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POLITICAL AND SOCIAL CHALLENGES FACING THE REDUCTION OF UGANDA'S MATERNAL MORTALITY RATES

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SUMMARY

- While there has been a recent worldwide decline in maternal mortality rates, mothers in developing countries, like Uganda, continue to face challenges in receiving effective reproductive health care.
- Uganda's maternal mortality and morbidity rates remain high as a result of inaction in addressing physical, socio-cultural, and financial obstacles to maternal health services.
- Political will, increased funding and social support for women's health are all needed before significant and lasting decreases in maternal mortality will be achieved in Uganda.

BACKGROUND

While there has been a significant worldwide decline in maternal mortalities rates (MMR) over the past three decades — 526,300 in 1980 to 342,900 in 2008 — developing countries such as Uganda have made much more modest gains in improving maternal health (Hogan et al, 2008: 1609). Based on its annual rate of MMR decline, in fact, Uganda will take until at least 2031 to fulfill Millennium Development Goal (MDG) number five, which aims to achieve universal access to reproductive health care and reduce MMR by three quarters by 2015 (Lozana et al, 2011: 1161).

Though decreases have been modest, Uganda's maternal mortality rate has experienced an overall decline over the past 15 years. This can be attributed to policies that encourage improved health care and financial support for mothers and pregnant women. Many researchers and practitioners, however, point to

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a number of problems that continue to hinder a more significant decline in MMR rates that have been achieved elsewhere in the developing world. This paper examines Uganda's successes and failures toward improving maternal health, and suggests ways forward for international and domestic policy makers.

MATERNAL MORTALITY RATES IN UGANDA

In 2011, *The Lancet* estimated Uganda's maternal mortality rate had dropped from 561 deaths/100,000 live births in 1990 to 274 deaths/100,000 live births in 2011 (Lozana et al, 2011: 1148). Though this seems to show significant improvement at first, the figures have been met with a great deal of controversy. Firstly, throughout the developing world, there are substantial annual variations in MMR measurements due to incomplete registration systems and monitoring regimes (Lozana et al, 2011: 1162).

Uganda, for instance, has yet to release its own figures for maternal mortality in 2011, though their estimates for MMR in previous years are typically much higher than those offered by *The Lancet*. The Uganda Health and Demographic Survey (DHS) reports that MMR only lowered from 527 deaths per 100,000 live births in 1995, to 505 in 2000 and 435 in 2006 (Republic of Uganda, 2006: 280). The DHS notes that the decline in 2006 could be attributed to a change in measurements and data collection since 2000. Further, lower MMR does not correlate with other indicators of improved maternal health such as increased antenatal visits, or skilled attendants at birth or hospital deliveries (Republic of Uganda, 2006: 280). Given these factors, the DHS could not state with confidence that maternal health has improved across the country, and certainly not as much as *The Lancet's* figures would suggest.

POLITICS BEHIND THE NUMBERS

After years of publishing stagnating maternal mortality rates in Uganda, *The Lancet's* report of a global decline in MMR deaths generated mixed reactions. Though used improved data collection and statistical methods, the report was not entirely welcome news to those in the field. The *New York Times* reported that some wanted to delay the release of the statistics, fearing that positive news would overshadow the urgency of the issue

(Grady, 2010). Several organizations also expressed concern that an improvement trend might divert attention and funding away from further efforts improve maternal health.

UGANDA'S CAUTIOUS SUCCESS IN IMPROVING MATERNAL HEALTH

What can be attributed for the decline in Uganda's MMR? There have been a number of NGO and government initiatives targeting different aspects of maternal health in the country. It is difficult to single out one initiative to an overall national decline, although it has been suggested that Uganda has created a conducive policy environment for maternal health initiatives (EASSI, 2010: 11; Kyomuhendo, 2003: 17). Resulting policies have improved services and protocols that establish quality care for women during pregnancy and childbirth. These also acknowledge challenges that need to be addressed in order to make complimentary improvements to accessing maternal health care (Republic of Uganda, 2010: 85-6). Furthermore, Uganda has established an implementation framework from the national to the local level that provides a mechanism for converting these policies into practice. Finally, the country has strengthened public-private partnerships that engage stakeholders at a national level to work towards accountability and consistency (EASSI, 2010: 11). Together, these efforts may be contributing to the observed improvements in maternal health.

