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Bridging the Gap for Maternal Newborn and Child Health Human Resources in Rural Uganda: Experiences and Lessons Learnt from World Vision East African Maternal Newborn and Child Health Project Implementation, Kitgum District

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ABSTRACT

90% of mothers reported having attended antenatal care at least once in their last pregnancy and deliver from the health facility. However 25% of the midwives' positions in the project area were filled, this therefore meant that skilled providers were not conducting ANC and safe deliveries. The project therefore went into a private-public partnership with the District to hire midwives. The Purpose of this paper is to document the processes, contributions and lessons learnt during the implementation of the Human Resource support offered to the District of Kitgum through the EAMNCH project. A mixed methods explanatory study design was adopted to assess the contribution of supporting the Human Resource for Health in the project area. This approach used qualitative and quantitative research approaches where qualitative and quantitative viewpoints, data collection, analysis, inference techniques were applied. Finding point to the fact that availability of skilled human resource for health is still visibly a challenge and there is need for a strong advocacy agenda focusing on health delivery systems from the lower level. Health-care partners implementing MNCH activities that are engaging a specific cadre in the health system need to be cognizant of the fact that achieving the set goals of such interventions requires a well thought out implementation plan. There is need to introduce a dual implementation strategy between the actual technical support with staff and the utilization of advocacy platforms that created demand for services. MNCH projects being implemented by Districts supported by partners need to strengthen the baselining processes to include services availability and readiness assessments and the Global partnership for improvement of MNCH needs to redefine sustainability for implementation.

Keywords

Human resources for Health, private sector contribution, MNCH, Midwives, Memorandum of Understanding, public-Private partnership for healthcare.

Introduction

Human Resources for Health; A global health perspective

Based on a threshold of 4.45 skilled health professionals per 1000 population, it's estimated that the needs-based shortage of health workers globally would be about 17.4 million of which 2.6 million are doctors and 9 million are nurses and midwives. The largest needs-based shortage is in the South East Asian and African regions [1]. Health systems can only function with health workers, health services coverage and outcomes are dependent on their availability, accessibility, acceptability and quality [2]. However, most countries at socioeconomic development face difficulties in the education, deployment, retention, and performance of their workforce. Health priorities of the emerging post-2015

development framework such as achieving drastic reductions in maternal mortality, ending preventable deaths of newborns and under-5 children will remain wishful unless accompanied by strategies involving transformational efforts on health workforce capability [1].

The inaction of the Sustainable Development goals call for action to people and leaders across the world to ensure a life of dignity for all. The health workforce is a critical part of the proposed health goal, with a target of increasing substantially the recruitment, development, training and retention of the health workforce in developing countries. [3]. globally, many countries are failing to support adequate health systems, with actual investments in the health workforce being lower than is often assumed. The chronic underinvestment in education and training of health workers in some high-income countries is resulting in permanent shortage, and contributing to international recruitment of health workers from low resource settings [4].

The Uganda Human Resources for Health situation

Uganda has 127 local governments (Districts, Municipalities and Divisions), which have been increasing with the aim of making administration and delivery of social services easier and bringing these closer to the people. This is turn has increased the need for more health facilities and expansion of existing health infrastructures including work force for health. Along with the social-related sectors, the health sector has been undergoing a process of decentralizing responsibilities from the central government sectors to the local government departments; particularly to the office of the District Health Officer (DHO) under the District Health Team (DHT). This has had implications on human resource planning and recruitment [5]. The Human Resource for Health (HRH), and the HRH Strategic Plan, recognized HRH as one of the major reasons that caused slow progress on achievement of the Millennium Goals (MDGs). This also caused slow achievement for Uganda on the targets set in the Health Sector Strategic Plan (HSSIP) II, 2005/06-2009/2010 and HSSIP 2010/11-2014/15; whose goal is to attain and maintain adequately sized, equitably distributed, appropriately skilled, motivated and productive workforce matched to the changing population needs and demands, health care technology and financing [6].

In Uganda, the health-worker to population ration is 1.49 core health workers per population which is still below the benchmark. The available workforce is inequitably distributed with about 71% of doctors and 41% of the nurses and midwives located in urban areas where only 13% of the population lives; while 87% of the population is rural [6]. Accessibility to facility based health services is low, at about 72% of the population. The doctor to population ratio is at 1:36,045 while the nurse to population ration is 1: 5,190 and midwife to population ratio stands at 1: 10,107 [6]. The productivity of the health-workforce is low, characterized by high rate of absenteeism estimated at an average of 40%. This is partly attributable to weak leadership and management, and unsatisfactory work environment characterized by the shortage of supplies and basic equipment and lack of staff accommodation [6].

The value of having a midwife at a health facility for MNCH implementation

Despite the World's reduction of maternal mortality ratio by 44% from an estimated 385 death per 100,000 in 1990 to 216 per 100,000 in 2015, 303,000 women still died in 2015 while giving birth and 99% of these deaths occurred in low and middle income counties. Similarly, global neonatal rates fell from 36 deaths per 1000 live births in the same year to 19 in 2015, living 2.7 million newborns dying each year [7]. Despite the availability of considerable evidence to demonstrate the positive impact of skilled birth attendance on maternal and newborn health outcomes, it is not just the number of skilled birth attendants (SBAs) needed, but also the quality of care that matters [8].

