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Towards Sustainable Development

POLICY BRIEF

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Addressing regional disparities in access to child and maternal health services

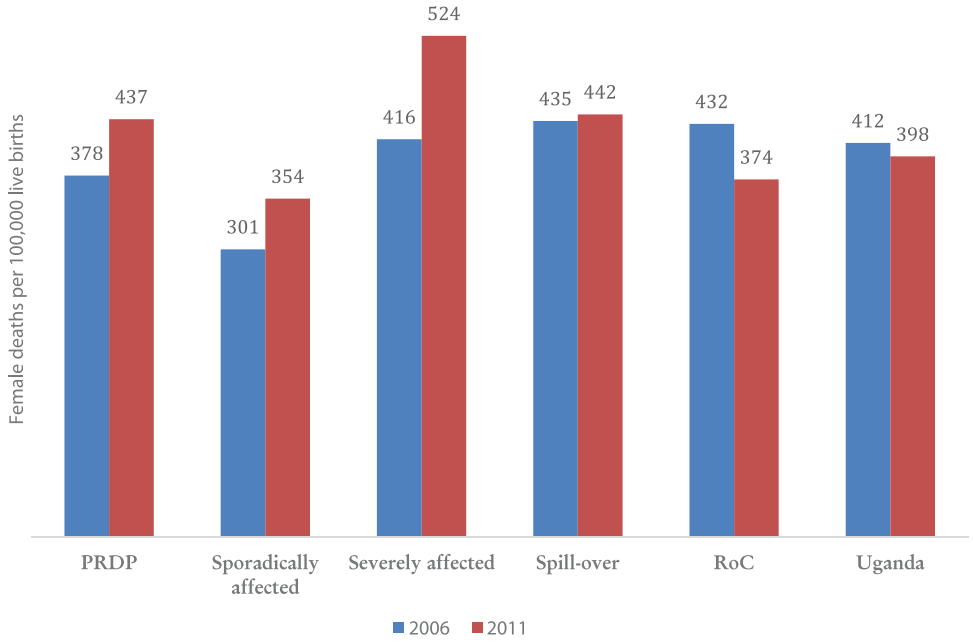
Introduction

Ensuring healthy lives through access to essential, affordable, quality health care for 'all' is the cornerstone of sustainable development and is what proponents of Universal Health Care (UHC) advocate for. Although Uganda has made some progress towards UHC, challenges remain with persistent inequality in access to maternal and child care services. Using the recently concluded MDG framework as an example, Uganda's achievement on the various MDGS was mixed. A number of health related goals- which are of interest to this brief remained unachieved by the close of the September 2015 deadline; Uganda failed to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio and narrowly missed target 4A that aimed to reduce the under-five mortality rate by two thirds, between 1990 and 2015.[1] To date in Uganda, an estimated 16 women still die every day from preventable causes linked to pregnancy and child birth while approximately 90 per 1000 live births still die from preventable causes annually. Disaggregated analysis further reveals stark regional disparities in health outcomes; the PRDP region[2] and in particular the Northern region continues to lag behind the rest of the country – hence pulling down national human development progress. As we embark on the journey towards achieving Sustainable Development Goals by 2030 which call for 'leaving no one behind", there is a need to address binding constraints in such lagging areas. This brief unpacks the disparities in achievements in maternal and child related health outcomes for the PRDP region in comparison to the rest of the country and proposes reforms aimed at accelerating the movement towards universal health coverage.

Key Findings

Mixed progress in reducing maternal mortality rates (MMR): Although Uganda witnessed reduction in MMR over the 2006-2011 period, the regional disaggregated data reveals a negative and worrisome picture (see figure 1). While the rest of the country registered some significant improvements, the reverse is noted for the PRDP region. Specifically, the mortality rate in the PRDP increased from 378 per 100,000 live births to 437 per 100,000 live births between 2006 and 2011. The severely affected sub-region[3] of mid north was the major driver of this reversal; the results may partly be explained by the fact that since the 2006 cessation of armed hostilities in region, the majority of people who had been in Internally Displaced Peoples (IDPs) camps with some access to health services returned to their communities where health facilities and services had been dilapidated. Furthermore, women in the severally affected regions are the least likely to attend the recommended four antenatal care (ANC) visits during pregnancy; although nationally, the rate of ANC attendances remained fairly unchanged over the 2006-2011 period. ANC attendance dropped in 2011 for the severely affected sub-region, falling from 50.8 percent in 2006 to 47.9 percent in 2011. This is further compounded by high adolescent fertility rates in the region yet it is widely known that teenage pregnancies are highly correlated with high maternal mortality rates. In addition to this, the number of births per 1000 women aged 15-19 years stands at 133 for Uganda as a whole, while the figure for the PRDP region is alarmingly higher at 158 births per 1000 women.

