Improving the Health of Rural Women and Young Girls in Mubende District- Uganda

Submitted to the MAIA Foundation by:
Program for Accessible Health Communication and Education (PACE)

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I. Executive Summary

The Program for Accessible health, Communication and Education (PACE) is pleased to submit the following proposal to improve maternal health among rural women and young girls in Mubende district in Uganda. To accomplish the goal and objectives in this proposed project, PACE is requesting $50,000. The project will target pregnant women and Secondary school going young girls in the same seven sub counties where PACE has been implementing the MAIA funded project for the last three years.

Using a network of three community-based organizations, PACE proposes to consolidate the locally-driven intervention that pairs necessary products and service delivery with effective communications and education campaigns. Included in the products are a health kit that contains a complete clean delivery kit (CDK), WaterGuard® tablets and five sachets of Oral Rehydration Salts (ORS) with zinc tablets. The CDK is used by pregnant women at the time of delivery to prevent infection, WaterGuard® is used to treat drinking water at point of use or PuR in areas with turbid water using the process of flocculation, and zinc and ORS are included for the management of diarrhea in children under five. The kit contains an instructional insert on using the components and an immunization card. Twenty local health facilities will be stocked with Misoprostol® a drug that will help prevent the risk of postpartum Hemorrhage (PPH). In addition, the inserts will have information on prevention of unwanted pregnancies and proper nutrition of children under five years. 1,400 young girls in the seven secondary schools will be equipped with the basic life skills of preventing early pregnancies.

II. Health Justification

Uganda is still far behind its targets for the fourth Millennium Development Goals on maternal health, but the Uganda Ministry of Health (MoH) has earmarked the reduction of maternal morbidity and mortality as a priority goal. The country's maternal mortality rate is 435 per 100,000 live births[1]. Uganda has one of the world's highest fertility rates at 6.9 children per woman. While fertility peaks between the ages of 20 and 24 years old, over 25% of 15 to 19 year olds are already mothers. Fertility rates are higher among rural women and those with less education. Only 24% of married women use contraception, with 18% using a modern method. Mubende district leaders have highlighted early pregnancies as one of the major causes of school dropout among young girls[2].

The total unmet need for family planning in Uganda is 41%, and the contraceptive prevalence rate varies between rural areas (14.7%) and urban areas (41.6%). Approximately 58% of women deliver at home in poor conditions, largely contributing to the high maternal mortality rate. Traditional birth attendants deliver 23% of births and 25% are delivered by friends or relatives, many of whom are neither well-trained nor appropriately equipped to carry out this procedure. The final 10% of births occur without the mother receiving any assistance during childbirth[1]. Furthermore, severe bleeding contributes 25% to the maternal mortality ratio in Uganda yet active management of the third stage of labor for PPH is not practiced thus mothers losing their lives[3].

The infant and children under five mortality rates are 78 and 134 per 1,000 live births, respectively. Over 40% of all childhood deaths are also linked to malnutrition, and diarrhea is one of the leading causes of death among children under five in Uganda. In rural and urban areas, the diarrheal episode prevalence rate is 26.2% and 21.3%, respectively1. The prevalence rate increases to 38% for children from 6 to 11 months old, when breastfeeding is typically

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[1] Uganda Demographic and Health Survey, 2006
[2] Mubende district health annual report, 2009
[3] Ministry of Health Annual Report, 2004

supplemented by infant formula prepared with contaminated water[4]. Eighteen percent of children below 6 months and 45.3% of children between 6 and 12 months were reported to have had at least one diarrhea episode in the two weeks preceding the survey[1].

III. Project Goal, Results and Activities

Goal: Contribute to reduction of maternal mortality among women of reproductive age in rural Uganda (Mubende District)

Outcome Indicator

- *% of Women of Reproductive Age who gave birth in the last 12 months who report using safe delivery contents of the CDK.*

Target populations:

- Women of reproductive age group (15-49 years) and their partners
- School going young girls aged between 13 and 19 years
- Caretakers of children under five years old

Target zones:

PACE proposes to continue operating in the project within the sub counties of: Bukuya, Kitenga, Bageza, Kasambya, Kiganda, Kiyuni, and Mubende town council to address the unmet need of approximately 4,860 pregnant women. In addition, seven schools will be reached.

Result 1: Increased access and availability of health kits for women of reproductive age (WRA) and children under 5 years old.

