MATERNITY FOUNDATION

Annual Report 2014

Integrated Maternal Health Project, Ethiopia

March 2015

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Abbreviations

ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHP	Community Health Promoters
EMA	Ethiopian Midwife Association
EmONC	Emergency Obstetric & Newborn Care
GAH	Gimbie Adventist hospital
GPH	Gimbie Public Hospital
HEP	The Health Extension Program
HEW	Health Extension Workers
IGA	Income Generating Activity
MNH	Maternal and Newborn Health
MoU	Memorandum of Understandings
OB/GYN	Obstetrician and Gynaecologist
OCSSCO	Oromia Credit and Saving Share Company
PPH	Post-Partum Haemorrhage
SBF	Safe Birth Fund
ToT	Training of Trainer
UNFPA	United Nations Population Fund
WHO	World Health Organization
VSLA	Village Savings and Loan Association

1.0 Foreword

Despite increased attention and focus over the past 15 years, maternal mortality is still among the most frequent causes of death among women of reproductive age in developing countries. Each year 289,000 women in pregnancy and childbirth and almost 5 million babies die during childbirth or in the first weeks of life. 99% of these live in developing countries.

The causes of maternal and infant mortality are complex, but we know that if women have access to contraception and give birth with a skilled birth attendant the majority survives. An estimated 90% of all deaths related to pregnancy and childbirth could be prevented if the woman had given birth with skilled birth attendance.

In our main country of operation, Ethiopia, progress has been in reducing maternal mortality, but still many women continue to die of complications that could have been prevented. Only 10% of women deliver with a skilled birth attendant and although the figure has been declining over the last decade, about 13,000 women still die every year during childbirth. Morbidity is also a serious issue, as it is estimated that for every woman who dies, about 30 women will have a chronic disability due to complications related to pregnancy and childbirth, e.g. obstetric fistulas.

In West Ethiopia, Maternity Foundation's response to maternal and newborn mortality and morbidity is based on an integrated approach focusing on:

- Building up clinical capacity for quality of care
- Community Health Education
- Community empowerment through livelihood activities

With this approach Maternity Foundation aims to support national efforts to reduce maternal and neonatal mortality rates and supports targeted districts' efforts in scaling up maternal and newborn health interventions.

Anna Cecilia Frellsen
Chief Executive Officer (CEO)
Maternity Foundation

2.0 Executive Summary

This annual report documents the main activities of Maternity Foundation's Integrated Maternal Health Project in West Wollega, Ethiopia in 2014. A brief summary of key achievements is given below.

Building up clinical capacity for quality of care:

- Two hospitals had 100% obstetric coverage incl. ability to handle comprehensive emergency situations such as caesarean sections and blood transfusions.
- 130 birth attendants were trained in Basic Emergency Obstetric and Newborn Care (BEmONC).
- Solar power installed at 32 health facilities.

Community Empowerment through health education and livelihood strengthening:

- 161,485 community members were reached with community health education.
- 1,683 poor women were empowered through livelihood strengthening activities such as micro loans and in kind donations combined with training in small-scale business management.

3.0 Where We Are: Program Location

Our Integrated Maternal Health Program covers five districts in the West Wollega Zone in the Oromia Region. In addition, we target three adjacent zones (Kellem, West, East and Horo Gudiru Wollega) with health worker trainings. The local headquarter is in the capital of West Wollega, Gimbie.

The Oromia region is one of the nine ethnically based regions of Ethiopia. It covers 284,538 square kilometres, stretching from the western border to the south-western corner of the country. The estimated population is over 32 million, making it the largest state in terms of both population and area.

The West Wollega Zone is one of the 18 administrative zones of Oromia region. The zone has 21 districts, of which 19 are rural and two are urban. The districts are sub-divided into 533 kebeles/villages. Gimbi is the capital city of the West Wollega Zone and is located 441 km from Addis Ababa.

