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Cultural and Resource Determinants of Severe Maternal Morbidity: Lessons from Some 'Near Miss' Experiences

Abstract

In Uganda severe maternal morbidity remains a problem to reckon with. This paper reports part of a wider study conducted in Kiboga, Hoima and Kampala districts, Uganda between 1999 and 2000 (Okong et al. 2001), the aim of which was to document the circumstances that led women to death-threatening medical crisis situations. It emerged that severe maternal illness is not necessarily a result of direct (biomedical) causes per se but may stem from other factors deeply rooted in culture and gender relationships. These factors notwithstanding, women are hampered by deficiencies in the formal health care system including inter alia inexperienced health workers, especially at lower level units, poor referral systems and the lack of a well-functioning transport system, limited space in the wards or operating theatre, and inability to access the busy health staff. These constraints often lead to critical delays, which aggravate women's morbidity experiences. Appropriate interventions, including delivery of culturally accepted maternal health information and addressing the lack of quality maternal health services, are required.

Introduction

Background

In Uganda, as in a great part of Sub-Saharan Africa, maternal mortality and maternally related severe morbidity still pose a serious health problem. In fact Uganda has some of the worst maternal health indicators globally. The revised figures for 1990 from the World Health Organisations for Uganda were as high as 1,200 maternal deaths per 100,000 live births (WHO and UNICEF 1996). Recent estimates of 500-600 per 100,000 in 2000 and 2001 are mostly based on small-scale hospital based studies (Uganda Ministry of Health 2001, Ministry of Planning and Economic Development 2000). Considering that most women live in rural areas, and do not deliver in formal health facilities, the figures are likely to be much higher, with marked variation between the districts.

In 2000, Uganda had a total fertility rate of 6.9 and contraceptive prevalence rate of only 23 percent. The average age at first sexual intercourse was 16, the adolescent pregnancy rate stood high at 43 percent and the average age at birth

was 18.7 years. Only 38 percent of births were attended to by trained attendants (Ministry of Health 1989). Compared to the previous decade, apart from a rise in the contraceptive prevalence rate (which was 5 percent in 1991) and large drop in the HIV prevalence rate, these indicators have barely changed in the past ten years.

In the past, high maternal mortality and severe morbidity rates were largely and justifiably attributed to the country's socio-economic and political instability, characterised by destruction of health infrastructure, chronic shortfalls in staffing and material supplies/equipment, poor remuneration of health workers, and erosion of medical ethics. Today a favourable and enabling policy environment is in place, including good policies with regard to gender equity, universal primary education, reproductive health, and decentralisation of health services. These contain measures to be implemented by government, NGOs and other stakeholders to increase health facilities, improve quality of services and care, and improve the numbers of professional health staff, equipment and supplies (Uganda Ministry of Health 1999).

However, there has not yet been an increase in utilisation by women of obstetric services at health units nor a significant reciprocal reduction in cases of severe maternal morbidity and deaths. Although this can be attributed to the currently minimal implementation of these policies and interventions due to resource constraints, for example, lack of skilled attendants, emergency obstetric supplies, blood, and anaesthesia, or facilities capable of offering emergency obstetric care, it can also be argued that these factors *per se*, though valid, do not offer a sufficient explanation. Many authors believe that maternal mortality and severe morbidity in Uganda and elsewhere in Sub-Saharan Africa, is significantly influenced by socio-cultural beliefs including gender and power relations, and differences in roles and status between the sexes (Mukhopadhyay and Higgins 1988:461-95, J. C. Caldwell and P. Caldwell 1990:118-25, Koblinsky et al. 1993, Ubot 1992, Vlassoff and Bonilla 1994:37-53).

It is in this context that the study on which this paper draws investigated women's near to death experiences due to complications from pregnancy and childbirth. The study *inter alia* sought to describe women's severe morbidity experiences, highlighting factors that constrain their ability to seek and obtain timely and appropriate obstetric care at formal health facilities when faced with life-threatening situations.

