

Increasing Access to Skilled Birth Attendance

Kampala, Uganda
23 August 2011

Report

This report was prepared by the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative.

This policy dialogue was informed by the following policy brief: Nabudere H, Asimwe D, Amandua J. Improving Access to Skilled Attendance at Delivery (SURE policy brief). Kampala, Uganda: College of Health Sciences, Makerere University, 2011 www.evipnet.org/sure



What is a policy dialogue?

A structured discussion focused on an evidence-based policy brief

The agenda from the policy dialogue is attached as Appendix 1

Who participated in the dialogue?

People with relevant expertise and perspectives, including policymakers, civil society and researchers

The complete list of participants is attached as Appendix 2

What was the aim of the policy dialogue?

+ That discussion and careful consideration should contribute to well-informed health policy decisions

× The dialogue did not aim to reach a consensus or make decisions

What is included in this report?

+ Views, opinions and insights of individual participants reported without attribution

The opinions included in this report reflect the understanding (or misunderstanding) of individual participants in the dialogue

× These opinions may or may not be consistent with or supported by the policy brief or other evidence

It should not be assumed that the opinions and insights in this report represent a consensus of the participants unless this is explicitly stated

Nor should it be assumed that they represent the views of the authors of this report

Key messages

The following statements represent views, opinions and insights of individual participants in the policy dialogue.

- There was general agreement about factors contributing to a high maternal mortality in Uganda such as; inadequate resources, corruption, poor leadership in the health sector, poor procurement systems. There was emphasis on addressing corruption to maximise benefits from the available resources for the health sector.
- Significant human resources for health are required to scale up the proposed policy interventions, as well as stronger communication and referral systems.
- Both supply side and demand side incentives are needed to improve service coverage. Many health workers reject postings in rural or hard-to-reach areas. Many mothers are reluctant to use public health facilities.
- The government should set up a comprehensive regulatory framework for non-state health service providers in the private sector.
- Other policy options such as provision of maternity services at household level should be considered.
- The supportive role of fathers and male partners should be emphasized to reduce maternal mortality.

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Background

The Director General of the Uganda National Health Research Organisation (UNHRO), Dr Sam Okware welcomed participants and asserted the role of UNHRO not only in coordinating national health research but translating research findings into policy and practice. The REACH policy initiative – SURE project under UNHRO in collaboration with the College of Health Sciences, Makerere University had produced a policy brief on increasing access to skilled birth attendance which was the focus for discussion in this meeting. The brief describes the problem, highlights three policy options and implementation considerations that need to be taken into account. He requested the participants to introduce themselves. He introduced the moderator, Dr Freddie Ssenooba, from the School of Public Health, Makerere University, and requested him to facilitate the proceedings. Dr Ssenooba assured the participants that a record of the meeting would be kept but would not attribute comments to the participant speakers and thus encouraged them to freely express their views.

The problem

Maternal mortality is still a big problem in the country, but how do we engage politicians' interest in addressing the problem? One way could be to describe this in terms of the amount of money lost from women dying for maternal reasons. The 2 million mothers delivering every year in Uganda could be framed as 2 million voters who require adequate delivery services. There is 8 billion shillings in reproductive health commodities with the National Medical Stores. We have the resources; the problem is with the health systems. Resources can be available for health but these are not utilized because of other factors, e.g., corruption, mobilization, poor leadership and management. These are the problems that need to be addressed.

Health centre IIIs are not supposed to buy their own drugs from anywhere else except the National Medical Stores which is many times out of stock for these drugs and supplies which are actually available on the open market. NMS does not have the capability of procuring sufficient supplies for the entire public health system hence creating an artificial 'scarcity' of supplies.

Other issues such as livelihoods, for example, pastoral communities do not use health centres being mobile groups. The feasibility, cost-benefit analysis, acceptability for nomads using health facilities should be investigated. How do we compare with our neighbours in the region?

