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DESIGN, IMPLEMENTATION, AND EVALUATION OF A PRACTICE-BASED DEVELOPMENT PROJECT.

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Abstract.

Background.

A project is being undertaken to improve the functionality and well-being of children with disabilities, particularly in Fort Portal City and Kabarole District, through improved access to quality health care, habilitation, and rehabilitation services. The initial phase of the project targeting Kabarole Hospital started in March 2021 and ended in June 2022.

Project design.

The project seeks to increase access of CWDs to comprehensive, friendly services and information, strengthen the capacity of health facilities to provide quality health care and rehabilitative services to CWDs, and increase community and family awareness, support, and care to CWDs.

Results.

By the end of the first phase (July 2021- June 2022) of actual implementation of the project notable achievements included training 18 health facility staff as CWD FPs, formation of nine community support groups, conducting 98 monthly outreaches to community support groups and nine monthly support supervision visits to the health facilities in addition to 211 home visits to families of CWDs. Training of 22 CHWs and 9 sensitization meetings have been conducted, 25 referrals for specialty care made, and 177 CWDs have been identified and recruited into health care at the lower-level health facilities. Quality of life for CWDs has improved to 60% (from a baseline), and patient satisfaction improved to 80% (from a baseline of 30%). Access to care improved by 52%.

Conclusions.

Improving access to quality care for CWDs and engaging the family, peers, and larger community with active participation of CWDs and their parents/caretakers enhances the well-being of CWDs.

Recommendations.

While services need to be built up, a lack of interventions on multiple fronts is visible. There is therefore a need for the government and partners to give higher priority to the disability issue in the child and adolescent health agendas.

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Background.

Disability is universal, and the World Health Organization recognizes it as a global public health issue as well as a human rights and development issue (WHO, 2015). It is estimated that globally, there are one billion (15%) people with some form of disability (WHO, 2015). It is generally considered that disability is more common in low and middle-income countries and Africa in particular, than in other countries (WHO, 2004). Taking a look at children, it is estimated that the number of CWDs between zero and 18 years globally ranges from 93 to 150 million, depending on the source (UNICEF, 2013). Again, the WHO/World Bank World Report on Disability indicates that, in low and middle-income countries, the child disability prevalence is high, varying from 0.4 to 12.7% depending on the study and assessment tool used (WHO & World Bank, 2015). The United Nations Educational, Scientific and Cultural Organization (UNESCO) (2010) further adds that out of the 100 million CWDs under five years of age worldwide, 80% live in developing countries (UNICEF, 2013), and most of them are in Sub-Saharan Africa.

In Uganda, it is estimated that about 15% of the Ugandan population are PWDs (Government of Uganda, 2014). Based on estimations in 2004, the child disability prevalence is about 12% (UBOS, 2O05), i.e, approximately 2.5 million children live with some form of disability (Government of

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Uganda, 2014). Relatedly, UBOS (2018) notes that seven percent of children aged 5 to 17 years and four percent of children aged 2 to 4 years had a disability.

Disability has low priority in the general agenda of child and adolescent health. People with disability are among the world's most marginalized and discriminated against groups. Children and older adults have the highest rates of disabilities in Uganda, but often have the least access to healthcare (GoU 2019a). There are limited services and support available for parents and children with disabilities (Smith et al, 2018). A needs assessment conducted by the author in the Kabarole district found limited access to care and rehabilitative services uptake by CWDs in particular and the entire PWDs fraternity in general.

The evidence further revealed that the provision of health care and rehabilitation services to children with disabilities in Kabarole (like on the national and international stage) was still lacking. Despite the effort put in by several civil society organizations (like KCDC, YAWE, and Ruwenzori Special Needs Foundation, among others) to assist the government in the care of CWDs, the work was still enormous. To this effect, an effort was made and continues to be made to address low levels of health care and rehabilitative services access and utilization among CWDs accessing care services from facilities in Kabarole District. However, due to time and resource constraints, this evidence-based development project targeted Kabarole Hospital in the Northern division of Fort Portal City.

The author, in collaboration with the care team at Kabarole Hospital and eight other lower-level facilities in Fort Portal City and the wider Kabarole district, sought to improve the quality of care provided to CWDs and re-energize peer, community, and family support to CWDs. Therefore, a project is being undertaken with the overall goal of improving access to and utilization of health care and rehabilitative services among CWDs in Fort Portal City in particular and Kabarole district in general. The project commenced in July 2021. The first phase ended in June 2022, and a gradual roll-out is underway and is expected to end in June 2023. This report mostly highlights undertakings in the first phase.

Goal three of the United Nations Development Goals (SDGs) enlists ensuring healthy lives and promoting well-being for all at all ages. In particular, target 3.8 calls for achieving universal health coverage, including financial risk protection, access to quality essential healthcare services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all (United Nations, 2015). In response, the World Health Organisation developed the "WHO global disability action plan 2014–2021 with the theme 'better health for all people with disability' (WHO, 2015), one of whose three objectives is to remove barriers and improve access to health services and programs.

The preceding adds to earlier and later commitments that can be noted like documents, declarations, international as well as local legal and policy frameworks that are meant to protect and address the plight of people with disability in general and children with disabilities (CWDs) in particular.