In recent maternal health care research, the category of 'near to death' (sometimes termed 'near miss' cases) represent a 'grey zone' category, i.e. a group of women who under slightly more adverse logistical or other circumstances would not have survived. Studies from South Africa, Benin, Ireland and France demonstrate the usefulness of analysing such cases (Mantal and Buchmann 1997, Filippi et al. 1996, Fitzpatrick et al. 1992:37, Bonvier-Colle et al. 1996:121-5, Stones et al. 1991:13-15). It has been estimated that there

may be as many as 100 acute maternal morbidities per maternal death (Graham 1989:581-4), a factor that renders such morbidities a more practical and useful indicator of deficient maternal health than the mortality figure. This paper, however, does not attempt to assess the magnitude of the problem of near to death cases vis-à-vis maternal deaths, but rather explores the cultural and practical factors that contributed to selected women's experiences with severe maternal morbidity. Its contribution lies in establishing the background and context of these medical crises, through in-depth interview information.

Study Design and Methods

The project was designed as a prospective, descriptive study aiming at providing a baseline to elucidate the magnitude of the problem of adolescent maternal death in rural and urban settings, and the magnitude of severe morbidity 'near miss' cases in pregnant or puerperal women in selected hospitals. In relation to the latter, the issue of avoidability was a major concern, and the hospital based in-depth interviews were hence tailored to discern the circumstances directly linked to and associated with the severe morbidity experienced. The focus was on capturing issues of delay at various levels including domestic factors, cultural factors, local health facilities, transport deficiencies and intervention delay at any health unit. The women were particularly questioned about the initial danger signs, their first reaction, self-treatment, persons consulted and what was prescribed, the process of formal healthcare seeking, the use of private clinics, costs incurred and by who, who decided on hospitalisation, who helped her to get to hospital, mode of transport, the role of husband/partner, mother, or other significant persons, and type of treatment received at hospital.

The conversations with the women were loosely structured according to the above themes and conducted in a way that encouraged them to dwell upon the issues they perceived as most important or problematic. The interviews were transcribed soon after the hospital visits. Qualitative content analysis was done through classification of data according to emerging themes. These included medical factors, and attitudinal factors related to cultural realities including practical gender problems that impeded the women's ability to obtain appropriate healthcare before their condition become critical.

Study Settings and Ethnography

The study was conducted in two rural districts, Hoima and Kiboga; and one urban district, Kampala. In the respective districts, the study sites were Hoima, Kiboga, Nsambya, and Mulago hospitals.

Hoima district with a population of 197,857 represents a typically rural area where subsistence farming, cattle keeping and fishing are the main means of livelihood. The Banyoro, the indigenous ethnic group, predominate. In 1997 there were approximately 9,000 total births, of which around 8,500 were live

births. With an estimated maternal mortality ratio of 500, the number of maternal deaths would be 45 per year, corresponding potentially to 130-140 deaths among women of reproductive age (Okong et al. 2001). Hoima hospital is a referral hospital for the mid-western region. It has one obstetrician/gynaecologist also supervising other district hospitals. There is also one district medical officer responsible for public health in the district and for supervision of health centres. Health indicators for Hoima district are not much different from national generalisations, such as 60 percent of the mothers were delivered by untrained individuals, lack of surveillance system and lack of up to date data.

Kiboga with a population of 141,607 is a new district consisting of both semi-pastoralist Banyarwanda and Baganda peasant farmers. There is one hospital, Kiboga, that offers essential obstetric care. The hospital has a maternity ward with 30 beds, a labour ward (6 beds) and one operating theatre bed. There is also one minor theatre for Manual Vacuum Aspiration (MVA) and post-abortion care services. One medical officer (1-2 years post-qualification) is usually allocated to be in charge of the maternity ward.

Kampala district is an urban district, with an estimated population of 980,000. It has the highest concentration of maternal services in the country with four referral hospitals. It also has the only functioning maternal mortality review committee. Kampala district has seven administrative divisions, including Makindye with a population of 187,000. Nsambya hospital is assigned to cater for Makindye west with a population of 100,661 (52,355 women). Nsambya hospital is a 360-bed general and maternity hospital with about 6,500 deliveries per year. The total number of maternal deaths ranges between 40 and 60 per year giving a maternal mortality of 700-800 per 100,000 live births. The number of 'near misses' would be in the range of 800-1000 per year depending on the criteria applied for this category of cases.

