

UNICEF Eastern and Southern Africa Institutional Support in Programme Monitoring and Response Initiative 2014-2018

Lessons Learned, Uganda: The role of near real-time monitoring as a tool for maternal and child health resource mobilization

Introduction

UNICEF Uganda has automated the reproductive maternal, newborn, child and adolescent health (RMNCAH) scorecard as a dashboard within the sub-national health management information system (HMIS) using District Health Information System (DHIS2). The aim is to support more real-time evidence-based monitoring, operational decision-making, and action on the RMNCAH scorecard at the decentralized level, initially in eight districts, Adjumani, Butambala, Isingiro, Moyo, Mukono, Nebbi, Rubirizi and Yumbe, with a total of 452 health facilities.

The RMNCAH dashboard sits alongside four other near real-time monitoring (NRTM) dashboards on: data quality assurance; bottleneck analysis (BNA); an action tracker which monitors the status of proposed solutions to the identified bottlenecks; and stock management. Supply side data from health

facilities is supported by demand side data from clients via community dialogue meetings and the UNICEF citizen feedback SMS platform U-Report.

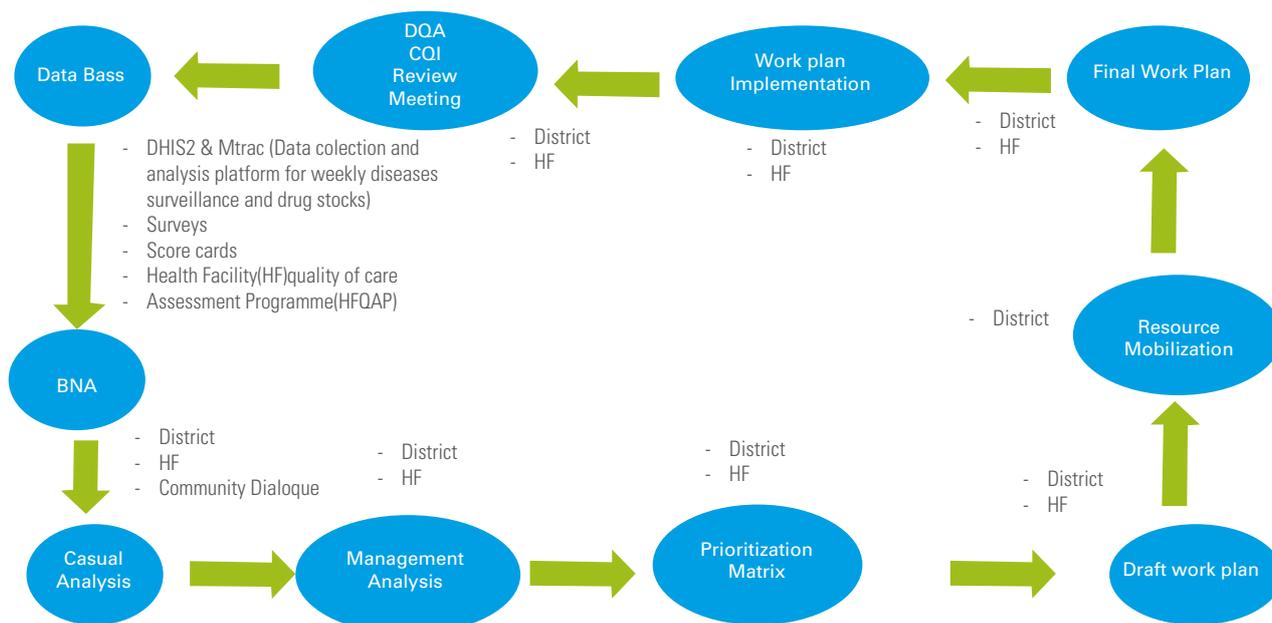
The new suite of dashboards has been developed as part of UNICEF's Eastern and Southern Africa Region Programme Monitoring and Response (PMR) Initiative, funded by the Bill and Melinda Gates Foundation and the U.S. Fund for UNICEF. A key benefit of the NRTM system is a BNA tool, an important innovation unique to Uganda's electronic health management information system (eHMIS). The BNA tool facilitates the identification of bottlenecks, root causes, and management responses required for interventions in health facilities to reduce maternal, newborn and child vulnerability and deaths. A key use of the BNA tool is resource mobilization for under- or unfunded priorities (figures 1 and 2).

