# HEALTH PROMOTION TANZANIA (HDT)

# END OF PROJECT REPORT FOR MATERNAL AND CHILD SURVIVAL PROGRAM

*Reporting Period: January - November 2016*
*District Geographical Covarage: Ngara and Biharamulo*


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USAID FROM THE AMERICAN PEOPLE

Maternal and Child Survival Program


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## Contents

## Abbreviation

| | |
|---|---|
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **CDC** | Centre for Disease Control |
| **CHF** | Community Health Fund |
| **CHMT** | Council Health Management Team |
| **CSO** | Civil Society Organization |
| **DRCHCo** | District Reproductive and Child Health Coordinator |
| **EPCMD** | Ending Preventable Child and Maternal Deaths |
| **FGC** | Facility Governing Committee |
| **FP** | Family Planning |
| **HDT** | Health Promotion Tanzania, maintains |
| **HIV** | Human Immunodeficiency Syndrome |
| **LGAs** | Local Government Authorities |
| **MCSP** | Maternal and Child Survival Program |
| **MDAs** | Ministries Departments and Agencies |
| **MER** | Monitoring Evaluation and Research/Reporting |
| **M/F** | Mother and Father |
| **NGO** | Non-Government Organization |
| **RMNCH** | Reproductive Maternal Newborn and Child Health |
| **SBCC** | Social Behavior and Communication Change |
| **USAID** | United State Agency for International Development |
| **VEO** | Village Executive Officer |
| **VHC** | Village Health Committee |
| **WEO** | Ward Executive Officer |
| **WDC** | Ward Development Committee |

## ACKNOWLEDGEMENT

HDT implemented the Maternal and Child Survival Program in Ngara and Biharamulo District Councils. However, it would not have been possible without the kind support and help of many individuals and organizations. We would like to extend our sincere thanks to all of them.

HDT is highly indebted to our donor MCSP-JHPIEGO for trusting us to implement this program. In addition to this, their guidance and constant supervision as well as for providing necessary information regarding the project was paramount. In particular we would like to thank Dr. Dunstan Bishanga the chief of Party, Senior Technical Advisor-Community Engagement Mr. Kenneth Chima, MCSP Grant Manager Mr. Henry Patrice, Finance and Grants Officer Lusajo Athanas and the Kagera Regional Coordinator Madam Janeth Mselemu. We thank them for their support through the course of project implementation.

We would also like to express our sincere gratitude towards special individuals of Ngara District who supported us throughout the implementation of this project. The District Executive Director Mr. Aidan J. Baham; District Council officials especially Health department led by previous DMO Dr. Rufano, the current DMO-Dr. Revocatus Ndyekobora, DRCHCo-Madam Mecktrida Byambwenu, CHWs District Coordinator Madam Dorothy Ntakamulenga and CHF District Coordinator Rodgers Baijuki.

We extend our heartfelt thanks to the Biharamulo District Council including the DMO Dr. Joel Maduhu, DRCHCo-Domina Lugaiganisa, Health Officer Mr. Kashegwe Niwagira and CHWCo Elizabeth Rubandama.

Many thanks and special appreciations go to all the CHWs in Ngara and Biharamulo whose names may not be all mentioned here. We salute them for tireless work, without them the results presented in this report would not have

been registered. HDT understands how devoted they all were in ensuring all the projects goals are achieved.

HDT also thanks the honorable Councilors and WEOs from all projects wards which are Bukiriro, Murusagamba, Keza,Mabawe, Kirushya and Kasulo of Ngara district and Nyabusozi, Nyakahura, Kalenge, Runazi and Lusahunga of Biharamulo district without forgetting all the VEOs and village chaipersons in all villages of MCSP.

Last but not least, the board and management of Health promotion would like to thank the field team in Ngara and Biharamulo for their dedicated work. They include Sixbert Eustad, Samwel Simon, Mariethan Thomas, Lemmy Nkinga, Paschal Kamugisha, Emmanuel Magarinza, Frank Mukama, and Joana Simon. Finally we hope the gains from this work will be maintained for the welfare of mother and child and that we will have another opportunity to serve these communities.

## 1.0 PROJECT STATUS SUMMARY REPORT

This section provides summary status of performance comparing from targets and final achievement in absolute number and percentage.

### BIHARAMULO

| ACTIVITY | ANNUAL TARGET | ACHIEVEMENT | % INDICATOR |
|---|---|---|---|
| Orient and distribute SBCC materials monthly | 9 | 8 | 88.9 |
| Conduct cinema shows to villages | 21 | 21 | 100.0 |
| Gulio la Afya monthly | 9 | 12 | 134.0 |
| Gender dialogue, 51 groups a year | 34 | 43 | 126.5 |
| Score cards meetings to monitor implementation; 2 wards, 8 meetings | 8 | 9 | 112.5 |
| CHWs monthly meetings, pay stipends and transport monthly | 12 | 12 | 100.0 |
| Supportive supervision by program officers monthly | 9 | 6 | 66.7 |
| Joint supportive supervision with MCSP, quarterly | 4 | 4 | 100 |

### NGARA

| ACTIVITY | ANNUAL TARGET | ACHIEVEMENT | % INDICATOR |
|---|---|---|---|
| Orient and distribute SBCC materials monthly | 9 | 9 | 100 |
| Conduct cinema shows to villages | 21 | 19 | 90 |
| Gulio la Afya monthly | 9 | 9 | 100 |
| Gender dialogue, 57 groups a year | 38 | 43 | 113 |
| Score cards meetings to monitor implementation; 2 wards, 8 meetings | 8 | 7 | 87 |
| CHWs monthly meetings, pay stipends and transport monthly | 12 | 12 | 100 |
| Supportive supervision by program officers monthly | 9 | 6 | 66.7 |
| Joint supportive supervision with MCSP, quarterly | 4 | 4 | 100 |

Above 86% | Above 71%-85% | Above 50%-70%

[1]This status summary is extracted from HDT project performance Dashboard which is colour coded to alert offices on quarterly basis when performance is not good enough.

