

Maximizing our circle of influence to defend midwifery care services amidst COVID-19: Uganda's Perspective

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The current pandemic of coronavirus disease 2019 (COVID-19) caused by severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) has caused significant disruptions to normal life in many communities across the globe [1, 2]. Consequently, the World Health Organization (WHO) declared COVID-19 outbreak a Public Health Emergency of International Concern on 30th January 2020 [3]. With a sustained spread to all continents and nearly all countries and territories across the globe within three months since the first detection from the epicentre of the outbreak in Wuhan, (Hubei Province, People's Republic of China), the WHO officially recognized COVID-19 a pandemic on 11th March 2020 [4].

As of 13th June 2020, there were 7,553,182 confirmed COVID-19 cases and 423,349 deaths globally [5]. The confirmed cases and subsequently mortality has been highest in Europe and Americas with Africa and South-East Asia being the least affected regions [6]. Although at present the pandemic is more in Europe and Americas, Africa is expected to be the most hit region in the coming weeks owing to their weak health systems and poor political governance that makes them ill-prepared to handle outbreaks of COVID-19 stature [7]. In Uganda, as of 13th June 2020, there were 808 cases and 00 deaths of COVID-19 [5]. These figures suggest a slow but steady increase in COVID-19 cases since the detection of the first case on 22nd March 2020. This pattern could be largely due to a host of mitigation measures that were announced by the governments to curtail the spread of the virus. Some of these mitigation measures included re-structuring in regards to infrastructure and human resources within the healthcare sector to accommodate the new burden of COVID-19 across the country. However, these adjustments have markedly disrupted service delivery including for maternal and newborn care in numerous health facilities. This is partly because some units had to close down to make up space for COVID-19 triage, quarantine, and treatment of positive cases. Besides, some staff have been forced to take up roles in COVID-19 task force at facility and District levels as a way of task-shifting. With the steady increase in the number of COVID-19 cases, there is already a steady encroachment or tendency of encroachment on routine maternity care services as a way of tackling COVID-19.

A case in point, my hospital was approached by a team from the District, Ministry of Health and WHO with a view of using our facilities as a quarantine and treatment centre. Ironically,

my hospital director could only think of the maternity block as the potential quarantine and treatment centre. Even with the lure of extra funding and relocation of some of these services, I could not comprehend why the maternity block of all services would suffer such ill fate. There was a high likelihood that this would result in women not accessing maternity services at all with a significant loss of life. As the Clinical Supervisor-Midwifery services for my hospital and an ICM Young Midwife Leader (YML) endowed with the skills of navigating organizational politics, I stepped in and influenced against making my hospital serve as quarantine and treatment centre. I am proud of my actions because deep down I know I owe our mothers and their newborn and families the first priority. Therefore, I urge all midwives to rise up and use all tools within their means to defend and advocate for childbearing women, and their newborns amidst this pandemic and refrain from the lure of increased hospital funding for providing Covid-19 services as this would not serve the interest of mothers and families.

References

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