The New Mulago hospital is the largest national referral and university teaching hospital. It is a 1,000-bed facility, handling nearly 17,000 deliveries annually. The true 'near miss' figures for this hospital are estimated to be in the range of 2-3 times the figures for Nsambya hospital.

The Case Studies of ('Near-miss') Women

Out of the eleven women interviewed in the respective hospitals, six have been selected for this paper because they are most illustrative in regard to the circumstances that led the women to end up in death-threatening medical crisis. It will thus be helpful to summarise the circumstances of these cases prior to a thematic consideration of what emerged from all the eleven interviews.

Six of the women were married and five were single. Six were aged over nineteen, and the rest under eighteen. Three women experienced severe morbidity related to abortion complications, three had ectopic pregnancies, one suffered from eclampsia, two experienced puerperal sepsis, and one went into a

coma due to a reproductive infection. At the time of interview, the women were in various recuperative stages in hospital.

Case 1: Savia, Narrowly Survived Complications Due to Ectopic Pregnancy

Savia was aged 27, married with three children and educated up to primary two. Her husband worked as a police constable in a distant town and came home only once a month. To supplement her spouse's meagre income, Savia operated a fruit and vegetable stall on her veranda, besides her routine household chores. Her problem started one morning when she was mopping the floor of the single tenement (*muzigo*) where she lives with her three children. 'Suddenly I felt excruciating pain in the lower back and collapsed on the floor. At first I suspected pregnancy as I had missed my period the previous month.' Previously Savia had suffered an ectopic pregnancy (a condition where the fertilised egg implants and develops out of the uterus, in the fallopian tube), and correctly suspected that this could be a repeat of a similar condition. When the pain subsided, she called in her neighbours who helped her to walk to a local clinic, one kilometre away. At the clinic she was given panadol tablets, but after explaining her previous condition, she was given a verbal referral to Mulago hospital, 40 kilometres away. As her husband was not around, she entrusted her children to the neighbours and boarded a public taxi to Kampala. After an hour of terrible discomfort as the pains kept recurring, she eventually reached Mulago hospital but had to wait for six hours to be attended to. A scan was done and an ectopic pregnancy confirmed. Savia however could not be admitted as the wards were full and the theatre fully booked. She was advised to secure accommodation in close proximity to the hospital and report the following morning for an operation. 'It was terrible not to be worked on immediately. Luckily I had an aunt near the hospital where I spent the night in sheer agony.' The following morning when Savia was brought to hospital, she could barely stand upright, and a stretcher was used to take her to theatre. The operation was successful though she lamented losing the pregnancy. She was further unaware of the fact that she would never conceive again, this being her second operation to remove an ectopic pregnancy. Her husband, despite being informed, was yet to show up and Savia was footing all the hospital bills from her savings. She attributed her survival foremost to God, and to past experience, which prompted her to seek timely and appropriate care at the referral hospital.

Case 2: Teopista Narrowly Survived Complications Due to Severe Post-Abortion Sepsis

Teo, as she is fondly known to her family, was a young woman aged 17, married with one child and had no formal education. She lived with her husband, a peasant farmer, in a village about 45 kilometres away from Kiboga town. Teo on top of her routine household work also helped her husband with subsistence

farming. She shared her homestead with a co-wife, senior to her in age and experience despite being childless. Teo's pregnancy, which almost went full term, was problematic, characterised by pain in the lower abdomen and a greenish, foul smelling vaginal discharge (*amazzi ge mundula galinga ga dodo*). Despite the pain and discomfort, she did not consider this a serious problem, and continued to rely solely on traditional herbal medicines provided by her grandmother. As with the first pregnancy, she did not seek prenatal care at any health facility.