## 2.0 INTRODUCTION

Health Promotion Tanzania **(HDT)** with outstanding experience on Maternal and Child health interventions, implemented a USAID funded Maternal and Child Survival Program (MCSP) in Ngara and Biharamulo districts through Jhpiego.


The Maternal & Child Survival Program is a multi-partner, flagship program in support of USAID's priority goal of ending preventable child and maternal deaths in a generation. It is an evidence-based and results oriented, focusing on increasing coverage and utilization of high-quality reproductive, maternal, newborn and child health interventions at the household, community and health facility levels.

Although MCSP was a three year Program, HDT only implemented for one year due to late start of the project in the region. HDT started implementation officially in January and ended in November 2016. MCSP will be successed by Maternal and Child Health Integrated Program (MCHIP).

In line with Tanzania's goals, MCSP focuses on increasing the utilization of quality health services across the continuum of care (from the hospital to the community) in Kagera and Mara regions. In these two regions, MCSP is working with the MoHSW, Regional Health Management Teams (RHMTs) and Council Health Management Teams (CHMTs) to improve the coverage and quality of RMNCH services. MCSP is also supporting health systems strengthening, prevention of malaria in pregnancy, prevention of mother-to-child transmission of HIV and health information systems.

HDT has been implementing MCSP in Ngara and Biharamulo districts, working with well-trained Community Health Workers (CHWs) and Health facilities in their locations towards increased access and coverage of quality reproductive, maternal, newborn and child health (RMNCH) services in order to reduce maternal, newborn and child morbidity and mortality.

## 3.0 OPERATING CONTEXT

Maternal and Child Survival Program was implemented while aligning to the Tanzania Strategic Plan to Improve Reproductive, Maternal, Newborn, Child and Adolescent Health in Tanzania One Plan II (2016 - 2020). It also aligns to the SDGs which aim at ending maternal, newborn, child and adolescent deaths by 2035. MCSP aims at reducing maternal, newborn and child mortality by putting more emphasis on the improved health seeking behaviours and promotion of maternal and child health services including family planning, ANC, male involvement, postnatal care, exclusive breastfeeding and safe delivery plan.

Coverage of MCSP implementation revolved around a Health Facility whereby all catchment-villages covered by the facility formed part of the implementation coverage. Low performing facilities in RMNCH were targeted and 4 community health workers were identified from each village. Therefore, HDT worked with 5 health facilities in Biharamulo and 6health facilities in Ngara.In Ngara and Biharamulo, HDT worked with MCSP and CHMT to improve the coverage, quality and sustainability of a fully integrated package of services.

Biharamulo district has an estimated population of 323,486

(NBS National census 2012); males were recorded 160,486(49%) and females 162,914 (51%). Between 2009 and 2012; the district recorded an average of 92 and 171 maternal and under five deaths respectively[2]. Anecdotal information shows that among the reasons to why there is low uptake of health services, the assessors found poor community referral system, distantly located health facilities, inadequate number of health providers, poor attitude for few available health providers, inadequate health budget, inadequate obstetric equipments and shortage of lifesaving medicines[3].

| Ward name | Population |
|---|---|
| Nyabusozi | 23,988 |
| Nyakahura | 26123 |
| Kalenge | 34147 |
| Runazi | 14,472 |
| Lusahunga | 37,234 |
| **Total** | **135,964** |

Table 1: Estimated population of wards covered by MCSP in Bmlo

The Program covered five wards (17 villages) namely Nyabusozi, Nyakahura, Kalenge, Runazi and Lusahunga; According to National Bureau of Statistics, these wards have an estimated population of 135,964; which is 42% of total district population. The wards covered has an estimated 62,298 Women of Reproductive age and 70,402 Under-five children.

Ngara district has an estimated population of 320,056 people according to NBS 2012. It has a network of 52 health facilities among which 46 provide RCH and FP services. Health indicators show that the district records high fertility rate of 6.3 and 5.3 household average size above 4.8 of national average (ibid).

[2]Reproductive and Child Health Annual Reports, (2009, 2010, 2011 and 2012): Key RCH indictors including Family Planning, Antenatal Care and Postnatal Care Services and Delivery at the Facility.

[3]Health Promotion Tanzania (HDT) and AFP, 2012: Landscape Assessment on RCH situation in Biharamulo District Council

For instance, between 2010 and 2012; the district recorded an average of 56 maternal deaths per annum and an average of 20 per 1,000 under five deaths in the same time period.

| Ward Name | Estimated Population |
|---|---|
| Murusagamba | 18,093 |
| Keza | 9,525 |
| Bukiriro | 19,875 |
| Mabawe | 12,823 |
| Kasulo | 18,432 |
| Kirushya | 10,628 |
| **Total** | **89,376** |

Table 2: Estimated population of wards covered by MCSP in Ngara

The Program coveredsix wards (19 villages) namely Murusagamba, Keza, Bukiriro, Mabawe, Kirushya and Kasulo; According to National Bureau of Statistics, these wards have an estimated population of 89,376; which is 28% of district population. The wards covered has 72,401Women of Reproductive age, and 65,113 Under-five children.