At the international level, several conventions with a connection to people with disabilities in general and children with disabilities in particular have been declared. Some of the most important and relevant conventions include: the Alma Ata Declaration 1978 (WHO, 1978), the World Programme of Action on People with Disabilities (United Nations, 1983), the Vienna World Conference on Human Rights (United Nations, 1993), UN Standard Rules for Equalization of Opportunities (United Nations, 1994), African Decade of Persons with Disabilities 2010-2019 (Department of Social Affairs African Union Commission, 2012), United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (United Nations, 2006), United Nations Convention of the Rights of Children (UNCRC) (United Nations, 1989), African Charter on the Rights and Welfare of the Child (African Commission, 1999)

In the Ugandan context, the regulatory framework relating to the rights to life, health services and rehabilitation consist of the Constitution of Uganda of 1995 (Republic of Uganda, 1995), the NDP of 2010 (MoFPED, 2010), the PWDs Act of 2006 (Government of Uganda, 2006) the National Policy on Disability of 2006 (MoGLSD, 2006), the Children Act of 1996 (Government of Uganda, 1996), the National OVC Policy of 2004 (MoGLSD, 2004) and the NHP II of 2010 (MoFPED, 2010), the National Child Policy 2020 (MoGLSD, 2021) among others.

These laws and policies assess the current situation and barriers faced by PWDs in accessing rehabilitation and health services, highlighting the lack of affordable assistive devices, while others call on government and stakeholders to address these challenges. Other policy documents highlight the unfriendliness and inaccessibility to health infrastructures, and negative attitudes of healthcare staff towards PWDs, and others propose ways to address these barriers and reiterate the right to equal access to health services by PWDs and CWDs as well as describing measures, that need to be taken to deliver these services to persons and children with disabilities (ACPF, 2011).

Uganda's disability legislative and policy framework is one of the best in the sub-Saharan region. However, it has also already been well-documented that there is a significant gap between what is written on paper and what is being done on the ground, in particular around funding for the implementation of programs, awareness of policies, and inconsistencies across policies (MoGLSD, 2020)

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Project Description.

Project Title

Improving the well-being and functionality of children with disabilities in Kabarole District through improved access to quality health care, habilitation, and rehabilitation services.

Goal

To improve access and care outcomes among children with disabilities in Kabarole district, Uganda.

Purpose.

To increase access to health care, habilitation, and rehabilitation services for children with disabilities in Kabarole district.

Specific objectives.

To increase access to comprehensive, quality, disability-friendly health care services and information for CWDs in Kabarole district.

To strengthen the capacity of health facilities in Kabarole district to provide CWDs with quality and friendly health care services.

To increase community and family awareness, support, and care for CWDs in Kabarole district.

Project design

The practice-based development project was developed and is being implemented with the partnership of CWDs, health facility staff, the district health team, the community, and the civil society (KCDC, YAWE, and Rwenzori Special Needs Foundation). The first step involved improving access to quality healthcare services provided to CWDs through the formation and or reactivation of quality improvement teams, quality work improvement teams, and the designation of a CWD-only clinic at Kabarole Hospital in Fort Portal City. Training and re-training of staff in CQI and care for children with disabilities were done through the scheduled CME/CPD programs.

Peer and community support groups were selected and trained at the facility, and the mentors were assigned the responsibility to follow up with CWDs in the community for the provision of services (counseling, conducting assessments, treatment, physiotherapy) in collaboration with the facility staff through outreaches. Through outreach, the facility staff offered services through the community-based models.

In each component, the involvement of CWDs was considered of paramount importance with strong liaison and collaboration with health facilities, family, and the district health team, as well as the local leadership for mobilization. But also, collaboration has been elicited from partners such as Kyaninga Child Development Centre (KCDC) and Ruwenzori Special Needs Foundation.

Project Log frame matrix.

Summary of Objective/Activities	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Goal: Improving the well-being and functionality of children with disabilities in Kabarole District through improved access to quality health care, habilitation, and rehabilitation services	The proportion of CWDs with improved well-being accessing care at Kabarole Hospital increased by 30% by June 2022. Proxies: 1. The proportion of CWDs seeking care for common conditions reduced by 30% by June 2022. 2. The proportion of CWDs classified as "stable" increased by 30% by June 2022.	Health facility HMIS reports. Project reports.	Health facility HIMS records are up-to-date and accessible. Project reports filled and submitted.
Purpose: To increase access to health care, habilitation, and rehabilitation services for children with disabilities in Kabarole district.	The attendance of CWDs at Kabarole Hospital increased to 70% by June 2022	Health facility Project Reports HIMS records	Health facility HIMS records are up-to-date and accessible. Project report filled and submitted.

	Over 90% of CWDs retained in care		
Specific objectives To increase access to comprehensive, quality disability disability-friendly health care services and information for CWDs.	The proportion of CWDs accessing health care services at Kabarole Hospital increased by 70% by June 2022	Health facility HMIS records	Quality services are available and disability friendly.
To strengthen the capacity of health facilities in Kabarole district to provide CWDs with quality and friendly health care services.	Increase in quality of care by 30% over the baseline of 40% in April 2020 by June 2022.	Quarterly quality of care (QoC) assessment reports	Dedication and competence of the DHT to conduct QoC assessments
To increase community and family awareness, support, and care for CWDs in Kabarole district.	Number of sensitization meetings conducted with community members to discuss issues affecting CWDs	Meeting minutes and attendance lists.	Community members shall be willing to attend meetings with active participation.
Expected outputs 1. Increased availability and accessibility of comprehensive and quality disability friendly information and services to CWDs.	The availability and accessibility of health care and rehabilitation services to CWDs at Kabarole Hospital increased by 40% from a baseline of 40% in April 2021 to June 2022	Health facility service availability and accessibility quarterly surveys	Staff are willing to reorient themselves to improve service delivery, and resources are available to conduct surveys.
2. Strengthened the capacity of health facilities to provide quality health care and rehabilitation services to CWDs.	The capacity of staff and facilities to offer quality adolescent-friendly services improved from the initial 45% in March 2021 to 75% by June 2022	Staff and facility performance appraisals	Strong commitment from staff and supervisors on QoC improvement
3. Strengthened the capacity of families and communities to offer support to CWDs.	Improved confidence levels of family and community members to offer support to CWDs from a baseline of 20% in March 2021 to 60% in June 2022	Family/caregiver and community bi-annual surveys	Families/caregivers and the community are willing to undergo re-orientation to provide support to CWDs and ensure the availability of resources.
Activities			
Output 1 1. Conduct an evidence-based needs assessment	Evidence-based needs assessment conducted by March 2021	Needs Assessment Report	