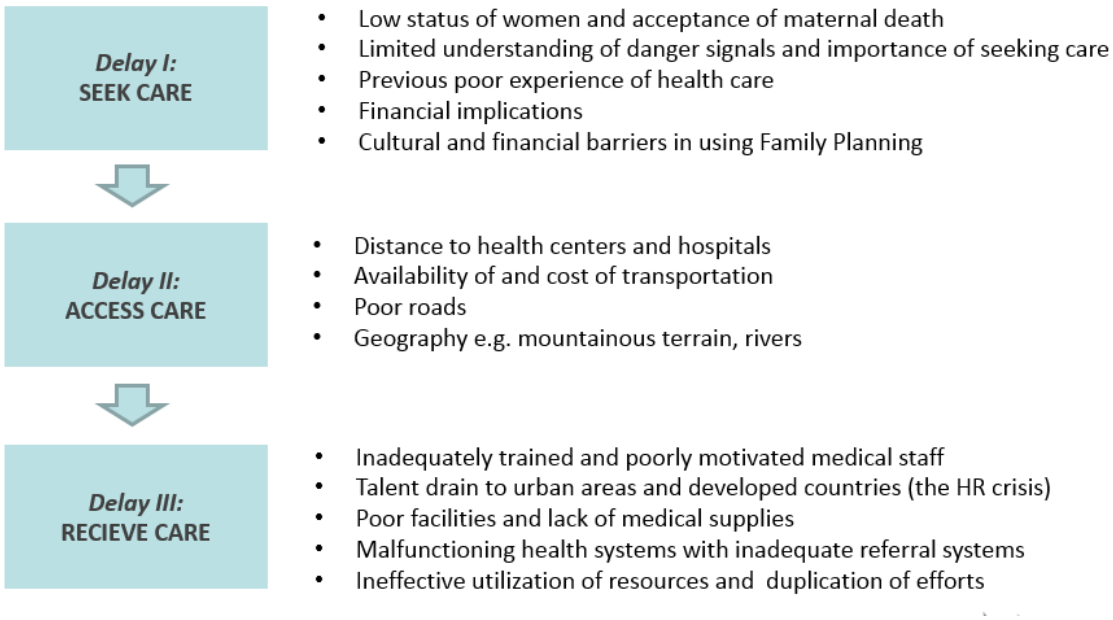
The estimated population of the West Wollega Zone is 1.7 million. The major ethnic group is Oromo, constituting 96% of the total population. The remaining 4% is Amhara, Ma'o and Gurage.

Afan Oromo is the official language of the zone. A great majority are Christians followed by Muslims and traditional African religious groups. Over 89% lives in rural areas and agriculture is the main economic activity both for food production and income.

The West Wollega Zone health sector includes five hospitals (three governmental and two non-governmental), 53 health centres, 40 clinics (25 governmental and 15 non-governmental), 440 health posts (governmental), 54 rural drug vendors, 10 drug shops, two pharmacies in the zone.

4.0 Who we are: Program intervention

Maternity Foundation's program builds on an integrated approach that focus on strengthening clinical as well as community capacity on reproductive, maternal and newborn health. This approach is designed to address the commonly acknowledged Three Delays Model that describes phases and factors affecting health care seeking behaviour and outcomes. The delays place at 3 different levels: I) At household level - Delay in Decision to Seek Care; II) At referral level - Delay in Accessing Care; and III) At health facility level - Delay in Receiving Care. The factors affecting these delays are described in below in The Three Delay model by Thaddeus & Maine:



Maternity Foundation's objective is to address these delays by:

- Empowering and mobilizing the local community through reproductive health education and information;
- Empowering women by improving their social status and financial security and promoting women's rights through a network of income generating groups;
- Improving the quality of basic/comprehensive emergency obstetric and neonatal care at health facilities;
- Improving the availability of professionally trained health workers.

4.1 Integrated Maternal Health Project

Project Goal: To contribute to the reduction of maternal and neonatal deaths and morbidity among women and newborn in West Wollega and beyond.

Project Objectives: To increase percentage of skilled birth attendance (births occurring at the health facility attended by skilled birth attendants) from 12% to 60% in the targeted districts by end 2014.

Project Outputs:

Primary

- 75% of the health institutions offer basic emergency obstetric and newborn care;
- 85% of all births are attended by skilled birth attendants.

