MANeSCALE project reducing maternal and neonatal deaths but stillbirths remain unchanged in six hospitals in Eastern Uganda

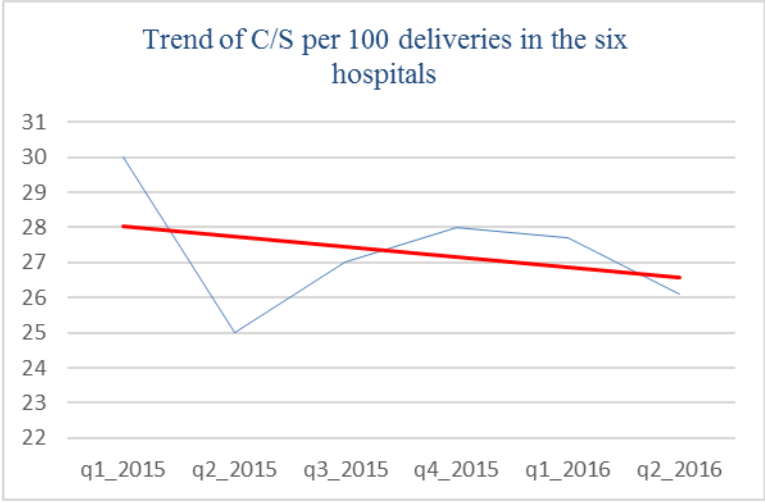
The time of delivery is the most dangerous time in the life of a mother and a baby. Almost three-quarters of maternal and newborn deaths in Uganda happen during this time. For two years the Maternal-Newborn Scale up Project (MANeSCALE) of Makerere University School of Public Health has been working with the six hospitals (annual births about 20,000) of Busoga sub-region to reduce deaths around the time of delivery. The hospitals include Jinja Regional Referral, Iganga, Bugiri, Kamuli General Hospitals, as well as Kamuli and Buluba Mission Hospitals. The goal of the project is to create a regional network of hospitals that functions to reduce deaths of mothers and babies at the time of birth.

MANeSCALE has a package of five main interventions including:

i) Integrated maternal and newborn training health workers
ii) On-job mentorship of health workers
iii) Re-enforcing maternal and perinatal death audits, and
iv) Engaging leaders in the region
v) Provision of basic equipment and catalytic drugs

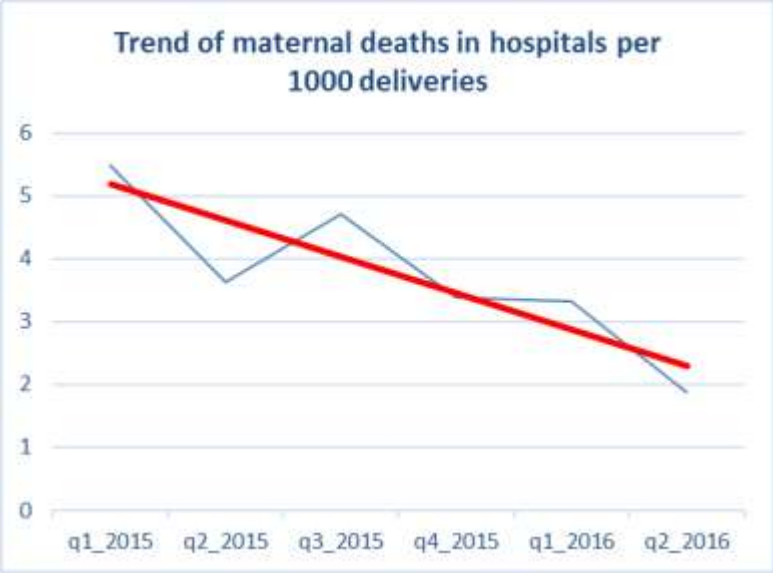
Over the last two years, we have seen hospitals improve the care they provide for mothers and as quality improved there was an influx of mothers coming to deliver in the six facilities. Since January 2015 to date, the number of deliveries have more than doubled from 1000 deliveries a month to a staggering 2000 deliveries a month in the six hospitals..