2. Train staff on CWDs' friendly health care service delivery.	Staff trained in child disability friendly health care delivery by May 2021.	Training report	The DHT and partners shall provide personnel and materials for staff training.
3. Select and assign a staff member to oversee the provision of health care and rehabilitation services to children with disabilities	Staff member selected by the department in charge by May 2021.	Minutes and availability of the designated staff member	The selected staff shall accept the nomination and work to oversee the provision of health care and rehabilitation services to CWDs
4. Generate a list of CWDs in care	List of CWDs in care generated by May 2021	List of CWDs in care available.	MCH staff shall be motivated to generate a list of CWDs in care.
5. Start or reorient monthly CWD-only clinics.	Start or reorient monthly CWDs-only clinic by 1st June 2021	CWDs are only available and operating.	Space, resources, and personnel are available to set up the CWDs' only clinic.
6. Develop a peer education program for parents of children with disabilities	Peer education programme developed by August 2021	Peer educators were selected and trained. Ongoing peer-led education sessions for parents of children with disabilities.	The DHT and partners shall provide resources for the peer education program, and parents willing to volunteer to support the peer education program.
7. Form a facility-based peer group of parents for parents/caretakers of CWDs	Facility-based peer group formed by August 2021	List of members of the peer group. Peer group activity reports	Parents/caretakers shall be willing to form and participate in peer group activities.
8. Design and implement a local communication campaign that focuses on the needs of CWDs	A local communication campaign focusing on the needs of CWDs was designed.	• Minutes • Copies of the program. • Program implementation reports	The DHT and partners shall be willing and able to support the development and implementation of a communication campaign for CWDs.
9. Conduct monthly community outreaches for assessments, education, sensitization, and therapy.	Monthly community outreaches for assessments, education, sensitization, and therapy started in August 2021	Outreach activity reports	The Health facility and DHT shall provide resources and personnel to conduct outreach for CWDs.
10. Generate a real-time list of CWDs who miss clinic appointments	Ongoing real-time lists of CWDs who miss appointments are generated at the end of each monthly CWDs'	List available	Staff shall have time and motivation.

	only clinic, effective June 2021		
11. Intensify follow-up of CWDs through phone calls to parents and/or caretakers	Phone calls are made to parents/caretakers who miss clinic appointments at the end of each CWD's clinic.	List of recipients, responses, and follow-up actions available	Staff shall have airtime and motivation, and parents/guardians shall positively respond to phone calls.
Output 2 1. Retrain staff in QI methodologies.	Health facility staff trained in QI methodologies by May 2021.	Training report	The DHT and partners shall provide materials and personnel, and staff shall be willing to undergo retraining.
2. Re-institute health facility QI committees	Facility QI committees reconstituted by May 2021	Minutes and list of committee members	Health workers shall accept to be members in the QI committees.
3. Monitor CWDs related training needs of staff	Bi-annual staff training needs assessments are conducted.	Training Needs Assessment Reports.	
Output 3 1. Conduct sensitization meetings with health workers, CWDs, parents/guardians.	8 monthly sensitization meetings (at 8 health centers) between health workers and parents/legal guardians conducted beginning June 2021	Minutes and reports	Staff, CWDs, and parents shall be willing and able to attend meetings.
2. Conduct radio talk shows	Monthly radio talk shows on VOT FM have been conducted beginning May 2021.	Talk show reports	Rwenzori Special Needs Foundation and DHT shall sponsor radio airtime for the talk shows.
3. Conduct a home visit	Monthly home visits to selected CWDs' homes were conducted beginning in July 2021 by facility staff.	Home visit reports	Resources shall be available, and staff shall be willing to conduct home visits.
4. Form community support groups comprised of parents/ legal guardians, community leaders, and community health workers	Community support groups formed by November 2021	Minutes of meetings and lists of community support groups.	Parents/guardians, community leaders, and community health workers shall be willing to form community support groups for CWDs.
5. Select and train community CWD focal persons	Selection and training of the first batch of 20 CWDs FPs by June 2021	List of CWDs FPs Training report	The DHT and partners shall provide resources and personnel, and the selected CWDs FPs shall accept nomination, training, and service.

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Action Plan

An action plan is a series of steps that must be taken or activities that must be executed well for a strategy to succeed. Action plans provide change managers/agents and their teams with a clear direction for taking action, monitoring progress, and measuring results (Chand, 2013). A well-thought-out and well-written action plan also serves as a token for an organization's accountability (Community Toolbox, 2013). The action plan should include activities/actions to be implemented, timelines, quantified targets, responsible persons for each action, and the resources needed to implement the actions (Mansour, 2005). The action plan for the project is to improve the well-being and functionality of children with disabilities in Kabarole District through improved access to quality health care, habilitation, and rehabilitation services.

Monitoring and Evaluation Plan

While monitoring and evaluation are considered collectively here and may seem to mean the same thing, they are two different phenomena for this project. Monitoring is the periodic oversight of the implementation of an activity, which seeks to establish the extent to which input deliveries, work schedules, other required actions, and targeted outputs are proceeding according to plan so that timely action can be taken to correct deficiencies detected (UNDP Evaluation Office, 2000). It involves a systematic collection and analysis of information as the project progresses and aims at improving the efficiency and effectiveness of the project based on the set targets and planned activities of the project. It (monitoring) helps to keep the work on track and lets project management know whether things are going as planned (Shapiro, n.d). Evaluation, on the other hand, is a process that attempts to determine as systematically and objectively as possible the relevance, effectiveness, efficiency, and impact of activities in light of specified objectives (UNICEF, 1990).

