Policy Brief

http://speed.musph.ac.ug December 2018

Emergency Obstetric Care In Uganda: Time for a paradigm shift

Authors: *Elizeus Rutebemberwa[1], Suzanne N. Kiwanuka[1], Elizabeth Ekirapa-Kiracho[1], Freddie Ssengooba[1]*

1. Makerere University School of Public Health, Department of Health Policy, Planning and Management

For more details contact:

Elizeus Rutebemberwa, ***Email:*** *ellie@musph.ac.ug*

Website: *www.speed.musph.ac.ug*

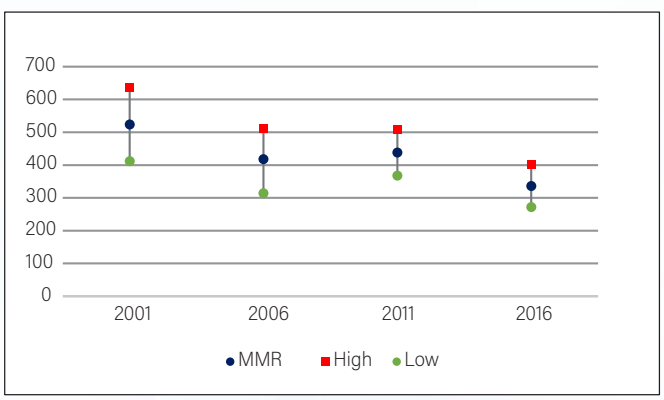
Key messages:

- ✓ *1. Focusing on facilities alone to assess EmOC policy implementation is narrow. A wider lens needs to be used to generate possible implementation hurdles upstream and at community level.*
- ✓ *2. Central government level is fundamental to the EmOC policy implementation in assessing training and distribution of human resources, provision of funding and availability of guidelines.*
- ✓ *3. Districts need to offer effective coordination to both the public and private sector leveraging on each sectors' contribution to EmOC services especially with a heavy presence of the private sector in EmOC activities.*
- ✓ *4. Communities need to be engaged to generate effective demand through using IEC materials, increasing male involvement and building on the contribution of the community health workers.*

The Problem

Emergency obstetric care (EmOC) is an intervention aimed at reducing the high maternal mortality ratio (MMR) in Uganda currently at 336 (CI: 272 – 401)[1] . MMR in Uganda has not changed significantly over the last 20 years as seen in Fig 1 below.

Fig 1: Maternal mortality ratio in UDHS of 2000/01, 2006, 2011 and 2016



Analysis of the problem

EmOC implementation is assessed at facility level. Facilities offering basic EmOC administer parental antibiotics, uterotonic drugs like oxytocin and parenteral anticonvulsants, manually remove the placenta or retained products, perform assisted vaginal delivery and deliver basic neonatal resuscitation. To offer comprehensive EmOC, a facility needs to perform caesarean section and blood transfusion[2]. Availability of doctors and midwifes is essential but not reflected as part of the EmOC package. An assessment done in 2004 found gaps at facility level in delivery of EmOC[3]. HC IVs were designed to spearhead EmOC. An assessment of financial years 2005/06 – 2015/16 indicated a rise in functionality of HC IVs when central government increased drastically the remuneration of doctors working at HC IV during the 2012/13 financial year.

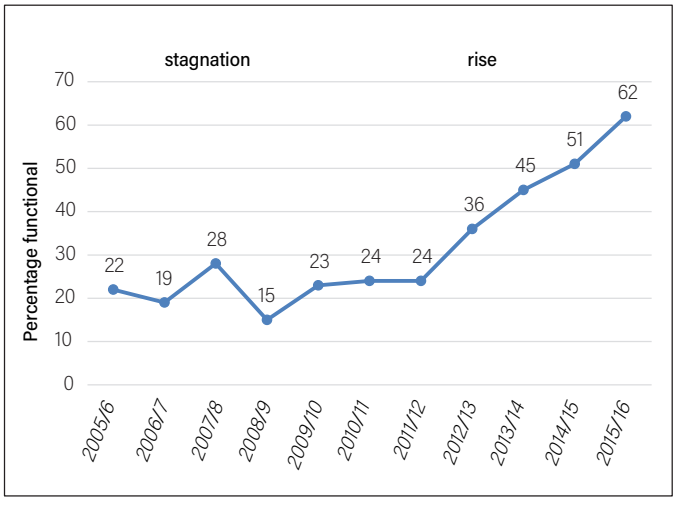
1 Uganda Bureau of Statistics (UBOS) and ICF: Uganda Demographic and Health Survey (UDHS) 2016: Key Indicators Report. In. Edited by ICF UA. Kampala, Uganda: UBOS, and Rockville, Maryland, USA; 2017

2 Organization WH: Monitoring emergency obstetric care: a handbook. Geneva: WHO press; 2009.

3 Orinda V, Kakande H, Kabarangira J, Nanda G, Mbonye AK: A sector-wide approach to emergency obstetric care in Uganda. International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics 2005, 91(3):285-291; discussion 283-284.