## 3.1 Project Underlying Assumptions

Although MCSP has six intervention areas namely (1) Community Health, (2) Reproductive Health, (3) Immunization, (4) Malaria, (5) Maternal Health and (6) New Born Health, HDT participated mainly on community health that cut across Maternal health, Malaria, new born health and immunization. With this in mind, MCSP implementation envisaged to undertake:

1. Promotion of community engagement by using existing structures to support implementation of RMNCH interventions.
2. Working with community health workers to sensitize the community on health seeking behaviors.
3. Strengthening the capacity of community structures to coordinate and implement quality programs to address RMNCH issues.

### 3.2 Key areas to be addressed by MCSP Community Component include:

1. Creating Demand for use of RMNCH services,
2. Improve referrals through creating linkages between Health facilities and community,
3. Increase enrolment for Community Health Fund (CHF),
4. Create transport mechanism at community level to facilitate access to health facilities,
5. Conducting health promotion activities with focus in addressing gender issues hindering access of RMNCH services.

## 4.0 PROJECT TARGETS

Although the project has set target between MCSP and HDT on the start, there were modification based on implementation experiences. As a result of this modification, this report sets its benchmark on the final agreed targets.

**BIHARAMULO DISTRICT COUNCIL**

| ACTIVITY | ANNUAL TARGET |
|---|---|
| Orient and distribute SBCC materials monthly | 9 |
| Conduct cinema shows to villages | 21 |
| Gulio la Afya monthly | 9 |
| Gender dialogue, 51 groups a year | 34 |
| Score cards meetings to monitor implementation; 2 wards, 8 meetings | 8 |
| CHWs monthly meetings, pay stipends and transport monthly | 12 |
| Supportive supervision by program officers monthly | 9 |
| Joint supportive supervision with MCSP, quarterly | 4 |

**NGARA DISTRICT COUNCIL**

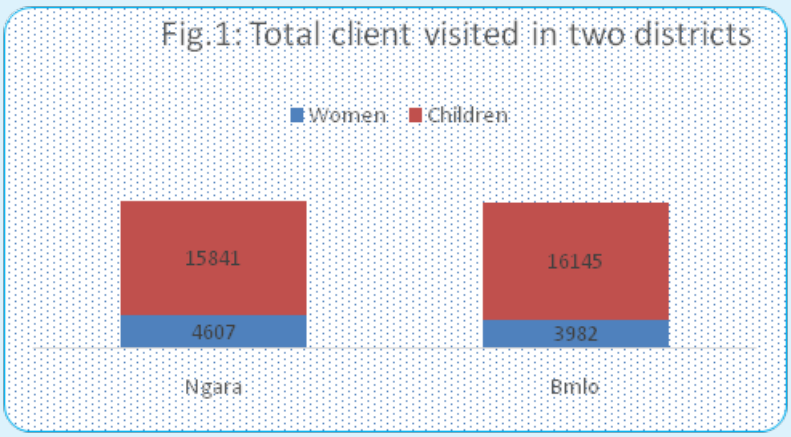
| ACTIVITY | ANNUAL TARGET |
|---|---|
| Orient and distribute SBCC materials monthly | 9 |
| Conduct cinema shows to villages | 21 |

| | |
|---|---|
| Gulio la Afya monthly | 9 |
| Gender dialogue, 57 groups | 38 |
| Score cards meetings to monitor implementation; 2 wards, 8 meetings | 8 |
| CHWs monthly meetings, pay stipends and transport monthly | 12 |
| Supportive supervision by program officers monthly | 9 |
| Joint supportive supervision with MCSP, quarterly | 4 |

## 5.0 RESULTS

### 5.1. Community Health Workers Visits

One hundred and forty-Four Community health workers (144) were empowered to conduct home visits, community events and gatherings with the purpose of promoting health seeking behaviours through delivery of messages by discussion and information and education materials.76 community health workers in Ngara serving 7353 households and 68 in Biharamulo serving 6276; on average one CHW serves 95 households. During the reporting period, a total of 40,575 visits to pregnant women, post-natal and under-five children were made in two districts, making average of 25 visits by CHW per month. *Refer detailed CWH visit in* ***Annex I***




Through CHWs, improved health seeking behaviors is observed with evidence of increased number of ANC especially with early attendance

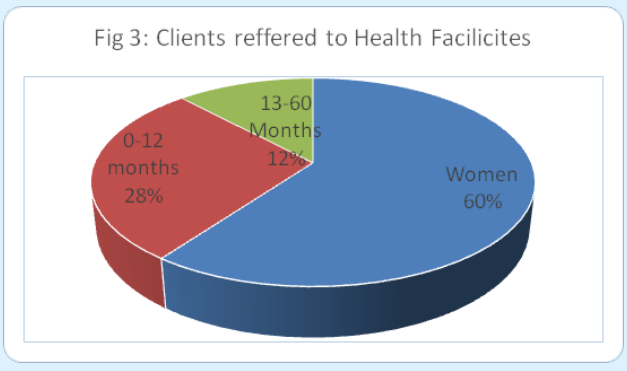
within 12 weeks of pregnancy, male involvement and demand for family planning services. Ms. Valeria Gerald (36) speaks ofhow their community health worker Miss ElivinaFelician changed her attitude on maternal and child health.

