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COVID-19 IN UGANDA: THE FATES AND FUTURES OF MATERNAL HEALTH

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Introduction

The importation and transmission of Coronavirus Disease 2019 (COVID-19), in Uganda, has led to challenges related to maternal health services (MHSs). First, restrictions occasioned by COVID-19 were hurried. Some were initially inattentive to the special needs of women whose access to MHSs is critical to their health and that of their babies. Second, the strain put on the country's weak health services infrastructure and systems implies limited resources left to attend to pregnant women and others in need of reproductive health services like contraception and family planning. Third, COVID-19 has forced government to enforce social measures to slow down or stop its spread, by declaring curfews and lock-downs upon people and transport systems, rendering it impossible to access MHSs in formal institutions. This has been done without availing awareness and advice on alternatives to formal services. While at the time of writing Uganda has not registered large numbers of infections – only 54 confirmed COVID-19 cases - and zero deaths - these after-effects have serious implications for thinking about the possible balance between COVID-19 response efforts and the need for maternal health services in Uganda.

A multi-stakeholder, multi-agency, task force was created to respond to Covid-19, focusing state energy to the pandemic that has had devastating impact on countries like China, South Korea, UK, France, USA, leading to confirmed total global morbidity of 1,991,562 and mortality of 130,885 by 16th April 2020 (WHO, 16 April 2020). When state and non-state actors have concentrated on Covid-19, what happens to women in need of MHSs? This question reflects the awareness that MHSs in Uganda are inadequate. This is more so when one considers ongoing efforts to reduce maternal and infant mortality through utilisation of formal health services. Besides, Uganda's weak health sector is further constrained by Covid-19. Movement and access to health facilities is restricted. Women in need of these services must seek permission from government officials. Maternal health seems to have become secondary.

Following Uganda's COVID-19 restrictions and curfews, most women cannot easily access or call Resident District Commissioners (RDCs). Yet the permission of RDCs is now necessary before expectant women can travel to health facilities else they face the wrath of security personnel enforcing the COVID-19 curfew. In a country where, by 2016, about 4,600 births were registered per day (UNICEF 2020), and the number may be higher today, limiting freedoms to access MHSs, presents serious threats to the lives of mothers and their children, endangering almost 10,000 lives per day. How are COVID-19 restrictions on movement and

To answer this question, the paper examines the possible balance between management of COVID-19 and provision of maternal health services in Uganda. Developed at a time COVID-19 is still active in the country and the world, the paper relies heavily on media reports and reports of governmental and inter-governmental agencies that are accessible online. Academic publications and social media exchanges are used to supplement this effort. Attention is paid to the fate and future of maternal health services when the country is under COVID-19 lockdown: how are women accessing MHSs, the challenges they are facing due to Covid-19, and the possible measures to prevent similar difficulties in future. The failure to access clearance to seek MHSs may endanger the progress the country has made, of 73% deliveries in health facilities (UBOS 2018), thus dimming the attainment of Sustainable Development Goal 3 (UN 2015). Recommendations are made on how future responses to pandemics can be balanced with maternal and reproductive health services.

The rest of the paper is organised as follows.

The first section briefly outlines the state of health and maternal health services in Uganda prior to Covid-19. The second section underscores the concentration on COVID-19 in the country. The third section examines maternal health services under conditions of Covid-19, showing the different aspects of maternal health services, behaviours, and practices that have been severely impacted by COVID-19 since declaration of the national curfew. The conclusion sums up these findings and makes recommendations for possibly balancing national pandemic responses and maternal health services in Uganda.

The State of Health and Maternal Health Services in Uganda

COVID-19 is a challenge to national and global health. It came at a time Uganda has, over the years, been struggling to achieve better health for her people. This effort has been mainly pursued through five-year Health Sector Strategic Plans (HSDP) that started in 2000. Over the past two decades, the country has among others, reduced maternal mortality ratio from over 500/100,000 (UDHS) live births in 2000 to 336/100,000 live births in 2016 (UBOS 2018).