"This publication was produced with the financial support of the European Union. Its contents are the sole responsibility of the authors and do not necessarily reflect the views of the European Union."

Fig 2: The functionality of HC IVs from 2005/06 – 2015/16 financial years [4]



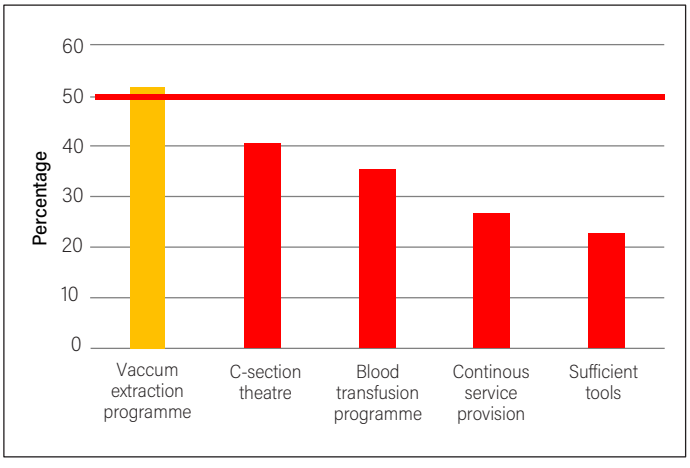
Methods

The SPEED project conducted a survey among central government officials, district officers and health facilities (health centres and hospitals) and assessed how the EmOC policy is being implemented. A six level likert scale was used to assess perceptions of the respondents on how the EmOC policy had been implemented. Respondents would indicate: Don't Know, Strongly Disagree, Disagree, Moderate, Agree and Strongly Agree. During analysis, those who responded with "Did not know", or "Disagree" or "Strongly Disagree" were combined. Those who chose "Moderate" were categorised separately and those who "agreed" or "strongly agreed" with the propositions in the survey questions were also combined and formed the third category. Details of the methodology can be accessed in the published protocol[5].

Results

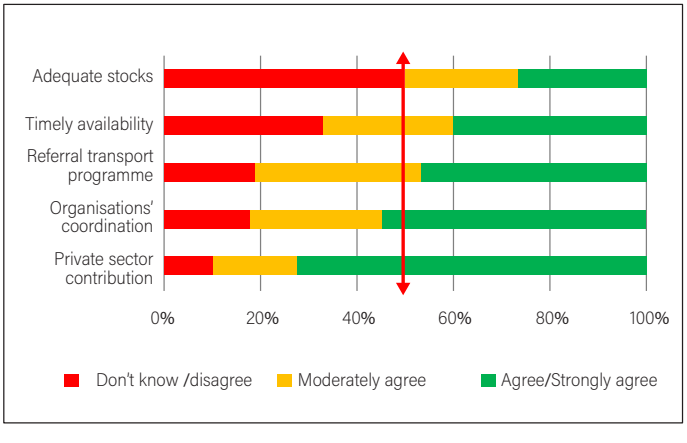
At facility level, only vacuum extraction was identified as adequately practiced. Participants indicated that other functions were less than 50% supported and at least one in every five highlighted the challenge of insufficient tools - **See Figure 3.**

Fig 3: Perception of facility level implementation



At district / coordination level, apart from the acknowledgement of the private sector contribution and organization's coordination, most respondents indicated that the referral transport was not well implemented, stocks of medicines were not adequate and timely availability of the supplies was a problem. This is shown in **Figure 4** below.

