REPUBLIC OF UGANDA

THE STATE OF UGANDA POPULATION REPORT 2011

Population and Reproductive Health: Broadening Opportunities for Development

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Theme:

Population and Reproductive Health: Broadening Opportunities for Development

REPUBLIC OF UGANDA

United Nations Population Fund

MAP 1: MAP OF UGANDA SHOWING DISTRICT ADMINISTRATIVE HEADQUARTERS

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FOREWORD

Every year, Population Secretariat in the Ministry of Finance Planning and Economic Development, in its State of Population Report publishes key population concerns that need to be addressed in Uganda's quest to improve the quality life of its people. The key object of this report is to provide comprehensive information and data to stimulate broader and deeper thinking; and to contribute to the public debate about Uganda's future. The report reflects on the most important population and development challenges facing our society, and their causes and consequences.

In line with the Governments commitment to improving the quality of life of our people, and specifically to address maternal and child health, the stakeholders in 2011 decided on the theme "***Population and Reproductive Health: Broadening Opportunities for Development***" to guide the content of the report. The State of Uganda Population Report 2011 focuses on the Population and Reproductive Health issues in Uganda; and therefore examines the relationship between population and reproductive health and its implications on population trends, economic, social and health challenges facing the country.

Population and Reproductive Health framework provides a critical opportunity to integrate population and reproductive health issues in the national, sectoral and sub-national plans and to help accelerate progress towards achieving the International Conference on Population and Development (ICPD) and Millennium Development Goals (MDGs), internationally agreed upon goals for global development. Population, Reproductive Health and Development issues are closely interrelated in cause, consequence and policy implication. Reproductive Health care must form part of any strategy that aims simultaneously to improve people's living conditions, raise the quality of human resources and reduce socio-economic inequalities. It is important for Government to give Reproductive Health greater prominence to enable the Country to realize its development aspirations as reflected in the National Development Plan 2010/11 – 2014/15.

On behalf of the Government, I wish to congratulate the Population Secretariat, Development partners, and Stakeholders that contributed to the development and authoring of this report. I hope this report will stimulate dialogue about population, reproductive health and development issues and I appeal to all concerned to use it to determine the best way to address the issues identified. I also encourage those concerned to examine the policy recommendations in this report and where appropriate take the necessary action.

Matia Kasaija, M.P.
Minister of State for Finance, Planning and Economic Development (Planning)

ACKNOWLEDGMENT

The State of Uganda Population Report development process is a result of joint effort of collaborating institutions and stakeholders in multi sectoral consultative meetings under the leadership of Population Secretariat. We therefore do recognize the fundamental inputs of all stakeholders who participated in the production of this report. This year's report comes at a time when the Members of Parliament of Uganda had serious discussion on the issue of Reproductive Health, its causes and effect on maternal and child health; and its implication on the development outcome of the country. Following the debate, the Social Service Committee of the Parliament recommended that a clear budget line be indicated and funds allocated for Reproductive Health in the FY 2011/2012 in the Health Sector budget.

Population Secretariat is particularly grateful to the United Nations Population Fund (UNFPA), and the Government of Uganda for the financial support that enabled them to develop and produce the State of Uganda Population Report 2011 with the theme ***"Population and Reproductive Health: Broadening Opportunities for Development".***

It is not possible to mention everyone but in a special way Population Secretariat recognizes and appreciates the role and contribution of the following people mentioned below. The report benefited tremendously from the technical advice and rigorous reviews of the Editorial Committee whose members consisted of; Ms. Catherine Biira Promise (Chairperson), Ms. Stella Kigozi, Ms. Grace Ikirimat, Ms. Eva Nakimuli, Mr. James Peter Olemo and Mr. Tiondi Andrew all of Population Secretariat. We further appreciate the contribution of these authors in drafting chapters of this report: Ms. Catherine Biira Promise and Mr. Peter James Olemo (POPSEC), Dr. Olive Ssentumbwe (WHO Country Office, Uganda), Dr. Ojok Samuel (Dokolo District Local Government), Ms. Demeter Namuyobo (Reproductive Health Uganda), Dr. Betty Kyaddondo (Population Secretariat), Mr. Julius J. Lebbo (Butabika National Mental Referral Hospital), Mr. John Ariko Okalai (Makerere University Business School, Arua Branch), Mr. Elwange Bob (Kyambogo University) and Ms. Sarah Nahalamba (National Planning Authority).