Analysis of 58 countries in "The state of the world's midwifery" showed that there was a global shortage of an estimated 350,000 midwives a third of whom where needed in the world's poorest countries. It further highlighted that increasing women's access to high-quality midwifery services was a focus of global efforts to realize the right of every woman to the best possible health care during pregnancy and childbirth [9]. The Uganda Sharpened Plan, noted that Uganda had improved on the staffing norms, however, disparities in the type of carder especially midwives is still notable. For example, the Health center IIIs are only allocated 2 midwives and 3 for Health center IVs [10]. The investment case for Uganda notes that these disparities range between 30 to 90% among districts. However, the rural and new districts face a worse situation since they lack the ability to attract and retain health workers. The current midwife staffing norms also falls short of the international standard which requires a ratio of one midwife to 175 mothers, since the country's ratio is one midwife to 700 mothers. The ratios tell the fact that the current midwives are overloaded with work which often lead to high turnover, and contributed to poor quality of MNCH service delivery [11].

The status of midwives in the EAMNCH project at the onset of the Project

According to the Kitgum analysis done in 2009, generally the district presented poor ratio figures when it came to access and utilization of health services for example, the Practicing Doctor to population ratio was 1: 85,867, that of the Nurse to the district Population ratio was 1: 2,862 and that of Midwives to pregnant women ratio was 1:307. 72 expected posts to be filled by midwives, of which 48 positions were filled and 29 were empty. This therefore meant that 59.7% of the Human sources gap for midwives in Kitgum District was actually filled and functional [12].

That same year a special report on the state of midwives in the district was done and it revealed that a shortage of midwives in Kitgum district is forcing expectant mothers to use the services of semi-skilled traditional birth attendants, putting their lives and the lives of their unborn children at risk and therefore 56% of women in the district were using traditional birth attendants. The special pullout revealed that some of the health centers have only one midwife while the majority do not have any maternal staff at all. The Report highlighted that the problem with using traditional

birth attendants was that many of them did not have sufficient knowledge of how to deal with problem cases. Most of them are ill equipped and do not practice proper sanitary hygiene, putting the lives of both mothers and children at risk of disease and death [13].

The East African Maternal Newborn and Child Health project (EAMNeCH) at the onset facilitated a baseline and human resources for health were part of the focus of this study. The Project that was planning to kick start the role out in 2 sub counties which had 6 health centers (2 HCIIIs and 4 HCII) also revealed that although the Health centers level 3 each require to have two midwives, only one health center had one mid wife. This therefore meant that only 25% of the midwives staffing norms were filled. The baseline also revealed that deliveries are occurring at the health center level two and a mid-wife does not assist these. [14]

Problem Statement

According to the EAMNeCH project baseline report, 90% of mothers reported having attended antenatal care at least once in their last pregnancy, furthermore, over 90% of the mothers deliver from the health facility. However, the same baseline report pointed out that only 25% of the midwives' positions in the project area were filled, this therefore meant that skilled providers were not conducting ANC and safe deliveries. This was a shortcoming to the project since one of its core indicators was to improve and sustain deliveries by a skilled birth attendant, and to offer quality ANC and PNC services. Without adequate staffing for the specific cadre in question, achieving the project objectives seemed to pose an up-hill task.

Objective

To document the processes, contributions and lessons learnt during the implementation of the Human Resource support offered to the District of Kitgum through the EAMNeCH project.

Specific Objectives

- To highlight the steps taken to facilitate the acquisition of midwives for the EAMNeCH project Health facilities.
- To establish the contribution of the recruited midwives to the EAMNCH indicators throughout the implementation process
- To highlight the key lessons learnt along the implementation of the EAMNCH project.

Justification

The EAMNeCH baseline statistics showed poor access to MNCH services at the community level; moreover, there was a constraint on human resource. Even though the project design had a strong advocacy component through the community driven Citizens Voice and Action [15], that has instigated demand for the recruitment of health facility staff from the district leadership, there was still a challenge since the district had a ban on recruitment positioned by the central government.

To respond to the situation, the project in collaboration with the district service commission recruited 6 midwives for the 6 health centres in the project implementation area. The recruitment process, their placement in the health centers, guidance through their roles in the implementation framework, and making ensuring they deliver was both an thought-provoking and strategic venture. This undertaking presented a vigorous recruitment process following the health systems strengthening approach, a result oriented implementation strategy and systematic closure process that generated both positive and negative lessons learnt; which will be documented in this publication.

Methodology

Study area

This study area was Kitgum, one of the districts in the Northern region of Uganda. It is bordered by Gulu district in the Northwest, Lamwo in the North, Agago District in the South East, Pader District in the South, Republic of Southern Sudan in the Northeast and Kotido District in the East. It lies between latitudes 2 0 North and 4 0 N and longitudes 320 East and 340 West. The study was conducted in two sub-counties of Lagoro and Mucwini. Lagoro consists of 4 parishes and 45 villages; Mucwini has 10 parishes and 84 villages. A total of seven health facilities exist in both sub-counties; three in Mucwini (Pudo, Lagot Health Center II, and Mucwini Health center III) and four in Lagoro (Pawidi, Oryang ,Lukwor Health Center II, and Akuna Laber Health center III).

Study Population

The study focused on the human resource recruited for the health centers in the project implementation area. This focused further on the deliverables and the contribution of this recruitment. Together with the district leadership, it was agreed that 6 mid wives be recruited and posted in the 6-health center.

Study Design

A mixed methods explanatory study design was adopted to assess the contribution of supporting the Human Resource for Health in the project area. This approach used qualitative and quantitative research approaches where qualitative and quantitative viewpoints, data collection, analysis, inference techniques were applied. The study explored quantitative aspects of the HMIS data to ascertain contribution of the hired midwives on given indicators in the project site and qualitative approaches to amplify and understand issues encompassing the results of the quantitative analyses conducted by the project.

