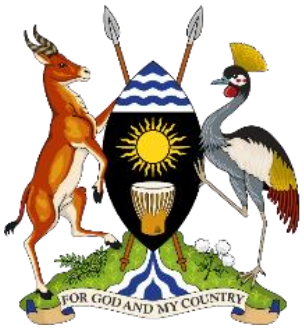


AIDS CONTROL PROGRAMME OF UGANDA

COMMUNITY LED DRUG DISTRIBUTION POINT (CLDDP) IMPLEMENTATION TOOLKIT

JULY 2021

Table of Contents

1. Implementation Guidelines

The purpose of this document is 1) to describe the Community Led Drug Distribution Point (CLDDP) approach and 2) to integrate implementation guidelines into the existing differentiated service delivery (DSD) implementation guidelines of the Ugandan Ministry of Health.

1.1. Community Led Drug Distribution Point (CLDDP) Approach

The Community Led Drug Distribution Point (CLDDP) approach is a strategy that targets clients in remote and underserved areas with poor access to health facilities and services like ART. These include hard-to-reach areas like islands, landing sites, pastoral areas and districts with few facilities accredited to offer ART.

This approach offers increased community participation and most importantly, ownership of ART care by the clients.

1.1.1. What is a CLDDP?

A Community Led Drug Distribution Point (CLDDP) is **a service delivery approach in which health care workers provide integrated health services** (ART, HIV counselling and testing, TB services, and other primary health care services) **in a community, and the community plays a role in mobilisation and oversight.**

These are the key components of a CLDDP:

1. **Human Resources**
    - **At least two healthcare workers** (ideally three or more in order to offer a range of services that are in demand in the community)
    - **Local Community Association (LCA), Village Health Team (VHT) member,** or other local leader to organize the space, oversee wealth pooling, and the VHT/focal person helps in registering clients during the outreach.
2. **Supplies & Equipment**
    - **Means of transportation for the healthcare workers** to go to the CLDDP and return at the end of the day
    - **Availability of supplies** like ART, OI treatment, laboratory investigations, PPE, etc to ensure that patient needs are met
3. **Site Preparation**
    - **Location to provide health services** (ideally indoors at a community building, school, church, mosque, etc)
    - **Registration book** for attendance and accountability of funds collected only if the LCA is funding the activity.
    - **Privacy** to allow health care workers to meet with patients (this can be achieved by using curtains, screens, and/or keeping patients at a distance).
    - **Mobiliser** who uses a megaphone or other means to let the community know that the CLDDP is going on. Mobilisation is a very key determinant of

outreach performance and whoever is chosen should be sure to do a good job.

4. **Community Wealth Pooling**
    - **Local Community Association (LCA)** established and identified to help residents pool their wealth to improve access to livelihoods, health care, and other social services
    - **Wealth pooling strategy** (e.g., community contribution, social welfare fund, savings and loan contribution, etc) set up and administered by the LCA to improve on community welfare.
5. **Service Provision**
    - **Availability of multiple health services for recipients of care** (not just ART clients). The package of services should meet community needs and requests.
    - **Regular, predictable schedule** of CLDDPs in each community served, such as biweekly, monthly, or bimonthly
    - [optional] **Health education** to build personal skills and knowledge of important health topics. VHTs or Peer Educators at the outreach can be very helpful with organizing and leading these sessions.

1.1.2. Guiding Principles of the CLDDP Approach

1. **Is led by the community.** The setup, administration, and service delivery should be overseen by community members
2. **Prioritizes community needs.** The needs and preferences of the communities should drive the design and service provision. There should be processes in place to monitor patient demand and feedback on the approach
3. **Is aligned with Ministry of Health policies and SOPs.** Implementers should follow the Standard Operating Procedures (SOPs) of the Ministry of Health, such as community health service delivery, M&E, Infection, Prevention and Control (IPC), Water, Sanitation and Hygiene (WASH), etc.
4. **Integrates services.** Health care workers should integrate health services that serve the needs of the health system and partner communities
5. **Uses existing funding lines** Transport and setup costs should be covered by the government e.g PHC funds, RBF, IPs and other lines of funding.
6. **Builds community capacity.** Structures established should help communities to take control of their care and organize around important initiatives

1.1.3. What is the CLDDP group size?

The more services that are integrated, the greater the benefit to the community and the more clients/patients will attend.

Services can be incorporated and alternated, such as collecting blood samples one month and providing FP services the following month.

Table 1: Number of health workers and the range of services and estimated clients that they can serve

No of health workers	Range of services	Estimated clients
2	ART, basic OPD/general treatment	20-30
3-5	ART, VL testing, HIV testing, FP, OI, immunization, OPD/general treatment	50+

1.1.4. Who is eligible for the CLDDP approach?

The CLDDP approach is a strategy that targets clients in remote, underserved areas with poor access to health facilities for ART. These hard-to-reach areas can include islands, landing sites, pastoral areas, and districts with few facilities accredited to offer ART.

Here are the conditions for choosing a host site for the CLDDP approach:

Necessary

- Is at least 5km from the nearest health centre III or above

Should meet ***at least one of the following conditions*** (ideally both):

1. Has a population of over 150 residents and at least 25 PLHIV
2. Has many residents with problems of defaulting in ART, maternal health, or others

Initially, the target population should be stable clients living in remote areas. Since ART-accredited healthcare workers are present at CLDDPs, the approach may eventually be used to serve unstable clients, pregnant mothers, and other at-risk populations.

As per the MOH CDDP guidelines, children and adolescents 2 to 14 years old can be served at a CLDDP outreach if a caregiver is also enrolled in the same approach. Adolescents and adults above 15 years old may join the approach without any supervision if they choose to.

CLDDP is an integrated approach of service delivery, so implementers should be regularly assessing and incorporating patient and community healthcare needs. Implementers should consult the guiding principles when choosing which services and patients to integrate.

1.1.5. What is the cost breakdown of a CLDDP?

Here is a template breakdown of the costs:

Table 2: Template Cost Breakdown of one CLDDP. CLDDPs are conducted on a regular basis (e.g., biweekly, monthly, or bimonthly) at each site, so these expenses need to be covered each time.

Item	Cost/Unit	Units	Cost
Safari Day Allowances (SDA) for Health Workers	X	2 to 5	(2 to 5) * X
Fuel or transport costs	Y	1	Y
VHT allowance and mobilisation costs	Z	1	Z
		Total	

The expenses listed above are the necessary expenses of the approach. Optional expenses can include payment for a mobiliser, hiring of a megaphone, etc. Expenses will vary depending on the location of the community. For example, island communities may need to hire and fuel a boat, and very remote communities may need to hire and fuel a car. The project implementation must be adjusted accordingly.

1.1.6. Steps in Establishing a CLDDP

Step 1. Identify need for CLDDP

a. Use Geographic Information System (GIS) analysis, census, Health Management Information System (HMIS) records, and other relevant data sources to identify communities that are remote from the nearest DSD/ART health facilities where CLDDP can be established.

