11	No - not studying or learning	2 sources of earnings	Yes - married	Living with parents or other family
MSF-2	34	Female	11	No - not studying or learning	2 sources of earnings	Yes - married	Living with husband or wife
MSF-4	25	Female	10	No - not studying or learning	2 sources of earnings	Yes - married	Living with husband or wife
MSF-5	22	Female	11	No - not studying or learning	2 sources of earnings	Yes - married	Living with husband or wife
MSM-10	28	Male	11	No - not studying or learning	3 sources of earnings	Yes - married	Living with husband or wife
MSM-16	25	Male	4	No - not studying or learning	2 sources of earnings	Yes - in a relationship (boyfriend/girl friend)	Living with parents or other family
MSM-17	31	Male	6	No - not studying or learning	3 sources of earnings	Yes - married	Living with husband or wife
MSM-4	25	Male	11	No - not studying or learning	3 sources of earnings	Yes - married	Living with husband or wife
MSM-7	27	Male	11	No - not studying or learning	3 sources of earnings	Yes - in a relationship (boyfriend/girl friend)	Living alone
MSM-8	24	Male	13	No - not studying or learning	3 sources of earnings	No - single because divorced, widowed or separated	Living alone

Appendix 3: Closed Question Summary

Resp ID	Health	Education	Money - Amount	Money - How Earn	Spending	Saving	Borrowing	Friendships	Intimate Relations	Knowledge SRHR	Social Status	Community Relations	Wellbeing	Aspirations
ILF-17	+	+	+	+	-	+	-	+	+	+	+	+	+	+
ILM-15	+	+	=	+	-	+	-	+	=	+	+	+	=	+
ILM-17	+	+	+	=	+	+	-	+	+	+	+	+	+	+
IRF-1	+	+	+	+	+	+	+	+	+	+	+	+	+	+
IRF-11	+	+	+	+	=	+	-	+	=	+	+	+	+	+
IRF-13	+	+	+	+	-	+	=	+	=	+	+	+	+	+
IRF-4	+	+	+	+	+	=	+	+	+	+	+	+	+	+
IRF-7	+	+	+	+	-	+	-	+	+	+	+	+	+	+
IRM-1	+	+	-	=	+	=	+	+	+	+	+	+	+	+
IRM-11	+	+	+	+	-	-	-	+	+	+	+	+	+	+
IRM-2	+	+	+	+	+	+	-	+	=	+	+	+	+	+
IRM-9	+	+	+	+	+	+	+	+	=	+	+	+	+	+
MSF-10	+	+	+	+	+	+	=	+	+	=	+	=	+	+
MSF-11	+	+	+	+	+	+	+	+	+	+	+	+	+	+
MSF-16	+	+	+	+	-	+	-	+	=	+	+	=	+	+
MSF-2	+	+	+	+	+	+	+	+	+	+	+	=	+	+
MSF-4	+	+	+	+	+	+	-	+	+	+	+	+	+	+
MSF-5	+	+	+	+	+	+	-	+	+	+	+	+	+	+
MSM-10	+	+	+	+	+	+	-	+	=	+	+	+	+	+
MSM-16	+	+	+	=	+	+	-	+	+	+	+	+	+	+
MSM-17	+	+	+	+	+	=	-	+	+	+	+	+	+	=
MSM-4	+	+	+	+	+	+	-	+	+	+	+	+	+	+
MSM-7	+	+	+	+	+	+	-	+	=	+	+	+	+	+
MSM-8	+	+	+	+	-	+	=	+	+	+	+	+	+	+