Uganda's emphasis on health infrastructure improved physical access to health facilities: the proportion of the population living within 5 kilometres of health facility is currently at 72% (Ministry of Health 2015). The current HSDP focuses on reducing the Maternal Mortality Ratio to 320 per 100,000 Live births as one of the key results in the plan period. This would be achieved by increasing deliveries in health facilities from 44% to 64%. This indicates that the state of maternal health in Uganda is below optimum or ideal levels. These inadequacies can be observed not just in terms of deliveries in formal institutions but also other aspects.

Maternal health – the health of women during pregnancy, childbirth and after childbirth – includes antenatal, delivery, and postnatal care given to women aged between 15 and 49 years specifically, when pregnant and thereafter. Pregnancy is a natural experience of all fertile females. It, however, puts the life of the expectant mother and that of the unborn child at risk by creating health vulnerability to the mother and the infant (UNFPA 2012). Thus, a pregnant woman [almost] oscillates between life and death. Newly-born babies also need critical health care and attention that is unique to their conditions of fragility and exceptional dependence (WHO 2019).

In Uganda, MHSs are provided at public and private health facilities like Health Center II (Parish/Ward Level) which offers family planning services and antenatal care (ANC), or Health Center III (Sub-County/Town Council/Division Level) that provide all the other services and attend to deliveries. These health centres have been overwhelmed by the need to attend to COVID-19 suspects and patients and observing all the precautions needed to attend to patient during this period of the pandemic.

With already-strained health facilities, in terms of personnel, equipment and supplies (Nabukeera 2016), health centres in Uganda are hard-pressed shouldering additional burdens of continuing with their normal maternal health services and other services while dedicating exceptional effort to combating Covid-19.

National Concentration on Covid-19

Since Uganda confirmed and announced the First Case of COVID-19 (21st March 2020), the country has dedicated its effort on combating the pandemic. This entailed making policy choices and putting crafting measures to prevent further importation of cases, limiting/preventing new infections, and containment of possible asymptomatic cases to avoid further contamination. Health-related policy making has been dedicated mainly to combating COVID-19. Because of its complex linkages with other sectors, COVID-19 has encroached on policy spaces of the entire government infrastructure.

Two examples demonstrate these claims. First, between 15th March and 14th April 2020, a period of 30 days, the President of Uganda has given over eight addresses to the nation, all of them centring on combating the spread of COVID-19. Never before, had it been the case for the president to make all these addresses in a short period of time, all of them touching the same issue. In almost all these speeches, new measures to combat the pandemic were communicated to the population. Some measures required additional presidential clarification. He, for instance, clarified the guidelines given in his 6th Address on 30th March 2020 after the public raised concerns on the requirement for pregnant women to seek permission from RDCs to use private transport or motorcycles when all public and private transport, including motorcycles, had been banned (The Independent, 31st March 2020). This means no other policy issue has been of more importance in this period.

Technical operations against COVID-19 took a multi-sectoral dimension. Aside from strict medical activities, other anti- COVID-19 measures have involved many sectors. These include: the Ministry of Health (lead Institution), Ministry of Local Government, Uganda Virus Research Institute, Joint Clinical Research Centre, Local Governments, Office of the Prime Minister, Ministry of Water and Environment, International Agencies, Private Sector and NGOs as stipulated in the disaster preparedness Policy (OPM 2010). The success of this method had been tested on other activities and seems to be working. The district COVID-19 task forces, led by RDCs, are the first coordination committees at district level.
At this level, the RDC, DHO, DPC, DCP, and all other local government departments ensure that all SOPs and guidelines, given by the President on 18th, 21st, 22nd, 24th, 25th 30th and 31st March 2019, are followed. The social distancing and lockdown were added to quarantining suspected members of the population. This had been tested as an effective social measure to reduce spreading the virus in other affected countries
(Anderson et al 2020).

District teams attend to emergencies and handle suspects in their areas of jurisdiction. The President, on 30th March 2020, advised: "In order to deal with some unavoidable health issues like mothers in child birth or very sick people, permission can be sought from the RDC to use private transport to take such a person to hospital" (State House, 2020). The RDC, as leader of the COVID-19 task force, is mandated to give permission to those with emergency health problems, who then go to health centres either using private means with a sticker or by an ambulance mobilised by the RDC and his/her team. This has been the case since the abolition of public transport on 25th March 2020 (The Independent, March 26th2020) and later abolition of private transport means on 30th March 2020. These measures led to deaths of some pregnant women as the process of getting permission got lengthy, leading to complications and death (Reuters, 2020).