Figure 1: Sample analysis and action for resource mobilization from a Mukono District workplan for reproductive health (RH) and family planning (FP)

Bottleneck	Cause	Objective	Activity	Indicators	Means of verification	Target	Location	Responsible person	Time frame	Budget (Ug Shs'000)	Source
Inadequate funds available for priority RH/FP activities	Inadequate central government and district budget allocated for RH/FP	Mobilize funds for unfunded activities for RH/FP	Carry out resource mobilization targeting implementing partners (IPs) and Civil society Organizations (CSOs)	No. of unfunded activities implemented out of resources mobilized from IPs and CSOs.	Reports	All CSOs and IPs	District	District Health Officer (DHO)	1 2 3 4		

Source: Ivan Mwesigwa, Biostatistician, Mukono District 2017

Figure 2: Flow chart showing how resource mobilization results from real-time DHIS2 data



Source: Ivan Mwesigwa, Biostatistician, Mukono District 2017

Muyomba Siraj Wagwa, Biostatistician, Butambala District Local Government, Uganda, comments: "The RMNCAH scorecard and dashboards helps a person, at a glance, know where to focus resources. It promotes evidence-based planning and management and creates an increased sense of accountability. I can now analyse the root causes of any challenge and intervene for improvement with the available resources or I can budget for unfunded activities."

Ivan Mwesigwa, Biostatistician, Mukono District, Uganda, agrees: "As a district we make our work plans based on programmes such as child health. Using the NRTM system, we look at what the bottlenecks are, the solutions to those, and can easily see what is funded and what is unfunded."

Partnerships for funding

Some of the service gaps identified by the BNA can be addressed using existing resources such as by changing work procedures or through reprioritization of staff time and budgets. However, challenges needing additional resources are also frequently identified. If this funding is not found, especially for the most pressing concerns, then enthusiasm for the analysis and identification of problems and solutions can quickly wane. Districts therefore aim to act efficiently to ensure resources are found.

“Funding gaps are identified and all key stakeholders are brought together, priorities are identified for funding, and funding is freed up from duplication. In so doing, the demand for additional resources is lessened, and existing resources can be redeployed to critical areas or districts.”

Dr. Eddie Mukooyo, Assistant Commissioner of Health Services, Health Information Division, Ministry of Health, Uganda



Dr. Eddie Mukooyo, Executive Chairman - Uganda AIDS Commission Board

Photo © UNICEF Uganda 2017

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In Mukono district, a community dialogue meeting revealed that community members believed the health facility maternity block was unsafe for women to deliver their babies there. They explained the wards were leaking, the ceiling was almost falling in, and it needed painting. Jennifer Ajambo, Senior Clinical Officer in-charge, Seeta Nazigo Health Centre III, Mukono, Uganda, comments: “The result is we were getting mothers coming for antenatal care (ANC) appointments, but they were not coming back to deliver. We have now approached an implementing partner for funding so that we can do a major renovation of the ward.”

Health facilities routinely involve more than one partner to fill funding gaps. Ivan Mwesigwa, Biostatistician, Mukono District, Uganda, explains: “We do not rely on one funder. We do resource mobilization through all civil society organizations, community organizations, and all implementing partners supporting the district. Health facility in-charges present unfunded priorities in workplans at a workshop, and we ask for stakeholder commitment to fund what they can afford.”

In the past, work plans for health facilities were not evidence-based and so it was difficult to mobilize resources on the basis of speculation, and also to identify which would be the most powerful investments. Health facilities now use BNA for monitoring and planning with improved data analysis for evidence-based decision making by health facilities. Dr. Elly K Tumushabe, District Health Officer, Mukono District, Uganda, comments: “We have increased resources for health facility work plans for unfunded priorities and these have been mobilized outside the box, such as targeting renovations and increasing space for quality service delivery.” Ivan Mwesigwa agrees: “Some facilities have funded water tanks which have multiple implications for health, so we look across service delivery indicators as well as systems management.”

Improved health outcomes for women and children

The PMR Initiative has led directly to improved health outcomes for women and children in the targeted districts through the reallocation of existing resources and identifying and addressing funding deficits. Most notably in the area of RMNCAH, for example in supporting institutional deliveries.

Dr. Eddie Mukooyo comments: “Stakeholders are interested in the data made available to them and the transparency this has created. The BNA and scorecard has allowed districts to mobilize resources from partners so that over time we have noted a gross improvement in performance especially in saving the lives of mothers and children.”

