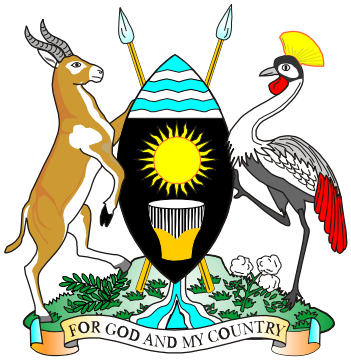

THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

NATIONAL EMERGENCY MEDICAL SERVICES POLICY

September 2021

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List of Abbreviations

A&E	Accident & Emergency
AFEM	African Federation for Emergency Medicine
CHEW	Community Health Extension Workers
CPD	Continuous Professional Development
CSO	Civil Society Organization
ED	Emergency Department
EFR	Emergency First Responder
EMS	Emergency Medical Services
EMAS	Emergency Medical and Ambulance Services
EMT	Emergency Medical Technician
HC	Health Centre
HSD	Health Sub District
ICT	Information and Communication Technology
IP	Implementing Partner
LG	Local Government
MaKCHS	Makerere University College of Health Sciences
MDAs	Ministries Departments and Agencies
MoH	Ministry of Health
MOU	Memorandum of Understanding
NCD	Non Communicable Diseases
NDP	National Development Plan
NECOC	National Emergency Coordination and Operation Centre
NGO	Non-Governmental Organization
NPA	National Planning Authority
NRH	National Referral Hospital
OHEC	Out of Hospital Emergency Care
OP	Operational Partner
OPM	Office of the Prime Minister
PHP	Private Health Provider
PNFP	Private Not for Profit
PWD	Persons with Disability
RMNCAH	Reproductive Maternal Neonatal Child Adolescent Health
RRH	Regional Referral Hospital
SDGs	Sustainable Development Goals
UHI	Uganda Heart Institute
UPDF	Uganda People`s Defense Forces
UPF	Uganda Police Forces
URCS	Uganda Red Cross Society
SWAP	Sector-Wide Approach

Definition of key words

Emergency: The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part (Prehospital Systems and Medical Oversight, 3rd edition).

Emergency Care: An integrated platform for delivering accessible, quality, time-sensitive health care services for acute illness and injury across the life course (2019, WHA 72 resolution 72.16).

Emergency Medical Services (EMS): The ability to deliver health services for conditions that require rapid interventions to avert death or disability, and for which delays of hours can worsen prognosis or render care less effective. (Reynolds and others 2017).

"EMS" at operational level means any of the following

(i) The medical care including medical assessment, monitoring, treatment, transportation and observation which may be provided to a person in responding to an actual or reported emergency to prevent or protect against loss of life or deterioration in physiological or psychological condition; or to address pain or morbidity associated with the person's condition.

(ii) The transportation of an individual with medical assessment, monitoring, treatment or observation during the transport and at Emergency Units in Health facilities.

EMS System: The arrangement of personnel, facilities and equipment for the effective and coordinated delivery of EMS required in the prevention and management of incidents which occur either as a result of a medical emergency or of an accident, natural disaster or similar situation. EMS systems refer to the broad range of emergency care from the pre-hospital first responder to the intensive care unit setting (Prehospital Systems and Medical Oversight, 3rd edition).

Scope of EMS

(a) Out of Hospital Emergency Care (OHEC) – first responder, pre-hospital care, medical emergency call and dispatch center; major incident and disaster management; mass gathering and event medical coverage.

(b) Hospital based services – triage services, emergency clinical care and observational medicine.

(c) Specialty emergency and trauma services – such as Intensive Care Unit (ICU) and operational theatre.

(d) Ancillary services: Emergency Medical Teams (EMT) and follow up clinics
(e) Psychiatric and occupational services.

EMS Agency: Is an entity that engages in the service or business of providing emergency medical services to patients by operating any of the following vehicles: advanced life support ambulance, basic life support ambulance, or quick response service.

Emergency Unit: Is a treatment area within a health facility/hospital, specializing in acute care of patients who present without prior appointment, either by their own means or by ambulance.

Pre-hospital Care: Is medical management which occurs before the hospital, usually delivered by ambulance services professionals and/ or fire Department.

Out-of-Hospital emergency care (OHEC) is an umbrella term which refers to emergency medical management that occurs outside of formal health care facilities and includes first responder care, pre-hospital care and emergency medical care in a two-tier structure.

An ambulance is a vehicle licensed under the Uganda Traffic & Road Safety Act and as such, designed or adapted for the treatment and conveyance of patients in an emergency situation, marked as such, appropriately equipped and deployed with a minimum of two emergency care providers in accordance with Ministry of Health set standards (MOH, 2018).

There are various types of Medical Emergency Vehicles (road, water and Air):

(i) **Type A** - Patient Transport Vehicle

(ii) **Type B** - Basic Life Support/ Emergency Ambulance

(iii) **Type C** - Advanced Life Support/ Intensive Care Unit Ambulance

(iv) **Isolation Ambulance (Negative Pressure Ambulance)** - Is defined as an ambulance vehicle designed for transportation of patients with highly infectious diseases or contagious substances to a definitive treatment center. The rise of biological, chemical, radiological and nuclear disasters has increased risks for the first responders attending to patients that may carry contagious ailments.

(v) **Air Ambulance** – is defined as an aeronautical vehicle that is appropriately designed to transport ill patients from the scene or facility by air and licensed under the Civil Aviation Act as such.

(vi) **Boat/Marine Ambulance** – is defined as a water vessel that is appropriately designed to transport critically ill patients from the scene or facility by water and registered by Ministry of Works and Transport for this purpose as such.

(vii) **Medical Rescue Vehicle**: Is defined as a vehicle that is appropriately equipped, designed or adapted solely for the purpose of providing medical rescue licensed under the Uganda Road and Traffic Act 2008, amended 2020 (MOH, 2018).

(viii) **Medical Response Vehicle**: Is defined as a vehicle that is appropriately equipped, designed or adapted solely for the purpose of providing medical response (MoH, 2018).

FOREWORD

The development of this National Emergency Medical Services Policy comes in response to the public outcry over limited response to emergencies right from the scene of an emergency (home, school, work or location) to accident and emergency units in health facilities, non-functional ambulances, and lack of coordination of the various stakeholders. The Health Sector Development plan (HSDP) 2016/17-2020/21, H.E. the President's Strategic Directives to the Health Sector and the NRM Government Manifesto 2016- 2021 spell out the establishment of a functional ambulance and referral system as one of the key deliverables by 2021.

Emergency care is an essential element of Universal Health Coverage. It covers a spectrum of activities, including prehospital care and transport, initial evaluation, diagnosis and resuscitation, and in-hospital care. It demands a multi-disciplinary approach. The interventions provided along this continuum make a difference between life and death. Emergency care providers deal with non-critical to very critically ill patients along a continuum from the community at the roadside, or at mass gatherings and disasters to emergency units in health facilities. They should be knowledgeable and skilled but above all have a humane attitude and resilience.

The UDHS 2016 shows that the health sector performance has greatly improved. Key indicators show an upward trend: life expectancy is 64 years, Maternal Mortality Ratio (MMR) reduced from 438 to 336/100,000, infant mortality rate reduced from 64/1000 to 44/1000 deliveries at health facilities is at 73%, HIV sero-prevalence reduced from 7.2% to 6%, malaria specific mortality rate reduced from 30% to 20% and full immunization coverage at 56% (UDHS 2016). Despite these improvements, the community (users of health services) are still dissatisfied with the quality of services delivered. This is due to the high mortality and morbidity arising from poorly managed emergency conditions.

Addressing the gap in emergency care response and referral services shall contribute significantly to community satisfaction and confidence in the health services in the country.

The Ministry of Health has developed this policy to guide pre-hospital care, emergency communication and dispatch systems, acute critical care in hospitals and health response during disasters and mass gatherings.

This policy creates a framework for the development of the Emergency Medical Services Strategic Plan, Protocols, Guidelines and Standards.

I present this policy to you and urge every stakeholder: Ministries, Departments, Agencies, Local governments, Civil Society Organizations, Faith based Organizations and private ambulance service providers to utilize it as the overarching framework for the delivery and coordination of emergency medical services in the country.

This Policy will lead the way for the expansion, standardization, and fortification of Emergency Medical Services across the country to gradually match international standards.

'For God and My Country'

Hon. Dr. Jane Ruth Aceng Ocero
Minister of Health

ACKNOWLEDGEMENT

To establish a robust and functional emergency care system in the country, there is need to have the National Emergency Medical Services framework i.e. the National EMS Policy, the EMS Strategic plan, EMS Standards, Protocols and Guidelines. A multi-sectoral National Task Force chaired by the Permanent Secretary MOH and co-chaired by the OPM was set-up to fast track the development of the EMS framework in April 2017.

The task force consisted of the Ministry of Health, Office of the Prime Minister, Uganda Peoples Defense Forces, Uganda Police Forces, Ministry of Works and Transport, Uganda Red Cross Society, Private not for Profit Health Providers, St. John Ambulance, Makerere College of Health Sciences, Makerere University School of Public Health, Kampala Capital City Authority, Uganda-UK Health Alliance and the Emergency Care Society of Uganda. These entities were selected based on their role and expertise in emergency care and ambulance service delivery.

I would like to thank everyone who was involved in the development of the EMS Policy. Special appreciation goes to the individual officers and the department of EMS who put in effort to ensure the completion of this task.

We appreciate the stakeholders who were consulted to review the documents, specifically the Government of Uganda Ministries, Departments and Agencies, District Local Governments, Regional Referral Hospitals, National Referral Hospitals, Development Partners, Academia, Professional Associations, Private Ambulance Operators, and Emergency Care Health workers. I further appreciate the Members of the Parliamentary Health Committee for their input and support towards this noble cause.

Special appreciation goes to Malteser International (MI), Germany Funded International NGO who funded the completion of this policy framework. We also recognize other development Partners supporting EMS establishment in Uganda i.e. Korea Foundation for International Health Care (KOFIH), Clinton Health Access Initiative (CHAI), ENABEL, Centers for Disease Control (CDC) and Seed Global Health.

This work would not have been possible without the technical guidance of the African Federation for Emergency Medicine (AFEM), the World Health Organisation (WHO) country office for Uganda and the WHO Headquarters in Geneva.

I am optimistic that with the Emergency Medical Services Policy framework in place, the advocacy and allocation of material and financial resources towards a functional emergency care system in Uganda will be a reality.

Thank you.

Dr Diana Atwine
Permanent Secretary
Ministry of Health

CHAPTER ONE

INTRODUCTION

1.1 Background

Government of Uganda is cognizant of the urgent need to establish a functional and integrated Emergency Medical Services (EMS) system in Uganda. There are currently insufficient investments in EMS from out of hospital emergency care (OHEC) to hospital emergency care. The Health Sector Development Plan (HSDP)[1] as well as the Strategy for Improving Health Service Delivery 2016-2021, emphasize the need to establish ambulance and referral services as key outcomes for the period.

Prioritizing the provision of initial resuscitation, stabilization, and treatment to acutely ill and injured patients, and delivery of those patients to the best available definitive care have been shown to reduce the mortality from a range of medical, surgical, trauma and obstetric conditions.[2]

Emergency care can make an enormous contribution to reducing avoidable death and disability in low- and middle-income countries. Effective emergency care needs to be well planned and supported at all levels and should consider the entire spectrum of care, from the occurrence of a medical emergency in the community to the provision of definitive care at a health facility.

