INCREASING ACCESS TO MATERNAL AND CHILD HEALTH, HYGIENE AND SANITATION SERVICES IN THE DISTRICTS OF NAKASONGOLA AND KAYUNGA

FOR TWO YEARS

2015 –2017

SUBMITED BY

THE ROTARY CLUB OF KAMPALA NSAMBYA

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List of acronyms

ANC	Antenatal Care
BEmOC	Basic Emergency Obstetric Care
CIDI	Community Development Integrated Initiatives
CPR	Contraceptive Prevalence Rate
CSOs	Civil Society Organizations
DHT	District Health Team
EID	Early Infant Diagnosis
FY	Financial Year
GDP	Gross Domestic Product
GoU	Government of Uganda
HC	Health Centers
HIV/AIDS	Human Immune Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HSD	Health Sub Districts
IEC	Information Education and Communication
IPT	Intermittent preventive treatment
ITN	Insecticide Treated Mosquito net
KIs	Key Informants
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MoH	Ministry of Health
NGOs	Non-Governmental Organizations
NRH	National Referral Hospital
PMTCT	Prevention of Mother to Child Transmission
PNFP	Private Not for Profit
RH	Reproductive Health
RRH	Regional Referral Hospital
SRH	Sexual Reproductive Health
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic Health Survey
VHTs	Village Health Teams
WHO	World Health Organisation

EXECUTIVE SUMMARY

Project title	**Increasing Access to Maternal and Child Health, Hygiene and sanitation services in the Districts of Nakasongola and Kayunga.**	
Objectives	**Development Goal** Overall the development goal of this project is to contribute to better health status of communities in the two districts of Kayunga and Nakasongola. **Project Objectives** **Objective 1** Increased community access to immunization, diagnostic and treatment services through extended outreach medical camps and provision of basic essential items for deliveries in 4 needy Health center IIIs of Nakasongola and Kayunga districts. **Objective 2** Improved sanitation conditions and solar lighting in the target Health Center IIIs and surrounding community**.**	
Target groups	**Project beneficiaries:** The project will directly benefit about 11,000 community members served by the 4 target HC IIIs: Bamugologge HC III and Kalungi HC III in Nakasongola district and Nkokonjeru HC III and Namusala. HC III in Kayunga district.	
Time Span	**Two years 2015-2017**	
Legal Holder of the project	Rotary Club of Kampala Nsambya Local Partner: CIDI Looking for International Partner (s)	
Contact Persons	Fulgensio Jjuuko: **President RC** Kampala Nsambya Godfrey Musisi-**Director Service Projects** Rosette Nabuuma: **Public Relations**	
Total project cost	**UGX: 247,500,000**	**USD:75,000**

1.0 Introduction

This is a two year project proposed for implementation in two districts of Kayunga and Nakasongola. The overall goal of the project is to contribute to better health status of communities in the two districts of Kayunga and Nakasongola, particularly improved maternal and child health service delivery. Specifically in the short term, the project is aiming at increasing community access to immunization, diagnostic and treatment services through extended outreach medical camps in needy communities, as well as improving provision of basic essential items for deliveries, solar lighting, The project also aims at improving hygiene and sanitation around the health units and surrounding communities. Primarily the project is targeting women, children and men in Nakasongola and Kayunga districts for realization of increased uptake of antenatal, prevention of mother to child transmission and family planning services, increased number of skilled deliveries, improved child survival, reduction in teenage pregnancies, improved referral system, improved access and utilization of MCH and immunization services available.

2.0 Overview of the National Health Context

Geographically Uganda comprises of 241,038 sq km, a population of 34.9million people, with an annual growth rate of 3.03%. Census results 2014. Birth rate of 47/1000 live births, natural rate of Increase of 3.4% and Death rate of 13 per 1000 all expressed of the total population. Population below 15 years of age constitutes 48.54% (2012), while the population that is 60+ is only 3.72% (2012). The urban population constitutes 13 % of Uganda's total population. Uganda being a developing country, its health status lags behind many other countries but is at par with the countries in the WHO AFRO region. Recent statistics show that life expectancy at birth in Uganda is around 57 years (2012). Child mortality (death before the age of five years) occurs in 69 of every 1000 live births (2012). Total health expenditure as a percentage of GDP was 8% in 2012.