Contextualization of the Study

At the onset of the project, information from the baseline clearly provided a recommendation of working in collaboration with the district leadership to provide human resource to facilitate MNCH interventions at the health facilities. There was need for midwife-specific interventions to be able contribute to the project midwife-driven specific indicators; such that in the absence of this cadre it would be impossible to report true values on these variables.

During implementation and execution of this deliverable there were several key events that arose from all these processes. This study was conducted as part of the end of project evaluation process to ascertain the contribution of the recruited staff towards project

results achieved. It was commissioned to document successes and challenges, lessons learned and make some recommendations toward contentious issues around human resource for health in Kitgum district and in Uganda generally.

Sampling and Sampling Procedure

The sampling procedure of choice was purposive and non-probability that was reached was basing on the fact that all required information was from the 6 health facilities. The research results presented in this paper include judgmental, selective and subjective processes of the health centers. As far as the quantitative data included in this paper is concerned, total population sampling was involved and information was collected from all the 6 health centers in the project site.

Data Collection Methods and Tools

Most of the quantitative data used in this paper is from the review of archives. The data tools used to collect data were primarily the Ugandan Ministry of Health, Health Management and Information system (HMIS). The Project also developed a tool called the Project Outreach report that captured all data from community outreach services to children under two years, pregnant and lactating mothers. Qualitative data from secondary data sources was also reviewed. This was mainly project documents, the process concept, Terms of references, minutes from meetings and engagements with government, appointment letters given to the midwives and Reports from the Health facilities and district health Information systems (DHIS) data.

Data Analysis

Qualitative data was analyzed through triangulating; a process worthy to be included in the study as it was used in several documents provided by the project. The trigger of this information in the first place was the reliance on the institutional memory from key staff within the project for the project life span. Quantitative data analysis focused on comparison graphs from the DHIS and the database of the project for outreach data of the same indicators through histograms, line graphs, pie charts and bar graphs. The cleaning was done initially by using the SPSS software before exporting it to Microsoft-excel to draw the required comparison figures.

Ethical Considerations

The study was part of the EAMNeCH project end term review process and concepts. Ethical approval was sought and obtained from Makerere University School of Public Health Higher Degrees, Research and Ethics committee. In addition, The Uganda national council for science and technology (UNCST) also approved the study under files number SS 5029. Informed consent was also sought from the population interviewed and other participants by signing on the administered consent forms.

The Conceptual Framework

At the onset of the project, it was anticipated that if the health centers were facilitated to have midwives, they would be able to provide all the necessary MNCH related services at both the static posts and community outreaches. For recruitment and placement to be done, there was need for the project to understand the dynamics and the way the District Health system attracts and retains midwives. This entailed the engagement of the district service commission in the selection and performance management was key. The midwives needed all the commodities and supplies required to perform. This was coupled with understanding and supporting the system's approach along the continuum of care; from the HC to the community (outreach posts) ensuring health service delivery was achieved in an integrated way.

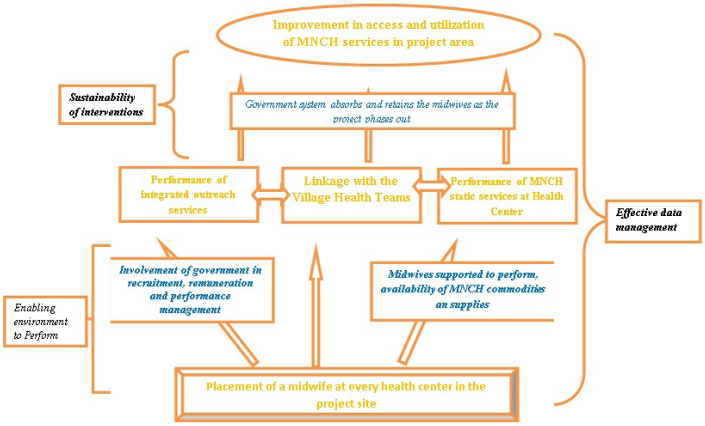

Figure 1: The implementation conceptual framework.

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An advocacy approach was used to ensure that the district when doing their recruitments would absorb the staff into the mainstream system. The other key issue was to guarantee that the whole process aimed at strengthening management of MNCH indicator-based data through the HMIS; to be able to track progress towards the improvement of access and utilization of MNCH services throughout the project lifespan.

Data Management and storage throughout the Project Life Span

The inception of the project focused on development of an efficient Monitoring and Evaluation framework that included a dissemination plan for the project results. Because of this elaborate dissemination plan, the project had a research and documentation objective embedded in it. This meant that any data collected and documented as agreed upon would eventually lead to development publications. The project developed a database that was managed and cleaned on a quarterly basis. The data and information was

utilized at different platforms during the project lifespan. The Monitoring and Evaluation theme managed the quantitative data and the Documentation and research theme was responsible for all the qualitative and photographic pieces of the project. The information presented in this paper is generated from those two archives.

Utilization of observations and documentation of lessons learned

The project implemented a deliberate observation principle from both the staff and beneficiaries of the project. These observations were documented and achieved through the qualitative approaches using the Lot Quality assurance (LQAS) timelines of the project. Key Informant Interviews and Focus Group Discussions were conducted at Baseline, Mid Term and End term reviews of the project. The Project also documented observations and opinions from key stakeholders during the projects annual planning of interventions cycle. The Project implemented a stakeholder consultative meeting at the beginning of a financial year, a project feedback and reporting session at the end of the year, a meeting with Village Health Teams each quarter and commemoration of the World Breastfeeding week where Parent support group members that included mothers and fathers were consulted. All these deliberate consultations were achieved through the documentation and research Theme. It is these facts that have been used to develop the content of this publication

Study Limitation

- Quality of data. Since the study mainly relied on secondary data such as DHIS, there was a risk of analysis of poor quality data due to missing values and bias. This is because the DHIS provides estimates for population coverage rates of key health indicators; with some assumptions made about the data, denominators and population.
- Limited coverage of the study. The study was conducted in two of the ten sub counties in the district; this could possibly affect the external validity of the findings.
- It was known by the recruited midwives that their salaries were being facilitated by a project; despite being hired through the local government system. This could have been a motivation to the hired staff as there were no salary delays and could have influenced the results of the project.

