Monitoring Maternal Health and Safe Motherhood Policies

Policy-Making in Practice:
What can be Learned from Uganda's National Budget Implementation?

May 2010

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Abbreviations

ANC	Antenatal Care
BEmOC	Basic Emergency Obstetric Care
CPR	Contraceptive Prevalence Rate
CYP	Couple Years Protection
CEmOC	Comprehensive Emergency Obstetric Care
DANIDA	Danish International Development Agency
DDHS	District Director of Health Services
DFID	Department for International Development
EC	Emergency Contraceptive
EmOC	Emergency Obstetric Care
EMHS	Essential Medicines and Health Supplies
FGM	Female Genital Mutilation
FP	Family Planning
GoU	Government of Uganda
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HSD	Health Sub District
HSDP	Health Systems DevelopmentProgramme
HSSP	Health Sector Strategic Plan
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IUD	Intra Uterine Device
JMS	Joint Medical Stores
MCH	Maternal and Child Health
MoGLSD	Ministry of Gender, Labour and Social Development
MMR	Maternal Mortality Rate
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
MVA	Manual Vacuum Aspiration
NDA	National Drug Authority
NGOs	Non-Governmental Organizations
NMS	National Medical Stores
PAC	Post-abortion Care
PACE	Programme for Accessible Health Communication and Education
PEAP	Poverty Eradication Action Plan
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PNFP	Private Not For Profit
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RHU	Reproductive Health Uganda
SGBV	Sexual and Gender-Based Violence
SIDA	Swedish International Development Agency
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
SWAp	Sector Wide Approach
TBA(s)	Traditional Birth Attendant(s)
TFR	Total Fertility Rate
UDHS	Uganda Demographic and Health Survey
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UNMHCP	Uganda National Minimum Health Care Package
USAID	United States Agency for International Development
VVF	Vesico Vaginal Fistula
WHO	World Health Organization
WFP	World Food Programme

Director's Message

Executive Summary

Globally, more than half a million women die every year because of complications related to pregnancy and child birth (UNICEF, 2008). According to UNICEF (2008), of that half a million, 99% are from developing nations - with about a half occurring in Sub Saharan Africa while about 187,000 occur in Asia. For every woman who dies, 20 more women suffer injuries, infection and disability. A woman's life risk in Sub Saharan Africa is 1 in 22 compared to 1 in 8000 in the industrialized countries. This report presents a review of the policy framework for maternal health and safe motherhood in Uganda and implementation issues relating to service delivery. The review provides analytical linkages between policies and implementation framework, and gaps in maternal health and safe motherhood service delivery. Data was mainly obtained from the desk review of policy documents and studies that have been conducted in the country. A few key informant interviews of policy makers and service providers in both government and civil society organizations were conducted to supplement the secondary data.

Key Findings

Maternal Health and Safe Motherhood Policies

In Uganda, maternal health and safe motherhood have been high on the country's agenda for addressing Sexual Reproductive Health and Rights (SRHR) issues. This commitment is reflected and demonstrated by the general policy and implementation frameworks that have been put in place to address maternal health issues in the country. Commitment to address maternal mortality and safe motherhood is clearly articulated in the successive overall national development frameworks, namely, the Poverty Eradication Action Plan (PEAP) 1997 - 2007 and the National Development Plan (NDP) 2008/9 – 2012/13. This is further articulated and operationalised in the following policy documents: National Health Policy (NHP); National Health Sector Strategic Plan (HSSP) I & II; National Population Policy; National Hospital Policy; Sexual and Reproductive Health Care Minimum Package; National Reproductive Health Policy Guidelines for Reproductive Health Services; Guidelines for Gender Mainstreaming in Reproductive Health; Strategy to improve Reproductive Health in Uganda 2005-2010; Guidelines for Strengthening Sexual and Reproductive Health in Uganda for District Health Planners, Programme Managers and Implementers of RH Programmes; and the 2007 Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda

Nature of Maternal Health and Safe Motherhood

- Uganda has experienced a slight reduction in maternal health indicators including slight reduction on maternal mortality rate over the

years, from 527/100,000 (1990) to 505/100,000 (1995) and 435/100,000 (2006). Total Fertility Rate (TFR) reduced from 6.9 (2001) to 6.5 (2006), contraceptive prevalence rate increased from 23% (2001) to 24.4% (2006), the proportion of deliveries in the health facilities increased from 25% (2004) to 32% (2006) and PNC within the first week of delivery currently stands at 26%. In addition, the percentage of health units providing EomC increased from 20% (2004) to 45% (2006/07) – UNFPA supported districts, ANC attendance of 4 visits improved from 42% to 47%, while teenage pregnancies reduced from 32% to 25%.

- The major causes of maternal mortality include haemorrhage, sepsis, obstructed labour, unsafe abortion and hypertension in pregnancy, malaria, HIV/AIDS and others. Morbidity among pregnant women is related to obstetric fistula, chronic pelvic infection, post-abortion complications, infertility, HIV/AIDS and general maternal ill-health. Studies attribute maternal ill-health and deaths in Uganda to a number of factors including limited utilization of health facilities[1]; inadequate health facilities characterized by limited accessibility; poor quality of maternity care services; few trained health workers; limited access to safe blood and limited supplies; low contraceptive use; gender inequality manifested in low levels of schooling; limited opportunities for employment; limited male involvement in RH issues; and limited mobility brought about by societal gender norms.

1 *While a significant proportion of maternal deaths occur in the health facilities, there are over 62% of pregnant women delivering either by themselves or in the hands of unskilled health workers (Mallinga and Mbonye, 2008)*

Policy Implementation Framework

- There is a well established policy implementation mechanism with the Ministry of Health (MoH) taking the lead role and responsibility for ensuring good health of the country's population. The MoH collaborates with MoFPED Population Secretariat on policy development, advocacy and awareness creation on maternal health and safe motherhood issues outlined the NHP, HSSPII and NPP. The MoH has a well developed National Health System (NHS) through which health outputs are delivered. It works through a five-tier structure by which health services are delivered nearer to the people including National-level Institutions, National Referral Hospitals (NRH); Regional Referral Hospitals (RRH); District Health Services; Health Sub-District (Referral Hospital/General Hospital/ Health Centre IV (HCIV), Health Centre III (HCIII), Health Centre II (HCII) and Health Centre I (HCI) or the Village Health Team (VHT). Other implementation mechanisms include the Sector Wide Approach (SWAp) that promotes inter-sectoral collaboration and other stakeholders including civil society organizations and the private sector.

Issues in the Implementation of Maternal Health and Safe Motherhood Policies

Best Practices

- Establishment of a conducive policy environment for addressing SRHR, in particular maternal health and safe motherhood, is an important step towards

averting pregnancy and birth-related illnesses and deaths in the country.

- Establishment of an institutional framework for implementing the policies that runs from national through to the lowest level of local government to ensure that services are closer to the people.

- Commitment to strengthen public private partnership that engages all stakeholders in national health development. This is a strategy that enhances service delivery and promotes participatory development and good governance.

Emerging Issues and Gaps

- While there are a number of policies and strategies to address maternal and health and safe motherhood issues in the country, the apparent weak implementation of these policies has lead to persistent poor maternal health outcomes (Republic of Uganda, 2010). In addition, the policies, plans and the Roadmap give little or no concrete discussion of the gender-specific barriers to service access. The Roadmap, which by far offers the most comprehensive discussion on the causes of maternal mortality and morbidity, does not articulate concrete actions to address gender-related barriers to service access.

- While unsafe abortion is identified as a major contributor to maternal mortality and morbidity, the policies - particularly the NHP and HSSP II - offer limited discussion of how it can be addressed. When they do acknowledge unsafe abortion and the need for post-abortion care, the discussion is truncated, failing to articulate concrete actions and targets to address it. Another area that is given minimal attention and yet it is a serious concern for maternal morbidity is obstetric fistula.

- The National Health Policy and the Roadmap to Accelerating the Reduction of Maternal and Neonatal Mortality (2007) identified male involvement as crucial in maternal health. However, this focus is not reflected in the strategic plan. The discussion on maternal health largely focuses on it as a "women-only-issue" with no comprehensive focus on men and their involvement in maternal and reproductive health, given the fact that they are central in household decision making, particularly on issues of access to, control and distribution of resources, movement outside the home, as well as control over one's sexual life. Male involvement is briefly highlighted as a cause of increased maternal deaths but no particular attention is paid to it as a priority area of focus. The policies also offer little discussion on the role of the community in maternal health issues.

Financing of Maternal Health and Safe Motherhood Policies

Budgeting in Uganda has been guided by the PEAP, Uganda's national development framework and medium-term planning tool since 1997[2] to 2009.

2 *PEAP has been replaced with a five-year comprehensive National Development Plan (NDP) that articulates the planned strategic interventions of all sectors of Uganda's economy.*

The health sector emerges as the third among the priority sectors accounting for 10.8% in FY 2008/09 with a slight decline to 10.5% in FY 2009/2010 Budget estimates. Donor funding constitutes a significant proportion of the Health sector.

While there are a number of donors supporting the Health sector, the main development partners supporting maternal health initiatives[3] include UNFPA, providing support to Family Planning equipment and contraceptives, EmOC equipment and supplies, capacity building for health workers, sensitization and awareness raising on RH issues and development of policies and guidelines; African Development Bank (ADB) with support to infrastructural development in terms of construction and renovation of maternity units at HC IV and IIIs, delivery equipment, FP activities and EmOC; and GoU providing support scaling up of EmOC, purchase of folic acid, ANC, maternal reviews, mama kits, and RH supplies. Given the integrated approach to addressing health care service delivery, the available information does not explicitly show allocation and utilization of resources for the specific components of maternal health.