Over the last twenty years, Uganda has experienced slow progress in reduction of child and maternal mortality rates (MDG 4 and 5). Government and Development Partners have made commitments to actions to reduce excess maternal and child mortality and this has seen remarkable progress in reduction of child mortality rates. The progress has been inspiring; occurring in some of the poorest and disadvantaged populations. But it is not enough. Uganda has also seen improvement in five out of the six maternal health indicators under Millennium Development Goal (MDG) 5. Maternal mortality in Uganda has declined from 527 deaths per 100,000 live births in 1995, to 438 deaths per 100,000 live births in 2011 away from the MDG target of 131 deaths per 100,000 live births by 2015. This translates into an annual decline rate of 5.1% and an average of 18 women dying every day. Based on the rates of progress to date in MDG 4 and 5, Uganda is unlikely to achieve 2015 targets for these goals. There is glaring disparity between the rate of child and maternal death across wealth quintiles and geographical regions – disparities that will persist unless Uganda takes action. (A Promise Renewed 2013).

The most important direct causes of maternal mortality is haemorrhage accounting for 42% of deaths, obstructed or prolonged labour 22% and complications from abortion 11%. Important indirect causes include malaria, a factor in 36% of maternal deaths recorded, anaemia 11% and HIV/AIDS 7%. High total fertility rate (TFR), high teenage pregnancy rate, and high unmet need

for family planning increase exposure to the risk of pregnancy and hence pregnancy- related deaths for both women and newborns.

The strategic plan aligned and anchored with key national priorities like Uganda's Vision 2040, the National Development Plan as well as the National Health Strategic plans, policies and related sectoral plans, all aim at improving the quality of the population over the vision period where Uganda will focus on creating a more sustainable age structure by reducing the high fertility rate through increased access to quality reproductive health services and that government will focus on building an efficient health services delivery system which emphasizes prevention over curative services. The goals of the National Development Plan (NDP) 2010/11 – 2014/15 are similar to the MDGs especially for women and children.

The Central belt which comprises districts of Kayunga, Kiboga, Luwero, Nakaseke, Mubende, Mityana, Mukono and Nakasongola even though has good indicators parts of Kayunga and Nakasongola have challenges with regard to health service delivery. This has resulted in poor health outcomes marked by poor health indicators with only 27% of health facilities HC III and above providing Basic Emergency Obstetric Care (BEmOC) compared to 33% for national; focused antenatal care at 42%; HIV prevalence at 6.7. Currently GoU needs US$28 per capita to finance its health strategy on the National Healthcare Minimum Package but has only been able to raise US$8 per capita. Moreover, a number of factors including among others the growing population, the expensive (HSD) concept, inflation and high HIV/AIDS prevalence continue to drive high expenditures in the health sector.

Government Services available

Health services are provided by the public and private sector with each sector covering about 50% of the standard units of outputs. For the public sector, the Uganda National Minimum Health Care Package has been developed for all levels of the system, and services are supposed to be based on this package. Uganda's government health system consists of the district health system (village health teams (VHTs), HCs II, III and IV and district general hospitals) and regional (RRH) and national referral hospitals (NRH), which are self-accounting and autonomous institutions, respectively. District health services are managed by the Ministry of Local Government.

The district health system is further divided into Health Sub Districts (HSDs). In general, district management capacity is still very limited in many districts where leadership, management and specialist skills are in short supply at all levels of health care yet high levels of attrition tend to curtail capacity building initiatives. While Community Health Departments (CHDs) exist at RRH to provide support to districts, this has not been fully implemented. The increase in the number of districts over the last decade has overstretched the capacity of the MoH to manage the districts to the edge. Though 72% of the households in Uganda live within 5km from a health facility (public or PNFP[1]) utilization is limited due to poor infrastructure, lack of drugs and other health supplies and the shortage and low motivation of human resource in the public sector.

3.0 General Information on the Target Area (Kayunga –Nakasongola)

The project will target children, men and women in Nakasongola and Kayunga districts.

[1] National Health Policy: Reducing Poverty Through Promoting People's Health, Ministry of Health 2009

Kayunga district is made up of 2 Counties Bbaale and Ntenjeru, 8 Sub-counties, 1 Town Council, 61 Parishes and 375 Villages. The district is made up of 3 Health Sub districts namely, Bbaale, Ntenjeru North and Ntenjeru South Health Sub districts. There are 20 health facilities: 1 Hospital, 2 Health Centre (HC) IVs, 8 HC IIIs and 9 HC IIs with 4 Private Not for Profit health facilities of which all are HC IIs. The district has a total population of 370,210. (UBOS, 2014). The urbanization level is 6.7% indicating that the majority of the population lives in rural areas. The district government aided hospital that is Kayunga hospital has on average 100 beds occupancy offering both therapeutic and precautionary services. The frequently treated diseases include malaria, diarrhoea, upper respiratory tracts infections, mal-nutrition and HIV/ Aids which are preventable.