Step 2. Get approval and determine logistics for CLDDP approach in community

a. Presentation of CLDDP approach takes 3-to-5 visits in each community before CLDDP can begin:

   i. **Introduction visit** with local leaders. The Community Officer describes the approach, wealth pooling, and roles of stakeholders. Community Officer conducts environmental health assessment and identifies relevant leaders and LCAs or CBOs. Participants are able to ask questions. LCAs can be registered at the sub county level with 1) a constitution and 2) signed meeting minutes in which members form the association.

   ii. **Presentation of MOU and setup of LCA and wealth pooling strategy** (1-3 visits) with local leaders, LCA members, and other key contacts. The MOU

is read out loud, and the members discuss potential wealth pooling strategies. Some LCA members are identified, and members make a plan for organizing the group.

iii. **LCA submits a request for CLDDP outreach services to District Health Office.** IP staff can help prepare and submit the request

iv. **Full community meeting** with a healthcare worker present where LCA members and other community residents sign MOU. The first CLDDP is scheduled.

b. Community members, LCA members, health facility representatives, and the implementing organization must be guided to identify some of these key logistics in the community:

i. **Location for CLDDP**

1. An enclosed public location, e.g., Health Centre II, church, mosque, school, Local Community Association (LCA) premises, etc.
2. Offers some kind of privacy. Curtains and room dividers can be used
3. Has a room to be used for safe blood sample collection
4. Implementing organizations may choose to provide curtains, room dividers, or other necessary equipment and supplies to communities hosting CLDDPs

ii. **Which services will be provided and at which intervals**

1. HCWs can choose to integrate whichever services they think are in demand
2. These potential services should be discussed with stakeholders to assess demand and availability of HCWs
3. Some services can be staggered according to community demand/need, such as having monthly CLDDPs but only having HIV testing and counselling every two months, immunisations every month, etc.
4. Integrating more services may require more HCWs to attend CLDDPs. This has a cost implication and should be agreed upon by the funders.

iii. **Ensure that Infection Prevention and Control SOPs are in place.**

1. These ensure that the CLDDP is run according to the MoH standard operating procedures (SOPs).

iv. **Coordinator(s) of CLDDP**

1. In most cases this person will be one or more LCA members and/or community health workers (CHW, aka VHT), but some communities may use people who are good organizers but not CHWs.

2. A coordinator is selected by the community and LCA members at the community entry meeting with guidance from the health care worker.
3. Coordinators will be in charge of preparation of the location, following the schedule of CLDDPs, communicating information to the mobiliser and patients, overseeing wealth pooling collection, maintaining the registration book, ensuring that funds are distributed to cover costs, and managing any surpluses
4. Thus, these coordinators should be trusted by their neighbours to fulfil these duties
5. There should be a back-up person in case coordinators are not available on the day of a CLDDP

v. **Methods for mobilising patients**

1. In most cases someone will be tasked with walking around with a megaphone to announce the CLDDP one day before and on the day of the CLDDP. The mobiliser should announce which services will be available so that community members know what to expect. These available services should be communicated by HCWs to the CLDDP coordinator and mobiliser.
2. Some communities that are more spread out may choose to hire a motorcycle or car with a larger megaphone or to ask two mobilisers to go around.
3. Implementing organizations may choose to provide megaphones to communities hosting CLDDPs.
4. Any gatherings happening in the community should be used as opportunities for mobilisation. These include worship places, burials, market days, etc.

vi. **Frequency of CLDDPs**

1. The frequency of the CLDDP can be determined based on some of these factors:
    a. Patient demand for health services
    b. HCW availability at health facility
    c. Population of host community
    d. Drug refill amounts
    e. Regularity of demand for non-ART services
2. Most communities are able to host monthly CLDDPs. In case outreaches to a specific community are monthly, ART Clients should be given refills according to MoH guidelines

vii. **Wealth pooling strategy**

1. The LCA members should decide the mission, which activities they want their association to undertake, and how they will pool community wealth.
2. Based on estimated capacity to conduct CLDDP events and expected attendance, the community, LCA, HCWs, DHO, and the implementing organization decide on a strategy to undertake the activities.
3. If there is already an LCA operating in the site of a potential CLDDP, and the members of that LCA want to oversee CLDDP activities and wealth pooling, then the implementing organization can work within those structures.
4. For example, constitutions and MOUs for how to structure the wealth pooling, please see the appendices.

c. [Optional] The HCW presents approach to PLHIV residing in community (at the health facility) and takes the list of names for those who agree to receive ART services at CLDDP
    i. This step is optional because ROCs should have the option to participate or not.
    ii. Some HCWs and implementing organizations may want to make sure that they are prepared for initial CLDDP visits with the right client forms and sufficient quantities of drugs.

Step 3. Implement the CLDDP

a. HCWs retrieve files of the CLDDP members and put them together in one big file folder that they will take to the community when services are delivered.
b. Thereafter, members are given an appointment at the CLDDP for subsequent ART refills, consultation, and ART monitoring by the clinical team.
c. ARV drugs are pre-packed for the CLDDP members. Additional supplies to be pre-packed include FP supplies, OI drugs, condoms, laboratory supplies, etc.
d. Transportation is organized.
e. The facility agrees on the health team to visit the CLDDP.

NOTE: VL monitoring should be synchronized for all clients on one date (the date when the CLDDP outreach is held).

1.1.7. Examples of key services offered in the CLDDP approach

The service package should meet the needs of the community. Here are some examples of services that can be included:

1. ART, HTS, TB screening and referral, Viral Load Testing
2. Noncommunicable diseases (NCDs) (Hypertension (HTN), Diabetes Mellitus (DM)) screening, monitoring and treatment

3. Psychosocial support
4. Nutrition assessment and referral
5. Family planning and pregnancy screening
6. Ante-natal care and post-natal care
7. Immunizations
8. Management of common illnesses e.g. Malaria, URTI, UTI etc

Table 3: Service package for communities in the CLDDP approach

	**Clinical consultations**	**Refills** (ART, CTX, TB, FP)	**Laboratory tests**	**Adherence support**
When	• Quarterly/bi-annually	• Quarterly/bi-annually	• Annual VL • Quarterly STI screenings • Other tests as needed • Sputum Follow up	• At every visit
Where	• CLDDP	• CLDDP	• CLDDP	• CLDDP
Who	• MO/CO, Nurses, Midwives	• Nurses, Dispensers, Counsellors, Expert Clients	• Laboratory personnel • Trained nurse/clinician	• Counsellor/ nurse/ expert clients/ peers
What	• OI & TB screening • Nutrition assessment • Adherence assessment • STI screening & treatment • Family Planning and screening for CaCx • PHDP	• Dispense ARVs and OI drugs • STI treatment • TB treatment • Treatment Literacy • Pill counting	• STIs, other tests as indicated • VL • Sputum collection • Point of care testing	• Adherence support

1.1.8. Resource Needs for the CLDDP Approach

Table 4: Human resource cadres and their responsibilities of CLDDP approach

Cadre	Responsibilities
Nurse/Counsellor	Dispense drugs, measure clients' weights, support the group to select one volunteer to become the CASA or a known CASA from another group is invited to join.
Community ART Support Agents (CASAs)	Provide peer support and counselling at the time of drug distribution, client mobilization and follow-up.

Laboratory Technician	Collect samples.
Dispensers	Liaise with supervisors of expert clients and community HCWs, plan for required drug supplies on the specific days, and ensure safe transportation of packages.
Clinician/Nurse	Support team on six-monthly appointments to collect blood samples and conduct health assessments.

1.1.9. Logistic needs

Table 5: Logistics needs of CLDDP approach

Location	Logistics Needs
Facility	1. Enough stock of drugs and supplies for all clients 2. Markers for labelling 3. Portable scales, MUAC tapes 4. BP machine 5. Big file folders (box files) 6. Tools (HMIS tools—data collection/reporting, registers, patient cards, informed consent form (ICF)) 7. Health education, job aids, client flyers, etc. 8. Transport means to deliver drugs to the CLDDP group 9. Cool box with ice packs, sputum containers, triple packaging 10. HIV and/or TB testing kits 11. Viral load testing kits
Community	1. Appropriate venue for the group meetings where members feel free (safe zone/meeting point) 2. Megaphone or other equipment for mobilisation 3. Curtains or room dividers 4. Health education job aids, client flyers, etc. 5. [Optional but preferred] Examination bed and Mackintosh mattress

2. Roles of Stakeholders

In order for the CLDDP approach to function properly it is important that all the stakeholder's roles are clearly defined and understood. The following scope of work will apply.

