

Adolescent motherhood and maternal deaths in Uganda

Executive Statement

Despite the reduction in the rate of maternal deaths during child birth over the past decade, Uganda's maternal mortality ratio (MMR) remains high compared to other East African countries. At 375 deaths per 100,000 live births in 2017, Uganda's MMR is 51 percent more than that of Rwanda (248 deaths per 100,000 live birth). On the other hand, the major causes of maternal deaths during child birth in Uganda are preventable. Major drivers of maternal deaths include the high prevalence of teenage pregnancy and associated adolescent motherhood as well as inequitable distribution of health facilities across the country.

Introduction

Maternal deaths during child birth remains a major public health concern in sub-Saharan Africa. In 2015, the sub region accounted for 67 percent of the 300,000 global maternal deaths due to complications of pregnancy and childbirth.¹ A large proportion of women in SSA die due to inappropriate reproductive health care—inappropriate to address the “3 delays” i.e. (i) delayed recognition of a pregnancy complication and decision to go to a facility, (ii) delays in reaching an emergency obstetric care facility, and (iii) delays in receiving adequate and appropriate obstetric care at a health care facility.² Globally, the reductions in maternal mortality have been prioritized as part of Sustainable Development Goals (SDGs) 3—which targets to reduce maternal death to less than 70 maternal deaths per 100,000 live births by 2030.

Using secondary data from the Uganda Bureau of Statistics (UBoS) and World development indicators and publication by the GoU, this brief examine some of the drivers of high maternal death. The focus is on the critical issues of : (a) adolescent motherhood, (b) low ante-natal care attendance, and (c) inequitable distribution of health facilities that continue to contribute to the observed country's maternal mortality levels as an important move to guide health service delivery system and for public health policy or programme formulation, implementation and evaluation.

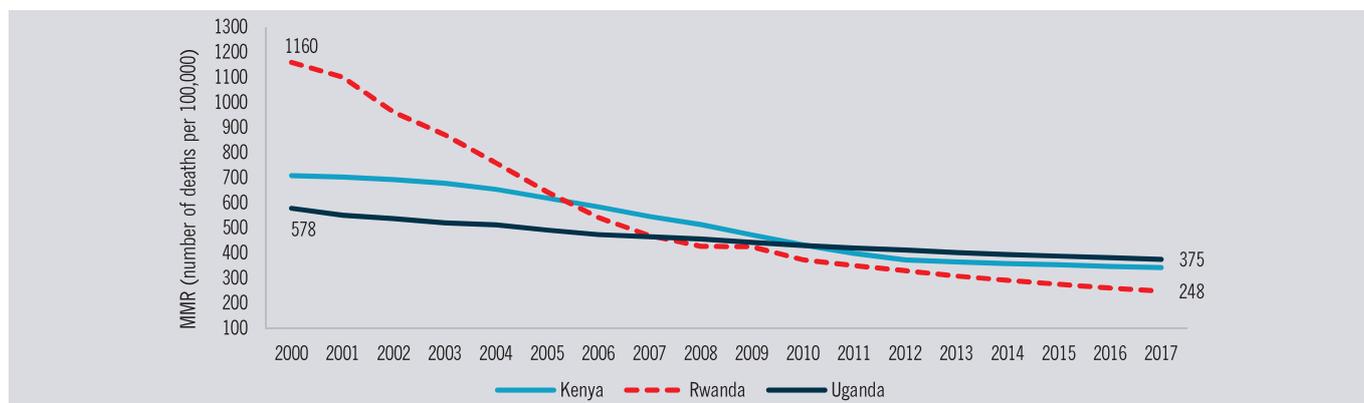
Maternal Mortality in East Africa

Ugandan government is committed towards the goal of reducing maternal deaths during child birth. A number of strategies have been undertaken by both government and private actors in the health sector. The 2015/16 – 2019/20 Health Sector Development Plan (HSDP) outlines strategic interventions such as Universal

