Policy dialogue

Increasing Access to Skilled Birth Attendance

Kampala, Uganda
25th 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, Asiimwe D, Amandua J. Improving Access to Skilled Attendance at Delivery (SURE policy brief). Kampala, Uganda: College of Health Sciences, Makerere University, 2011
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Regional East African Community Health Policy Initiative

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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.

- The health infrastructure is insufficient with some administrative areas, such as districts and parishes having poorly functional health facilities or lacking facilities altogether, such as hospitals. There are inadequate numbers of midwives.
- Mothers with disabilities have unique challenges in having their healthcare needs met, in addition to the shortfalls of the health care system in general.
- The role of traditional birth attendants within the health system should be acknowledged, as they meet the gap left by healthcare professionals. Many mothers do not distinguish between professional midwives and non-professional traditional birth attendants.
- Mechanisms should be adopted to ensure a sufficient health workforce in rural and hard-to-reach areas such as recentralisation of recruitment and bonding of newly trained personnel.
- There was general agreement about adoption of the three policy options; however, some of the options could be gradually scaled up for various geographical, urban or rural regions.
- The role of Village Health Teams was emphasized in strengthening communication between households and the health system, such as registering and educating expectant mothers.
- The supportive involvement of fathers and husbands is needed to improve maternal health.

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Background

The Director General of the Uganda National Health Research Organisation (UNHRO), Dr Sam Okware welcomed the distinguished guests to this dialogue on skilled birth attendance. He reiterated the role of UNHRO in communicating research evidence to inform health policy and practice. He invited the participants to introduce themselves.

The DG informed the participants that the policy brief has both a short and full report which contains three options: operationalizing health centres II; working with the private practitioners and thirdly, establishment of maternal waiting homes so that women with complications can come nearer health facilities. What information do the 'champions' here need to contribute to a wider discussion on improving maternal health?

He introduced the moderator, Dr Freddie Ssengooba from the School of Public Health and invited him to facilitate the proceedings. Uganda loses about 6000 women every year from maternal causes. The moderator clarified that the dialogue would capture perspectives from different constituencies including communities, policy makers, technical people and legislators. Mothers giving life should not lose their lives in the process. How do we increase access to skilled birth attendance? Evidence is a good starting point in policymaking but what other considerations need to be taken into account in making decisions for the improvement of maternal health?

The dialogue is off the record to encourage a free discussion by participants. The views of participants will be treated with high confidentiality by not linking contributions with names/ institutions, in the dialogue report.

The problem

How far are we to meet the MDGs? Uganda's 1990 levels stood at 500/100,000 live births and at 2005 stood at 435/100,000 live births and the target for 2015 is 131/100,000 live births.

There are many health centre IIs that do not have midwives, there is a gap of 2000 midwives. There are many parishes which do not have health centre IIs and many health facilities do not have functional theatres. A regional referral hospital, in Mubende district (Mudende hospital) was using charcoal stoves as boilers, when visited by Members of Parliament. There

are functional and structural issues with health centres, some districts do not even have district hospitals. Services need to be taken closer to the mothers, large distances to access services are a hindrance.

We need statistics for mothers with disabilities, for example, the midwives need to be assisted by someone who can communicate in sign language. Affirmative action is needed for disabled mothers.

Nurses and midwives are overwhelmed because of the high fertility rate in Uganda. Midwives at health centre IIs get mothers referred by traditional birth attendants, how do TBAs feature in this system? Practitioners feel offended when mothers seek care from TBAs. TBAs will always be there unless government equips health facilities adequately. Mothers actually expect to deliver from health centres II and do not differentiate between services at health centres III from health centres II. Disregarding the work of TBAs is of concern. Most of the TBAs do a lot of work in helping rural mothers who cannot travel long distances. We should improve health service delivery through TBAs working together with health professionals in caring for mothers. The issue of TBAs needs to be addressed somehow, because mothers are still using TBAs at the community level. Village Health Teams, proposed by the Ministry of Health are envisaged to facilitate referral from the community, of mothers with complications.

Training and equipping a TBA could be cheaper than equipping a health centre. How do we move from this model to the model of skilled attendance?

85% of mothers will deliver normally. 15% of mothers face complications, the largest contributor is bleeding. These are the mothers we are trying to save, not the 85%. The TBAs could support the 85% normal deliveries, but because it is difficult to identify which 15% of the mothers will have complications, all mothers must deliver under supervision of skilled attendants not TBAs.

Who is in charge of recruiting staff for these health centres? Some health centres, for example in Mutoma, were built 4 yrs ago but are not operational. Recruitment of health workers is still an issue because hard to reach areas do not attract health workers. As a result, some districts like Bukedea does not have a doctor and functional theatre. One MP informed the participants that the 8th Parliament of Uganda suggested to government to recentralize recruitment of health workers to benefit hard to reach areas as well.