Local Community Association (LCA)

- Establish wealth pooling
- Oversee CLDDP requirements

- Set up social distancing and privacy measures
- Select the coordinator/focal person to be in charge of the CLDDP
- Mobilise ROC's with community announcements

Community

- Agree to join the approach
- Set demands for health care and other social services
- Host CLDDP events

Health Care Workers

- Attend at least one initial setup meeting with community
- Prepare for CLDDP with commodities, equipment, patient records, and forms
- Provide integrated health services
- Ensure that indoor site with adequate privacy is prepared for CLDDP
- Ensure that ROC's abide by social distancing and privacy protocols
- Provide support to HCW's in providing some health services
- Maintain records
- Sensitise and give referrals in between CLDDP days

District Health Office

- Identify which health facilities and sites to target with CLDDP approach
- Give introduction letter and request in-charges to dedicate resources (staff time, equipment, and commodities) to the set up and maintenance of CLDDP's

Implementing Partner

- Present CLDDP approach to all stakeholders in the district
- Ensure that adequate transportation is available to HCW's
- Help target communities establish wealth pooling model where one is not already present
- Support H/Fs to set up and start CLDDPs in target communities
- Monitor and evaluate approach for quality assurance and to ensure that the approach is meeting the needs of stakeholders involved
- Convene stakeholders for annual meetings/workshops to identify and address key issues
- Coordinate reporting on service delivery to the District, MoH and other national stakeholders

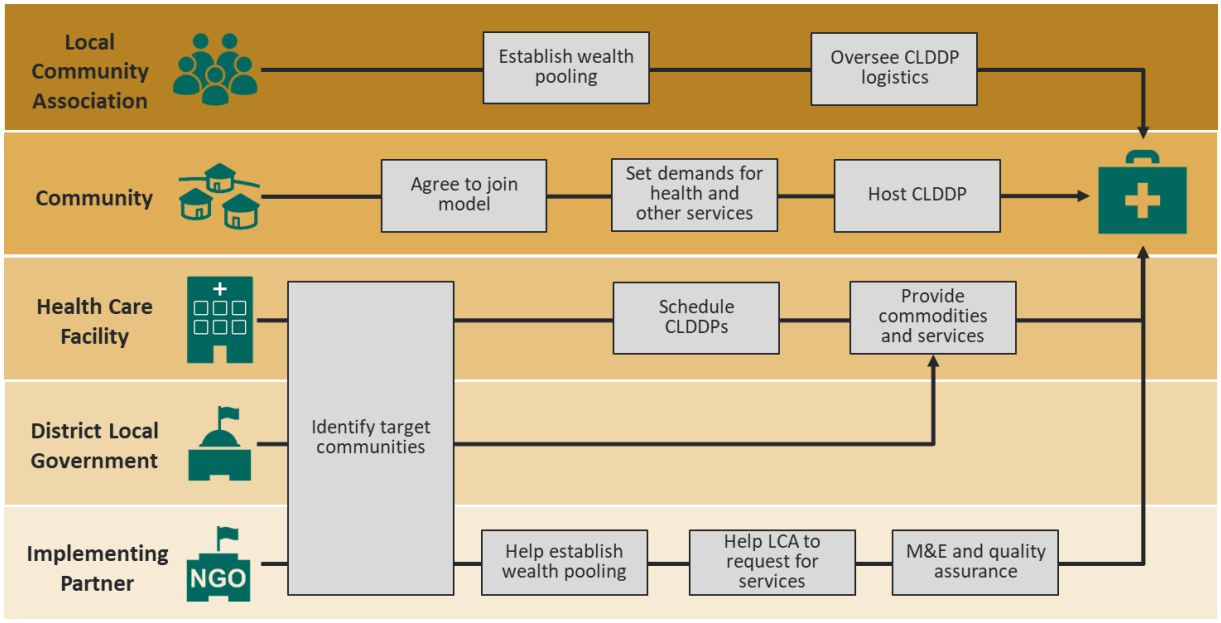


Figure 1: Roles of stakeholders in the CLDDP approach

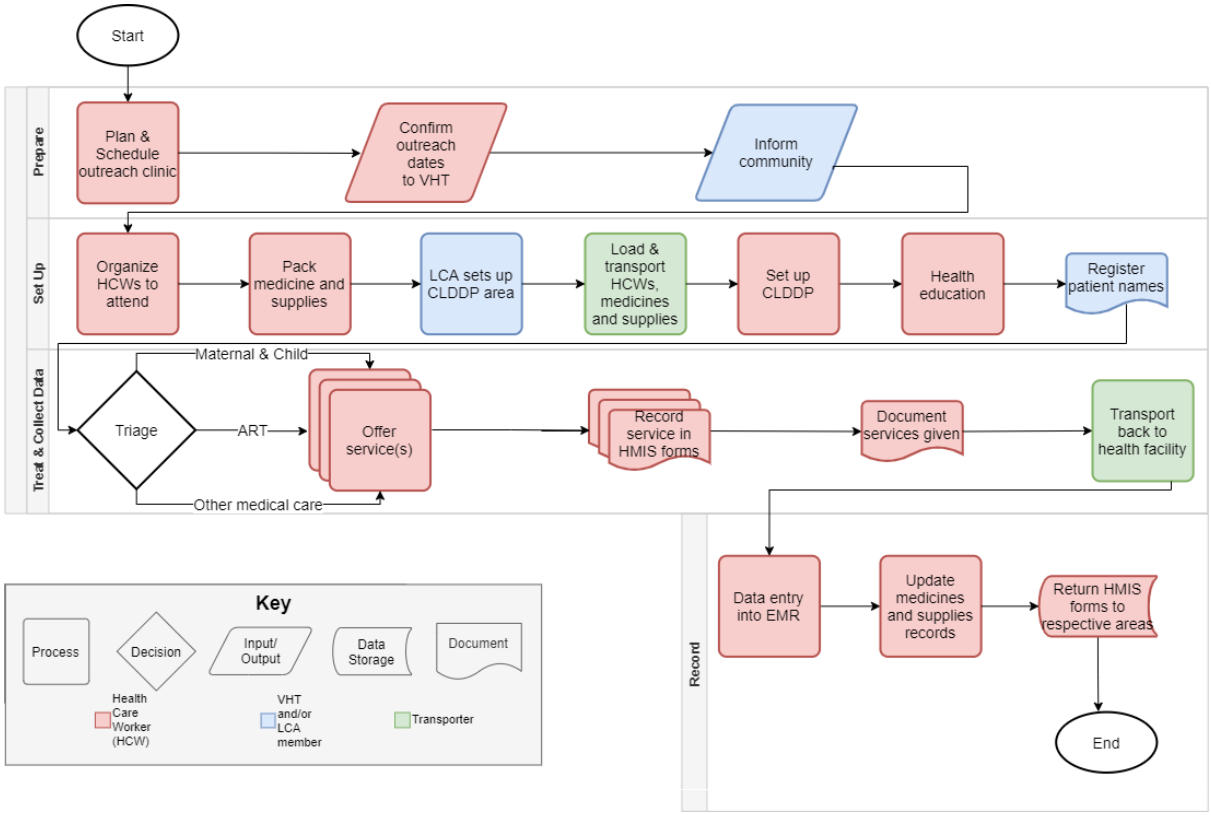


Figure 2: Process & Information Flow at CLDDPs

3. Key Performance Indicators (KPIs)

A set of key performance areas has been identified to measure, report, and improve the service delivery. The KPI's will be used to report regularly to stakeholders. The KPI's listed below will be used initially but could change as the programme evolves

