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The Makerere University School of Public Health (MakSPH) has conducted several maternal health related projects over the years. Interaction with a diversity of key stakeholders has majorly been at the beginning and at the end of these studies. However, under the auspices of two projects under the Future Health Systems Research Consortium (Maternal and Neonatal Implementation for Equitable Systems study - MANIFEST and the Maternal and Newborn Study - MANEST) and the EQUIP study, MakSPH held a Maternal and Newborn Health symposium on May 14, 2014 in Kampala to herald a new beginning in dealing with key stakeholders.

The main focus of the symposium was for the MakSPH study team to share MANIFEST, MANEST and EQUIP progress (early successes, lessons and challenges) to date, but at the same time also get experiences from stakeholders who are implementing or have implemented similar interventions.

In addition to hearing from the three MakSPH projects, the symposium was also graced with presentations from HealthPartners Uganda and the Association of Obstetricians and Gynaecologists of Uganda. It is the day’s five presentations that formed the basis for the symposium discussions. However, a poem titled *The Man in the Land Cruiser* and opening remarks from the first two chairs were a good starter to the symposium and set the scene for the presenters of the day.

**Contextualizing the MNH Symposium**

The man in the Land Cruiser! Sorry. I saw your Land Cruiser passing by. I saw the crowd running up to you. Sorry I could not lift my hand to wave. Actually I tried to wave but the baby kicked my naval. So I stopped halfway. But the crowd looked so good. It looked so big. So I guess, you are having a good time.

I guess you are happy. By the way, do you remember me? Can you recall my name? I am the woman who danced lame at your victory party. I am the woman who fought with her husband during your campaigns. I am the woman who neglected her shamba following your trail. I am the woman who carried loads of soap, distributed quarter kilos of sugar.

I am the woman who recited your promises like a creed. I am the woman now heading to the hospital. I need to hear your voice. Say something to me. This is more important to me than sugar; more important than soap. Didn’t you promise to give me a better deal? I remember you said our mothers shouldn’t die giving birth to life. But now answer me; will I find someone at the hospital to deliver my baby?

**Editors**

**“Uganda is not doing well when we compare the health of mothers and newborns to that of older children. However my usual message is that older children can get vaccines, we can buy medicine but mother and newborn need a system that delivers quality care. Recently, a publication in the Lancet by the Institute for Health Metrics and Evaluation showed that the Maternal Mortality Ratio in Uganda was still very high. The UN published another one. In fact according to that report, MMR in Uganda by 2013 is estimated to be 360, within a range of 230 to 580. So they [publications] are all the same if you look at the confidence interval. But both reports say Uganda is among the top ten countries in the world that contribute to maternal deaths. This makes this meeting very relevant.”** - Dr Peter Waiswa, Principal Investigator of MANEST

**“We at Makerere University are always producing knowledge. We would like you to tell us the most important key questions that we may be missing out. You are going to give us feedback to stimulate us to think about these problems. People from universities tend to think about complicated things, but it is important to listen to stakeholders. And that could make a huge impact in terms of outcomes.”** - Prof. David Serwadda, immediate former dean MakSPH

**The Man in the Land Cruiser**

By Catherine Ruhweza

I am the woman who recited your promises like a creed. I am the woman now heading to the hospital. I need to hear your voice. Say something to me. This is more important to me than sugar; more important than soap. Didn’t you promise to give me a better deal? I remember you said our mothers shouldn’t die giving birth to life. But now answer me; will I find someone at the hospital to deliver my baby?

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**Experiences from Implementation:**

**Working with Districts & Community to improve maternal & newborn health**

Mr. Moses Tetui the study coordinator of MANIFEST (maternal and neonatal implementation for equitable systems) together with Dr. Ahmed Bumba the DHO of one of the implementing districts (Kibuku) shared the experiences of researchers working with district stakeholders and communities to improve maternal and newborn health.

From the duo, the symposium learnt that the study is in three districts (Kamuli, Pallisa and Kibuku) in eastern Uganda and is using a Participatory Action Research approach. PAR was chosen to encourage local ownership, use of local resources, and ensure stakeholder participation. Ultimately, this is expected to build local district capacity for sustainability, empower communities to make a contribution towards improving their health outcomes and increase chances of program scale up.