Figure 4: Perception of district coordination

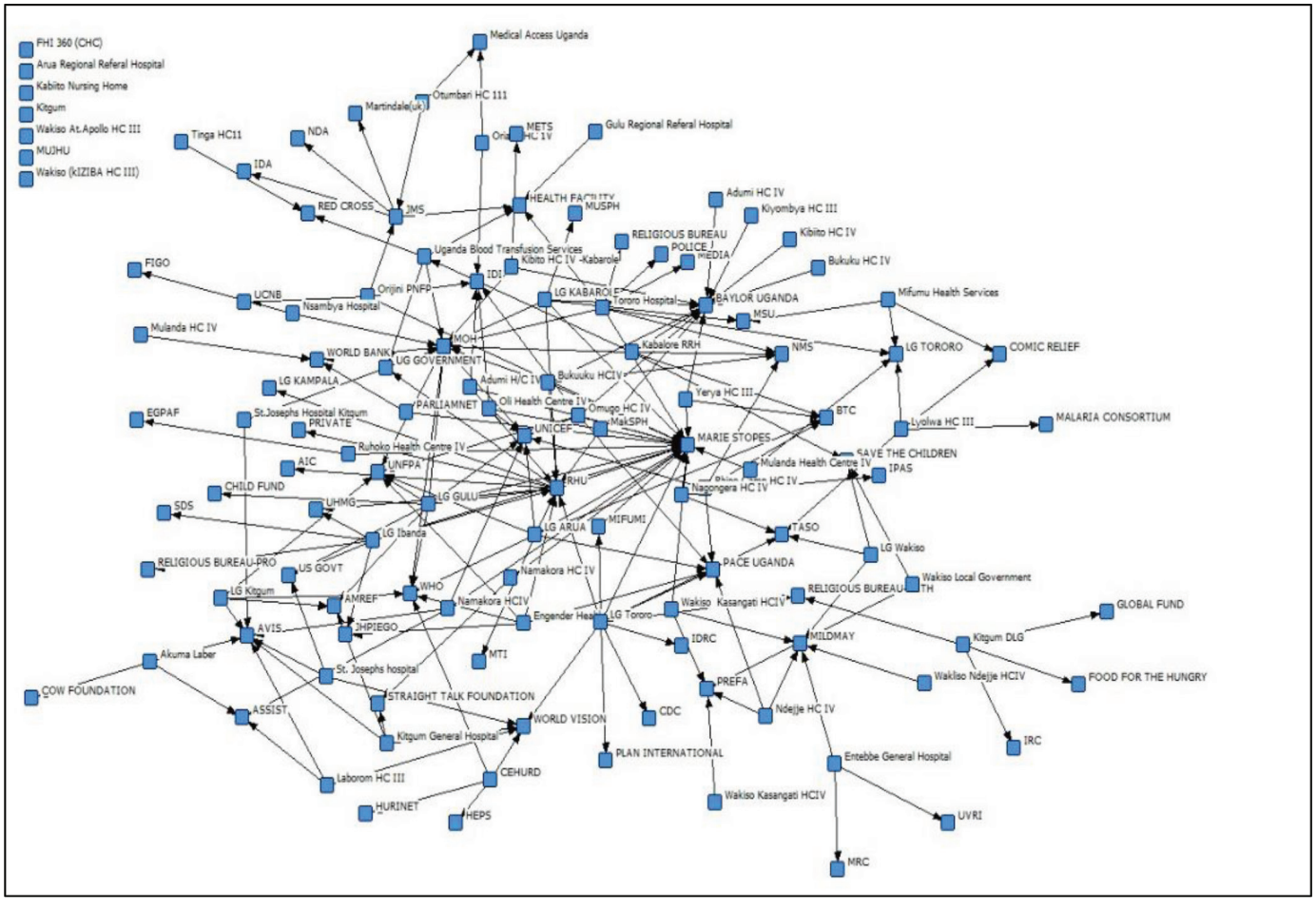


Our network analysis revealed a pre-dominance of Ministry of Health, Local Government and private sector players such as Reproductive Health Uganda, Marie Stopes, Baylor, UNICEF and Mildmay in the implementation of EmOC – **Figure 5**.

4 Rutebemberwa E and C. Hongoro 2018: How is physical infrastructure in Uganda supporting Universal Health Coverage? Universal Health Coverage in Uganda edited by Freddie Ssengooba et al., Makerere University, Kampala, pp. 236.