1. **Decongestion** – The number of ROC that are decanted from facilities to CLDDP, expressed as a % of ROC receiving FTDR at facilities by district
   Average monthly facility clinic attendances – Total number of ROCs attended to in a month / Number of clinic days in a month
2. **New Stable ROC** – The number of stabilized ROC referred to an CLDDP programme by the health facility
3. **Attendance** – Each health facility will keep a record of attendance and also follow up with any patient who has not picked up their medicines, in order to ensure adherence and retention on treatment
4. **Suppression** – ROC attending to pick up their medicines will be routinely checked by health facilities to check their suppression status
5. **Service quality** – Exit interviews to be conducted on stable ROC by ADDP Regional Coordinators to get feedback on quality and impact of service
6. **Non-ART Service Provision** – Number of non-ART patient services provided
7. **Access to livelihoods** – Number of beneficiaries of wealth pooling and LCA activities

Element	Indicator	Description	Level of Disaggregation	Numerator	Denominator	Data Source	Reporting frequency	Assumptions
Health facility Decongestion	% stable ROCs that are in community approaches	Denotes stable ROC that are decanted from facilities to community approaches	Age category, Sex, Facility level, Community approaches – CDDP, CLDDP, CRPDDP, CCLAD	# stable ROCs that are in community approaches	# stable ROCs in facility approaches	EMR, ART register	Monthly	All ROC have update VL Right categorization of ROC by HCW
Identification and linkage of new HIV positive	% PLHIVs newly identified at CLDDP	HIV yield at CLDDP	Age category, Sex, Facility level	# tested HIV positive	# received an HIV test	EMR, HTS register	Monthly	
	% newly identified PLHIVs at CLDDP linked to care at the health facility	Linkage of newly identified HIV positive to HIV care at the parent health facility	Age category, Sex, Facility level	# newly identified HIV positive linked to Health facility for HIV care	# tested HIV positive	EMR, HTS register	Monthly	Linkage and referral system that links CLDDP to health facility
Retention on CLDDP	% ROCs active and on treatment in CLDDP at 6-, 12- and 24-months post enrolment on to CLDDP	ROCs retained on CLDDP 6-, 12- and 24-months post enrolment on to CLDDP	Age category, Facility level	# ROCs active and on treatment in CLDDP at 6-, 12- and 24-months post enrolment on to CLDDP	# ROCs enrolled on CLDDP 6, 12 and 24 months	EMR, ART register	Quarterly	Updated status of ROC at end of each reporting period
	Net retention on CLDDP	ROCs retained on CLDDP	Age category, Facility level	# ROC active on CLDDP at the end of reporting quarter	# ROC active on CLDDP at the end of previous reporting period plus all newly enrolled on CLDDP in the reporting period	EMR, ART register	Quarterly	

Viral load Coverage and Suppression for ROC on CLDDP	% of ROC on CLDDP who accessed a VL test in the past 12 months	Viral load coverage for ROC on CLDDP	Age category, Sex	# ROC on CLDDP who received a VL in the past 12 months	# active clients on CLDDP	EMR, ART register	Quarterly	
	% of ROC on CLDDP virally suppressed	Viral suppression rates for ROC on CLDDP	Age category, Sex	# ROC on CLDDP with a suppressed Viral load (most recent) within the past 12 months	# active clients on CLDDP	EMR, ART register	Quarterly	
Service quality	% of ROC on CLDDP satisfied with quality of services provided under CLDDP	ROC perceptions on services provided under CLDDP	Age category, Sex, Facility level	# ROC on CLDDP reporting satisfactory service delivery under CLDDP	# ROC on CLDDP interviewed	ROC Survey reports	Semi annual	
Non-ART Service Provision	Number of non-ART patient services provided	Shows other clients/patients who benefit from the approach	Age category, Sex, service category	# of non-ART patient services provided	# of non-ART patient services provided at the health facility	IP data collection, outreach and health facility registries	Quarterly	
Access to livelihoods	Number of beneficiaries of wealth pooling and LCA activities	Provides background on how	Age category, Sex	# of beneficiaries of wealth pooling and LCA activities	# of LCA members	IP data collection	Quarterly	

4. Implementing Partner and Health Facility CLDDP Training Curriculum

Training and support will be conducted with participating IPs, health facilities, and communities to ensure uniform implementation and operation of the programme. Sample MOUs, LCA constitution, and data collection tools can be found in the appendices.

4.1 Core competencies

These are some of the core competencies that partners should have in order to implement CLDDPs effectively:

Health Care Workers

- Understanding of how to set up scheduling to fit in timetables and ensure regular service to communities
- Understanding of how to allocate commodity stocks
- Understanding of how to use M&E tools to follow up with patients when necessary
- Understanding of wealth pooling
- Understanding of expectations of health care workers and community members
- Understanding of social distancing, quality of service, and privacy guidelines

LCA Members

- Understanding of best practices in mobilizing community members for CLDDPs
- Understanding of wealth pooling and shared goal of accessing livelihoods
- Understanding of record keeping
- Understanding of social distancing, quality of service, and privacy guidelines

Community Members

- Understanding of CLDDP approach objectives and processes
- Understanding of wealth pooling model
- Understanding of social distancing, quality of service, and privacy guidelines

Implementing Partner Staff

- Understanding of roles of each stakeholder
- Understanding of how to help establish, register, and monitor LCAs and wealth pooling
- Understanding of social distancing, quality of service, and privacy guidelines

4.2 Training Curriculum

Training will be conducted with participating health facilities to ensure uniform implementation and operation of the programme. More than one person will be trained at facilities to ensure continuity should resignations take place.

a. National level orientation
b. Training of trainers of implementing partner staff at regional level
c. Training of health care workers, conducted by IP operating in the district

CLDDP Training Elements

This is the outline for the training for staff of partner health facilities:

1) Differentiated Service Delivery
    a) Overview
        i) Definition
        ii) Principles
        iii) Building blocks
    b) Differentiated HTS
    c) Differentiated care and treatment
    d) Implementation status
2) The Community-Led Drug Distribution Points (CLDDP)approach
    a) Background on CLDDP approach
    b) Wealth Pooling & Local Community Associations (LCAs)
    c) Implementation of CLDDP approach
    d) Scheduling, preparation, and stock management for CLDDPs
    e) Privacy and Quality of Service at CLDDPs
    f) Monitoring & Evaluation of CLDDPs
    g) Role playing discussing CLDDP approach with recipients of care
    h) Introducing CLDDPs in your area
3) Health promotion, adherence and appointment tracking
4) Action Plans

5.Site Identification

Here are the conditions for choosing a host site for the CLDDP approach:

Necessary

- Is at least 5km from the nearest health centre III or above

Should meet ***at least one of the following conditions*** (ideally both):

3. Has a population of over 150 residents and at least 25 PLHIV
1. Has many residents with problems of defaulting in ART, maternal health, or others

