

the ACQUIRE TANZANIA project

Annual Report

October 2007 - September 2008

Submitted to
**Office of Population and Health
United States Agency for International Development
USAID Tanzania**
by
The ACQUIRE Project Tanzania

Under
**Associate Cooperative Agreement No. 621-A00-08-00006-00
LCA No. GPO-A-00-03-00006-00**



**MINISTRY OF HEALTH AND
SOCIAL WELFARE**

the ACQUIRE TANZANIA project



EngenderHealth
for a better life



USAID
FROM THE AMERICAN PEOPLE

TABLE OF CONTENTS

Acronyms	3
Executive summary	4
Introduction	7
Project performance in FY 2007/08	9
IR 1: INCREASE SUPPLY OF QUALITY FAMILY PLANNING/LAPM	9
IR1.1: Increased use of FP/LAPM	9
IR1.2: IMPROVED QUALITY OF FP/LAPM SERVICES	11
IR1.3: IMPROVED CONTRACEPTIVE SECURITY	15
IR2: Increased demand for FP/LAPM & Integrated PMTCT	15
IR2.1: INCREASED KNOWLEDGE OF FP/LAPM	15
IR2.2: INCREASED KNOWLEDGE OF PMTCT	16
IR3: Improved advocacy and policy in support of FP/LAPM, cPAC, and PMTCT	16
IR3.1: STRENGTHEN CAPACITY FOR PLANNING AND MONITORING FP/LAPM, cPAC & PMTCT	16
IR3.2: POLICY CHANGE PROMOTED TO REMOVE BARRIERS TO LAPM	17
IR4: Provision of cPAC in 10 districts	18
IR4.1: STRENGTHEN FP WITHIN cPAC SERVICES	18
IR5: Improved PMTCT services linked to CTCs, FP and other MCH services	18
IR5.1: IMPROVED QUALITY OF PMTCT SERVICES	19
IR5.2: INCREASED INTEGRATED PMTCT SERVICES	19
Challenges and Opportunities	20

List of tables and figures

Table 1: ACQUIRE Project Results Framework	8
Table 2. Total number of LAPM clients served Oct 2006-Sept 2007 and.....	9
Oct 2007 –September 2008.....	9
Figure 1: CYP contribution by LAPM method – 2007/08	11
Table 3: Number of Trainees by Topic and Field office – Oct 2007 – Sept 2008.....	13
APPENDIX A: Project Performance Indicator Table	23
APPENDIX B: Actual and targets for OP indicators in FY 2008 and FY 2009	25
APPENDIX C: List of Health facilities rehabilitated in FY 2007/08	25

Acronyms

ACQUIRE	Access, Quality, and Use in Reproductive Health Project
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
BCC	Behavior change and communication
CCHP	Comprehensive council health plans
CEDHA	Center for Education Development on Health
CHMT	Council Health Management Team
CTC	Care and treatment center
cPAC	Comprehensive post abortion care
CPR	Contraceptive prevalence rate
CYP	Couple years of protection
DRCHCo	District Reproductive and Child Health coordinator
FP	Family planning
FP/RH	Family Planning and Reproductive Health
FS	Facilitative supervision
HC	Health center
HIV	Human immunodeficiency virus
HMIS	Health management information system
HSR	Health sector reform
IEC	Information, Education and Communication
IP	Infection prevention
IR	Intermediate result
IUCD	Intra-uterine contraceptive device
LAPM	Long-acting and Permanent Methods
LDP	Leadership development program
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
ML/LA	Minilaparotomy under Local Anesthesia
MOHSW	Ministry of Health and Social welfare
MVA	Manual vacuum aspiration
MSD	Medical Stores Department
NACP	National AIDS Control Program
NGO	Non-governmental organization
NSV	No-scalpel vasectomy
OJT	On-the-Job Training
PMP	Performance management plan
PMTCT	Prevention of Mother-to-Child Transmission
QI	Quality improvement
RCH	Reproductive and Child Health
RCHS	Reproductive and Child Health Section
RH	Reproductive health
RHMT	Regional Health Management Team
SP	Service providers
STI	Sexually transmitted infection
TA	Technical assistance
TFR	Total fertility rate
T-MARC	Tanzania Marketing and Communications: AIDS, Reproductive
TOT	Trainer of trainers
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
VHW	Village health worker

Executive Summary

In November 2007, the USAID Tanzania Mission awarded EngenderHealth USD 33 Million for a 5 year period (2007 – 2012) under the Associate Award Agreement No. 621-A00-08-00006-00. The *Access, Quality, Use in Reproductive Health (ACQUIRE) Tanzania project (ATP)* is designed to support the Ministry of Health and Social Welfare (MOHSW) in its efforts to increase access to, quality of and use of family planning. ATP, in collaboration with MOHSW, also decentralizes comprehensive post-abortion care (cPAC) down to the lower level health facilities. In addition, the project supports the MOHSW to scale up quality PMTCT services in Manyara and Iringa regions to ensure that PMTCT services are integrated with maternal and child health programs with strong linkages to care and treatment programs, through improved facilities and strengthened referral systems.

During the reporting period (FY 2007/08), the ACQUIRE Tanzania Project (ATP) programmed interventions holistically by addressing supply, demand and advocacy components in the design and implementation of RH/FP activities. ATP initiated key activities in five intermediate result areas and substantial accomplishments were achieved:

- A total of 157,107 LAPM clients were served in this FY 2007/08 compared to 128,857 clients served in the baseline FY 2006/07. This represents a 22% increase from the baseline year. The LAPM clients served generated 828,833 CYPs.
- The project strengthened the capacity of 4, 275 health staff to provide quality LAPM services by training them in a full range of LAPM skills. The breakdown shows that: 875 health staff were trained to provide IUCD; 447 on implants; 82 surgeons to perform Minilap; 10 on vasectomy; 1,315 trained on Monitoring and evaluation of FP; 1,052 received on the job training (OJT) in various skills; 45 trained in leadership development program (LDP); 314 in quality improvement; and 135 received updates in contraceptive technology (CTU).
- As a result of the MOHSW's regionalization plans, EngenderHealth – in close collaboration with USAID, CDC, MOHSW and other stakeholders – scaled up the number of sites supported to provide PMTCT services from 48 to 159. Regionalization is a MOHSW (mainland) strategy meant to ensure equity of PMTCT services and accelerate the scale up of the PMTCT activities to all health facilities in the country. USAID, CDC and all other stakeholders worked closely with MOHSW to map out and implement the regionalization strategy. During the same period, EngenderHealth received \$ 250,000 PMTCT Plus up funding through field support to improve the quality of PMTCT services and to increase facility deliveries in 4 facilities in Njombe district. ATP leveraged these funds to train more service providers in PMTCT particularly in Iringa region. During the reporting period, ATP worked closely with respective districts to ensure that adequate numbers of HIV testing kits were made available to support the expansion.
- A total of 582 providers were trained to provide a minimum package of PMTCT services. A minimum package for PMTCT services includes at least all 4 of the services: counseling and testing for pregnant women; ARV prophylaxis to prevent MTCT; counseling and support for

safe infant feeding practices and family planning counseling or referral. The higher number of service providers trained to provide PMTCT was the result of combined efforts to support existing and new sites to provide better services.