*"I have had five deliveries before, all delivered at home. This is my sixth child who I delivered at the facility. I never came early to clinics, but this time I did, escorted with my husband. I made four visits to the clinics though I used to come at 7 or 8 months pregnant. Our CHW miss Elivina Felicia has done an incredible work and I am done bearing more children. My husband and I, have decided Bahati to be our last one"*

## 5.2. Referrals Provided

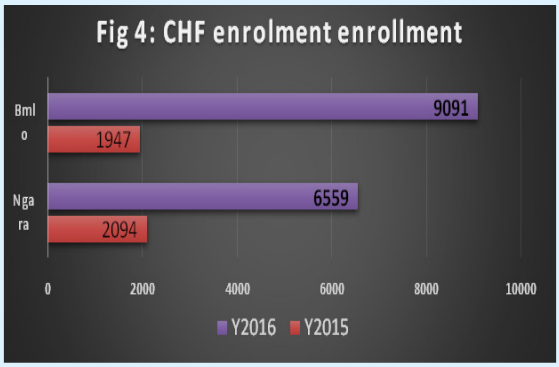
In an attempt to identify risk factors and increase antenatal attendance of both mothers and children, CHWprovided referrals for their clients to attend health services in nearby health facilities. Figure 2 shows that a total of 1503 referrals were provided during the period of implementation.

A total of 902 referrals were made for pregnant women for ANC attendance, home delivered newborns for Post Natal Care, which constituted 60% of all referrals. Other referrals, 421 to infant (0-12 Months) for Antenatal Care and 180 children between one to five years were referred to health facilities. ***Annex II*** provides details of referrals by CHW by district.



## 5.3. Community Health Fund (CHF)

As Tanzania embarks on its efforts to universal access under SDG agenda and its Health Strategic Plan Four, Promotion for enrolment into Community Health Fund would increase access to health care services especially in rural areas where access to cash is often seasonal. In B'mlo, CHF enrolment in 2016 increased from 1,947 to 9,091 by November 2016, which is an increase by 78% and in Ngara district CHF enrolment increased from 2,094 in 2015 to 6,559 which is an increase of 68%.




Evidence has it that health facility staff has confirmed that this intervention has contributed to their increased income to run health facilities as a result of increased enrollment in CHF. Health Officer In charge for Nyakahura Health Center Mr. Matthew said: "*We see the fruit of the good work this project has done, we are now seeing more mothers coming to the clinic pretty early and also our revenue has increased as a result of more clients for community Health Insurance*".

## 5.4. Capacity Building to Health governing committees

To build the capacity and sustainability of interventions, introduction meetings and capacity building to health governing committees were made. These include:

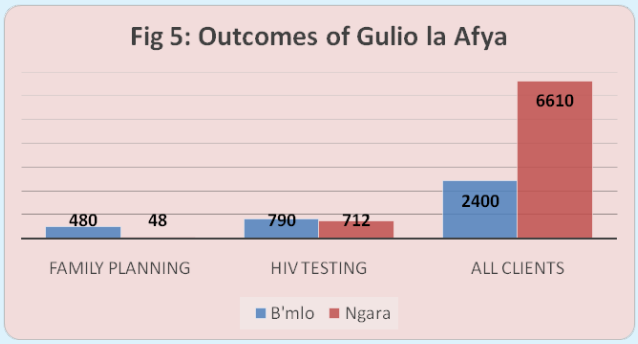
- Organized one day meeting with CHMT members for the purpose of introducing MCSP project, scope and roles of each part in Ngara and Biharamulo
- Organized one day meeting with WDC members in 5 wards of Biharamulo

DC and 7 wards of Ngara DC for the purpose of introducing HDT as implementing CSO of MCSP project.

- In collaboration with MCSP Regional office organized and conducted one day orientation to 34 village health committees. The orientation of Village Health Committees (VHCs) was conducted at the village level in 17 villages in five (5) wards of Biharamulo and 17 villages from 7 wards of Ngara. Out of expected 221 VHCs & CHWs, only 199 VHCs & CHWs were met reaching 90% coverage.

## 5.5. Gulio la Afya and Cinema show

HDT in collaboration with CHWs and community leaders conducted cinema shows in 17 villages of Ngara and and 21 villages of Biharamulo. Annex III provides details of villages which received these interventions. Cinema shows communicated messages on ante-natal clinic (ANC), family planning, Malaria and HIV/AIDS prevention, CHF and prevention of gender based violence (GBV) through movies such as Siri ya Mtungi and Yellow Card. About 7550 people were reached during cinema shows in Biharamulo and 6360 in Ngara. The followingleaflets were also distributed during the shows; 1850 brochures on family planning, 3115 brochures on HIV/AIDS messages and 2550 on Salama Condoms.

