

Improving Access to Skilled Attendance at Delivery

Executive Summary

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

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Who is this policy brief for?

Policymakers, their support staff, and people with an interest in the problem that this policy brief addresses

Why was this policy brief prepared?

This policy brief was prepared to summarize the best available evidence about the problem which it addresses and solutions to that problem

! This evidence-based policy brief includes:

- A description of a health system problem
- Viable options for addressing this problem
- Strategies for implementing these options

X Not included: recommendations

Full Report:

The evidence that is summarised in this policy brief is described in more detail in the Full Report

What is an evidence-based policy brief?

Evidence-based policy briefs bring together global research evidence (from systematic reviews) and local evidence to inform deliberations about health policies and programmes

What is a systematic review?

A summary of studies addressing a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise the relevant research, and to collect and analyse data from this research



The problem

MDG 5.A aims to reduce by 75% the maternal mortality ratio between 1990 and 2015; by monitoring two indicators: the proportion of births attended by skilled personnel and the maternal mortality ratio.(6)

Uganda's maternal mortality has moderately declined from 670 per 100,000 live births in 1990 to 430 per 100,000 live births in 2008. (7) This translates into an annual decline of 13 maternal deaths per 100,000 live births compared to the 20 maternal deaths per 100,000 live births annual decline that is required to meet the MDG target deadline.

Skilled attendance in Uganda stood at 42% in 2006 (23) and was under 50% by 2008. (24) ICM and FIGO proposed a target for developing countries to have at least one person with midwifery skills for a 5000 population, attending approximately 200 births per year.(18)

The current Ministry of Health policy provides for an enrolled midwife at Health Centre II which at present serves a population of 9,212; this estimate includes both public and private units (the ideal standard is Health Centre II for a population of 5000). (25) The enrolled midwife can only perform antenatal care services but not deliveries and has to refer expectant mothers to Health Centre III to be attended by a registered midwife and a clinical officer. (25-26)

Size of the problem

Maternal and perinatal causes constitute 13.2% of the total disease burden in the country.(27) Maternal causes account for a total 515,000 disability adjusted life years (DALYs), while perinatal causes account for 1,345,000 DALYs out of a total 14,146,000 DALYs for Uganda.(27) Maternal causes include obstructed labour, eclampsia, puerperal sepsis, and obstetric haemorrhage among others while perinatal causes include prematurity, low birth weight, birth asphyxia, birth trauma, neonatal infections and other neonatal conditions.

Uganda's maternal mortality is still high at 430 maternal deaths per 100,000 live births in 2008. (7) From 1990 levels of 670 per 100,000 live births, there has been an annual decline of 13 maternal deaths per 100,000 live births which is unlikely to meet the MDG-2015 target of 168 per 100,000 live births.

Cause of the problem

A number of factors hinder expectant mothers from accessing care at health facilities where skilled attendance could be available for their care.

Adequate facilities and sufficient numbers of skilled health workers are needed to achieve the desired maternal and child health indices. There is maldistribution of the health workforce with more workers preferring to work in urban areas versus rural areas, private sector rather than public sector because of higher compensation.

Several determinants influence delivery service use from the mothers' perspective including sociocultural factors, perceived need for care, economic and physical accessibility.

Policy options

The three policy options presented in this section could be adopted independently or complementary to the other to improve maternal outcomes. The Ministry of Health is deliberating operationalising Health Centres II for deliveries. The evidence for this is elaborated to support these decisions. Maternal waiting shelters and working with the private-for-profit sector to facilitate deliveries in health facilities are promising complementary interventions.

Policy Option 1:

Providing Intrapartum Care at first level Health Centre:

Intrapartum care refers to the provision of delivery services and immediate postpartum care for mothers and their newborn babies. Most maternal deaths occur during labour, delivery and immediate 48 hrs postpartum.(40) Many complications cannot be predicted or prevented and require timely diagnosis and appropriate management by skilled attendants to prevent death or morbidity.(48) This necessitates the need for routine delivery by mothers in an adequately functioning health facility providing basic emergency obstetric care with referral access for comprehensive EmOC at higher level facilities.(15)

Current facility-based provision of Intrapartum Care:

The basic package of services (MOH, 1997) puts deliveries at health centres III under sub-county administration with an average distance of 20km from the household. (49) 93.5% of pregnant women receive antenatal care from enrolled midwives posted at health centres II (average distance of 5km) who are not authorised to provide intrapartum care at this level. Consequently, only 42.1% of women deliver in health facilities indicated at a much further average distance of 20km.(23)

Impact of Intrapartum Care at first level Health Centre:

Country case studies from developing countries which achieved significant declines in maternal mortality over the past few decades were considered in terms of where the women gave birth (in a facility or at home) and who conducted the deliveries (a professional or lay attendant, e.g CHWs). Four models of care were compared from transitional middle income countries such as; Sri Lanka, Malaysia, China, Brazil, Mexico and high income settings; for example, the United Kingdom and United States of America. Successful models made use of well-trained midwives, with access to drugs for basic emergency obstetric care, protocols for identifying problem pregnancies and deliveries and means of referral to a comprehensive emergency obstetric care centre such as a hospital. One of these models with midwives at first level health centres is most feasible for the Ugandan context.

Policy Option 2:

Working with the Private-for-Profit sector to provide Intrapartum Care at first level Health Centre:

The private sector includes formally or informally-trained health providers who may be for-profit (PFP) or not-for-profit (PNFP). The private-for-profit providers control 40% of Health Centre IIs, nearly three times that of the PNFP sector for this level of care (14%) which is being targeted for increasing access to professional care at delivery for expectant mothers. (25)

Impact of working with the private-for-profit sector for healthcare delivery:

A systematic review on working with the private sector to improve utilization of quality health services by the poor identified 52 studies from low and middle-income countries. The review found low quality evidence suggesting that many interventions involving the private for-profit sector can be implemented successfully in poor communities. Positive equity impacts can be inferred from interventions involving providers who are predominantly used by poor people. However, stronger evidence of the equity impacts of interventions is needed for more robust conclusions to be drawn. The identified interventions for working with the private-for-profit sector include:

Provision of vouchers

A voucher is a form of demand-side subsidy that the recipient can use as part or full-payment for a product or service from identified providers. The distribution of vouchers can be targeted to improve access for an identified population group such as the poorest households or pregnant women.

Contracting-out

Contracting-out is a purchasing mechanism used to acquire specified services of a defined quality at an agreed price from a specific private for-profit provider and for a specific period of time. Governments may purchase clinical or non-clinical services from private for-profit providers to complement public provision.

Franchising

Franchising refers to a contractual arrangement between a health service provider and a franchise organisation, which aims to improve access to quality-controlled and price-controlled services.

Training

Training interventions can take various forms, including formal training sessions, vendor-to-vendor education, distribution of guidelines and job-aids. Training is often integrated into other interventions, such as franchising, accreditation and social marketing.

Policy Option 3: Maternity Waiting Homes

A Maternity Waiting Home (MWH) is a residential facility within easy reach of a hospital or health centre which provides emergency obstetric care. (EmOC) (71) Maternity waiting homes or shelters aim to improve physical access to emergency obstetric care for women in labour in remote areas.

Impact of Maternity Waiting Homes:

A systematic review describing studies on the effectiveness of MWHs found potential benefits of maternity waiting homes on outcomes for women and their newborns but with low utilisation levels due to access barriers.(75) Maternity waiting facilities may be a relevant option in rural populations with limited access to emergency obstetric care, however, there is insufficient evidence to evaluate the effectiveness of waiting facilities in low resource settings and high quality studies for this are still needed.

Implementation considerations

Key barriers to implementing the policy options and implementation strategies to address these are summarised in the table below.