Socio-cultural factors contribute to the lack of use of the services. Other issues include an enabling environment for the health workers to perform their duties. Use of local evidence can contextualize the issue such as a multi-sectoral analysis by Dr Okuonzi which highlighted poor supervision and poor motivation of health workers. A UNFPA document on comprehensive nursing could also be informative.

For the consumer, the important thing is what skill is actually available on the ground. In the community, the 'skilled attendants' being promoted by government are unfriendly and rude to the mothers, are not available at night or on weekends. The involvement of traditional birth attendants should be discussed since they are the majority service providers in rural areas.

The problem should be quantified for human resources aspects such numbers of skilled birth attendants, quality of the training of comprehensive nurses, motivation and workload, availability of transport and the state of communication/referral system. 30% of lower level facilities are not manned by a skilled health professional.

Some success stories such as the Iganga example to address the problem of maternal health used the training of midwives, improvement in transport using the three wheel vehicle, effective communication and community mobilization which attracted mothers to the health centres.

Although the Secretariat clarifies that the policy brief targets policy makers and therefore written in the technical language they understand, how do other stakeholders access this information? How do we communicate this to mothers at community level?

The problem statement should be aligned with national set targets in the Health Sector Strategic Plan and the National Development Plan, and as much as possible, current statistics should be used.

Policy options

Policy Option 1: Delivery Services at Health Centre II:

The policy options are addressing the problem of the three delays to access health services for mothers. What is the current status quo for each of the policy options? Should we go down to health centres II and further spread thin the scarce resources available or should we instead strengthen the higher centres? What other options are available? Policy option 1 if implemented, there would be no need for policy option 3 on maternal waiting homes. It would reduce on access issues in terms of geographical distance, financial access and 'temporal' access. However, this has significant human resource implications. The current human resource structure at health centre II is insufficient. You need at least 3 workers, the

midwife, an assistant and a cleaner. Infrastructural investment in delivery rooms is also indicated.

There is need for another policy option on strengthening communication between the service providers and the community. The policy options do not stand alone; they are supported by 'secondary strategies' in the implementation section of the brief which include improving communication, improving referral services, among others. The nurses and midwives should be trained to communicate better and establish good rapport with their clients.

The scope of work of the midwives is always increasing because too much is expected of them. Some health centre IVs do not have transfusion services, there is need to have some kind of outreach program to supply such services where needed. Kenya is training community midwives. All the options will need good monitoring and evaluation. It is important to know the number of midwives needed to scale up these options. There is another potential option of taking skilled attendance to household level; all the three options are facility based. Policy option 1 could work if the issue of human resources is addressed by fixing system problems, numbers, training of comprehensive nurses and motivation.

Consider allowing health centres 2 to deliver mothers, bearing in mind the geographical distribution of health centres 3. It was observed that mothers in difficult terrain in rural areas find access to health centre 3 extremely difficult, thus a need to allow health centre 2 to deliver mothers who after all often end up seeking services of traditional birth attendants.

Consider provision of incentives to attract mothers to health centres 3.

Consider provision of incentives to attract and retain midwives within health centres 3. Emphasize improvements in communication and referral system. Citing Kampala, it was noted that the Police has over 20 ambulances but there is lack of an effective communication system for these services.

Policy Option 2: Working with the Private-for-Profit Sector:

Can we get players in the private-for-profit sector to contribute to improvement of maternal services? The private sector already exists and is currently providing services how can government take advantage of this to scale up services?

What is the regulatory environment to back this policy option? It was observed that there is no comprehensive regulatory framework for the non-state health service providers. There is a public private partnership draft policy which is not yet passed. The private-for-profit providers do not usually work in rural areas so how well would they serve the rural poor? Even without a ministry policy, the private-for-profit sector already provides government services such as immunization to the public. An example of the voucher scheme for maternal services managed by private providers has been successful in Western Uganda.

It is important to know the coverage of delivery services under the private health centre IIs to see how this could be utilized to provide services in underserved areas in particular.

Government can provide support to private health providers for example through training.

