Maternal Health in Uganda

Dr Olive Sentumbwe looks into Uganda's progress in reducing maternal mortality

Uganda is among the bottom 40 countries in the world for maternal mortality, according to the WHO estimates. These estimates are derived from recent surveys with data on maternal and child health, including the 2016 and 2011 Uganda Demographic and Health Surveys (UDHS).

Uganda had 336 deaths per 100,000 live births – about 15 pregnant women dying every day – due to direct causes like hemorrhage and hypertensive disorders.[1] But this figure is lower than the 438 deaths per 100,000 live births recorded in the 2011 survey, highlighting marked progress.

Maternal deaths are caused by obstetric complications such as high blood pressure during pregnancy and severe bleeding or infections during or after childbirth, and increasingly due to an existing disease or condition aggravated by the effects of pregnancy such as HIV/AIDS.

The global target for ending preventable maternal mortality (SDG target 3.1) is to reduce the maternal mortality ratio (MMR) to less than 70 per 100,000 live births by 2030.The world will fall short of this target if the current pace of progress continues, to the cost of more than 1 million lives.

Inequalities

Despite efforts in many countries to provide safe, affordable, high-quality health services, the estimates also show vast inequalities worldwide, with women and children in sub-Saharan Africa facing a substantially higher risk of death than in all other regions).[2] Maternal deaths are nearly 50 times higher for women in sub-Saharan Africa and their babies are 10 times more likely to die in their first month of life, compared to high-income countries.[2] Women in sub-Saharan Africa face a 1-in-37 lifetime risk of dying during pregnancy or childbirth, compared to 1-in-6,500 in Europe. Sub-Saharan Africa and South Asia account for around 80% of global maternal and child deaths.

Achieving maternal mortality reduction as a development goal remains a major challenge in most low-resource countries. Previous work by both government and non-government organisations has demonstrated that maternal health in Uganda can be improved through implementing community and facility evidence-based interventions and district-wide health systems strengthening that reduce delays to appropriate obstetric care.

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Both the Making Pregnancy Safer and the Saving Mothers Giving Lives (SMGL) maternal health improvement projects implemented in Uganda have demonstrated that addressing the delays and designing interventions in the communities and the health facilities with ensuring a strong data collection and analysis component are important for achieving maternal and newborn health.[3]

For both projects, local communities were mobilised and engaged to address the challenges that confronted pregnant women and girls in their localities. They were taught the importance of family planning and all myths and misconceptions addressed through community dialogue sessions.

In the eastern Ugandan district of Soroti, model churches and local drama groups would then compose songs in their local language to promote positive practices such as family planning utilisation, attending antenatal care clinics and giving births in health facilities. They also discouraged adolescent pregnancy in their communities and called for support in transporting obstetric emergencies.

Leadership is key

In Soroti district, the political leadership was also heavily engaged in supporting project implementation. Leaders mobilised and educated their own communities and took important decisions on financial allocations to maternal health in their districts. The engagement of political, district leaders and local communities ensures accountability, while leadership and governance for maternal health are improved. This in itself guarantees sustainability and community ownership of interventions.

Male involvement

Recently, the Ministry of Health has launched the Male Involvement Strategy and implementation guidelines in order to intensify efforts to bring the men on board in promoting maternal health. This will go a long way in mobilising men to support service utilisation for family planning, skilled child birth and post-natal care, which are strong pillars for safe motherhood.

Emergency transport and communication

The second delay which causes death in obstetric emergencies results from inability to move from the household to the health facility to access the needed care due to poor transport networks and poverty in most Ugandan villages.

This component has been addressed through availing ambulances which navigate between critical care points

Mothers waiting for immunisation of their babies.

and the community. Through intensified advocacy, we begin to see some parliamentarians, church leaders and individuals procuring vehicles for their constituencies to have women to be transported to health facilities when there is an emergency. This shows that communities can support a cause, if they understand the benefits.

In some districts, community taxi commuters have also been mobilsed to participate in the transport and communication component. During community dialogues, local leaders disseminate the contacts of taxi drivers who can transport women with obstetric emergencies. In some districts, village phones were piloted as part of facilitating a community referral system. The village telephones were operated by a selected member of the Village Health Team who was given a log book as well, to document the reasons for the calls that were being made.

Solar-powered phones were placed in selected remote villages. Although their primary purpose of the phones was to ease communication in case of maternal health issues, the members were also given leeway to use them for other matters such as security and welfare.