**Approach**

**Expected outcomes**
- Improved awareness of maternal and newborn care seeking
- Improved awareness of maternal newborn care and care seeking
- Improved access and use of savings and transport mechanisms
- Improved maternal and newborn care practices
- Increased number of skilled attended deliveries, antenatal care and postnatal care.
- Improved skills among health workers and managers

**Early Results**

The early results from the project are indicated in the table below:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>LQAS 1</th>
<th>LQAS 2</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC 4 time attendance</td>
<td>4%</td>
<td>12%</td>
<td>30%</td>
<td>32%</td>
</tr>
<tr>
<td>Infant death from the Health Facilities</td>
<td>60%</td>
<td>70%</td>
<td>80%</td>
<td>84%</td>
</tr>
</tbody>
</table>

**Early lessons**

- Existing community structures such as financial networks, community health workers

**Challenges**

Community mobilization and empowerment component
- Dependency culture with a community that is used to free things
- Poor saving culture
- Slow process of creating linkages between transporters and saving groups
- Low VHT literacy levels - where selection guidelines are not followed, and where literacy levels are generally low
- Poor mobilization for Community Dialogues

**Health systems component**
- Health worker shortage
- Poor infrastructure in some health facilities
- Poor referral systems
- Drugs and supplies shortages
- Poor health worker attitudes

"Participatory approaches can empower local implementers to identify and solve local challenges that hinder the utilization and delivery of MNH services."
Dr. Gertrude Namazzi shared experiences from this study also known as the MANEST, which is being implemented in Buyende, Luuka and Iganga districts. The study, she said, seeks to scale-up interventions aimed at increasing access to institutional deliveries and care of complications through vouchers, and improving newborn care through home visits by community health workers (VHTs), within the existing health system.

**Intervention Approach**
- Use of VHTs for community based maternal, newborn care, Prevention of Mother To Child Transmission of HIV and family planning promotion;
- One way transport vouchers targeted at women who reside beyond 5km from a health facility in Buyende District.
- Health facility strengthening for improved quality services (Training, Bonus Payments, Support supervision) through existing systems

**Lessons for scale up**
- Payment of transporters using mobile money is easier, safer and faster
- Active participation of community through VHTs can improve demand

**Key challenges**
- Ensuring constant availability of night time transport
- Use of ‘Super’ VHT supervision requires close monitoring/support
- Management of VHT drop outs
- Supply side challenges: poor infrastructure, lack of equipment, limited supplies and medicines
- Managing referrals: Lack of appropriate ambulance services to transport women with emergencies to district hospitals
- Some mothers still deliver from home/TBA despite the strategies in place to improve access to care

**Innovations for Increasing Access to Integrated Safe Delivery, PMTCT and Newborn Care in Rural Uganda**

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Dr. Gertrude Namazzi
Expanded Quality Management Using Information Power to Improve Maternal and Newborn Health

EQUIP (Expanded Quality Management Using Information Power) is one of those projects that takes down the quality improvement approach from the conventional health facility district manager’s level to a very unconventional community level.

While making her presentation, Dr. Monica Okuga said the main objective of this study conducted in Mayuge District was “to assess the feasibility, cost and community effectiveness of an innovative approach of expanded quality management using information power that links communities and health facilities to increase the quality and utilization of health care services in order to improve maternal and newborn health in rural Uganda.”

EQUIP was a two arm study which included:

- Quality Improvement (QI) where the key intervention included the use of Plan-Do-Study-Act cycles at 3 levels of district, health facility and community.
- Continuous surveys to collect high quality data in 3 rounds/year- 4 months each from household and health facility census.

Challenges during implementation

General:

- It is possible to rapidly integrate maternal newborn and child health into existing QI interventions within the district
- QI is hindered by key bottlenecks that include drug stock outs and human resource shortages
- Integrating QI into the activities of VHTs is possible but this is hindered by understaffing at facility level.

Lessons learnt

- Engaging the district health team to lead with support from the project is critical for successful implementation.
- It is important to strengthen linkages between VHTs and health workers.

District level:

- Too many competing activities making it difficult to implement regular QI meetings

Health facility level:

- Inadequate skilled staff
- Frequent stock outs of drugs and supplies

Community level:

- Slow uptake because it was a new concept
- Low literacy levels

"QI is very feasible at the 3 levels we have seen –district management, health facility and community level- and we need it at all these levels- Dr. Monica Okuga"
A cross section of participants attending the Maternal and Newborn Health Symposium 2014.
Maternal and Newborn Health Symposium 2014
The FIGO Save the Mothers Initiative in Kiboga

**Constraints**
The project had a couple of challenges like lack of fuel for ambulances but abject poverty stood out because it affected the community’s use of skilled services. To try and minimize this problem, the project adapted Plan International’s Village Savings and Loan Association (VSLA) model. The main objective here was to establish emergency financing for safe motherhood at community level to reduce the delays to access emergency obstetric care (EOC) using the VSLA model of income generation.