Issues in the Financing of Maternal Health Safe and Motherhood Policies

Best Practices

- Putting in place finance management and monitoring mechanism that ensures expenditure against agreed work plans and outputs.

3 *Data on amount of contribution was not available.*

Emerging Issues and Gaps

- In spite of government commitment to increase funding for health development, the MoH operates on high budget shortfalls. The proportion of GoU allocation to the sector though increasing since 2004/05 (9.7%) and 2006/07 (9.6%) shows a declining trend and actually declined in 2008/09 to 8.3%, which is off target of the HSSP (13.3%) and far below the Abuja commitment[4] of 15%. The inadequate funding to the sector has serious implications for effective implementation of the Health sector activities and efficient service delivery.
- There were also reported difficulties in tracing resources on the off budget support that goes directly to the private sector and districts, yet this is where most donors channel their funding. The high donor funding to project and off budget support impairs predictability and hampers comprehensive planning, harmonization and alignment of development assistance with the HSSPII.
- The budget items are presented in general terms, making it difficult to ascertain how much money goes into Maternal Health and Safe Motherhood activities.
- It was reported that indicative figures are given late and this interferes with the budget and work plan development. In addition, the indicative figures keep changing alongside the work plan and budgeting process which sometimes makes planning difficult.

4 *In 2001, African Heads of State during a special summit on AIDS, TB and Malaria in Abuja made a commitment to allocate at least 15% of their annual domestic budget to the Health sector.*

- On accountability and financial management, there is reported failure by some officers to adhere to financial procedures, resulting in delayed accountability of funds and eventual delays in disbursement and implementation of activities. In addition, there is lack of transparency and openness by various stakeholders on decisions surrounding actual procurement of Essential Medicines and Health Supplies (EMHS) and their deliveries continue to derail predictability of availability of key EMHS.
- While community and clinical services accounts for the largest share of the health sector budget, it largely depends on donor support. The level of dependence raises questions about sustainability of the health sector interventions for community services. In addition, not all allocations are fully aligned with the priorities laid out at the outset. In the annual health sector performance report, it is noted that larger proportions of the donor project funds are not targeted against the sector priorities and inputs but rather are converted into management overheads, including the provision of expensive technical assistance. For example in 2004/05, of the Shs. 255bn expended through donor projects, only 44% was spent on agreed essential sector inputs.

Overall, lack of adequate resources to the sector translates into inadequate and inefficient service delivery characterised by limited capacity of the health facilities to provide adequate maternal health care and safe motherhood services.

Recommendations

- Efforts should be made to translate issues identified in the policies into concrete actions and corresponding budget allocations for effective implementation. Adequate finances are needed for implementation of the roadmap; otherwise it will remain on paper and reduction of maternal mortality will not be realized.
- Government should increase resources to the sector and, in particular, honor the Abuja commitment. More of sector resources should be put into addressing maternal health and safe motherhood issues. There is need for improved prioritization and alignment of available resources for basic service delivery and, especially, increasing grants for local government and PNFP health service delivery, including financial support for community participation in the Village Health Teams (VHTs) as well as extending services to HCIIs which are nearer to the poor women.
- There is need to strengthen family planning services among young people and provide emergency care, especially post-abortion care. It is essential that such services are provided to prevent further complications and death. It is noted that FP alone can reduce maternal mortality by 20-30% and, if combined with skilled attendance at birth and EmOC, can reduce maternal deaths by over 70%. The general maternal health services need serious attention.
- There is need to address human resource and capacity concerns in terms of recruitment and offering training.

- Encourage community as well as male involvement in maternal health care and continuous sensitization about the gender barriers to maternal health care and general reproductive health is critical.
- Harmonise public and private RHS providers to avoid service duplication and/or concentration of funding in similar areas.

1.0 Introduction to Maternal Health and Safe Motherhood Policy Framework

Globally, more than half a million women die every year because of complications related to pregnancy and child birth (UNICEF, 2008). According to UNICEF (2008), of that half a million, 99% are from developing nations - with about a half occurring in Sub Saharan Africa while about 187,000 occur in Asia. For every woman who dies, 20 more women suffer injuries, infection and disability. A woman's life risk in Sub Saharan Africa is 1 in 22 compared to 1 in 8000 in the industrialized countries. The United Nations Millennium Development Goals Report 2008 reveals minimal progress on MDG 5. Yet states including Uganda committed themselves to reduce maternal mortality ratio by three-quarters by 2015. The poor maternal health outcomes are attributed to a number of factors including policy implementation, resource availability and service delivery challenges. It is not clear whether this target will be realized, especially in the case of Uganda.

This report presents a review of the policy framework for maternal health and safe motherhood in Uganda and implementation issues relating to service delivery. The review provides analytical linkages between policies and implementation framework and gaps in maternal health and safe motherhood service delivery. Data was mainly obtained from policy documents and studies that have been conducted in the country. A few key informant interviews of policy makers and service providers in both government and civil society organizations were conducted to supplement the secondary data.

1.1 Maternal Health and Safe Motherhood Policies

Uganda is party to a number of international and regional instruments[5] that commit governments to end discrimination and work towards achieving gender equality and women's empowerment in all spheres of life. This commitment provides a basis for addressing obstacles to the enjoyment of sexual and reproductive health rights as a human rights issue. Maternal mortality is a human rights issue in terms of the right to life, health, non-discrimination and equality (Yamin and Maine, 1999).

Maternal health has been high on the country's agenda for addressing Sexual Reproductive Health and Rights (SRHR) issues. Through the Poverty Eradication

5 *Convention on the Elimination of all forms of Discrimination against Women (CEDAW) (1979), Universal Declaration of Human Rights (UDHR) (1948), Declaration on the Elimination of Violence Against Women (1993); The Beijing Declaration and Platform of Action (1995); The International Conference on Population and Development Programme of Action (ICPD - 1994), Protocal on the Rights of Women in Africa – Maputo Protocal 1993; Convention on the Rights of the Child (CRC) (1989), The International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966); The African Charter on Human and Peoples Rights (1981); The African Charter on the Rights and Welfare of the Child (ACRWC) (1990). Uganda is also party to the NEPAD Declaration (2001), The Abuja Declaration and The United Millennium Development Goals (2000).*

Action Plan (PEAP), which was the overall national development framework between 1997 and 2008/9, the Uganda government reaffirmed its commitment to achieving the MDGs and prioritised improving health outcomes under the Human Development Pillar (MoFPED, 2004). PEAP acknowledged the fact that a healthy population is a necessary condition for development and poverty reduction. PEAP recognised the significant contribution of maternal health conditions to the burden of disease in the country and identified inadequate RH services characterised by limited access to maternity services[6]; shortage of inputs such as qualified midwives, essential drugs and supplies and poor attitudes of staff and mothers as priority areas of intervention. The PEAP set priorities including increasing spending on preventive care such as FP commodities, procurement of malaria commodities such as insecticide-treated nets, as well as recruitment and deployment of health workers, provision of free essential drugs and supplies for all the pregnant women, and strengthening delivery and EmOC services in all health facilities. Reducing maternal mortality is among the main objectives of the recently launched five-year National Development Plan (NDP) which has replaced the PEAP. Through the NDP government pledges to reduce maternal mortality to 131/100,000 live births by 2015 (Republic of Uganda, 2010).

Within the overall national development framework, addressing health issues in the country is guided by the National Health Policy (NHP) developed in 1999 (MoH, 1999) which is now under review (draft policy 2009 in place). Maternal mortality and morbidity are key priority areas being addressed in an integrated manner through the Uganda Minimum Health Care package[7] (UNMHCP). The main focus is on essential Ante-natal and obstetric care[8], Family planning[9], ASRH, VAW[10] and improving nutrition for pregnant and lactating mothers, among others (MoH, 1999). These priority areas have been carried through in the revised NHP 2009 (draft). The revised NHP puts emphasis on investing in people's heath, focusing on promotion of people's health, disease prevention and early diagnosis and treatment of disease. It specifically prioritizes the delivery of the minimum health care package (in which maternal health is a major priority area), optimum provision of health resources, strengthening private and public partnerships for health and strengthening of district health systems.

The NHP is operationalized in a five-year National Health Sector Strategic Plan (HSSP) I & II. In 2005 the HSSP I was reviewed leading to the development and adoption of the HSSP II that has guided the health sector for the last 4 years. The HSSP II is aimed

6 *Aaccess to live-saving emergency maternal and obstetric services (EMOC) in HC4s and HC3s (estimated at only 6% at the time*

7 The Uganda Minimum Health care Package (UNMHCP) comprise interventions that address the major causes of the burden of disease and is the cardinal reference in determining the allocation of public funds and other essential inputs. Government allocates the greater proportion of its budget to the package in such a manner that health spending gradually matches the magnitude of priorities within the burden of disease (MoH, 1999).

8 To ensure safe pregnancy and delivery, improved management of complications and child birth including spontaneous or induced abortion, and reduce the unacceptably high rates of maternal and prenatal deaths through timely and effective emergency obstetric care provided at strategic and accessible locations.

9 To provide information and services for appropriate modern family planning methods and reduce the wide gap between desired and actual use of family planning services.