Once, however, she visited a district hospital (Mubende) where she reported her problem, but received no treatment. Soon after the Mubende visit, Teo experienced sporadic but weak contractions, which ended up in a stillbirth at home. After the stillbirth, which was attributed to the malevolence of the barren co-wife, the foul discharge and pains persisted. All the traditional home therapies she continued to receive (herbal orally administered medicines and abdominal massages) were not effective, and her situation worsened. Her husband was against seeking hospitalisation and continued to consult a spiritual medium who lived nearby to ward off the co-wife's evil. However, when Teo went into a coma, he panicked and decided to take her to Kiboga hospital.

The journey to Kiboga in a public taxi, which Teo could not recall, lasted over two hours. At hospital she was rushed to the theatre and successfully operated on. She regained consciousness after two days and was unaware of the treatment she underwent, apart from the several daily injections. Though Teopista lost the baby, she was saved from the severe sepsis, which had almost killed her. She attributed her survival foremost to God, and the staff at Kiboga hospital.

Case 3: Joyce Survived Complications Due to Incomplete Abortion

Joyce was aged 27, married with nine children and lacked formal education. She lived in a remote village, 40 kilometres from Hoima town. Joyce engaged in subsistence farming which she supplemented with making petty handicrafts (baskets and mats) for sale. Her husband, a tobacco farmer, had another family elsewhere, and was not permanently resident at Joyce's home. He dropped in a few days a month.

Joyce took much pride in her prolific reproductive history and when her problems started, she was pregnant with the tenth child. One night, luckily with her husband around, she suddenly felt sharp pains in the lower abdomen followed by bleeding. She consulted her husband the following day and he gave her white pain relief tablets. Joyce later that day visited Melani, a local Traditional Birth Attendant (TBA) who also doubled as a family friend. Melani could not diagnose any serious ailment though she prepared a herbal concoction for Joyce to drink. When there was no lapse in the pains after two days, the TBA advised Joyce to visit the nearby Kyangwali Health Centre. At this time Joyce could hardly walk unassisted, but thanks to Melani's help, she managed

to trudge to the centre. At the centre, she was urgently referred to Hoima hospital.

Despite the prompt referral, Joyce received no treatment at this facility and neither was she facilitated by way of logistics to travel to Hoima hospital. With her husband, who had a reputation for being not only uncompromising but also miserly, not around, Joyce turned desperately to her friend Melani for help. The latter sent a message to the husband, soliciting both permission and funds to enable Joyce travel to Hoima hospital. The husband came two days later and Joyce's grave situation prompted him to relent by giving permission and providing some of the required money. After entrusting the children to a relative, Joyce, escorted by Melani, squeezed herself on the back of an overloaded pickup truck and headed for Hoima town. Joyce did not remember much about the journey, as she was barely conscious by then. Melani, however, says it lasted about two hours, and the driver was kind enough to drop them at the hospital gate. At the hospital, she was rushed to the theatre and successfully operated on. She had suffered an incomplete abortion and lost the baby. Joyce was hospitalised for seven days, and on the eve of discharge, was in high spirits. Her main worries were not medical, but how to settle Melani's cumulative debt. Her husband had visited her only once. She owed her recovery foremost to her friend Melani, and the staff at hospital. Her husband on the other hand was blamed for all the misfortunes she has suffered. 'My husband does not take pregnancy and birth seriously ... [H]e thinks it is something normal and routine...'

Case 4: Sifa Survived Eclampsia

Sifa, aged 20 and single, was a student enrolled in a commercial school in Kampala. She lived with an elder brother and sister-in-law in Kitintale, one of the several peri-urban slums in Kampala. Sifa had one child from an earlier relationship with a man who despite accepting responsibility and taking the child, declined to have any marital or co-residence relationship with her. At least relieved of the childcare responsibilities, Sifa had moved to Kampala where she met another partner, a junior clerk, and became pregnant. Since the partner lacked accommodation of his own, Sifa was compelled to continue residing with her brother and sister-in-law. As with the first pregnancy, Sifa did not seek ante-natal care at any health facility preferring to rely on traditional herbal medicines (mainly *mmumbwa*) provided by her grandmother who lived upcountry. Her pregnancy progressed smoothly to full term, and she delivered normally at a local clinic, ten minutes walk from her home. However, complications started two hours after delivery. She suddenly started shivering, and feeling very ill. She experienced intense heart palpitations, fever, profuse sweating and thereafter became delirious and started hallucinating. The attendant nurse, scared and confused, and suspecting malevolence, hastily sent her away without any treatment. Her brother, who was fortunately around, hired a