**How it was done**
- Savings range 500 Ushs to 2500Lshs (20 US cents to 1.20USD) per week
- Welfare fund mandatory savings 200-500Ushs (5-20 US Cents) per week
- Welfare fund for borrowing for health care with no service charge
- Provided 100,000 Ushs (50USD) as a startup capital revolving fund

**Why VSLA?**
- Lack of financial resources usually results in delay in access to quality maternal care. The major costs for access to care include transport, procurement of sundries for the clean delivery, “under the table” payments to health workers. Most of the funds used are obtained from family resources
- Rural women do not access or control family resources. It is therefore important to empower women and communities to save money for emergency preparedness

**Impact**
“Mothers are no longer dying because of lack of transport. There are no more cases of malnourished children, deaths in the area have generally reduced and so many things. Thank you to the initiators.” IDI woman, group 19

Assessment of 2013 by an MBA student

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**Health Cooperatives: Increased Access to Care**

Dr Nakiwala Regina Stella

Dr Nakiwala Regina Stella shared how Health Partners Uganda, a nationally registered cooperative, is helping communities establish health cooperatives in Western Uganda. This, she said, is done by empowering groups and providers to develop partnerships that meet their health needs. Training, tools and technical support are also provided.

**Why Cooperatives for Health?**
They [Coops] empower members to improve their health; offer financial solutions to increase access to care; are 100 percent sustainable by local partners and; do not need reinsurance or subsidies.

**How do Health Coops work?**
- Groups sign MOUs with health providers
- Members pay premiums and get ID cards
- Members pay a small copay when they go for care
- There is risk sharing
- Not all members fall sick at the same time

**Linking MNCH to Cooperatives**
Between 2008 and 2012 implemented a project of malaria communities program with funding from USAID. The focus was on helping pregnant women and children. The following success was registered.
- The percentage of pregnant women using long lasting insecticide treated nets (LLINs) increased from 5.5% to 51.9%
- The percentage of children under 5 using LLINs increased from 6.5% to 42%
- The percentage of pregnant women seeking antenatal care increased from 16.2% to 31.3%
- The percentage of sick children who received malaria treatment within 24 hours of onset of fever increased from 1.1% to 29.5% 1.1% to 29.5%

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Dr Jolly Beyeza

It was conducted jointly by the Society of Obstetricians and Gynaecologists of Canada (SOGC) and the Association of Obstetricians and Gynaecologists of Uganda (AOGU), in collaboration with the district health team.

Dr Jolly Beyeza shared the experiences of implementation as indicated below:

The intervention entailed recruiting midwives, enhancing EOC skills of midwives & doctors, supportive supervision, provision of equipment & accountability, providing birth registers, community mobilisation, and emergency transport

**Use of partnerships**
The use of partnerships enabled:
- Soliciting support from the political leaders.
- Dialogue with Local Councils to advocate for skilled birth attendance.
- Seeking support for emergency transportation at community level.

The FIGO (International Federation for Gynaecology and Obstetrics) Save the Mothers Project was conducted in the district of Kiboga from 1999-2004. It aimed at reducing maternal mortality and morbidity in the district by promoting the availability, access and utilization of emergency obstetric services for women.
Dr. Angela Akol

“I would like to throw a challenge to Makerere and other institutions of higher learning. Why isn't Government using your data? Could it be that perhaps some of the data that is coming out from these studies are things that Government is already doing? I will take the example of the quality improvement strategies. And I know that since the 90s the same exert strategies have been applied in Government health centres. Those who are as old as I am or perhaps older, might have heard of the yellow star program. The yellow star program has used these strategies at scale and many of them have been replicated elsewhere. So perhaps we need something new.

We have also talked of improvement in hospital deliveries but that is not what will change maternal survival. What will change maternal survival is the coverage of skilled delivery, not delivery in a health unit. You have all seen hospitals, labour units manned by nursing assistants. Even if you get 500 hospital deliveries up from 5 in a month you are not making an impact because those deliveries are attended by an unskilled person.

So as a university perhaps you can help us, these increases we are lauding in hospital deliveries, are they actual increases in skilled delivery? Do some analysis that will inform implementation of some maternal health strategies.” - Dr. Angela Akol - Country Director, FHI360

Dr. Anthony Mugasa

“What I learn from Dr. Beyeza’s presentation is that it was done long ago and we are now hearing of durable effects. The other presentations were looking at people still working intensively in the short term. We are not sure if they are building durable effects in the long term.