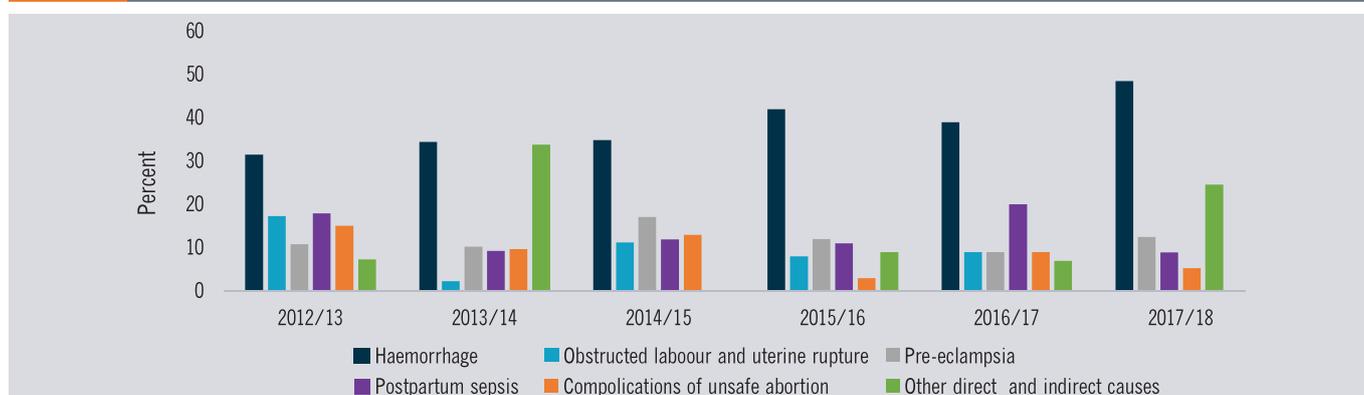
Health Coverage (UHC), universal access to Antenatal Care (ANC) services, among others to achieve maternal health outcomes. Earlier initiatives include Saving Mothers, Giving Life (SMGL)—a five year programme which was launched in Uganda in 2012 aimed at building upon existing district health strategies and platforms to address the “Three Delays” mentioned earlier. Over the intervention period (2012-2017), the programme led to a reduction in MMR from 342 to 222 per 100,000 live births in the 4 SMGL supported districts.³ In addition, facility MMR for obstetric haemorrhage decreased from 131 to 77 per 100,000 live births.

Other interventions such as primary health care (PHC) through basic Emergency Obstetric Care (EMOC) services, skilled health workers, and increase focused antenatal care through prevention of mother to Child Transmission of HIV have also been implemented. The USAID/Uganda Voucher Plus Activity which aimed at increasing access to quality obstetric, new-born, and postpartum family planning services to poor women through the private sector in 33 districts in Northern and Eastern Uganda also aimed at reducing maternal mortality.

The aforementioned interventions have yielded some dividends in the reduction in the maternal mortality ratio (MMR) from 578 maternal deaths per 100,000 live births in 2010 to 375 maternal deaths in 2017 (Figure 1). Despite the reduction to 375 deaths in 2017, Uganda's MMR is still much higher than that of Rwanda and Kenya. Uganda's National Development Plan (NDP) II targets to reduce maternal deaths to 320 per 100,000 live births by 2020.

Figure 1 MMR of selected EAC countries (2000-2017)

Source: World Development Indicators, 2019

Figure 2 Causes of Maternal death during child birth in Uganda (%)

Source: The state of Uganda's Population report (2019)

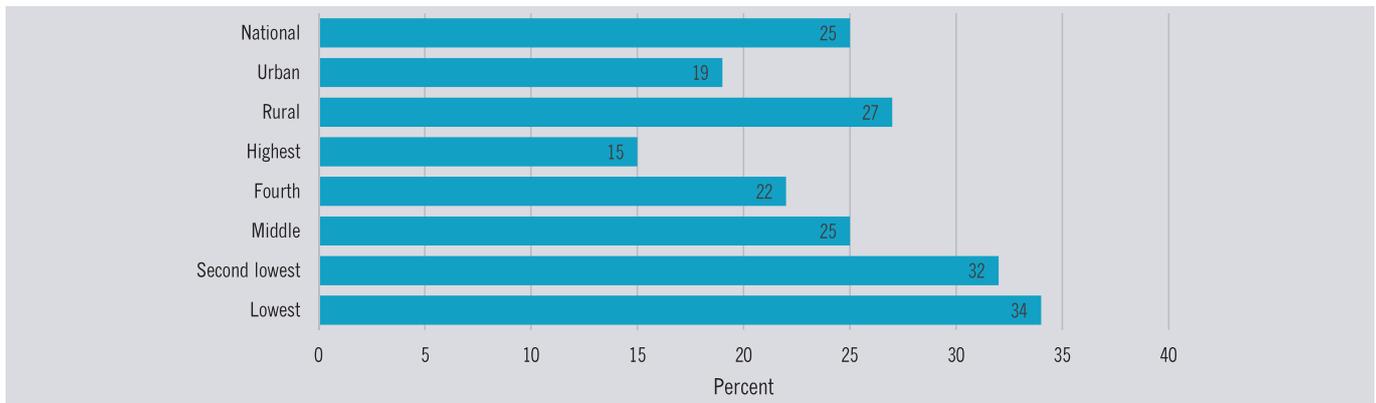
The major drivers of maternal mortality in Uganda are mostly preventable. These include: haemorrhage, obstructed or prolonged labour, complications from abortion, among others (Figure 2).⁴ There has been an increasing trend in percentage contribution of haemorrhage to maternal mortality and yet through MMR facilities for obstetric haemorrhage, this could be reduced (as the case was from 131 in 2012 to 77 maternal deaths per 100,000 live births in 2016 in SMGL supported districts). This shows that much effort is still needed by the country Uganda to achieve significant reduction in MMR as well as target to achieve the SDG 3.

