Maternal and newborn health in Karamoja:
What can be done?

Policy Brief: UNICEF & MoH, Uganda

Call to Action

Adopt a tiered and mixed approach to inpatient newborn care – from HBB+ at all facilities to highly specialised care (quaternary).

Reinforce existing quality improvement systems.

Specialise training and recruit to bridge the human resource gaps and skills mix.

Bridge clinical and community care.

Improve demand creation using a robust and integrated community system.

Strengthen documentation and shared learning. **A lot can be learnt from Ethiopia's CBNC strategy.**

Introduction

Uganda has registered mixed success in maternal, newborn and child health (MNCH) for the last three decades. While significant improvements have been noted in child health, few have been realized in maternal health and neonatal mortality rate (NMR) has remained stagnant at 27 deaths for every 1,000 live births. Regional disparities in MNCH have been noted, with several challenges experienced in contexts like the nomadic Karamoja region. An equity analysis of the maternal and neonatal deaths further points to higher mortality rates among the country's poorest and rural populations. This policy brief arises out of a situation analysis on maternal and newborn health in Karamoja.

Background

Uganda is one of the countries still faced with high maternal and neonatal mortality and morbidity rates. The current maternal mortality ratio (MMR) and NMR are 368 deaths/100,000 Live births and 27 deaths per/10000 births respectively. Although there has been a slow decline in maternal mortality over time, the NMR has remained stagnant despite increased facility deliveries. Low postnatal care utilization has been noted and the majority of the maternal and newborn deaths are largely a result of preventable causes.

UNICEF, in close collaboration with Ministry of Health (MoH) and District Local Governments with CUAMM and AVSI as the main implementing partners on ground, has been implementing a maternal and newborn health (MNH) programme in the Karamoja region. The MNH programme aims at increasing access of mothers and newborns to an integrated package of quality health and nutrition services provided along the continuum of care from community to facility.

The Study

Makerere University's Centre of Excellence for Maternal, Newborn and Child Health conducted a situation analysis on the state of MNH in Karamoja region. This mixed-methods cross sectional study, used both quantitative and qualitative approaches with facility assessments, analysis of in-patient care

and community survey in all districts of Karamoja. A total of 574 respondents were interviewed.

The Key Findings

- Multiple partners and (multi-sectoral) interventions in the region (such as vouchers and food distributions) have improved service delivery and care seeking among expectant/mothers. However this is not the same for newborns – fewer newborns than mothers are seeking care at health facilities.
- Maternal health: There is positive demand for services but this is limited mainly to ANC and delivery care. Of interest, almost 70% of the women attend ANC four times which is higher than the national average. Food distribution is an active incentive for ANC compliance. The ANC content is generally good and 64% of the women delivered in a health facility. However most women use natural remedies before visiting health facilities. Also there's low use of fansidar to prevent malaria in pregnancy (40%) and tetanus toxoid (37%). The pathway to care for most women includes preference for natural remedies before visiting health facilities postnatal care attendance is also very low.
- Newborn health: Health facilities have limited capacity for in patient care for newborn and the young infant. Illness recognition is poor and care seeking delayed. Despite 94% newborns receiving care outside the home, only a half do so within one day. Like in maternal health, neonatal care involves a fusion of medico-herbal practices. However some positive newborn care practices were noted to exist in Karamoja.
- In patient care for newborns and sick young infants is inadequate. Almost all facilities mix sick newborns/young infants with the older child during admission care. Most facilities lack essential staff, skills, infrastructure, commodities and protocols for newborn care. The referral system for sick newborn babies is also non-existent or is weak.
- Human resources capacity particularly numbers (currently at 50% staffing levels), specialized skills and tools for newborn care remain a great challenge – at both facility and community level.

What does the Evidence say?

- Maternal and newborn survival remains a significant challenge for LMIC, with most dying from preventable causes.
- Skills for handling newborns and very sick infants are unique and improved with continuous practice in the newborn domain. Significant investment is necessary for targeted maternal and newborn survival.
- Distinctions and categories of newborns have to be made for quicker danger identification and related action. However this classification model remains problematic globally and requires further contextual specificity in LMIC.
- Significant gains are registered when the unique geopolitical and sociocultural dynamics of any setting are considered. For example some countries have successfully implemented a community-focused and based model.

The Solution

Based on our findings, we recommend as follows:

1. Adopt a phased approach to strengthen inpatient newborn care in Karamoja. Start with all health facilities providing basic essential newborn care as per the national Helping Babies Breathe Plus (HBB+). In addition, higher level facilities should have neonatal care units able to effectively manage referred and very sick newborn babies. Separate and manage newborns in exclusive rooms or newborn care corners, not mixing them with other sick children as is currently the case in most health facilities. The same principle should be applied to babies managed in KMC care.

2. Recruit additional staff to bridge staffing gaps in the region. Include at least two paediatricians to bridge the skills mix. In addition, staff management must be strengthened to reduce absenteeism, but also to ensure that at all times newborn units have well trained health providers.
3. Strengthen the existing Quality Improvement (QI) and Maternal and Perinatal Death Surveillance Reviews (MPDR) systems in the region. The districts should consider introducing QI Learning Sessions where facilities QI teams come together on a quarterly basis to promote facility to facility learning. Document these QI activities to promote learning in Karamoja and beyond.
4. Strengthen the diagnostic and newborn care capacity in the region by procuring and installing key equipment (including some advanced newborn care equipment for hospitals) in all health facilities providing newborn care. This must be coupled with the necessary training and a system for equipment maintenance in the region.
5. Improve the leadership and management capacity of and within health facilities) through training and strengthened support supervision. Also, support health facilities to establish functional health unit management teams.
6. Strengthen the regional referral and follow up system from home to health facilities; also between health facilities and hospitals. This should include improving the motorised referral system and also improving referral practices. This should include establishing referral and follow up protocols specific to newborn care.
7. Improve demand creation through a strengthened and supported VHT system. These should promote early and complete ANC attendance; illness recognition and early care seeking in case of maternal or neonatal danger signs. These improvements need to be done within the context of general improvement of the welfare of women including their ability to make decisions on care seeking.
8. Strengthen documentation through monitoring and evaluation to promote learning. This should include ensuring all sick newborn care is well documented in newborn registers. The MoH could consider adopting some registers that have been piloted in various projects in East Central Uganda and in the Saving Mothers Giving Life (SMGL) project. Embedding implementation research within the scale up efforts could provide regional and national level learning of what works and what does not to improve inpatient care.

Long Term/Policy Recommendations

1. In the long run, the country should start plans for training and rolling out specialised newborn care cadres such as neonatal nurses and neonatologists. Once trained, these should accordingly be deployed in hospitals and health centres where newborn sick babies are managed.
2. Develop and adapt a national level advanced newborn care training curriculum to complement the existing HBB plus modules. The MoH could consider adopting a training curriculum jointly developed and tested by Makerere University and the Uganda Paediatric Association.
3. Address the wide spread practice of rotation of nurses and midwifes in health facilities and hospitals as it affects patient care. Future health systems should promote specialisation for some areas of health care such as newborn care.
4.

The Cost of Inaction

The significant investment by multiple stakeholders and resulting gains especially in maternal health in the Karamoja region will be lost. Inaction will result in not only continued avoidable maternal and newborn mortality but also growing inequities.

Some References

- MakSPH (2018) Report on Situation Analysis of newborn care in Karamoja region, Uganda
- IDEAS (2017) Community based newborn care (CBNC) in Ethiopia
- Stark AR (2004) Levels of neonatal care

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