THE REPUBLIC OF UGANDA

unicef

SAFEGUARDING CHILD AND MATERNAL HEALTH

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BMAU/UNICEF POLICY BRIEF NO. 2/15

INTRODUCTION

The under-five mortality rate has fallen from 169.5 per 1,000 live births to 54.6 in the past two decades. Progress notwithstanding, Uganda is unlikely to meet the Millennium Development Goal (MDG) target of 30 per 1,000 live births by the end of 2015. Furthermore, the neonatal mortality rate has decreased at a slow rate, from 38 deaths per 1,000 live births to 22.1 in the past two decades (United Nations Interagency Group on Child Mortality Rates). Antenatal care (ANC) visits in Uganda remain low: only 48% complete the World Health Organization (WHO) recommended minimum of four antenatal visits (2011 Uganda Demographic and Health Survey), which is far below the national target of 75% by the end of 2015. This is a surprising statistic, considering that approximately 95% of pregnant women attend the first ANC visit. Notably, only 21% of women make their first ANC visit before the fourth month of pregnancy, which leaves insufficient time for four ANC visits. Finally, approximately 58% of births are attended by a skilled health service provider, far lower than the Government target of 70% (2011 Uganda Demographic and Health Survey).

Through the careful scrutiny of maternal health indicators vs. primary health care (PHC) allocations, in spite of receiving the highest PHC release per capita nationwide, performance in the Karamoja sub-region remains below par on a number of indicators including deliveries in Government and private not for profit (PNFP) facilities, and the proportion of women attending four ANC visits. The remainder of this brief focuses on a case study of the Karamoja sub-region to provide a deeper understanding of the factors affecting child and maternal health in Uganda.

CASE STUDY: KARAMOJA SUB-REGION (FY 2013/14)

The Karamoja sub-region receives the highest Primary Health Care (PHC) release per-capita, yet it has the lowest percentage of women delivering in Government or PNFP facilities, and a low rate of women attending 4 ANC visits (Figures 1 and 2). Within the Karamoja sub-region the proportion of deliveries in Government or PNFP facilities and the proportion of women attending four ANC visits vary significantly as do budgetary allocations. In per capita terms, when compared to Nakipiripirit, Napak receives nearly twice the amount of PHC allocations, yet it records a similar rate of supervised deliveries (Figure 3) and a slightly lower rate of women attending 4 ANC visits (Figure 4).

Figure 1: Deliveries in Government or PNFP facilities vs. PHC release per capita

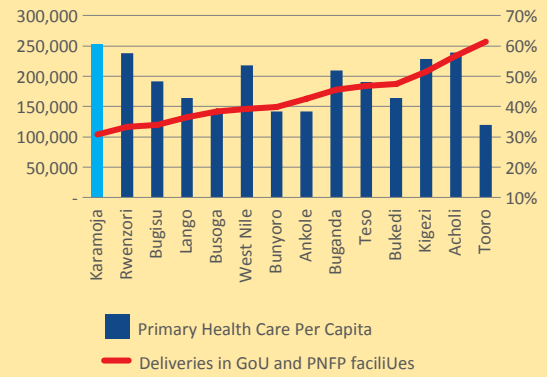


Figure 2: % women attending 4 ANC visits vs. PHC release per capita

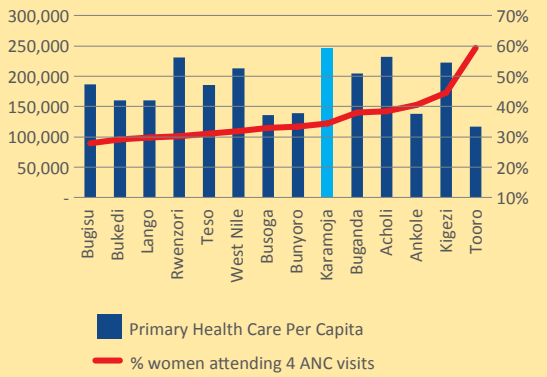


Figure 3: Deliveries in Government or PNFP facilities vs. PHC release per capita

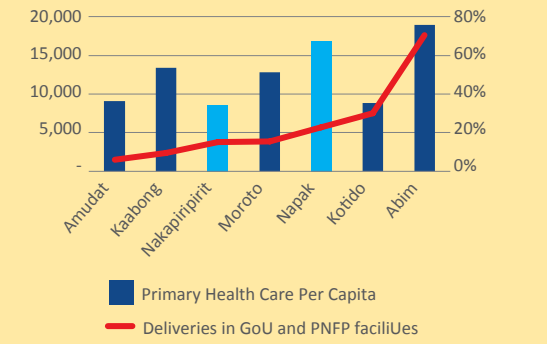
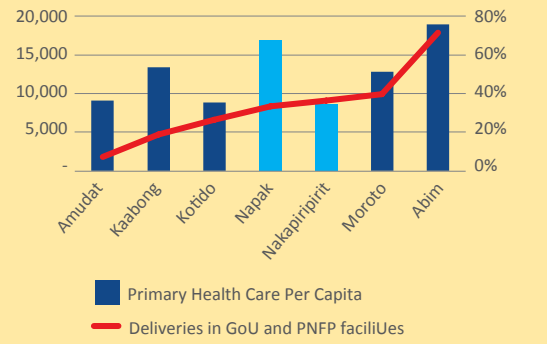