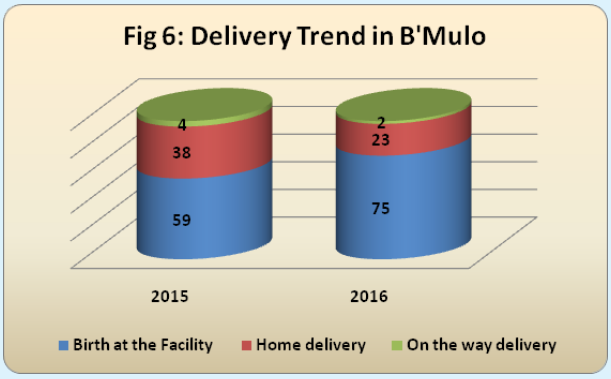


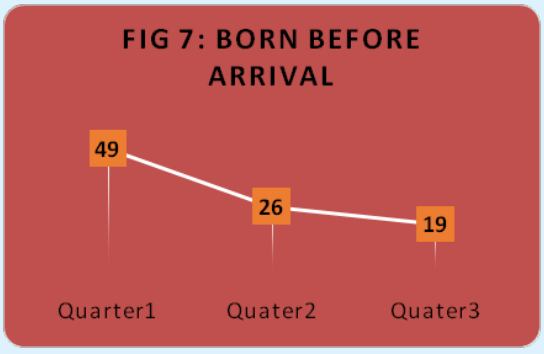

Twelve events for Gulio la Afya were conducted in Biharamulo reaching about 2,400 clients. Over half of them (53%) received either HIV counselling and testing or Family planning. 790 (33%) received HIV counselling and Testing and 480 (20%) received Family Planning services.

In Ngara, nine events were conducted reaching a total of 6,610 participants. 712 were counseled and tested for HIV, 48 joined family planning and 21 joined CHF. A total of 3633 condoms and 5648 brochures featuring HIV/AIDS prevention were distributed.

## 5.6.Women Delivery at Health Facilities

Through the course of implementation, the percentage of women giving birth at the facility has been increasing in both Ngara and Biharamulo from 57% to 85% and 59% to 75% respectively. As seen in Figure 6, the percentages of women who gave birth at home and on the way have decreased abundantly, exemplifying effectiveness of the work of community Health Workers. Comparing delivery data in Biharamulo district, there were 4,109 women who gave birth in Biharamulo in 2015, 38% of them happened at home, this decreased to 23% in 2016. Mothers who delivered on the way ( partly due to inability to plan for delivery) was 4% in 2015 and decreased to 2% in 2016, again depicting the value added by MCSP in decreasing home deliveries.



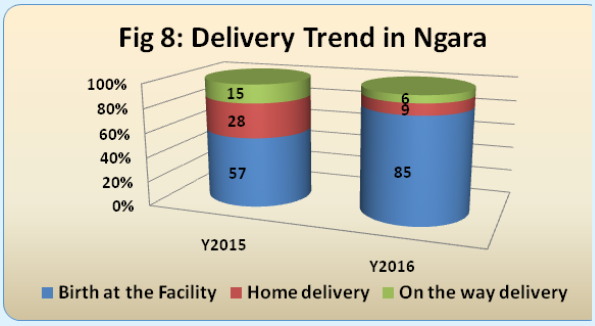




MCSP aimed at educating women to plan for the deliveries so as to reduce maternal complication associated with deliveries at home such as bleeding, infection, asphyxia etc. As a result, the

[6]The percentages were calculated by comparing the reported total number of women who gave birth in 2015 and 2016 from the facilities covered with MCSP in both districts.

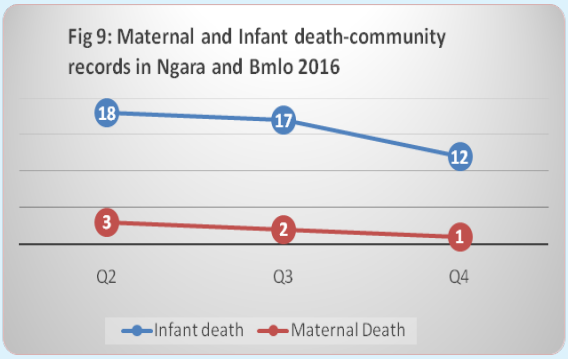
number of women delivering on the way to hospital decreased in both Bmlo and Ngara during the implementation period. Figure 7 presents data recorded in January to March 2016, March to June and July to September 2016. Evidence shows that within the three quarters there was a reduction by 60% of mothers delivering on the way due to poor planning.

In Ngara district, MCSP supported facilities displayed an increased number of women delivering at health facilities in 2016 as compared to 2015. Figure 8 shows an absolute increase of mothers delivering at health facility from 57 to 85; a corresponding decrease of those delivering at home from 28 to 9. Women delivering on the way to health facilities also decreased from 15 to 6 during the year of implementation. One can assume that if the same intervention continues, it is likely that the culture can change into communities planning not to have any home deliveries.




## 5.7:Maternal and Child Mortality

According to CHWs reports only six maternal deaths had happened from January to November 2016 in both Ngara and Biharamulo. Two cases were reported in Ngara and four in Biharamulo. A total of 47 infant death occurred. Figure 9 shows decreasing trend of decreasing reported death possibly as a result of increased health seeking behavior in community under consideration. The fact that Each CHW had designated households, contributed to increased accountability.



## 6.0 CHALLENGES AND HOW THEY WERE ADDRESSED

6.1. Most women do not respond to referrals provided due to distance and economic status. Therefore, more community owned income generating activities is required to allow availability of community resources that can be used to support women who are disadvantaged.

6.2. Some dispensaries have only one or two providers making some times facilities to remain closed for a day or some days. The following facilities has only one SP; Kumubuga, Magamba, Mumuhamba and Ibuga while the following has two SP; Murubanga, Keza, Djuruligwa, Mukubu, Muganza and Mukalinzi

6.3. During Ghulio la Afya events, the demand for HIV testing and family planning services was too high compared to resources available such as HIV test kits. With this lessons, future implementation will need to fact in adequate resources (finance and human) to provide services during the event.