On this note, the project "Improving the well-being and functionality of children with disabilities in Kabarole District through improved access to quality health care, habilitation, and rehabilitation services" employs a periodic monitoring and evaluation approach where monitoring is being done every quarter to rhyme with the MoH reporting format whereas evaluation was done midterm (June 2022) and at the end of the project (July 2023). Thus, a project monitoring and evaluation framework has been developed from the project framework matrix (see Appendix B) to monitor the activities and progress of the project. The M&E framework includes the goal, outputs, indicators, definition of indicators, baseline data, targets, frequency of data collection and reporting, and responsible persons. The plan has been aligned with the existing Ministry of Health data collection and reporting system (HMIS), which captures service utilization, staff performance appraisal, quarterly reports, and quality issues, among others (Ministry of Health, 2015c).

Change Management Process.

Change management is the application of a structured process and set of tools for leading the people side of change to achieve a desired outcome and to realize that business changes effectively within the social infrastructure of the workplace (PROSCI, 2020). It relates to processes, tools, and techniques to manage change among people to achieve the required results (Shirey, 2013). The process of change involves three stages- planning, implementing, and sustaining (Dickson, 2012), and this process dictates that supporting managers, professionals, and change agents align their behaviors to specific or desirable conduct. This, in turn, requires effective leadership that can formulate and articulate the vision for the anticipated change, set strategies and a plan, and desire to direct stakeholders and services to a future goal (Mahoney, 2001).

Preparing for Change.

Preparing for change consists of facilitating the mental preparation necessary to achieve successful change (Iles et al., 2001). An evidence-based needs assessment (EBNA) was conducted to establish the level of access to healthcare services by CWDs in the Kabarole district, with a special focus on Fort Portal City (then a municipality). Further synthesis of the evidence base revealed that access to care by CWDs is becoming a major issue in attaining universal health coverage and achieving sustainable development goals. To this effect, therefore, there is an insatiable need for change agents to understand the reason for the change and the importance of the change from a personal, organizational, or political point of view, and thus, to begin the preparation for change, the environment of an organization must be analyzed fully. This includes the political and economic forces and influences, as well as social trends and technological innovation, ecological factors, and legislative requirements (Iles & Sutherland, 2001). Guided by LFA and the PMI body of knowledge areas, a comprehensive project/organization scan was done using the PESTELI (with the first four- PEST- applying for this project) model and Force-field Analysis to inform the design, implementation, and sustainability of this practice-based development project.

The Logical Framework Approach was the main architectural background for this project. Once the evidence base had been assembled, it was apparent that addressing access to health care among PWDs in general and CWDs in particular would significantly contribute to improving their well-being and thus contribute to the attainment of universal health coverage (United Nations, 2015). The LFA has been adopted in particular to guide the preparation phase of the project because of its being participatory allowing the views of different stakeholders; helping to articulate the causes and

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effects of the problem; allowing possible solutions to be identified and different strategies to be analyzed; making uncertainty within the project to be made explicit; and providing a guide for a meaningful monitoring and evaluation (SPC, 2013).

Some authorities adopt a five-step LFA (SPC, 2013), but for purposes of this project, we adopted the 8-step approach advanced by the IPPF and Japan Trust Fund-JTF (2006). The eight-step approach was adopted for its comprehensiveness in facilitating a systematic analysis of the problem, proposed interventions, as well as alternative interventions. This elaborate approach further informs a systematic project implementation process, monitoring and evaluation, and anticipation and planning for the management of possible resistance to change. The eight steps are divided into two phases. Phase one (the analysis phase) has four steps (steps 1 to 4), thus stakeholder analysis, problem analysis, objectives analysis, and alternatives analysis. Phase two (project planning phase), on the other hand, also has four steps (steps 5-8), including defining the project elements, assessment of assumptions, developing indicators, and identifying the Means of Verification (MOV). These culminated in completing the PPM.

Bearing in mind that healthcare organizations are complex, consisting of health workers (including healthcare professionals and staff) and decision-makers (including management and policymakers) (Al-Abri, 2007), there has been a need to take into account their distinct interests by having a clear understanding of healthcare objectives and strategies. The preparation phase thus must involve the development of a common picture and understanding of the current situation (Accounts Commission, 2002). For this project, again guided by the logical framework approach, a comprehensive ***stakeholder analysis*** was conducted by the change agent. This was done by listing all the people, interest groups, and institutions that were interested and/or affected by the problem that had been identified such as the CWDs, DHT, health facility staff and management, civil society, parents/legal guardians among others; prioritizing them (stakeholders) - five most important ones; analyzing the interests of these stakeholders in terms of name, problems, interests, potential and linkages (in a stakeholder matrix); considering the prominent issues/themes; and making a choice for the plan of action. A reflection was then made on the provision of health services to PWDs and, more particularly, to CWDs.