10 Promote and support agencies and organizations that work to reduce domestic violence, female genital mutilation and other forms of VAW.

at achieving delivery of the UMHCP to all Ugandan households. One of the overriding priorities of HSSP II is the fulfilment of the health sector's contribution to the PEAP and MDG goals of reducing maternal mortality and morbidity; reducing fertility; malnutrition; the burden of HIV/AIDS, among others. The HSSP II prioritizes addressing life-threatening health problems, particularly pregnancy and birth-related deaths and childhood killer diseases. HSSP II works on principles of integrated service delivery, increased efficiency in resource allocation and use of resources, community participation and empowerment, and focus on maximizing service outputs, health outcomes and client satisfaction. Other key policies include lowering the morbidity and mortality of women in childbearing ages, promoting and expanding comprehensive family planning delivery system, facilitating individuals and couples wishing to practice family planning with the means to do so, and enhancing the role of men in the promotion and utilization of family planning services as clearly stipulated in the National Population Policy (Government of Uganda, 2008). The policy underlines empowerment of women, provision of higher education and capacity to make informed decisions as crucial in positively influencing women's reproductive health. Commitment to address maternal health is clearly articulated in a number of policy documents including the Sexual and Reproductive Health Care Minimum Package (MoH, 2001a); the National Reproductive Health Policy Guidelines for Reproductive Health Services (MoH, 2006); Guidelines for Gender Mainstreaming in Reproductive Health (MoGLSD, 2007); Strategy to Improve Reproductive Health in Uganda 2005-2010 (MoH, 2004); National Drug Policy[11] and Guidelines for Strengthening Sexual and Reproductive Health in Uganda for District Health Planners, Programme Managers and Implementers of RH Programmes (MoH, no date), and the National Hospital Policy (MoH, 2006).

To further consolidate the strategies for addressing maternal health issues identified in all the above policies and guidelines, in 2007 the Ministry of Health developed a Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (Republic of Uganda, 2007). The roadmap's vision is "to have women in Uganda go through pregnancy, child birth and postpartum period safely and their babies born alive and healthy". The Roadmap acknowledges the causes of ill-health and death among mothers as both facility and non facility (social and cultural) related factors as highlighted in the other policies. The Roadmap underlines the importance of family planning in reducing maternal deaths and illnesses. The roadmap sets priorities and strategies including: promotion and improvement of the legal framework and policy environment for effective formulation and implementation of maternal health programmes; ensuring availability, accessibility and utilization of quality maternal and newborn health services; strengthening human resource capacity; advocating for increased allocation and distribution of resources; strengthening coordination and management of maternal and newborn care services; and empowering communities to participate in care, as well as strengthening monitoring and evaluation mechanisms for better decision-making and service delivery.

11 To guide supply of essential medicines and health supplies

The Legal Framework

While there is no specific legislation for maternal health, Uganda is a signatory to a number of legal instruments that provide a basis for a legal framework on maternal health. The legal framework for addressing maternal health is within the broad framework of addressing sexual and reproductive rights founded on the principles of human dignity and equality. Maternal health and maternal mortality in particular is, therefore, a human rights issue in terms of the right to life, liberty and security; the right to health, non-discrimination, and freedom from any harmful cultural practices. These rights have been enshrined Uganda's Constitution of 1995. The constitution further provides for districts to engage in comprehensive and integrated development planning and implementation. The Local Government Act 1997 mandates the district local councils the responsibility of providing medical and health services to the district population and, in this regard, the HSD is instituted to make the services more accessible and manageable by user communities.

1.2 Nature of Maternal Health and Safe Motherhood

Given the government efforts, there have been slight improvements in maternal health and safe motherhood indicators. According to the MOH performance reports (MoH, 2005; 2008; 2009) there has been a slight reduction on maternal mortality rate over the years from 527/100,000 (1990) to 505/100,000 (1995) and 435/100,000 (2006). Total Fertility Rate (TFR) reduced from 6.9 (2001) to 6.5 (2006), contraceptive prevalence rate increased from 23% (2001) to 24.4% (2006); the proportion of deliveries in the health facilities increased from 25% (2004) to 32% (2006); and PNC within the first week of delivery currently stands at 26%. In addition, the percentage of health units providing EomC increased from 20% (2004) to 45% (2006/07) – UNFPA supported districts; ANC attendance of 4 visits improved from 42% to 47% and teenage pregnancies reduced from 32% to 25%.

Due the meek progress in maternal health indicators, maternal mortality remains the leading cause of death among Ugandan women and girls of reproductive age, accounting for 20.4% of the burden of disease in the country. According to the Republic of Uganda (2007), 15% of all pregnancies develop life-threatening complications that require Emergency Obstetric care. Maternal mortality ratio in Uganda has persistently remained high at 435 deaths per 100,000 live births in 2006 (UBOS, 2006). This implies that about 6,000 women die every year due to pregnancy-related causes (Republic of Uganda; 2007). It is reported that that haemorrhage causes 26% of the deaths; sepsis - 22%; obstructed labour - 13%; unsafe abortion 8-10%; hypertension in pregnancy - 6%; malaria, HIV/AIDS and others - 25% (Republic of Uganda, 2007). An estimated 297,000 unsafe abortions occur every year with over half of them (55%) occurring among young women aged 15 to 20 years (National Abortion Survey Report 2005). The MoH indicates that over a quarter of maternal deaths (26%) result from complications of abortion (Republic of Uganda, 2007). Approximately 15-23% of female youths (15-24 years of age) who have ever been pregnant have had an abortion and as many as 1,200 unsafe abortions result in death each year.

For every woman who dies, six survive with chronic and debilitating ill-health (Republic of Uganda' 2007; Mallinga and Mbonye, 2008)[12]. Maternal morbidities in Uganda relate to obstetric fistula, chronic pelvic infection, post-abortion complications, infertility and general maternal ill-health. Nearly a quarter (23%) abortions result in serious complications. It is also reported that anaemia is common among breastfeeding mothers, contributing to about 53% of the deaths. HIV/AIDS has become a significant indirect cause of maternal and newborn morbidity and mortality in the last fifteen years. The HIV/AIDS Sero-prevalence in pregnant women is estimated at 6.2% over the last four years (MoH, 2005). All these causes of maternal morbidity and mortality are preventable.

Studies attribute maternal ill-health and deaths in Uganda to a number of factors including limited utilization of health facilities[13]; inadequate health facilities characterized by limited accessibility; poor quality of maternity care services; few trained health workers; limited access to safe

blood and limited supplies (Mallinga and Mbonye, 2008; UBOS, 2006; Engender Health, 2003; Family Care International; 2000; Mbonye, 2000; Mothercare; MoFPED, 2004; Bantebya, 2009); low contraceptive use[14]; gender inequality manifested in low levels of schooling and limited opportunities for employment, limited male involvement in RH issues, and limited mobility brought about by societal gender norms[15] (UBOS, 2006). All these inequalities have a negative influence on women and men's sexual and reproductive rights - in particular maternal health and safe motherhood.

1.3 Maternal Health and Safe Motherhood Policy Documents and Implementation Framework

Uganda has a number of policy documents that articulate government's commitment to address the persistently high maternal mortality rates in the country (Table 1.)

12 Maternal Morbidity and Mortality in Uganda, All-Party Parliamentary Group on Population, Development and Reproductive Health Hearings scheduled for 8th and 9th December 2008 – UK

13 While a significant proportion of maternal deaths occur in the health facilities, there are over 62% of pregnant women delivering either by themselves or in the hands of unskilled health workers (Mallinga and Mbonye, 2008).

14 24% for all methods; 18% for modern methods and 6% for traditional methods.

15 It is noted that gender norms (such as unequal power relations, gender division of labour, access and control of resources) put women at a disadvantage and reduce their choices, including choices about marriage, sex, contraception, and childbearing and restrict women's ability to obtain health care (ANC, FP, PNC etc).

Table 1. Policy documents that articulate government's commitment to addressing maternal mortality and morbidity

Year of Adoption	Policies, Plans, Guidelines and Road- maps	Goals and Objectives
National Policy and Planning Context		
1997, 2000 & 2004	Poverty Eradication Action Plan (PEAP)	This has been the national planning framework for over the last decade (1997 – 2007/08. It was aimed at providing an overarching framework to guide public action to eradicate poverty through increasing people's incomes, improving human development and reducing powerlessness.
2010	National Development Plan (NDP)	
Health Policies, Plans, Guidelines		
1999[1]	National Health Policy	The policy derived guidance from the national health sector reform programme and national poverty eradication programme. Goal: Attainment of a good standard of health by all people in Uganda in order to promote a healthy and productive life. Objective: to reduce mortality, morbidity and fertility.
1995 & 2008	National Population Policy	First promulgated in 1995 aimed at improving the quality of life of the people of Uganda and transformation of society. After thirteen years the policy was reviewed to accommodate new and emerging challenges leading to the current 2008 policy. The current policy retained the same goal of improving the quality of life of people. It highlights a number of objectives among which is the promotion of improving the health status of the population.
2006	National Hospital Policy	Goal: Provide a framework for hospital services in the country and guide the future development of the hospital sector. Objectives: to define the mandate, organization, structures and roles of hospitals.
Guidelines		
2001	National Reproductive Health Policy Guidelines for Reproductive Health Services	Goal: improve SRH and quality of life of every one in the country Objective: guide planning and implementation, monitoring and evaluation of quality integrated gender-sensitive RH services; standardize the delivery of RH services and ensure optimum and efficient use of resources for the sustainability of RH services.
2006	The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights	Goal: : Improve SRH and quality of life of every one in the country Objective: guide planning and implementation, monitoring and evaluation of quality integrated gender-sensitive and rights-based RH services; standardize the delivery of RH services; ensure optimum and efficient use of resources for the sustainability of RH services and promote sexual and Reproductive health rights.
Date not indicated	Guidelines for Strengthening Sexual and Reproductive Health in Uganda for District Health Planners, Programme Managers and Implementers of Reproductive Health Programmes	Aimed at providing guidance to district Health Management Teams and all stakeholders as they draw annual plans for SRH programmes at district level; guide districts in mobilization and allocation of appropriate resources to those cost-effective interventions geared at reduction of maternal and peri-natal mortality and morbidity.
2007	Guidelines for Mainstreaming Gender in RH	Goal: Facilitate mainstreaming of gender in RH policies, programmes and interventions. Objectives: Promote understanding of gender issues and concerns in RH and guide RH policy makers, planners and service providers in addressing gender issues in the delivery of RH services.