1.2 Situation Analysis

The second National Development Plan 2015/16 – 2019/20, under the theme "Strengthening Uganda's Competitiveness for Sustainable Wealth Creation, Employment and Inclusive Growth" sets Uganda's medium term strategic direction, development priorities and implementation strategies. Emergencies and disasters exert negative economic impact on countries, making it difficult to achieve sustainable wealth creation, employment and inclusive growth as envisaged in the National Development plan. The 2018 Uganda road safety performance review showed that on average, the country loses 10 people per day in road traffic crashes, which is the highest level in East Africa. The overall annual cost of road crashes is currently estimated at approximately UGX 4.4 trillion ($1.2 billion), representing 5% of Uganda's gross domestic product (GDP).[3] Natural disasters result in damages constituting between 2% to 15% of an exposed country's annual Gross Domestic Product (GDP).

Despite the high prevalence of emergencies and their negative health and economic impact, baseline assessment of an enabling environment and the capacity for response, conducted

[1]Health Sector Development Plan 2015/16 – 2019/20
[2]Disease Control Priorities Project

in 32 countries in the Africa Region in 2011 showed that the health sector in the assessed countries lacks relevant policies and capacities necessary for an effective emergency medical response. The Uganda traffic and road safety report 2017 and recent annual Health Sector performance reports have clearly indicated that there is an increase in mortality rates due to the growing number of road traffic injury related emergencies and sets the need for Ministry of Health to plan for Post-crash response as guided by the UN Decade of Action on Road safety. There are no policies in the Ministry of Health or nationally that directly address emergency response at pre-hospital level & referral, ambulance management, human resource and financing for emergency care.

The EMS survey 2018 found that there is no national lead agency to coordinate emergency medical services and that a toll-free number 912 allocated by Uganda Communications Commission has not been functionalized.

Only 16% of districts have a designated office or agency responsible for EMS and only 13% of districts reported a budget allocation specific for EMS in the FY 2016/17.

At community level, the knowledge and capacity to provide first aid is limited. There are few trained first responders in the country and the country lacks a legal framework, such as a Good Samaritan Law, to protect by-standers who offer first aid to victims of road traffic crashes or illness. It was also found that in congested urban areas and hard to reach rural areas formal care was not immediately available.

Regarding ambulance services, the country has a rudimentary unregulated ambulance network that attempts to respond and rescue emergency victims. The current ambulance network consists of many forms of ownership such as government (Ministry of Health, Police & Local Governments), Private not for Profit (PNFP) Health sub-sector, Private health sub-sector, Members of parliament, Charity organizations and private agency ambulance providers that are not coordinated. The catchment areas that these ambulances generally serve are mostly concentrated in the urban areas; with limited coverage in the rural areas, leaving the larger rural populations with limited access to ambulances. There is no governance structure responsible for coordination of pre-hospital/ambulance care services. Additionally, there is no national medical emergency call and dispatch centre responsible for coordination of emergency medical care calls in the country. The existing call centers are focused on security and crime prevention (police) whereas the OPM is focused on disasters which leaves out routine medical emergencies. Access to care is hindered by limited geographical mapping and physical address location infrastructure and capacity.

Of the 441 patient transport vehicles across the country, 173 (39.22%) are GOU-owned. 172 (39.0%) PNFP/ NGO and 96 (21.7%) are privately owned[3]. These are of different standards and operate without ambulance crews. Most importantly, ambulance services are not

[3]MOH National EMS policy, 2018

coordinated and do not meet the minimum standards of operation as ambulances. Majority of these ambulances are patient transport vehicles without ability to support life in case of life threatening conditions. They lack lifesaving medicines and equipment to monitor and treat patients.

At health facility level, all Hospitals and Health Centers (HCs) are not adequately equipped and staffed to deal with patients requiring emergency care. The Uganda Hospital and Health Center IV Census Survey 2014 reports that capacity to offer emergency services at hospitals/ HC IVs is generally poor, with only 5% and 25% of the hospitals/HC IVs classified as having very good and good capacity respectively. The rest of the hospitals/HC IVs were classified as having moderate (38%), poor (35%) and very poor capacity (5%). At Health centre IVs, General Hospitals and Regional referral hospitals there was lack or shortage of medical equipment necessary for assessment of patients presenting with emergency conditions. There are limited numbers of emergency care specialist health workers at the facilities. Patients experience delays in receiving care due to the requirement for pay before receiving care in the private facilities that have fee-for-service arrangements.

The 2018 EMS Survey established that majority of EMS service (64%) is funded by government and the rest by a combination of NGOs, Charity Organizations, Members of Parliament and Private companies. The main EMS service provider was Uganda Police Force. There was a wide range of costs to patients ranging from UGX 30,000 to as high as UGX 3.3 Million for an ambulance transfer. The current pre-hospital service is managed by hospitals and their staff (ambulance crews).

In May 2016, Government of Uganda established the Ambulance Services Department which was later renamed Emergency medical services to provide a framework to enable universal access to emergency medical services in the country. The core mandate of the department is to: initiate the formulation of policies; provide strategic direction, plan and coordinate EMS activities, resource mobilization, and supervise EMS service delivery, provide in-service training, guide pre-service training, monitor and evaluate of emergency care service provision in the country.

1.2.1 WHO Emergency Care System Framework

Effective emergency care ensures access to critical life-saving interventions for emergency presentations of communicable and non-communicable diseases, obstetric conditions and injury[4]. Both out-of-hospital and facility-based emergency care are essential components of the healthcare continuum. The Disease Control Priorities 3 (DCP3)[5] states that pre-hospital care encompasses first responder care provided by the community - from the scene of injury, home, school, or other location - until the patient arrives at a formal health care facility - and

[4]World Health Organization: Injury and violence: the facts online – 2004.Available from: http://www.who.int/violence injury_ prevention/key_facts/VIPkey facts.pdf. [Accessed February 27th, 2018]
[5]Disease Control Priorities, third edition (DCP3): Pre-Hospital and Emergency Care chapter

paramedical care such as paid ambulance personnel or fire or police personnel. The African Federation of Emergency Medicine (AFEM) in 2018, introduced the term Out of Hospital Emergency Care (OHEC) to define emergency medical first responder care, pre-hospital care and interfacility transfer care.

The combination of acuity-based triage, rapid intervention, and a syndrome-based approach to undifferentiated patients, which together comprise effective emergency care practice, greatly reduces the morbidity and mortality associated with a range of medical, surgical, pediatric, and obstetric conditions[6].

The WHO Emergency Care System Framework provides a guide for essential emergency care functions at the scene of injury or illness, during transport, in the to emergency unit and during early inpatient care.

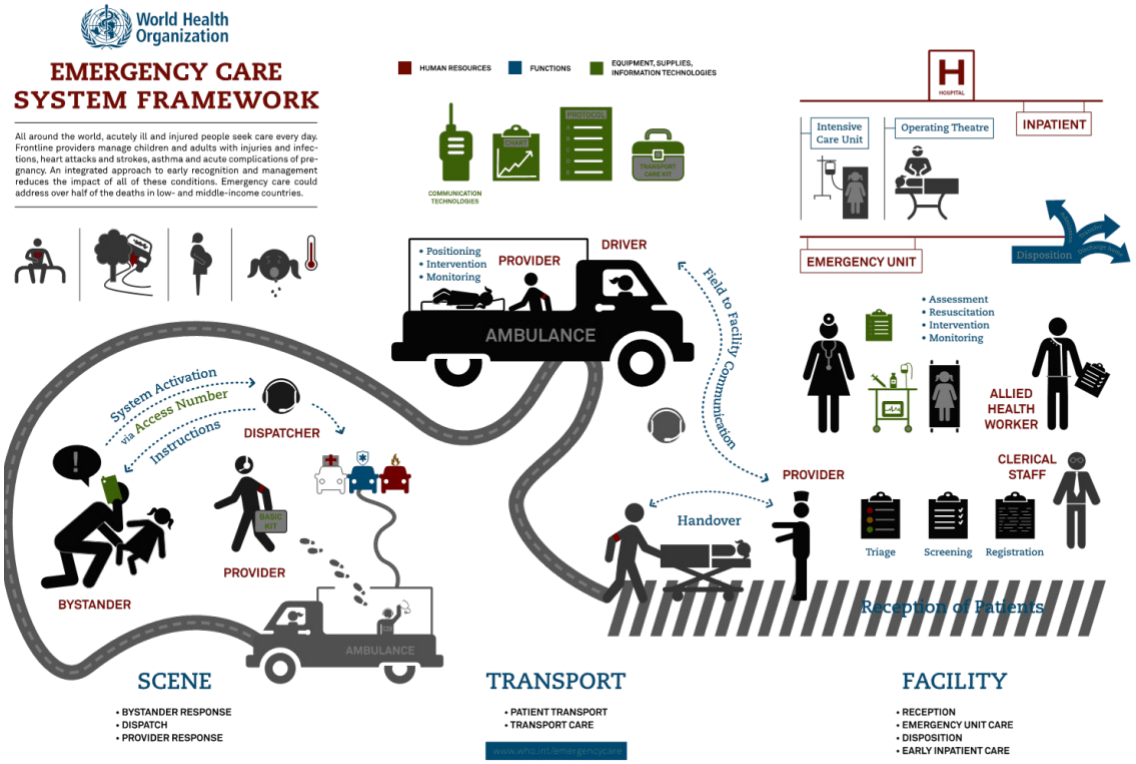

Figure 1: WHO Emergency Care System Framework

The WHO Emergency care system framework model has three levels:

1. Emergency care at the scene
2. Emergency care during patient transport
3. Emergency care at the health facility

[6]Reynolds, Teri A., et al. "AFEM consensus conference 2013 summary: emergency care in Africa–where are we now?." African Journal of Emergency Medicine 4.3 (2014): 158-163.

1.2.2.1 Emergency Care – Global Context

Every year 45million preventable deaths occur in Low and Middle Income Countries (LMICs)[7]. Injury contributes significantly to these conditions. The World report on Road Injury Traffic prevention (2004)[8] stated that > 5 million people die from violence and injury and; over 100 million people sustain injuries alone. Strengthening emergency care could effectively save > 400,000 lives globally every year[9]. Non-Communicable Diseases, infectious diseases, and obstetric conditions also contribute to the burden of emergencies. 951 million women of reproductive age do not have access to emergency obstetric care[10]. Weak pre-hospital care, with delays in initiating care and prolonged transportation of patients to health facilities results in many preventable deaths. Introduction of pre-hospital systems has been shown to improve response times of ambulances to patients in both rural and urban settings[11]. According to the WHO, functional emergency care systems can reduce preventable deaths in LMICs by 54%.

1.2.1.2 Emergency Care – Africa Context

As little as 19%, have the capacity to deliver 24-hour emergency care[12]. In Africa, the number of deaths and injuries from traffic incidents has been increasing over the last decades. According to the 2015 Global status report on road safety, the WHO African Region had the highest rate of fatalities from road traffic injuries worldwide at 26.6 per 100 000 population in the year 2013[13]. Children are affected significantly on the continent, where the global burden of incidence and severe disease for both diarrhea and pneumonia being very high[14]. Epidemics continue to pose a major public health risk on the African continent with a massive toll on health services and economies as evidenced by the devastating Ebola outbreaks in West Africa in the past decade[15].

However, there are efforts to improve access to emergency care. The 1997 WHO Regional Committee for Africa, recognized the role of emergency care in the region and adopted Resolution AFR/RC47/R15, on the Regional Strategy for Emergency and Humanitarian Action[16].