Secondary

- Strengthen capacity on maternal health at government facilities in targeted districts;
- Improve referral system in targeted districts;
- Increase awareness and demand for maternal health care in the communities;
- Improve livelihood status for 50% of the poor women in the targeted districts.

5.0 Enhancing clinical capacity for quality of care

Skilled birth attendance is the single most critical intervention for ensuring safe motherhood. Hereby, the probability of timely delivery of life-saving emergency obstetric and newborn care increases *(Delay III).* All major life threatening complications (haemorrhage, sepsis, unsafe abortion, hypertensive disorders, obstructed labour and birth asphyxia) can be treated at a well-staffed, well-equipped health facility.

"Skilled Birth Attendance" does not only include the presence of a 'Skilled Attendant' (people with midwifery skills, trained to manage normal deliveries and diagnose, manage, or refer obstetric complications), but also the appropriate facilities, supplies and transportation means to provide basic and comprehensive emergency obstetric care.

To strengthen the health system's capacity for delivering quality care and ensure safe motherhood Maternity Foundation works across three levels of care in the health system in West Wollega: Hospital level, Health Centre level and at front-line (Health post) level. In addition, work on strengthening the referral link across the three levels of care *(Delay II).* Our activities at each level are described below.

5.1 Hospital level

Maternity Foundation supports two district hospitals (Gimbie Public and Gimbie Adventist Hospital) with strengthening both their Comprehensive and Basis Emergency Obstetric and Newborn Care. Retention of qualified doctors in rural areas is a huge challenge. Consequently, there is no access to comprehensive care such caesarean sections in many rural areas. Our support therefore includes salary subsidy to qualified doctors and support to equipment and drugs.

In addition to ensuring comprehensive care coverage at the hospital level, Maternity Foundation supports the hospitals with training in BEmONC.

Outcome 2014:

Two hospitals (Gimbie Public and Gimbie Adventist Hospital) had 100% obstetric coverage covering both comprehensive and basis care.

The number of deliveries increased in 2014 at Gimbie Public Hospital (GPH see table below). In general, there is a significant increase in inflow of women in our program area giving birth at the health facilities rather than at home. This is both driven by our community mobilization program and by the fact that deliveries at public facilities has been offered for free by the government since 2012. In addition, we have worked on strengthening the referral system in the area, so that women giving birth at health centers (the majority) are timely referred to hospitals.

The number of births at the Gimbie Adventist Hospital has decreased. This is most likely driven by the fact that an increasing number of women go to the public hospital for free service and that the health centers in the area are handling a larger proportion of the normal deliveries.

Hospital deliveries	2010	2011	2012	2013	2014
GPH	167	387	1,085	1,857	2,106
GAH	1,572	1,750	1,146	947	429
TOTAL	1,739	2,137	2,231	2,804	2,535

5.2 Health Center level

The most critical part for strengthening the health centers is to ensure access to skilled health care workers that can perform BEmONC**.** Improving availability and quality of BEmONC is therefore one of Maternity Foundation's key activities.

5.2.1 Basic Emergency Obstetric Care (BEmONC)

BEmONC training is an intensive, high standard, and dynamic three weeks training with 16 participants and four trainers. After aligning with the government's BEmONC strategy in 2013, Maternity Foundation has established a BEmONC training centre in Gimbie and conducted the first two rounds of BEmONC trainings.

In 2014, Maternity Foundation has trained a total of **130** health workers across **60** districts covering four zones (Kellem, West, East and Horo Gudiru Wollega).

BEmONC training in 2014

5.2.2 Infection Prevention

In early 2014 Maternity Foundation developed an Infection Prevention Training Package for Maternal and Newborn Health. The training package was pilot tested in Gimbie in 2014. The content of the training package includes trainers' manual, nine modules to different target groups, practical exercises and films. It is based on best practices and global guidelines from WHO, Jhpiego and EngenderHealth.

The training consists of three separate trainings; one for each target group. The three target groups are:

1. Healthcare Administrators and Supervisors;
2. Doctors, Midwives, Nurses and Technicians;
3. Frontline workers and Cleaners.