Nakasongola District neighbors Kayunga district and they both share similar problems. Nakasongola covers an area of 3424.7Km with 1 County, 5 Sub counties, and 1 Town Council. The district population has continued to grow with the recent 2014 population census showing the total population being 181,863 from 141,000(Yr.2000 projection from 1991 Population and Housing Census). The district has one health sub district, 14 government health units (1 hospital, 1 H/C IV, 4 H/C III and 8 H/C II) and 2 Private Not for Profit health facilities (1 H/C III and 1 H/C II). The district's top ten causes of morbidity include malaria 25.7%, acute respiratory infection 20.8%, trauma/accidents 5.7%, intestinal worms 5.5%, diarrheal diseases 6.3%, dental diseases 5.4%, anaemia 3.2%, protein energy malnutrition 1.9%, and maternal complications 3.4% among others.

Improving health service delivery in general and in particular maternal and child health continues to be recognised nationally as public health priority. Despite some efforts by government to address these challenges, Ugandan health indicators are still poor. Sexual reproductive health problems constitute a significant portion of the burden of disease and disability. Evidence not only shows the size of the huge health challenge afflicting women and children, but also the opportunity available for proven interventions to reduce mortality and morbidity if fully implemented, scaled up, and sustained are still poor.

3.1 Lighting and Power Supply

Despite notable improvement in one way or the other, Kayunga district has remained with challenges especially with solar lighting where some health facilities have continued to run without both the grid power system and an alternative power source e.g. solar. For example at Namusala H/C III in Busana sub county, there is no any source of power, no wheel chairs / stretchers for the terminally ill patients and on the side of the ANC, the situation is worse with one room serving all purposes associated with deliveries, ANC and postnatal services. Similarly in Nkokonjeru H/C III in Kitimbwa Sub County, there is no solar power at the theater and even one that was installed at the general outpatient area is no longer functional plus an incinerator, few mama kits supplied by NMS and the poor and old toilet structure at the facility yet the outpatient numbers are big for example on a daily basis approximately 100 mothers are seen at the maternity side. Other facilities such as Lugasa H/C III still in Kitimbwa Sub County, the situation is not different coupled with the limited waiting area, dilapidated maternal facility with only 4 beds depriving patients their privacy. Any opportunity to support these HCs most especially, solar lighting would be very much welcome.

3.2 Latrine Coverage

The latrine coverage is at 59% with a distribution of latrine Coverage in some sub counties still wanting and with poor hand washing coverage being as low as 15.4%. Similarly, latrine coverage in Nakasongola is only 50% hence in both districts open defecation is a common phenomenon contributing largely to water borne diseases and sometimes Hepatitis B spread. A hygiene and sanitation education program in the surrounding villages coupled with increased latrine coverage would greatly reduce the disease burden in these health units and improve community welfare.

3.3 Immunisation & Other Equipments

Among the challenges effecting health service delivery in Nakasongola district is the Poor social mobilization for immunization activities, Low deliveries in health units approximately which stands at 32 %, Low contraceptive prevalence rate 12%, High HIV Sero positivity prevalence rate 4.5% (VCT) and 5.5% (PMTCT), High incidences of dental problems among the people plus the High incidence of mortality and morbidity due to malaria (48%) (Nakasongola LG DDP 2011 – 2015). Key health facilities that need urgent attention are; Kalungi HC III and Bamugolodde HC III and the project will target these in Nakasongola. These are remote health units handling large numbers of people but lacking basic equipments or those that are there are very old and dilapidated e.g. Delivery beds & Kits, MVA, BP machine, Fetoscope, Hb machine, Buckets, other patient Beds, Mattresses, Autoclave, Resustation bag and set, IUD SET, freeges, gas and several others.