Policy Option 3: Maternity Waiting Homes:

The maternity waiting homes could help to solve the problem of physical access for obstetric care. Waiting homes should be part of a wider solution to support functioning health facilities to deliver at risk mothers. They are useful if mothers get 'false labour', or if mothers are near term but live in remote areas. The mothers are not admitted in the hospital but live in a more or less domestic setting, provided with shelter and food, pending delivery. Most maternity homes do not provide food, but some provide food. The maternity waiting homes could provide an opportunity for health education of mothers. The downside of maternity waiting homes is removing the mother from her home, where she is the main care provider for the family in terms of food, water, taking care of the family's' needs.

Other potential options suggested; taking skilled birth attendance to household level since it's known that mothers do not want to go to health centres and improving the relationship between health workers and consumers of services.

Implementation considerations

These are 'secondary' strategies to support the 'primary' strategies discussed under the policy options. Implementation strategies depend on the region where options are being implemented for example some community mobilization strategies will work in some communities but will not work in others. We should rethink cost-sharing to pay for services to increase funding. Strong communication linkages are needed to strengthen the system. The government has not recruited midwives for the past ten years; hence there are unutilized human resources for health that could be recruited into the system. There should be incentives to attract health workers to work at health centres 2. These do not have to be financial incentives. They could include housing, social amenities such as good schools. The referral system should be strengthened.

Next steps

The Commissioner for Clinical Services, Ministry of Health:

Dr Amandua noted that maternal health is a huge problem to the health sector and mothers comprise a big proportion of the clientele who receive services at the public facilities. The College of Health Sciences has worked hand in hand with the Ministry of Health in searching for evidence to support increasing access to skilled birth attendance. The Ministry has a proposal to scale up deliveries at health centre II level. The Permanent Secretary will attend the dialogue for senior policymakers and legislators to reiterate the ministry's position on this. Usually policymakers have to write policy briefs themselves but now we have the support of initiatives like SURE to provide research evidence when it is needed. Commendations to the Uganda National health research organization for the institutions' support in this process. Next steps include wider stakeholder consultations, lobbying for resources and updating designs for the health centres.

The Director General, Uganda National Health Research organization (UNHRO)

Dr Sam Okware, reechoed that the purpose of the dialogue was to interface with various stakeholders. However, he observed that the meeting shied away from discussing the role of male partners and fathers in child delivery. He then advised that the next events of this kind should address this gap. The next steps should be positive engagement with the stakeholders. We should adapt what is good about the policy options both at national and local government levels. The issue of human resources for health, motivation, compensation is pertinent; the issue of domiciliary maternity services might be an important strategy to consider.

He thanked Dr. Jacinto Amandua, the Commissioner, Clinical Health Services at the Ministry of Health for his contributions and the good working relations the Commissioner's office has maintained with UNHRO and the College of Health Sciences. He then thanked the moderator and all the participants for their vital participation.

The meeting adjourned at 1.30 pm.

Appendix 1: Agenda

8.30 – 9.00 AM	Registration	SURE Secretariat
9.00 - 9.05AM	Welcome by the DG, UNHRO	Dr Sam Okware
9.05 - 9.20 AM	Introduction of participants and Moderator	Dr Sam Okware
9.20 – 9.30 AM	Procedures and Rules of the Dialogue	Dr Freddie Sengooba
9.30 – 10.30 AM	Problem Section of the Policy Brief	Discussion
10.30 – 11.00 AM	TEA/COFFEE BREAK	
11.00 – 12.00 AM	Policy Options Section of the Policy Brief	Discussion
12.00 – 01.00 PM	Implementation Section of the Policy Brief	Discussion
01.00 – 01.15 PM	Wrap up and Way Forward	Dr Jacinto Amandua
01.15 – 01.30 PM	Evaluation of the policy dialogue	Dr Harriet Nabudere
01.30 – 01.45 PM	Closing Remarks	Dr Sam Okware
01.45 PM	LUNCH	
	Departure	

Appendix 2: Participants

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Competing interests

None known.

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