Strategic Plans		
2000 & 2005	National Health Sector Strategic Plan I & II	Was first developed in 2000 to operationalize the 1999 NHP. The HSSP I laid a foundation for health development in the country. In 2005, the HSSP I was reviewed to the current HSSP II and retained the NHP goal. Both HSSP I & II aimed at reducing morbidity and mortality from the major causes of ill-health and premature death. The current HSSP II is guided by 4 main programme objectives, namely: effective, equitable and responsive health care delivery system; strengthening the integrated support systems, reforming and enforcing the legal and regulatory framework and ensuring an evidence-based policy, programme and planning in health development.
2004	Strategy to Improve Reproductive Health in Uganda 2005 - 2010	Goal: To reduce MMR by 20% from 505 to 408 per 100,000 live births by 2010 through improved access to RH services including Family Planning and EmOc. Objectives: Increase access to institutional deliveries and emergency obstetric care and strengthen FP service provision and implement goal oriented Ante Natal Care.
2000	RH Division 5-year Strategic Framework – 2000 - 2004	Goal: Contribute to the improvement of quality of life of the people of Uganda. Objective: Reduce MMR by 30% from 506 to 354/100,000 live births, increase Contraceptive Prevalence Rate from 15% to 30%; increase deliveries supervised by skilled health workers from 38% to 50%; increase ANC attendance to at least 4 visits per pregnancy with the first visit in the first trimester, to increase Tetanus coverage among pregnant mothers receiving at least 2 dozes from 50% to 80% and incorporate gender concerns among RH programmes.
Road Maps		
2007	Roadmap for accelerating the reduction of maternal and neonatal mortality and morbidity in Uganda	Goal: To accelerate the reduction of maternal and neonatal morbidity and mortality in Uganda. Objectives: increase the availability, accessibility, utilization and quality of skilled care during pregnancy, child birth and post-natal at all levels of the health care delivery system; promote and support appropriate health-seeking behaviour among pregnant women, their families and the community; and strengthen family planning information and service provision for women, men, couples who want to space or limit their childbearing thus preventing unwanted and/or untimely pregnancies that increase the risk of a maternal death.

1.3.1 Implementation Framework

The Government of Uganda through the Ministry of Health takes the lead role and responsibility for ensuring good health of its population. The MoH is charged with policy initiation and formulation as well as coordination of all health development activities at the central government, district and community levels. The MoH's other core functions include resource mobilization, setting standards, quality assurance, capacity development and technical support, coordination of health research; health emergency preparedness; epidemic prevention and control and M & E of the overall sector performance. Within the MoH, issues of Sexual and Reproductive health and rights, and in particular maternal health issues, are addressed by the Reproductive Health Division (Unit) under the Department of Community Health. In addition, there is a multi-sectoral working group on Infant and Maternal Mortality to oversee the maternal and new born health policy formulation and monitor the implementation of the maternal and newborn mortality and morbidity roadmap. The MoH collaborates with MoFPED Population Secretariat on policy development, advocacy and awareness creation on maternity health and safe motherhood issues outlined the NHP, HSSPII and NPP.

The MoH has a well-developed National Health System (NHS) through which health outputs are delivered. The NHS comprises all the institutions, structures and actors that work to achieve and sustain good health (MoH, UBOS and Macro International Inc, 2007). It includes the public sector, which also covers the health services of the army, police, and prisons within its ambit; the private health delivery system comprising of the private not-for-profit organizations (PNFP); private health practitioners (PHP); the traditional and complementary medicine practitioners (TCMP); and the communities. Government plays an important role in health service provision and recognizes full integration of private providers into the National Health System as key in health development. The NHS works through a five-tier structure by which health services are delivered nearer to the people as reflected below:

- Ministry of Health and other National-level Institutions
- National Referral Hospitals (NRH)
- Regional Referral Hospitals (RRH)
- District Health Services
- Health Sub-District (Referral Hospital/General Hospital/Health Centre IV (HCIV), Health Centre III (HCIII), Health Centre II (HCII) and Health Centre I (HCI) or the Village Health Team (VHT)

Each of the health levels has its own functions and responsibilities as far as safe mother- hood and maternal health are concerned. The most critical aspect of NHS is the District Health System (DHS) that includes the District Health Team and Health Sub-District (HSD) established to extend services nearer to the people and interface with the local community in terms of service provision. DHS allows for identification of local priorities; involvement of communities in the planning and management of health services, and increasing the responsiveness to local needs (MoH *et al*, 2007).

Uganda's implementation of all development programmes is through the Sector-Wide Approach (SWAp) mechanism that promotes inter-sectoral collaboration to facilitate involvement of other sectors in promoting good health for mothers in the country. The different sectors contribute to addressing maternal health issues with their mandates including Parliament (promoting maternal and newborn health activities in the constituencies, increasing allocation of resources); MoFPED (resource mobilisation); Ministry of Lands, Water and Environment (mapping availability of water to all health facilities); Ministry of Agriculture, Animal Industry and Fisheries (food production); MoGLSD (community mobilisation and gender mainstreaming; advocacy for prevention of GBV); Ministry of Works, Housing and Communication (road construction and maintenance for accessing health facilities, construction and rehabilitation of health centres); MoES (literacy, training of health workers, research and development); Ministry of Public Service (recruitment and staff welfare); MoLG (recruitment and deployment of health workers, delivery of health services; supervision of health services deliver); Ministry of Trade and Industry (setting and enforcing standards for manufactured and imported goods) (see details in Republic of Uganda, 2007). MoH's responsibility stretches not only to public provision but also to supervision of the private sector, which provide a significant proportion of the health care in Uganda.

Through the Public Private Partnership the government of Uganda encourages involvement of all stakeholders in health development and service delivery to build synergy. The Private sector consists of NGOs (facility and non-facility-based), private practitioners, the traditional health care system of traditional healers and midwives, and an expanding private pharmaceutical sector. It is noted that this sector has been responsible for a significant proportion of health care in the country (MoH, 1999; MoH, 2005).

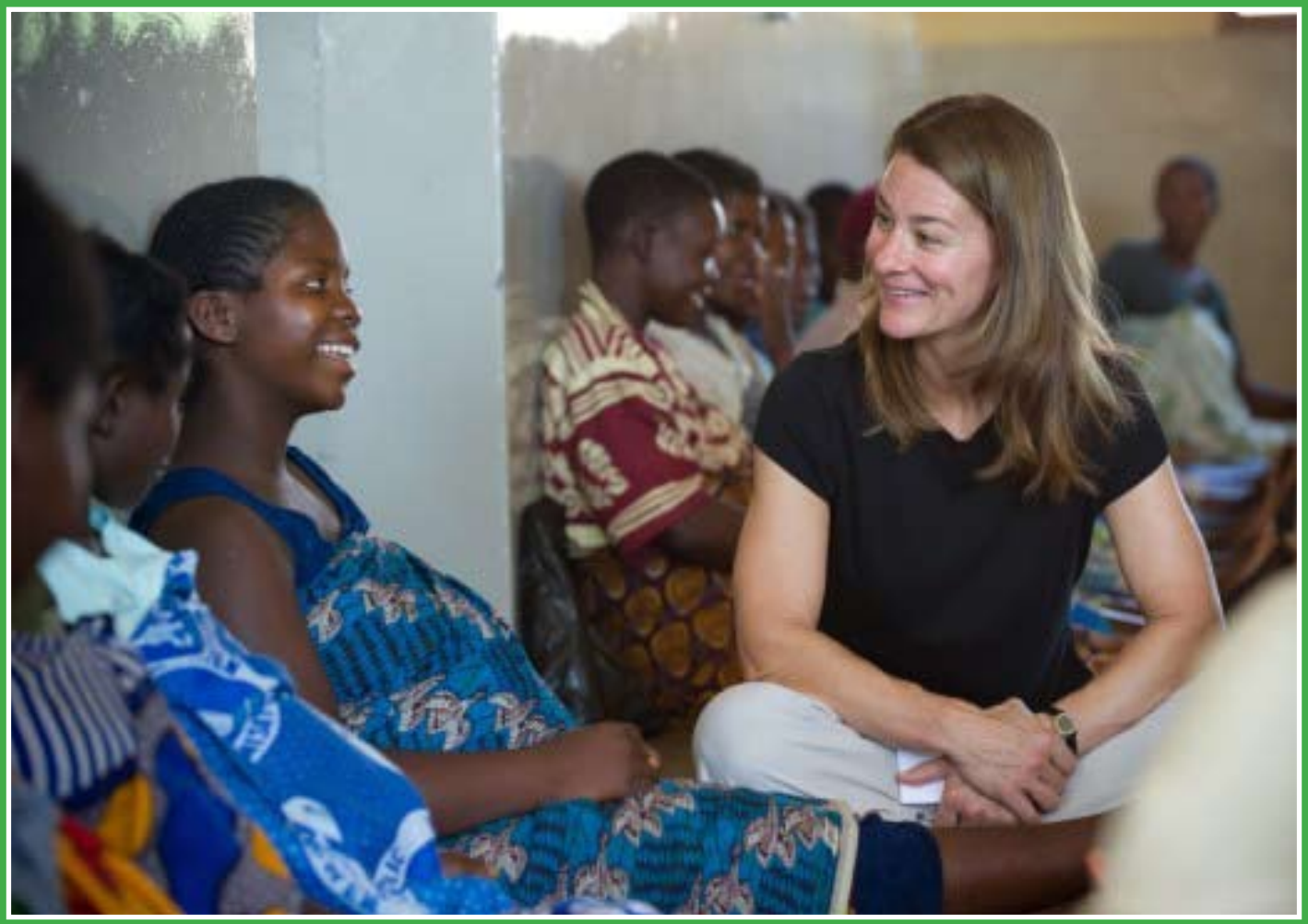
1.4 Issues in the Implementation of Maternal Health and Safe Motherhood Policies