6.4. Gender dialogue sessions did not start well in the beginning since men did not turn-up to meet equal number of 15 men and 15 women to make a group of 30 participants. Community leaders were used to facilitate formation of groups and therefore, this area will need more strategies for male involvement in future.

6.5. Poor communication in some villages of Kabanga, Murusagamba and Muganza wards challenged implementation of the program. Communication with CHWs on implementation of activities was difficult and therefore any information had to be sent early through sms. Due to poor communication, not all CHWs managed to attend monthly meetings at Murusagamba Health center. This was the same case in Mabarevillage of

Nyakahura ward, but the village also had poor and expensive transport facilities which caused CHWs not to attend the monthly meetings most of the time.

6.6 Hindsight the good intention to quality assure the program, there were noticeable delay of guidelines to implement some activities. Such guidelines include training to VHC which were brought in May, community score card process and gender dialogue sessions which were provided in the third quarter of implementation. As a result, some initiatives done by HDTsuch as coordinating 2 radio programs, and community score card sessions in 2 wards were disqualified. Efficient implementation in future will benefit early preparation and delivery of tools.

6.7. Two CHWs dropped and therefore denying services to communities they serve. Elisha James from Murubanga village in Biharamulo and ElivinaFelcian from Nyabihanga Village in Ngara dropped. However, the latter is attending a certificate course on community health service and has promised to resume after she graduates.

## 7.0 LESSONS LEARNT

i. It was leant that that fighting to reduce maternal, newborn and child morbidity and mortality is a multidimensionalissue,whichneeds to address many other factors. For example, increased community healthy seeking behavior needs to be sustained by availability of medical supplies, adequate, qualified and committed service providers. Therefore, there are many other factors that need to be addressed including work overload and distances which are additional challenges mentioned by the community. Again, these determine the willingness of the community to join CHF.

ii. It was found that deliberate and adequate capacity strengthening to health management system at all levels is highly needed. For example, most villages did not have VHCs, if available they were not trained and therefore did not know their roles. It was also found that, facility governing committees (FGC) had inadequate capacity to monitor or supervise service delivery at the facilities while CHMT had limited resources to perform regular supportive supervision.

iii. Community score card process is most effective if done in villages with CHWs. This is because they will sensitize the community and work closely with village leaders to oversee implementation of action plans.

iv. Although the program could not cover all the wards in the Districts, the demand is high regardless of level of performance. Therefore there is high demand for scaling up the program.

## 8.0 CONCLUSIONS AND RECOMMENDATIONS

Although there were delays in beginning implementation and other operational challenges highlighted under section six, this project achieved largely what it was sent to achieve in Ngara and Bmlo districts. Twelve of Sixteen (75%) deliverables anticipated to be accomplished were accomplished by 100%. Three out of the remaining four were achieved by above 85% which is also good. Only one indicator performed 66%. Based on these results, it can therefore be concluded that at output level this project was successful by 93%.

At outcome level the project demonstrated a contribution to all four target indicators for the One Plan II (Accelerating reduction on Maternal and child death in Tanzania). Which are shown below

- Reduce maternal mortality from 432 to 292 per 100,000 live births by 2020.
- Reduce neonatal mortality rate

from 21 t0 16 per 1,000 live births by 2020.

- Reduce infant mortality rate from 45 to 25 per 1,000 live births in 2020
- Reduce under-five mortality from 54 to 40 per 1,000 live births by 2020

Beyond the above, the project has also contributed to test and treat- A HIV campaign through its HIV testing and Gulio la Afya, contributed to women Family Planning.

Beyond immediate outcomes of the target beneficiaries, the project also built the capacity of Community Health workers, and Village Health Workers. Since supportive supervision were done with CHMT members, there is local capacity that has been built at the committee level that the benefit of this project will last long.

Finally HDT will conduct exit meeting with CHMT in Ngara and Bmlo to hand over operations that need continued supervision. In such meeting, achievements, challenges will be shared and in addition the database for all CHWs will be shared.

## 9: SUCCESS STORIES

### 9.1. MWASHAMU RAMADHANI, CHF CHAMPION

"I was not aware of how helpful CHF was but I was educated by our CHW Mr. KasifaMussa and I finally joined. But there is a Swahili say which says ***kizuri kula na mwenzio*** so I had to convince my neighbors to join too". Courageous words from Mwashamu Ramadhan a mother of 4 children, 28 years old with STD 7 education. Formerly she was not willing to neither join CHF nor use family planning services since she did not know the importance of the same. She was initially visited by KasifaMussa (CHW in her village) but never took him serious. After several education sessions, she was convinced and agreed to join family planning once she regains her menstrual period. Mwashamu is one of the community members who joined CHF in March 2016 and currently 7 neighboring households have joined CHF. Mwashamu is cooperating with Kasifa to further sensitize community members on CHF and RMNCH issues and she is also interested to save the community as Community Health Worker.

## 9.2. SHE ALMOST LOST HER LIFE OVER POOR DECISION

Clementina from Kikomakoma almost lost her life during delivery due to poor decision. Clementina was brought to KikomakomaHC by her husband Eliya while she was in a pretty bad shape after trying to deliver at home. Clementina was giving birth at home but the placenta couldn't come out, she lost a lot of blood and hadn't she gotten help fast she would have lost her life.