Outcome 2014 at health center level:

- 130 health workers across 110 health centres and 5 hospitals were trained;
- 8 health centres in four districts were supplied with necessary medical equipment and drugs for BEmONC;
- Number of skilled deliveries has increased significantly in our program area in 2014 - a total 249% from 2013;
- 16 administrators, 42 health workers, and 16 cleaners from one district (Haru) and Gimbie Public Hospital received Maternity Foundation's training on infection prevention.

	Number of Deliveries				
Health centre	**2010**	**2011**	**2012**	**2013**	**2014**
Homa	179	393	240	424	968
Genji	84	172	115	411	1,120
Nole	180	248	207	424	745
Haru	120	179	239	198	518
Ujumo	-	-	-	116	455
Chonge	-	-	-	132	439
SibaKochi	-	-	-	69	224
UlaBabu	-	-	-	134	288
Total	**-**	**-**	**-**	**1,908**	**4,757**

5.3 Strategic service delivery

5.3.1 Medical equipment and drugs

When giving BEmONC and other clinical trainings, Maternity Foundation strategically delivers some of the essential equipment in order for the trained health professionals to be able to implement what they learn. The supply of sufficient drugs and equipment, can serve as a model for best practice to lobby towards duty bearers for better and more sustainable supply to health facilities.

5.3.2 Solar power

Access to electricity is essential for ensuring a safe birth. Most health centers and health do not have electricity installed. Many deliveries happen at night and the ability to light up the delivery ward is therefore critical.

In 2014, Maternity Foundation facilitated solar-powering at 32 health facilities in the five targeted districts (Gimbie, Genji, Nole, Haru and Homa) in West Wollega.

The solar powering of health facilities was installed in June 2014 followed by training in solar power system maintenance at each health facility.

To ensure sustainability and local ownership the solar power systems were handed over to the local authorities after installation.

The technical specifications and capacity of the solar systems for the health facilities are as follows, contracted by Ever Bright PLC:

12 Health Centers and 20 Health Posts got solar power electrification with the following specifications:

I. Charger Controller - 12V, 10A
II. Gel Battery (HC: 12V, 100AH, HP: 12V, 100AH)
III. Mobile Charger - DC mobile charger
IV. Module/Panel (HC: 80 watt mono crystalline, HP: 60 watt mono crystalline)
V. Led Lamps (3 per HP, and 8 per HC)
VI. Solar TV - 15.4' (HP)
VII. Switch
VIII. DC Cable
IX. Grounding cable
X. Lamp holder
XI. Connecter & Clips

5.4 Ante-Natal Care (ANC)

Quality focused ante-natal care is a core part of maternal and newborn health. Regular check-ups allow detection, treatment and/or prevention of health problems throughout pregnancy. Ante-natal care is therefore an integrated part of our model.

Outcome 2014:

2014	Number of ANC visits (all visits - 1st to 4th)				
Health centre	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Homa	164	197	266	473	**1,100**
Genji	803	767	890	835	**3,295**
Nole	473	404	376	575	**1,828**
Haru	324	325	302	245	**1,196**
Ujumo	302	289	267	273	**1,131**
Chonge	252	290	286	287	**1,115**
Siba Kochi	121	110	152	173	**556**
Ula Babu	117	127	155	158	**557**
Total	**2,556**	**2,509**	**2,694**	**3,019**	**10,778**

5.5 Construction of Birth Waiting Home

Gimbie Public Hospital (GPH) is the governmental referral hospital in the area, covering a population of nearly two million. One of the challenges has previously been the ability to admit pregnant women prior to delivery with the result that they had to send high-risk pregnant women home. Due to the common access barriers (distance, lack of transport, lack of finance, lack of decision making power in women etc.), this has placed the women and their babies at great risk of adverse delivery outcomes. There has therefore been an unmet need for providing the women a place to wait until in labor.