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[7]Thind A, Hsia R, Mabweijano J, et al. Prehospital and Emergency Care. In: Debas HT, Donkor P, Gawande A, et al., editors.
[8]Essential Surgery: Disease Control Priorities, Third Edition (Volume 1). Washington (DC): The International Bank 8Peden, Margie. "World report on road traffic injury prevention." (2004).
[9]Mock, Charles, et al. "What World Health Assembly Resolution 72.16 means to those who care for the injured." World journal of surgery 32.8 (2008): 1636-1642.
[10]Holmer, Hampus, et al. "The global met need for emergency obstetric care: a systematic review." BJOG: An International Journal of Obstetrics & Gynaecology 122.2 (2015): 183-189.
[11]Henry, J. A., & Reingold, A. L. (2012). Prehospital trauma systems reduce mortality in developing countries: a systematic review and meta-analysis. Journal of trauma and acute care surgery, 73(1), 261-268.
[12]Hsia, Renee Y., et al. "Access to emergency and surgical care in sub-Saharan Africa: the infrastructure gap." Health policy and planning 27.3 (2011): 234-244.
[13]Global status report on road safety 2015. Geneva: World Health Organization; 2015.
[14]Walker, Christa L. Fischer, et al. "Global burden of childhood pneumonia and diarrhea." The Lancet 381.9875 (2013): 1405-1416
[15]Shiwani, Haaris A., et al. "An update on the 2014 Ebola outbreak in Western Africa." Asian Pacific journal of tropical medicine 10.1 (2017): 6-10.
[16]AFR/RC47/R1: Regional strategy for emergency and humanitarian action.1997

In 2018, WHO convened the 1st African Road Safety forum at Marrakech, Morocco which was attended by Ministers of Health. Countries were urged to develop sound policies and effective strategies backed up with appropriate action plans in an effort to mitigate the worsening epidemic of road fatalities and serious injuries (WHO, 2018).

1.2.1.3 Emergency Care –Uganda Context

Burden of Emergencies

Uganda is among the top-ranking countries for Road Traffic Injuries along with South Africa, Nigeria, Iran, Thailand and Dominican Republic[17]. According to the annual traffic and crime reports of the Uganda Police Force, an average of 3,000 victims were killed and an average of 12,000 victims were seriously injured due to RTAs in Uganda between 2011 and 2016[18].

Table 1: Number of fatalities and serious injuries over past five years (National Road Safety Policy 2017)

Year	Fatalities	Serious injuries
2011	3,343	14,438
2012	3,124	13,137
2013	2,937	12,794
2014	2,845	13,516
2015	3,224	13,736
2016	3,503	10,981

The urban population is at a higher risk than the rural population, especially due to the rise of the boda-boda industry. On average Mulago National Referral hospital admits over 800 cases of trauma cases monthly and 75-80% of these are due to Road traffic injuries. About 60% of the RTIs are due to boda-boda accidents. Young adults, in their productive years, are infliated by trauma as there is a greater loss of productive years[19].

Obstetric and neonatal emergencies significantly contribute to the burden of emergencies, with an estimated 16 maternal deaths per day and 40,000 stillbirths occurring every year in Uganda.[20] UDHS 2016 showed a high maternal mortality ratio of 336/100,00.

[17]World Health Organization. Global status report on road safety 2013: supporting a decade of action. Geneva, Switzerland: WHO, 2013
[18]Uganda Police Force. Annual Crime and Traffic/Road Safety Reports 2013. Kampala, Uganda: Uganda Police Force, 2013
[19]Kobusingye O, Guwatudde D, Lett R Injury patterns in rural and urban Uganda Injury Prevention 2001;7:46-50
[20]McCue, A., et al. "Failures in the emergency obstetric and neonatal care referral chain lead to high rates of intrapartum stillbirth in southwestern Uganda." Annals of Global Health 83.1 (2017): 108.

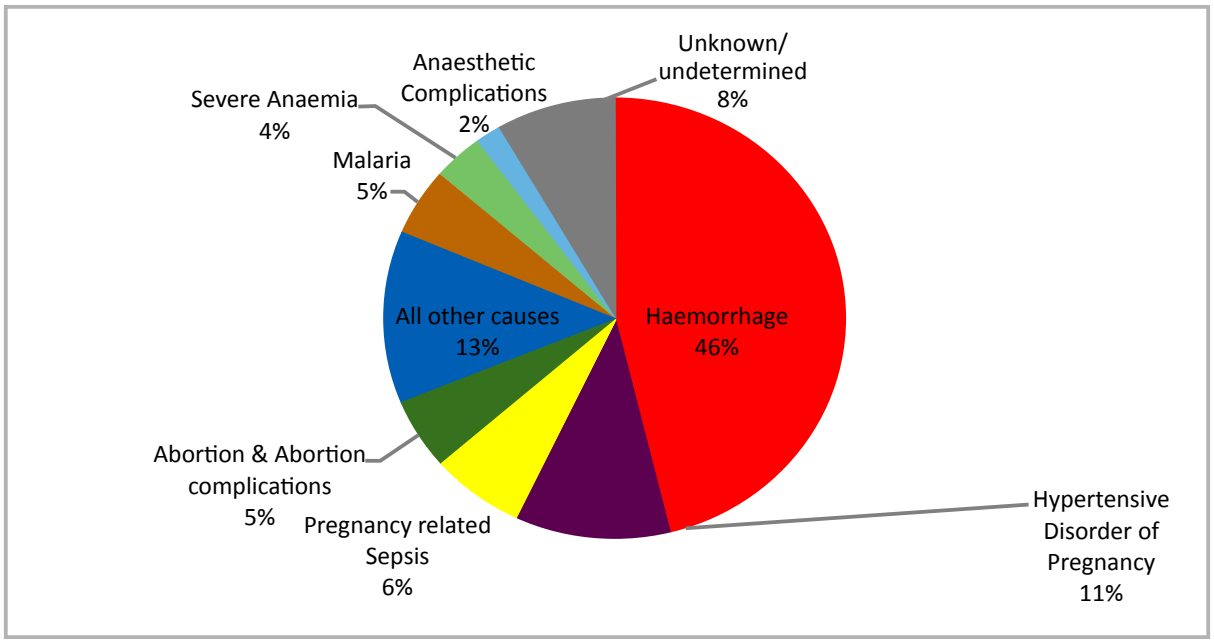

Figure 2: Leading causes of maternal deaths (AHSPR 2018/19)

Uganda is also experiencing an increase in non-communicable diseases such as hypertension, diabetes, cardiac disorders and sickle cell disease with rising incidents of emergencies like stroke and cardiac arrests.[21]

Communicable public health emergencies like ebola, marburg and cholera have become common in Uganda with limited ambulances to transport these patients. The Public Health Emergency Operations Centre coordinates Public Health Emergencies and has done a commendable job. Uganda is renowned for timely and effective response to epidemic diseases. Emergency care professionals can play a critical role in case management of Public Health Emergencies (PHEs) whenever they occur.

Neuropsychiatric (mental health) emergencies have also had a toll on the population with most of the mentally challenged people left unattended to on the streets and health facilities. Mental Health Emergencies should be taken as seriously as any other medical emergency condition.

Inadequate number of first responders, poor quality of first aid delivery and limited functional ambulances with dedicated emergency providers are the key challenges in provision of the critical pre-hospital emergency care.

[21]Kaddumukasa, Mark, et al. "Modifiable lifestyle risk factors for stroke among a high-risk hypertensive population in Greater Kampala, Uganda; a cross-sectional study." BMC research notes 10.1 (2017): 675.
[23]Opiro, Keneth, Lee Wallis, and Martin Ogwang. "Assessment of hospital-based adult triage at emergency receiving areas in hospitals in Northern Uganda." African health sciences 17.2 (2017): 481-490.
[24]Maes, Jan, et al. "The persisting gap between knowledge and action in disaster risk reduction: Evidence from landslides in Uganda and Cameroon." book of Abstracts. 2017.

Financing for emergencies

There has been increased financing for health services (increased by 93% over the 5 years (FY 2010/11-2015/16) from UGX 660 million (FY 2010/11) to UGX1, 271 billion (2015/16). Despite this increase, limited funds have been earmarked for managing EMS in the country. Having realized this, the Ministry of Health in July 2017 re-organized and renamed the department of ambulance services as department of emergency medical services with the explicit mandate of developing emergency care services in the country.

1.3 Problem Statement

Uganda has inaccessible and poor-quality emergency care with limited nationally coordinated emergency care network and evacuation mechanisms to respond to emergencies. The reasons for this include poor structures for EMS leadership and governance across all levels of health service delivery, inadequate and poor human resource capacity, lack of appropriate infrastructure in both prehospital and facility settings, inadequate essential medicines and supplies, and poor monitoring and evaluation of EMS.

The existing policies do not adequately address emergency medical response and management of ambulances in the country which has led to inaccessible and poor-quality EMS services. There are multiple stakeholders offering EMS, yet it remains the most poorly delivered service in the health sector.

This National Emergency Medical services Policy is premised on the need to streamline the national response to emergencies at pre-hospital and hospital level in accordance with best practices, locally and internationally.

1.4 Vision

A healthy population with quality emergency care services accessible to all.

1.5 Mission

To reduce mortality and morbidity through ensuring high quality, safe and patient centered Out of hospital emergency care (OHEC) and hospital emergency care services that meet the needs of the population.

1.6 Goal

To contribute towards Universal Health Coverage through providing accessible and affordable emergency medical services.

1.7 Policy Priority Areas

The attainment of the above goal shall be ensured by the following priority areas:

1. Leadership and Governance
2. Health Work Force
3. Health System Financing
4. Access to Essential Medicines
5. Health Information System
6. Health Service Delivery

1.8 Policy Objectives

1. To strengthen leadership and governance structures for EMS across all levels of health service delivery by 2030.
2. To ensure dedicated human resources for emergency care through training, capacity building and review of the HRH structure at Health facilities and pre-hospital level by 2025.
3. To develop and maintain appropriate infrastructure for the delivery of EMS including a robust call and dispatch system by 2030.
4. To ensure adequate provision of essential medical products and technologies for delivery of emergency care services by 2025.
5. To mainstream emergency care data into existing health information systems by 2021.
6. To mainstream structures for monitoring and evaluation of emergency care services by 2021.

1.9 Values

The core values of Emergency Medical Services will be based on the health professional ethical values as guided by the Health Service Commission 2012, the ten core values in the Uganda National Values Policy 2013, and social values in the National Health Policy 2010.

1. **Commitment**

   Commit to look after and provide emergency care to all acutely ill and or injured patients.

2. **Equity and Fairness**

   Ensure fair and impartial treatment to all patients irrespective of gender, socio-economic status, race, religion, health status, disability, ethnic background and political affiliation.

3. **Quality Care**

   Provide emergency care according to MoH service standards.

4. **Compassion**

   Show love, kindness and willingness to help the acutely ill and injured.

5. **Trust**

   Be reliable and honest while providing emergency care.

6. **Learning**

   Keep up to date with emergency care knowledge and skills.

7. **Stewardship**

   Be stewards of patients in our care and the resources at our disposal.

8. **Respect for Humanity**

   Respect and have high regard for patients, community and service providers.