car, which transported her to Nsambya hospital 5 kilometres away. He also dispatched a message to their mother in the village to come urgently. Sifa meanwhile arrived at hospital barely conscious. Despite her critical condition, admitting her was not easy since she had no Antenatal Care (ANC) records, let alone a referral letter. Eventually she was admitted out of compassion, and diagnosed with eclampsia (a potentially fatal condition, where a patient becomes delirious and mentally confused due to high blood pressure and protein in the urine). After two days of treatment Sifa steadily improved. She attributed her survival foremost to her brother who rushed her to hospital and was footing the bills, and the competence of staff at Nsambya hospital.

Case 5: Margaret Survived Post-Partum Haemorrhage (PPH)

Margaret, aged 18, grew up an orphan at her grandmother's home. She never attended school and married at sixteen to a partner three times her age. They lived in a remote village about 40 kilometres from Hoima town. Her husband was a petty trader and Margaret brewed and sold a local alcoholic brew to boost her family income. She had two children (twins) both surviving, and her complications started during the second pregnancy. Two and a half months into the pregnancy, she developed abdominal cramps, followed by sharp pains and later bleeding '... I knew I was having a miscarriage and hurried to the clinic for help'. At the clinic which is operated by Nursing Aides, malaria fever was diagnosed and an injection given. Chloroquine and other white tablets were also dispensed. Margaret's partner further procured for her other drugs from unspecified sources. Meanwhile, Margaret's mother-in-law prepared herbal medicinal concoctions, some of which were orally ingested and others inserted in the vagina to stop the bleeding. Margaret however did not respond to these medications and grew weaker with each passing day. This prompted her to seek help from another private clinic about 5 kilometres away, near the sub-country headquarters. At this facility, Margaret was treated though not examined by a *musawo*, i.e. any practitioner presumed to be a doctor due to his/her white attire. The *musawo* diagnosed an abscess in the womb and verbally referred her to Hoima hospital, 40 kilometres away. Margaret's deteriorating condition prompted her husband to seek permission from his father (Margaret's father-in-law), who lived next to their homestead, to take her to hospital. Margaret and her father-in-law never enjoyed good relations, and the decision to take her to hospital took two days to make! Margaret's husband escorted her to hospital and the journey in a crowded taxi took over one hour. Margaret had by then lost a lot of blood, and fainted on arrival at the hospital. Her attendant said that getting her admitted was not easy and it was not until the following day that the patient received attention. She was taken to the theatre and had a successful operation. She had suffered an incomplete abortion, and lost the baby. She steadily improved and attributed survival foremost to God, and the health personnel at Hoima hospital. She blamed her 'near miss' experience on her mean

father-in-law and the lack of her own money which initially compelled her to seek care from inappropriate sources. She declined to comment on her husband's role.