- A total of 60,545 pregnant women out of the annual target of 67,445 women were tested and received their results. This represents a 90% achievement against the original target based on services provided in the original 48 sites.
- The project expanded comprehensive post abortion care (cPAC) from one district to 10 districts covering 65 sites in 2 regions. We trained a total of 216 service providers against the target of 108 to provide cPAC services. This was possible because the Council Health Management Teams (CHMTs) agreed to supply MVA kits to all health facilities.
- With the cPAC support provided under the project, 87% of post abortion care clients (1,289) were counseled and were provided a family planning method of their choice before leaving the health facilities. This achievement has surpassed the international set standards for cPAC programs, which advocates for an average of 60-70 percent of PAC clients accepting FP methods after the service (WHO, 2005).
- ACQUIRE/Tanzania worked with Council Health Management Teams (CHMTs) to improve the quality of 26 health facilities earmarked this year to provide FP/LAPM service by undertaking renovations and providing needed medical equipment to selected health care facilities to bring them up to national standard to provide quality FP/LAPM services.
- ATP provided technical assistance which allowed MOHSW “champions” to lead a Family Planning Revitalization effort in all eight RCH zones. High level advocacy meetings provided a forum for key decision makers at regional and district levels to refocus their attention on family planning in order to address unmet need for family planning and allocate more funds to the services. A total of 449 top regional and district officials attended these meetings including 8 Regional Commissioners, 55 District Commissioners, 47 District Executive Directors and 2 Members of Parliament. In attendance were also Regional Administrative Secretaries, Regional and District Medical officers, and other stakeholders working in FP/RH. A comprehensive approach was taken and included contraceptive technology updates, community engagement and mass media events that were implemented concurrently to improve knowledge and awareness of LAPMs and family planning in general.
- A total of 1,631 community members were trained on demand creation activities in the regions of Arusha, Manyara, Kilimanjaro, Mwanza, Mbeya, Dodoma and Mtwara. The trainings targeted leaders such as village executive officers (VEOs), ward executive officers (WEOs) and religious leaders. The leaders were oriented to various methods of modern family planning and how to sensitize other members of the community.

- Regular updates, quarterly reports, and both formal and informal meetings with USAID mission staff ensured that both agencies were in touch and communicating implementation progress

All these achievements can be attributed to the integrated and mutually reinforcing activities that are the basis of EngenderHealth's supply, demand and advocacy model. This comprehensive programming approach has allowed ATP to influence each of the key elements in ensuring greater access to and use of high quality family planning services across Tanzania.

Introduction

The ACQUIRE Tanzania project (ATP) - *Access, Quality, Use in Reproductive Health*, entered a new phase of implementation in November 2007 when USAID Tanzania Mission awarded EngenderHealth a total of \$ 33 Million for 5 years under the Associate Award Agreement No. 621-A00-08-00006-00. ATP is designed to support the Ministry of Health and Social Welfare (MOHSW) in its efforts to increase access to, quality of and use of family planning. ATP, in collaboration with MOHSW, focuses on long-acting and permanent methods of contraception (in all 26 mainland regions and Zanzibar), and decentralizes comprehensive post-abortion care (cPAC) down to the lower level health facilities. The project also supports the MOHSW to scale up quality PMTCT services in Manyara and Iringa regions to ensure that PMTCT services are integrated with MCH programs with strong linkages to care and treatment programs, through improved facilities and strengthened referral systems.

The ACQUIRE Tanzania Project (ATP) programs its interventions holistically by addressing supply, demand and advocacy components in designing and implementation of RH/FP service. This model synchronizes supply, demand and advocacy to strengthen health care services, provide relevant information to ensure that women and men are assisted to make and act on informed choices about planning their families. Overall ATP assists the districts in refining current systems for assessing the quality of care and for improving quality on a continuing basis in order to increase access, quality and use of LAPM and, comprehensive post-abortion care (cPAC); increase demand for FP/LAPM and integrated PMTCT services and improved advocacy and policy in support of FP/LAPM, cPAC, and PMTCT.

ATP builds on the work EngenderHealth was doing in Tanzania under the global ACQUIRE project **Cooperative Agreement No. GPO-A-00-03-00006-00**, which ended on September 30, 2008. During FY 2006/07, USAID/Tanzania requested EngenderHealth to scale up its ACQUIRE project nation-wide to assist the Tanzanian MOHSW to reposition family planning in the country. In May 2007, EngenderHealth's scale-up strategy was approved and implementation initiated. To ensure synergies/continuation of the momentum under the global ACQUIRE project, data collected during FY 2006/07 implementation has been taken as a baseline against which to measure both the activities and the outputs of ATP.

In order to effectively manage the scale up program, at the same time ensure equitable provision of services in all regions, ATP has adopted a two – tiered implementation approach: (1) in 84 districts the project is providing comprehensive, direct support to CHMTs and to 3,225 facilities (148 hospitals, 311 health centers and 2,731 dispensaries) providing family planning and reproductive health services. This comprehensive program package includes intensive training of service providers, provision of project equipment to all health facilities providing FP services (IUD and Minilap Kits, HIV test kits, theater beds, infection prevention equipment such as sterilizers, etc); support to outreach activities, support service days in hospitals and selected health centers; and improve routine FP/RH service provision in all health facilities providing family planning services; and support RHMTs and CHMTs to conduct timely supportive supervision to health facilities.(2) The remaining 53 districts are receiving general indirect support through project assistance at the zonal and regional level. This general support include training of LAPM trainers; training of RHMTs on the use of data for decision making; support

zonal and regional supportive supervision to districts; support quarterly contraceptive security meetings; and support of regional FP advocacy meetings. This segregated approach was chosen to ensure that the whole country receives FP interventions at all times. The decision for general vs. comprehensive support was made based on the expansion strategy which envisioned that by the end of ATP project the whole country will have received comprehensive support.

Using its district approach¹, ATP continued to strengthen the provision of FP/LAPM nationwide while cPAC interventions were focused in Mwanza and Shinyanga regions, in the Lake Zone. In addition, ATP implemented PMTCT activities aimed at supporting the MOHSW to scale up quality PMTCT services to ensure that PMTCT services are integrated in MCH programs with strong linkages to care and treatment programs, through improved facilities and strengthened referral systems in 12 districts in Manyara and Iringa regions.

The project continued to operate within a district approach that works in the existing decentralized health sector management structures of the Ministry of Health and Social Welfare (MoHSW) and aligns with the development, budgeting, reporting and implementation of the comprehensive council health plans. The MOHSW national and regional level strategic leadership support and supervision serve as the foundation of all interventions. The project apex goals are to ensure health of Tanzanian Families is improved and reducing transmission and impact of HIV/AIDS in Tanzania.

The ACQUIRE Tanzania Project contributes to USAID/Tanzania’s Health strategic objective that aims at improving health status of Tanzanian families and to the PEPFAR strategic objective of reducing transmission and impact of HIV/AIDS in Tanzania. To achieve the overall strategic objective, implementation of the project’s activities focused on five project intermediate results as shown in Table 1 below.

