26 April 2012

An Evidence Brief for Policy

Improving Access to Skilled Attendance at Delivery

Executive Summary

Included:
- Description of a health system problem
- Viable options for addressing this problem
- Strategies for implementing these options

Not included: recommendations
This policy brief does not make recommendations regarding which policy option to choose

Who is this evidence brief for?
Policymakers, their support staff, and other stakeholders with an interest in the problem addressed by this evidence brief

Why was this evidence brief prepared?
To inform deliberations about health policies and programmes by summarizing the best available evidence about the problem and viable solutions

What is an evidence brief for policy?
Evidence briefs for policy bring together global research evidence (from systematic reviews*) and local evidence to inform deliberations about health policies and programmes

*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

Full Report
The evidence summarised in this Executive Summary is described in more detail in the Full Report

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

The problem
High Maternal Mortality

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. This annual decline of 13 maternal deaths per 100,000 live births is unlikely to achieve the MDG target of 168 per 100,000 live births by 2015. The proportion of pregnant women delivering from public and private non-profit facilities was low at 34% in 2008/09. Increasing skilled birth attendance is desirable to reduce maternal mortality.

Policy options:
1) Providing Intrapartum Care at first level Health Centre
2) Involving the Private-for-Profit sector
3) Maternity Shelters

1. An efficient intrapartum care intervention is to provide for mothers to routinely deliver in a primary level or first level health facility (Health Centre II) with midwives as providers but with other attendants working with them in a team.
2. Many interventions involving the private-for-profit sector could be implemented successfully in poor communities with potential improvements in equity particularly for those providers frequently used by low income groups.
3. Maternity waiting facilities may be a relevant option in rural populations with limited access to emergency obstetric care.
   o Given the limitations of the currently available evidence, rigorous evaluation and monitoring of resource use and activities is needed for all the options.

Implementation strategies:
A combination of strategies is needed to effectively implement the proposed options

   o Education and training strategies to improve knowledge and competence of health workers.
   o Optimisation of health worker roles, strengthening of public health infrastructure and investment in public-private partnerships in order to improve access to health services.
   o Improvement of service demand through community referral and transport schemes as well as financial subsidies.
   o Use of Village Health Teams and community mobilisation programs to improve mothers’ knowledge and care-seeking behaviours.
The problem

Target 5.A of the MDGs 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 almost 50% by 2008. (24) 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) 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)

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.

The primary involvement of a skilled attendant from the onset of labour up to 48 hours after delivery is needed to prevent, appropriately manage and/or refer the major causes of maternal mortality.

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. (35) Several determinants influence service delivery use from the mothers’ perspective including sociocultural factors, perceived need for care, economic and physical accessibility. (37-41)
Overall, mothers value high quality of care relative to other factors such as cost and distance. (42)

Policy options

The three policy options presented in this section could be adopted independently or complementary to the other to increase access to skilled birth care. The Ministry of Health is deliberating operationalising Health Centres II for deliveries and requested for evidence support these decisions. Maternal waiting shelters and working with the private-for-profit sector to facilitate deliveries in health facilities are promising complementary interventions that have been initiated in both the public and private health sector.

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. Only 42.1% of women deliver in health facilities. (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). (50) 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.(57) 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. Challenges of using these facilities include: costs of stay, lack of privacy and lack of respect from health workers.

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 determine 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 1. Implementation considerations

<table>
<thead>
<tr>
<th>Barriers to implementation</th>
<th>Strategies for implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge and care seeking behavior of expectant mothers</td>
<td>Village Health Teams&lt;br&gt;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. (83)</td>
</tr>
<tr>
<td>Socio-cultural factors and negative perceptions are factors associated with low utilization of health based interventions by mothers. (23, 80) 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)</td>
<td>Community Mobilisation programs&lt;br&gt;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)</td>
</tr>
<tr>
<td>Social and economic constraints of expectant mothers</td>
<td>Maternity waiting homes&lt;br&gt;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. (75)</td>
</tr>
<tr>
<td>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</td>
<td>Community referral and transport schemes&lt;br&gt;Schemes that are used vary widely and may include paying for travel</td>
</tr>
<tr>
<td>Knowledge, Competency and Attitudes of Health Workers</td>
<td>Educational meetings and training</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Lack of supervision of health workers in charge of maternal waiting homes and staff attitudes during ANC and delivery are among the key determinants of using waiting shelters.</td>
<td>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.</td>
</tr>
</tbody>
</table>

**Inadequate financial resources**

Inadequate investment for basic infrastructure of public facilities, medicines, equipment and supplies has impacted negatively on service quality. Private expenditure on health is as high as 81% of the total health expenditure. The National health insurance scheme is yet to be effected.

**Financial Strategies**

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.

There is need for increased public investment in staff, supplies and infrastructure.

**Inadequate human resources**

The availability, access and quality of health services are affected by insufficient numbers of trained staff and uneven distribution of available skilled personnel.

**Optimising health worker roles**

Optimization of health worker roles could improve the delivery of maternal and child health care.

**Inadequate facilities**

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 that provide delivery services. Long distances and poor drug availability are among the most significant factors affecting access to health care.

**Strengthening Health Infrastructure**

Strengthening the public and private health infrastructure to provide a continuum of care to mothers and new born babies. There is moderate evidence on securing limited space or restructuring existing public and private health facilities to accommodate Maternity Waiting facilities for EmOC.

**Public-Private healthcare partnership**

Partnership between public and private-for-profit sectors in delivery of health care to achieve public goals is limited.

**Strengthening Public-Private collaboration**

The private-for-profit 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. Effective public private partnerships can increase access, improve equity and raise quality of service.
Authors
Harriet Nabudere, MD, MPH
Delius Asiimwe, BA, MA
Jacinto Amandua, MD, MMED, MScO
On behalf of the REACH Uganda Skilled Birth Attendance Working Group

Regional East African Community Health (REACH) Policy Initiative, Uganda and
Supporting the Use of Research Evidence (SURE) for policy in African Health Systems Project, College of Health Sciences, Makerere University, Kampala, Uganda

OCommissioner for Clinical Services, Ministry of Health Headquarters, Kampala, Uganda

§Members of the working group in addition to the named authors include: Dr Jacinto Amandua, Dr Dan Kaye, Dr Jackson Amone, Prof Nelson Sewankambo and Dr Rhona Mijumbi

Address for correspondence
Dr Harriet Nabudere
SURE Project Coordinator
College of Health Sciences, Makerere University
P.O. Box 7072, Kampala
Kampala, Uganda
Email: hnabudere@gmail.com

SURE – Supporting the Use of Research Evidence (SURE) for Policy in African Health Systems – is a collaborative project that builds on and supports the Evidence-Informed Policy Network (EVIPNet) in Africa and the Regional East African Community Health (REACH) Policy Initiative. SURE is funded by the European Commission’s 7th Framework Programme. www.evipnet.org/sure

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

The Evidence-Informed Policy Network (EVIPNet) promotes the use of health research in policymaking. Focusing on low and middle-income countries, EVIPNet promotes partnerships at the country level between policymakers, researchers and civil society in order to facilitate policy development and implementation through the use of the best scientific evidence available. www.evipnet.org