Adolescent motherhood (15-19 years old mothers)

Complications related to childbirth and pregnancy are the leading cause of death for girls aged 15 to 19 years in Africa.⁵ A girl between the age of 15 and 19 is twice likely to die during pregnancy or childbirth than an adult woman. The risks are 5 times higher for adolescents under 15 years. This is primarily due to the high risks associated with giving birth before becoming fully developed physically, emotionally and psychologically and eventual contribution to maternal mortality. Early childbearing is associated with poor maternal health outcomes such as preterm birth and low birth weight, which in turn can aggravate and maternal mortality (monography 2018⁶, WHO, 2018)⁷.

In Uganda, adolescents form one of target age cohorts for 2015/16-2019/10 HSDP interventions to ensure a healthy population through promotion of sexual and reproductive health education in schools and communities. These have had various interventions such as the adolescent health strategy-2012, the Reproductive Maternal, Newborn and Child Health Sharpened Plan for Uganda (RMNCAH) 2013 among others. However, the interventions have had minimal effect on teenage pregnancies.

According to the NDP II, it is estimated that adolescent mothers contribute up to 28 percent of Uganda's maternal mortality ratio due to high teenage pregnancy. Figure 3 shows that 25 percent of Uganda's young girls (aged 15-19 years) have started child bearing by the age of 19 years. Teenage pregnancy is higher in rural (27 %) compared to urban (19 %), yet still, girls from poor households (34 percent) are more likely to get pregnant at an early age compared to those from wealthy households (22 percent). This is partly due to limited access to sexual reproductive health information and services. Teenage pregnancy exposes teen mothers to increased risk of ill health, adverse pregnancy outcomes and eventual contribution to Uganda's high mortality rates.

Figure 3 Percentage of young girls aged 15-19 years who have started child bearing

Source: GoU (2019) Population report 2019⁶

Low antenatal care attendance

Antenatal care (ANC) is critical for improving maternal and newborn health. Routine focused ANC can prevent maternal deaths through prevention of conditions that may have unfavourable effects on the health of the mother and child; treatment of complications; and provision of information about pregnancy, childbirth and the postnatal period to the mother. The 2016 WHO Antenatal guidelines recommends that a woman should have at least eight antenatal care visits to reduce maternal mortality, instead of Uganda's HSDP of 4 visits. Findings from UDHS show that six in 10 women who had a birth in 5 years preceding the survey (60%) attended the recommended four ANC visits during the pregnancy leading to their most recent birth. Although this achievement surpasses the target Uganda's NDP II target of 55%, it falls short of the ideal universal recommendation by WHO of Antenatal care guidelines.



According to the UNHS 2016/17, the most prevalent factors that prevent women from receiving or seeking care during pregnancy and childbirth at public health facilities were; unavailability of medicines/supplies (23%), long waiting time (13%), long distance (12%), limited range of services (14%) and understaffing (10%). Whereas, in private facilities, it was found that the services being expensive (39%) ranked top followed by limited range of services (23%) and long distance (9%). With the high population growth in Uganda (3% annually) and a total fertility rate of 6.2, means that Uganda will have to address the barriers to women's attendance to ANC to attract more women to seek ANC. Other important inputs are appropriate equipment and supplies, and quick transport that can facilitate the transfer of women with complications to higher levels of care.

Inequitable distribution of health facilities

The maternal mortality rate remains high due to inadequate action to address access to health facilities. Uganda's HSDP targets to have 85% of Ugandan households within 5km distance to health facility by 2020, through both public and private intervention in national health systems. Private sector which account for over 45% of the country's health facilities in Uganda,⁷ has fewer than 20% of private health facilities classified as level III health centres or higher, with the minimum level at which maternal health services can be provided.⁸ This implies that the biggest burden to deliver maternal outcomes is vested with government.