Maternal Health Services are provided for free in government health facilities (Burnham et al. 2004; Nabyonga et al. 2005). There are, however, access and other related costs involved like transport to the health facility. These costs increased with outbreak of COVID-19. Women must add the cost of calling and waiting for RDCs' permission. Some poor rural women were automatically kicked out of free access to health facilities because they likely lack enough confidence to call RDCs for permission.

Health infrastructure in Uganda is organized along four levels of health care: primary (comprising of health centres and other lower units); secondary (a network of district and rural hospitals); tertiary (all General Referral Hospitals based at regional capital); and quaternary – the highest level of care – Mulago and Butabika national referral hospitals (Nabukeera 2016). It is a self-reporting system, where a patient takes him/herself to the health facility. Many people live more than 5km away from these health facilities. With the strain on public transport, access to these facilities is impossible to many would-be patients. Lucky women got permission and delivered from health facilities; others delivered from home successfully. Unlucky ones died or their young ones did or both died. The health infrastructure has not been dynamic enough to locate its clients, especially pregnant women and other women in need of reproductive health care, so that a plan to pick them up, when their time is due, would be put in place to save lives of these innocent and expecting mothers. This was not the case and many lives have been lost.

Maternal Health Services amidst Covid-19

Maternal health care seeking and health problems tend to be private for many women. Women prefer to seek health care where privacy is respected. With COVID-19 threats worldwide, Ugandan Government put in place strict measures. These include: abolishing public transport and motorcycles carrying passengers. After realising that many pregnant women were being beaten as they tried to go to health centres for delivery, the president gave additional guidance. The most direct effect of COVID-19 lockdown has been the physical and psychological harassment of pregnant women, as well as other women seeking family planning services.

The ugliest aspect of harassment has been physical attack on – beating of – pregnant women. In Kampala, Rubaga Division, a seven-month pregnant woman, named Mercy Nakate, was beaten on 27th Match 2020, by a group of policemen and members of Local Defence Units (LDU) conducting patrol. They accused her of disobeying presidential guidelines on non-movement and non-congregation, for, apparently, she and other people had sought shelter in that makeshift structure. She had moved out of her house to buy some herbs, reportedly one of those ethno-botanical products that pregnant women use. Rain forced her to seek shelter in a makeshift facility used by residents. The patrol team found them. Others ran away, leaving her behind: "...It was then that the policemen who were on patrol found us and immediately began beating us. The other people ran away but given my condition, I could not run. They descended on me, hitting and kicking me despite my cries for mercy" (Daily Monitor, 4th April 2020).

Suspension of public transport (25th March 2020) and private transport (30th March 2020) was the last blow to movement other than walking. It made it almost impossible for many women to access maternal health services. Transport to health facilities was reduced to cycling, or self-riding on a motorcycle. Many women could only reach hospitals walking on foot, yet some health facilities are located in distant places and the burden of walking on pregnant women is not simple. Where the three -Walking, self cycling and self riding on a motorcycle- were impossible, then, women in need of MHS were required to ask for permission from the RDC to allow them be driven or otherwise taken to the health centre. Some women who were already in health facilities for delivery had no way of returning home. Some stayed longer after discharge as they waited for permission from RDcs to be picked by appropriate means of transport. The rate of maternal health services utilisation during COVID-19 might have been greatly affected and led to negative outcomes..

The cost and risk of non-access have been high: Scovia Nakawoya (39) died in labour as she walked to the hospital after public transport was suspended. She did not know whom to call for permission. Uganda's ambulance system is not accessible in most rural areas, and is not effective in such situations. Her husband reportedly tried to look for passenger motor-cycle transport (boda-boda), but the operators feared arrest because boda-boda transport had been suspended. She tried to walk to a nearby health centre. By the time she reached, the baby had died, undelivered. She also died shortly thereafter. By 8th April 2020, at least seven women in labour had reportedly died on their way to hospitals, according to one media report (Reuters, 8th April 2020).