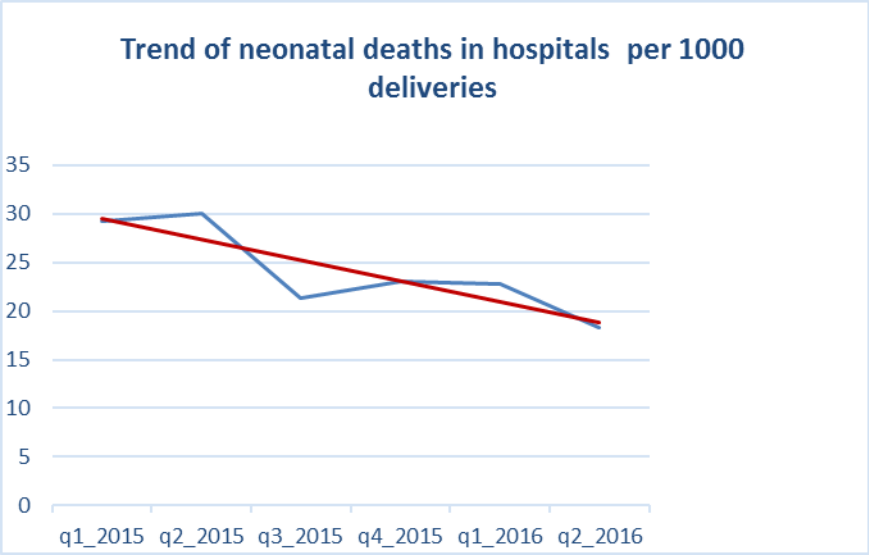
C-Section reduction
The caesarian section rates have reduced from 35 per 100 deliveries to 26 per 100 deliveries.



Mortality reduction

- At the beginning of 2015, for every 1000 deliveries, there was an average of 9 maternal deaths, but this has reduced to 2 deaths per 1000 deliveries.
- At the beginning of 2015, for every 1000 deliveries there were 42 newborn deaths, but this has reduced to 18 newborn deaths per 1000 deliveries.





Not much reduction in stillbirths

- The downside to this great achievement is that the rate of stillbirths has not reduced. At the beginning of 2015 there were 46 stillbirths per 1000 births and the rate is now 49 per 1000 births.
- At least 80 to 90 babies who are term are born already dead (stillbirths) and can't benefit from resuscitation.
- Through audit, we have verified that many of the stillbirths are due to delays by mothers reaching hospitals due to:
  - i) Poor quality care at lower level health facilities.
  - ii) Poor referral system due to lack of an ambulance system.
  - iii) Multiple care seeking due to Uganda's hierarchical health system, leading to delays.

Key challenges

i) Regular blood shortages in all six hospitals
ii) Routine stock outs of key medicines and a general lack of life-saving medicines like phenobarbital which is used to treat convulsing newborns following severe birth asphyxia and
iii) Lack of an ambulance system that can be used to transport mothers with severe conditions.

Recommendations

i. Continue lobbying through the regional referral for a regional b collection center to overcome problem of blood shortage
ii. Redesigning the mentorship process to ensure that it is more sustainable through increased utilization of locally based mentors rather than those from other regions.
iii. Continue re-enforcing maternal and perinatal death audits.
iv. Bring on board some low level facilities.

Key lessons learned

i) A well conducted death audit is a strong tool for identifying gaps in the process of care.
ii) Making recommendations alone during in death audits and mentorship is not enough to bring change, these recommendations must be implemented by those responsible.
iii) Hospital leaders have ability to influence practices and help avoid the bureaucracies in facilities. Their support is critical in successful and sustainable implementation of almost all activities in hospitals.
iv) An increase in number of deliveries should always be taken as a warning sign for potential negative impact on quality of care. And actions have to be taken immediately.

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