4.0 Description of Target Group

Women and children below the age of 5years still face numerous challenges that have contributed to high morbidity and mortality rates in Uganda. Faced with socio cultural and gender inequities the contributory factors make the situation even more unpleasant. Uganda being a paternal society, males take control of most of the resources at household level yet even outside home, males tend to be dominant in most institutions be it workplaces, social setting, churches and hospitals. Males tend to have more power and authority in most of these institutions leaving women, girls and children at a disadvantaged position. Despite the strategies that have been instituted like Education to raise the status of women, gender issues have not been effectively addressed. More so, the adolescent, maternal and child health related problems that this project seeks to address also have their roots in the gender aspects. Violence against women in Uganda is still the cause and consequence of most of SRH problems including Malaria and HIV/AIDS. Research has confirmed a strong correlation between sexual and other forms of abuse against women and women's chances of contracting unwanted and or early pregnancies and Sexually Transmitted Infections (STIs). Additionally, the fear of violence prevents many women from asking their partners to use safer sexual methods, accessing ANC, Family planning, HCT services, even when they strongly suspect they have been infected. Worse still, Adolescent Friendly services are still limited yet most adolescent mothers fear disclosing their SRH problems to their guardians or parents. The fear of being beaten, abandoned or thrown out of their homes makes several women fear up taking SRH and HIV services available. Besides, knowledge of available SRH services is still limited amongst the target group yet those who know where these services are have strong misconceptions that affect utilization. All these have greatly contributed to the poor sexual and reproductive health indicators Uganda as country is experiencing as well as the targeted areas.

THE PROJECT

5.0 Goal

Overall the development goal of this project is to contribute to better health status of communities in the two districts of Kayunga and Nakasongola.

5.1 Objectives

Long term objective

Contribute towards improved maternal and child health service delivery, hygiene and sanitation in the districts of Nakasongola and Kayunga. .

Short term objective 1

Increased community access to immunization, diagnostic and treatment services through extended outreach medical camps and provision of basic essential items for deliveries in 4 needy Health center IIIs of Nakasongola and Kayunga districts.

Short term objective 2

Improved sanitation conditions and solar lighting in the target Health Center IIIs and surrounding community**.**

5.2 Description of the desired situation

At the end of the project cycle, we anticipate to see:

- Increased uptake of antenatal, prevention of mother to child transmission and family planning services.
- Increased number of skilled deliveries and improved child survival.
- Reduction in teenage pregnancies.
- Improved referral system.
- Improved access and utilization of MCH and immunization services available.
- Increased uptake and utilization of ITN's among expectant mothers and children below 5 years of age.
- Improved hygiene and sanitation in targeted HC IIIs and surrounding community
- Improved responsiveness of health service providers (District) towards provision of maternal and child health services.

5.3 Activities

Objective 1: **Increasing community access to immunization, diagnostic and treatment services through extended outreach medical camps in needy communities**

5.3.1 Integrated Medical Camps / Outreach Activities.

Integrated medical camps / outreaches will be carried out within the communities with the aim of bringing services closer to the communities. This will help in solving the issue of accessibility and affordability of MCH services. Outreaches will involve provision Dental services, Ante-natal services, HCT Services, Distribution of Albendazole and ILLINS, Immunization of all

immunisable diseases, Health Education on sanitation, hygiene, HIV, and nutrition, Provision of Family Planning services and Provision of eye services. Outreaches will be mobilized by the VHTs and services shall be provided by health workers from the health centers.

RCKN working with CSOs in the area notably CIDI and with support from the District health teams will ensure that the necessary requirements and facilities for the camp to take place are availed for effective service delivery. The health camps will be a week long activity supervised by the district and sub county/division health staff and coordinated by RCKN and other project volunteer staff. Eight health camps be conducted, two per each district for a period of two years.

5.3.2 Radio Programmes, Jingles And Spots.

Thirty radio programmes will be carried out on an agreed upon radio station. They will involve capturing of community MCH issues, editing them and then airing them on radio as an ice breaker. The programmes will be hosted by a radio presenter and three participants, two from the health wing and a politician. It will involve call-ins from the community which the hosted people will react to. The radio programme will aim at creating extensive awareness about aspects of MCH and they will be putting issues of MCH to the public agenda. The Jingles will be both in English and in the local language to complement the efforts of putting MCH issues on the public agenda for public appeal.

5.3.3 IEC Materials.

The RCKN will liaise with the ministry of Health to reprint available IEC materials related to maternal and child health. The IEC materials shall be translated into the local language of target communities for easy understanding. The RCKN will only develop those IEC materials that are not available, yet relevant to the achievement of project outputs. They will be distributed to the targeted communities to help in enriching their knowledge as regards MCH issues. Two thousand Five hundred IEC materials will be reprinted. This will also include Promoting of mother and child records where copies of mother passport books containing information from the start of antenatal, delivery, postnatal, immunization, family planning up to when the child is six years will be reprinted and distributed out to health facilities.