Case 6: Fatuma Survived Severe PPH after a Normal Delivery

Fatuma was aged 36, had ten children and lacked formal education. She was a third wife to a Hajji who operated a local butchery. On top of her routine household and childcare chores, Fatuma operated a small business making pancakes and banana juice, which her children sold to passers-by at the roadside. Her husband had to divide his time between his other households and Fatuma's, hence his long absences from the latter's home. Fatuma's home is some over 30 kilometres away from Kiboga Township. Her problems started after delivery of her eleventh child. As with all previous pregnancies, she did not seek pre-natal care, relying instead on traditional herbal medicines and advice from a local TBA, who was also a neighbour and close friend. Onset of labour was sudden, and as with most of the earlier deliveries, she sent for her friend, the TBA. Childbirth was not problematic but several hours later the placenta was still retained. Full of confidence the TBA prepared for her a herbal concoction to induce uterine contractions to expel the placenta. Fatuma drank two half-litre mugs of the medicine and soon after became very ill. She experienced intense and painful contractions and the placenta was expelled. However the contractions did not stop and severe bleeding followed. All attempts to stem the profuse haemorrhage failed and by the time the TBA prepared another concoction to counter the effects of the previous one, Fatuma had already fainted. Alarmed the TBA called in the husband, who was at his butchery at the time. In panic, the husband hastily organised transport to take Fatuma to Kiboga hospital. The rough one-hour journey aboard a pickup truck further exhausted Fatuma and on arrival at the hospital, she was initially taken for dead. According to her attendants, her heart was however still faintly beating, and blood was readily available at the hospital. A transfusion was given and the remains of the placenta removed. Fatuma regained consciousness after two days. She attributed her survival to the health workers at Kiboga hospital, and another 'doctor' who remained at home, warding off malevolent spirits whose sources she declined to disclose. Fatuma also expressed gratitude to her TBA friend especially for safely delivering her baby, and trying hard to rescue her life.

Women's Culture Concerning Pregnancy and Childbirth

There is significant evidence from the cases of the six women that socio-cultural realities, including gender and power relations at family level, have a profound effect on women's behaviour in pregnancy, birth and the post-partum period. The findings also delineate the significance of other institutional and practical factors like failures in the formal healthcare system,

insufficient logistics and long distances to health facilities, in subjecting women to various risks and uncertainties when seeking care during episodes of critical obstetric complications. Though these factors work in synergy to put women's lives at risk, often resulting in death or 'near miss' situations. The six cases above have dwelt on each separately so as to discern their individual effects.

Interviews with the women in the study point to the existence of an elaborate and vibrant women's sub-culture concerning pregnancy and childbirth. The rules, practices, normatively sanctioned behaviours, expectations and rationale of this 'birth culture' appear to be clearly known within the local communities in which the women live, irrespective of their ages, marital or socio-economic status and morbidity experiences. This 'birth culture', it can be argued, had evolved in order to prepare women, their families and the local communities to cope with the events of pregnancy and birth, and to rationalise whatever outcomes follow. Community perceptions and cultural expectations have considerable significance in this context.

For instance in the study settings, as elsewhere in Uganda, descent is patrilineal and in such communities where continuation of the lineage is a central dynamic and the individual subordinated to the group, the importance of women lies in their ability to bear children. In regard to power dynamics, pregnancy and childbirth are two of the main areas of contestation of status and power. Women want to keep control of a factor that increases their status, not only within the home but the community at large. Further, their ability to conform to the local 'birth culture' validates their individual experiences.

In this context women are expected and taught to be stoical during pregnancy and childbirth, and in conformity, many of them delay seeking timely care until the symptoms have reached crisis level. This in turn leads to loss of lives, or as in the case of most of the women studied, a narrow escape from death. All the six women, apart from Savia, who had had a similar previous experience, exhibited various degrees of stoicism before seeking help, with disastrous consequences. Teopista for instance persevered with the foul discharge for a long time, Joyce and Margaret bled for several days before seeking outside professional help, and the severely haemorrhaging Fatuma was rushed to hospital only when unconscious. The stoic demeanour exhibited by the women is however not limited to the study communities. In another study involving other communities in Kiboga, it was commonly said that pregnancy prepares women for the 'women's battle' of childbirth (*lutalo lwa bakyala*), which every woman is expected to win, with stoicism and without showing any signs of fear (Kyomuhendo and MacNairn 1998).

The conceptualisation of childbirth as 'the women's battle' was also found to be prevalent in West Africa where maternal mortality was explained as 'she fell in the battlefield in the line of duty' (Diallo 1991). A study among the Baariba of Benin describes how women take pride in giving birth unassisted

and are 'in turn silently admired' (Sargent 1990:11). However, the view that birthing wields immense power, attributed to the unique nature of child bearing, is especially noticeable in societies where women command much less power than men in the public domain (Howson et al. 1996).

