Box 1: Causes of maternal mortality

• Hemorrhage	25%
• Infection	15%
• Unsafe abortion	13%
• Hypertensive	12%
• Obstructed labour	8%
• Other direct causes	8%
• Other indirect causes	20%

existing, inexpensive medical or surgical interventions.

The principle underlying medical cause of high maternal mortality is that about one-half of all women in developing countries don't have a skilled birth attendant at delivery; in fact, many women deliver alone. In addition, 201 million women who would like to use contraceptives, can't access them. Not surprisingly, many women die from complications after undergoing unsafe abortions.

Insufficient numbers of trained health professionals is a widespread problem. *The Lancet's* frequently cited series on maternal survival (September 2006) concluded that the health centre model could achieve 73% coverage by

2015 for 75 priority countries if 334 000 more health care professionals could be recruited and 24 000 birthing units plus 11 000 maternity units established.

The Lancet estimated that achieving Millennium Goal 5 would cost between US\$5.5 billion and US\$6.1 billion in additional funds. Yet, in 2004, donors invested just US\$530 million in newborn and maternal health.

"Yes, we need a lot. But does that mean we can't do it? I don't think so," said Shaw, adding that "decreasing maternal mortality is the key to improving the health of the population."

Depending upon the country, the Fédération identifies as priority activities the need to track maternal mortality; establish partnerships with ministries of health, midwives and others; establish effective family planning; avoid unsafe abortions; institute competency-based training for emergency obstetrical services; and effectively share more information.

"We know what to do," said Shaw. "We know how to do it. We can't do it alone. We can't do it all at once." The first goal, though, is access to emergency obstetric care. — Barbara Sibbald, *CMAJ*

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Ugandan government resolves to make safe motherhood a priority

While progress on reducing maternal mortality is moving at an excruciatingly slow pace in much of the world, Uganda, where 6000 women die annually of pregnancy-related causes, recently passed a resolution of Parliament making safe motherhood a priority.

The resolution, introduced in December 2006 by Member of Parliament Sylvia Ssinabulya and overwhelmingly endorsed by all parties, establishes a maternal mortality control to assess how to deal with the problem and makes registration of maternal deaths compulsory, with the aim of targeting remedial action, such as establishing blood banks or obstetrical care, where it is most needed.

More recently, and for the first time, efforts to mitigate maternal mortality were specifically funded in Uganda's mid-June budget. It provided funding for emergency obstetrical care at local health centers (level 3), which serve people in a 12 km radius. Currently, this level of care is only provided at district health centers. Funding was also committed to revitalizing family planning at these clinics in an effort to limit unsafe abortion.

Not content to rest on this progress, Ssinabulya, a member of Parliament since 2001, has since organized a network of 38 female members of parliament to create a master plan involving all ministries. Transportation to clinics, for example, is hindered by poor roads. "We want to task government to put up tangible things we can do to reduce maternal mortality."

In Ottawa on June 21 as the featured speaker at an international symposium on maternal health (see page 243), Ssinabulya told *CMAJ* that safe motherhood is everyone's responsibility and everyone — politicians, couples, journalists, local leaders, lawyers and religious leaders — has a role to play, be it advocacy, community mobilization or changing personal attitudes.

While acknowledging that obstetrician-gynecologists "have done a lot

Françoise Couturier

Mali nurse, Djeneba, poses with one of her 4 children, for photographer and long-time colleague, Dr. Françoise Couturier, a physician in St. Lambert, Que. The photo was first runner-up in a contest run by the Society of Obstetricians and Gynaecologists of Canada's International Women's Health Program.

despite limited resources,” she says that maternal mortality remains “a nightmare.”

Uganda has the world’s third fastest growing population (after Niger and Timor), with a fertility rate of 6.9 children per woman. Only 18.5% use modern contraception methods. And only 38% of women deliver in hospital or with skilled attendants. “A woman may deliver herself, as she has for the past 5 pregnancies, but this time, things don’t go well, maybe the placenta doesn’t come out, and she dies,” says Ssinabulya.

In addition, abortion is illegal and many unsafe abortions end in death. “We can’t even talk about [abortion] without being attacked for promoting immorality in society,” she laments. “Every day in Uganda, 16 women die. Today 16 have died. Tomorrow 16 will die. Everyday, 16 will die. It’s unacceptable.”