5.3.4 Provision of basic essential items for deliveries.

Some of the basic necessities needed for deliveries are supplied in small numbers making it difficult to cater for all deliveries. Among the basic essential items are the gloves, the anti septics and mama kits. Government through the Ministry of Health provides only two pairs of gloves in the mama kits availed, yet at times they are not even enough for both the patient and the health worker because the health worker is required to use at least six pairs of gloves on a delivery. This leaves health workers in dilemma opting to ask their clients to buy more gloves. This to most clients is perceived as a bribe creating an antagonistic relationship with the health workers contributing to the low skilled deliveries recorded in most public health facilities. Provision of basic essential items for deliveries will thus help in increasing the number of skilled deliveries besides reducing on the number of clients asked to buy gloves. A total 9,720 pairs of surgical gloves, 90 waste disposals facilities and 18 cartoons of antiseptics will be procured and distributed to 4 health centers in the 2 districts of Kayunga and Nakasongola. Waste disposal materials shall be categorized into four namely Non infectious waste, sharps waste, infectious

waste and highly infectious waste. All the different waste types shall be provided with a disposal facility.

5.3.5 Strengthening the Referral System

A concern was expressed towards improving and functionalizing the Health referral system as a way of improving health service delivery. Much as the system is in place, most of the referral components are non-functional and need to be rejuvenated especially at Health Centre level III. To respond to this concern, the RCKN plans to intervene by re-printing already designed copies by the MOH and availing them to VHTs for use. Besides, 1,000 referral cards shall be printed to add to those provided by government to ensure constant supply and thus an effective functional referral system. VHTs shall use the referral cards during their field visits to identify and refer clients to health centers for a wide range of MCH services.

Objective 2: Improved sanitation conditions and solar lighting in the target Health Center IIIs and surrounding community.

5.3.6 Sanitation Facilities for Targeted Health Centers and Surrounding Community

At each of the 4 selected health Centers, the hardware facilities to be constructed shall consist of; 4 stance pit latrines to boost the sanitation and hygiene in the area. The RCKN will work with district authorities to guide on the proper standard plans to be used for latrine construction. Besides, the RCKN will educate surrounding communities on hygiene and sanitation and support them to put simple latrine facilities by providing at least 600 sun plats to 600 households. This with hope that disease burden in homes and to the health units shall be reduced through preventive measures.

5.3.7 Installation of Solar Power Panels on Selected Health Facilities

Identified four health facilities in need of solar power will be availed with solar panels to help improve service delivery. Solar batteries, panels, Regulators, Bulbs, Lamp holders, Switches, Wires, Main/lead wires, Sockets and Molded boxes will be purchased and installed at the above 4 facilities in collaboration with the district authorities..

5.3.7 Handover of Facilities

The facilities will be officially handed over to respective beneficiaries and a certificate of completion handed over. This will help to avert any queries of standard of works because the stakeholders will attest to the quality and approve of the final piece of work but also taking care of issues to do with transparency and accountability. Besides, the participatory M&E system to be adopted through established community structures will ensure tracking of construction activities by the community at all phases.

6.0 Proposed Project Management Structure

There will be Project Management Committee Set up by the RCKN. A paid Project Manager and accountant shall be recruited to work with volunteer staff of the RCKN. The committee will provide technical guidance in the management of the project, review project progress in accordance to the project objectives and expected outputs and report to partners.

- The executive director is fully accountable for all CIDI projects operations, finances and administration and he will play this key role in the project.
- The project manager will be responsible for the day to day management and supervision of the project and give guidance and support to the extension staff. The Project manger will ensure that the planned activities are implemented according to the agreed time frame through. The project manager will prepare periodic monthly and quarterly reports to RCKN management and biannual reports. In the performance of tasks and functions, the Project Manager will be guided by the RCKN Project management committee and Committee Chair in charge of projects who shall be supervising the implementation of the project.

- RCKN Project management committee will monitor project implementation with the objective of capturing and documenting relevant data, statistical reports and tracking project indictors on outputs and outcomes. The RCKN Project management committee will be fully charged with research and documentation and publications. Periodic Project management committee reports shall be prepared which will form part of the project progress reports.

- RCKN Project management committee, Treasurer who is one of the committee and Project accountant will manage the project resources and will ensure timely disbursement of funds, compliance with established accounting principles and procedures, monitoring of project expenses/costs. The accountant is charged with prompt preparation and submission of financial reports to CIDI as per stipulated guidelines and to the donor at agreed intervals. Also to prepare audit reports and participate in audit exercises.