Results

Staff management processes for sustainability; what prompted the Need for midwives?

In 2011, the Government of Australia through Australia Africa Community Engagement Scheme (AACES) program [16] supported Kitgum district local government through World Vision Uganda EAMNCH project aimed at improving access and utilization of MNCH services in Mucwini and Lagoro sub counties. From the project baseline, the district had low staffing levels at 40.3% [14] and critical cadres lacking were midwives. All the six health centers in the two sub counties had only one midwife despite being in position to provide MNCH services.

The project was supporting implementation of monthly-integrated community outreaches and VHTs were responsible for mobilizing their catchment households every month to attend these outreaches. However, when clients came to the outreach posts, there usually wasn't enough human resource to handle these clients. In short, there was a capacity gap at the health facilities to manage clients and also at the outreach posts. It is well known in Uganda that the Ministry of Public service through the District Service Commission indicates that health center IIIs should have two enrolled midwives and health center IIs; one enrolled midwife [5]

The EAMNeCH project provided guidance through the M&E framework that skilled birth attendants; in this case midwives, should be responsible for key services that contributed to deliverables like Oriented Antenatal Care (ANC), institutional delivery of babies, quality Postnatal care services, and the young child services including immunization. Additionally, the recruitment of midwives was to ensure that the mothers and children in the two sub-counties received quality health-care through skilled personnel. The void that had been created by luck of midwives had accelerated the presence of traditional birth attendants, who were not only burdening the women with out of pocket demands but also discouraging institutional safe deliveries.

To address the above-mentioned hindrances, the project through its health advocacy framework commissioned the agenda through community dialogues; to demand for the recruitment of midwives in the 6 health centers. These dialogues with the district authorities generated an interim solution of human resources for health approaches (enrolled midwives) in support of key interventions to accelerate MNCH results in the project coverage areas.

The Human Resource recruitment process

Recruitment process of the midwives begun with several engagements between the World Vision Uganda leadership and the District Health Team. The meetings where aimed at having the two parties understand the extent of the problem and benchmark a common buy-in of the idea of hiring the midwives. The negotiation process brought out the fact that there would be challenges hiring midwives. These included; limited wage budget to cover their salaries, failure to attract and retain the carders to rural and hard to reach areas, poor working conditions that would not facilitate work at the health facilities and lack of funds in the district services commission to conduct recruitment.

To mitigate these barriers, the EAMNeCH project and Kitgum District Local Government developed a memorandum of understanding; clearly stipulating each parties' roles. The project paid salaries to the midwives including their hardship allowances in line with the government standards and facilitated the district services commission to conduct the recruitment. The district's role was to advertise, hire and supervise the midwives in accordance to the public service guidelines. This gave the midwives an opportunity for inclusion on the district pay roll after two years of support. After signing of the memorandum of understanding, the process was fully undertaken and implemented by both parties.

Key to this recruitment process were the DHO, the CAO, World Vision Uganda Management and the District Service commission was to ensure to ensure an efficient and effective process. These covered the need determination, drawing of deployment plans, planning of the process, sourcing, selecting, hiring and deployment of staff. One key staff the EAMNeCH project was allowed to sit on the recruitment panel on behalf of the World Vision Uganda Human Resource department to manage and coordinate the recruitment processes and ensure that all entities achieved their objectives from the process.

Involvement of the district in the recruitment, and supervision of the midwives for sustainability

As was stipulated in the memorandum of understanding, the district through the District service commission advertised the positions, the District health office was fully charged with the processes of shortlisting successful candidates, interviews of candidates, the recruitment processes including offering the contracts, documentation and even orientation of the 6 midwives that were recruited.

To increase the productivity of the enrolled midwives significantly, the DHT with support from the project, conducted support supervision, on job mentorships, continuous education and performance appraisals. This was to foster positive work environments and improved recruitment and retention of these enrolled midwives. The Staff needed to adhere to the code of conduct set by the District service commission.

The district signed a Memorandum of Understanding with the EAMNeCH project to have the project pay the salaries of the midwives until the fourth year of the project. Thereafter the district; through the Chief Administrator's Office (CAO) would take on the responsibility of paying these midwives by absorbing them into the district pay roll when the government approves salaries for the district. However, the project provided the funds but the salaries were transferred on a quarterly basis in advance to the CAO's office for remittance to the midwives.

Salary Determination

Since the project was implementing through the health system strengthening approaches, for purposes of sustainability, salaries were aligned in accordance to the Kitgum District service commission guidelines. This included the relevant government taxation protocols.

The salary scale was calculated and based on the Public service commission salary scales for enrolled midwives and in line with the MoU signed, the district would eventually absorb the payment processes and eventually take up these midwives as part of the system. This was done to achieve sustenance of employment of the midwives and ensure that the district easily does the absorption when that time comes.

Also, Kitgum district is one of the districts that the government had designated as "hard to reach" and all health workers posted there are entitled to benefit from "hard to reach allowances". The salary determination further accrued this cost.