1.10 Guiding Principles

The implementation of this policy shall be consistent with the National Development Plan, National Health Policy[26] and the Health Sector Development Plan.[27]
The principles of the National EMS Policy are intended to guide its implementation and include:

(i) Available and Accessible care

Emergency care will be made available through the national and regional call and dispatch centers 24 hours 7 days a week using a National EMS Short Code. The medical emergency dispatch centre will use a triage system to ensure the patient receives the right care at the right time, in both standard and scaled-up situations. Both public and private health care providers will provide emergency care.

(ii) Transparency

As much information as possible regarding patient care will be given to patients, care takers and health service providers. The MoH shall on a regular basis provide a report on progress of EMS system development in Uganda.

(iii) Professionalism

Emergency care will be provided by qualified and competent staff that approach and treat patients with professionalism and respect. The National Protocols and Standards will guarantee the uniformity and transparency of professional emergency care.

[26]Second National Health Policy (NHP II) 2010
[27]The second National Development Plan 2015/16 – 2019/20

(iv) Quality Control and Patient Safety

Ensure quality and safe emergency care through provision of high quality human resource with the requisite skills and functional equipment that guarantee safe and quality care. MoH will ensure continuous improvement of quality care to meet patient's demands through supervision and mainstreaming of Monitoring & Evaluation.

(v) Consent

The health care providers will seek permission to provide the service and will act in accordance with professional standards and ethics.

(vi) Continuity of Care and Coordination with Partners

The regional EMS coordination centers will work closely with key emergency care providers within the region to ensure continuity of care. All stakeholders will cooperate with MoH in provision of emergency care services. Pre-hospital providers will ensure that the patients are handed over responsibly to the next level of health care.

(vii) Equality and equity

Emergency care services will be responsive to equal opportunity in accessing and utilizing emergency care services. Emergency care services will be provided without discrimination and inequalities against any individual, or group of persons on the ground of age, sex, race, color, ethnic origin, tribe, birth, creed or religion, health status, socio-economic standing, political opinion or disability.

(viii) Mainstreaming of emergency and ambulance services in all policies

Emergency medical services will be mainstreamed in all relevant policies. MoH will guide other government ministries, departments, agencies, the private sector, CBOs, CSOs and any other stakeholders on emergency care issues.

1.11 Theory of Change

The EMS policy targets the entire population of Uganda with special consideration to the vulnerable communities, disabled, women, children, and those living in hard to reach areas. The strategic focus is on strengthening leadership, human resource, infrastructure, essential medicines and supplies with the anticipated outcomes of reduction in mortality and morbidity from emergency conditions, and increasing public satisfaction and confidence in the health system.

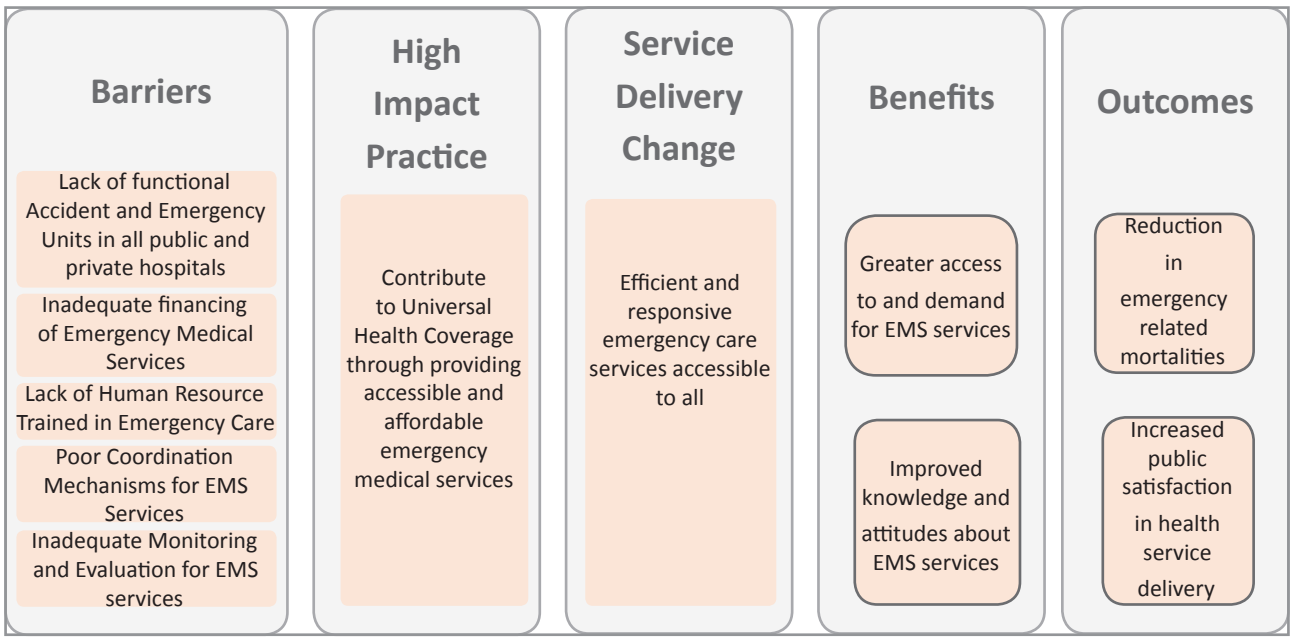

Figure 3: Improving access to Emergency Medical Services: Theory of Change

1.12 Justification

The existing policies do not adequately cover for emergency medical response and management of ambulances in the country which has led to inaccessible and poor-quality emergency care services. The policy therefore seeks to guide, harmonize, enhance and promote the distinctive but complementary roles of all stakeholders in emergency medical services.

CHAPTER TWO

2.0 POLICY CONTEXT

2.1 Introduction

The MoH AHSPR 2014/2015 and 2016/17 clearly show that the top ten causes of mortality in Uganda are emergency related conditions. There is an increasing burden of trauma, neonatal and maternal emergencies, non-communicable diseases contributing to morbidity and mortality in Uganda. Except for the limited ambulance services in some referral and district hospitals, Kampala City Council Authority, West Nile and Rwenzori regions, the country has no coordinated ambulance network or emergency call centre that can coordinate quick response to emergencies. Emergency care knowledge of lay first responders is limited proper training may have the most impact when emergencies occur in congested urban areas and hard to reach rural areas. The Hospitals and Health centers are not well equipped to deal with emergency victims.

2.2 Economic Context

Emergencies and disasters exert negative economic impact on countries. Natural disasters result in damages constituting between 2% to 15% of an exposed country's annual GDP. Despite the high incidence and prevalence of emergencies and disasters and their negative health and economic impact, a baseline assessment of the enabling environment and the capacity for response, conducted in 32 countries in the Africa Region in 2011 showed that the health sector lacks relevant policies and capacities to guide effective EMS systems development.

In Uganda, the National Health Financing strategy (2015/16 – 2024/25)[28] shows that the percentage of government budget allocated to the health sector has stagnated at about 8.5% in the period 2010/11-2014/15 and it fell substantially to 6.9% in 2015/16.

The sources of health financing are public, private funds (mainly household out-of-pocket expenditure), development partners (ODA) and voluntary health insurance. There are efforts to establish a National Health Insurance Fund (NHIF) that will contribute funding towards emergency care.

2.3 Socio-Political Context

The second National Development Plan 2015/16 – 2019/20, under the theme "Strengthening Uganda's Competitiveness for Sustainable Wealth Creation, Employment and Inclusive Growth" sets Uganda's medium term strategic direction, development priorities and implementation strategies.

[28]MOH Health Financing Strategy 2015/16 – 2024/25

The HSDP commits to start a national ambulance and emergency service as a core project while the government plan 2016-2021 underscores the need for a coordinated EMS system.

Government of Uganda prioritized improvement of the health status of people in Uganda as evident by the development and implementation of HSDP.

2.4 Environmental Context

Ministry of Health will ensure that implementation of the National Emergency Medical Services policy is inline with the provisions of the National Environmental Act (1995). The cause-effect environmental analysis for the implementation of the Emergency Medical Services policy has the following considerations:

(i) Air quality:
To work with Ministry of Works and Transport to ensure that ambulances are certified for road worthiness to mitigate the environmental and health risks of air pollution.

(ii) Unsafe public space:
To minimize the infection risk to medical personnel and patients by adapting the infection control guidelines and providing infection control training to both pre-hospital and facility-based emergency care providers.

(iii) Poor disposal of medical waste:
To ensure that EMS key stakeholders follow proper waste disposal procedures as a counter for biological waste pollution risks. Ministry of Health will work with NEMA to ensure enforcement of the waste disposal legal framework.

(iv) Effects of hazardous substances:
To reduce the risks of medical errors, injury or death that may result from poor management of hazardous substances through; training of emergency care providers and working with MoGLSD to enforce the occupational health and safety legal law.

CHAPTER THREE

3.0 POLICY PILLARS

Government of Uganda is aware of the lack of well-coordinated emergency medical services that will enhance quality of care for the people of Uganda at all levels of health care delivery. The implementation of the National Emergency Medical Services policy will be achieved through the following priority areas.

1. Leadership & Governance of Emergency Medical Services
2. Human Resource for Emergency Medical Services
3. Essential Emergency Medicines and Health Supplies
4. Emergency Care Health Infrastructure
5. Essential Emergency Care Package for healthy facilities
6. Ambulance Service Standards
7. Emergency Care Data, Monitoring, Evaluation and Quality Improvement
8. Research
9. Legal and Regulatory Framework for Emergency Medical Services
10. Financing for Emergency Medical Services
11. Public Private Partnership in Health (PPPH)
12. Emergency Referral and Disaster response Services
13. Community Health Education and Promotion on Emergency care Response

3.1 Pillar 1: Leadership and Governance of Emergency Medical services

3.1.1 Issue

Government recognizes that there is inadequate leadership and coordination of Emergency Medical Services.

3.1.2 Policy Statement

The government will strengthen leadership and governance of Emergency Medical Services across all levels of the health care delivery. There will be a multi stake holder EMS coordination committee at National and Regional levels. The EMS coordination committee will have members representing key emergency medical services stakeholders

3.1.3 Policy Strategies

1. Strengthen the capacity of the Department of Emergency Medical Services by establishing an Emergency Care Technical working group and a multi-stakeholder coordination committee.
2. Develop a policy framework (policy, strategic plan, standards and protocols/ guidelines) for EMS.

3. Establish and strengthen Regional Emergency Medical Services as the main coordination centers for EMS at all health regions. These will be technically led by the Regional EMS officer.
4. Establish multi-stakeholder emergency care coordination structures at referral levels of health service delivery (HCIII – NRH).
5. Establish strategic spots/stations for ambulances at key locations on the highways, major roads, counties and constituencies to increase access for the population.

3.2. Pillar 2: Human Resources for Emergency Medical Services

3.2.1 Issue

Government has recognized that human resources needed for delivery of emergency care services in terms of numbers, skill set and quality is inadequate. There are no specialized emergency care officers and specialists as is practiced internationally.

3.2.2 Policy Statement

Government will ensure adequate and competent emergency care officers and specialists are trained, recruited and deployed to offer critical emergency care services at the pre-hospital and hospital level.

3.2.3 Policy Strategies

1. Develop a scheme of service for emergency care officers for pre-hospital and hospital services
2. Work with Ministry of Public Service and professional councils to integrate emergency care professionals into the public service staffing structure for various service delivery levels in Uganda.
3. Recruit, develop and retain specialists in emergency care.
4. Work with Ministry of Education through the inter-ministerial committee to review existing curricula and training strategies in the universities and other health training institutions to integrate emergency medicine where appropriate.
5. Work with universities and health training institutions to support and expand training in emergency medicine at graduate, diploma and certificate levels. Ensure that pre-hospital emergency medical services are provided by certified emergency care professionals and trained providers.
6. Develop standards for accreditation of human resource for ambulance services.