The problem analysis is a process that identifies the cause-and-effect relationship. The result is commonly known as a 'problem tree' (SPC, 2013). A problem tree has the roots representing the causes, the trunk representing the core problem, and the branches representing the effects (IPPF & JTF, 2006). The problem analysis process is as important as the final product (the problem tree) in that it provides the stakeholders with the opportunity to critically analyze and reflect on the causes of a specified problem. By having different stakeholders present, different views and interests can be expressed, and this can be a learning and an empowering process for all those who take part. Participants for problem analysis were drawn from CWDs (5), health facility staff (5), civil society (8), parents/legal guardians (5), DHT/HSD (2), and district political leadership (1). The problem analysis workshop conducted at Kabarole Hospital took 4 hours and was participatory. Stick notes were written by each member, and a discussion was held until a core problem was identified. Yellow stick notes were then written, representing the hierarchy of causes of the core problem, and pink stick notes representing the hierarchy of effects of the core problem. The problem tree created was reviewed, gaps noted and rectified, and the problem copied onto paper.

Objective analysis. The purpose of the objectives analysis is to describe the range of potential solutions or improvements that can be made to the problems that people are currently experiencing (IPPF & JTF, 2006). The objectives tree helps us visualize the situation that we would like to see exist in the future. This was done by transforming the problem tree into an objectives tree by turning the negative statements in the problem tree into positive statements. This was followed by ***an alternative analysis*** whose purpose was to identify the most suitable way of addressing the problems that had been identified in the problem tree. This step helped in the consideration of the various alternatives or options highlighted in the objectives tree and to decide what would be the most realistic and strategic intervention to pursue, given the context and the organization's/change agent's mandate, capacity, time, and resources.

Defining project elements (the goal, the project purpose, the outputs, and the activities). This was meant to first identify and then reach a consensus on how to describe the various components of the project listed in the first column of the PPM. Step six- ***defining assumptions*** allows us to identify potential barriers, difficulties, or challenges in the environment that might negatively influence the project and cause it to be unsuccessful. Assumptions are external factors (such as events, situations, conditions, or decisions) that are outside the control of the project, but which must exist or take place for the project to achieve its outputs and its purpose (IPPF & JTF, 2006). They are identified at three levels in the project planning matrix: from the activities to the outputs; from the outputs to the project purpose; and from the project purpose to the goal. The assumptions identified for this project are also highlighted in the PPM.

Step seven-developing indicators. These are highlighted in Appendix Two (M&E Framework matrix). Indicators are signs or markers against which the project's progress and performance can be measured. They are a means by which one can assess the extent to which a project is reaching its identified goal, project purpose, and proposed outputs, and

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thus provide a basis for the monitoring and evaluation of the project.

Lastly step 8- identifying the means of verification which describes the sources of information or data that would be used to collect information and determine whether the indicator has been reached or not. They are also highlighted in the project planning matrix.

A project context analysis was conducted by key project stakeholders to establish the internal strengths and weaknesses as well as the external opportunities, and hence inform the design, implementation, monitoring, and evaluation, as well as the sustainability of the project outcomes. This was made possible by conducting a SWOT analysis (SWOT stands for an analysis of strengths, weaknesses, opportunities, and threats) (Ortengre, 2004), enhanced by PESTELI analysis. PESTELI checklist is used to analyze the external environment of an organization, which includes Political factors, Economic influences, sociological trends, Technological innovations, ecological factors, legislative requirements, and industry analysis (Iles and Sutherland, 2001). During the SWOT analysis for the project to improve access to care by CWDs, the first 4 components (PEST) of the PESTELI were used to analyze the opportunities and threats, whereas the remaining 3 were not applicable. A Force-field Analysis was also conducted, primarily to plan for resistance to change, but also to add impetus to the project context analysis.

Implementing the Change.

The implementation phase is where the change manager/agent and the project team do the project work to produce the deliverables. This phase involves doing the work as planned and keeping track of performance, thus keeping the project plan on track with careful monitoring and control processes to ensure the final deliverable is achieved (Watt, 2014). Therefore, the implementation phase for the project to improve access to care services among CWDs in Kabarole district involves executing the project work plan and the monitoring and evaluation plan as stipulated in Appendices 1 and 2, respectively.

Change Sustainability.

The sustainability of change is in the endurance of new methods and performance levels in the organizational setting (Martin et al., 2012). Some common practices that have been identified to increase sustainability include enthusiasm, reflexive practice, multiple levels of leadership, generation and use of evidence, and performance monitoring (Davies, Tremblay & Edwards, 2010). On the other hand, some of the challenges to achieving sustainability in the context of healthcare include a lack of prioritization, not having proper support networks throughout, and not being flexible or responsive to changing contexts (Martin et al., 2012). To secure sustainability in the longer term, inertia must be overcome. A service that can be more readily integrated into wider clinical systems seems to have a greater likelihood of sustainability (Martin et al., 2012), due in part to it being easier to secure stakeholder endorsement; it also makes these services difficult to abolish without significant knock-on effects for the rest of the system. One of the risks of becoming too integrated is that the change becomes a taken-for-granted part of the system, rather than a project that requires continued nurture and development. Sustainability, then, must be viewed as a continuum and not as a final steady state (Martin et al., 2012). Sustainability for this project has been embedded in the whole project cycle management.

The meticulous planning using the various project management tools, especially those that emphasized a participatory approach, also had an element of planning for sustainability. Use of the available resources, such as health facility staff, infrastructure, and equipment, as well as the existing Ministry of Health management processes, is thought to guarantee sustainability. But more importantly, making CWDs - together with their parents/guardians and the community- central to this project right from inception will go a long way in enhancing its sustainability.

Change Management Models.

Change management models are a crucial part of any organization's change management process. Change management can be a long process that's not guaranteed to be completed successfully. Healthcare settings, in particular, are known to be resistant to change and have a lot on the line when it comes to implementation. People are naturally resistant to change, which can often derail efforts to lead change in healthcare. Thus, to ensure successful change for this project, two change management models were employed. They were meant to provide a roadmap for change and a framework to get past barriers and help with strategies for implementing change using proven procedures based on human behavior. The McKinsey 7S model, as an outline of which areas needed to be addressed, and the ADKAR model for the step-by-step guide for managing the proposed changes were employed.