The Ministry policy of having a health centre II in every parish is to increase services to within 5km. For the hard to reach areas in particular, we need to scale up health centres II. For some districts, especially in the north, many health centres II are already conducting deliveries. Concerning recruitment of doctors for health centres IV, ministry is trying to work out a mechanism where new doctors get posted in remote areas. Doctors finish internship, but soon after training there is no deployment mechanism in place to prevent 'brain drain' of skilled workers to other countries. Medical personnel, nurses being trained here, should work for the public service for a minimum period of time before being allowed to migrate out of the country or elsewhere.

Regarding health centres in the rural areas, no staff are available on weekends, yet a mother delivers at anytime. Demoralisation of the health workers affects the consumers who lose

faith in the system. Communication and referral issues linking health centres II to health centres III should be addressed.

There is need for communication and sensitizing mothers around attending antenatal care. Poor mothers are asked for 'gloves, cotton wool, razor blades' and other supplies which should be provided for by government as basic facilities. There is under funding in the health sector. Health workers work under very difficult conditions, and are used as a scapegoat for failure of the health system in general. We should come up with concrete actions to these issues. We keep discussing the same issues over and over again without any concrete solutions.

Policy options

The three options include provision of delivery services at health centres II, working with the private-for-profit sector and use of maternity waiting homes.

Are the options complementary or they are mutually exclusive? They could be combined or implemented as single options.

All the policy options are good, however, we could go for policy option I if there is a midwife at health centre II to deliver mothers. Also midwives in private practice could be engaged to increase services. Maternity waiting homes appear promising but likely these would be an expensive option.

Hindrances to mothers seeking care are described as the primary delay, the secondary delay and the tertiary delay. Some countries are tackling maternal mortality by gearing solutions towards the 'delays'. The Village Health Teams could take care of the primary delay. The waiting homes could take care of the secondary delay, in reaching the health facility. In the hard to reach areas, option 1 would be relevant. Option 2 comes in to overcome the tertiary delay, which is accessing the actual care, as well as option 1 which could contribute to this.

Option 1 and community involvement go hand in hand.

The ministry made a proposal to bring delivery services down to health centres II, 10 yrs ago but the last two parliaments have not supported the ministry in this. Both the politicians and technocrats need to work together to deal with mothers dying in labour. In Europe, most of the mothers deliver at home because it is safe for them. This may not be possible in our circumstances, hence the emphasis on facility deliveries. The Village Health Teams should mobilize the communities to have mothers deliver in health facilities. 23% of health centres II are actually already delivering mothers.

Almost all the options could work for mothers with disabilities. Not all health workers are trained well to deliver mothers with disabilities, and this can lead to loss of life. There is need for a plan at community level. We need a separate dialogue to discuss reproductive health concerns specifically for mothers with disabilities. All the issues raised are very important but there is need for specific implementation concerns for women with disabilities. They may develop complications which cannot be handled at lower level facilities, hence the 'waiting

homes' could work for these mothers if these were placed at higher level centres, like hospitals, where they can access these skilled services.

We should get options which we know can be implemented, for example option 3. Government is still struggling to implement health centres II and health centres III, and it may not be feasible to implement all 3 at the same time. It should be more feasible for government to concentrate on implementing option 1 and option 2. For example, option 3 may not necessarily be scaled up across the whole country but only in certain areas, with a big problem of access. Maternity waiting homes could be placed near say health centres III. We also need to bear in mind that some husbands may not allow their wives to stay in waiting homes.

Voucher systems for services have been successful in Kagando with reduction in maternal deaths. In Adjumani district, taxi drivers have agreed to take mothers in labour to the health facilities free of charge. Vouchers are paid for by an organization, the mothers are given a 'passport' and this encourages mothers to go health units. Government can never fully equip all the health centres, therefore other fundraising alternatives need to be considered in reinforcing the healthcare system.

There are many health workers who have been trained but are not employed. Is there some kind of fund that could support these workers to start up private health care services? The Ministries of Finance, Public Service and Health need to collaborate together for better recruitment. If government is not employing more workers, can we expand space for the private sector such as in Option 2? How do we take this forward?

Parliament will support any good policy proposal that comes up. As parliamentarians, we are ready to support any policy options that will reduce maternal mortality.

If government has failed to manage and equip health centres II, then we should privatise these and hand them over to private midwives to run and manage.

I don't think government has a limit on filling the gap. The issue for private health centres will be the costs of mothers accessing services at these centres. Is it possible to facilitiate private health facilities to take up some of this extra burden? TBAs charge mothers but mothers are still willing to access services from them. If there is a skilled professional who is an entrepreneur, shouldn't government support these to scale up delivery of services?

Implementation considerations

There is need for a community component. Local community leaders, e.g. Local Council I (LC1) should be responsible for mothers under their community. LC1 is closest to the community and knows everyone in the community. The Village Health Team should move around the village and register expectant mothers and educate them about care seeking. We need to move to a community social support system. We need to talk about responsibility at community level; there is should be a mechanism to handle redress for health consumer issues. Supervision, both technical and political is one of the worst performing areas in the health sector.

How do we involve husbands at community level and household level? Health workers should get the male partners to save money for maternal care.