“Although we know there are institutional factors, maybe lack of blood, few anesthetists, few doctors or midwives, if you don’t look at the community factors which might hinder a woman from accessing the available facilities, then we can’t tackle the issue of maternal mortality.”

“Most of the causes of maternal mortality are community based. Either because the woman delays taking a decision to seek care, because the woman cannot take a decision on her own without first seeking permission from the husband or her mother-in-law, or because there’s maybe no community transport.”

“We need a multi-sectoral, multi-disciplinary, multi-professional approach.”

Informed and effective advocacy is the starting point for bringing about change. Ssinabulya got her training as a student in Save the Mothers’ Master of Public Health Leadership program at the Uganda Christian University. This Canadian initiative, led by Dr. Jean Chamberlain Froese, an assistant professor of obstetrics and gynecology at McMaster University in Hamilton, Ont., aims to mobilize influential, non-medical people. This year, 130 people applied for the 25 spots. Among those accepted were 3 other members of parliament.

Started in 2005, the first class of 25 will graduate in October. The program consists of a half dozen 3-week mod-

Barbara Sibbald

Canadian, Dr. Jean Chamberlain Froese (right) offers a masters in public health leadership program in Uganda aimed at mobilizing prominent people, such as MP Sylvia Ssinabulya, to help reduce maternal mortality.

ules. Tuition is \$1300, although scholarships are available, and each student receives US\$1000 toward a project of their choosing. Funded by private donors, the program recently received US\$150 000, which was matched by the university, to construct a building in which to operate.

Chamberlain Froese, the executive director of Save the Mothers (an affiliate of Interserve Canada, a Christian non-profit organization) hopes to expand the program into Kenya, Tanzania and perhaps Afghanistan. “When you work by yourself, when you’re a lone ranger, you quickly lose your enthusiasm,” she says. “What we want to do is encourage the Sylvias, people who are in very influential positions, to form a network of advocates for maternal health.”

Journalists and the clergy have already been mobilized. “The faith community is very powerful in Africa.” In Uganda, 80% of the population is Christian and 10% Muslim.

Advocates discuss barriers to healthy motherhood, including distance to facilities, societal attitudes, lack of services and the attitude of health workers, who expect gifts, though services are supposed to be free.

“So many Ugandan women have lost a child,” says Chamberlain Froese, “and so many know a woman who has died of pregnancy-related causes.”

Ssinabulya, a teacher by vocation and mother of 3, lost her first child, a breech delivery. “I may have died without a

skilled deliverer,” she says. Her sister-in-law died of pregnancy-related causes.

According to Ssinabulya, a fundamental, underlying problem is the lack of gender equity. “The majority of the women in Uganda are looked at as secondary citizens, as property,” she says. “The decisions are up to the man. The woman can’t decide how many children she should have. She can’t negotiate safe sex. She can’t negotiate contraception. It’s only when the man agrees to limit the number of children that she can go for contraception,” (see related article, Left Atrium, page 275).

Uganda’s constitution guarantees women’s rights, but implementing it will take time and education, says Ssinabulya, adding that with universal primary education, the future looks more promising.

As a member of parliament, Ssinabulya also sees underlying political and economic causes. She says that the policies of the World Bank and International Monetary Fund are hindering progress. They emphasize liberal economic privatization in the hope that this will stimulate growth and development, and increase employment and wealth, after which “you can then address these other issues.”

“The World Bank policies look at social services as expendable, they see spending on health as they see spending on welfare: wasted money,” says Ssinabulya. Per capita spending on health in Uganda is \$5; the WHO recommends \$40 for low resourced countries.

The World Bank encourages a limit on spending and donations for non-business purposes in an effort to control inflation; lower inflation (now at 9%) will, in turn, encourage investors. It’s difficult to make progress until the “World Bank accepts that its policies aren’t helping Africa... the social sector is made to suffer,” says Ssinabulya.

“Africa has been dependent on foreign aid so we had to tow the line of the World Bank. Now as our economies are growing, it’s time that countries be allowed to look at their priorities and approach.” Uganda’s June budget was 67% financed internally. — Barbara Sibbald, *CMAJ*

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