The question I would like to throw to the panel is, how are the things we are doing going look like 10 or 20 years down the road from now? Because, I think we have a lot of short term capital intensive efforts, which actually do not lead to long term. And we as academics are not interested in going back to look at what happened for the big push we had.

As I end we are looking at universal coverage, how do we take these things from small islands of excellence so that the Uganda map looks a like?" - Dr. Freddie Sengooba – Associate Professor at MakSPH

Dr. Freddie Sengooba

“I think the issue is what can we do now that can lead to auto-pilot? In other words the things we leave in the system working. And I think right now we see that at community level there are some effects – things that can remain in auto pilot.

“The third point I want to make is that everybody is rushing to the community downstream to pilot things but no one is looking upstream to see what it takes to sustain those efforts. You are playing roles that should be played by upstream institutions during implementation. We are not looking at these institutions to see if they can provide that level of effort, level of funding, level of supervision, and level of design and babysitting the design? In other words, our research is missing a key aspect. We actually don’t look at upstream capacity to sustain downstream innovations. How can we improve on that?

As I end we are looking at universal coverage, how do we take these things from small islands of excellence so that the Uganda map looks a like?” - Dr. Freddie Sengooba – Associate Professor at MakSPH

Dr. Anthony Mugasa

“These are very good innovations. This being a very high powered scientific body of researchers you need to form partnership with advocacy groups. When I was at university we were never taught advocacy skills although we have some of them now. I think the ministry needs some other people to push it. I think I would have loved to have in this meeting the Uganda National Health Consumers Organisation and other advocacy groups so that we can advocate for fund allocation. And there are people who can influence how the ministry of Health works. I would have liked the parliamentarians see some of these results so that when they are in their various groups in Parliament can help us to advocate and lobby for more funds.” - Dr. Anthony Mugasa -Consultant MoH
Thematic Sessions

In order to improve ongoing studies and interventions, MakSPH put to participants 3 thematic questions and below are the views from the three groups:

Group 1: Mobilizing and sensitizing communities: Using VHT’s and community meetings

Strategies for sustaining the use of VHTs
- Training and strengthening health unit management committees that would help in strengthening the linkage between the VHTs and the Health workers
- Organizing VHTs in groups and strengthening these groups through trainings in income generating activities for example by giving them seed grants, linking them to other partners,
- Putting in place a platform for VHTs to share success stories
- Attach VHTs to the health facilities where they can be supervised by health workers
- Recognition of VHTs at various levels- for example at the health facilities, the health workers should make sure VHTs receive Health services without any disturbances
- Organize interactive group discussions where VHTs performance and success/challenges can be shared

Strategies for improving community dialogue meetings
1. Strengthen the relationship between local leaders and VHTs. Local leaders like LC 1 chairperson play a key role in mobilizing people to attend community meetings
2. Utilize dance and drama as one way of mobilizing and sensitizing the community-this is because the community is more interested in watching rather than listening to messages. For example the community can be interested in watching films, games, and traditional wrestling.
3. There is need to utilize other community days like market days, as one way of reaching a larger group of people.
4. There is need to target areas where more people gather for example Trading Centers, Facilities during ANC days, Outreaches like Immunization, e.t.c.

Group 2: Increasing financial access and transport for maternal and newborn health services

How to improve access to transport services using public and private transport systems

Public transport system
- Efficient motorised transport is required for transporting mothers who have emergencies. Therefore the Ministry of health and districts should continuously lobby for ambulances at the different referral levels through politicians (MP), donors, increased allocation to the health sector, among others.
- Districts should have a reserve fund for fuel for the ambulance. This could be provided through community credit schemes, district allocations etc. Drivers for facility ambulances should also reside at the health facility.
- Improved fleet management for public ambulances is recommended e.g. vehicle maintenance, close supervision and monitoring of vehicle use, and recruiting qualified drivers.
- Communication between lower levels and upper levels of referral should be improved

Local transport systems
- Work with associations of transporters if they exist.
- Sign agreements that clearly indicate the duties of the transporters and terms of payment

if a third party will be responsible for payment in order to minimise confusion. Separate payment rates for the night and the day should be agreed upon, since the rates are higher at night.
- Provide basic training so that transporters know what to do in case a mother delivers enroute to the health facilities
- Plan for communication between
the transporters and the community. This may include the use of mobile phones or even word of mouth

- Plan how to increase access to the transport services by posting telephone numbers of transporters on the facility walls, giving VHT’s the numbers of transporters etc
- Payment of transporters may be done by a third party group in order to ensure cash is available when it is needed; therefore links with a local accessible financial network that can play this role may be important.
- Locally existing groups such as VHT’s and other financial social networks can purchase their own motorbike that can be used to provide emergency transport free or at subsidized rates. Such motorbikes can also be used to generate extra income for the group
- Multisectoral action to ensure the roads are in good condition is required
- Where the number of transporters are inadequate it will be necessary to identify innovative ways of attracting people to provide transport services
- Mapping of the area is necessary to understand areas that have transport constraints.