Table S-1. Implementation considerations

<i>Barriers to implementation</i>	<i>Strategies for implementation</i>
<p>Knowledge and care seeking behavior of expectant mothers</p> <p>Socio-cultural factors and negative perceptions are factors associated with low utilization of health based interventions by mothers.(23, 80)</p> <p>Societal and familial expectations often influence women's choices to seek care and may lead to delays in seeking essential professional care. Community has inadequate information on birth preparedness and emergency readiness, danger signs of pregnancy, delivery and after child birth as well as risks and danger signs in newborns.(81)</p>	<p>Village Health Teams</p> <p>Village Health Teams (VHT) and scale up of Community Integrated Management of Childhood Illness (IMCI) strategy could be used to provide accurate health information and mobilize mothers for health action, checks for danger signs of pregnancies and provide linkages to maternity waiting homes and or referring each mother for appropriate use of health services.</p> <p>Community Mobilisation programs</p> <p>Increasing community demand for obstetric care. There is moderate evidence that community mobilization programs can reduce early neonatal and perinatal mortality and increase skilled birth attendance.(83)</p>
<p>Competency of expectant mothers</p> <p>Economic constraints are associated with low utilization of health based interventions by mothers.(23, 80) Life-saving practices are not always followed due to poverty, cultural beliefs, lack of household food security and poor access to health care.</p> <p>Social responsibilities such as need for women to provide for their families and care for young children sometimes stand in their way of using needed services including refusing hospital admission when complications requiring admissions are detected during antenatal visits.(81)</p>	<p>Maternity waiting homes</p> <p>Maternity Waiting Home (MWH) facilities could be established to help women stay at the end of their pregnancy with arrangements to be assisted by skilled birth attendant once labour starts.</p> <p>Community referral and transport schemes</p> <p>Schemes that are used vary widely and may include paying for travel costs, establishing a transportation plan, and providing various means of transport, including loan for a truck, and ambulance transport using bicycles, motorcycles, vehicles.</p> <p>Enhanced communication between community -based health workers and medical professional as well as primary and referral level facilities is a key factor in accessing services.</p> <p>Financial Subsidies and Increasing service demand</p> <p>There is no evidence that subsidies would attract more pregnant women to utilize MHW. But high costs are a deterrent to MWH utilization.(74)</p>

	Increasing community demand for obstetric care.(83)
<p>Knowledge, Competency and Attitudes of Health Workers</p> <p>Lack of supervision of health workers in charge of maternal waiting homes and staff attitude during ANC and delivery are among the key determinants of using waiting shelters.(74)</p>	<p>Educational meetings and training</p> <p>Educational meetings e.g. training workshops, educational outreach, support supervision by a higher health cadre to MWH and feedback (a summary of performance over a specified period of time given in a written or verbal format) can be used alone or in combination with each other and other interventions to improve health. Pay for performance</p>
<p>Inadequate financial resources</p> <p>Inadequate investment for basic infrastructure of public facilities, medicines, equipment and supplies has impacted negatively on service quality.(90) Private expenditure on health is as high as 81% of the total health expenditure.(53) The National health insurance scheme is yet to be effected. (25)</p>	<p>Financial Strategies</p> <p>Financial strategies to increase community demand for obstetric care include elimination of user fees, community based insurance schemes, community loan funds, conditional cash transfers, voucher schemes contracting out and pay for performance.</p>
<p>Inadequate human resources</p> <p>The availability, access and quality of health services are affected by insufficient numbers of trained staff and uneven distribution of available skilled personnel.(32)</p>	<p>Optimising health worker roles</p> <p>Optimization of health worker roles could improve the delivery of maternal and child health care.(91)</p>
<p>Inadequate facilities</p> <p>Lower grade facilities which provide limited care services despite being closer to the rural communities where maternal and child mortality risks are highest. There is imbalance in the distribution of health facilities between rural and urban regions particularly for higher level centres which provide delivery services. (89) Long distances and poor drug availability are among the most significant factors affecting access to health care. (23, 80)</p>	<p>Strengthening Health Infrastructure</p> <p>Strengthening the public and private health infrastructure to provide a continuum of care to mothers and new born babies. (25, 89) There is moderate evidence on securing limited space or restructuring existing public and private health facilities to accommodate Maternity Waiting facilities for EmOC. (74, 89)</p>
<p>Public-Private healthcare partnership</p> <p>Partnership between public and private-for-profit sectors in delivery of health care to achieve public goals is limited.(56)</p>	<p>Strengthening Public-Private collaboration</p> <p>The private sector that includes for profit and not-for-profit providers may be used to deliver health services on behalf of the public sector. The schemes that are used vary and may include social marketing, use of vouchers, pre-packaging of drugs, franchising, training, regulation, subsidies, accreditation and contracting-out.</p> <p>Effective public private partnerships can increase access, improve equity and raise quality of service.</p>

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