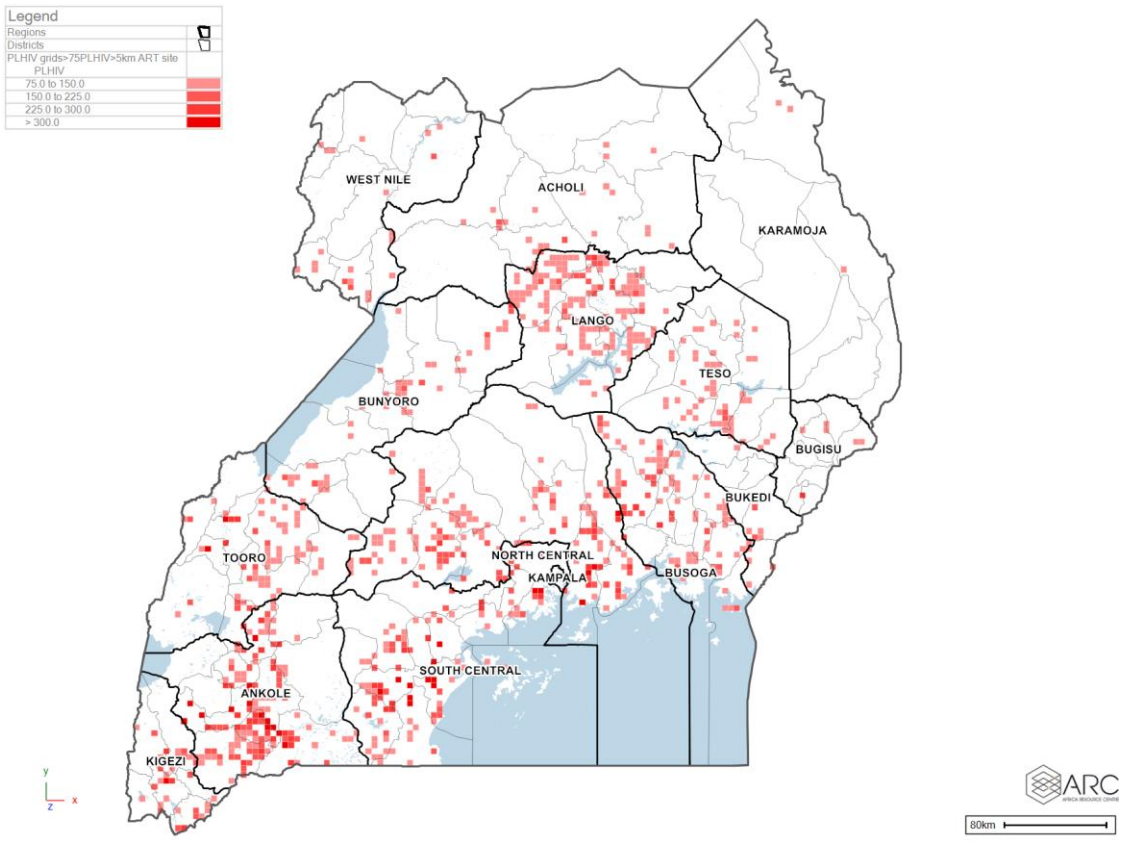
5.1 GIS tools

Participating IP's will have a copy of SpatialXl GIS analysis software installed and be trained in the operation to use in the implementation of CLDDP.

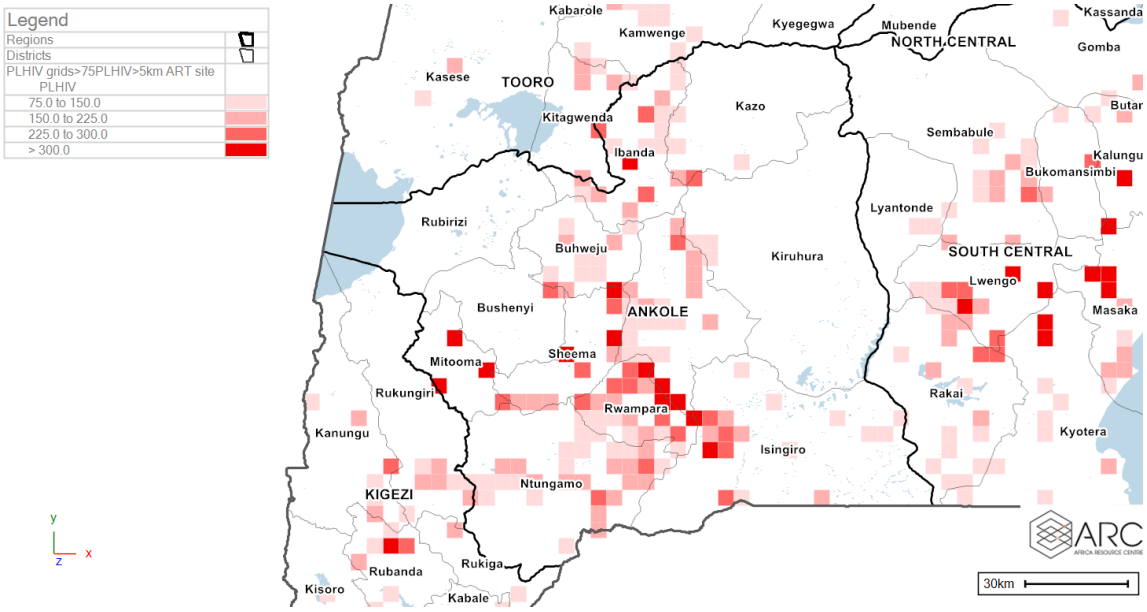
The SpatialXL tool to be installed at IP's is a mapping and analytics add-in to Microsoft Excel, which allows for seamless interaction between spreadsheets and maps. MoH users will be able to quickly view and update any GIS data layers such as healthcare facilities; analyse data for decision making and planning; and create and distribute maps for improved communication and reporting.

5.2 Maps

Here are some samples of maps that can be used for site identification:



Map 1: Areas with high numbers of PLHIV residing over 5km from the nearest ART distribution point (HCIII and above)



Map 2: Closer view of the Western region with high numbers of PLHIV residing over 5km from the nearest ART distribution point

6. Appendices

Appendix A: MOU of District and Implementing Partner

THE REPUBLIC OF UGANDA

THE NON-GOVERNMENTAL ORGANIZATIONS ACT, 2016

TEMPLATE OF MEMORANDUM OF UNDERSTANDING

MEMORANDUM OF UNDERSTANDING

BETWEEN

THE LOCAL GOVERNMENT OF _____

AND

_____

[Address]

Introduction

This Memorandum of Understanding (MOU) records the understandings reached between the Local Government of _____ District (the District) and _____ (the Implementing Organization) to implement the Community Led Drug Distribution Point (CLDDP) approach.

Objectives

A Community Led Drug Distribution Point (CLDDP) is **a service delivery approach in which health care workers provide integrated health services** (ART, HIV counselling and testing, TB services, and other primary health care services) **in a community, and the community plays a role in mobilisation and oversight.** The main objective of the CLDDP approach is to improve the health and access to livelihoods of people in remote communities. The approach works toward this objective by setting up regular outreaches/CLDDPs that occur in remote communities and are led by Local Community Associations (LCAs) made up of members of affected communities who have set up wealth pooling to improve access to livelihoods, health care, and other social services.

The CLDDP approach enables communities through LCAs to set up integrated outreaches/CLDDPs by working with the healthcare workers and community members to coordinate the outreaches/CLDDPs and come up with a wealth pooling strategy to improve on their livelihoods. The CLDDP approach targets comprehensive, integrated health services with a special focus on Antiretroviral Therapy (ART), HCT, perinatal care, family planning, and other essential health services.

Commencement

This MOU shall commence on the _____ day of _____ 20____.

Variation

Any variation to this MOU will be mutually determined in writing by both parties.

Agreement of the District

The District agrees to undertake the following key tasks:

- Identify target areas and health facilities to work with.
- Introduce the Implementing Organization to administration staff at the district, District Health Office (DHO), and health facilities that will implement the CLDDP programme.
- Support the activities of the Implementing Organization by discussing them with relevant officials and partners.
- Help the DHO to assure that health facilities keep and share records of CLDDP-related activities.

- Collaborate with the Implementing Organization to evaluate the programme and suggest ways to improve and expand it.
- Inform the Implementing Organization if there are any related activities or conflicts going on in the district, that may interfere with CLDDP performance.
- Introduce the Implementing Organization to national and district officials and representatives from civil society organizations and or Local Community Associations (LCAs) that can help to expand the reach of the CLDDP programme.

Agreement of the Implementing Organization

The Implementing Organization agrees to undertake the following key tasks and responsibilities:

- Expand the programme to communities that are identified in cooperation with DHO.
- Ensure that they work with Local Community Associations (LCAs) to form saving groups and also their formation where they are none exisitent.
- Oversee the activities of the LCAs to ensure effectiveness of the programme
- Regularly check in with local leaders to ensure that the programme is functioning and serving people's needs.
- Regularly check in and give periodic reports to the DHO and CAO to assure that the programme is meeting their needs.
- Make necessary changes if there are any problems or if circumstances deem it necessary.
- Assist communities and Health Facility Staff, when they have enquiries or suggestions of how the programme should be improved.