Background of the Proposed Models

The McKinsey 7s Framework.

The model is the product of the excellence approach that Peters and Waterman explained in their book, "In Search of Excellence" (Peters & Waterman, 1982). Peter and Waterman argued that there exist seven organizational factors that separate excellent businesses from others. It is one of the tools used to facilitate change management in healthcare. It is unique from the other strategies for implementing change in health care in that it doesn't give a step-by-step approach but rather helps the change focus on seven key areas of the organization in focus. All seven areas are equally important and should be harmonized with each other. When going through change management in

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healthcare projects, the McKinsey 7S model helps the change agent identify and understand the impacts and keep the organization in alignment. The 7S's in McKinsey's model are: structure (the organizational hierarchy); strategy (how to plan to drive change forward); systems (physical tools and workflows); shared values (culture, belief system); staff (those being impacted by change); style (personal managerial or working styles); and skills (current and future skills needed (Eren, 2002). The main argument of the 7S McKinsey model is that the success of a business depends on interrelated seven factors (Crew, 2002; Fox, 2002). The other distinctive argument of the 7S model is that the process of strategic management is not only made up of creating strategies but also considering the other factors expressed in the model (Cater, 1994). Thus, it is claimed that businesses will succeed with the coherent cooperation of the strategy factor and other factors (Ülgen and Mirze, 2007:342). The 7S model enables systems that determine the strategy's facilitation of effective appliances to be created (Dinçer, 2004).

The ADKAR Model

This is a framework for understanding and implementing change at the individual level (Hiatt, 2006). It is designed to assist in the successful transition of changes in the planning of activities, diagnosing gaps, developing shared actions, and supporting implementers of projects –managers, and supervisors (Hiatt & Creasey, 2003). The model is set on 5 goals that need to be achieved to bring about change thus; *Awareness* – convincing the people involved that there is a real need for change; *Desire* – having the stakeholders personally invested in the undertaking and gaining their support; *Knowledge* – arming the people with the right tools and knowledge to help them carry out the changes; *Ability*-the ability to use the knowledge gained and apply it in practice; and re-enforcement –implementing a system that make sure that people stick to the new routine

Application of the Models

In the project to improve access to health care services for CWDs in the Kabarole district, the two models (The McKinsey 7s Framework & ADKAR) are being employed concurrently. The McKinsey 7s Framework targets changing behaviors while simultaneously improving productivity and improvement in the quality of services offered to CWD, whereas the ADKAR targets individuals (health workers, children with disabilities, guardians, parents, and treatment supporters).

The McKinsey 7s Framework.

For this evidence-based development project, the model was applied thus;

Strategy. The change agent assessed the practice of the health care system in providing care to PWDs. A SWOT analysis was conducted, and the required changes were identified and aligned with the project's goal and objectives. Possible sources of resistance were explored, and the availability of resources, including the identification of possible partners, done.

Structure. The agent with the assistance of health facility staff and the district health team took a snap shot analysis of the organization and physical structure of the health facilities and resources as far as provision of care to CWDs was concerned. Those aspects that would enhance access to care for CWDs were enhanced.

Systems. A brief analysis was made of the Ministry of Health's and other government agencies' policies and guidelines regarding the provision of health care and ensuring equity for children with disabilities. An assessment was made on the extent of implementation of the various conventions, laws, policies, and guidelines meant to foster the rights of children with disabilities and, in particular, their access to quality health care. Shared Values. An analysis of the core values of the Ministry of Health was done and aligned with the local facilities. Long-term goals were defined especially for facilities participating in the project.

Staff. Meetings were conducted with staff with the view to discovering what they needed to effect the proposed changes. Their roles, strengths, weakness and competences highlighted. Their training needs were also highlighted.

Style. Efforts that ethically required the approval of health authorities were identified. The segregation of change efforts into those that needed a top-down or bottom-up approach was identified and listed. The key responsible people/personnel were enlisted.

Skills. The ability sets of healthcare staff were appraised. Through arranged support supervision with the HSDT and DHT, the change agent closely monitored the skills of the healthcare workers and sought to work with the immediate supervisors to make sure that those skills were in line with what was needed for providing healthcare to children with disabilities.

Application of ADKAR

At the individual level, awareness creation on the need for change is targeting the health professionals, the parents/legal guardians, as well as the CWDs themselves, at the heart of the project. Meetings (with individual CWDs; combined meetings of the CWDs, health workers, and parents /guardians); meetings with the DHT and HSDHT, training, workshops, and CME sessions, among others, are ensuring this is achieved. The active engagement of the change agent/project sponsor and building of a coalition with the DHT/HSDHT, civil society (particularly KCDC, YAWE, SOS Children's Village, TOCI, and Rwenzori Special Needs), and facility in-charges are being undertaken. But also, at the health sub-district, sensitization of the health team about the current state of care for CWDs, and the low access to health care services as part of the awareness phase, is being implemented.

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Soliciting the support of the senior district leaders (both technical and political) as well as the facility in-charges is significant in influencing the desire for change and ensuring sponsorship. Demonstration of effective leadership by the project sponsor and proactively building the leadership effectiveness of other stake holders is having an influence on increasing the desire for change. A preliminary risk assessment and pro-active involvement of health care workers and most importantly the CWDs has been key in creating the desire for change and hence success for the project.

Knowledge of how to change and how to perform effectively in the future state is a key aspect of any change effort (Hiatt, 2006). To achieve this, effective training and re-orientation has been and continues to be conducted for the staff on quality improvement methodologies, access monitoring and follow-up as well as health education and counseling skills. The use of job aids on a one-to-one coaching and mentorship and support supervision by the DHT and HSDHT and peer engagement ensures effective knowledge transfer.