Recruitment of health workers is still an issue. It is not fair to encourage mothers to go to health facilities when there are no health workers to attend to them at the facilities. It may not be enough to get to a health facility but the health facility should be functional. The technocats at the Ministry of health should explain the failures of the system. The problem in this country is nobody is deciding that mothers should be safe. We have not invested adequately in the health system.

What should be done? Deliveries should be brought down to health centres II and there is need for finances, resources and political will to implement this.

In the training of nurses, are health workers trained to relate effectively with their clients. Are we emphasizing roles of the midwives and doctors alone? What about the other health workers?

Just like for teachers working in hard to reach areas, health workers should be provided with an allowance.

For the workers and labour fraternity, both rights and obligations come hand in hand and should be fulfilled. The midwives are not well remunerated; however they should still observe good ethics and good morals regarding relationship with the communities and families.

Supervision needs to be scaled up at health centres II.

Next steps

<u>The Commissioner for Clinical Services, Ministry of Health:</u>

Dr Amandua mentioned that this dialogue on mothers delivering safely is very timely and will go a long way helping policymakers to make decisions. Almost everyone here has lost someone or knows someone who has lost a family member or friend from maternal causes. We would like to thank the College of Health Sciences for sourcing for research evidence in support of policy formulation.

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

Dr Okware reiterated that we must invest in human resources. We need to have domiciliary midwives working at all levels. We need to bring back shared values; serving in health is a calling to help our fellow human beings. Government is the people, we are the government. When we talk about government it is not they versus us, we should all work together. I would like to thank the College of Health Sciences for their contribution in this process.

Honorable Member of Parliament, Sylvia Ssinabulya

Chairperson, National Association of Women Members of Parliament

Thank you for organizing this policy dialogue and inviting us as MPs to participate. In the earlier Parliaments there was minimal interaction between legislature and the executive i.e., the Ministries. It is good this has been improving over the years. One of the key issues parliamentarians face when running for office are issues of health. 'You have been an MP for ten years and this hospital has not changed' It is because of this, that the MPs are so hard on the technocrats from the Ministry of health regarding these issues. She reechoed the call for strong political will to save the women of Uganda from maternal death. She then thanked the MPs for sparing their valuable time to attend and contribute to the dialogue. We shall continue to advocate for these issues that have come out of this dialogue.

At 1.40pm the Hon. Ssinabulya declared the meeting closed.

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

Hon. Nakadama Rukia Isanga
Minister of State for Gender
Ministry of Gender, Labour and Social Development

Hon. Amongin Jacquiline
Member of Parliament
Republic of Uganda

Hon. Ekwau Ibi Florence
Member of Parliament (UWOPA)
Republic of Uganda

Hon. Bayigga Michael Lulume
Member of Parliament
Republic of Uganda

Hon. Safia Nalule Juuko
National Woman Member of Parliament – Persons with Disabilities
Parliament
Republic of Uganda

Hon. Kamateeka Jovah
Member of Parliament
Republic of Uganda

Hon. Rose Najjemba Muyinda
Member of Parliament
Republic of Uganda

Hon. Bintu Jalia Lukumu Abwooli
Member of Parliament
Republic of Uganda

Hon. Mutyabule Florence
Member of Parliament
Republic of Uganda

Hon. Kiiza Winfred
Member of Parliament
Republic of Uganda

Hon. Ssinabulya Sylvia
Member of Parliament
Republic of Uganda

Hon. Sarah Netalisire
Member of Parliament
Republic of Uganda

Hon Kasule Robert Sebunya
Member of Parliament
Republic of Uganda

Hon. Mulindwa Patrick
Member of Parliament
Republic of Uganda

Hon. Mary M.N. Tuunde
Legislator
Republic of Uganda

Ms. Kaitiritimba K. Robinah
Executive Director
Uganda National Health Users/ Consumers Organization

Dr. Jennifer Wanyana
Assistant Commission for Health Services (Reproductive Health)
Ministry of Health

Prof. Emmanuel M. Kaijuka
Makerere University, School of Public Health

Dr. Amandua Jacinto
Commissioner Clinical Services
Ministry of Health

Dr. Oware Sam
Director General
UNHRO

Dr. Freddie Ssengooba
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Dr. Dan K Kaye
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Mr. Hannington Mwanje
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United Nations Population Fund (UNFPA)

Dr. Jackson Amone
Assistant Commissioner Curative Services
Ministry of Health

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Natural Chemotherapeutics Research Institute
Ministry of Health

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Assistant Coordinator NAWMP-U / Parliament of Uganda

Ms. Nalubanja Florence
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Competing interests

None known.

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The **Regional East African Community Health (REACH) Policy Initiative** links health researchers with policymakers and other vital research users. It supports, stimulates and harmonizes evidence-informed policymaking processes in East Africa. There are designated Country Nodes within each of the five EAC Partner States. The REACH Country Node in Uganda is hosted by the Uganda National Health Research Organisation (UNHRO).
www.eac.int/health

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