# Heathy bodies Empowered Women

Policy brief

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## Gaps in the Implementation of Reproductive Health Policies in Uganda

### Introduction

Globally, 1,500 women die from pregnancy related complication or childbirth daily, while 10,000 babies die daily within the first few months of life. Most of these deaths occur in the so called developing countries and are avoidable. In 2008, an estimated 358,000 maternal deaths occurred worldwide. This means that each day about 1,000 women die worldwide because of complications related to pregnancy and childbirth. Developing countries account for 99 per cent of the deaths. Two regions, Sub-Saharan Africa and South Asia, accounted for 87 per cent of global maternal deaths. Sub-Saharan Africa suffers from the highest Maternal Mortality Rates (MMR), at 640 maternal deaths per 100,000 live births, followed by South Asia, with an MMR of 290. In bleak contrast, MMR in industrialized countries is 14[1].

In Africa achieving Sexual and Reproductive Health Rights (SRHR) remains a challenge and unrealized in all countries despite being guaranteed in international and regional human rights instruments and national legislations. SRHR in Africa are shaped by the socio- cultural beliefs and practices that determine the extent to which the rights are respected, protected and realized. These beliefs either violate

or protect individual's rights. SRHRs have been articulated in various declarations; among them: the Abuja Declaration on HIV and AIDS, Tuberculosis and other Related Infectious Diseases (2001), the Bamako Declaration on the Reduction of Maternal and Neo-Natal mortality (2001), the Maputo Declaration on Malaria, HIV and AIDS, Tuberculosis and other infectious diseases (2003), the Maputo Plan of Action on Sexual and Reproductive Health and Rights of Operationalization of the Continental Policy Framework on Sexual and Reproductive Health and Rights (2006), the Ouagadougou Action Plan to Combat Trafficking in Human Beings, especially Women and Children (2006), the African Health Strategy (2007-2015), the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) and generally in all the activities of the Women and Gender Directorate of the African Union Commission.

Despite the fact that all countries in Africa have ratified a number of international and regional treaties to uphold sexual and reproductive rights; maternal mortality continues to be a problem, with the ability of women to bear children still posing a risk to their health and life in most African countries. In Niger and Ethiopia only 47% and 27.6% of pregnant women respectively have access to antenatal care and only 17.2% and 5.3% respectively have qualified care during delivery.

There are diverse forms of gender based violence in most countries including, female genital mutilation (FGM) and the trafficking of women for sexual exploitation. The health situation and the sexual and reproductive rights of young people require urgent attention. In Namibia, at least one in five adolescents have been pregnant at least once and in Mali, Niger and Mozambique SRHRs are of particular concern because the figure jumps to one in three girls being or having been pregnant[2].

Complications of pregnancy and childbirth are among the leading causes of morbidity and mortality among Ugandan women. Recent estimates suggest that there are 435 maternal deaths per 100,000 live births, indicating that more than four women die of pregnancy-related causes for every 1000 live births. This translates to about 6,000 women dying every year due to pregnancy related causes (OF)[3],[4]. 23% of all births annually occur to women in their teens, before the female body is physically fully developed[v]. Although obstetric fistulae are quite common, it continues to be a silent morbidity among Ugandan women. In spite of its physical and psychological trauma, it arouses little interest and no data on its prevalence is available.

According to United Nations Population Fund (UNFPA) women's access to effective Reproductive Health (RH) services such as antenatal care, skilled attendance at birth, post natal care and family planning would prevent 30% of maternal deaths, 20% of child's deaths and 90% of abortion related deaths. Although Uganda has developed a number of relevant policies to address most of the reproductive health concerns, women's reproductive health rights continue to elude health planners and implementers as policies put in place are not implemented as expected.

This policy brief aims to discuss reproductive health, policies provided to ensure reproductive health of women in Uganda, the gaps in implementation and recommendations for policy makers and implementers to ensure the attainment of the reproductive health and rights of majority of the country's population.

# 1. Reproductive health policies in Uganda

The International Convention on Population and Development (ICPD, 1994), to which Uganda is a signatory, defines reproductive health as a state of complete physical, mental, emotional and social well-being in all matters related to the reproductive system, its functions and processes and not merely the absence of disease or infirmity.

Reproductive health includes sexual health, the enhancement of life and personal relations, counseling and care related to reproduction and sexually transmitted diseases. Reproductive health therefore implies that people are able to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when and how often to do so.