Changing the wide gap between knowledge and ability is of paramount importance in using the ADKAR model of change management. The use of experts, like physiotherapists, and speech therapists among others, hands-on exercises during training, and performance monitoring has ensured the fostering of ability among health workers, and the use of peer groups is enhancing ability among CWDs in accessing health care and rehabilitation services. Reinforcement is key for sustaining and preventing individuals from slipping back to the old ways. Acknowledgment of individual success on a one-to-one basis for staff and CWDs, ensuring feedback with staff and CWDs, and continuous evaluation of performance to inform decision-making are enhancing reinforcement and project sustainability.

Project Results and Evaluation.

Implementation could not start as had been planned, partly due to a lack of resources and clearance from the district authorities, but mainly due to the repeated lockdowns as the COVID-19 pandemic raged on. But with the help of several civil society organizations dealing with disabled children, a synergy was built and we began work beginning July 2022. As of June 2022, the project has registered some commendable successes, several challenges notwithstanding. Notable among these achievements included: training sessions for 18 health facility staff- two from Kabarole Hospital and two from each of the following lower-level facilities: Kasusu HC III, Kagote HC III, and Kataraka HC IV- in Fort Portal City; Kabende HC III, Nyakitokoli HC III, Kigarama HC III, Nyantaboma HC III, and Nkuruba HC III- in Kabarole District. Nine community support groups have been formed, 98 monthly outreaches to community support groups have been conducted, and nine monthly support supervision visits to the health facilities have been conducted in addition to 211 home visits to families of CWDs. A training workshop for community health workers with 22 participants was conducted, and 9 community sensitization meetings were held.

Other notable achievements so far include the referral of several children with disabilities for subspecialty care: 11 have been referred for inability to sit, 6 for inability to firmly hold articles/utensils, and 8 for walking problems. Relatedly, 177 children with disabilities have been identified and referred to nearby health facilities. In a minimum quality of life assessment for children with disabilities, 90% of the parents reported that their children's quality of life had improved. Also, in min patient satisfaction survey, 90% of the parents/caretakers of CWDs reported contentment with the services offered to CWDs at Kabarole Hospital. A second quality-of-life assessment conducted in early July 2022 is under review.

At Kabarole Hospital- the epicenter of the first phase of the project- the number of CWDs accessing care at the facility has improved from the baseline of 52 at project inception to 109 at the close of June 2022 (an increase of 52%)

A min review is underway – to be completed at the end of July- to inform project continuity/consolidation and scale up.

Resistance to Change and Its Management**.**

Organizational managers face many intractable challenges, with employees' resistance to change being one of the most common issues. Resistance to change is a problem that is witnessed in all organizations and change projects across all sectors and according to Kuiper et al. (2014), it may assume several forms such increase in transfer requests and "quits", chronic quarrels, persistent reduction in output, slowdown strikes, sullen hostility or even numerous pseudo logical reasons on why changing guard in a new organization would not work.

In any given change effort, there is always a restraining force (resistance) attempting to maintain the status quo (Pederit, 2000). As Elizur and Guttman (1976), Oreg (2011), and Rafferty and Jimmieson (2017) note, change response is conceptualized as a tridimensional attitude composed of three components: cognitive (opinions about changes, their usefulness, advantages, and disadvantages, etc.), affective (feelings about changes), and intentional/behavioral (actions already taken or which will be taken for or against changes). In addition, people's dissatisfaction with the current state of an organization or development issue that is seen as not feasible or too costly informs their response or resistance to change (Passenheim, 2010).

Perceived incompatibility of the anticipated change with existing cultural norms, customs, beliefs, knowledge, practices, and dysfunctional group relationships (Dunleavy & Margetts, 2002); inability to see its (the change) advantage about time and prestige; and the fear that the anticipated change may expose lack of knowledge or

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understanding can also be some of the sources of resistance to change. But also, lack of time, complex organizational culture coupled with internal politics, poor leadership, lack of confidence in management, lack of diplomacy, poor timing, unfavorable environment, and lack of motivation (Kotter, 1996) can compound to increase resistance to change. Throw in the inadequacy of resources (Yilmaz & Kilicoglu, 2009), knowledge and skill obsolescence, security in the past, and fear of the unknown and economic implications (Powell & Posner, 1997; Mullins, 2005; Lunenburg & Ornstein, 2008; Robbins & Judge, 2009), the picture becomes even bleaker.

In the health sector, Matos & Esposite (2014) observe that people will always resist change if they feel that the proposed changes could modify the formed working relationships among individuals in healthcare facilities. The duo further people will always resist change if it seems to threaten jobs, the status of certain individuals, or their power within their organization, or if they cannot see the benefits or the rewards of the incoming.

However, not all employees will respond in the same way to anticipated changes. As Coetsee (1999) notes, there are seven forms of change responses, from aggressive resistance, active resistance, and passive resistance to indifference, support, involvement, and commitment.

Mitigating Resistance to Change

Bearing in mind that resistance to change is multidimensional, it is management and mitigation was planned early on as the project progressed. All the project management tools such as the LFA, the SWOT analysis, the change management models (Mckinsey 7S framework and ADKAR) to mention but a few were also chosen partly because they had some element for the mitigation and management of resistance to change.

But in particular in the project to improve access to health care services among CWDs, resistance to change was managed by employing six strategies developed by Kotter & Schlesinger (1979) which include education and communication, participation and involvement, facilitation and support, negotiation and agreement, manipulation and co-optation, explicit and implicit coercion.