The Orientation process

After the recruitment process, it was important to conduct a dual orientation before the midwives commenced their duties for them to understand the modalities encompassing their hire. During the 5-day orientation, they were made aware of this arrangement between world Vision and the District and also to affirm to them that they were not World Vision but Kitgum District Local Government staff.

The orientation was conducted by the District Leadership in collaboration with the EAMNeCH project. The orientation program was based on the deliverables that were expected from midwives. Key technical personnel both at the district and within the project made presentations during the orientation process.

The enrolled midwives were given team orientation by ADHO and team on Health facility rules and regulations, procedures, physical layout and service delivery; for 3 days and then followed by 2 days of technical orientation by the project staff specifically to ensure the enrolled midwives get to know the modules and their expected deliverables to the project objectives.

Agreed Key functions and deliverables

The MoU clearly stipulated that the staff recruited would follow the expected deliverables as laid out in the Kitgum District Service commission guidelines for enrolled midwives. However, it was also important to note that the roles had to be strongly linked to the EAMNeCH result framework so that the project Health systems strengthening objectives were achieved.

The staffs were tasked to conduct MNCH services such as: Antenatal (ANC) and post-natal care (PNC), care for mothers in the labour wards, conducting safe deliveries of babies, and provide sensitization classes to mothers during ANC and PNC visits. These services were cascaded to the communities through monthly scheduling and conducting integrated community outreach services covering ANC, PNC, Health education, Prevention of mother to child transmission of HIV, couple counselling and testing and Provision of family planning services and commodities.

Further still these recruited staff worked at the in-patient care units, out-patient departments (OPD), registration of admissions, discharges and deaths participating in clinical officers ward rounds, participating in besides nursing procedures as members of the caring team, carrying out observations, keeping records and ensuring their safe custody, managing and accounting for allocated resources, compiling daily ward reports and handover to in-coming shifts. These staff had to work in collaboration with the VHTs and support them during the monthly meetings, reporting and referral processes.

Reporting lines

The mid-wives followed the normal procedures of reporting to

the health facility in-charge at the Health center level. The in-charge would check to ensure the project expectations were met; especially sharing the community outreach reports and ensuring the data on indicators in the project monthly reporting format were well aligned to the HMIS. This was evidence of work for the staff and basis for remittance of salaries by the project.

For technical subject matter support, the midwives reported to the senior nursing Officer. This was the officer in charge for their technical work, capacity building, technical support supervision, mentorship and any disciplinary action processes. They also had a dotted line reporting function to the Community Development Facilitator (CDF) of the EAMNeCH project. They were responsible for sending quality data from the outreach processes to this officer.

Ownership and streamlining

To ensure sustainability and ownership, the partnership recruited 6 enrolled Midwives on contract for 4 years and deployed them in the designated project area where each midwife was expected to submit quality outreach data summary extracted from the HMIS for the number of outreaches supported as per their performance.

To mainstream the midwives into the District system, the terms of payment were in form of a sub grant to the district; with two instalments of funds on annual basis. World Vision Uganda; Kitgum Cluster wrote a 3 months' payment cheque to Kitgum District Local Government account for the 6 midwives; a process that commenced in February 2014. The District in turn wrote an acknowledgement receipt to World vision as accountability and submitted monthly approved outreach results to the project.

At the end of the third project year as highlighted in the agreement (MOU), the project wrote a formal letter requesting for the district to advertise for the positions of midwives and the normal recruitment procedures were followed.

For purposes of sustainability, the following were put into consideration:

- Payments and transfer of funds were to be effected through the CAO's office; on a quarterly basis.
- The District Service Commission took over the management of these midwives in the third year of the project as agreed in the MoU
- The midwives were required to perform their work diligently and ensure they were present at the health facility and at the outreaches to provide services to the communities; as stipulated in their contracts. Moreover, the district provided them with accommodation to ensure they were fully stationed at the health facilities
- It was agreed that any breach of contract would ensure termination of contract; after agreement by the district office and the EAMNeCH project leadership

Contribution of the Human Resource to MNCH service delivery in the project area

The main contribution of these midwives as agreed at their recruitment was to conduct integrated community outreaches in addition to the health center services. The outreach posts acted as an extension of the services to promote the broader objective of promotion of access to MNCH services to the population. For the purpose of this documentation, focus has been placed on provision of goal oriented ANC services, access to family planning services and commodities, routine HIV counselling and testing and couple counselling and testing for HIV.

The approach considered was that when the staff conducted outreaches, the client data collected during the service delivery would be consolidated using the HMIS tools and submitted routinely to the district HMIS desk. However, outreach data would also be submitted separately to the World Vision Office in Kitgum on a monthly basis. The results presented below represent the contribution of outreach data to the HMIS.

Contribution to the Goal oriented ANC services

The Project together with the district authorities basing on the population projections of the project area agreed that on an annual basis the health staff should facilitate goal oriented ANC. However, the focus was on ensuring that the 4th ANC visit was conducted on pregnant women. The projection for this indicator was at least 700 women attending the visit. Figure 2 below shows the number of 4th ANC visits that were conducted annually. Generally, apart from the first and last year of the project; according to HMIS results the staff hit the target.