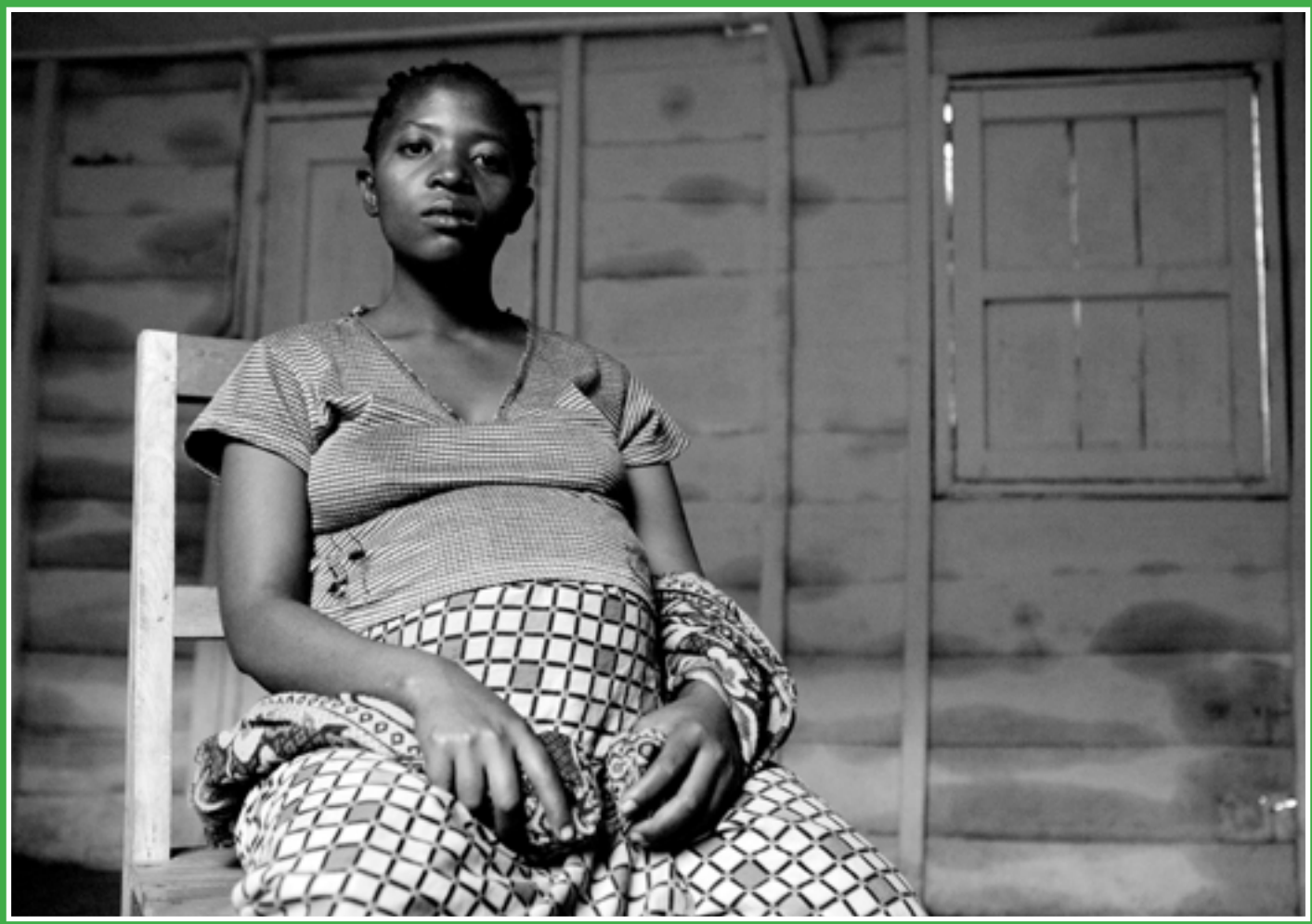
1.4.1 Best Practices

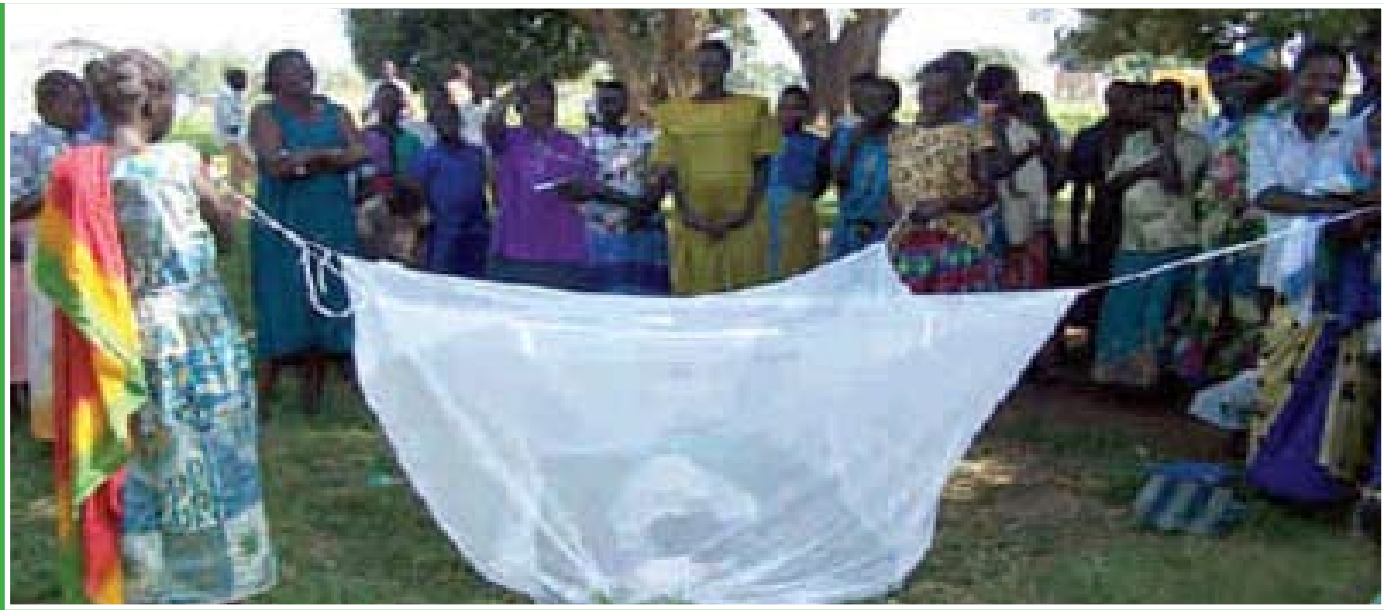
- Establishment of a conducive policy environment to address SRHR, and in particular, maternal health and safe motherhood is an important step towards averting pregnancy and birth-related illnesses and deaths in the country.
- Establishment of an institutional framework for implementing the policies that runs from national through to the lowest level of local government to ensure that services are closer to the people.
- The commitment to strengthening public private partnership that engages all stakeholders in national health development. This is a strategy that enhances service delivery and promotes participatory development and good governance.