Education and communication have been and continue to be employed in the project in cases where resistance is expected to be a result of inaccurate or a lack of information. Health facility staff and management, CWDs, and parent/legal guardians, among other project stakeholders, have been educated about the nature of and need for change before implementing, and the logic of change expounded. This strategy goes hand in hand with the p*articipation and involvement strategy*, which has seen the project allowing key project stakeholders such as civil society, CWDs, DHT, and health facility staff, among others, in planning, designing, and implementing the project.

The facilitation and support strategy involves helping key stakeholders, especially CWDs, parents/legal guardians, and staff, to deal with emotional and material issues. Listening to them about their ideas, problems, and complaints makes the project/work environment more satisfying and enjoyable for the change process. *Negotiation and agreement*, on the other hand, involve the provision of incentives to actual or potential change resisters. Negotiating and bargaining with health staff to effect project changes, coupled with an openness to proposed adjustments, is seeing several staff who had earlier expressed uncertainties about the project soften their hardline attitude. The negotiating strategy is to enhance full staff involvement in the change process, hence reducing resistance by being more supportive of the change. However, as advanced by Passenheim (2010), the strategy is time-consuming.

Manipulation and co-optation approaches are being employed in situations where influencing project stakeholders, especially health facility staff, such as the provision of the necessary information and structuring the required events for change, is required. Last but not least, opposition to change in the project has been the employment of the 'e*xplicit and implicit coercion'* strategy on facility staff by making use of the force of authority. Negative effects of employing this approach, such as frustration, fear, revenge, and alienation, which in turn may give birth to poor performance, dissatisfaction, and turnover (Woodman & Passmore, 1988), are, however, being kept in mind.

Success Factors, Limitations/Challenges, and Lessons Learnt.

Numerous challenges notwithstanding, a number of achievements have been registered as we move into the second phase of the project. Some important lessons have too been learnt.

Success Factors

The mutual and participatory approach by the change agent, the health facilities staff, the DHT, civil society particularly KCDC, parents/legal guardians, community extension health workers aka village health teams in planning, design and implementation of the project is guaranteeing ownership, commitment and resource mobilization for the undertaking. The elaborate planning and the application of the various models and tools for change management are so far yielding tremendous results.

Limitations/Challenges

Resource limitation is a big challenge. The project does not have a specific budget and only relies on existing programs of the facilities and other partners like KCDC. Workload and lack of skill among health workers limit their participation in facilitating peer support group sessions. CWDs are still discriminated against and feel stigmatized.

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This affects their care-seeking, participation in treatment and care, disclosure, retention in care, and medication adherence. The lack of a formal system for involving parents/guardians in adolescents' care and treatment, and the poor socio-economic status of most parents/guardians, as well as the lack of the necessary knowledge and skills, affect their participation in the care and treatment of CWDs. Last but not least, the emergence of COVID-19 right at the time of project take-off has had a lot of negative effects on the project. Meetings, travel arrangements for outreaches, as well as resource mobilization, have been affected negatively**.**

Lessons Learnt.

Scaling up the peer approach within the health facilities by having specially trained young health workers attend to CWDs is helping win the trust of CWDs in care and treatment services. Continued engagement of communities through home visits and joint sensitization meetings is increasing community awareness about the healthcare needs of CWDs and strengthening the delivery of services in communities. Peer educators are helping to sustain the continued provision of Friendly Health Services to CWDs. Active participation of various stakeholders in the planning, design, and implementation of adolescent health programs can augment success even with a scarcity of resources.

Conclusions.

Improving access to health care services for disabled children meets several challenges. To be up to the task, therefore, programs to improve access and utilisation of care among this population group need to address these challenges. While striving to improve the quality of care provided to PWDs and CWDs in particular, improving accessibility and engaging the family, peers, and larger community is of paramount importance. In all this, the active participation of CWDs and their families is key if any success is to be registered.

Recommendations.

While services need to be built up, a lack of interventions on multiple fronts is visible. There is therefore a need for the government and partners to give higher priority to the disability issue in the child and adolescent health agendas.

To move forward, we need a shift in attitudes and the commitment of all relevant parties in the disability and health sectors.

Governments need to scale up service delivery with a strong focus on primary healthcare. This will help widen access and meet rising demand from the growing number of children with disability, many of whom will require services close to home.

Government to expand the provision of rehabilitation services to reach all children in need through integration into the health system and specifically at the primary care level. Providing early access to rehabilitation services is crucial to ensure optimal outcomes and mitigate the risks of ongoing complications that may affect health and overburden health systems (Stucki et al., 2005).

Sensitizing and training the health workforce, who need the necessary information and skills to provide specific services.

The government and partners need to give families support and education, including on stigma and discrimination, which are at the root of many barriers.

Governments need to look at children with disability with fresh eyes and bring them out of their invisibility to inclusion. There is a need for commitment to prioritizing children who are among the most disadvantaged in many societies.

List of abbreviations.

AAP	: American Academy of Paediatrics
ACPF	African Child Policy Forum
ADKAR	Awareness Desire Knowledge Ability Reinforcement
CHWs	: Community Health Workers
CMS	Centers for Medicare & Medicaid Services (U.S)
CME	Continuing Medical Education
COVID-19	Coronavirus Disease
CWDs	: Children with Disabilities
CQI	Continuous Quality Improvement
DHT	District Health Team
EBNA	Evidence-Based Needs Assessment
FPs	Focal Persons
HC	Health Centre
HSD	Health Sub-District

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Availability of data.

Data used in this study are available upon request from the corresponding author.

Authors contribution.

EK designed the study, reviewed the literature, cleaned and analyzed data, and drafted the manuscript. JFN supervised all stages of the study from conceptualization of the topic to manuscript writing and submission, and DK & EO supported in study conceptualization, general supervision, and mentorship.

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