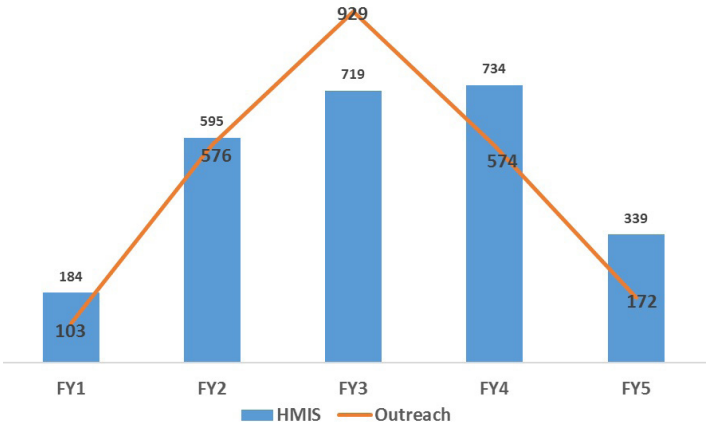

Figure 2: Annual 4th ANC attendance contribution of outreaches to HMIS.

Of the 700 Visits of the fourth ANC, it was agreed that; to be able to promote access to MNCH services, 60% of the attendance should be from services conducted at the outreach posts especially to the underserved communities. Figure 3 below shows the annual percentage contribution of the outreaches to the 4th ANC targets. It is only in the first and last year that the staff did not surpass the target of 60% contribution of outreaches to the HMIS contribution. The teams struggled through the first year because at the point, the framework hadn't been implemented. In the last year, the mid wives were taken over by the district service commission and majority of were redeployed to other health centers creating a

vacuum for service provision and therefore the decline.

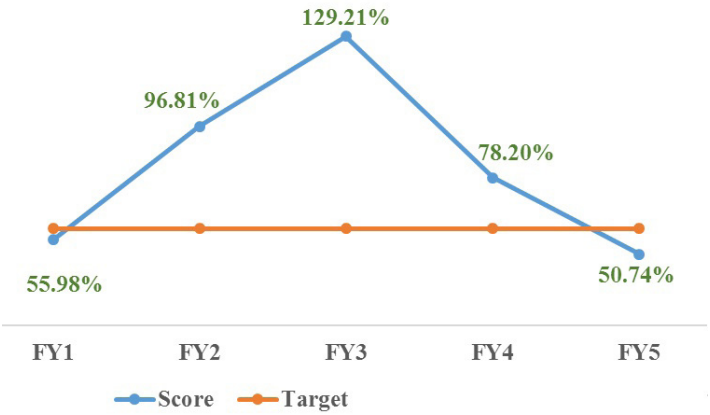

Figure 3: Annual 4th ANC achievement from Outreaches.

Contribution to the Family planning services

In the project area, it was agreed that on an annual basis the staff should provide healthy timing and spacing of pregnancy services to 420 women of reproductive age. Figure 4 below shows the annual achievements from the HMIS and the contribution of outreaches to that information. Apart from the first year, the staff exceeded the target. And the contribution of the outreach services indicates that most women prefer having these services brought near to them than moving to the Health centers.

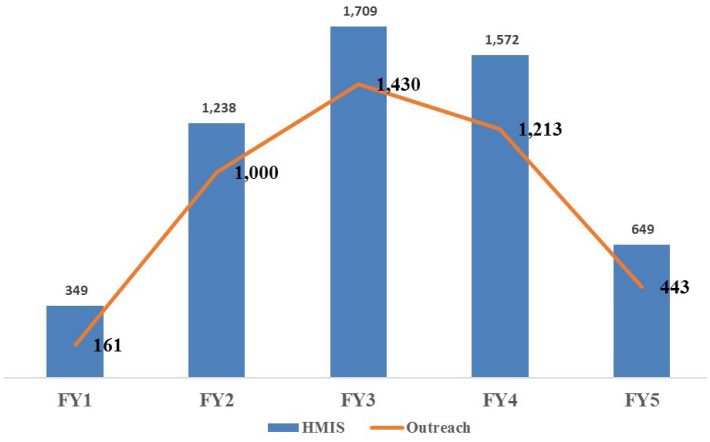

Figure 4: Annual access to Family Planing services contribution of outreaches to HMIS.

The deliverable of the midwives in this regard was to make sure that access is promoted and 50% of all women accessing family planning services would get these services from outreaches. Figure 5 shows that; apart from the first year, this target was well achieved. The first year was challenging because the staff initially felt it was not necessary to offer services like injector plan and pills to mothers during the outreaches. An orientation from the DHT, together with the Ministry of Health followed by on job mentorship was conducted to prove the feasibility of these services at outreaches and this was eventually sustained throughout the project life span.

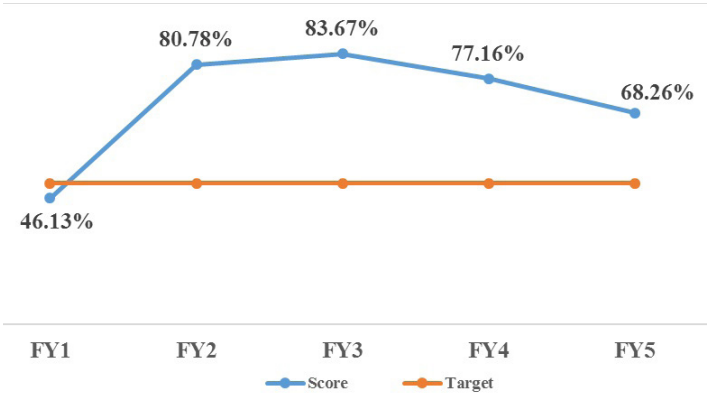

Figure 5: Annual family planning achievement from Outreaches.