Table 1: ACQUIRE Project Results Framework

SO:	Improve health of Tanzanian families and reduce transmission and impact of HIV/AIDS
IR 1	IR1: Increased supply of quality FP/LAPM IR 1.1: Increased use of FP/LAPM IR 1.2: Improved quality of FP/ LAPM services IR 1.3: Improved contraceptive security
IR 2	IR2: Increased demand for FP/LAPM & Integrated PMTCT R2.1: Increased knowledge of FP/LAPM IR2.2: Increased knowledge about PMTCT
IR 3	IR3: Improved advocacy and policy in support of FP/LAPM R3.1: Strengthen capacity for planning and monitoring FP/LAPM, cPAC and PMTCT IR3.2: Policy change promoted to remove barriers to FP/LAPM
IR4	IR4: Provision of cPAC services at lower level facilities IR4.1: Strengthen FP w/in cPAC services
IR5	IR5: Improved PMTCT services linked to CTCs, FP and other MCH services IR5.1: Improved quality of PMTCT services IR5.2: Increased integrated PMTCT services (# sites, availability)

¹ District approach is defined as the approach that works within the MOHSW decentralized structures and aligns with development, budgeting, reporting and implementation of the comprehensive health plans

Project performance in FY 2007/08

This report summarizes accomplishments for ACQUIRE Tanzania Project (ATP) for FY 2007/2008 (year 1 of implementation).

IR 1: Increase supply of quality family planning/LAPM

On the supply side, the project is designed to strengthen service delivery components which include quality of services, contraceptive security and use of FP/LAPM services. To achieve this ACQUIRE/Tanzania provided technical assistance, consultation and training in planning, management, supervision, and provision of FP/LAMP skills and knowledge. This in turn increased availability of skilled and motivated service providers and more effective and efficient provision of services resulting into high achievements. Also, to assure availability of FP services ATP worked closely with the CHMTs in the 84 districts with comprehensive programming to improve access to and increase use of LAPM.

IR1.1: Increased use of FP/LAPM

In order to assure availability of FP/LAPM services, ATP collaborated with the CHMTs and District and Regional reproductive and child health coordinators (DRCHCO and RRCHCO) to strengthen routine services in static health facilities and organize outreach services to remote areas and hard to reach populations. All these initiatives focused on ensuring FP services are available where needed and when needed.

The number of clients served with LAPM contraception—sterilization, IUCD, implants and NSV increased from 128,857 clients served in the baseline FY 2006/07 to 157,107 clients served during this FY 2007/08 representing a 22% increase. This translates to 828,833 CYPs generated from all districts in the country irrespective of the LAPM intervention approach (direct support Vs indirect support).

Table 2: Total number of LAPM clients served Oct 2006-Sept 2007 and Oct 2007 –September 2008²

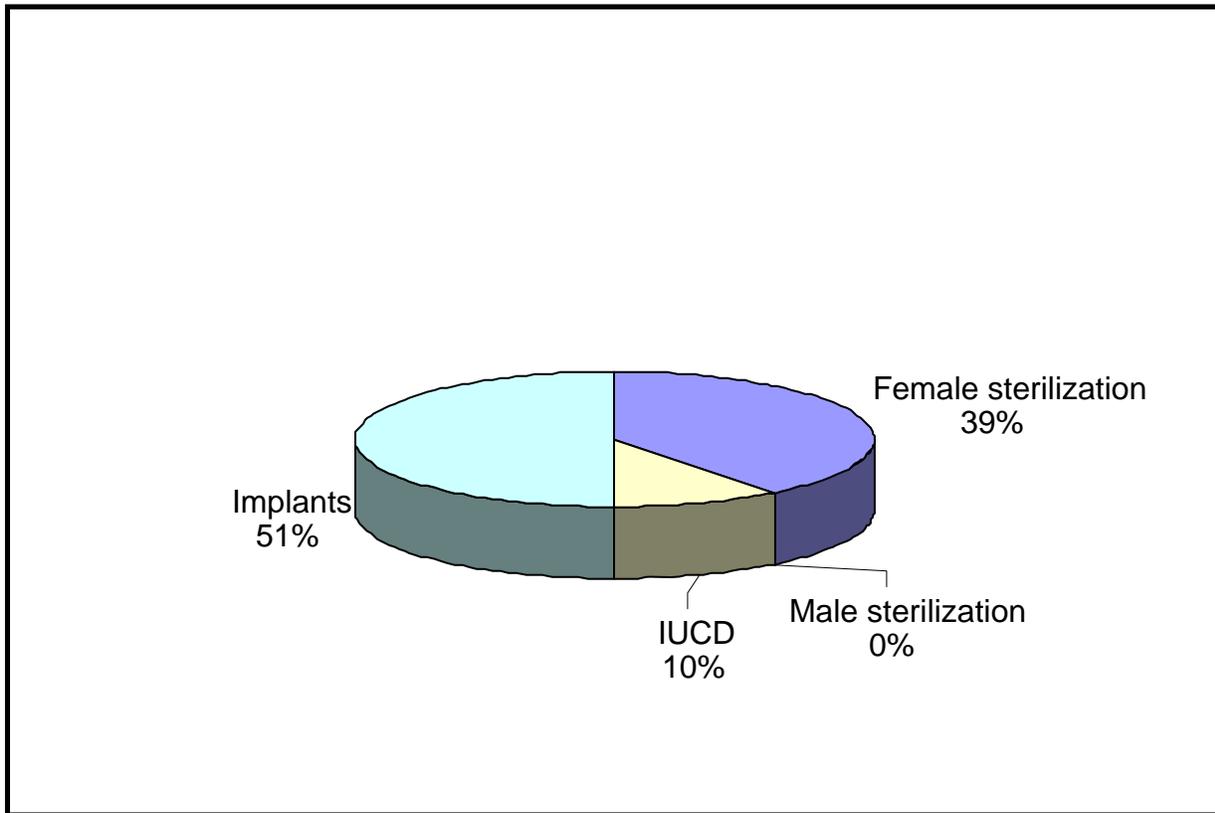
	Oct 2006– Sept 2007	Oct–Dec 2007	Jan –Mar 08	Apl-Jun 08	July-Sept 08	Oct 2007– Sept 2008	%change from FY 07 to FY 08
Total clients	128,857	25,346	39,504	40,900	51,357	157,107	22%
Female sterilization	55,550	12,590	15,935	14,371	18,856	61,752	11%
Male sterilization	153	40	42	49	108	239	56%
IUCD	20,230	2,340	4,457	3,199	6,433	16,429	(19%)
Implants	52,924	10,376	19,070	23,281	25,960	78,687	49%
Total CYP (LAPM)	701,663	145,546	210,160	208,040	265,087	828,833	18%

Table 2 above shows the number of LAPM clients increased by 22% from last year. The largest increases were in the use of the implants followed by female sterilization. These increases can be

² This table presents data collected from all 26 regions. The comparison is made by the LAPM clients served in FY 2006/07 and 2007/08 where in both FYs data was collected in 26 regions.