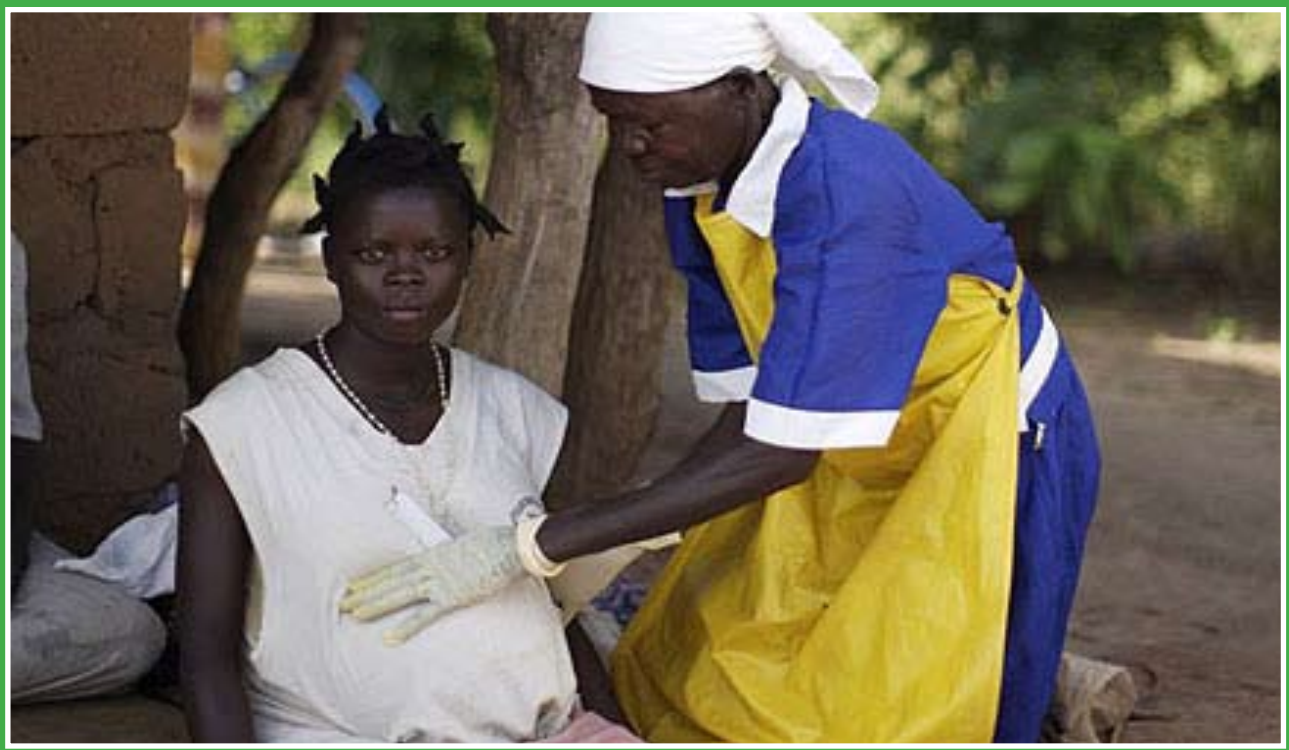
1.4.2 Gaps

- While there are a number of policies and strategies to address maternal health and safe motherhood issues in the country, the apparent weak implementation of these policies has lead









to persistent poor maternal health outcomes (Republic of Uganda, 2010). In addition, the policies, plans and the Roadmap give little or no concrete discussion of the gender-specific barriers to service access. The Roadmap, which by far offers the most comprehensive discussion on the causes of maternal mortality and morbidity, does not articulate concrete actions to address gender-related barriers to service access.

- While unsafe abortion is identified as a major contributor to maternal mortality and morbidity, the policies, particularly the NHP and HSSP II, offer limited discussion of how it can be addressed. When they do acknowledge unsafe abortion and the need for post-abortion care, the discussion is truncated, failing to articulate concrete actions and targets to address it. Another area that is given minimal attention, and yet it is a serious concern for maternal morbidity, is obstetric fistula.

- The National Health Policy and the Roadmap to Accelerating the Reduction of Maternal and Neonatal Mortality (2007) identified male involvement as crucial in maternal health. However, this focus is not reflected in the strategic plan. The discussion on maternal health largely focuses on it as a "women-only-issue" with no comprehensive focus on men and their involvement in maternal and reproductive health, given the fact that they are central in household decision-making particularly on issues of access, control and distribution of resources, movement outside the home, as well as control over one's sexual life. Male involvement is briefly highlighted as a cause of increased maternal deaths, but no particular attention is paid to it as a priority area of focus. The policies also offer little discussion on the role of the community in maternal health issues.

1.5 Financing of Maternal Health and Safe Motherhood Policies

Budgeting in Uganda has been guided by the PEAP, Uganda's national development framework and medium-term planning tool since 1997[16] to 2009. The national budget is financed from three main sources, namely, taxes, non-tax revenue (fees and licences), loans (by multilateral agencies) and grants (bilateral development partners). The sources of financing for the health sector include the national budget (central government budget) that includes GoU, donor budget support and project funding), local government and private sources including parastatal contributions, private not-for-profit agencies, private firms, and households (through insurance and out-of-pocket contributions). The government budget includes both government funds and donor budget support and is the most preferred mode of funding because it is flexible and government has the control to allocate resources to agreed priorities. Donor Project Funding encompasses funding that goes directly to projects and addresses the HSSP priorities under the Long Term Expenditure Framework (LTEF). There is a well-established finance management and monitoring mechanism which reinforces a similarly a well established accounting system in ensuring expenditure is made against agreed work plans and outputs.

16 *PEAP has been replaced with a five-year comprehensive National Development Plan (NDP) that articulates the planned strategic interventions of all sectors of Uganda's economy.*

The Health sector emerges as the third among the priority sectors accounting for 10.8% in FY 2008/09 with a slight decline to 10.5% in FY 2009/2010 Budget estimates (Annex 2). According to the Annual Health Sector Performance reports of 2007, 2008 and 2009, donor funding constitute a significant proportion of the Health sector. For the Fiscal Year 2007/08 donor support to the sector off budget was higher (USD $8.2) than GoU and donor support funding (USD $7.84). It is reported that donor support has been declining over the past 4 years from 54% (2005/06) to 40% in 2008/09, leading to significant inadequacies in the delivery of outputs, especially service delivery.

While there are a number of donors supporting the Health sector[17], according to a technical staff of the MoH, the main development partners supporting maternal health initiatives[18] include UNFPA (support to Family planning equipment and contraceptives; EmOC equipment and supplies; capacity building for health workers, sensitization and awareness raising on RH issues and development of policies and guidelines); African Development Bank (ADB) (support to infrastructural development in terms of construction and renovation of maternity units at HC IV and IIIs, delivery equipment, FP activities and EmOC); and GoU (scaling up of EmOC, purchase of folic acid, ANC, maternal reviews, mama kits and RH supplies).

17 Swedish International Development Agency (SIDA); Netherlands (ORET); United States Agency for International Development (USAID); United Nations Children's Fund (UNICEF); Japan International Cooperation (JICA); World Health Organization (WHO); Danish International Development Agency (DANIDA); United Nations Fund for Population Activities (UNFPA); Italian Cooperation; African Development Bank (ADB); European Union (EU); Department for International Development (DFID); German Cooperation (BTC); the World Bank, Belgium, European Union; France; the Unites States through the global funding initiatives, such as PEPFAR, GFATM and GAVI Alliance.

18 Data on amount of contribution was not available

Within the Health sector, reproductive health is identified among the priority areas that require increased resource allocation. Given the integrated approach to addressing health care service delivery, the available information does not explicitly show allocations and utilization of resources for the specific components of maternal health. Spending on maternal health care and safe motherhood is integrated in vote functions under the Health Systems Development (rehabilitation and equipment supply for the hospitals and health facilities); community and clinical services; human resource (recruitment of health workers); safe blood provision; Mulago Hospital (equipment, maintenance of health facilities and provision of specialised medical services – surgical emergency and reproductive health services); referral hospitals (provision of specialised medical services – surgical emergency and reproductive health services) and local government (Primary Health Care).

From Annex 3 Table 1, there has been a consistent increase in the vote for community and clinical services over the years which currently accounts for the largest proportion of the budget (36.9%) followed by Primary Health Care[19] under the decentralized service delivery (36.5%). Other large increases are experienced in the provision of the specialised medical services vote for Mulago Hospital attributed to additional resources for the heart, cancer and infectious disease institutes from the domestic development budget (MoFPED, 2008). At the decentralized level, increase is witnessed in 2008/09 under the PHC (to assist in the provision

19 Spent on consolidation of lower level health infrastructure; preventive health care through immunisation and IEC/social mobilisation - provision of surgical and medical services – C-sections, deliveries, and construction of maternity facilities in HC IVs among others.

of medical equipment for HCIII and IVs) under the decentralized health care development grant.

Over the last three years, under the health systems development vote, the sector has spent on rehabilitation maternity wards and delivery units; solar energy installation; equipping selected hospitals and district health services including pre-installation works for imaging equipment, generators, maternity laboratory and theatre equipment. On community and clinical services, spending has been on prevention of malaria with provision of free antimalarials (HOMAPAK/ COARTEM at all health facilities) and supply of insect treated nest (ITNs) to pregnant mothers; provision of protective gear for health workers and training of health workers. Spending has also been committed to the recruitment of health workers (Health Service Commission) to address the shortfall of staff in the health centres. Collection and provision of blood is another area of spending that government has taken on as a priority area - in particular procurement of blood bags and coordination of blood collection.

At Mulago Hospital complex, the National Referral Hospital part of their budget went into the procurement of equipment and maintenance of facilities including purchase of hi-tech anaesthetic machines[20] as well as provision of specialised medical services including surgical emergency and reproductive health services such as C-sections. In referral hospitals, money was and is spent on surgical emergency and reproductive health services.[21] Other expenditures in FY 2008/09 included procurement and distribution of reproductive health commodities (Shs. 6bn) under the donor support to the Health sector as well as gender and equity issues (Shs. 1.1bn) for rolling out the roadmap for reduction of maternal and neonatal mortality with specific focus on BEmOC in 400 HCII. Activities here included training, supervision and mentoring of health workers, FP commodity security, involvement of males in FP and conducting maternal audits. However, available data does not provide enough evidence to show that this expenditure was made on the proposed activities.