Termination

The parties may terminate this Memorandum of Understanding, at any time, by mutual agreement in writing.

In the event of termination, the Implementing Organization will take immediate steps to bring its work to a close in a prompt and orderly manner and to reduce expenditure to a minimum.

Extraordinary Events

Neither party shall be liable for any failure to perform or any delay in performing under this MOU to the extent that the cause of such failure or delay is beyond that party's reasonable control (*force majeure*) provided notice claiming suspension of its obligations is given as soon as practicable.

The parties may mutually determine to suspend or terminate any part or all of the MOU in the event of *force majeure*.

This memorandum of understanding shall be governed by the Laws of Uganda.

District Representatives

Signature:

Name:

Title:

Implementing Organization Representative

Signature:

Name:

Title:

Appendix B: MOU of Community and Implementing Partner

MEMORANDUM OF UNDERSTANDING

Local Community Association, Community Members, and Implementing Organization for establishing and sustaining a Community Led Drug Distribution Point (CLDDP)

_____

Local Community Association

and

_____

Community

and

_____

Implementing Organization

Date:_____

Description

This Memorandum of Understanding (MOU) is to establish a working relationship under the Community Led Drug Distribution Point (CLDDP) approach.

Objectives

A Community Led Drug Distribution Point (CLDDP) is **a service delivery approach in which health care workers provide integrated health services** (ART, HIV counselling and testing, TB services, and other primary health care services) **in a community, and the community plays a role in mobilisation and oversight.** The main objective of the CLDDP approach is to improve the health and access to livelihoods of people in remote communities. The approach works toward this objective by setting up regular outreaches/CLDDPs that occur in remote communities and are led by Local Community Associations (LCAs) made up of members of affected communities who have set up wealth pooling to improve access to livelihoods, health care, and other social services.

The CLDDP approach enables communities through LCAs to set up integrated outreaches/CLDDPs by working with the healthcare workers and community members to coordinate the outreaches/CLDDPs and set up a system to save money and improve on their livelihoods . The CLDDP approach targets comprehensive, integrated health services with a

special focus on Antiretroviral Therapy (ART), HCT, perinatal care, family planning, and other essential health services.

In this MOU we outline the expectations and duties of the implementing organization, the LCA, and the community to ensure that the programme is successful and serves the needs both of health workers and the people of the area.

Roles & Responsibilities

_____

Implementing Organization

The members of this organization will be expected to complete the following activities:

- Identify existing organizations to roll out LCAs and where there is none, organize community members to form LCAs for this cause.
- Ensure that all participating LCAs are fully registered and in compliance with national and district policies.
- Provide necessary training of all stakeholders in respect to their responsibilities.
- Oversee LCA activities and provide support supervision to ensure effective performance.
- Ensure that health facilities provide the beneficiaries with schedules of activities.
- Monitor the privacy and quality of service provided at CLDDPs/outreaches and address gaps to ensure good quality of service.
- Regularly check in with local leaders to ensure that the programme is functioning and serving people's needs.
- Regularly check in with health facility staff to ensure that the programme is meeting their needs.
- Make programme changes if there are any problems, or if circumstances deem it necessary.
- Assist communities, health facility staff, and LCAs when they have enquiries or suggestions of how the programme should be improved.

_____ and _____

Local Community Association *Community*

The LCA members, Village Health Team members (VHTs), Local Council I Chairperson, and other community members will be expected to complete the following activities:

- To voluntarily subscribe to the saving groups formed under LCAs for the purpose of leading and sustaining CLDDPs/outreaches.
- To participate in matters concerning the CLDDPs/outreaches at LCA meetings whenever called upon.
- To identify a suitable site for the outreach to always take place in, that meets the minimum standards of privacy and quality as guided by the healthcare workers and implementation organization staff.
- Inform community members, both HIV positive and negative, about the CLDDP activities, services offered, and upcoming outreaches.

- To participate in choosing a committee that will be responsible for managing funds for the outreaches.
- Identify potential locally available resources that can help improve performance of CLDDPs and make recommendations to the LCAs and IP.

We shall be happy if our collaboration is successful.

Sincerely,

Implementing Organization Representative

Signature:

Name:

Title:

Local Community Association and Community Members

Members (print and sign). LCI Chairperson to Sign and Stamp the document:

Appendix C: Environmental Health Profile

This tool is used by IPs to build a profile of the environmental health resources and needs of the communities that they serve. This tool can be filled out on a paper form or a digital survey tool.

1. Name of community/village
2. Date and time of observation
3. GPS coordinates taken from the center of the village
    - Latitude
    - Longitude
4. Population estimate of the community
    - Source of the population estimate
5. Estimate of number of people living with HIV (PLHIV) in the community
    - Source of PLHIV estimate
6. Number of the public shared latrines (count each latrine individually)
    - Comment on the kind of latrine and toilets available
7. Number of water access points
    - Lake
    - River or creek
    - Well
    - Faucets
    - Other
    - Comments on water access points
8. Forms of transportation available to residents
    - Boda Boda
    - Taxi
    - Special Hire
    - Boat
    - Others (describe)
9. Number of active VSLA village saving and loan associations (VSLAs)
10. Does the village have a health centre II?
    - Outpatient clinic staffed by nurse, midwife, 2 nursing assistants and 1 health assistant*
11. Name of closest health facility
    - Distance to closest health facility in kilometers
    - Is it public of private?
12. How much is the average or most common cost of reaching the nearest health facility?
13. Comments on the Health facilities
14. Number of Traditional birth attendants
15. Number of drugs shops/pharmacies
16. Does the pharmacy currently stock:
    - Family planning
    - Malaria treatment
    - Diarrhea treatment
17. Comments on Drug shops or Pharmacies
18. Primary contacts

- Name
- Title
- Telephone

Appendix D: Sample CLDDP Data Collection Form

CLDDP DATA FORM A

To be completed by village health team (VHT) member.

Person filling form _____ Position

Village District

CLDDP INFORMATION

Date Intended Start Time

Actual start time End time

Was an IP staff present? (circle) Yes No

Were any other organizations involved or contributing to this CLDDP? Yes No

If yes, name of organization

Total Patients			
Ages	Male	Female	**Total**
0year-9years			
10-19 years			
20+ years			
Total			

List names of villages patients came from

Money Collected			
	Number of people	UGX per person	Total Collected
Adults			
Children			
Exceptions:			
Reduced payments			
Fees waived			
Total			

Explanation of any exceptions above

Money Distributed	
	Amount Distributed
Total given to HCWs	
Total given to VHTs	
Transporters	
Other Costs	
Total	

Explanation of other costs

Total Surplus (+) or Deficit (-): _____

CLDDP DATA FORM B

To be completed by clinical officer or equivalent.

Person filling form Position

Health Centre Village Date

CLDDP INFORMATION

Names of health workers who attended

Number of Health Workers									
Total Health Workers	*Enrolled Midwives*	*Registered Midwives*	*Clinic Officer*	*Counsellors*	*Lab Technician*	*Nursing Assistant*	*Enrolled Nurse*	*Registered Nurse*	*Other (specify)*

Services offered:

- General Treatment
- Family Planning
- HIV Counselling/Testing
- ART Refills
- ANC/PNC
- Viral Load
- Other _____

Were there stockouts? (circle one) **Y / N**

What services were IMPACTED OR UNAVAILABLE due to stockouts?		
General Treatment	• *Malaria treatment* • *Amoxicillin*	☐ *Other* _____
HIV/ART	• *ART* • *Testing*	☐ *Other* _____
Family Planning	• *Pregnancy tests*	☐ *Other* _____
ANC/PNC		

ANTI-RETROVIRAL TREATMENT (ART)

1. TB	
Diagnosed	*Treated*

2. Number of patients given each ART duration			
1 month		_____months	
2 months		**Total number of people**	
3 months		**Total no. months given**	

3. Patients Receiving ART		
Age	Male	Female
0-9 year		
10-14 years		
20+ yrs		
Total		
4. Patients Newly Linked to Care		
Age	Male	Female
0-9 year		
10-19 years		
20+ yrs		
Total		
5. Viral Load Blood Samples Taken		
	Male	Female
Total		

CLDDP DATA FORM C

To be completed by clinical officer, nurse, or other health worker offering general treatment.