Figure 4: % women attending 4 ANC visits vs. PHC release per capita



These trends and the poor relationship between financial resources and district level performance raise some pertinent questions regarding the efficiency of spending across the sub-region. A closer look at inputs vis-à-vis budget allocations reveals chronically low rates of medicine orders submitted on time (Figures 5). The data also points to wide variations between the number of approved posts filled in Nakapiripirit vs. Napak (Figure 6). Interestingly, in terms of this indicator Napak (73%) visibly outperforms Nakapiripirit (51%) casting further doubt on the efficiency of spending.

Figure 5: % medicine orders submitted on time

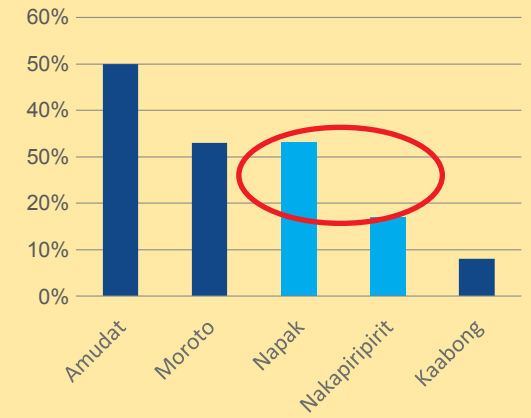


Figure 6: % approved posts filled

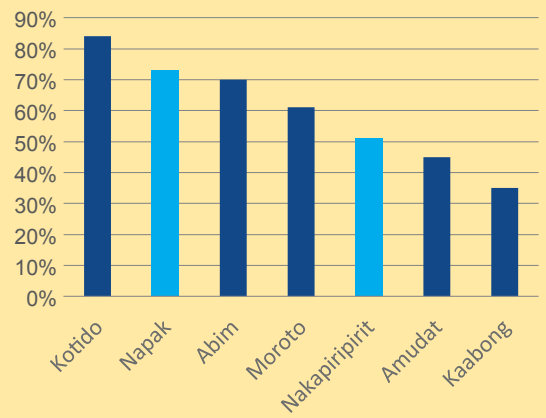


Figure 7: PHC development release per capita

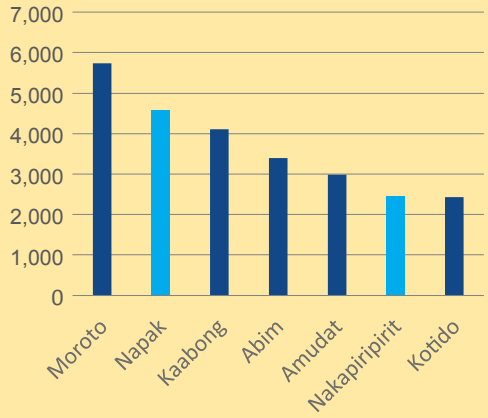
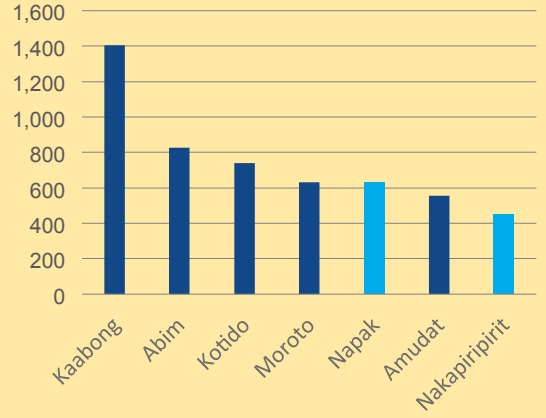


Figure 8: PHC non-wage per capita



Figures 7-8 show that the PHC development release per capita and the PHC non-wage per capita are also consistently higher in Napak. This is probably due to the fact that Napak is a recently created district requiring greater start-up investments as illustrated by the fact that in Napak health service provision remains very basic. To illustrate, the district is yet to benefit from the construction of a HC-IV, suggesting that the pace of human capital accumulation in Napak may not be matched by developments in basic infrastructure for service delivery especially in hard to reach areas.

EVIDENCE FROM THE FIELD

Field work consisted of Focus Group Discussions (FGDs) with mothers and pregnant women in health facilities in Napak and Nakapiripirit, as well as larger FGDs with communities neighbouring the selected health facilities, and in-depth interviews with District Health Officers (DHOs) and Facilities Managers. Discussants identified medicine stock-outs and understaffing in critical areas like midwifery as key hurdles to the effective delivery of basic services affecting children. Long distances to health facilities, cultural norms and gender dynamics were also cited as significant bottlenecks.