The hardly-accessible RDCs make it equally cumbersome for especially poor and illiterate women. When you require a woman to ask for permission from an RDC – a stranger to whom she has to explain sometimes in English, when majority Ugandans are not schooled enough to express themselves freely in English in instances where the RDC may not speak the local language of the area – then, it is as good as saying "do not seek maternal health services". This has affected the level of utilisation that had reached 73% delivery in health facilities. Reduced utilisation of facility-based MHS increases the risk of maternal and new-born mortality. Lack of access to contraception services increases the risk of unwanted pregnancies with a possible child boom in the near future. All these worsen the population pressures Uganda already faces.

The foregoing restrictions may have resulted in home deliveries, less at-birth immunisations, limited medical care for postnatal mothers, other family planning services, and increased risk of maternal and child mortality. For now, the impact of this interrupted access may not be adequately assessed because the country is still in response mode and each section of the state is concerned with reducing Covid-19 spread as much as possible.
There are 135 districts in Uganda, each with one RDC and one deputy. That is, the entire population of about 41 Million, with millions of women of reproductive age, have to call only 135 RDC contacts as part of other health emergences. These calls are in addition to other calls for COVID-19 suspects, other work because RDCs head COVID-19 response teams in their districts. This measure affected women, especially those who were pregnant and needed to access health facilities for Antenatal Care, delivery and child health care, postnatal care and contraception.

The impact can only be established in a survey. This is presently impossible, but would be important in future to guide proper responses to similar emergencies. Women's failure to access family planning services may increase the number of unwanted pregnancies in this period, hence increased risk of maternal mortality to this group of women. For instance, Ekwaro Obuku, who previously headed Uganda's national association of physicians, said transport lock-downs likely worsened Uganda's already-high maternal mortality ratio: "Other medical emergencies like maternal have not stopped because coronavirus has come". While insisting that "No mother in labour pains should ask for permission to deliver her baby", and that "We will end up having unnecessary and preventable [maternal] deaths", Obuku's fears are not distant from those of Adrian Jjuko, head of Human Rights Awareness and Promotion Forum, who is concerned that we are going to have people dying en masse not from COVID-19 but rather from preventable deaths, preventable medical emergencies." (DispatchLive, 5th April 2020).

Consider family planning. Birth control and other sexual and reproductive health needs are unreachable when public transport is suspended and stay-homes are fully imposed by state machinery. Confined home, and lacking contraceptives with which women always "lock down their uteruses", women may face unwanted pregnancies due. This is more so in rural areas and amongst the urban poor: family planning services may be available in some health facilities, but women fear venturing out, being beaten by security forces, contracting Covid-19, or appearing to be socially irresponsible by defying COVID-19 restrictions. Other health facilities may have stopped to avoid crowding: crowds are associated with the spread of Covid-19. It is unclear whether health facilities and non-governmental agencies promoting contraceptive use in Uganda were authorised to continue providing those services where needed – at home. This possibly explains the supposition that there will likely be a "baby boom in Africa" because millions of people can neither access contraceptives nor effectively avoid lovemaking with their partners with whom they are locked at home: men no longer freely work in the fields, have no distraction of sports, and are confined with their wives for weeks. "Husband and wife, what else can they be doing in that house?" Some of the resulting pregnancies may be unintended and may result in unsafe abortions, domestic violence, and other ills. Uganda's Marie Stopes country director, Carole Sekimpi, reportedly could not access her shipment of emergency contraceptives from India because of travel lock-downs, and yet some hospitals in Kampala, Uganda, have suspended some services, and "the one service suspended was family planning." With everything diverted to fight COVID-19, the challenge of contraception and family planning can be predicted as worsening (Associated Press, April 9, 2020).

Maternal health has been a global concern before the COVID-19 pandemic. Globally, 99% of 830 women who die everyday from preventable causes related to pregnancy and childbirth are from developing countries. Young adolescents, rural women and those among poorer communities are at a higher risk of maternal death. There is global effort to save lives of women and newborn babies by increasing skilled care attendance before, during and after child birth. The target of Sustainable Development Goals is to reduce the global maternal mortality ratio to less than 70 per 100 000 live births which calls for consolidated effort to reduce inequities in access to health services (UN 2015).