For the past couple of years, Maternity Foundations have rented a simple 2-room house, constructed with local materials, in close proximity of the hospital to function as a Maternity Waiting Home (MWH). The house was equipped with five beds and simple cooking and bathing facilities. The land lady of the house was assigned to keep a registry book of admitted women. This has helped the hospital and the rural catchment health facilities to refer high-risk pregnant women. The waiting home was a success and utilization high.

With request from the government hospital and funding from MSD Denmark, Maternity Foundation therefore decided to build a waiting home on the compound of the hospital allowing the women to be right next to the delivery ward at the hospital and allowing the midwives and OBGYN to assess the women throughout the waiting time. The Maternity Waiting Home (MWH) was constructed and finalized in May 2014.

The MWH has two rooms at 4 x 4 meters each, as well as a separate kitchen and shower room. The house itself is made of concrete. Piped water and electricity are connected for MWH from the hospital. The hospital toilet is quite near to the house, so no separate toilet has been built for the MWH.

5.6 Safe Birth Fund (SBF)

As a consequence of recent developments, and to work more sustainable, Maternity Foundation has reshaped its Safe Birth Fund (SBF) scheme to only target the most poor and vulnerable women in the remote villages who are unable to meet both direct and indirect costs of accessing emergency obstetric and newborn care. Vulnerable families thus have the opportunity to access Maternity Foundation's safe birth fund scheme to pay related costs for emergency referrals from Gimbi Public Hospital (GPH) to Gimbi Adventist Hospital (GAH).

Outcome 2014:

- 35 poor women have been referred through the SBF scheme from the GPH to GAH for better service and management.

6.0 Community Empowerment

The role of community empowerment in improving health outcomes is indisputable. Maternity Foundation works with two legs of community empowerment – a community health education program and a livelihood strengthening program.

6.1 Empowerment: Community Health Education

Empowering local communities with needed information and awareness, builds up people's capacity to better take care of their own health. Community health education thus plays a critical role in facilitating access to health services and promoting participation. We target four districts with our Community Health Education covering a population of more than 278,000.

6.1.1 Community Health Promoters (CHPs)

Maternity Foundation uses "Community Health Promoters" as an integrated part of the Community Health Education program. Maternity Foundations trains a number of different categories of Community Health Promoters that then go back to their communities and teach each of their groups of community members. The CHP's are change agents from different categories of people: Men Group Leaders, Health Extension Workers, Religious Leaders, Village Managers and Village Leaders.

Thereby we ensure a trickle-down effect of our Community Health Education Program across key target groups.

i. Men Group Leaders

Male involvement is crucial to achieve improved reproductive health. Men are the decision makers in the home and control access to resources. Low awareness from men about maternal health, therefore highly contributes toward the first delay. Attitudinal change can happen in the women, but men may not believe or listen to what the women say. Therefore, male change agents are key. The men that were involved in this program are men group leaders who are role models or have a powerful position in the society. In the training, government representatives were involved as they lead the male activities. Also it is important that the government know the content and take ownership over the trainings in order to have a sustainable change in behaviour in the society. Their involvement is highly helpful to get a high number of male participants. **530** men group leaders were involved in the community health education as community health promoters; the men group leaders came from a total of 88 villages (kebeles); and have reached more than **27,000** men with their community health education.

ii. Health Extension Workers (HEWs)

HEWs are the community health promoters who are employed by government and posted at village (kebele) level mainly to work on disease prevention through community education. Their main role as community health promoters is to make sure the community in their village is getting health education, to conduct health education and to monitor that a report on community health education is being sent on time. During 2014, **168** HEWs were trained on maternal health topics and they have managed to reach more than **34,000** people.

iii. Religious leaders

Religious leaders are highly respected and trusted and have a great influence in the community and speak to large congregations. They are part of defining moralities connected to health behaviour in communities and as such they are potentially very effective change agents. About **507** religious leaders from more than **10** villages were trained from the targeted districts and they have managed to reach more than **33,000** people.

Community Health Education: Religious Leaders taking training

iv. Village (Kebele) Managers and Village Leaders

Village Managers are employed by government and assigned in each village to oversee every activity in their village and report the activities every month. Village Leaders are elected by their village community, but not paid, and their job is to serve their community. They are in charge of organizing every community meeting and different activities in their village. Maternity Foundation uses both as community health education facilitators.