With Uganda signing the Maputo protocol, its article 14 requires that States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes: the right to control their fertility; the right to decisions on when and how to have children; the right to choose any method of contraception and self-protection; the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS; and the right to have family planning education. Additionally, State Parties shall take all appropriate measures to provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas among others. The Ugandan National Health Policy II of 2009 aims to facilitate the attainment of a good standard of health by all people of Uganda in order to promote a healthy and productive life[6].

The national Safe Motherhood Program (SMP) has been one of the major interventions for the promotion of maternal health in Uganda. Its aim is to ensure that no woman or newborn dies or incurs injuries due to pregnancy and/or childbirth; enhance quality of safe motherhood services; thereby reducing maternal and newborn morbidity and mortality in the country. It is also to ensure that delivery of maternity services is provided 24 hours every day in units that are licensed and equipped to provide them.

A number of other policies to promote reproductive health have been adopted in Uganda. They include the Safe Motherhood Policy that seek to provide services through a continuum of care from the community to health centre II, III, IV; and the hospitals; including developing a roadmap for reduction of maternal mortality and morbidity in Uganda[7]. In recognition of the need to use fistula as a catalyst to improve safe motherhood, the health policy provides for improved social and political environment and service delivery for prevention, treatment and management of obstetric fistula in Uganda. This can be done through increased awareness and support among stakeholders and the integration and management of obstetric fistula in the existing sexual reproductive health services.

The Reproductive Health Policy aims at providing information and services that will enable individuals and couples to decide freely and responsibly when, how often and how many children to have. It also seeks to increase access to quality, affordable, acceptable and sustainable family planning services to everyone who needs contraception. The goal of the adolescent sexual and reproductive health policy is to mainstream adolescent health concerns in the national development process in order to improve their quality of life and standards of living. This can be done through the provision and increased availability and accessibility of appropriate, acceptable, affordable quality information and sexual reproductive health services to adolescents to influence positive behavioral change.

Other policies include the Adolescent Sexual and Reproductive Health Policy to mainstream adolescent health concerns in the national development process; and the National Population Policy, which seek to reduce fertility

## 2. Reproductive Health Trends for Uganda

| | Past Trend | Present Trend |
|---|---|---|
| Maternal Mortality | 435/100,000 live births[9] in 2006 | 352/100,000 live births 2008[10] |
| Infant Mortality | 88/1000 live births in 2000 | 76/1,000 live births in 2006 |
| At least one ante natal care visit[11] | - | 94% |
| A least two to three ante natal care visit | - | 42% |
| A least four or more ante natal care visit | 42% in 2000/2001 | 47% in 2006 |
| Access to postnatal care within the first week of delivery | - | 26% |
| Percentage of women delivering in fully functional comprehensive emergency obstetric care[12] | - | 11.7% |
| Proportion of births in health facilities | 37% in 2000/2001 | 425 in 2006 |
| Unmet Family Planning needs[13] | 35% in 2000/2001 | 41% |
| Contraceptive rate – married women | 15% in 1995 | 22.8% |
| Percentage of married women age 15-49 currently using a method of contraception | 19% in 2000/2001 | 24% in 2006 |
| Annual rate of birth among teens[iii] | 31% in 2000/2001 | 23% |
| Total fertility rates | 6.9% in 2000 | 6.7% in 2006 |
| HIV/AIDS prevalence | - | |
| **Sexual and Gender Based Violence indicators** | **Male** | **Female** |
| Ever experienced physical violence since age 15 | 52.7% | 60% |
| Violence from husbands/partners | 34.1% | 63.3% |
| Violence from former husband/partner | - | 22.5% |
| Ever experienced sexual violence | 10.9% | 40% |

# 3. Gaps and challenges

A number of core interventions have been identified to tackle this unacceptably high maternal mortality rate. Key among these is the operationalization of Emergency Obstetric Care (EMOC) services at health centre III, IV and in the hospitals. Others included the establishment of maternal deaths reviews, scaling up goal oriented antenatal care (ANC) including the provision of intermittent presumptive therapy (IPT) in pregnancy (Roadmap for accelerating the reduction of maternal and neonatal mortality and morbidity in Uganda 2007-2015).

However, poor functionality of HC IV and hospitals has hampered the developments. In the Support to the Health Sector Strategic Plan Project (SHSSPP) supported districts; only 15 (2 HC IV and 13 hospitals) out of 49 health facilities (30.6%) in these districts have capacity for the provision of comprehensive EmOC (caesarean section and blood transfusion)[14]. The main factors that constrain the functionality of HC IVs are poor infrastructure and equipments, few qualified health workers especially medical officers because of poor remuneration, inadequate medical drugs and supplies; and weak supervision.