3.3. Pillar 3: Essential Emergency Medicines and Health Supplies

3.3.1 Issue

Inadequate supply of essential medicines and health supplies for emergency care at Health facilities.

3.3.2 Policy Statement

Government will ensure that essential, efficacious, safe, good quality and affordable medicines and health supplies for emergency care are always available and used rationally in the pre-hospital and hospital environment.

3.3.3 Policy Strategies

1. Provide adequate financing for emergency medicines and health supplies.
2. Build capacity for rational use of emergency medicines and health supplies.
3. Develop and specify appropriate essential emergency medicines and supplies according to the levels of service delivery for incorporation into the Uganda Essential medicines and Health supplies list.
4. Review the Uganda National Minimum Health Care Package to prioritize emergency care at Health facility level and in the pre-hospital phase.

3.4. Pillar 4: Emergency Care Health Infrastructure

3.4.1 Issue

Government recognizes that there is inadequate infrastructure (emergency units, medical devices and equipment, ICT) for emergency medical care.

3.4.2 Policy Statement

Government will provide and maintain functional, efficient & safe health infrastructure & equipment for the effective delivery of emergency care services.

3.4.3 Policy Strategies

1. Construct, renovate and equip Emergency Units at Referral Hospitals, General Hospitals, HCIVs and HC IIIs. All building plans for these levels will provide for Emergency Units that are fully equipped and staffed to provide emergency care. The regional referral hospitals will provide for intensive care units and observational wards.
2. Establish and equip Regional Ambulance Call and Dispatch Centers at the 14 regional referral hospitals as Regional EMS Coordination Units. These call centers

will be linked to the National Call Centers of Police and OPM.

3. Establish and equip a central National Coordination Center as part of the National Emergency Coordination and Operation Centre to oversee the functionality of all the regional ambulance call and dispatch centers.
4. Recognize the value and make available alternative forms of patient transport vehicles or ambulances (motor bikes, stretchers, marine and tri-cycles) for hard-to-reach areas.
5. Work with the UPDF, UPF and private aviation providers to provide aero-medical evacuation (Helicopter, airplane) ambulance services.
6. Work with MOWT Maritime department, uninformed forces and NGOs to provide maritime health services including boat ambulance care services.
7. Strengthen and ensure rationale planning for ambulance vehicles and equipment.

3.5 Pillar 5. Essential Emergency Care Package for Health Facilities

3.5.1 Issue

The Uganda National Minimum Health Care Package does not include an emergency care package for health facilities and Pre-hospital level. This has affected emergency care service delivery in the country.

3.5.2 Policy Statement

Government will develop an essential Emergency Care Package for health facilities and pre-hospital levels and incorporate into UNMHCP.

3.5.3 Policy Strategies

1. Develop the Emergency Care package for Uganda to include all emergencies according the different levels of health service delivery.
2. Align the package to cater for four levels of service delivery: pre-hospital, health centres, general hospitals and referral hospitals
3. Revise the composition of the Emergency Care Package periodically.
4. Develop an emergency care kit to be made available to health facilities and Ambulance crews for pre-hospital services
5. Develop and use drone technology in a cost-effective way to deliver life-saving commodities to health facilities especially those in hard-to-reach areas.

3.6. Pillar 6: Ambulance Service Standards

3.6.1 Policy Issue

The country has a rudimentary unregulated ambulance network that cannot effectively respond to emergencies

3.6.2 Policy Statement

Government will develop National Standards and Guidelines for ambulance services.

3.6.3 Policy Strategies

To achieve this policy pillar, Government will;

1. Develop ambulance standards and guidelines for vehicles, motor tricycles, boat and helicopter ambulances
2. Ensure that ambulance vehicles and other patient transportation conforms to the type and specifications provided by the MoH in the standards
3. Recognize 3 types of Ambulances vehicles: Type A Patient transport vehicle, Type B Basic Life Support/Emergency ambulance, Type C Advanced Life support/ Intensive Care Unit Ambulance
4. For vehicle ambulances Government will adopt type B emergency ambulance for universal coverage and Type C intensive care ambulance for regional referral hospitals and super-specialized medical centers like Uganda Heart institute (UHI).
5. Ensure that allocation and distribution of ambulances is in accordance to accepted norms, standards and policy guidelines.
6. Establish a multi-stakeholder accreditation body for ambulance services
7. Ensure that ambulance vehicles are accredited by the MoH or its established body.
8. Ensure that ambulances are professionally staffed, positioned and consistent with their role in pre-hospital and hospital services
9. Ensure ambulances are equipped with a standard list of medical equipment, devices and supplies endorsed by the responsible institutions.
10. MoH will guide other MDAs and private sector during ambulance procurement.

3.7 Pillar 7: Emergency Care Data, Monitoring, Evaluation and Quality Improvement

3.7.1 Issue

There is inadequate data on emergency care in HMIS for decision making, supervision, monitoring and evaluation, research and quality improvement in emergency care delivery.

3.7.2 Policy Statement

Government will integrate EMS data into the Health Management Information System (HMIS), and develop an EMS monitoring and evaluation framework to ensure that the policy achieves its purpose.

3.7.3 Policy Strategies

1. Develop and integrate emergency care data elements and indicators into HMIS.
2. Develop a monitoring and evaluation framework for emergency medical services.
3. Ensure utilization and dissemination of information on emergency care to other stakeholders for purposes of performance management, learning, quality improvement and development.
4. Build capacity at all levels of policy implementation to carry out supportive supervision, monitoring and evaluation of EMS.
5. Establish continuous quality improvement (CQI) frameworks that are evidence based.
6. Align with the broader supportive supervision strategy of the Ministry of Health.
7. Conduct stakeholder information sharing and dissemination meetings on emergency care services.

3.8. Pillar 8: Research

3.8.1 Issue

There is inadequate research to support evidence-based policy and intervention formulation, identification of gaps and critical factors for emergency care.

3.8.2 Policy Statement

Government will promote the use of health research in guiding policy formulation and action to improve the delivery of emergency care services to the people of Uganda.

3.8.3 Policy Strategies

To achieve this objective, Government will:

1. Develop and implement, with the support of academia and relevant institutions, a prioritized National Emergency Care research agenda aligned to the overall Health Research agenda.
2. Harness development partners' and government funds to successfully implement the National Emergency Care Services research agenda.
3. Promote dialogue and information sharing between the policy makers, researchers, healthcare providers and communities in emergency care to ensure that research is relevant to the needs of the people and consistent with NHP II and Health Sector Strategic Development Plan, and that research findings are utilized by the relevant stake holders for decision making.
4. Strengthen health emergencies research capacity in institutions at all levels.
5. Fast track translation of research findings into policy.

3.9. Pillar 9: Legal and Regulatory Framework for Emergency Medical Services

3.9.1 Issue

Lack of a legal framework, with unregulated and fragmented emergency medical services at all levels of health care delivery.

3.9.2 Policy Statement

Government will review and develop relevant laws and regulations to govern emergency medical services in Uganda.

3.9.3 Policy Strategies

1. Develop a National EMS Policy, Act, Regulations, Guidelines and By-Laws.
2. Develop legislation on by-stander protection (Good Samaritan Law) in collaboration with Ministry of Works and Transport (MOWT) and other stakeholders.
3. Support Professional Councils to develop and implement regulation for registration of emergency care health professionals.
4. Establish a career pathway for training and accreditation of emergency care providers.
5. Emphasize the need for relevant institutions like health professional councils to enforce emergency care regulations.

6. Support and provide an effective regulatory environment that will enforce existing legislation and policies.
7. Support the development and enforcement of by-laws and regulations at local government level that can directly impact on the social determinants of health emergencies.

3.10. Pillar 10: Financing for Emergency Medical Services

3.10.1 Issue

Funding for pre-hospital care and health facility emergency care services is inadequate and has not grown in line with the increased needs for the service.

3.10.2 Policy Statement

Using the PPP framework, government will mobilize sufficient financial resources for emergency medical services to cover the scene of emergency, transportation care and care at Accident and Emergency units at health facilities.

3.10.3 Policy Strategies

1. Establish alternative health care financing mechanisms for emergency medical services including insurance schemes, private sources and development partners.
2. Provide adequate budgetary allocation to emergency medical services in the national budget.
3. Provide financing for both pre-hospital and hospital emergency care in the National Health Insurance Scheme and other funding modalities like private health insurance, and community health financing mechanisms.
4. Third Party Vehicle Insurance; The Ministry of Health will work with the insurance regulatory authority to raise public awareness on the third party motor vehicle insurance and work with National Road Safety Council to develop guidelines for providers and victims on how to access third party motor vehicle insurance.
5. In order to quickly establish EMS in the country government will solicit for development grants and loans in the medium term.
6. Develop contracting mechanisms for emergency medical services with the private sector including establishing a contingency fund for compensating the private services providers to resuscitate and stabilize critical emergencies before referral.

3.11. Pillar 11: Public Private Partnership in Health (PPPH)

3.11.1 Issue

The MoH developed the PPPH policy in 2012 as a framework for the linkage of the public and private health sector stakeholders. In 2015 the GOU enacted the PPP act to guide the country in private sector investments. Many private emergency medical service providers exist in the country, so there is need to strengthen that collaboration. There is inadequate participation of the private sector in public education on prevention and recognition of emergencies, provision of first aid, availability of ambulance services and health facilities with emergency care services.

3.11.2 Policy Statement

Government will build and utilize the full potential of public and private partnerships to promote emergency medical services in accordance to the PPP Act and PPPH policy.

3.11.3 Policy Strategies

1. Engage the private sector in the process of policy development, planning, effective implementation and quality assurance of emergency medical services.
2. Finance emergency care services using the PPP framework.
3. Provide for participation of the private sector in coordination structures at national, regional and district levels.
4. Promote the multi-stakeholder prevention strategies that have been proven effective against acute illness, injuries and maternal-neonatal emergencies.

3.12 Pillar 12: Emergency Referral and Disaster Response Services

3.12.1 Issue:

Emergency and disaster response and referral services are inadequate leading to patients dying either during transport or immediately on arrival at receiving health facilities.

3.12.2 Policy Statement:

Government will establish a coordinated emergency and disaster response and referral system in line with the national policy for disaster preparedness and management and the national referral guidelines.

Each heath region will develop region-specific EMS disaster preparedness and response plans that ensure surge capacity plans as well as coordination with other emergency response agencies to implement standard incident command system (ICS) procedures for all major incidents. The policy fosters the integrated approach to medical response planning

and operations by employing unified incident management within the national disaster preparedness and management mechanism under the Office of the Prime Minister (OPM) for Uganda Police force, marine, fire, EMS, public health and other agencies.

3.12.3 Policy Strategies

1. To set disaster/major medical incident response structures in all health regions.
2. Work with OPM to respond to medical/health needs during disasters.
3. Develop emergency referral protocols as part of the national referral guidelines.
4. Develop emergency referral directory per region in Uganda.
5. Use standard referral forms with explicit direction on health facility of referral.
6. Establish uniform patient referral system that handles emergency referral and inter facility transfers. Emergency referral of specimen and images for specialist interpretation and diagnosis should be given consideration.
7. Ensure establishment of regional Emergency Medical Teams to participate in national level or disasters outside their respective regions once called upon.
8. Ensure all EMS regions and districts have disaster response plans including resources with clear activation protocols.
9. Develop a national response plan to support mass gatherings and major events of national importance.