Person filling form

Health Centre Position

Village visited Date

OTHER SERVICES

Total Pregnant Women Served for any reason	***Syphilis***			***Blood Pressure***			***Malaria***		
	Total Tested	Tested Positive	Given Treatment	Total Tested	Tested High	Given Medication	Total Tested	Tested Positive	Given Medication

Diabetes Referrals	*Child Check-ups*	*Patients Given Pain Relievers*	*Immunisations Given*	*Vitamins Given*

	Worms	***Fungal*** *(Non-Candidiasis)*	***Candidiasis***	***Ulcers***	***Diarrhoea***	***Stomach Illness (Non-Diarrhoea)***	***Allergy***	***Chronic Respiratory Disease***
Diagnosed								
Given Treatment								

	Measles	***RTI***	***Malnutrition***	***Injuries***	***UTI***	***Gonorrhoea***	***Eye Infection***
Diagnosed							
Given Treatment							

Additional treatments or tests given and number of patients for each

Additional comments/concerns (continue on back if necessary)

CLDDP FORM D

To be completed in collaboration between lab technicians and counsellors.

Person filling form

Health Centre Position

Village visited Date

HIV COUNSELLING AND TESTING (HCT)

Total No. of clients served		***Counselled***		***HIV Test Results***		***Counselled & tested as couple***	***Received results as couple***	***Discordant results***	***Returned for viral load results***	***TB Suspect***
Male	*Female*	*Pre-test*	*Post-test*	*Total Positive*	*Total Negative*					

New Positives		
Age	Male	Female
18 mos-4 years		
5 - 9 years		
10 - 14 years		
15 - 19 years		
20+Yrs		
Total		

Patients Tested for First Time		
Age	Male	Female
18 mos-4 years		
5 - 9 years		
10 - 14 years		
15 - 19 years		
20+ - years		
Total		

CLDDP DATA FORM E

To be completed by midwife.

Person filling form

Health Centre Position

Village visited Date

FAMILY PLANNING, MATERNAL & CHILD HEALTH

Total served	***Male condom (# of patients)***	***Male Condom (# dispensed)***	***Oral Contrac. (# of patients)***	***Oral Contrac.*** *(# of cycles)*	*Depo-Provera*	Sayana Press	***Other Injectable***

Implanon	*Jadelle*	*Other Implant*	*IUD*	*Emergency Contraception*	*Female Condom*	*FP referrals*	*FP counselling only*

Other Family Planning Methods (name and number distributed)

Perinatal Health			
Total served	*Antenatal Care (ANC)*	*Postnatal care (PNC)*	*Immunisation referral*

Privacy and Quality of Service Scorecard

Purpose

This scorecard is to ensure the privacy and the quality of services provided at CLDDP outreaches. It also emphasizes the importance of privacy and confidentiality.

Scorecard

- Name of village
- Name of person filling form

Privacy Checklist

- The privacy checklist should be used to ensure that patients are able to be examined and receive services without others seeing or hearing them. Outreaches should strive to use indoor settings, such as houses, with individual rooms with doors that close. Medical documentation should be kept securely by health workers and should not be accessible to patients.

REGISTRATION
Slips of paper with numbers are handed out to ensure first come first serve and ensure privacy (by calling numbers and not names)

Overall score: 0 to 10

MEDICAL RECORD CONFIDENTIALITY
Medical files are kept securely and only accessed by health workers so that confidential patient health information is not disclosed (e.g. files are not kept in a place where patients can search through them and read other patients' names and medical information)

CLINIC EXAM ROOM

- Give a 10 if located inside a building with a private room that is soundproof
- Give a 7 if located inside a building that blocks others from viewing inside but is not soundproof
- Give a 5 if outside with curtains
- Give a 0 if outside with no privacy

LABORATORY SERVICES

- Give a 10 if located inside a building with a private room that is soundproof

- Give a 7 if located inside a building that blocks others from viewing inside but is not soundproof
- Give a 5 if outside with curtains
- Give a 0 if outside with no privacy

MEDICATION DISTRIBUTION

- Give a 10 if located inside a building with a private room that is soundproof
- Give a 7 if located inside a building that blocks others from viewing inside but is not soundproof
- Give a 5 if outside with curtains
- Give a 0 if outside with no privacy

GENERAL COMMENTS:

- Positives?
- Negatives?

Checklist completed by:
Date:

Quality of Services Checklist

Implementing organization Community Officers should use the checklist below at each outreach and report any missing items or services in the comments.

VHT Duties

Mobilization (1 day before and day of)

- Y/N

Collecting Money

- Y/N

Registering Patients

- Y/N

VHT Quality of Services = 0 / 3.

Registration

1 Table

- Y/N

2 Chairs

- Y/N

Registration Book

- Y/N

Registration Quality of Services = 0 / 4.

Waiting Area

Chairs or Benches

- Y/N

Rubbish Bin
- Y/N

Waiting Area Quality of Services = 0 / 2.

Clinical Exam Room

Disposable Gloves
- Y/N

Disposable sharps container
- Y/N

BP Machine
- Y/N

Stethoscope
- Y/N

Weighing Scale
- Y/N

Thermometer
- Y/N

Measuring Tape
- Y/N

Black Rubbish Bin for General Waste, Red Rubbish Bin for Biological Waste
- Y/N

Hand-washing station
- Y/N

Adequate lighting for examination
- Y/N

Exam table
- Y/N

Disinfecting wipes or spray for exam table
- Y/N

Tables and chairs for medical provider and patient to have a private conversation
- Y/N

Clinical Exam Room Quality of Services = 0 / 13.

Laboratory Services

Registers
- Y/N

Testing Kits (HIV, STIs, pregnancy test, malaria)
- Y/N

Sample collection containers (e.g. vacutainers, sputum mugs)
- Y/N

Disposable Gloves
- Y/N

Disposable sharps container
- Y/N

Black Rubbish Bin for General Waste, Red Rubbish Bin for Biological Waste
- Y/N

Hand-washing station

- Y/N

Adequate lighting for examination

- Y/N

Tables and chairs for medical provider and patient to have a private conversation

- Y/N

Laboratory Quality of Services = 0 / 9.

Medication Distribution

Registers

- Y/N

Table and chairs for medical provider and patient to have a private conversation

- Y/N

Black rubbish bin for general waste

- Y/N

Medication Distribution Quality of Services = 0 / 3.

Health Education

Flip charts/posters on health promotion topic such as FP, HIV prevention, nutrition, antenatal care, etc.

- Y/N

Blank flip charts and markers

- Y/N

Attendance tracking tool (name, age, gender)

- Y/N

Health Education Quality of Services = 0 / 3.

