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Pregnancy in an Ebola outbreak—protecting women and health workers

Efforts to contain the spread of Ebola shouldn't compromise healthcare for women experiencing pregnancy complications, says Benjamin Black

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It's late at night when a pregnant woman arrives at a hospital. She is feverish, semiconscious, and has vaginal bleeding. She says the pregnancy is not far along. Without urgent medical care she's at risk of permanent injury or death. Now, imagine she's come from an area where people have Ebola virus disease (EVD). Should she be admitted for obstetric treatment? Should she be isolated, awaiting a negative EVD test? What is the correct care pathway for her? What is safest for the health workers treating her?

In Uganda today, where an Ebola outbreak is rapidly evolving, health workers are on high alert to identify patients with symptoms suggestive of EVD, to contain the spread of the infection. Among the non-specific signs of possible EVD, special attention is given to unexplained bleeding. When healthcare professionals suspect a patient has EVD, the patient should be isolated and tested, which can involve waiting to be transferred to another facility where specialised obstetric treatment may not be available. For women with a pregnancy complication, such delays in care increase the risks of morbidity and death. As EVD cases in Uganda continue to rise, mitigating these delays for pregnant patients must be considered at the beginning of the outbreak response.[1]

Bleeding in pregnancy is common and has many causes, especially in a country with high rates of poverty, a low maternal health baseline, and restrictive abortion laws. However, the pervasive fear that walks alongside EVD outbreaks, and the high stakes at risk in making the wrong call in identifying it, can lead to widespread stigmatisation of women and girls in need of emergency (and routine) healthcare.

In the 2014-16 west African Ebola epidemic, fear of women with pregnancy complications resulted in some patients being denied emergency obstetric care and the closure of essential health facilities.[2] This fear travels in both directions: as health centres become associated with screening for EVD, patients might delay or avoid accessing healthcare facilities for fear of being identified as a suspected case. This avoidance of clinics has already begun in affected regions of Uganda.[3]

For women experiencing pregnancy complications, health workers become judge and jury, deciding whether they're allowed entry into maternity facilities or made to isolate for Ebola testing. For health workers, a pregnant woman with possible symptoms of EVD presents a confusing conundrum, with the wrong verdict having far reaching consequences for all involved. The risks of EVD to health workers at the frontline are staggering. In the 2014-16 outbreak in west Africa, health workers had a risk of death from EVD that was 32 times greater than the local population.[4] At the time of writing, it's been reported that six health workers have died in Uganda,[5] including one midwife.[6]

EVD is a terrible disease for its high mortality rate, but also for the fear, confusion, and mistrust it spreads—often more contagious than the pathogen itself. Balancing access to healthcare against protections for health workers becomes a precarious judgment call, requiring robust communication and carefully implemented policy that considers a range of risks and their trade-offs.

The precedent set by previous outbreaks warns us of the harm that blanket assumptions about symptoms can have for maternal or reproductive healthcare. Research from the largest EVD epidemic in the Democratic Republic of the Congo (in North-Kivu and Ituri from 2018 to 2020) recorded the tragic testimonies of healthcare workers who feared women seeking medical care, while women and girls described long and deadly delays for the management of obstetric complications.[7]

The difficulty in differentiating between EVD and complications of pregnancy requires more nuance than ticking boxes on a triage questionnaire. Health workers with experience of providing maternal and reproductive healthcare need to work alongside the staff tasked with triaging patients for suspicion of EVD. The shared acumen they can apply when assessing a patient's clinical history can help healthcare services to distinguish unexplained from explained bleeding.

The trajectory of this outbreak sits at a precipice. Uganda is experienced in EVD, it has international support, and has implemented the core pillars of outbreak response. But EVD outbreaks can overwhelm the systems and services that aim to contain them.

As efforts ramp up to halt EVD transmission and manage those who have been infected, pre-existing (limited) health resources risk being diverted into the outbreak response architecture. This paints a worrying picture for women seeking, and health workers providing, maternity and reproductive care. Any reduction in the availability of or access to care will further increase the vulnerability of all involved to poor health outcomes. As the outbreak develops, it's imperative that these services be protected and

the lessons of the past be heeded. We know what can happen if maternal and reproductive health services aren't given appropriate support from the outset of an outbreak—discrimination, denial of care, and avoidable deaths.

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