Contribution to Prevention of Mother to child transmission of HIV

As part of the projects, contribution to the Ministry of Health Uganda strategy of zero new infection achieved through ensuring no transmissions through pregnancy and infancy [17] the project included provision of services geared to this target in the roles played by the midwives. In this regard, routine HIV counselling, testing and provision of results to the clients was key. The project set an annual target of 700 pregnant women tested for HIV and knowing their results. Figure 6 below shows that there was good progress in the 2nd, 3rd and 4th year of the project with, most of the numbers being contributed to by the outreach services. It was in the 1st year that the project was challenged as the midwives claimed that it was not practical to carry out HIV testing at an outreach post. Also, that same year the district did not have sufficient diagnostic test kits. The transfer of the midwives due to the absorption principle affected the 5th year. These midwives had been trained in testing and counselling for HIV and then they were transferred; which entailed facilitating training for the new staff, preparing them mentally to be able to provide these services at the outreach sites because under normal routine, outreach services are usually only focused on immunization.

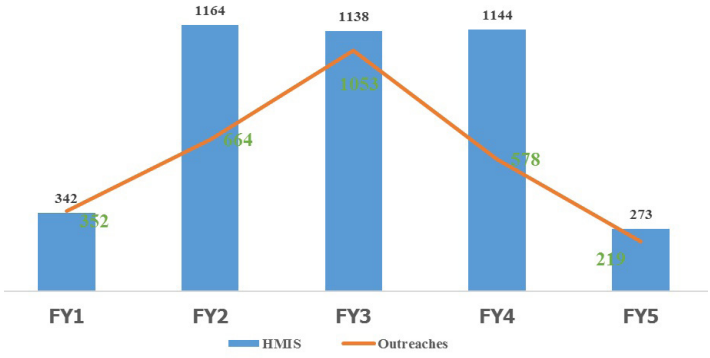

Figure 6: Annual HIV counseling, and contribution of outreaches to HMIS.

To promote access to the Prevention to mother to child transmission

of HIV services for all women, and basing on the growing fact that majority of ANC visits was suspected to happen at the outreach level, the midwives agreed to meet an annual target of more than 60% of all mothers getting this service at the outreaches. Figure 7 below shows that in the 2nd and 4th year the project failed to achieve the target and this was attributed to the fluctuating availability of field friendly HIV testing kits.

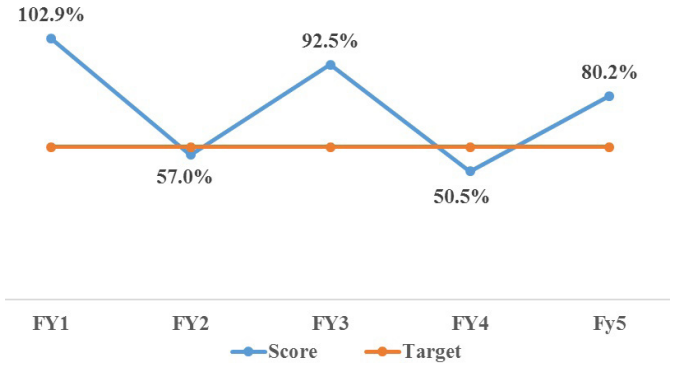

Figure 7: Annual HIV testing achievement from Outreaches.

Contribution to male involvement in MNCH services

The midwives were tasked with the role of offering services that promote male involvement in MNCH. The assumption was that if men could escort their partners to the health center or outreach post then joint counselling and uptake of services would be effective. It was agreed that 400 couples would be counseled, tested and given results during ANC visits to create a platform for male involvement. Figure 8 below shows the achievement of that plan. The 1st and 5th year had similar trends of not achieving the target for similar reasons as other indicators presented. It is important to note that in the first year of the project, this service was not offered at the outreach posts because men were not sensitized enough to take up the service, however during the second year, the initiation of Parent Support Group (PSG) approach at the household level facilitated the process of drawing more men to accompany their partners for ANC and PNC services [18].

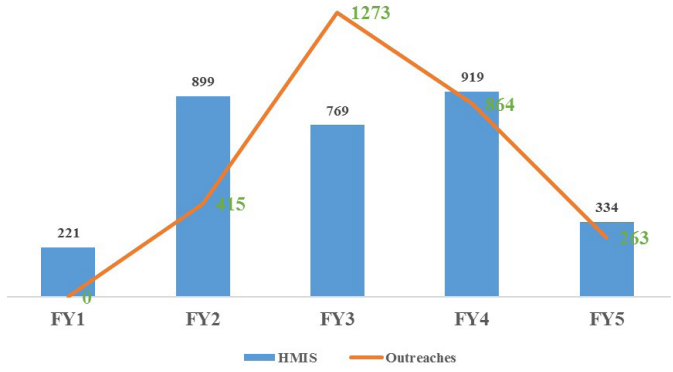

Figure 8: Annual couple counseling, and contribution of outreaches to HMIS.