3.13 Pillar 13: Community Health Education and Promotion on Emergency Response

3.13.1 Issue:

There is a lack of community awareness on emergencies, their prevention and how to respond when they occur.

3.13.2. Policy Statement

Government will promote and educate the public on emergency medical services.

3.13.3 Policy Strategies

1. Promote the multi-stakeholder prevention strategies that have been proven effective against acute illness, injuries and maternal-neonatal emergencies.
2. Educate the population at all levels on emergency medical services available, to understand their rights and responsibilities during emergency events.
3. Strengthen first aid capacity at households and community level for medical emergencies using the Community Health Workers.

4. Train Community First Responders in emergency care.
5. Communication on emergencies should follow guidelines established by the Ministry of Health/government. To avoid doubt, there should be a communications focal person/expert.

CHAPTER FOUR

LINKAGES TO EXISTING STRATEGIES, POLICIES, REGULATIONS AND LEGISLATION

4.1 Introduction

The emergency medical services policy is linked to existing National, Regional and International strategies, policies, regulations and legislations on health care delivery and governance.

4.1. Uganda

4.1.1 Constitution of the Republic of Uganda, 1995

Article XX. Medical Services, "The state shall take all practical measures to ensure the provision of basic medical services to the population."

4.1.2 Vision 2040

Article 252 of Vision 2040 states that there will be a paradigm shift from facility based to a household-based health care system. This is in line with the strengthening of the out of hospital Emergency Care System provided in this policy.

4.1.3 National Development Plan (NDP) II

Article 571 (iii) of the National Development Plan states "Government will strengthen the referral system to ensure continuity of care including the Uganda National Ambulance Service taking care of hard to reach areas such as islands and mountainous areas.

4.1.4 National Health Policy (2010) 6.1.& 6.1.2 (ii) and 6.1.4 (c).

6.1: While decentralization shall be the focus, the regional referral hospitals shall be strengthened to effectively supervise and support health systems at the regional level.

6.1.2.(ii): Establish a regional level of administration to serve as a link between the national and district health system.

6.1.4 (c): Strengthen a National Referral system for primary, secondary and tertiary care.
The establishment of the Regional EMS Coordination Unit at RRH is aimed at strengthening RRH's to supervise and support District Health Systems

4.1.5 Health Sector Development Plan (HSDP)

The HSDP has prioritized emergency medical and ambulance services as key intervention areas for introduction and scale up. The HSDP supports the scaling up of production of Emergency Health Professionals.

4.1.6 The National Policy for Disaster Preparedness and Management, 2010

The National Policy for Disaster Preparedness and Management 2010 (2.1), provides that the MoH will be a lead institution in response to human epidemics and pandemics. It is also one of the responsible institutions during transport related accidents and other disasters with medical implications.

4.1.7 National Road Safety Policy, 2017

According to the National Road Safety Policy the MoH is responsible for post trauma care and the health sector can do this by establishing on scene care and ambulance emergency services.

4.1.8 Occupational Safety and Health Act, 2006

The Occupational Safety and Health Act requires that preventive measures should be in place for any hazardous accident or disaster. In the event of an accident, emergency response should be available.

4.1.9 Kampala Capital City Authority (KCCA) Act 2010

As stipulated in 5.1.17, Kampala Capital City Authority is responsible for ambulance services in their area of jurisdiction.

4.2 Health Sector Departmental Policies

Health Sector Departmental Policies like RMNCAH Policy, Referral Guidelines and Hospital Policy.

These provide for referral services for Emergency obstetric cases and other emergencies, as well as the establishment of emergency departments, operating theatres and intensive care units.

4.3 East African Community

Uganda is a member of the East African Community. The EAC Health Department has developed several frameworks and instruments to respond to identified regional health challenges and priority interventions.

4.4 Global

4.4.1 May 2019 World Health Assembly resolution 72.16

WHA Resolution 72.16 urges member states to prioritize emergency care services and to strengthen national trauma and emergency care systems.

4.4.2 UN Global Plan for the Decade of Action for Road Safety (2011)

Pillar 5 of the UN Global Plan for the Decade of Action for Road Safety (post-crash response) calls for increase in responsiveness to post-crash emergencies and improvement in the ability of health and other systems to provide appropriate emergency treatment and longer-term rehabilitation for crash victims.

4.4.3 World Health Assembly resolution 68.15

WHA resolution provides recommendations on strengthening emergency and essential surgery and anesthesia care as a component of universal health care.

4.4.4 Sustainable Development Goal 3:

SDG 3- Ensure healthy lives and promote wellbeing for all at all ages.[30]

It provides targets that are directly addressed by emergency care.

1. Target 3.1: By 2030 reduce the global maternal mortality ratio to less than 70/100,000 live births.
2. Target 3.4: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.
3. Target 3.6: By 2020, halve the number of global deaths and injuries from road traffic accidents.
4. Target 3.9: By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.
5. Target 3.d: Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

[30]https://www.eac.int/health

CHAPTER FIVE

5.0 ROLES AND RESPONSIBILITIES OF STAKEHOLDERS

5.1 Introduction

Government, private health sector, development partners, Civil Society Organizations and communities all play a role in emergency care, training and research and in this regard the Government of Uganda shall foster and sustain partnerships with all the relevant institutions, including corporations and business communities that are involved in service delivery.

5.2 GOVERNMENT

5.2.1 Ministry of Health

Ministry of Health is the overall body responsible for policy formulation in all matters pertaining to health service delivery and in this case with direct focus on emergency medical service delivery.

The Ministry is responsible for provision of overall guidance on management of emergency medical services, provision of standards, coordination of all stakeholders, resource mobilization, support supervision, in-service training for emergency care service providers, monitoring and evaluation. The Ministry of Health also implements stepwise referral system by level of health facility from Health Center 1(HC 1) upto National referral hospital.

MoH provides technical guidance to other MDAs in their areas of domain like MOES for Professional training.

5.2.1.1 Department of Emergency Medical Services

The Department of EMS represents the MoH in all aspects of emergency care Services and provides guidance to other MDAs and private sector on medical emergency issues. The department of EMS will work closely with regional referral hospitals to ensure establishment of a regionally coordinated EMS system. The regional hospital is the representative of Ministry of Health at regional level. The regional health structures (Regional Referral Hospitals) will be responsible for ensuring efficient and effective provision of emergency and ambulance care services. They shall act as the regional coordination centers for emergency care at service delivery level. A Regional EMS coordination unit will be responsible for designation of ambulances to specific locations.

5.2.1.2 Health Professional Councils

The four health professional councils (Uganda Medical and Dental Practitioners Council (UMDPC), Uganda Allied Health Professionals Council (UAHPC), Uganda Nurses and Midwives Council (UNMC) and Uganda Pharmacy Council) shall be responsible for licensure, regulation and adherence to professional standards for emergency care providers at all levels while MoH will be responsible for setting standards and certification of first aid trainees.

5.2.1.3 Service Providers – Hospitals and Health Units

Health care providers at hospital/health unit level will include trained general health professionals, professional emergency care officers and specialists in emergency medicine and other specialized areas. They will be responsible for provision of emergency care to patients received at the hospital/health unit. Emergency Care officers will be registered as professionals and certified to provide emergency medical services. All emergency care providers will be required to undergo courses or drills in emergency medicine before certification to practice. The department of EMS shall liaise with hospitals to ensure adequate clinical case management for routine emergencies, disasters and epidemic disease outbreaks.

5.2.2 Local Governments (LGs)

The Government of Uganda implements a decentralized health service delivery system where each district is responsible for service provision in its area of jurisdiction. According to the Constitution and the Local Government Act 2007 (as amended) the legal mandate of districts is to manage general hospitals and health centers in their areas of jurisdiction, deliver the UNMCP, monitor and supervise service delivery in private sector and enforce the various health related Acts. The LGs will ensure that communities, households and individuals are empowered to play their role and take responsibility for their own health and well-being and to participate actively in the management of health emergencies in their households and communities. The LGs will promote community participation in emergency care service delivery and management. LGs will enhance capacity of Community Health Workers, Red Cross Volunteers and others to provide pre-hospital emergency care by training and equipping them with basic emergency tool kits.

The LGs will be represented in the regional coordination Committee for EMS. The DHOs will support the regional EMS officer in ensuring the functionality of ambulance services in the districts.

5.2.3 Office of the Prime Minister (OPM)

Under its mandate, the Directorate of Relief, Disaster Preparedness and Refugees, Office of the Prime Minister, developed a policy that details mechanisms and structures for the effective and practical management of disasters. The policy covers the broad subjects of vulnerability assessment, mitigation, preparedness, response and recovery, which constitute

"comprehensive disaster management". It networks all the lead sectors, local governments, international development and humanitarian partners, the private sector and the NGOs under the principle of a multi-disciplinary and multi-skilled consultative approach. It also presents an institutional framework under which the partners coordinate their operations. It further recognizes the need to place emphasis on the vulnerable groups and persons with special needs.

For major health disasters including public health emergencies like disease outbreaks, and massive road, crashes the Ministry of Health takes the lead as a technical Ministry. However, the overall coordination for a multi-sectoral response is by the Ministry of Office of the Prime Minister.

For routine medical emergency conditions, the Ministry of Health has overall responsibility to ensure adequate and well planned emergency coverage.

5.2.4 Uganda Police Force (UPF)

The Uganda Police Force has directorates that deal directly with Ministry of Health in the provision of Emergency care and ambulance services. These are Directorates of Traffic and Road Safety, Fire and Rescue Services, Uganda Police Air, Marine Police and Police Medical Services. The Fire and Rescue respond to fire emergencies, drowning and disasters. The traffic police are on the roads and highways, and as such often become first responders during road traffic accidents and other emergencies. The medical directorate also has medical police staff who are called upon to support the traffic police when the need arises. They operate ambulance vehicles which are mobilized to respond during emergencies. The MoH Department of EMS shall work with the police in coordination and provision of emergency cover during mass gatherings, disasters and state functions.

5.2.5 Uganda Peoples' Defense Forces (UPDF)

The Directorate of Medical Services of the UPDF responds during disasters such as terrorism, bomb blasts, chemical poisoning and in cases of major incidents. The UPDF responds rapidly when called upon to support the police, health sector and Office of the Prime Minister (OPM) in response to major emergencies. In EMS, the aero-medical rescue response will be supported and coordinated by the UPDF.

5.2.6 Ministry of Works and Transport (MoWT)

The Ministry of Works and Transport is responsible for ensuring transport safety standards are set and adhered to, designing standards for roads, water and air transport and providing adequate safety measures. They coordinate the development and review of Uganda road safety laws and regulations. The MoH shall work with MoWT to improve emergency responsiveness on roads through a strong public health awareness campaign and creation of ambulance lanes on roads. The Transport Licensing Board (TLB) is mandated to regulate

the licensure and use of public service vehicles, omnibuses and goods vehicles. The TLB shall conduct a road-worthiness inspection of ambulance vehicles; a certificate of which is to be presented to the MoH for assessment of ambulance standards before licensure. TLB will only issue licenses to ambulances based on the recommendation by MoH.

5.2.7 Ministry of Education and Sports (MoES)

Ministry of Education is responsible for training programms of tertiary institutions. They approve the training curriculum through the National Curriculum Development Centre (NCDC). They are responsible for the development of the certificate and diploma programs in emergency care. MoH will work with MOES to develop the Emergency Care Providers training guidelines and curriculum.