Indicators:

- *% of WRA reporting that they know where to find the health kit*
- *% of local health facilities with misoprostol in stock*
- *% of women with kit who deliver at facility*
- *% of drug shops and kiosks that stock health kits contents*

PACE proposes to implement the following activities to achieve Result 1:

1.1 Community-based organizations (CBOs) Capacity building and Networking

PACE intends to continue with the three implementing CBOs which are part of the Rural Empowerment and Action for Communities (REACt) network that PACE has built across districts and continue to engage in health promotion and social marketing of health products and services. PACE is committed to intensive capacity building support of this network with emphasis on local ownership of program-related activities. In addition, PACE will connect the mapped out functional health facilities (both private and public) to ease referrals of beneficiaries of the project for PPH management and access long term Family planning.

1.2 Production, packaging and delivery of the health kits

PACE will pack and distribute 1000 health kits to the partner CBOs with a buffer of 10 kits for advocacy, based on past experience where exhibitions are done and some kits for demonstration are needed this buffer will be utilized. The health kits will contain a complete CDK (3 pairs of sterile gloves, 2 razor blades, 2 polythene sheets, 1 tablet of dettol soap, 2 cord ligatures, child health card and cotton wool), three months worth of WaterGuard® tablets, and five sachets of Oral Rehydration Salts (ORS) with zinc tablets. Lessons learned from year three of implementation indicate that there are some areas with very turbid water hence PACE intends to include PuR instead of WaterGuard® in the kits that will be distributed in these implementation area. PuR is more effective at cleaning very turbid water. The kit will contain an instructional insert on using the components and a child growth Card

[4] Ministry of Health, Child Division annual report, 2006

The kit will be embossed to clearly indicate the recommended retail price of the kit. In addition, PACE will deliver misoprostol sourced through the Women's Health Project (WHP) to local clinics in the seven sub counties to ensure pregnant mothers have access to treatment of (PPH)

1.3 Orientation and refresher training of "Mama Ambassadors"

Following the experience of MAIA III with CBOs where mama ambassadors were followed up and later evaluated. Fifty eight (58) of the mama ambassadors will be retained and two from Hope for the needy and Rural Health will be replaced. Instead of the class room training PACE intends to utilize the monthly meeting to orient the mama ambassadors on the new developments and the two mama ambassadors will be trained on job with intensive support from the CBOs. The orientation will focus on marketing, selling and counseling techniques, as well as community sensitization activities targeted to women and men's groups. They will review ways to promote maternal and child health in their villages. In addition, training will include sensitization on the use of misoprostol for the prevention and treatment of PPH and Family planning with emphasis on long term methods as well as key messages on child nutrition, treating water, hand-washing at critical times, malaria prevention, use of latrines and use of ORS and zinc to treat diarrhea and prevent dehydration. Mama Ambassadors will also be supported to increase referrals for maternal care at facilities.

1.4 Orientation of health workers

Following lack of support to clients with Mama kits by health providers at one of the public facility, PACE plans to hold a half day orientation training with the midwives from the maternity ward and administration to have them understand the benefits of the kit to the mother and the health workers

1.5 Distribution and social marketing

PACE proposes to continue offering the health kit at a subsidized cost as the target populations have very low incomes. Therefore the final sale price of the kit will be subsidized to 20% of cost recovery price—approximately $2.5. The CBOs will supply the kits to the mama ambassadors who will make home visits to households with pregnant women to market the kit. Mama Ambassadors will be encouraged to offer credit facilities over the pregnancy period allowing expectant mothers to split the cost for the kit over several months. The income from the sales will be taken by the mama ambassadors as an incentive. Without these incentives, it requires many supervision visits and spot checks to keep the mama ambassadors motivated. With this incentive the number of support visits will be minimal, thereby reducing the cost of supervision hence being more cost effective.

Due to the limited funding, the project can only distribute 650 health kits yet the demand is high. Based on the experience of the previous phases, because of the high demand, kits are finished quickly therefore PACE intends to provide credit to the implementing CBOs for the cost recovery Kit targeting pregnant mothers who can afford to pay so as to have program continuity and sustainability. In addition, PACE will continue to social market the health kits contents through the private sector outlets like private clinics and drug shops

Result 2: Increased knowledge on correct use of health kits, including misoprostol for PPH prevention and FP availability among 2,500 WRA and their partners, as well as of diarrhoea prevention & treatment and nutrition for children under five among care takers.