A critical analysis of government efforts to have Ugandan households within 5km distance to a public health facility shows that only 68% of the households live within the target distance (Figure 4), and yet these are the centres that are most likely to offer maternal care. The situation is worse for rural areas (61%). This implies that rural mothers still continue to use nearby services of Traditional Birth Attendants (TBAs) within close proximity to access basic health care during and after pregnancy and childbirth. This increases maternal related risks because the TBAs cannot handle complications that require emergency procedures, which have led to the death of many mothers and the babies. In addition, the babies delivered under the TBAs also miss out on the first immunization doses that are given to babies in their first 24 hours at birth.

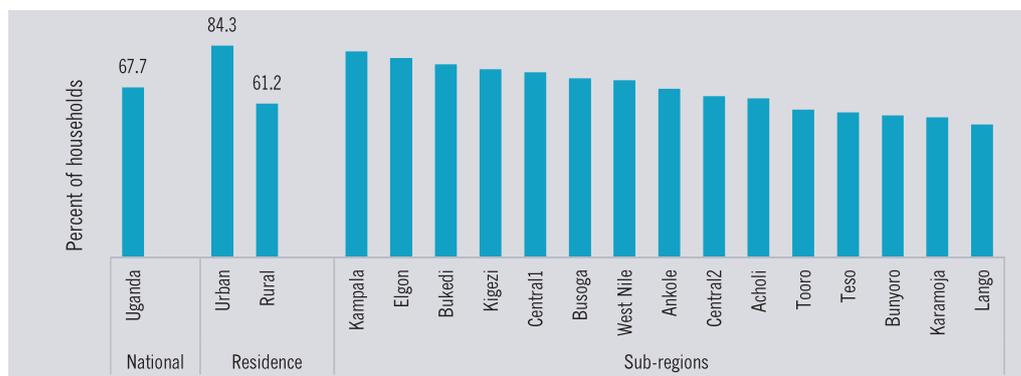
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Figure 4 Households within a 5 Kilometer distance to a public health facility (%)



Source: UBoS, 2017⁹

It is also worth noting the regional disparities are quite alarming for Lango, Teso, Karamoja, Tooro and Bunyoro (Figure 4). This shows that access to health facilities by mothers is still limited, and are more likely to die due to pregnancy and related maternal conditions. Many maternal deaths would be avoided if the households had health facilities within their reach to seek for maternal related services when need arises. As a consequence, access to basic maternal health services, as well as emergency obstetric care service, has become compromised leading to observed MMR levels.

Conclusion and policy recommendations

The Ugandan health system has had a great reduction in MMR over the last decade from 465 maternal deaths in 2007 to over 375 maternal deaths per 100,000 live births in 2017. However, this is still above the NDP target of 320 deaths per 100,000 live births by 2020 and SDG 5 goal of less than 70 deaths per 100,000 live births by 2030. This is indicative that major issues in the health sector that need to be addressed. Efforts to achieve targeted reduction in MMR requires collective interventions that build on past efforts to accelerate progress in the following areas:

a) Ensure equitable access by households to health facilities. It includes access to

services, goods, and information and the removal of inequities. Regions such as Teso, Acholi, Lango, Karamoja, Tooro and Bunyoro should be prioritized in the next phase of action for health service delivery given the least percentage (below national level) of households within a 5 km distance to a health facility.

- b) Increase access to National health insurance: Improvements in Rwanda’s maternal health is partly due to a national health insurance that made maternity care affordable and increased use of modern health care services. Transport for referrals improved, as did quality of care (Overseas Development Institute, 2012).
- c) Sensitize expecting mothers on the importance of attending at antenatal care in abid to reduce the scourge of maternal mortality. Provide care for a greater numbers of births, strengthen health service delivery, including expanding capacity of the health system to handle maternal related cases.
- d) Strengthen adolescent maternal initiatives in order to ensure better maternal and child health outcomes. Increase access to sexual reproductive health information such as use of modern contraceptives

Endnotes

- 1 World Health Organization (WHO). Trends in Maternal Mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: WHO; 2015.
- 2 Serbanescu, F., Clark, A.T., Goodwin, M.M., Nelson, J.L., Adetunke, M.B., Adeodata R. K., Kaharuzza, F., Picho, B., Morof, D., Blanton, C., Mumba, M., Komakech, P., Carlosama, F., Michelle M. S., Claudia Morrissey Conlon, M. C. (2019) Impact of the Saving Mothers, Giving Life Approach on Decreasing Maternal and Perinatal Deaths in Uganda and Zambia. *Global Health: Science and Practice*, 7 (Supplement 1)
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- 4 GoU (2015). The republic of Uganda: Second National Development Plan (NDPII) 2015/16 – 2019/20
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adolescents compared with women of other ages: evidence from 144 countries. *Lancet* *Globe Health* 2014; 2: e155–164

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