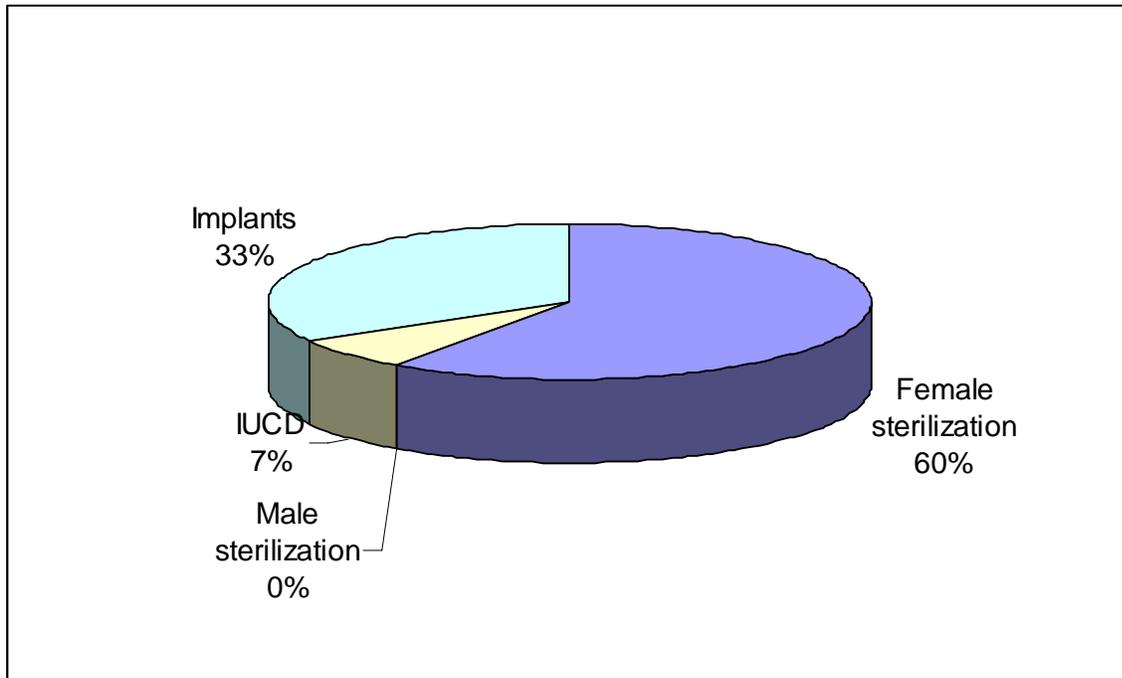
attributed to the increased number of trained service providers, provision of equipment (IUCD and Minilap kits) and the efforts of the MOHSW to ensure commodities reached the regions. The huge increase in the use of implanon could also be attributed to women switching from injectables to implants.

Figure 1: Distribution of LAPM services by method provided in FY 2007/08



The CYP coverage for the first year of ATP is 828,833, an 18% increase compared to the baseline FY 2006/07. Figure 2 below shows the distribution of CYP coverage by method. The majority of CYP is provided by sterilization (60%), followed by implants, IUCD, and vasectomy. This may be due to various reasons; major ones being the fact that services reached many women who want to limit their families. This is also true for implants and IUD as many women wishing to space their families for a longer term opted for implants or IUCD especially during outreach visits. During the year male sterilization increased in each quarter as a result of ATP efforts to involve men in family planning issues. This was done by actively involving men in open discussion forums which later triggered discussion at household level.

Figure 2: CYP contribution by LAPM method – 2007/08



Outreach LAPM services

ATP continued to support districts to conduct outreach visits in order to complement efforts made at lower level static health facilities (health centers and selected dispensaries) to provide a wide range of family planning services. An outreach visit is the visit made by a team of LAPM trained service providers to provide services to a distant facility whose health staff members do not have LAPM skills and in hard to reach geographical areas. Before conducting an outreach activity, districts usually make arrangements with community leaders, service providers and clients within close proximity of facilities. Clients previously counseled are encouraged to register for LAPM methods of their choice in advance. A team from the district hospital consisting of doctors, nurses and support staff provide the services over a number of days depending on the number of clients.



Clients respond after mobilization in Karatu district

During this first year of ATP 94,264 clients were served via the outreach services, contributing 60% of the number of clients served.

Renovation of health facilities

ACQUIRE/Tanzania worked with Council Health Management Teams (CHMTs) to improve health facilities, through minor renovations and procurement of needed equipment, to enable them provide quality FP/LAPM services. A total of 26 facilities were renovated and equipped to provide LAPM, cPAC and PMTCT services in this reporting period.



EngenderHealth President Dr Ana Langer officially opening RH/FP waiting bay at USA dispensary in Arumeru district

IR1.2: Improved quality of FP/LAPM Services

To improve the quality of FP/LAPM services we worked with Reproductive and Child Health Section (RCHS) and CHMTs to: 1. improve the skills of providers through trainings; 2) monitor provider performance through follow up visits made by trainers; 3) provide technical assistance and training to MOHSW in facilitative supervision techniques; 4) institute ongoing facility-based quality improvement systems; and 5) identify quality FP services and support exchange visits so that less successful districts can learn lessons from successful ones. This initiative has been planned to start in the FY 2008/09

Training

Human resources for health in Tanzania, as elsewhere on the continent, continue to be a challenge to (government) efforts to improve the use of FP/LAPM services: Tanzania has an aging healthcare workforce, with many moving rapidly into retirement; an inadequate cadre of Service providers (especially doctors) eligible to be trained in LAPM; the challenge of healthcare workers finding a career within the public sector less attractive due to difficult living and working conditions, especially in rural areas; low pay; significant emigration; and, limited in-service and pre-service training capacity.³ While the majority of these challenges are beyond the scope of the ATP to address, the project includes significant support to strengthen the quality and quantity of in-service training. ATP assistance to CHMTs to conduct in-service trainings was based on the districts' demand and the work plans submitted to EngenderHealth/ACQUIRE Tanzania project by respective districts. The trainings conducted this year include; LAPM skills, OJT training in LAPM, quality improvement, whole site training, M&E orientation, PMTCT skills, demand creation, FP and PMTCT counseling skills, advocacy and cPAC skills. The project successfully trained a total of 7,153 individuals during the year which included service providers, trainers, supervisors, community leaders and district key decision makers as shown in Table 3. Trainers conducted follow up visits to health facilities to oversee how the trainees are doing their work after training and provide on-the-job training where necessary. This is followed by certification in case a service provider demonstrates competency. Further, the quality management tool (QMT) has been proposed to be used in the FY 2008/09 to measure quality of LAPM services we are providing in the health facilities.

³ McKinsey and Co. "Acting Now to Overcome Tanzania's Greatest Health Challenge: Addressing the Gap in Human Resources for Health", Tanzania 2004.

Table 3: Number of Trainees by Topic and Field office – Oct 2007 – Sept 2008

Type of Training	Field Offices				Total
	Coast	Iringa	Mwanza	Arusha	
LAPM Skills	379	67	522	446	1,414
OJT- LAPM	276	131	386	259	1,052
cPAC Skills	-	-	122	-	122
cPAC Orientation	-	-	94	-	94
PMTCT Skills	-	248	-	124	372
LDP	-	-	45	-	45
PMTCT Orientation	-	64	-	146	210
Quality Improvement	159	53	-	102	314
CTU Update	42	30	31	32	135
Demand Creation	313	106	649	563	1,631
M&E Orientation	54	27	681	553	1,315
Advocacy FP Repositioning	133	55	196	65	449
Total	1,356	781	2,726	2,290	7,153

Facilitative supervision

Facilitative Supervision is an oversight/management approach used by EngenderHealth that emphasizes the supervisor's role in quality improvement among a team of staff. It emphasizes mentoring, joint problem solving and two-way communication between a supervisor and those being supervised. During this reporting period, the ATP staff constantly worked with Regional reproductive and child health coordinators and the CHMTs at district levels and continued to support CHMTs provide facilitative supervision to service providers at facility level on quarterly basis. During the supervision visits the CHMT members and RCH coordinators, discuss progress, and provide on-the-job training to service providers with a special focus on informed choice, medical monitoring, mentoring and coaching and data management issues. In this reporting period, facilitative supervision as conducted by districts helped to improve data collection, completeness of data submitted and data submission. However, due to limited funding at regional levels, RHMTs in most regions were unable to conduct quarterly facilitative supervision to districts as required by the MOHSW; an area that needs attention. During the year, ATP provided limited funding to CHMTs to conduct facilitative supervision to lower level facilities on quarterly basis. Furthermore, ATP continued to advocate for MOHSW through DHS to financially support regions to conduct facilitative supervision regularly.