Outcome 2014:

- 176 Village managers and Village Leaders were trained or refresher trained facilitators of community health education;
- A total of 1,205 Community Health Promoters were trained (530 men group leaders, 168 HEWs, 507 religious leaders);
- A total of 94,000+ community members were reached by the Community Health Promoters (Men: 27,000, HEWs: 34,000, Religious leaders 33,000).

6.1.2 Women group leaders (1:5 leaders)

Another approach for the Community Health Education is to tap into the government organized "health army". Here 25-35 households form a cluster, and they appoint one woman as a cluster leader. The formation is used for many different purposes, and Maternity Foundation has tapped into this structure and educates the cluster leaders on reproductive, maternal and newborn health issues. The cluster leaders disseminate the information to their own cluster.

Community Health Education: Women Group Leaders training

Outcome 2014:

- **917** Women group leaders (cluster leaders) were trained;
- **49,000** women received community health education.

6.1.3 Community Conversation Sessions

A third approach under our Community Health Education program is the Community Conversation approach. Here trained Community Conversation Leaders facilitates a conversation in the community related to a specific health or social topic. The community choose the relevant topic e.g. family planning, harmful traditions, breastfeeding, domestic violence or other. Maternity Foundation supports the leader with facilitation techniques and concrete insight for the conversations to take place. The Community Conversation sessions can bring radical change in the community, and historically this is the most effective model for changing harmful attitudes and practices toward maternal and newborn health. It is change driven from the communities themselves.

Outcome 2014:

- **136** Community Conversation facilitators were trained;
- **10,485** people were partaking in the community conversation session.

Community Health Education: Community Conversation Facilitators training

6.1.4 School Reproductive Health Clubs

Youth is also a crucial target group for change. The project has organized groups of secondary school youth in Reproductive Health clubs. These students are the change agents and the future of their communities and enhancing their capacity on sexual, reproductive, maternal and newborn health is vital. The clubs has been established with support from Maternity Foundation, but were running independently (without the help of Maternity Foundation) during the reporting period. This ensures the sustainability of the clubs.

Outcome 2014:

- **Five** reproductive health clubs have had weekly/once in two weeks meetings, and given health education to the school community every week or twice a month and 2 newly opened high schools were approached for the establishment of the RHC;
- **8,000** School community were reached by Community Awareness Dramas, poems, education, etc. on Maternal and Newborn Health.

6.1.5 Radio programs

Using radio is another documented best practice in rural Africa to effectively disseminate health messages. In general, mass media has shown it can play an important role in development, impact on attitudes and promote health-seeking behaviours. Therefore, we use Radio Programs as an integrated part of reaching communities with key maternal and newborn health messages.

Outcome 2014:

- Maternity Foundation has managed to engage about **10** health professionals in the Radio based health education;
- **52** radio programs were aired, covering five zones and a population of more than **5 million** people in **70** districts.

Summary of Community Health Education 2014

Community members reached directly	
Community Health Promoters	94,000+
Women Group Leader (cluster leaders)	49,000+
Community Conversations	10,485+
School Community	8,000+
Total	**161,485+**
Community members reached indirectly	
Radio programs	5,000,000+

6.2 Empowerment: Livelihood and social status

Women's low status and lack of financial capacity is known as one of the key social determinants of maternal and child health. In societies where men traditionally control household finances the health of women is often not prioritized. In addition, women are often not in a position to decide if or when to become pregnant and the number, spacing and timing of their children. It is documented that when women are financially empowered and able to control resources, her health seeking behaviour and health outcomes improve. The financial empowerment of women heightens her social status in society as well. Therefore, Maternity Foundation emphasizes the need to address the underlying socioeconomic status of women, through our Community Empowerment program by focusing on livelihood strengthening programs for poor women.

6.2.1 Micro-credit loans for small-scale business

Maternity Foundation collaborates with the micro-finance institution Oromia Credit and Saving Share Company (OCSSCO) about training and distributing micro-credit loans to poor women to enable them to start small-scale businesses.