Indicators:

- *% of WRA and their partners aware of at least 2 benefits of using the safe delivery contents of the health kit*
- *% of under five years care takers who are aware of at least 2 benefits of using the diarrhea prevention and treatment contents of the health kit*
- *% of under five child care takers who are aware of at least 2 ways of diarrhoea prevention and the correct steps of diarrhoea treatment*
- *% of under five child care takers who believe that treating water with WaterGuard*

is a safe way to prevent waterborne diseases

- *% of under five child care takers who are knowledgeable about the basic nutritional practices*
- *% of WRA and their partners reporting importance of FP and where they can access it*

PACE proposes to implement the following activities to achieve Result 2:

2.1 Reproduction and distribution of IEC materials

PACE will reproduce 1,000 low literacy, highly illustrated information, education, communication (IEC) materials on reproductive health and include information on PPH as well as child spacing and nutrition as complimentary tools to existing training materials for CBOs. These materials will emphasize and reinforce key messages given by Mama Ambassadors and will serve as reminders and reference materials. Lessons learnt in the previous phase show that mama ambassadors usually do not use the t-shirts while conducting sessions and home visits therefore following their advice PACE intends to produce 200 aprons that comfortably fit their dress attire.

2.2Conduct Interpersonal Communications

Each CBO will also integrate reproductive health messages into their agenda during meetings scheduled once every month. CBOs will supply kits to the Mama Ambassadors who will conduct 1,440 home visits (during LOP) to households with WRA to market the kit. On the day of the visit, Mama Ambassadors will provide information on reproductive health, including FP and prevention of PPH and information on where to find the services referral facility network, child nutrition, diarrhea prevention including good hygiene and using latrines and diarrhea treatment using ORS and zinc. Mama Ambassadors will be required to map all the households with pregnant mothers and children under five in there catchment area to enable them be more focused and efficient in implementation. During their visit, Mama Ambassadors will capture biographical data of expectant mothers on a simplified client card and help in setting up and maintaining the kitchen gardens.

Result 3: Increased knowledge on dangers of early pregnancy among school going young girls aged between 13 to 19 years.

Indicators:

- *% of secondary schools with youth friendly teachers trained to support the young girls in school to delay first sexual debut*
- *% of school drop outs due to pregnancy*
- *% of youth friendly sessions held by the teachers*
- *% of school girls reached with messages*

PACE propose to implement the following activities to achieve Result 3:

3.1 Review Mapped secondary schools` performance

With support from the district education officer, PACE will review willingness and program support/interest by the schools mapped in year 3 for continued collaboration and a decision will be made to either drop or continue with them as we pilot this result area.

3.2 Peer Education

The peer educators` health clubs are running in the seven secondary school targeting female students and have been a highly successful vehicle for mobilization, awareness and Interpersonal communication. The Peer Education program will continue to focus on delayed sexual debut, career planning, life skills and professional development. PACE will continue to work with the trained female peer educators but will recruit at least two male peer educators from each of the seven secondary schools. The peer educators will be responsible for the video shows, sessions and peer counseling. However because of the limited funds, PACE will collaborate with the Straight talk foundation to distribute reference materials on a quarterly basis

IV. Monitoring and Evaluation

Implementation of project M&E activities will be guided by the M&E plan (Annex 3: Project M&E matrix). The PACE M&E Manager will coordinate and oversee the implementation of all project M&E activities. Together with the regional team, they will conduct monthly/quarterly support supervisory visits and data Quality assessments to the partner CBOs. The annual project work plan will be used to monitor all project activities and ensure they happen as scheduled. PACE will provide monthly reports to district officials to update them on project activities in their localities. The on-going end of year 2 evaluation will further guide the strategy for the year 3 application. PACE will provide quarterly reports to MAIA foundation.

M&E at CBO level: The CBO director will have overall responsibility for monitoring project activities and reporting to PACE. PACE will train CBO staff in monitoring techniques and use of different project M&E tools. CBOs will be expected to submit a progress report to PACE regional offices on a monthly basis.

V. Project Management

Management of the program falls under the Programs department at PACE. Program implementation will be the direct responsibility of the MCH/Special Projects Program Manager. The central regional team led by the Maternal and Child health Coordinator (MCH-C) will be responsible for monthly supervision of the CBOs who will in turn work with Mama Ambassadors to implement project interventions. Capacity implementation gaps identified will be improved through on-job training. The project annual work plan will guide implementation.

Annexes

Annex 1: Project Budget and Budget Notes
Annex 3: Project Monitoring and Evaluation Matrix
Annex 4: PACE's Organizational Structure and Management
Annex 5: PACE Background and Major Accomplishments