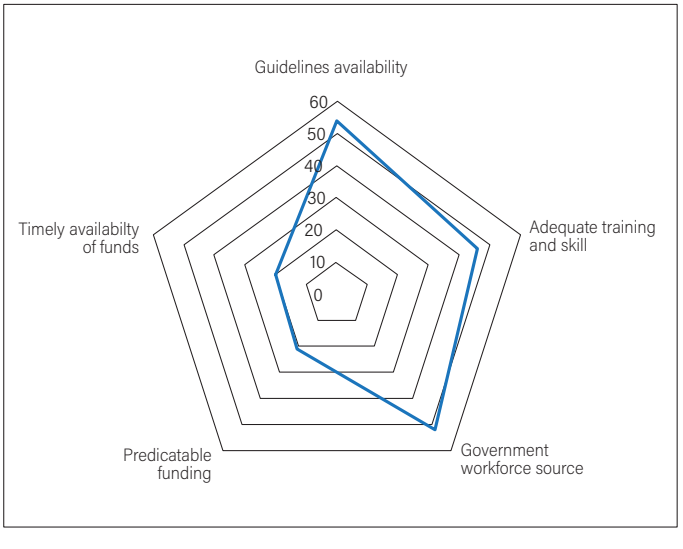
5 Hongoro C, Rutebemberwa E, Twalo T, Mwendera C, Douglas M, Mukuru M, Kasasa S, Ssengooba F: Analysis of selected policies towards universal health coverage in Uganda: the policy implementation barometer protocol. Archives of public health = Archives belges de sante publique 2018, 76:12.

Figure 5: National network analysis of institutions working in EmOC



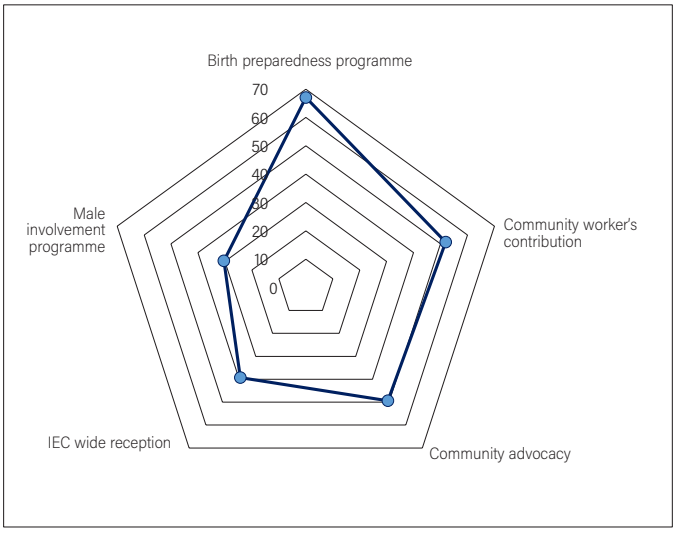
Assessing central level function produced a mixed picture. Whereas most participants agreed that the guidelines were available and that the health workers were mostly from government and had adequate training and skills, it was also indicated that funding was unpredictable and untimely. **See figure 6** below.

Figure 6: Perceptions of central government support to the EmOC implementation



Community level implementation to generate adequate demand yielded a mixed picture. There was low IEC reception and low male involvement while community advocacy and the community health workers were seen as active. This is shown in **Figure 7** below.

Figure 7: Perceptions on community aspects supporting EmOC



Concluding remarks

Assessing challenges facing the implementation of the EmOC policy highlights the importance of using a wide lens. Whereas the policy guidelines may be perceived to be clear, the system inputs in terms of human resources, logistical supplies and finances remain inadequate to support good quality and coverage of EmOC services. Districts need to explore strategies to make private capabilities more visible and affordable. Communities need to be mobilized for effective demand and male involvement needs to be central to this strategy. EmOC demands upstream and downstream activities. It is time to shift the implementation assessment paradigm to focus on both central as well as facility level activities.

SPEED Brief

The Supporting Policy Engagement for Evidence-based Decisions (SPEED) for Universal Health Coverage in Uganda is a 5 year partnership supported by European Union that started in 2015. The partnership comprises Makerere University School of Public Health (Lead Agency), Uganda National Health Consumers' Organization (UNHCO), Economic Policy Research Centre (EPRC), National Planning Authority (NPA), Institute of Tropical Medicine (ITM) Antwerp Belgium and Human Science Research Council (HSRC), South Africa.

For details about SPEED

Makerere University School of Public Health, College of Health Sciences
Level 3, School of Public Health Building, Mulago Hospital Complex
Office: *Room 323, MakSPH Building* ***Website:*** *speed.musph.ac.ug* ***Email:*** *speed4uhc@musph.ac.ug*
Tel: +256 772-509316 *@SPEED4UHC* *@SPEED4UHC*