Quality Improvement Activities

ACQUIRE Tanzania project supports several types of quality improvement activities to strengthen the capacity of health care personnel to provide quality services. During this reporting period, ATP collaborated with MOHSW (RCHS section) and district CHMTs to train 314 service providers in Client-Oriented, Provider-Efficient Services (COPE) and Whole Site Training approach. As a result, more than 257 facilities (mainly hospitals and health centers) introducing COPE in their facilities: COPE committees were formed, 24 hour services at some health centers were initiated, Signboards for parking and services were posted, IEC materials (including Tiaht posters) were placed in family planning waiting rooms and infection prevention procedures put in place. From reports received from CHMT members, staff in charge of health facilities, service providers and monitoring visits, COPE, where introduced, has improved the quality of service delivery, increased the number of clients served and improved client satisfaction.

COPE is a quality improvement process developed by EngenderHealth that assists health care staff to continuously improve the quality, efficiency, and client responsiveness of the services at their facility. The COPE quality appraisal process includes self-assessments, client interviews, record reviews, and client flow analysis (when feasible). The findings from these are brought together in an Action Plan developed by the health care facility staff.

PASUA Urban Health Center: Moshi Urban, Quality Improvement Strengthened with COPE

The COPE committee and the CHMT admitted this was one of the first tools which had been used in their facility and had been enthusiastically accepted at all levels. The COPE exercise resulted in changes in a short time period and at a very reasonable cost:

- IEC materials (including the Tiaht poster) have been placed in the family planning waiting room.
- An ambulance was shifted from the district hospital to the health center to cater for emergency transport
- 24 hour services at the HC were initiated.
- A waiting bay for doctors in the OPD was constructed.
- A TV/Video for training and information was purchased and installed.
- Waste bins were erected.
- Goggle glasses and boots were purchased.
- TASAF funds were used for the construction of a modern incinerator.
- Signboards for parking and services were posted.
- The general environment has been improved by planting flowers and keeping the grounds clear.
- The total cost for making these improvements was only Tsh. 650,000 (~\$500 USD).



In addition, CHMTs in 84 districts were introduced to whole site training approach which actively engages supervisors in the identification of learning needs of all staff at a site, planning and implementing the required training (on-the-job, on-site, or off-site), and facilitating the implementation of newly-acquired skills through coaching, mentoring and teamwork. WST includes *in reach* (staff orientations, referrals, linkages between departments, and adequate signs) to ensure that clients do not miss opportunities to access information and services for all their reproductive health needs when they come to the site.

IR1.3: Improved contraceptive security

ACQUIRE/Tanzania collaborated with the MOHSW to improve contraceptive security. The ATP role was to track delivery point outlet statistics for both LAPM and short acting methods. The statistics in service delivery were compared to distribution figures held in the Ministry of health through other implementing partners in RH/FP. ATP is training service providers on how to complete the reporting and requesting (R&R) forms during the LAPM skills trainings. During this reporting period 32 zonal contraceptive security meetings were held to ensure equitable distribution of FP commodities in the country as per specific district needs. Representatives of the Medical Stores Department (MSD), important distributors of FP products, attended all the meetings and worked with Zonal and Regional RCH Coordinators and other stakeholders to improve commodity distribution. At national level, regular security meetings resulted into improved commodity projections, equitable distribution of commodities and looming stockouts were anticipated in good time and whenever necessary, the ministry accelerated procurement of commodities especially implanon. As a result fewer facilities reported stockouts during the year.

IR2: Increased demand for FP/LAPM & Integrated PMTCT

The ATP supports MOHSW efforts to improve the image of FP/RH services overall, along with LAPMs, and to reduce stigma and increase acceptance of PMTCT services. ATP in collaboration with the MOHSW developed FP messages around the behavior change communication (BCC) campaign “Have a Plan” (in Swahili *Jipange Ki-maisha Katika Uzazi*). An experienced marketing company AY&R was subcontracted to design and implement the BCC campaign. The BCC messages were linked to community participation and information activities. Engaging communities, providing up-to-date, accurate information about FP/LAPM methods and services not only increased knowledge but also improved the image of FP services making them more acceptable. Similarly, IEC materials, community involvement, communications and marketing approaches were employed to increase knowledge about integrated PMTCT services, which led to increased use of FP and integrated PMTCT services. During this reporting period ATP in collaboration with MOHSW launched family planning repositioning campaigns in Mbeya, Mtwara, Mwanza and Arusha regions where a total of 106,190 individuals attended the FP campaigns. The main activities in these campaigns included; 304 clinic sessions held to allow women to discuss FP issues openly, 50 road shows conducted to sensitize the community on FP/LAPM where and when to seek for these services; 214 community forums involving men held to trigger FP discussion at household level, 3,100 posters and 57,500 leaflets distributed and 11 billboards displayed at strategic areas such as main entrance gates of health facilities, market places and main roads.

IR2.1: Increased knowledge of FP/LAPM

To increase knowledge FP/LAPMs we focused on three areas; 1) engaged the news media to provide correct information and to address myths and rumors related to LAPMs, 2) used behavior change communications to improve correct knowledge and key benefits of LAPMs, 3) increased community participation in support of FP/LAPMs. Example activities implemented during the year include: television and radio interviews with satisfied FP/LAPM clients; feature programs and talk shows on FP/LAPM and male participation in FP; and special editions and newsletters on local and national media. A total of 90 journalists were oriented on FP/LAPM messages; 1,191 community leaders at different levels were involved in demand creation activities

and 350 religious leaders were oriented on FP. The key FP/LAPM messages delivered to the community are as follows:

- Family planning helps to improve your life
- A wide range of family planning methods is available, the choice is yours
- It is not by chance, I and my husband we have chosen to use IUCD
- This man is smiling because he has chosen vasectomy as his family planning method
- LAPM methods are safe to use



Demand creation activity in Mbeya

IR2.2: Increased knowledge of PMTCT

To increase knowledge of PMTCT as a key component of maternal and child health, district authorities, community and theater groups were engaged and oriented to PMTCT in order to provide correct information on the importance and availability of PMTCT services in their respective areas. District health staff conducted peer education meetings to provide correct information to men on PMTCT; also local theater groups were used to encourage women in Njombe communities to deliver at health facilities. These interventions resulted into more pregnant women accepting to test for HIV and other subsequent PMTCT services. The key PMTCT messages delivered to the community are as follows:

- PMTCT services will protect your baby from HIV infection
- Pregnant women have a right to PMTCT services
- PMTCT services are available in public health facilities free of charge

In addition, ATP renovated 26 health facilities to provide quality PMTCT services as part of the integration with FP/LAPM.