Isingiro District has a population of over 500,000, but only 30 sites that can conduct a guided delivery, such as in hospitals (at least one per district), health centre IIIs (one per subcounty), and health centre IVs (one per county). A BNA in the district discovered a relatively high attendance of antenatal care (ANC) appointments, but a low number of institutional deliveries. When analysing the root cause of low institutional deliveries, it was discovered that most mothers who visit health facilities for their ANC travel long distances over hilly terrain. So, by the time of the delivery they are too heavily pregnant to walk to the facility, but there are not the resources at the family or household level to travel by other means.

The district therefore designed a workplan informed by the BNA and community dialogue meetings, especially in three sub-counties with sparse populations (Kashumba, Ruborogota, Masha). Amos Namara, HMIS Focal Person, Isingiro District, Uganda, comments: “We decided that all health centre IIs, which are located at the parish level, be upgraded to deliver, where this was simple and cost effective. For example, we mobilized resources with all partners in the district for the health centre II in Masha, and we outsourced a partner that was able to construct a maternity ward. The district posted a qualified midwife there.”

Two other health centre IIs also have a qualified midwife including in the valleys and deep hills of Nyakitunda subcounty. Amos Namara continues: “We have mobilized funding for communities

that are hard to reach and which could not access deliveries in health centre IIIs and IVs. One health centre II can now deliver 10 mothers a month, potentially saving the lives of those mothers and babies due to professional care.”

Lessons Learned and next steps

Lesson 1: Expectations versus resource reality

There is a risk that the BNA and community dialogue will identify issues that can be addressed through funding, but without that funding being forthcoming. Expectations of health workers and community members are therefore raised, but in the absence of effective resource mobilization to undertake the necessary interventions, stakeholders may become disillusioned with the impact of NRTM.

Dr. Flavia Mpanga, Health Specialist, UNICEF, Uganda comments: “There are financial constraints, so while districts in Uganda now produce evidence-based work plans, they are not fully funded. This calls for resource mobilization at district level. This needs to be done in a timely manner and be effective to maintain the momentum of the NRTM programme. When calls for funding are evidence-based, partners listen, as it is not just a plea made as a result of a District Health Officer’s gut feeling”.

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The valleys and hills of Nyakitunda subcounty where resources have been mobilized so that parish level health centre IIs can conduct institutional deliveries

Photo © Amos Namara, HMIS Focal Person, Isingiro District, Uganda

Lesson 2: Adjustments to service delivery are sometimes the answer

Many causes in the BNA are to do with resource constraints that cannot be solved right away. Dr Jakor Oryema, District Health Officer, Nebbi District explains: “Many problems are with human resources and funding. You have to prioritize what you can do and improve little by little even if you can’t improve quickly. Health facilities find ways to be more efficient through for example, integrated service provision. You should not duplicate visits. If you are doing immunization you can provide family planning at the same visit.”

In Nebbie district, institutional deliveries are low due to a lack of human resources and the attitudes of health workers and mothers (figure 3). While resource mobilization for more staff and their capacity building are needed, solutions such as community and health worker sensitization can occur as part of routine meetings.

Human resources can also be redeployed rather than recruited. One community advocated during a dialogue meeting that a room in the health facility be partitioned to provide accommodation for the midwife so that she could spend the night rather than leave at 10pm. Dr. Flavia Mpanga comments: “Most deliveries happen at night and so birthing mothers can now be attended to 24 hours a day. The impact is life-saving in terms of safe deliveries at night. The communities were very appreciative of that approach and the impact of their input. This did not need additional money as the midwife was already working in the district, but the workload where she was stationed was not as much.”

Conclusion

The PMR Initiative has created huge interest in Uganda among health workers, district leaders, beneficiaries and facility management. Stakeholders have embraced the data now available to them and districts have mobilized resources from partners, directly impacting the lives of mothers and children.

Figure 3: Nebbi District bottleneck analysis revealing the need for increased funding and sensitization of health workers and the community to support institutional deliveries

INSTITUTIONAL DELIVERIES				
Type of bottleneck	Common bottle neck	Managerial factor	Cause	Proposed intervention
Physical access	45% of the HF do not provide basic emergency obstetric care centre (BEmOC) services		Inadequate number human resources (HR)/ mid wives low wage bill inadequate funds limited priority	recruitment of HR advocate for increased funding
Effective quality	31.8% of mothers do not deliver in the hands of skilled health workers		Negative attitude of mothers no culture-sensitive HF No culture-sensitive training for mid wives use of old curriculum for training	Sensitization of health workers and community on culture-sensitive practices/delivery Advocate for culture-sensitive curriculum

Source: Uganda PMR Initiative





Further information

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