Some women felt that the outcomes of pregnancy and birth are beyond human control implying that fate is the main determining factor. Savia, Teopista, Margaret and Fatuma attributed their narrow escape from death foremost to divine powers, i.e. God, ancestral spirits or relatives/friends even though they were still in hospital recovering from a 'near miss' situation from which they had been rescued by health workers. The fatalism encountered here which is also a component of the local birth culture aimed at rationalising pregnancy and birth outcomes, also serves to explain the women's care seeking patterns; for example why none of them sought prenatal care or sought treatment late. Sifa's eclampsia condition could, for instance, have been detected early and prevented had she sought antenatal care from a health facility. As a consequence of fatalism the women were reluctant to publicise their pregnancies, choosing to accept silently whatever outcome. Problems were generally ignored for as long as possible, and in all the cases described except Savia, who had had a similar experience, the women were at first unwilling to discuss the problems they experienced.

This 'culture' of silence definitely has an impact on women's care-seeking behaviour i.e. whom they consult and at what stage of the problem. The utilisation of options like self-treatment either with traditional herbal medicines or unprescribed over the counter (OTC) pharmaceuticals despite their questionable efficacy can be explained in this context. All the six women at one stage or another treated themselves, or if this did not help, consulted close female relatives or traditional healers who, being custodians of the local birth culture, could not publicise their problems. Formal biomedical options, even where readily available (Sifa), were not utilised until the danger symptoms reached crisis levels. All cadres of health workers, irrespective of their competence, are regarded as outsiders who may only be consulted as a last resort. This was seen in the cases of Teopista, Joyce, Margaret and Fatuma.

Other factors also rooted in culture, especially aspects of prevalent gender and power relations at family level, emerged as important determinants of women's pregnancy and birth outcomes. As a result of illiteracy and acute material poverty, most of the women lacked authority in many respects and were hence ill prepared to respond to the severe subsequent morbidity they experienced. On top of lacking their own money to use in seeking appropriate care, some of the women (Joyce, Margaret, Fatuma, Teopista) even lacked the power to make decisions as to where and when to seek care. In the cases of Joyce and Margaret, it was only the husband or father-in-law respectively who could make the decisions. Even when it was agreed they needed to obtain

medical care outside the community, it was only the men who could arrange for their transport and other logistics.

Another key element was the limited support these women received from their husbands/partners at the time of their pregnancy or birth-related problems. Though most of them were married, hardly any reported receiving significant financial, moral or other assistance from their husband or partner at the time of their crisis; in fact most of the interviewees shied off from the topic of the man's role, preferring to discuss other issues. Lack of male participation results in part from the local 'birth culture' since conception and childbirth are commonly viewed as a woman's business. Thus, like health workers, men are also treated as outsiders, even if they are relatives, and are consulted only as a last resort. As is evident in most of the cases, even when men were contacted, the aim was to seek specific financial or logistical support, like finding transport to hospital or paying medical bills. Men are aware that routine monitoring of the progress of their wives' pregnancies is not welcome, and in most cases they were not even around when the complications arose (Savia, Joyce, Sifa and Fatuma). This not only leads to poor preparedness during pregnancy or birth but also deprives the women of vital support at critical times, often aggravating their morbidity situations.

The minimal involvement of men can also be viewed in the context of the broader gender and power relations prevalent in the patriarchal communities where all the six women live. Men stay away from issues of women's health during pregnancy and childbirth in part because those matters are seen as unimportant. Married women in these communities are not encouraged to have their own money or to make independent decisions, not even decisions concerning their healthcare. Therefore, in addition to the financial constraints that undermined their ability to seek timely and appropriate care when faced with obstetric complications, most women even if they had money would still lack the fundamental power to decide whether, where or when to seek care.