Key lessons learnt from this collaboration

- **Engaging district structures:** There is value addition when the district structures are involved in any intervention that is intended to strengthen the health system and create sustainability. Right from inception while drafting the MoU, the district was committed to several clauses and fulfilled the key clause of absorbing the midwives into the mainstream recruitment processes. It is important to note that this was one of the successes of this project.
- **Agreement and targeting deliverables is important in joint engagements:** The recruitment of the midwives was aimed specifically at making sure that skilled health workers conduct institutional safe deliveries. The project laid out mandates expected of the staff and the district under the Health service commission also had a standard job description for midwives operating in the district. An middle ground agreement had to be achieved to ensure recruitment of these staff met all desired goals. Key project learning was that having these deliverables harmonized through a MoU is important.
- **Embed data management in the MoU:** For similar engagements, it's key to have a clear road map on how information and data from activities jointly implemented will be flowing and roles and responsibilities being laid out clearly in the MoU. The biggest challenge throughout the implementation period was timely submission of data to World Vision by the District Health team. Further still provision should be made to encourage "data celebration" meetings between the partners to harmonize deliverables and make adequate adjustments. It's key to note that for some indicators outreach data provided more information than data extracted from the HMIS; which simply means that there was a possibility of some outreach data not being entered into the HMIS system and therefore the district could be under reporting on the achievements reported in the project area.
- **Guidelines for Staff absorption into the Mainstream recruitment process:** The process of the district absorbing the staff and adding them on the district pay roll was a costly one. It was a good innovation and the district met its end of the partnership. When the moratorium on the recruitment and retention budget for the district was lifted, the 6 midwives were given priority. However, both partners had not thought through the implication of this move, so during the migration process, the district was at liberty to post these staff to any health center even outside the implementation area. The result of this was that some of the health centers were left without staff. In some insistencies, the staff themselves requested for the transfer and new midwives replaced them. This had a negative impact on the service delivery during the last project year as evidenced in the findings above.
- **Synchronization of financial requirements is Key:** The MoU was between two institutions whose accounting and financial management are different. The MoU managed to articulate the mandates of each organization and the timelines for each partner to either account or remit funds. However, it is important for both parties to find a realistic framework that would not affect the hired staff. In this case, World Vision systems could not allow remittance of another tranche of money to the District unless the last quarter's funds had been accounted for. For the District to account for the money,

it needed to have been reflected on the district, salary staff account a process that required funds being remitted first appearing through the Ministry of Finance and this caused frequent delays. These delays meant that the staff would get their salaries late, accounting for the money would also be delayed, and therefore World Vision would also delay the release of funds.

Discussion

Health center based childbirth, with the ultimate achievement of universal access to skilled birth attendance is a key strategy to avert the maternal and newborn rated deaths in many developing countries [19]. It is this same reason as to why projects like the EAMNeCH project focused on mobilization of households for institution delivery and inclusion of delivery at health facility related indicators in the monitoring and evaluation framework. Because the EAMNeCH project was determined to make this a reality, the availability of skilled birth attendants at the service delivery point was included in the baselining processes and the results triggered the partnership between the project and the district.

Pregnancy care through quality goal oriented ANC is fundamental to reducing maternal and newborn mortality [20]. Promotion and acceleration of MNCH services through access and utilization at household level is key in making sure that all mothers and children are reached before its late. It is a common practice for mothers not to attend ANC at the health facility with distance being a barrier in the Ugandan setting. Further still, most women in Uganda assume that because they are not feeling sick or felling any pain during pregnancy, there is no need to visit the health facility. The introduction of the integrated community outreaches was to make sure that every mother utilizes MNCH services that have been brought closer to them. For these outreaches to operate, human resource needed to be readily available.

During project planning and implementation, it is of great importance to put into consideration the role of human resource for health. The objective should be to provide the right number of healthcare workers with the right knowledge, skills, attitudes and qualifications, performing the right tasks in the right place at the right time to achieve the right predetermined health targets [21]. The EAMNeCH project further considered the fields of personnel financial efficiency, productivity, clinical quality and patient satisfaction. The linking of the targets and project outcomes to the role the midwives played in the project was of an advantage to both the district and the community served.

The project through its CVA advocacy approach lobbied and created demand for increased budget for MNCH and increased numbers of SBAs to ensure mothers and newborns are safe. The approach was aimed at the implementation framework through collaboration among MNCH partners targeting policy makers [22]. However, during the project implemention, a dual approach bearing in mind that advocacy efforts are not immediate was put into consideration. The immediate need was availability of staff at the health centers but co-currently ensuring their absorption and retention into the system as they implemented their tasks.

Recommendations

- For countries like Uganda, availability of skilled human resource for health is still visibly a challenge and there is need for a strong advocacy agenda focusing on health delivery systems from the lower level. There is need for development of a district based human resources for health agenda. The Key gaps and issues to be advocated for should be specific to a particular district and should be all inclusive of all partners in Healthcare at the district level
- Health-care partners implementing MNCH activities that are engaging a specific cadre in the health system need to be cognizant of the fact that achieving the set goals of such interventions requires a well thought out implementation plan. Joint recruitment with the District service commission could be one of the ways to close this gap and contribute to Maternal and Child Survival for Uganda.
- There is need to introduce a dual implementation strategy between the actual technical support with staff and the utilization of advocacy platforms that created demand for services. Neither of the two can operate independent of the other. Experience from the pilot shows that both platforms operate effectively if implemented co-currently guided by a MoU in the same geographical location. District service commissions understand better how to support such initiatives.
- MNCH projects being implemented by Districts supported by partners need to strengthen the baselining processes to include services availability and readiness assessments. This should be done deliberately to include identification of barriers to services availability and utilization to be able to score the contribution of human resources for Health to these barriers so that programs can ascertain the relevance of the availability of staff to implementation of program activities.
- The Global partnership for improvement of MNCH needs to redefine sustainability for implementation. There is need for an agenda to be put in place to link the current sustainability agenda to lives saved. This is because there was a lot of fear and concern on what would happen if the District did not absorb the midwives. However, much focus needs to be put on the number of lives that were saved by this intervention.
- There is need for proper guidance to be provided to any other partner who wishes to engage in a partnership like this one. Key considerations in such a case could be put on transfer of staff, availability of staff after the MoU timeframe ends and data management and harmonization at district level.

Conclusion

The implementation of this partnership to avail staff at the health center provided an opportunity for the EAMNeCH project to contribute to the staffing norms of the district. This further provided the community a chance to access and utilize equitable MNCH services. The collaboration can be duplicated elsewhere however the key lessons and recommendations need to take precedence when replicating.

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