5.2.8 National Council of Higher Education (NCHE)

NCHE is responsible for the qaulity accreditation of degree programs in all degree awarding institutions for example the incorporation of emergency medicine in undergraduate curricula approving postgraduate trainings in emergency medicine e.g Master of Medicine (MMed), for doctors, and Master of nursing in emergency and critical care among others.

5.2.9 Ministry of Local Government (MoLG)

The Ministry of Local Government is responsible for the creation, supervision and guidance of sustainable, efficient and effective service delivery in the decentralized system of governance. In terms of health service delivery, the ministry is responsible for the harmonization and support of all local government health functions and to contribute towards positive socio-economic transformation of Uganda. District administration offices oversee the effective functioning of all district health facilities services from general hospitals to HCIIs. MOLG will guide MoH on the implementation of a regionally coordinated EMS in a decentralized framework.

5.2.10 Ministry of Finance Planning and Economic Development (MoFPED)

Ministry of Finance Planning and Economic Development is mandated to provide the overall framework for mobilization of public resources and expenditure. It is responsible for formulation of sound economic policies that lead to sustainable economic growth and development. MoFPED will support MoH in development of an emergency medical services financing framework and strategic plan. The MoFPED will provide a certificate of financial implications, review the regulatory impact assessment and mobilise resources for emergency care. EMS will be funded through direct budget allocations, loans and grants secured by MoFPED.

5.2.11 Ministry of Internal Affairs (MoIA)

The Ministry of Internal Affairs is responsible for the facilitation of legal and orderly movement of persons to and from Uganda, regulate the residence of immigrants in the country, verify and process Uganda citizenship and enforce national and regional immigration laws for the development and security of Uganda. Through its mandate, Ministry of Internal Affairs shall support Ministry of Health in facilitation of legal movement and settlement of expatriates working with the department of emergency medical services.

5.2.12 Ministry of Foreign Affairs (MoFA)

The mandate of the Ministry of Foreign Affairs is the Implementation and Management of Uganda's Foreign Policy. The Ministry will facilitate attraction of investment and transfer of technology, coordinate the mobilization of resources from abroad for development, and promote of inter-institutional partnerships and capacity building for emergency medical services.

5.2.13 Ministry of Justice and Constitutional Affairs (MoJCA)

The Ministry of Justice and Constitutional Affairs is responsible for the provision of legal advice and legal services to government, its allied institutions and to the public and to support the machinery that provides the legal framework for good governance. It shall play a big role in guiding the signing of MOUs with partners, EMS policy making process and the enacting of the EMS Act and other laws.

5.2.14 Ministry of Gender, Labour and Social Development (MoGLSD)

The Ministry of Health will work with the Ministry of Gender, Labour and Social Development to harness the potential of the community in provision of first aid as the first response to emergencies. MoH will provide the technical expertise while MoGLSD will mobilise the society for emergency response. MoH will guide MoGLSD in implementing the occupational safety and health measures at the institutional level.

5.2.15 Kampala Capital City Authority (KCCA)

In Article 7 (3) KCCA Act 2010, states "The Ministries responsible for Health and Environment shall oversee the public health and environment matters respectively in the Capital City" and in Schedule 3: Functions and Services for which Kampala Capital City Authority is responsible in the Health Sector are; ambulance services, clinics, dispensaries, health and inoculation centers. The Department of EMS MoH shall therefore in liaison with the Directorate of Public Health and Environment KCCA oversee the delivery of Ambulance services in the City. Ministry of Health is in advanced stages of establishing a regional emergency call and dispatch center to coordinate the delivery of emergency care services in the Kampala Metropolitan Area. The Medical Call and Dispatch center will be established at one of the referral hospitals in KCCA to ensure 24/7 coverage.

5.2.16 Uganda Bureau of Statistics (UBOS)

Uganda National Bureau of Statistics is mandated to coordinate, monitor and supervise Uganda's National Statistical System. UBOS shall summarize and publish information on health using health data from various sources. Reports shall inform decision on investment for health and particularly considering emergency care services in the country.

5.2.17 Uganda Investment Authority (UIA)

The UIA works with the government and the private sector to promote the economic growth of Uganda through investment and infrastructure development. UIA shall support and guide both government and private sector investment in infrastructure for emergency care services.

5.2.18 Insurance Regulatory Authority Uganda (IRAU)

The Insurance Regulatory Authority of Uganda is a government agency mandated to ensure the effective administration, supervision, regulation and control of the business of insurance in Uganda. IRAU will guide MoH in the development and implementation of the health insurance scheme which is intended to offer Ugandans an opportunity for affordable health care, including emergency care services. IRAU shall support MoH in the realization of the benefits of third party insurance financing for emergency medical services.

5.2.19 Uganda National Bureau of Standards (UNBS)

UNBS is responsible for the formulation and promotion of the use of standards; enforcing standards in protection of the public, health and safety and the environment against dangerous, counterfeit and substandard products; ensuring fairness in trade and precision in industry through reliable measurement systems and quality assurance, among others. UNBS shall support MoH in the development of ambulance standards and quality assurance protocols for ambulance vehicles.

5.2.20 Ministry of ICT and National Guidance

The National Ambulance service shall be supported by a robust call and dispatch system. This shall require support from Ministry of ICT and National Guidance and Uganda Communications Commission (UCC).

5.2.21 Ministry of Science, Technology and Innovation (MoSTI)

The National Ambulance service shall be supported by the MoSTI to provide continuous science driven technology and innovative solutions to emergency medical services delivery.

5.2.22 Ministry of Energy

The National Ambulance service shall be supported by the Ministry of Energy to adapt EMS services to the unique challenges in oil and gas exploration areas such as aero-medical evacuation services.

5.3 PRIVATE SECTOR

5.3.1 Private not for Profit (PNFP)

PNFP health facilities will provide emergency care services to the public through their network of health facilities under the EMS National Policy Framework. Providing lifesaving care before referral shall be a guiding principle for all private not for profit health care providers. Government support to PNFPs shall be hinged on their ability to provide Emergency Care responsive services.

As per section 125A of the Traffic and Road Safety Act 1998 (Amendment) Act 2020, a person involved in an accident shall have access to medical treatment at a hospital, clinic or any other health facility without proof of financial ability to pay until he or she has been stabilised.

5.3.2 Private Health Providers (PHP)

The EMS Policy shall apply to all facilities including those that fall under the umbrella of private health providers. These include ambulances based at private health facilities and those operated by private providers. All PFPs shall provide emergency stabilizing care for the critically ill/ injured before referral.

As per section 125A of the Traffic and Road Safety Act 1998 (Amendment) Act 2020, a person involved in an accident shall have access to medical treatment at a hospital, clinic or any other health facility without proof of financial ability to pay until he or she has been stabilised.

5.4 Community Based Organisations, Non-Government Organisations, Faith Based Organisations and cultural organisation

The EMS Policy shall apply to all organisations that fall under the umbrella of Community Based Organisations and Civil Society Organisations. These include Uganda National Health Users/ Consumers Organisation (UNHCO), Uganda Red Cross Society, St. John Ambulance and others. MPs ambulances will be classified among the Non-Governmental organizations and those handed over to local governments will be classified as government ambulances.

These organisations shall provide and advocate for emergency medical services to the public under the National EMS Policy Framework.

5.5 Academia

Academic institutions are responsible for training specialist emergency care health care workers which is intended to increase human resource capacity in the country. Some universities have already started postgraduate MMeD program in Emergency medicine. There is a need for training at certificate, diploma and degree levels in emergency medicine.

5.6 Health Development Partners (HDPs)

Health service delivery is through strategic collaboration between government and development partners to improve people's health through shared program implementation, and using agreed structures and processes for health system policy, governance and joint performance review. HDPs shall work with MoH to support planning, implementation, monitoring and evaluation of this policy.

Where plausible the HDPs shall support MoH/MoFPED in acquisition of loans and grants for EMS.

CHAPTER SIX

6.0 IMPLEMENTATION FRAMEWORK AND STRATEGIES FOR PARTNERSHIP FOR COMPLIANCE

6.1 Coordination and Leadership Framework

A National Coordination Committee consisting of key stakeholders in emergency medical services shall be set up at MoH to support the operationalization of the EMS framework. The MoH through the department of EMS shall provide the secretariat, leadership and oversight of EMS among MDAs, private sector, academia, NGOs and CSOs.

Government shall establish structures at regional, district and sub-district levels to deliver EMS.

6.2 Information, Education, Communication and Dissemination (for awareness creation and popularization of the policy)

6.2.1 Policy Statement

To ensure that this policy is communicated, accepted and adhered to, the MoH shall include it in the overall MoH communication strategy to inform stakeholders including public, private sector, NGOs and civil society.

6.2.2 Policy Strategies

The priorities for communication and dissemination of the EMS policy are:

1. To plan and coordinate stakeholder education workshops at all levels.
2. To develop and regularly circulate comprehensive public information guidelines on emergency medical services.
3. To develop targeted campaigns on emergency medical services.
4. To participate in planned promotional programs by stakeholders.

6.3 Implementation Arrangements

6.3.1 Policy Statement

To develop an Emergency Medical Services Strategic plan, linked to the Health Sector Strategic Plan and National Development Plan to operationalize this policy. The EMS Strategic plan shall be executed through annual work plans developed with input at all levels.

6.3.2 Implementation stages

The EMS policy will be implemented over a 20 year period in the phased approach below:

1. Establishment (short term) phase: 1-3 years
2. Growth (medium term) phase: 4 -6 years
3. Consolidation (long term) phase: 7- 10 years

6.3.3.1 Establishment (Short term) phase: 1-3 years

(i) Policy, Standards and Guidelines set.

(ii) Identify and specify equipment for emergency services

(iii) Incorporate emergency care data into the national HMIS

(iv) Mapping of emergency care infrastructure and services

(v) In-service training in emergency medicine for health workers

(vi) Training of specialists in emergency medicine

(vii) Establishment of Emergency Medical Technician training and career path for ambulance professionals

(viii) Se up National and regional call and dispatch centers.

(ix) Public sensitization on EMS services and ambulance short code 912.

(x) Renovation, construction and establishment of emergency units at health facilities at regional and district levels.

(xi) Ambulance vehicles procurement

(xii) Establishment of regional EMS structures.

6.3.3.2 Growth (Medium term) phase: 4 -6 years

(i) Monitoring & Evaluation for emergency care mainstreamed.
(ii) Community First responders trained.
(iii) Establish EMT training institutions
(iv) Setting an EMS Act

6.3.3.3 Consolidation (Long term) phase: 7- 10 years

- Fully functional coordinated EMS services

6.4 Implementation Drivers

EMS Implementation Drivers are the key components of capacity and the functional infrastructure supports that will enable the program's success in a developing country like Uganda. Reliable and valid measures of EMS implementation components are essential to

effective planning, assessing progress toward implementation capacity, and conducting rigorous research on implementation. There are three categories of EMS Implementation Drivers that MoH shall adopt:

6.4.1 Competency Drivers:

MoH will put in place mechanisms to develop, improve and sustain EMS human resource capacity to implement interventions as intended for the common good. Human resource is the foundation of building a competent EMS workforce that has the knowledge, skills, and abilities to implement evidence-based practices which benefit the public. EMS human resource competence goes beyond academic qualifications or experience to include basic professional skills, basic social skills, common sense, empathy, good judgment, knowledge of the field, personal ethics, sense of social justice, willingness to intervene and willingness to learn. MoH shall develop job descriptions and methods, protocols and criteria for selecting professionals with the required skills and abilities for the different levels of the health care system. Competence will be driven by continuous staff improvement, staff coaching and performance assessment.