IR3: Improved advocacy and policy in support of FP/LAPM, cPAC, and PMTCT

ATP provided TA to the MOHSW, Local Government Authorities and other affiliated health institutions and stakeholders to promote advocacy activities and policy dialogues that focused to create favorable environment for increasing uptake of FP/LAPM, cPAC and PMTCT services. A Family Planning Revitalization effort was implemented in conjunction with the MOHSW covering all eight RCH zones. High level advocacy meetings provided a forum for key decision makers at regional and district levels to refocus their attention on family planning in order to address unmet need for family planning and allocate more funds to the services.

IR3.1: Strengthen capacity for planning and monitoring FP/LAPM, cPAC & PMTCT

The project is committed to strengthening the capacity of districts to collect and manage accurate data that will be useful during planning sessions. Capacity building has been the main strategy of improving data quality. CHMT members and Service providers were trained on completing data collection tools, making simple interpretation of data for decision making and preparing action plans for facilitative supervision for districts that were revealed by data to have poorly performed. A total of 1,315 health staff were oriented on the importance of data collection, timely submission and use of data for planning and decision making. Although improvement in data collection and

reporting was noted during the year, more CHMT members still need in-depth training data management. In the coming year, ATP will focus on training key members of CHMTs including District Reproductive and Child Health Coordinators, District Medical Officers, District Health Secretaries and District Planning Officers (co-opted CHMT members) in data collection, simple data analysis, data interpretation and use of data for planning.

As part of the advocacy strategy for increasing budget allocations for family planning at district level, the ACQUIRE project organized a one day seminar for district planning teams. This meeting brought together district budgeting authorities and planners at district level to ensure a common understanding on the role of family planning in reaching national development goals, and in reducing maternal and child mortality in particular. Participants included members from Council Health Management Teams, (CHMT), Council Health Boards (CHB), Council Social Services Boards (CSSB) and District Chairpersons. Participants had a chance to review their Comprehensive Council Health Plans (CCHP) to see how family planning was addressed. It was interesting to note that of the 31 districts involved, 20 districts had allocated funds for family planning from the district's own resources and basket funds. At the end of this workshop each district came up with priority FP activities, (which included staff training, procurement of equipments and supplies, funds to support FP outreach services, funds to rehabilitate some lower level facilities) for inclusion in the 2009/2010 CCHP. In the next FY, ATP will plan with more districts to ensure that all 84 districts with comprehensive programming are encouraged to allocate basket funds for FP activities and document the specific amount allocated to family planning during the year.

Additionally, ATP is developing an in-house FP and PMTCT MTUHA system that parallels the MOHSW MTUHA system. By entering this narrow band of data points on FP and PMTCT MTUHA data into an ATP database, we will be able to turn around analyses relatively quickly. These simple analyses will then be shared with the District RH Coordinators and CHMTs to assist them in their planning and decision making for quality improvement

IR3.2: Policy change promoted to remove barriers to LAPM

ACQUIRE/Tanzania collaborated with the MOHSW to address policy issues that will promote usage of FP/LAPM services. We are actively advocating for DRCHCOs to become full CHMT members; District authorities to increase budget allocation for FP activities; conduct a study to generate evidence of the ability of clinical officers to perform surgical contraception and involve medical schools to include surgical contraception into their training curriculum. During this reporting period, a Family Planning Revitalization effort was implemented in conjunction with the MOHSW covering all eight RCH zones. High level advocacy meetings provided a forum for key decision makers at regional and district levels to refocus their attention on family planning in order to address unmet need for family planning and allocate more funds to the services. A total of 449 top regional and district officials attended these meetings including 8 Regional Commissioners, 55 District Commissioners, 47 District Executive Directors and 2 Members of Parliament. In attendance were also Regional Administrative Secretaries, Regional and District Medical officers, and other stakeholders working in FP/RH. Other activities included contraceptive technology updates, community engagement and mass media events conducted concurrently to improve knowledge and awareness of LAPMs and family planning in general

IR4: Provision of cPAC in 10 districts

In this year, Mwanza field office scaled up its pilot project to decentralize cPAC to lower level health facilities from one district (Geita) to 10 districts. The ACQUIRE/Tanzania rolled out cPAC to 9 new districts in Mwanza and Shinyanga regions based on the lessons learned in Geita. When cPAC services were made available at dispensaries and health centers of Geita district, there was an increase of cPAC clients treated at lower level facilities and subsequent decrease of PAC clients at district referral hospital. This change might have been due to the fact that services were available at a walking distance. The strategy supports post-abortion clients by giving them medical treatment at a nearby health facility. Clients are also counseled to choose and leave with an FP method of their choice in order to avoid repeat unwanted pregnancies or give those women who want children time to rest before the next pregnancy. Other project strategies included community involvement and provision of FP methods to prevent future unwanted pregnancies, renovation of MVA rooms in 5 facilities and provision of equipments in 65 sites to improve the quality of services provided. ATP worked with CHMTs to ensure basket funds were set aside to procure MVA kits for those sites with trained Service providers; build capacity of service providers through training and encourage community participation in order to promote the habit of families seeking cPAC services early enough. In addition, RCHS provided adequate MVA kits for training and project start up.

IR4.1: Strengthen FP within cPAC services

ATP worked with CHMTs to ensure that service providers' are trained to provide relevant treatment for post abortion, counseling and offering of FP methods of their choice to prevent future unwanted pregnancies. CHMTs ensured that health facilities that require PAC rooms are created and equipped with MVA kits. In addition, the project introduced community PAC in the 10 districts in Mwanza and Shinyanga regions. Community PAC mainly aim at giving the community correct information on the importance of immediate seeking care at health facilities.

Strengthening the family planning counseling component of post abortion care is a crucial maternal health intervention. The ATP takes an active role in addressing PAC/FP integration through comprehensive post abortion care (cPAC). During this reporting period a total of 1,482 PAC clients were served. All clients were counseled for FP methods, and 87% (1,289) of women who received PAC services were discharged with FP methods of their choice. Informal discussion with service providers during facilitative supervision has revealed that the number of PAC clients at district hospitals has decreased because the services are now available at dispensaries and health centers.

IR5: Improved PMTCT services linked to CTCs, FP and other MCH services

Using a district model, as we do for all our other program activities, ACQUIRE/Tanzania worked to provide a continuum of integrated MCH/RH-HIV services, in close partnership with the RHMTs, CHMTs and other care and treatment partners working in the same communities in Manyara and Iringa regions. Provision of integrated PMTCT services in health facilities of Manyara and Iringa regions started in this financial year. A total of 48 health facilities: 20 in Manyara region and 28 facilities in Iringa region were targeted. Under this initiative of PMTCT service provision, women and their partners are able to access this service regardless of whether they are attending antenatal clinic, under-five clinics or labor ward. Moreover, FP services are provided at the same health facility on the same day. Our activities aimed to improve and

increase HIV counseling and testing services, promoting family planning for HIV-positive women, and assuring treatment for women and their infants during and following pregnancy and labor and delivery.

IR5.1: Improved quality of PMTCT services

In order to provide quality PMTCT services in Iringa and Manyara regions the project conducted an environment scan in 50 health facilities to identify needs such as training received by service providers; situation of infection prevention at facility level; and availability of services such as early infant diagnosis for care and treatment.

IR5.2: Increased integrated PMTCT services

To ensure increased integrated PMTCT services, district and regional authorities from 12 districts of Iringa and Manyara were equipped with facilitative supervision skills, assisted to conduct mapping of facilities to enable formal integrated referral system and documentation of integration effects.

