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WHY ARE MOTHERS AND BABIES STILL DYING? VOICES FROM THE COMMUNITY AND SERVICE PROVIDERSAloysius Mutebi. *Makerere University School of Public Health, Kampala, Uganda*

10.1136/bmjopen-2015-forum2015abstracts.61

Background Neonatal and Maternal mortality in Uganda is high (26/1000) and somehow underestimated. As a result Makerere University School of public health, with support from Comic Relief initiated a maternal and newborn care Study in Eastern Uganda. The implementation uses VHTs to sensitize women on maternal and newborn danger signs as well as encouraging them to access services from the health facilities. Early results indicate that, ANC 4th visit attendance has increased from 43% to 68% and Health Facility deliveries has increased from 66% to 84%. However, there are maternal and newborn deaths that are happening in the community and health facilities thus a need for understanding the factors associated to these deaths.

Objectives To ascertain the factors associated to maternal and newborn deaths in the districts of operation.

Methods The qualitative assessment was carried out in the districts of Kamuli, Pallisa and Kibuku in the Intervention area where maternal project is being implemented. This was done as one way of monitoring the implementation of the project and its effects on maternal and newborn deaths. Purposive sampling was used to select the study participants using in-depth interviews that involved women who had lost their babies during/immediately after delivery (10), Sisters of the women who died during/after delivery (2) in the last seven months and Maternity health workers (9). Nine (9) Facility health workers were also interviewed to seek their views on the maternal and newborn deaths.

Result Both Health workers and community indicated lack of transport at both levels as a contributing factors to newborn and

maternal deaths. Lack of essential items, medicines and Skilled health workers, and Delays in reaching the facilities at the time of delivery were the most factors mentioned by the Health Workers who were interviewed. Delayed decision making health facility for example in referring the women for further management was revealed to be a contribution factor. Other factors included age and parity where women who lost their newborns where of the age <20 years and those who had parity of 5 and above.

Conclusion The review of maternal and neonatal death is a key instrument in improving the quality of maternal and neonatal health care services by identifying the causes of deaths and what could have been done to avoid each death. It enables the identification of major contributing factors at both community and health facility levels in order to take appropriate decision making in addressing the challenges. Availability of Skilled personnel, essential equipments and drugs are very important in addressing maternal and newborn deaths. There is need to address the transport challenges at both levels.