The availability of medicines is a key factor in attracting pregnant mothers to deliver at a health facility. Notably, all facilities monitored experienced stock-outs of essential medicines, such as antibiotics. At the time of the monitoring visit, many of these health facilities had been out of stock of antibiotics for several weeks. Respondents unanimously attributed high frequencies of drug stock-out to the "push-system" (Box 1) imposed by the National Medical

BOX 1: The "push system"

In 2010 the MoH and the National Medical Stores (NMS) reintroduced the kit supply system (push-system) for HC-II and HC-III, because supply chain management was weak at the lower-level health facilities. An *Assessment of the Essential Medicines Kit-Based Supply System in Uganda* (Ministry of Health, 2011) revealed that availability of drugs improved significantly after the supply system shift. The monitoring visit, however, showed that several essential medicines were in undersupply at the lower-level health facilities, while other less routine drugs were in oversupply with the risk of expiry. Facilities managers and DHOs attributed this to the kit supply system. On the basis that at the beginning of each financial year, District Health Officers (DHOs) and health facilities managers develop a one-year medicine supply schedule in consultation with the National Medical Store (NMS), stock-outs are the likely consequence of inadequate projections and planning.

Store (NMS) on HC-II and HC-III. This system appears to consistently result in the overstock of low-demand drugs, and concurrent understocking of crucial and critical medicines, such as antibiotics.

Health facilities managers in both Napak and Nakapiripirit highlighted the problem of under-staffing in critical areas like midwifery. According to District Health Officers from both districts, a key factor explaining low staffing levels is the fact that many midwives had returned to school for further training. While this "upgrading" of midwives is unequivocally regarded as a positive development, it creates a critical staffing gap further resulting in significant reductions in the absolute number of mothers choosing to deliver in health facilities as was the case in Nakapiripirit between 2013 and 2014.

Box 2: The "opt-out" option

In order to increase coverage of Preventing Mother-to-Child Transmission (PMTCT), in 2006 the Ugandan Government launched new policy guidelines replacing voluntary counselling and testing (VCT) to a provider-initiated opt-out HIV testing model. Focus Group Discussions in the Karamoja sub-region revealed that while the testing model *in theory* centers around the opt-out option, *in practice* women are often turned away for their first ANC visit if they are not accompanied by their husbands.

In terms of **long distances** to the nearest health facility, most respondents noted that incentives, such as transport vouchers and MAMA Kits, have a large and positive impact on health-seeking behaviours – findings further corroborated by U-reporters[1]. Transport vouchers provided to boda-boda drivers have eased access to health facilities, but are not entirely adequate as transportation back home is not provided after delivery. MAMA Kits (Safe Delivery Kits) are provided free to all mothers who deliver in Government Health Facilities and are procured, stored and distributed by the NMS on behalf of Government. The kit includes 500 grams of cotton wool, baby soap, two razor blades, two polythene sheets, two gauze pieces, three surgical gloves, and an immunization card.

Finally, many women noted that as a result of deeply rooted **gender dynamics** it was sometimes difficult for them to get their husbands to accompany them for ANC visits. This often leads to a delay in starting ANC visits, as the women are often turned away if they don't attend their first ANC visit with their husband (see Box 2). **Cultural norms** in certain communities also lead to a delay in women attending the first ANC visit, as it is not considered appropriate to disclose their pregnancy status before the fourth or fifth month or pregnancy.

1 U-report is a free SMS-based system that allows young Ugandans to speak out on what's happening in communities across the country, and work together with other community leaders for positive change (www.ureport.ug).

POLICY RECOMMENDATIONS

i. Ensure timely delivery of essential medicines

a) DHOs to review their planning and quantification processes vis-à-vis more accurate patient load projections for HC-II and HC-III. NMS to revisit the essential medicines kit-based supply system for HC-II and HC-III, whilst ensuring timely provision of essential medicines in response to "refill" requests.

ii. Guarantee adequate staffing in critical areas like midwifery

a) Local Government to prioritize midwives recruitment, and develop temporary programmes such as internship schemes to fill existing staffing gaps.

iii. Ensure equitable distribution of human resources and equipment at district level

a) Local governments to review annual plans for a more equitable provision of human resources and equipment supply.

iv. Offer tangible and equitable incentive schemes for pregnant women to attend 4 ANC visits and deliver in health facilities by building child-sensitive social protection interventions in the health sector strategic plan

a) MoH to enforce the opt-out option and ensure that women attending the first ANC visit without their husbands are not turned away.

b) NMS to scale up the supply of MAMA Kits at health facilities.

FOR ADDITIONAL INFORMATION:
Margaret Kakande, Head / BMAU, Ministry of Finance, Planning and Economic Development
Margaret.Kakande@finance.go.ug
Diego Angemi, Chief / Social Policy and Advocacy, UNICEF, Uganda
dangemi@unicef.org