After being rushed to Kikomakoma, Clementine had to be referred to Biharamulo district hospital because her condition was critical. Surprisingly, the husband had no money at all so they had not prepared for the delivery. It was late at midnight but with the support from Kikomakoma HC she was successfully sent to the hospital where she got the help she needed.

When confronted her husband regretted what they did and that they will never try to deliver their babies to home again. In his defense he complained of staying so far from the facility though it wasn't a strong point because they could rush his wife to the facility when things got complicated.

Speaking with so much concern, Dr. Domitina Prosper of Kikomakoma HC says their situation is not so well especially on maternal and child health. Women deliver at home, they report so late to the ANC almost at 7 to 8 months, don't want family planning and they never plan for their deliveries. She insisted of being considered for another program because their community needs education as people are not educated and that Kikomakoma serve so many communities not just the nearby places.

Kikomakoma was not included in the MCSP but having talked to Dr Domitina and saw the situation at the facility made us conclude that, the facility being located at a developing community is not a guarantee for better maternal and child health. Things are better in the rural areas right now than they are in town. All women need education regardless of where they reside.

# 10: ANNEXES

## ANNEX I :COMMUNITY HEALTH WORKERS VISITS

### COMMUNITY HEALTH WORKERS' VISITS IN NGARA

| Client | Category | Jan | Feb | Mar | Apr | May | June | July | Aug | Sep | Oct | Nov | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pregnant Women | New | 84 | 88 | 116 | 165 | 97 | 170 | 164 | 159 | 144 | 215 | 217 | 1619 |
| | Repeated | 100 | 79 | 86 | 138 | 123 | 157 | 188 | 199 | 147 | 179 | 241 | 1637 |
| | **Total** | **184** | **167** | **202** | **303** | **220** | **327** | **352** | **267** | **291** | **394** | **458** | **3165** |
| Mothers after delivery | New | 83 | 71 | 90 | 118 | 88 | 136 | 120 | 296 | 118 | 131 | 91 | 1342 |
| **Overall** | **Total Women** | **267** | **238** | **292** | **421** | **308** | **463** | **472** | **563** | **409** | **525** | **649** | **4607** |
| Children | < 1 Month | 76 | 83 | 86 | 130 | 180 | 106 | 166 | 152 | 125 | 137 | 101 | 1342 |
| | > 1Month < 1 yr | 146 | 194 | 240 | 419 | 451 | 520 | 624 | 569 | 541 | 596 | 598 | 4898 |
| | > 1 yr <5yr | 323 | 303 | 569 | 785 | 812 | 1027 | 1185 | 1094 | 1205 | 1114 | 1184 | 9601 |
| | **Total** | **545** | **580** | **895** | **1334** | **1443** | **1653** | **1975** | **1815** | **1871** | **1847** | **1883** | **15841** |

### COMMUNITY HEALTH WORKERS' VISITS IN BIHARAMULO

| Client | Category | Jan | Feb | Mar | Apr | May | June | July | Aug | Sep | Oct | Nov | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pregnant Women | New | 88 | 75 | 96 | 79 | 64 | 232 | 184 | 164 | 155 | 145 | 139 | 1421 |
| | Repeated | 117 | 101 | 62 | 87 | 62 | 84 | 138 | 176 | 192 | 222 | 218 | 1459 |
| | **Total** | **205** | **176** | **158** | **166** | **126** | **316** | **322** | **340** | **347** | **367** | **357** | **2880** |
| Mothers after delivery | New | 70 | 66 | 75 | 69 | 60 | 109 | 113 | 105 | 97 | 100 | 135 | 999 |
| **Overall** | **Total Women** | **275** | **242** | **233** | **235** | **186** | **425** | **435** | **445** | **444** | **467** | **595** | **3982** |
| Children | < 1 Month | 74 | 66 | 75 | 73 | 69 | 122 | 105 | 108 | 116 | 106 | 106 | 1020 |
| | > 1Month < 1 yr | 345 | 271 | 310 | 337 | 248 | 431 | 464 | 527 | 567 | 528 | 422 | 4450 |
| | > 1 yr <5yr | 645 | 588 | 689 | 596 | 541 | 1068 | 1270 | 1428 | 1254 | 1479 | 1117 | 10675 |
| | **Total** | **1064** | **925** | **1074** | **1006** | **858** | **1621** | **1839** | **2063** | **1937** | **2113** | **1645** | **16145** |

## ANNEX II: REFERRALS PROVIDED

### REFERRALS PROVIDED IN BIHARAMULO

| Service Provided | Category | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | women | 24 | 24 | 25 | 28 | 16 | 91 | 57 | 38 | 60 | 32 | 37 | 432 |
| Referrals | Newborns | 9 | 13 | 23 | 12 | 13 | 21 | 16 | 12 | 11 | 8 | 14 | 152 |
| | > 1 Month < 1yr | 11 | 10 | 5 | 3 | 0 | 19 | 14 | 6 | 5 | 7 | 16 | 96 |
| | > 1yr < 5yr | 6 | 9 | 7 | 11 | 1 | 14 | 19 | 8 | 8 | 4 | 12 | 99 |
| | **Total** | **50** | **56** | **60** | **54** | **30** | **145** | **106** | **64** | **84** | **51** | **79** | **779** |