20 Though not sure whether this went into maternity services, it is a useful facility for pregnancy-related surgeries.

21 Data on actual amounts was not readily available.

1.6 Issues in the Financing of Maternal Health and Safe Motherhood Policies

1.6.1 Best Practices

- Putting in place finance management and monitoring mechanism that ensures expenditure against agreed work plans and outputs

1.6.2 Gaps

- According to the HSSP Mid Term Sector Review (MoH, 2008), actual money released for the entire sector was 84% of the entire approved sector budget. This implies that the sector does not have adequate resources to facilitate effective implementation of activities and general service delivery. For instance, it is reported that non-wage budgets for PHC grants and Hospital have remained constant for the past 4 years, yet the population and health care needs have been increasing, hence outstriping the per capita expenditure. While the

per capita cost of providing the current UMHCP was estimated at USD 41.2 in 2008/2009 (Republic of Uganda, 2010), it is reported that only USD 10.4 per capita was available in FY 2008/09 (MoH, 2008; Republic of Uganda, 2010). The proportion of GoU allocation to the sector, though increasing since 2004/05 (9.7%), 2006/07 (9.6%), shows a declining trend and actually declined in 2008/09 to 8.3%, which is of target of the HSSP (13.3%) and far below the Abuja commitment[22] of 15% (MoH, 2006, 2008, 2009). Analysis of expenditure on obstetrics and gynaecology in the national referral hospital (Mulago Hospital) reveals a percentage share of 16.6% (2008/09) (4th in rank of 7 departments) of the budget allocation which substantially reduced to 10.8% for 2009/10 (ranking 5th in the 7 departments) (Annex 3 - Table 2). Approved budget estimates for 2009/2010 indicate a significant shortfall of 86.1%[23] of the proposed budget for the obstetric and gynaecology department. This indicates a high budget offshort which has implications for effective implementation of the Health sector activities and efficient service delivery. It is important to note that public funding is critical for accelerating both equity and efficiency of health service delivery.

- There were also reported difficulties in tracing resources on the off-budget support that goes directly to the private sector and districts, yet this is where most donors channel their funding. Apparently, donor project expenditure is predominantly in the private sector at 74% compared to the public sector which is estimated at 26%. High donor funding to project and off-budget support impairs predictability and hampers comprehensive planning, harmonization and alignment of development assistance with the HSSPII. It was reported that a large proportion of the money goes into HSSPII non- priority areas.

- While the policies indicate government commitment towards increasing spending on maternal health and general reproductive health, the budget items are presented in general terms, making it difficult to ascertain how much money goes into maternal health and safe motherhood activities. For instance, recruitment of health workers does not explicitly show how many of these workers are midwives. Similarly, rehabilitation of facilities does not explicitly show how many are maternity facilities. Consequently, the amount of resources committed to maternal health at health sub district and sub county levels is very difficult to track and yet these are services that reach the poor woman. The tendency to allocate minimal funds to maternal and child care units has been noted in the tracking study by the Population Secretariat (2005). Funding to community-related activities is not clearly articulated in the budget and yet they are crucial in addressing community-related issues said to delay mothers from seeking medical care.

- It was reported that indicative figures are given late and this interferes with the budget and work

22 In 2001 African Heads of States during a special sumit on AIDS, TB and Malaria in Abuja made a commitment to allocate at least 15% of their annual domestic budget to the Health sector.

23 Only 14% of the proposed budget was approved.

plan development. In addition, the indicative figures keep changing alongside the work plan and budgeting process, which sometimes makes planning difficult.

- On accountability and financial management, it was reported that some officers fail to adhere to financial procedures, resulting in delayed accountability of funds and eventual delays in disbursement and implementation of activities. For instance, the budget performance for most vote functions of less than 100%, especially for PHC, is clear that the funds released are not spent. This is attributed to delays in the implementation of development activities and late releases from the centre. In addition, lack of transparency and openness by various stakeholders on decisions surrounding actual procurement of Essential Medicines and Health Supplies (EMHS) and their deliveries continues to derail predictability of availability of key EMHS. This was noted to significantly impact on timely procurement decisions (MoH, 2008b). There were also reported delays in procurement of services such as tenders for the rehabilitation of some hospitals and HCs, procurement and distribution of imaging and theatre equipment; essential drugs and health supplies. Such delays have been noted to cause drug stock outs in most health facilities countrywide.

- While community and clinical services account for the largest share of the health sector budget, it largely depends on donor support. The level of dependence raises questions about sustainability of the health sector interventions for community services. In addition, not all allocations are fully aligned with the priorities laid out at the outset. In the annual health sector performance report, it is noted that larger proportions of the donor project funds are not targeted against the sector priorities and inputs but rather converted into management overheads, including the provision of expensive technical assistance. For example, in 2004/05 of the Shs. 255bn expended through donor projects, only 44% was spent on agreed essential sector inputs.

Overall, lack of adequate resources to the sector is reflected by the inadequate service delivery manifested in limited capacity of the health facilities to provide services needed for family planning and maternity health care. The unmet need for family planning remains high, estimated at 41% with the majority of the women obtaining contraceptives from private medical centres and only 35% of women obtaining from the public sector (government hospital, government health centre, family planning clinic or outreach) (UBOS, 2006). Incidences of stock-outs of family planning supplies, especially in government facilities were reported in almost all the interviews conducted. Other issues relating to family planning include inherent feminization of family planning services that renders male responsibility muted and lack of national consensus on family planning use as illustrated by contradictory arguments from political and religious leaders about its role in socio-economic development and improved maternal health and child health (Republic of Uganda, 2007). Maternity care services[24] are of poor quality characterized by high national unmet need for EmOC estimated at 76.1% (MoH, UBOS and Macro International Inc.,2007) and

24 Antenatal care (ANC), safe delivery, post-partum care (PPC) and management of obstetric complications including post-abortion care.

limited access to fully functional comprehensive EmOC estimated at 11.7%, which is far below the minimum standards (15%). Only one in 10 facilities is able to provide basic and/or EmOC services. These are life-saving procedures which should be available at any first referral health facility if mothers are to be saved. There is apparent limited geographical access to general maternity services, leading high utilization of community resources such as traditional birth attendants (TBAs) and informal health providers, who are in most cases not skilled especially with handling complications of childbirth. In addition, the facilities have inadequate infrastructure, lack essential equipment, drugs and health supplies and have limited human resources and capacity. Only 6% of the hospitals have all the required medicines for managing complications of pregnancy, namely, broad-spectrum antibiotics (amoxicillin or cotrimoxazole); intravenous solution; antihypertensive hydralazine; injectable oxytocin (10%); Albendazole or mebendazole; methyldopa (Aldomet); a first line anti-malarial and, at least, one medicine for treating each of the four common STIs. Only 10% have methyldopa to manage hypertension during pregnancy. While good preventive care is key in ensuring safe pregnancy, the survey further noted frequent stock-outs for drugs, especially anti-malarials, and mosquito nets. The case of stock-outs was a major concern in all the interviews.

Most health units have limited capacity for post-abortion care. This is mainly due to the restrictive laws on abortion. For instance, it is reported that only 7% of the hospitals and HCs have the capacity of providing assisted vaginal delivery by means of vacuum extractor primarily in hospitals (especially private) and facilities in Kampala. It is also reported that use of parenteral sedatives, manual removal of the placenta and removal of retained products are predominantly missing in most of the facilities (Republic of Uganda, 2007). According to the MOH (2007), PAC services such as vacuum aspirators and dilatation and curettage kits to remove retained products are available in 22% and 15% of hospitals, HC IVs and HC IIIs that offer delivery services.

Regarding capacity issues, it is revealed that assessment and examination of mothers during ANC is inadequate. It was reported that only 29% of the mothers are assessed for all of their relevant medical history as well as receiving adequate counselling on issues relating to risks, signs and symptoms of complications; nutrition; family planning or on delivery plans. The survey further indicated that knowledge of proper sterilization procedures is limited and written guidelines for sterilization are available in only about 5% of the facilities, mainly hospitals. Delivery guidelines and protocols are also not readily available in 5% of the facilities offering delivery services. Consequently, only 53% of all facilities provide maternity care services but with limited capacity to handle routine deliveries and emergencies (MoH *et al*, 2007). Due to human resource constraints, waiting time to see the health worker is a major concern. As noted above, most deliveries occur at home but only 6% of the facilities offer services to support home delivery and 12% have programmes with Traditional Birth Attendants (TBAs).

While Post-partum and Post-natal care are essential for treating complications arising from the delivery as well as providing the mother with important information

on how to care for herself and her child, the services are only accessible to 31% and 26% of the mothers respectively. While Obstetric fistula is among the causes of illness and death among mothers, the facilities to address this condition are very limited.

Though the government abolished user fees, the quality of services forces women to seek care in private facilities which are in most cases costly and may not be affordable to many poor women

2.0 Conclusion and Recommendations

2.1. Conclusion

Although the policies and strategic plans state that every pregnant woman should be attended to by skilled health worker with all the needed supplies for emergencies readily available at all times, it is clear that there are serious gaps in service delivery. There is slow progress in improving the health care for mothers, particularly in scaling up and delivering comprehensive EmOC services. The budget remains inadequate to ensure effective service delivery. It is clear that increased access to good quality EmOC services and efficient health care systems with functional referral systems and routine monitoring and evaluation can lead to significant reductions in maternal mortality and morbidity. This definitely requires well resourced budgets and collaboration with all key stakeholders.

2.2 Recommendations

- Efforts should be made to translate issues identified in the policies into concrete actions and corresponding budgets allocated for effective implementation. Adequate finances are needed for the implementation of the roadmap; otherwise it will remain on paper and reduction of maternal mortality will not be realized. There is need to step up efforts to implement the many policies that are in place.
- There is need to increasing resources to the Healthsector and, in particular, government should honour the Abuja commitment. More of sector resources should be put into addressing maternal health and safe motherhood issues. There is need for improved prioritization and alignment of available resources for basic service delivery and especially increasing grants for local government and PNFP health service delivery. This should include financial support for community participation in the Village Health Teams (VHTs) as well as extending services to HCIIs which are nearer to the poor women.
- There is need to strengthen family planning services among young people and provide emergency care especially post-abortion care. It is essential that such services are provided to prevent further complications and death. It is noted that FP alone can reduce maternal mortality by 20-30% and, if combined with skilled attendance at birth and EmOC, can reduce maternal deaths by over 70%. The general maternal health services need serious attention.
- There is need to address human resource and capacity concerns in terms of recruitment and offering training.