Strategies

The third component of improving maternal health in Uganda is reflected within the past and current Health Sector Strategic Plan (HSSP) and the Reproductive Health Strategy which identify three main interventions to reduce maternal mortality namely: revitalisation of family planning, increasing access to quality antenatal care and Increasing access to quality emergency obstetric and newborn care services including post-natal care for both mother and newborn.

Efforts to redefine current interventions and develop a road map to reduce maternal mortality followed the realisation that many countries were unlikely to achieve the millennium development goals (MDGs) especially on child and maternal mortality and more recently the SDG targets. Several baselines and needs assessments have been done in Uganda and elsewhere in Africa which show that Uganda is still offering sub-optimal services for pregnant women and those in labour. Many women miss timely life-saving interventions when they need them most or receive sub-optimal health care at the most critical time of childbirth.

Emergency obstetric and newborn care (Emmons) refers to care given to manage complications that threaten the lives of the mothers and newborns either during pregnancy or childbirth.

Challenges

Emmons is categorised into basic and comprehensive. Basic signal functions can be performed at the level of health centres and are composed of parenteral antibiotics, oxytocics and anti-hypertensives, manual removal of placenta, removal of retained products and assisted vaginal delivery. Comprehensive Emmons is composed of basic signal functions in addition to caesarean section delivery and blood transfusion, which should be offered at all Health Centre IVs or hospitals within Uganda.

Expectant mothers wait for an antenatal class.

Recent reviews of availability of basic and comprehensive Emmons using relevant survey tools and Maternal and Newborn Quality Care tools, as well as the Service Availability and Readiness Assessment (SARA) surveys still show that there are various degrees of deficiencies. This is in relation to: skills of providers to offer RMNCAH services such HIV/AIDs-eMTCT/HIV testing and counselling services, family planning, antenatal care services, adolescent friendly services, blood transfusion and surgical services, availability of essential medicines for maternal and newborn health and standard precautions for infection control measures in maternal health care among others.

Many health facilities have scanty infrastructure for provision of all these elements of maternal health care. Coupled with the ever increasing population of women of reproductive age, this poses a great challenge.

According to 2016 UDHS, 60% of mothers made four antenatal care visits compared to 48% in 2011. Skilled Birth Attendance was 73% in 2016 from 57% in 2011.[1] This shows progress slowly being realised in maternal health care services in Uganda for child birth. If this increases further, it should have an impact on maternal and newborn morbidity and mortality.

However, it has also emerged that the rate of reduction of maternal and newborn deaths in Uganda is not matching the progress made in antenatal attendance and the increased health facility deliveries. This is attributed to poor quality of maternal and new born care services given to mothers during the process of childbirth and during ANC.

Ways forward

Performance improvement process in health care in general has been adopted by the Uganda government for all components. In 2017, Uganda joined the 11 pathfinder countries to accelerate steps in focusing on improving quality of care in maternal and newborn care components focusing on the 24 hours of child birth. This is the most critical time for both mothers and newborns during which 15% of pregnancies may experience life threatening complications which require a well prepared health care system offering quality MNH care services.

It is envisaged that quality improvement will greatly contribute to the survival of mothers and newborns who develop life threatening complications throughout the processes of pregnancy, childbirth and the post-natal period.

This strategy, which focuses on identifying and addressing problems in the provision of quality care, will be scaled up in many health facilities once the lessons learnt from the piloting districts are well documented for replication.

Uganda, like many other developing countries, has inadequate staffing at health units and this has implications for the provision of services and supervision at all levels. Thus scale-up of EmNOC and other mentioned maternal health services requires the ministries of health and finance to allocate more resources to recruit skilled personnel who will facilitate the performance improvement processes to address the burden of maternal.

Research has shown that necessary component of service provision include: health education, training of providers, explaining the side effects of family planning commodities and essential medicines and supplements used in maternal health care, giving instructions on how to follow the recommended dosage, and dissemination of national treatment policies.

In conclusion, Uganda is set to achieve a reasonable degree of reduction of maternal and newborn deaths if maternal and newborn Quality of care can be significantly addressed in all districts and communities are mobilised to use family planning services, antenatal care services as well as deliver in health facilities. This will also require community engagement and empowerment in order to increase utilisation of available services especially as they relate to family planning and HIV prevention. Community engagement will also contribute to reduction of the currently high adolescent pregnancy which results into rather high maternal deaths and morbidities such as obstetric fistulae. Other community engagement processes have included training of male action groups to enable men participate and promote maternal health program interventions.

References

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