During the reporting period, remarkable achievements were realized. By September 2008, the number of sites providing PMTCT services increased from the original target of 48 outlets to 159 (66 in Manyara and 93 in Iringa). This was as a result of MOHSW regionalization plans which saw EngenderHealth take over the support of sites that were previously supported by other organizations such as AMREF, QUAM, FHI, AIDS Relief and those supported by the MOHSW. However, since a large number of sites were only identified and joined the program during the last quarter of the year, ATP was only able to train service providers from these new sites during the reporting period. A total of 582 service providers were trained to provide a minimum package of PMTCT⁴. As a result, 60,545 pregnant women were tested and received their results.

To ensure effective collaboration in the two regions, EngenderHealth signed memorandum of understanding (MOUs) with Deloitte/FHI ‘Tunajali project’ and with AIDS Relief. The MOUs mandates EngenderHealth, through the ACQUIRE Tanzania project to coordinate the implementation of PMTCT activities while Deloitte/FHI and AIDS Relief will focus on providing care and treatment services in the two regions respectively.

ATP started a new intervention of early infants’ diagnosis (EID) to check whether children born to HIV positive mothers if given Nevirapine and other ART, and adhere to infant feeding options are protected from HIV infections. This service is implemented in close collaboration with MOHSW and Deloitte/FHI in Iringa and AIDS Relief in Manyara. During the reporting period, ATP trained 29 Service providers and trainers in EID and facilitated CHMTs to transfer dry blood samples to referral laboratories at KCMC and Mbeya referral hospitals for testing and results back to respective sites. By September 2008, a total of 107 infants from 5 districts (57 in Iringa and 50 in Manyara) were tested and received their results.

⁴ A minimum package for PMTCT services includes at least all 4 of the services: counseling and testing for pregnant women; ARV prophylaxis to prevent MTCT; counseling and support for safe infant feeding practices and family planning counseling or referral

Challenges and Opportunities

ATP was officially awarded to EngenderHealth in November 2007, and during the first year of implementation ATP has recorded tremendous achievements. However, during the reporting period, the project also encountered a number of challenges. ATP worked closely with MOHSW national level, RHMTS and CHMTs to address some of these challenges by exploring available opportunities that can be capitalized on to solve the problems. This section presents some of the challenges observed during the year and how the project has tried to address them.

High demand for LAPM

During this reporting period the MOHSW system served many more LAPM clients compared to the previous period last year. Multiple strategies, such as improving the quality of services at facilities to meet immediate demands as well as continuing the outreach strategy are among the approaches used to address FP demand.

Commodity stock outs

Many facilities still experience shortages of long acting methods/commodities: either stock outs, or irregular and inadequate supplies, particularly for Implanon. ATP staff will continue to work with MSD, JSI/DELIVER and the contraceptive security committee to resolve stock out problems.

Although the contraceptive security committees advocates for equitable distribution of FP products, in practice the problem arises during the time of delivering the products. Fewer products are delivered to regions as compared to what has been committed to in the meetings. ACQUIRE will continue to raise this issue in future contraceptive security meetings to ensure that decisions which are reached in the contraceptive security meetings are adhered to.

In adequate equipment

Availability of MVA kits continued to remain a major challenge since procurement of MVA kits cannot be purchased with USAID funds given the pace of cPAC services expansion in 10 districts of Shinyanga and Mwanza regions. The good news is that RCHS is willing and was able to provide enough MVA kits for training and project start up to meet demand of the new cPAC trainees. Districts are also increasingly buying MVA kits using baskets funds.

Erratic availability of HIV test kits in Manyara and Iringa regions has been a challenge. The project is working closely with DMO offices to improve projections of the kits and to ensure that HIV test kits are available every time they are required. However, this is subject to availability of test kits at national level.

Some health facilities faced a shortage of equipment such as IUCD and minilap kits. During the year, ATP procured and distributed various equipment including 840 minilap kits, 600 IUCD kits, HIV test kits and other medical equipment to ensure provision of quality services. However, the project will continue to assist CHMTs to develop an inventory of equipment available in all facilities to determine the magnitude of the need

and actual utilization of these kits. This will be followed by developing functional action plans by individual CHMTs to include funding in their CCHP to purchase FP equipment in future.

Poor Infrastructure

Although ATP intensified training of service providers in IUCD, implanon and Minilap, to enable them provide LAPM services on demand, poor conditions of health facilities and inadequate space for family planning activities in the facilities continued to be one of the challenges facing the ACQUIRE Tanzania project. In this reporting period, ATP worked closely with CHMTs to rehabilitate 26 facilities that were in poor condition to facilitate provision of quality health services. While ATP will continue to assist districts rehabilitate needy facilities, efforts will be intensified to encourage CHMTs include rehabilitation as an FP activity in their CCHPs.

Shortage of Human Resource at health facilities

Human resources for health in Tanzania continue to be in a weakened state, with an aging health workforce moving into retirement; inadequate eligible cadre of Service providers (especially doctors) to be trained in LAPM, public sector employees finding a career within healthcare less attractive due to difficult living and working conditions, especially in rural areas; low pay; urban or international migration options; and, limited in-service and pre-service training capacity. Many facilities where we work especially in the rural areas are either manned by low cadre of staff or do not have adequate staffing levels to provide LAPM. As a result communities around such communities depend on outreach services to access FP/LAPM services. ATP will continue to advocate districts to employ more staff.

Training

Training in LAPM contraception will therefore continue to be a priority for ATP program in the coming years. There are many providers who will retire in the near future, leaving gaps at many facilities. ATP uses a variety of approaches in training, based on need, appropriateness of the approach and cost-effectiveness. Approaches include: training of trainers at regional and district levels; limited central training, especially when caseload is a problem; district level training and follow-up on site; whole site training; training during outreach; and on the job training (OJT). ATP is finding that OJT is an effective method for getting providers trained without much disruption in services and is cost effective. ATP is working with RCHS to finalize the OJT curriculum as a means of standardizing and scaling up OJT training.

Facilitative Supervisions

In this reporting period, we have learned that inadequate facilitative supervision was mainly caused by insufficient funding especially to RHTMs. ATP is working with MOHSW and other partners to support funding for this activity.

Data collection and Data for decision making

Data collection in some health facilities continued to be a major problem. The ATP facilitated 2 day training to CHMTs on the importance of using data they collect for

decision making. After the training we expect CHMTs will improve their FP data collection, reporting and use of the data for planning.

Late submission of data from districts has been an obstacle to report writing and timely submission of project reports. Through the M&E orientation during the CTU workshop, districts initiated effective ways of getting data from health facilities to the district as opposed to reliance on traditional means which have proved ineffective. ATP will continue to provide such a training to cover all CHMTs. This is because, people are more likely to collect quality data and submit reports in a timely manner if they see the benefit of this exercise in their own work. Therefore, ATP will work to incorporate the use of facility-based data into COPE and facilitative supervision activities, as well as strengthen the use of these data for planning and decision making at the district and regional levels. In the next FY, ATP will monitor districts that received this kind of support to track improvement in data submission and reporting.

Local Ownership and Coordination

Leaders at all levels play a crucial role in the implementation of activities. Involving the CHMTs members in all phases of project activities in their districts has resulted in ownership, confidence in the project and improved quality of services, and supervision at districts level. During the high level advocacy meetings organized between May and June 2008, ATP added policy makers and key managers at regional level including Regional Commissioners, (RC), Regional Administrative Secretaries, District Commissioners and District Executive Directors to this group of leaders. ATP will continue to lobby these leaders to put FP as a priority on their development agenda and influence CHMTs increase FP budget in their CCHPs.