### REFERRALS PROVIDED IN NGARA

| Service Provided | Category | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | women | 84 | 88 | 116 | 165 | 97 | 170 | 139 | 144 | 132 | 194 | 208 | 1537 |
| Referrals | Newborns | 100 | 79 | 86 | 138 | 123 | 157 | 17 | 148 | 123 | 156 | 216 | 1503 |
| | > 1 Month < 1yr | 184 | 167 | 202 | 303 | 220 | 327 | 316 | 201 | 255 | 350 | 424 | 2949 |
| | > 1yr < 5yr | 83 | 71 | 90 | 118 | 88 | 136 | 104 | 287 | 106 | 118 | 80 | 1281 |
| | **Total** | **267** | **238** | **292** | **421** | **308** | **463** | **420** | **488** | **361** | **468** | **604** | **4330** |

## ANNEX III: GHULIO LA AFYA & CINEMA SHOWS

### PEOPLE REACHED DURING GHULIO LA AFYA IN NGARA DISTRICT

| S/N | Ghulio Name | | HIV/AIDS (counseling & testing) | | | Brochures Distributed | Participants who got FP Services | Condoms distributed | Total Participants reached |
|---|---|---|---|---|---|---|---|---|---|
| | | Tested | Ma | Fe | +Ve | | | | |
| 1 | Kadunduli | 49 | 16 | 33 | - | 1200 | 4 | 300 | 900 |
| 2 | Murusagamba | 86 | 46 | 40 | - | 700 | 5 | 450 | 800 |
| 3 | Rukole | 50 | 27 | 23 | 2 | 1220 | 2 | 600 | 1200 |
| 4 | Keza | 125 | 42 | 83 | - | 355 | 23 | 283 | 560 |
| 5 | Kirushya | 153 | 59 | 94 | 6 | 422 | 2 | 450 | 650 |
| 6 | Ntanga | 174 | 79 | 95 | 1 | 700 | 11 | 650 | 930 |
| 7 | Kumubuga | - | - | - | - | 310 | - | 300 | 390 |
| 8 | Magamba | 75 | | | - | 310 | - | 450 | 660 |
| 9 | Kadunduli | - | - | - | - | 431 | 1 | 150 | 520 |
| | **Total** | **712** | **269** | **368** | **9** | **5648** | **48** | **3633** | **6610** |

### PARTICIPANTS REACHED DURING CINEMA SHOWS IN NGARA

| S/N | Ward/ Villages | Number of shows | FP Brochures | HIV/AIDS Brochures | Condoms Distributed | Participants Reached |
|---|---|---|---|---|---|---|
| 1 | Murusagamba, Magamba, Murubanga, Ntanga & Kumubuga | 5 | 500 | 1000 | 750 | 1950 |
| 2 | Mabawe; Mukaliza, Murugina, Muhweza, Kumuzuza | 5 | 500 | 750 | 450 | 2200 |
| 3 | Burririro; Mumuhamba, Bukiriro | 2 | 200 | 312 | 300 | 640 |
| 4 | Keza | 1 | 100 | 200 | 150 | 320 |
| 5 | Kasulo; Kasulo | 2 | 320 | 413 | 300 | 650 |
| 6 | Kirushya; | 2 | 230 | 440 | 600 | 600 |
| | **Total** | **17** | **1850** | **3115** | **2550** | **6360** |

## PEOPLE REACHED DURING GHULIO LA AFYA IN BIHARAMULO DISTRICT

| S/N | Ghulio Name | | HIV/AIDS (counseling & testing) | | | Brochures Distributed | Participants who got FP Services | Condoms distributed | Total Participants reached |
|---|---|---|---|---|---|---|---|---|---|
| | | Tested | Ma | Fe | +Ve | | | | |
| 1 | Busili, Mafukwe & Isambala | 286 | 117 | 169 | 12 | 300 | 84 | 300 | 300 |
| 2 | Ngararambe | 70 | 33 | 37 | 2 | 650 | 22 | 30 | 200 |
| 3 | Nyabugombe & Mabale | 55 | 25 | 30 | 5 | 300 | 155 | 27 | 300 |
| 4 | Mwinyororo, Nyakasenga & Mwanga | 200 | 77 | 123 | 13 | 1000 | 185 | 7 boxes (1008) | 1100 |
| 5 | Mihongora, Mbindi & Rugese | 179 | 52 | 127 | - | 400 | 34 | 400 | 500 |
| | **Total** | **790** | **304** | **486** | **32** | **2650** | **480** | **1765** | **2400** |

## PARTICIPANTS REACHED DURING CINEMA SHOWS IN BIHARAMULO

| S/N | Ward/ Villages | Number of shows | FP Brochures | Condoms Distributed | Participants Reached |
|---|---|---|---|---|---|
| 1 | Mbindi, Karundi B, Mwengawabo, Nyabusozi, Nyamalagala & Nyakasenga | 5 | 750 | 750 | 2500 |
| 2 | Busili, Nyabugombe, and Ngararame | 3 | 500 | 450 | 900 |
| 3 | Mwinyororo, Mwanga, Nyabusozi, Mafukwe, Isambara | 5 | 416 | 1500 | 1720 |
| 4 | Nyakahura, Mabale & Mafukwe | 3 | 300 | 150 | 950 |
| 5 | Rugese, Mihongora, Kikomakoma, Kabangai, Midaho & Kigoi | 6 | 500 | 700 | 1600 |
| | **Total** | **21** | **2466** | **3550** | **7670** |