- The local community should be involved in the management of the transport system to ensure sustainability
- A monitoring and evaluation system is important for tracking use of the system and its effectiveness, accidents, etc.

Challenges that may be encountered
- Lack of associations
- Getting buy in from local transporters to provide transport services under such a system
- Over charging third party payers
- Safety at night
- Multiple visits incase of false labour
- Record keeping

Good practices for working with Saving/Financial networks
- The groups should use multiple channels for mobilizing funds. These may include:
  a. Promoting involvement in income generating activities by partnering with different groups that exist within the community, and encouraging them to add a component that allows the group to help mothers save money for maternal and newborn health
  b. Lobbying politicians (MPs and aspiring candidates) and well wishers to contribute money to such schemes
- Use locally existing saving groups or financial networks that are trusted by the local community e.g. VSLA, small local saving groups, circles, health cooperatives
- Ensure good management to minimise losses/ embezzlement through the following:
  1. Train the leaders in financial management
  2. Choose trusted local leaders
  3. Encourage good financial practices e.g. checks and balances, banking big sums of money etc
  4. Transparency through sharing information during meetings
  5. Use existing government structures to supervise and register groups
  6. Put in place measures for dealing with misuse of funds
  7. Encourage groups to have constitutions and to follow them

Group 3: Improving the quality of maternal and newborn health services

Good practices in support supervision and mentoring of health workers

- Training leadership at various levels (i.e. District Health Team, Health Sub-District, and Health units)
- Trainings should be on site, continuous and part of continuing medical education. The participants should be able to practice on site.
- Use champions within a unit. A health unit team secretary can document the trainings and identify areas that need training.
- The champions should be managers. This is because in some institutions if the top management is not on board there is usually no response.

- The champions including managers should create demand for services and improve the quality of services.

Improving referral of patients from lower level to higher-level facilities

- Some districts have set up referral protocols at the health units.
- : The higher level facilities should give feedback to the referring facilities to complete the loop.
- Improve documentation by using referral notes
- Provide communication gadgets and networking facilities
- Health workers should escort seriously ill patients
- Some cost sharing should be introduced for sustainability.
WRAP UP PLENARY: CLOSING REMARKS

“Most of our mothers die at the time of delivery and post delivery period. If you work at that level, you save a lot of lives and I thank these projects for trying to work around that period. We learn those best practices from these projects and scale them up.

Our out of pocket expenditure on reproductive health is high. So we are coming up with a National health insurance scheme. So we shall pull together resources and deliver quality health services. We want to harness improvements in delivery through insurance.

Regarding referral, together with our development partners, we have purchased ambulances. They are there but in different functional states. Some are on stones, some are lacking a tyre, some are lacking fuel, and others are working where community mobilisation has taken place like Yumbe. The community took over those ambulances and they are working. So other districts should learn from Yumbe.

But we are also not sitting down. We are developing guidelines to see how efficiently these can be managed.

Definitely facilities have failed to manage them because we have also failed to give them the means. They should have their own vote and be managed more efficiently. But we need to consult widely to see how we can improve the management of these ambulances.” - Dr. Collins Tusingwire – Asst. Commissioner for RH at MoH

Note: Look out soon for the entire audio recording of the symposium on the You Tube channel Maternal & Newborn Health @MakSPH

Acknowledgments

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We also thank HealthPartners Uganda and Dr Jolly Beyeza for accepting to join the symposium with interesting presentations.

Special thanks also go out to all those who managed to attend the symposium.

And with the industrious efforts of the organizing committee of (Mr. Kakaire Ayub Kirunda, Mrs. Josephine Adikini Oketch, Mr. Moses Tetui, Dr. Elizabeth Ekirapa – Kiracho, Ms Stella Kakeeto, and Mr. David Mutibwa) we were able to hold the symposium.

This report was compiled by Mr. Kakaire Ayub Kirunda and designed by Mr. Vincent Akumu

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