Women need unlimited access to ANC during pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth (Postnatal Care) as well as access to contraceptives (UNFPA 2012). COVID-19 has created new and exacerbated pre-existing challenges related to MHSs. Births should be attended by skilled health professionals for timely management, treatment of possible complications, and immunisation of the newly-born baby to save life for both the mother and baby. COVID-19 measures have eroded timely attendance and access to health facilities. These measures are additional barriers to utilisation of MHS like: poverty, distance to health facility, lack of information, inadequate services among others that need to be addressed at all levels of the health system.

Conclusion and Recommendations

COVID-19 like other health pandemic has been a test on existing and known health responses world over. Uganda has had problems in the health system before but these were worsened with the proposed responses to curb spread of COVID-19. The pandemic, which has, since January 2020 been declared a Public Health Emergency of International Concern (PHEIC) (WHO 2020), has affected access to ANC, delivery care, PNC, child immunisation and contraception. The most direct effect has been on delivery care where permission, access, communication, cost, availability of health personnel compounds the well known inadequacies in the country's maternal health services. Delivery does not wait for COVID-19 to end, when a women's delivery time reaches there is neither waiting nor bargaining with the natural-biological demand. Whereas other maternal health services can wait, delivery care cannot wait and the failures to respond to delivery demands has likely led to home deliveries, deliveries without professional care, non-immunised babies, and deaths of both mother and baby as the case of the late Nakawoya demonstrates.

The concentration of state and non-state efforts on COVID-19 has left women in need of maternal health services unattended to. While this is not deliberate, and results from the desire to contain the pandemic, the awareness that maternal health services in Uganda are inadequate raises important questions about the fate of maternal health services during these difficult times. The country's ongoing efforts to reduce maternal and infant mortality, through enhancing the utilisation of formal health services, has been short-changed by COVID-19 which found an already-constrained health sector. The fate of maternal health services is thus constrained and almost suspended.

It is reasonable to conclude that following COVID-19 restrictions and curfews, most women could not easily communicate to RDCs whose permission they need to travel to health facilities. In a country with high fertility rate, limiting freedoms to access maternal health services presents serious threats the lives of mothers and their babies while also making it difficult to access other MHSs like contraception.

The possible balance between management of the COVID-19 pandemic and provision of maternal health services in Uganda may not be easily discerned from desk research, such as this, and post-COVID-19 surveys may be worth the effort to assess the impact of this lockdown on MHSs, the possible "Baby Boom" resulting from COVID-19 restrictions, and the relative numbers of deliveries in health facilities before and during Covid-19. From these observations, the following recommendations are made on how future responses to pandemics can be balanced with maternal and child health services:

1. Future responses to pandemics should be balanced with reproductive and maternal health services by:

   (i) giving special consideration to women in all responses;

   (ii) creating a special task force decentralised to a village/cell to handle the MHSs-related emergencies; and

   (iii) using an already-created database of women seeking MHSs and using the same to track down and follow such women.

2. All health facilities should be enabled to create databases of women seeking MHSs. This database should be comprehensive and comprehensible enough to make it possible for health personnel to travel and access women under lock-downs and provide them with the requisite MHSs instead of demanding that women under lock-down seek MHSs from inaccessible and constrained health facilities.

3. The Ministry of Health should fast-track the development of a national emergency response strategy, in line with the National Disaster Management Policy, 2010, in order to ensure that when future pandemics break out health facilities are able to respond to MHSs needs.

4. Government, through a multi-stakeholder approach, should ensure that maternal health services are inevitable whether or not the country is in crisis. This is possible through the use of local government structures and health-facility records by means of which periodic follow up on MHSs clients is possible. When crises hit the country, priority should be given to women in need of MHSs who may be struggling to get to health facilities.

5. Government should provide for other health emergencies and put in place a mechanism for accessing health facilities by providing enough functional ambulances at sub-county level with known contacts.

6. Government should strengthen collaborative maternal health services, by capacitating Village Health Teams (VHTs) and Traditional Birth Attendants (TBAs) to conduct births in cases of national emergency or pandemics.

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