Currently there are very few hospitals and specialists who offer services to fistula patients. More so, fistula repairs are only being performed in some referral hospitals and in few general hospitals with limited skills. There is lack of equipments and supplies needed for the repair and most communities do not support the rehabilitation of obstetric fistula patients.

With regards to family planning, social, cultural and religious values have a strong influence on reproductive choices for women in Uganda. Many women are discouraged from using family planning by spouses or family members, or by political and community leaders or other community members[15]. In addition, there is lack of accurate information; lack of access to quality services [AHSPR 2009/10]; lack of prioritization and resource allocation and lack of understanding and commitment from leaders and decision makers at all levels to increase budget allocations for family planning.

Lack of reporting of SGBV cases to the health services has led to its increase. The few cases who report to health facilities are those who would have reported to police and thus come to health facilities to have the police form filled so that they can seek legal redress. Despite the high level of sensitization on SGBV by civil society organizations, inadequate knowledge of SGBV among health providers and lack of capacity of health facilities to manage SGBV has led to poor linkage between health facilities, the community and other agencies such as legal aid providers involved in the prevention and management of SGBV.

# 4. Financing Reproductive Health in Uganda

One of the most pronounced challenges faced by the health system in Uganda is the poor financing for medicines and supplies. The government's budget only funds 30 percent of requirements for essential medicines, and 72 percent of government health units have a monthly stock-out of at least one medicine. The Ministry of Health's budget line item for reproductive and maternal health supplies is often vastly under-spent against what is allocated, with less than ten percent of designated funds actually disbursed[17]. Whereas public sector health care is free of charge, government facilities usually ask patients to purchase their own medicines at pharmacies if supplies are stocked out.

The government has spent eight to nine percent of the national budget on health annually since the fiscal year beginning in 2005[18], well below the target of 15 percent established by African health Ministers in Abuja in 2001. Of the total health expenditures in Uganda, the government plays the smallest role. According to the draft National Health Policy, half of the health expenditures are borne by households, 35 percent by donors, and the remaining 15 percent contributed by the government[19].

Overall, there is weak institutional capacity to implement policies and to ensure effective delivery of health care services. This requires that policy promises are translated into concrete reproductive health services for women to benefit and for the achievement of the reproductive health rights of women.

# 5. Policy Recommendations

1. The government should recruit more health workers to fill the existing vacancies in the current staff establishment. This can be done by recentralising the recruitment and deployment of medical staff. To retain medical professionals, there is need to improve on the remunerations of all health workers to the level currently being paid by health related projects. In addition, health workers outside Kampala should be paid extra to encourage them to fill vacant posts in upcountry health units.
2. Increase availability of skilled attendance at birth by providing Health Centre IIs with skilled staff and facilities for delivery to reduce maternal mortality. Even with good ANC, up to 15% of all births are complicated by a potentially fatal condition, yet skilled attendance at birth is available for only 38% of women in Uganda. Since Health Centre IIs are in most parishes, these will be easily accessible by the women.
3. Improve domiciliary services in the communities. Domiciliary midwifery is part of training of midwives in Uganda but there has been very limited effort to implement it. This should be encouraged in both the public and private sector. This has great potential to improve care of the mother and newborn in the first week of birth when most deaths of newborns occur.
4. Government should increase the number of health workers they sponsor in midwifery/nursing, clinical officer and medical officer training. These health workers should be bonded to work in public sector for a specified period of time before they can be allowed to leave government jobs. This will increase the health workforce for patient care in the country
5. Improve the provision of medicines and medical supplies. This can be done by instituting regional branches of national medical stores. This will make the distribution of medicines and medical supplies easy in public hospitals and health units; thus improving the availability of medicines and medical supplies for women's reproductive health.
6. Improve on the equipments in the hospitals so that complicated cases like infertility, obstetric fistulae, reproductive health cancers, etc can be ably handled in the regional referral hospitals
7. Strengthen in-service training in the health sector by making the regional referral hospitals to take charge in the identification of the training needs and follow up of the trainees.
8. The government of Uganda must consider new financing approaches to overcome economic barriers and aim to achieve the 15% as clearly stipulated in the Abuja Declaration of 2001.

# (Endnotes)


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Isis-Women's International Cross-Cultural Exchange
*We Link Women Internationally*


Isis-Women's International Cross Cultural (Isis-WICCE)
Plot 23,Bukoto street, Kamwokya,
P.o.Box 4934, Kampala Uganda,
Tel: +256414543953,
Fax: +256414543954
Website: www.Isis.or.ug,
isis@starcom.co.ug




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