APPENDIX A: Project Performance Indicator Table⁵

Indicators	TOTAL-FY07	Oct-Dec 07	Jan – March 08	April-June 08	July-Sept 08	Total- FY 08	Percentage Change
Total LAPM clients	128,857	25,346	39,504	40,900	51,357	157,107	22%
Female sterilization	55,550	12,590	15,935	14,371	18,856	61,752	11%
Male sterilization	153	40	42	49	108	239	56%
IUD	20,230	2340	4,457	3,199	6,433	16,429	(19%)
Implant	52,924	10,376	19,070	23,281	25,960	78,687	49%
Total LAPM CYP	701,663	145,546	210,160	208,040	265, 087	828,833	18%
Female sterilization	444,400	100,720	127,480	114,968	144,912	494,016	11%
Male sterilization	1,224	320	336	392	376	1,912	56%
IUD	70,805	8,190	15,600	11,197	20,958	57,502	(19%)
Implant	185,234	36,316	66,745	81,484	84,490	275,403	49%
Rehabilitation of Health Facilities							
Number of health facilities rehabilitated	-	-	2	16	8	26	-
PMTCT							
# Number of service outlets providing a minimum package of PMTCT services according to National and International standards		54	72	78	159	159	194%
# Number of health workers trained in provision of PMTCT services according to national and international standards		130	76	107	269	582	347%

⁵ The data presented in this table were collected through the MTUHA system. ATP has been supporting CHMTs through facilitative supervision to train service providers how to identify errors in their reports before submission to DRCHCOs. Also, the M&E Team from ATP has conducted M&E training during LAPM and PMTCT skills training on how to complete respective data collection tools; and detecting data discrepancies at facility level and take appropriate action.

Indicators	TOTAL-FY07	Oct-Dec 07	Jan – March 08	April-June 08	July-Sept 08	Total- FY 08	Percentage Change
# Number of pregnant women received HIV counseling, tested and received their results	-	9,370	12,418	15,088	23,669	60,545	-
# Number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT	-	277	529	511	2,305	3,622	-
PAC							
# of Sites providing PAC services	11	11	19	61	91	71	545%
# of total PAC clients	796	166	121	188	1007	1,482	86%
# of total PAC clients counseled about FP methods	712	166	121	188	1007	1,482	108%
% of PAC clients counseled on FP	89%	100	100	100	100	100	12%
# of total PAC clients accepting a FP method	505	113	102	177	897	1,289	155%
% of PAC clients accepting a FP method	71%	68%	84%	94%	92%	87%	22%

APPENDIX B: Project Actual and targets for OP indicators in FY 2008 and FY 2009

S/N	Indicator	FY 2008 Actual	FY 2009 Target
1	Couple years of protection (CYP) provided by LAPM	828,833	1,066,613
2	Number of people trained in FP/RH	7,153	12,149
3	Number of health facilities rehabilitated	26	63
4	Percent of cPAC clients who accept an FP method	87%	80%
5	Number of service outlets providing a minimum package of PMTCT services according to national or international standards	159	160
6	Number of pregnant women who received HIV counseling, testing, and then received their results.	60,545	125,881
7	Number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT	3,622	7,267
8	Number of health workers trained in provision of PMTCT services	582	700

APPENDIX C: List of Health facilities rehabilitated in FY 2007/08

S/N	Facility Name	District located	Region
1	Usa – Dispensary	Meru	Arusha
2	Mrara- Health Center	Babati	Manyara
3	Pasua – Health Center	Moshi Urban	Kilimanjaro
4	Misasi Health Center	Misungwi	Mwanza
5	Seukotoure Hospital	Nyamagana	Mwanza
6	Lyasa Image Dispensary	Kilolo	Iringa
7	Njombe District Hospital	Njombe	Iringa
8	Iringa Reginal Hospital	Iringa Municipal	Iringa
9	Nkomaindo Hospital	Masasi	Mtwara
10	Shinyanga Regional Hosp	Shinyanga Municipal	Shinyanga
11	Lyabukande Health Centre	Shinyanga	Shinyanga
12	Nindo Health Centre	Shinyanga	Shinyanga
13	Salawe Health Centre	Shinyanga	Shinyanga
14	Tinde Health Centre	Shinyanga	Shinyanga

15	Samuye Health Centre	Shinyanga	Shinyanga
16	Ng'homango Disp.	Shinyanga	Shinyanga
17	Bukombe Hospital	Shinyanga	Shinyanga
18	Uyovu Health Centre	Bukombe	Shinyanga
19	Masumbwe Health Centre	Bukombe	Shinyanga
20	Bwelwa Dispensary	Bukombe	Shinyanga
21	Nyang'holongo Dispensary	Bukombe	Shinyanga
22	Ushirika Dispensary	Bukombe	Shinyanga
23	Bukandwe Dispensary	Bukombe	Shinyanga
24	Ikungu Igazi Dispensary	Bukombe	Shinyanga
25	Ilolangulu Dispensary	Bukombe	Shinyanga
26	Kahama District Hospital	Bukombe	Shinyanga

SUCCESS STORY

HOW PEPFAR INITIATIVES CHANGES LIVES OF INFECTED PREGNANT WOMEN AND THEIR FAMILIES



Veronica Paul, born in Njombe District, Iringa region 36 years ago, has a small business. She is married to Mr. Moses, the village mason. In November 2007, Veronica was diagnosed as having HIV during her first antenatal visit to Njombe Urban Health Center. The Center is among the several health facilities in Iringa region where EngenderHealth is training health professionals to provide better services to prevent mother-to-child transmission (PMTCT) of HIV, with funding from USAID through the PEPAFR initiative.

After undergoing thorough counseling with a nurse trained by EngenderHealth to provide comprehensive PMTCT services, Veronica agreed to voluntarily test for HIV. Initially she was shocked when she learned she was HIV+ lost hope of survival, and wondered about her unborn child and her small business. Her counselor, however, reassured her of good health for both herself and her baby through the PMTCT and Care and Treatment Center (CTC) services supported by PEPFAR. Further, her counselor explained to her that she will be able to proceed with her business activities as usual. *“I was afraid of frequent sickness of myself and my baby, and how I’ll be able to manage my business as usual”* Veronica explained during a recent Interview with EngenderHealth staff. After post-test counseling, Veronica received a Nevirapine tablet to swallow during the start of true labor pain. Also, she was counseled on infant feeding options after delivery. It was difficult for her to disclose her HIV status to her husband but the counselor explained why it was important and supported Veronica as she decided what to do. After about one month of deliberating, she chose to disclose her status to her husband. Initially, he was shocked, but later was convinced to test, too. He was also diagnosed as having HIV.

When she delivered her baby girl, Sara, at Njombe District Hospital, Sara received a dose of Nevirapine as well, and the blood test she received at birth showed she did not have HIV. With continued support from her counselor, Veronica practiced exclusive breastfeeding for four months, during which time repeat blood tests showed that Sara remained free the HIV virus. Up to now, Sara is healthy, learning to crawl, and speaks simple words like mum. Veronica and her husband Moses are enrolled at Njombe CTC and receive anti-retroviral therapy.