- Encourage community as well as male involvement in maternal health care. At the same time, continuous sensitization about the gender barriers to maternal health care and general reproductive health is critical. The community needs to take an active role on management boards of health facilities.
- Harmonise public and private RHS providers to avoid service duplication and/or concentration of funding in similar areas.

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Annex 1.

Development Partner Support to the Health Sector over the Last Two Years – Donor Projects and Global Initiatives

Donor	Expenditure (2006/07)	Budget releases (2007/08)
SIDA	2,936,813	
Netherlands (ORET)		2,166,310,000
USAID	254,249,644	
UNICEF	9,868,589	26,559,833,700
JICA	13,777,085	13,530,000,000
WHO	17,111,356	27,276,381,000
DANIDA	16,038,918	14,237,030,000
UNFPA	1,842,933	828,633,788
Italian Cooperation	24,094,963	
ADB		594,099,000
European Union	1,056,900	
DFID	11,149,480	
BTC	240,000	
Sub total	352,366,680	
GFATM	135,459,335	22,574,907,000
GAVI	21,477,231	25,379,300,000
Sub total	156,936,566	
Humanitarian Response	30,818,203	
Grand Total	540,121,449	133,146,494,488

Source: AHSPR, 2007; 2008

Annex 2:

National Sectoral Budget Allocation (in Billions) for Fisical Years 2006/07; 2007/08; 2008/09 and 2009/10

Sector	2007/2008		2008/2009		2009/2010	
	Approved Budget	% share	Approved Budget	% share	Budget Estimates	% share
Security	443.24	9.3	477.24	8.2	477.87	6.9
Works and Transport	625.59	13.2	1083.73	18.5	1 133.73	16.4
Agriculture	202.47	4.3	223.24	3.8	328.19	4.7
Education	767.09	16.1	899.34	15.4	1 061.11	15.3
Health	428.26	9.0	628.46	10.8	723.57	10.5
Water and Environment	156.31	3.3	150.35	2.6	163.63	2.4
Justice, Law and Order	234.56	4.9	280.38	4.8	350.88	5.1
Accountability	336.19	7.1	452.66	7.7	401.04	5.8
Energy and Mineral Development	449.34	9.5	461.25	7.9	698.86	10.1
Tourism, Trade and Industry	41.65	0.9	30.99	0.5	63.02	0.9
Lands, Housing and Urban Development	10.78	0.2	12.4	0.2	20.29	0.3
Social Development	24.17	0.5	24.07	0.4	31.01	0.4
Information and Communication Technology	6.5	0.1	6.5	0.1	9.50	0.1
Public Sector Management	486.03	10.2	511.28	8.8	698.17	10.1
Public Administration	174.53	3.7	136.13	2.3	215.21	3.1
Legislature	78.8	1.7	85.8	1.5	122.04	1.8
Interest payments	289.12	6.1	379.05	6.49	363.73	5.3
Unallocated					54.00	0.78
Total	4754.63		5842.87		6 915.85	

Source: Background to the Budget 2009/2010, MoFPED, 2009.

Annex 3:

Trends in Sector Budget Allocations within the Health Sector FY 2006/07 – 2008/09

Table 1

Vote Functions	2006/2007		2007/2008		2008/2009	
	Actual Expend	% share		% share	Proposed Budget	% share
MoH						
Finance and Administration	1.830	0.71	2.320	0.65	2.320	0.51
Sector Planning and Quality Assurance	2.037	0.80	2.220	0.63	2.220	0.49
Health System Development	30.463	11.90	13.270	3.75	15.170	3.33
Medical Research	1.969	0.77	1.270	0.36	1.270	0.28
Community and Clinical Services	24.067	9.40	103.830	29.31	168.480	36.94
Sub total MoH	**60.366**	**23.57**	**122.910**	**34.69**	**189.460**	**41.54**
Uganda AIDS Commission						
Finance and Administration	1.320	0.52	1.320	0.37	1.320	0.29
Coordination of Multi-sector Response to HIV/AIDS	1.344	0.52	3.040	0.86	3.520	0.77
Sub total UAC	**2.664**	**1.04**	**4.360**	**1.23**	**4.840**	**1.06**
Health Service Commission						
Finance and Administration	1.556	0.61	1.700	0.48	1.700	0.37
Human Resource Management for Health	0.050	0.02	0.050	0.01	0.050	0.01
Sub Total HSC	**1.606**	**0.63**	**1.750**	**0.49**	**1.750**	**0.38**

Uganda Blood Transfusion Service (UBTS)						
Safe Blood Provision	1.071	0.42	1.950	0.55	1.960	0.43
Sub total	**1.071**	**0.42**	**1.950**	**0.55**	**1.960**	**0.43**
Mulago Hospital Complex						
Finance and Administration	4.476	1.75	6.870	1.94	6.870	1.51
Provision of Specialised Medical Services	22.146	8.65	27.120	7.66	35.910	7.87
Sub Total	**26.622**	**10.40**	**33.990**	**9.59**	**42.780**	**9.38**
Butabika Hospital						
Finance and Administration	3.047	1.19	3.370	0.95	5.370	1.18
Provision of Specialised Mental Medical Mervices	6.815	2.66	7.680	2.17	7.680	1.68
Sub Total	**9.862**	**3.85**	**11.050**	**3.12**	**13.050**	**2.86**
Referral Hospital						
Finance and Administration	0.000	0.00	8.000	2.26	8.000	1.75
Provision of Tertiary Health Services	24.730	9.66	27.620	7.80	27.610	6.05
Sub Total	**24.730**	**9.66**	**35.620**	**10.05**	**35.610**	**7.81**
Decentralised - Local Governments						
Primary Health Care	129.150	50.44	142.640	40.26	166.590	36.53
Sub Total	**129.150**	**50.44**	**142.640**	**40.26**	**166.590**	**36.53**
Grand Total	**256.071**	**100.00**	**354.270**	**100.00**	**456.040**	**100.00**

Source: National Budget Framework Paper, MoFPED, 2008.

Table 2.

Budget allocation in Mulago Hospital for Maternal Health (FY 2008/09 and 2009/10)

Departments	**Approved Budget 2008/09**	**% Share**	**Budget Estimates 2009/10**	%/Share
Diagnostic Services	1 398 874 889	17.8	1 398 874 889	11.0
Surgery	1 520 719 944	19.4	1 483 637 623	11.7
Private Wing - Patients	459 000 000	5.9		0.0
Medicine	2 671 145 936	34.1	1 853 496 462	14.6
Obstetric and Gynaecology	1 299 926 551	16.6	1 369 123 868	10.8
Paediatrics	488 262 195	6.2	6 577 667 156	51.9
Grand Total	**7 837 929 515**	100.0	**12 682 799 998**	100.0

Source: Mulago Hospital Records

Annex 4:

Operational Definitions

Reproductive Health

This is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes.

Sexual Health

This is a state of physical, emotional, mental and social well-being in relation to sexuality. It encompasses individual's ability to have a satisfying and safe sex life and requires positive and respectful approach to sexuality, and sexual relations as well as a possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Family Planning

This is a practice of spacing children that are born using both natural (traditional) and modern (artificial) birth control methods.

Contraception refers to use of a device, drug, or chemical agent that prevents conception.

Safe Motherhood

This refers a situation where no woman or fetus or baby should die or be harmed by pregnancy or child birth. This is made possible by providing timely, appropriate and comprehensive quality obstetric care during preconception, pregnancy, child birth and puerperium to women and newborn babies with special emphasis to emergency obstetric care.

Ante-natal care

This is a planned programme of medical management of pregnant women directed towards making pregnancy and labour a safe and satisfying experience.

Delivery care

Every delivery may have complications. Hence, the emphasis should be on using skilled and trained delivery care providers and ensuring that all women have access to life-saving emergency interventions at the time of labour and delivery.

A skilled attendant

As defined by WHO and other international bodies, is a 'health professional—such as a midwife, doctor, clinical officer, or nurse—who has been educated and trained to proficiency in the skills needed to manage normal pregnancies, childbirth, and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns' (WHO, 2004b).

Post-partum care (PPC)

There is an increasing emphasis on ensuring that women receive PPC within 48 hours of delivery for early diagnosis of post-partum complications. PPC also provides an opportunity to counsel the new mother on family planning, to teach her how to care for herself and her newborn during the postnatal period,

to promote exclusive breastfeeding, and to assess the newborn for problems.

Basic essential obstetric care (BEOC)

Basic essential obstetric care includes preventive services as well as medical interventions and procedures for pregnant women that can be provided by well trained primary care physicians and non-physician providers. This includes ANC with early detection and treatment of common problems of pregnancy, as well as first aid for complications of pregnancy, labour, and delivery.

Comprehensive essential obstetric care (CEOC)

This includes basic essential obstetric care services, together with blood transfusions and caesarean sections.

Emergency obstetric care (EmOC)

This is urgent medical care given to a woman for complications related to pregnancy, labour, delivery and puerperium. Facilities that provide basic emergency obstetric care for women with pregnancy-related complications should provide a set of interventions called signal functions. The six basic signal functions are the administration of parenteral antibiotics, oxytocic drugs, and anticonvulsants, the manual removal of the placenta, manual vacuum aspiration of retained products of conception, and assisted vaginal delivery. In addition to these six signal functions, comprehensive emergency obstetric care includes the performance of caesarean sections and blood transfusions. Depending on the interventions available, a facility can be classified as a Basic EmOC (BEmOC) or a Comprehensive EmOC (CEmOC) facility.

(Footnotes)
1 The 1999 National Health policy is currently under review