Services Provided

Implementing organization Community Officers should check to see if the following services are being provided at outreaches:

HIV Counseling and Testing (HCT)

- Y/N

Antiretroviral Treatment (ART)

- Y/N

General Treatment

- Y/N

STI Testing and Counselling

- Y/N

Antenatal Care

- Y/N

Postnatal Care

- Y/N

Immunizations

- Y/N

Family Planning

Combined oral pill

- Y/N

Progestin only pill
- Y/N

Emergency Contraceptive Pill
- Y/N

Male condoms
- Y/N

Female condoms
- Y/N

Water-based sex lubricant
- Y/N

Implants
- Y/N

IUD-Copper
- Y/N

IUD-Hormonal
- Y/N

Injectable (Depo Provera)
- Y/N

Injectable (Sayana Press)
- Y/N

FAM-SDM Beads
- Y/N

Lidocaine
- Y/N

Pregnancy (HCG) Test Kits
- Y/N

Health education (e.g. nutrition, WASH, FP, HIV prevention)
- Y/N

Registers filled by health workers.
- Y/N

Quality of Services = 0 / 24.

Break Down

Ensure the health workers complete the clinical reports before leaving the outreach.
- Y/N

Pack up all supplies and leave the area clean.
- Y/N

Quality of Breakdown Services = 0 / 3.

Total

Overall Quality of Services = 0 / 63.

General Comments

Positives?
Negatives?
Date:

Appendix F: Sample Savings Local Community Association Constitution

SAVINGS LOCAL COMMUNITY ASSOCIATION CONSTITUTION TEMPLATE

BASIC INFORMATION

[Name of LCA]
[Address of LCA]

VISION, MISSION, AND OBJECTIVES

VISION

Quality social services and economic empowerment are accessible by all members of our community.

MISSION

to improve access to livelihoods, health care, social services, and economic empowerment in our community

OBJECTIVES

1. To bring health services from the government health system to our community on a regular basis
2. To establish wealth pooling and savings for the community
3. To promote unity among members and the community

ACTIVITIES & SERVICES

ACTIVITIES

- Setting up primary healthcare outreach activities in our community
- Establishing a wealth pooling structure to sustain those outreaches

SERVICES OFFERED

OUTREACHES

Government health workers conduct outreaches in the community at an agreed-upon frequency, e.g., monthly or bimonthly. Outreaches provide primary healthcare services that are available to any member of the community. Here are some important aspects of the outreaches:

- Conduct outreaches in designated buildings agreed to by health workers as sufficient to provide privacy and cleanliness to patients

- Enforce social distancing guidelines and ensure that handwashing stations are available
- Provide health workers with what they need to administer services in a clean, safe environment

WEALTH POOLING

Wealth pooling allows organization and community members to make sure that they improve their access to livelihoods. There should be a clear system for how members and nonmembers can contribute to the wealth pooling model.

RESTRICTIONS

- No loans will be given with any surpluses.
- The association will not borrow from financial institutions.
- Members' savings cannot be used as collateral for an external loan.
- Surpluses can be used toward expenses that help community members in need of accessing health services.
- The association shall sit and decide on spending money on emergency expenses. All decisions must be approved by 2/3 vote of the Management Committee and communicated to the members.

MEMBERSHIP

WHO MAY BE A MEMBER OF THE ASSOCIATION?

- Above 18 years of age
- Any gender
- Resident of our community (spends at least 50% of the year living in the community)

RIGHTS AND OBLIGATIONS OF MEMBERS

1. Abide by word and spirit of this constitution
2. To promote the good name of the organization and engage into full time organization activities.
3. Elect and respect officials in the organization on merit not justice
4. At all times know their roles and avoid interference in other roles, respect one's dignity, avoiding despising others, undertaking or doing anything abominable to human peace
5. Members shall have freedom to express their opinions in the proper manner.
6. All members shall be reliable to surpluses generated and deficits incurred by the organization.

LEAVING THE ASSOCIATION

- If a member leaves the Association because they have no alternative (such as if they move away). They will be entitled ONLY their contributions or shares saved up to date.
- If a person is expelled for failing to make regular share-purchase/savings deposits, shall be given ONLY their shares saved.

EXPULSION OF MEMBERS

- A person shall be expelled from the association if the Management Committee or General Assembly vote to expel them with cause. Causes can include disrupting meetings, harassing other members, or acting against the mission and interests of the association.

DEATH OF A MEMBER

- If a member dies, that member's savings will be retained in the organization's savings.

FINES

The following table lists the fines that can be charged for offences committed by members:

Offence	**Amounts**
Showing disrespect to a fellow member	2,000/=
Chatting through the procedure	1,000/=
Non-attendance at three meetings in one year for any reason	1,000/=
Late coming/early leaving	500/=
Chatting through the proceedings	500/=
Non execution of role by a member of management committee	1,000/=

Proceeds from fines are added to the savings box of the organization.

OFFICERS

OFFICER POSITIONS

Officers serve one year terms and may serve no longer than 5 years in any position.

CHAIRPERSON

- Serves as head of the executive of the organization
- Presides over meetings
- Oversees the announcement of outreach activities and mobilisation of patients

- Ensures that all policies and property of the organization are properly implemented and kept
- Keeps the chair neutral moving with majority decisions
- Ensures that organization activities adhere to the organization constitution
- Serves as a signatory to organization account

VICE CHAIRPERSON

- Assumes duties of the Chairperson when not available
- Assists the Chairperson in oversight of the organization

SECRETARY

- Oversees organization correspondences
- Assists the chairperson in the management of the affairs of the organization
- Records and keeps documentation of the minutes of organization meetings
- Calls meetings in consultation with the Chairperson
- Participates in all meeting and activity preparations
- Collaborates with the Treasurer to oversee organization's savings box

TREASURER

- Keeps the organization's savings box in between meetings
- Takes savings deposits in between meetings, placing money through the slot in the box, issuing tokens and keeping a simple temporary record.
- Verifies all movements of money both in and out of the cash-box
- Counts the money during each cash-box operation
- Informs the Secretary of each transaction
- Assists the Secretary and Outreach Manager in resolving any disputes, deficits, or irregularities in wealth pooling collection

OUTREACH FOCAL PERSON

- Oversees the setup and conduct of outreaches
- Communicates outreach schedule to community members
- Manages relationships with health workers and other organizations overseeing outreaches

ELECTION PROCEDURES

- One person serves on the Management Committee for one team but a member can be elected again.
- Elections must be held at the start of each new cycle.
- 2/3 of members must be present to hold an election.
- The election procedure will use a system that allows everyone's vote to be secret.
- The minimum number of people that must stand for each position is 2

- A candidate for election to a post must be proposed for office by another member.

REMOVAL OF OFFICERS

- Any member of the General Assembly can request a review of a member's suitability to be on the existing Management Committee.
- If a majority of General Assembly or Management Committee members decide that the person should be removed from the Management Committee, the member must step down and another member be elected to the same position.

BODIES, RESPONSIBILITIES, AND MEETINGS

GENERAL ASSEMBLY

The General Assembly is made up of all members of the organization. Only members of the organization may vote on resolutions. The General Assembly has the power to do the following in meetings:

- Approve amendments to the constitution by 60% majority
- Election of officers
- Removal of officers

MEETINGS

- Announcements of General Assembly meetings must be public and advertised in the community so that any member of the community may attend.
- The Treasurer or Secretary must report on the financial status of the organization at each General Assembly meeting.
- All resolutions must have time allotted for discussion before they can be passed.

MANAGEMENT COMMITTEE

The Management Committee is made up of the elected officers. The Management Committee has the power to do the following in meetings:

- Decide on activities and use of wealth pooling surplus
- Propose constitutional amendments to the General Assembly
- Remove officers
- Install interim officers if necessary

MEETINGS

- The Treasurer or Secretary must report on the financial status of the organization at each General Assembly meeting.

- All resolutions must have time allotted for discussion before they can be passed.

AMENDMENTS

Amendments to this constitution may be proposed and passed under the following conditions:

- Any member can propose a change to the Constitution.
- 2/3 of the members must vote at a General Assembly meeting before the constitution can be changed.

HISTORY

Constitution was approved on [Date]

Amendments

- [Description of amendment], approved on [Date]