Figure 1: Maternal mortality rates – death per 100,000 live births



Source: Ssewanyana and Ntale, 2015

The increasing maternal deaths in the region in an era growing use of antenatal services suggests a number of issues. First, either professional care utilized during pregnancy is not exploited during the actual childbirth process. Two, the quality of maternal care provided in some health facilities is generally poor. Or health facilities are too far for mothers to access during pregnancy related complications. To accentuate the former, the percentage of births assisted by a skilled health provider ranged from 30 percent in Karamoja to 58 percent at national level.[4] Moreover, the issue of drug stock shortage –particularly for mothers- continues to be a challenge in the majority of health facilities (partly explaining the limited improvement in MMR).

Although progress has been made in reducing infant mortality rate (IMR), challenges remain:

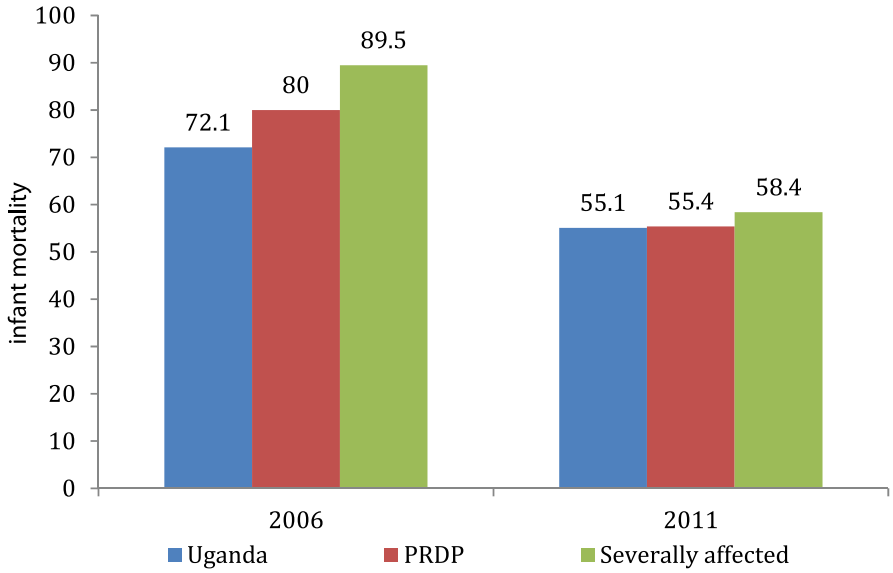
Uganda has registered significant progress towards reducing infant mortality rates although the current rate of 55 per 1000 live births falls short of the targeted 41 per 1000 live births by 2015 as outlined in the Health Sector Strategic Plan II. According to the UDHS survey results, one in every 19 Ugandan children dies before their first birthday, and one in every 11 children dies before their fifth birthday. Although IMR have reduced across the board, the IMR of 58.4 per 1000 live births in the severally affected region is above the national average of 55.1 (see figure 2)

Empirical evidence reveals strong relationships between a child's chance of survival and fertility behaviors. Normally, the probability of under-five mortality rate is higher for children born to mothers who are either very young or very old, born after a short birth interval, or born to women who have had more than three births. Very young mothers may experience difficult pregnancies and deliveries because of their physical immaturity while very short intervals (conceptions less than six months after birth) are detrimental to survival of the second child. As pointed out earlier, the severally affected region still has the highest number of adolescent pregnancies in comparison to the rest of the country.

Call to action

Promote good reproductive health practices to curb MMR: There is a need for continued government commitment towards combatting adolescent fertility, encouraging family planning and reducing the unmet need, promoting the use of health facilities throughout the pregnancy period and at child

Figure 2: Infant mortality rates per 1000 live births



Source: Ssewanyana and Ntale, 2015

birth and reducing the 3 delays (delay in deciding to seek care, delay in reaching care in time and delay in receiving care at the health facility).

Sensitize mothers: Since mothers are often the primary health care givers in the households, interventions to curb IMR should be specifically targeted towards their sensitization i.e. through promotion of immunization, nutrition, encouragement of post-natal growth monitoring, post-natal nutrition, basic healthcare understanding to help mothers steer their children away from avoidable illnesses.

Programs and interventions should take into account the idiosyncrasies and heterogeneities of the PRDP region in general and the Northern region in particular. Specifically, there is a need for a comprehensive approach towards improving maternal and child care; for example the building of health facilities without equipping them with the required drugs and skilled personnel may not translate to improved maternal and child health outcomes.

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About the Author

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Reference

The brief is an excerpt from Ssewanyana S and Ntale A (2015) "Status and progress of human development in Uganda", A Background paper for the 2015 Uganda Human Development Report".

Endnotes

1 (Government of Uganda, 2015).
2 Peace, Recovery and Development Plan- this covers the 55 districts in the broader northern Uganda
3 Severally affected includes districts that were severally affected by conflict/cattle rustling and they are: Adjumani, Gulu, Kitgum, Kotido, Moroto, Nakapiripitir, Pader, Abim, Amuru, Kaabong, Oyam, Agagao, amudat, Lamwo, Napak, Nwoya and Otuke
4 (Uganda Demographic Health Survey 2011)

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