Outcome 2014:

- **196** women were trained in entrepreneurship, small scale business management and micro-credit loan and savings
- **196** women took up a micro-credit loan and started income generating activities

6.2.2 Village Savings and Loan Associations (VSLA)

Not all women have the capacity to take on a micro loan from the start. Another way of strengthening women's and community members' financial capacities is through the formation of Village Savings and Loan Associations (VSLAs) - a tested model developed by CARE International. VSLAs are typically used as stepping stones for women to demonstrate their capability to save up and repay loans. Eventually they can become eligible for taking up a micro-credit loan from a micro-finance institution to scale up their businesses.

Outcome 2014:

- **197** VSLA management committee leaders were trained from 4 districts
- The committee leaders trained a total of **1,200** community members in VSLAs
- **50** VSLAs were formed by the trained participants

6.2.3 In-kind loans & women cooperatives

A third livelihood strengthening strategy targets the most vulnerable, who are also not eligible for micro-credit loans. The approach focuses on organizing and training women on a specific income generating activity (IGA), and the opportunity to take up an in-kind loan for the start-up of such income generating activity. Maternity Foundation, district Agriculture office and district Women and Children's affairs office have jointly done the screening and selection of the women, based on a set of criteria to ensure participation of the most vulnerable. Three types of IGAs were trained on in 2014.

Outcome 2014:

- **20** women from 1 district were trained and organised in a modern beekeeping cooperative
- **40** women were trained and organized in a collaborative Poultry scheme from 3 villages in 1 districts
- **30** women were trained in needle work from 3 villages in 1 district (10 in each)

Summary of Livelihood Strengthening 2014

Livelihood and social status strengthening	
Women empowered through micro-credit loans	196
Women empowered through VSLAs	1,397
Women empowered through in-kind loans	90
Total number of women financially and socially empowered	**1,683**

7.0 Appendix: Key Impact Indicators (2014)

Skilled birth attendance (2010 – 2014)

Name of Health facility	YEAR				
	2010	2011	2012	2013	2014
Homa Health Center	179	393	240	424	968
Genji Health Center	84	172	115	411	1,120
Nole Health Centers	180	248	207	424	745
Haru Health Center	120	179	239	198	518
Gimbi Public Hospital	167	387	1,085	1,857	2,106
Gimbi Adventist Hospital	1,572	1,750	1,146	947	429
Total	**2,302**	**3,129**	**3,032**	**4,261**	**5,886**
NEW Health Centers 2013					
Ujumo Health Center	-	-	-	116	455
Chonge Health Center	-	-	-	132	439
UlaBabu Health Center	-	-	-	134	288
SibaKochi Health Center	-	-	-	69	224
Grand Total (ALL)				**4,712**	**7,292**

Maternal and prenatal delivery outcomes 2014

Name of facility	Total births	Alive Baby	Stillbirth/ neonatal deaths	Maternal Deaths
Gimbi Adventist Hospital	429	443	17	0
Gimbi Public Hospital	2,106	2,171	84	1
Homa Health Center	968	965	13	0
Nole Health Centers	745	648	3	0
Genji Health Center	1,120	1,095	10	0
Ujummo Health Center	455	406	2	0
Chonge Health Center	439	432	4	0
Ula Babu Health Center	288	273	7	0
Siba Kochi Health Center	224	215	3	0
Haru Health Center	518	483	4	0
Total	**7,292**	**7,131**	**147**	**1**

Referrals from Health Centre to hospital 2014

Name of healthfacility	Number
Homa Health Centre	43
Nole Health Centre	105
Genji Health Centre	61
Ujummo Health Centre	46
Chonge Health Centre	25
S/Koche Health Centre	9
U/Babu Health Centre	18
Haru Health Centre	34
Total referrals	**341**

Number of Ante-natal care visits 2014

2014	Number of ANC visits (all visits - 1st to 4th)				
Health centre	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Homa	164	197	266	473	**1,100**
Genji	803	767	890	835	**3,295**
Nole	473	404	376	575	**1,828**
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