6.4.2 Organization Drivers:

MoH will develop organizational and administrative systems that are necessary to facilitate effective implementation of the EMS agenda. These will include;

(i) Decision Data Support Systems

MoH will establish sources of information to help EMS human resource in decision making, assessing key aspects of the overall performance of the organization and assuring continuing implementation of the evidence-based EMS interventions.

(ii) Facilitative Administration

MoH will provide facilitative administrators, who will ensure alignment of EMS policies, procedures, structures, culture, and climate with the needs of the public.

(iii) Systems Intervention

MoH will develop strategies intended to create a supportive context in which effective EMS will be established, maintained, and consolidated over the years to promote effective service delivery. These will include financial, organizational, and human resources to support the EMS system.

6.4.3 Leadership Drivers:

MoH and the mandated institutions will ensure that effective and relevant leadership is in place to make critical decisions, provide guidance, and support the functioning of the EMS system.

6.5 Funding

Government will mobilize resources for emergency medical services and explore innovative ways of funding.

6.6 Monitoring and Evaluation

A monitoring and evaluation framework for all stakeholders will be developed to monitor attainment of the policy objectives. Clear outputs and performance indicators shall be developed for purposes of measuring success of the policy implementation.

6.7 Legislative framework

Appropriate legislation will provide an enabling environment for the operationalization of the policy and is essential for effective emergency medical service delivery. Government will develop a by-stander protection legislation, such as the Good Samaritan Law and EMS Act.

6.8 Feedback Mechanisms

Government will integrate emergency care into the existing feedback mechanisms to ensure delivery of services is monitored.

6.9 Policy Reviews

The government will review the National Emergency Medical Service policy in consultation with stakeholders and subject matter experts and will update it periodically as the need arises.

7.0 FINANCING

The total amount required to finance the first 5 years of this policy will be to the tune of 164.381Million USD (608,209,700,000UGX).

Health development partners have committed 38,998,700 USD to supporting the funding of the EMS system implementation: Global Fund 8,000,00 USD, World Bank 10,000,000 USD, KOFIH 2,288,700 USD, ENABEL 2,137,900 USD, Malteser International 1,997,400 USD, CHAI 624,200 USD, CDC 400,000 USD, Seed Global Health and others 13,550,500 USD.

Emergency Care Systems for universal health coverage: ensuring timely care for the acutely ill and injured

SEVENTY-SECOND WORLD HEALTH ASSEMBLY **WHA72.16**

Agenda item 12.9 **28 May 2019**

Emergency care systems for universal health coverage: ensuring timely care for the acutely ill and injured

The Seventy-second World Health Assembly,

Having considered the report on emergency care systems for universal health coverage: ensuring timely care for the acutely ill and injured;[1]

Noting the importance of the organization of the health system as a whole, including by distinguishing between elective services and care, non-elective services and care, and emergency services and care in order to address the health needs of populations in a sustainable, effective and appropriate manner;

Recognizing that many proven health interventions are time-dependent and that emergency care is an integrated platform for delivering accessible, quality and time-sensitive health care services for acute illness and injury across the life course;

Emphasizing that timeliness is an essential component of quality, and that millions of deaths and long-term disabilities from injuries, infections, mental disorders and other mental health conditions, acute exacerbations of noncommunicable diseases, acute complications of pregnancy, and other emergency conditions could be prevented each year if emergency care services exist and patients reach them in time;

Noting that injury alone accounts for nearly 5 million deaths per year and that road traffic injury is the top killer of all those in the age group of 5–29 years;[2]

Noting also that emergency care is an essential part of health service delivery in health systems, and that well-designed emergency services facilitate timely recognition, treatment management and, when needed, continued treatment of the acutely ill at the appropriate level of the health system;

Acknowledging Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages), and recognizing that well-organized, safe and high-quality emergency care is a key mechanism for achieving a range of associated targets – including those on universal health coverage, road safety, maternal and child health, noncommunicable diseases, mental health, and infectious disease;

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[1] Document A72/31.

[2] Global Health Estimates 2016: deaths by cause, age, sex, by country and by region, 2000–2016. Geneva, World Health Organization; 2018

Acknowledging further Sustainable Development Goal 11 (Make cities and human settlements inclusive, safe, resilient and sustainable) and Goal 16 (Promote peaceful and inclusive societies for sustainable development, promote access to justice for all and build effective, accountable and inclusive institutions at all levels), and noting that a strong and well-prepared everyday emergency care system is vital for mitigating the impact of disasters and mass casualty events and for maintaining delivery of health services in fragile situations and conflict-affected areas;

Recalling resolutions WHA56.24 (2003) on implementing the recommendations of the *World report on violence and health*, WHA57.10 (2004) on road safety and health (echoed by United Nations General Assembly resolution 72/271 (2018) on improving global road safety), WHA60.22 (2007) on health systems: emergency-care systems, WHA64.10 (2011) on strengthening national health emergency and disaster management capacities and resilience of health systems, WHA66.8 (2013) on the comprehensive global mental health action plan 2013–2020, WHA68.15 (2015) on strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage, and WHA69.1 (2016) on strengthening essential public health functions in support of the achievement of universal health coverage, in which the Health Assembly prioritized integrated service-delivery models and identified the lack of access to timely emergency care as a cause of extensive and serious public health problems;

Recalling also the mandate of WHO's Thirteenth General Programme of Work, 2019–2023 to improve integrated service delivery and to serve in particular the most disadvantaged, marginalized and hard-to-reach populations, to ensure that no one is left behind;[1]

Noting that providing non-discriminatory access to all people in need of timely care in well organized, safe and high-quality emergency care services can contribute to the reduction of health inequalities;

Noting further that in many countries the emergency care system serves as the major health system safety net and the primary point of access to health services, in particular for marginalized populations, which is not an optimal use of health system resources;

Recognizing that the lack of organized emergency care in many countries leads to wide global discrepancies in outcomes across the range of emergency conditions;

Noting that many emergency care interventions are both effective and cost effective, and that integrated emergency care delivery can save lives and maximize impact across the health system;

Concerned that the lack of investment in frontline emergency care is compromising effectiveness, limiting impact and increasing cost in other parts of the health system;

Acknowledging that frontline health workers, nurses in particular, provide care for the acutely ill and injured, often without the benefit of dedicated training in the management of emergency conditions, and with limited possibilities for consultations;

[1] Thirteenth General Programme of Work, 2019–2023. Geneva: World Health Organization; 2018; as contained in document A71/4 (http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=1or, accessed 19 March 2019) and adopted in resolution WHA71.1 (2018).

Noting that improving outcomes requires an understanding of the potential and actual utilization of emergency care, and that existing data do not provide adequate support for effective planning and resource allocation for emergency care;

Considering that WHO has a range of guidance that allows policy-makers, planners and administrators to develop action plans that are best suited to their national contexts, along with resources for training, as well as standards for essential emergency care services and resources at each level of the health system,

1. CALLS FOR near-term additional efforts globally to strengthen the provision of emergency care as part of universal health coverage so as to ensure the timely and effective delivery of life-saving health care services to those in need;[1]

2. URGES Member States:[2]

(1) to create policies for sustainable funding, effective governance and universal access to safe, high-quality, needs-based emergency care for all, without regard to sociocultural factors, without requirement for payment prior to care, and within a broader health system that provides quality essential care and services and financial risk protection as part of universal health coverage;

(2) as appropriate, to conduct voluntary assessments using the WHO emergency care system assessments tool to identify gaps and context-relevant action priorities;

(3) to work towards, or promote, at appropriate levels of governance, the inclusion of routine prehospital and hospital emergency unit care into health strategies, and in other relevant planning documents, such as emergency response plans and obstetric and surgical plans;

(4) to develop a governance mechanism, as appropriate to their national context, for the coordination of routine prehospital and hospital-based emergency care services, including linkages with other relevant actors for disaster and outbreak preparedness and response, including the capacity of personnel in other sectors;

(5) to promote more coherent and inclusive approaches to safeguard effective emergency care systems as a pillar of universal health coverage in fragile situations and conflict-affected areas, ensuring the continuum and provision of essential health services, and public health functions, in line with humanitarian principles;

(6) to promote as appropriate, according to the level of health care services, from first level and above, the establishment of a dedicated area or unit for emergency services and care with appropriate equipment and capacity for management and diagnosis;

(7) to promote access to timely prehospital care for all, by using informal or formal systems, as resources allow, including by establishing, where they do not exist, toll-free universal access numbers that meet international standards;

[1] See Emergency and trauma care [website]. Geneva: World Health Organization; 2019 (https://www.who.int/emergencycare/en/, accessed 20 May 2019).

[2] And, where applicable, regional economic integration organizations.

(8) to implement key processes and protocols as identified in WHO guidance on emergency care systems, such as triage and checklists,[1] as appropriate;

(9) to provide dedicated training in the management of emergency conditions for all relevant types of health providers, including developing post-graduate training programmes for doctors and nurses, training frontline providers in basic emergency care, and integrating dedicated emergency care training into undergraduate nursing and medical curricula, and establishing certification pathways for prehospital providers, as appropriate to their national context;

(10) to increase awareness and capacity in communities to deal with emergency situations, including through campaigns, and through training of standard practices across educational and occupational settings, adapted to their corresponding target populations, so they can identify, mitigate and refer potential emergencies;

(11) to implement mechanisms for standardized data collection to characterize the local acute disease burden and identify high-yield mechanisms for improving the coordination, safety and quality of emergency care;

(12) to support efforts to ensure, based on local risks, that prehospital and hospital emergency units have plans in place to protect providers, patients and infrastructure from violence and to protect providers and patients from discrimination; and that they have in place clear protocols for the prevention and management of hazardous exposures;

3. REQUESTS the Director-General:

(1) to enhance WHO's capacity at all levels to provide necessary technical guidance and support for the efforts of Member States and other relevant actors to strengthen emergency care systems, including to ensure preparedness in all relevant contexts;

(2) to foster multisectoral networks, partnerships and action plans, and to facilitate collaboration among Member States, to support the effective dissemination and implementation of best practices in emergency care;

(3) to promote equitable and non-discriminatory access to safe, quality emergency care services for all people as part of universal health coverage;

(4) to renew efforts outlined in resolution WHA60.22 to provide support to Member States, upon request, for needs assessments, facility inspection, quality- and safety-improvement programmes, review of legislation, and other aspects of strengthening the provision of emergency care;

(5) to support Member States to expand policy-making, administrative and clinical capacity in the area of emergency care, by the provision of policy options and technical guidance, supported by educational strategies and materials for providers and planners;

[1] See Emergency and trauma care [website]. Geneva: World Health Organization; 2019 (https://www.who.int/emergencycare/en/, accessed 20 May 2019).

(6) to strengthen the evidence base for emergency care by encouraging research on the burden of acute disease and emergency care delivery, and by providing tools, protocols, indicators and other needed standards to support the collection and analysis of data, including on cost-effectiveness;

(7) to facilitate awareness and international and domestic resource mobilization, in line with the Addis Ababa Action Agenda of the Third International Conference on Financing for Development[1] by providing advocacy resources;

(8) to report to the Seventy-fourth World Health Assembly in 2021 on progress in the implementation of this resolution.

Seventh plenary meeting, 28 May 2019
A72/VR/7

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[1] United Nations General Assembly resolution 69/313 (2015).