Uganda has also achieved some financial success for maternal and child health. With maternal health initiatives gaining international attention in recent years, donors have pledged over \$40 billion (all figures USD) to improve child and maternal mortality worldwide, to be spent by 2015 (Loranza, 2011: 1162). In Uganda, the national government has increased maternal health funding through larger budgetary allocations, announcing \$122 million for maternal and reproductive health from 2010 to 2015 (Kagumire, 2010: E685). This will build on efforts to improve basic obstetric care and staff training at 400 health centres, increase access to medicines and supplies and provide better family planning services, avenues for male involvement and youth-friendly health services.

ENDURING CHALLENGES TO REDUCING MMR

The 15th session of the African Union on “Maternal, Infant, and Child Health and Development in Africa” was held in Kampala in July 2010. It was there that Ugandan President Yoweri Museveni announced his country would not meet MDG 5 by 2015, blaming slow progress on corrupt health care workers and insufficient funding (Kagumire, 2010: E685). Insufficient funding is indeed a major hindrance to the full implementation of policies for safe motherhood. Uganda has not abided by the Abuja Declaration to assign 15 percent of national budgets to health care (Kagumire, 2010: E685), and the Ministry of Health continuously faces shortfalls for maternal health services. The result on the ground is overcrowded maternity and antenatal wards, overworked health care staff and under stocked pharmacies. These conditions make it difficult for workers to ensure women receive appropriate care when they arrive for checkups and deliveries.

Despite persistent domestic shortfalls, foreign donors only provide for some of the services to populations in need. Obstetric fistula, for instance, is one of the most common and debilitating complications of unsafe motherhood—yet the Ministry of Health provides no funding to correct it. Instead, international donors provide funds to some hospitals to perform corrective surgery, though the funding available is “too small to have a meaningful impact” (Manyire, 2010: 8). Complaints of bribery indicate that the few supplies and services that make it to hospitals and health centres do not reach all women free of charge (Kyomuhendo, 2003: 25).

The lack of funding, both domestically and internationally, prevents Uganda’s Ministry of Health from addressing obstacles outlined in their policies (Republic of Uganda, 2010: 32). Unlike child health, which can be improved through measures such as immunization, deworming, and the distribution of Vitamin A supplements and insecticide-treated bed nets, maternal health is more dependent on a fully functioning health care system with the capacity for referral and emergency management. One study reports that only improved emergency obstetric care supplies and would help to improve MMR in facilities with rates higher than the national average (Mbonye et al, 2010: 286). These numbers can be significantly reduced when key issues to health care systems are addressed (Loranza, 2011: 1162), though this requires full funding, political will and long-term commitment to public and maternal health.

Uganda's challenges in reducing MMR, however, often move beyond corruption and insufficient funding; it is well-documented that a range of social, cultural, and practical barriers also exclude women from the formal health care system (Thaddeus and Maine, 1994; Gabrysch and Campbell, 2009). Regarding maternal health, studies find that "the majority of pregnant women attend antenatal check-ups at health facilities, but difficulties in physical access compounded by cultural restrictions mean women's use of health facilities for delivery is limited in Uganda" (MacKian, 2008: 107).

Social and cultural expectations of Ugandan women can also have consequences for maternal health. Delivering alone at home, surviving the battle of pregnancy and childbirth and having multiple children have the potential to contribute to a woman's increased social status in some parts of the country (Kyomuhendo, 2003 18-19). As a result, death during childbirth can also be viewed as her failing even when lack of transport or supplies can explain why she did not seek medical help. These expectations and pressures can affect how communities respond to medical problems during pregnancy, and help to explain why Uganda's MMR continues to be a pressing health challenge for the country's mothers and policy makers.

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