Institutional and Structural Factors

The study findings also provide evidence that, the socio-cultural constraints notwithstanding, other factors, especially deficiencies in the healthcare system, directly or indirectly predispose women to severe morbidity situations. For instance even when the women strove to seek care at health facilities, the treatment they received left much to be desired. In most cases no attempts were made to diagnose their problems, or what was diagnosed clearly reflected a lack of even rudimentary professional competence on the part of the health workers (Teopista, Joyce, Sifa and Margaret). The poor referral system is evident both in the rural and urban settings. Sifa who was in Kampala was chased away from the clinic without even a verbal referral to hospital. All the other women in the rural areas merely received verbal referrals, and in all the cases no facilitation was made available to them by way of transport to the referral hos-

pitals, or other logistics essential for hospitalisation. Even after reaching the referral hospitals, often in critical situations, some of the women were not immediately attended to (Savia, Sifa and Margaret). At the district hospital, which she had earlier visited, Teopista was not treated despite her obviously dangerous condition. Most of the problems like lack of space in the wards or the theatre (Savia, Margaret) at the referral hospitals were purely institutional. The long distances to the referral facilities and the poor transport system are also worth mentioning. Most of the women lived over 35 kilometres away and had to travel in crowded taxis or pick up trucks to reach hospital despite their critical condition. No wonder that most of them were barely alive by the time of arrival at hospital.

Conclusions and Recommendations

The study findings demonstrate that severe maternal illness is not necessarily a result of direct (biomedical) causes *per se* but may stem from other factors deeply rooted in the local 'birth culture' and gender relationships. Socio-cultural issues, especially how pregnancy and childbirth are perceived by individual women and the community, together with the gendered distribution of power at the household level, contribute significantly to severe maternal morbidity experiences. The expectation that women will not publicise their pregnancy and will maintain a stoic demeanour during labour and birth aggravates their morbidity situation, since danger signs or conditions that require urgent attention are suppressed and not communicated to qualified health personnel until too late. Many of 'near to death' experiences could otherwise have been avoided. Another detrimental consequence of such attitudes is reliance upon culturally accepted but high-risk options (e.g. self-treatment or consultation of relatives/friends, TBAs, or traditional healers), even in episodes of life-threatening obstetric complications. Utilisation of options of proven efficacy that lie outside that culture (e.g. seeking professional help at formal health units) is seen as irrelevant, often leading to near fatal consequences for the mothers.

This research also makes it clear that women's maternal health care is deeply embedded within a cluster of other gender and power based relationships. Women who lack income, access to resources, and the ability to make decisions even concerning their own survival, are inevitably at risk. This situation is compounded by the definition of pregnancy and childbirth as lying outside the scope of male concerns. Men have little if any involvement in their wives' reproductive activity and provide little support when problems arise.

The socio-cultural and gender-related bottlenecks notwithstanding, the severely sick and resource constrained women are more often than not hampered by the glaring deficiencies in the formal healthcare system including *inter alia*, incompetent health staff especially at lower level health units, the poor referral system, and the lack of an institutionalised transport system. Even

at the referral hospitals, lack of space in the wards or theatre, or inability to be seen by the busy medical staff may lead to critical delays, which aggravate women's morbidity experiences.

Recommendations

- (i) The evidence provided here about the significant contributory role of socio-cultural factors in severe maternal morbidity highlights the need to design new, alternative interventions to address the problem. These strategies must recognise the local 'birth culture' of the locality and confront directly the constraints that arise from it.
- (ii) Interventions should focus on active community involvement (sensitisation and mobilisation) aimed at preparing women for safer pregnancy. Delivery of culturally acceptable factual information and maternal health services should also be a priority issue. Enlisting community support in general and men's involvement in particular should be high on the agenda.
- (iv) More in-depth research is required in this area, to explore different aspects of prevalent 'birth cultures', especially among rural ethnic communities where most 'near death' cases occur. The knowledge generated will enable identification and possibly incorporation of the relevant (positive) aspects of the birth cultures into the alternative interventions mentioned above.
- (v) Measures should be taken to address the comparative lack or poor availability of maternal healthcare resources in the rural areas. The focus should be on training of health workers, providing relevant materials and supplies, improvement of the referral system and providing institutional transport.
- (vi) Facilities, especially wards and theatres at referral hospitals, should be increased and admission procedures streamlined to adequately cater for women in maternal morbidity situations.

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