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Charles Zirarema
Acting Director, Population Secretariat

LIST OF ACRONYMS AND ABBREVIATIONS

ADB	-	Africa Development Bank
AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	Ante Natal Clinic
BC	-	Before Christ
BCC	-	Behaviour Change Communication
CPR	-	Contraceptive Prevalence Rate
CSO	-	Civil Society Organization
DHO	-	District Health Office
DISH	-	Delivery of Improved Services for Health
DLG	-	District Local Government
DOT	-	Directly Observed Treatment
EARHN	-	Eastern Africa Reproductive Health Network
EMHS	-	Essential Medicine and Health Supplies
EmOC	-	Emergency Obstetric Care
EmONC	-	Emergency Obstetric and Newborn Care
FGM	-	Female Genital Mutilation
FP	-	Family Planning
FY	-	Financial Year
HSSP	-	Health Sector Strategic Plan (I, II and III)
GBV	-	Gender Based Violence
GDP	-	Gross Domestic Product
GNP	-	Gross Nationa Product
GoU	-	Government of Uganda
HC	-	Health Centre (II, III and IV)
HIV	-	Human Immuno Virus
HMIS	-	Health Management Information System
HSD	-	Health Sub District
ICPD	-	International Conference on Population and Development
IGWG	-	Interagency Gender Working Group
ITN	-	Insecticide Treated Nets
IV	-	Intravenous
KYU	-	Kyambogo University
MAF	-	MDG Acceleration Framework
MCH	-	Maternal and Child Health
MDG	-	Millennium Development Goals
MMR	-	Maternal Mortality Ratio
MoFPED	-	Ministry of Finance, Planning and Economic Development
MoGLSD	-	Ministry of Gender, Labour and Social Development
MoH	-	Ministry of Health
MPS	-	Making Pregnancy Safer
MPs	-	Members of Parliaments
MUBS	-	Makerere University Business School
NAWMP	-	National Association of Women Ministers and Parliamentarian
NDP	-	National Development Plan
NGOs	-	Non Governmental Organization

NHP	-	National Health Policy
NHS	-	National Health System
NMS	-	National Medical Stores
NPP	-	National Population Policy
NRH	-	National Referral Hospital
NTD	-	Neglected Tropical Disease
OPD	-	Out Patient Department
P7	-	Primary Seven
PAC	-	Post Abortion Care
PEAP	-	Poverty Eradication Action Plan
PPD	-	Partners in Population and Development
PMTCT	-	Prevention of Mother- to- Child Transmission
PNC	-	Post Natal Care
PNFP	-	Private not for Profit
POPSEC	-	Population Secretariat
REACH	-	Reproductive, Educative and Care for Health
RH	-	Reproductive Health
RHCS	-	Reproductive Health Commodity Security
RHU	-	Reproductive Health Uganda
RRH	-	Regional Referral Hospital
S4	-	Senior Four
SEAPACOH	-	Southern and Eastern Africa Parliamentarian Alliance Committee on Health
SME	-	Small Medium Enterprise
SRH	-	Sexual Reproductive Health
SRHR	-	Sexual Reproductive Health and Rights
STDs	-	Sexual Transmitted Diseases
STI	-	Sexual Transmitted Infection
SWAp	-	Sector Wide Approach
TBA	-	Traditional Birth Attendants
TFR	-	Total Fertility Rate
UBoS	-	Uganda Bureau of Statistics
UHDR	-	Uganda Human Development Report
UDHS	-	Uganda Demographic Health Survey
UN	-	United Nations
UNDP	-	United Nations Development Programme
UNFPA	-	United Nations Population Fund
UNHS	-	Uganda National Household Survey
UNICEF	-	United Nations Children Fund
UNMHCP	-	Uganda National Minimum Health Care Package
UPE	-	Universal Primary Education
USAID	-	United States Agency for International Development
USD	-	United States Dollar
USE	-	Universal Secondary Education
VHT	-	Village Health Team
WB	-	World Bank

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CHAPTER ONE

OVERVIEW OF POPULATION AND REPRODUCTIVE HEALTH

1.1 Introduction

The links between gender, population and reproductive health are complex, but inequalities that deprive women of rights and opportunities clearly influence population dynamics such as fertility rates, marriage patterns, and age and sex structures. Gender disparities also affect sexual and reproductive health because economically and socially disadvantaged women are less likely to access health services and information, negotiate safer sex and act upon self-defined reproductive choices. For many women and girls in developing countries, reproductive health outcomes are dismal. Hundreds of thousands of women die each year from pregnancy-related causes and nearly all of those deaths occur in the developing world. Additionally, 200 million women want to delay or avoid pregnancy but are not using effective contraceptives.

At the same time, youth ages 15 to 24 are the fastest growing population in the developing world. Adolescent girls in poor communities face obstacles, including early marriage and childbearing that impede their ability to make healthy transitions into adulthood, oftentimes with tragic consequences. Complications during pregnancy or childbearing are the leading cause of death for girls ages 15 to 19 in developing Countries.

Since the early 1990s, the international community has recognized that sound population and development policies depend on improving the status of women and protecting their rights. As a result, there is broad international consensus around goals to provide universal education, particularly for girls and women; ensure women's and men's access to reproductive health care; and empower women through equitable social and economic development. Women and men should be able to freely decide the number and spacing of their children. They also should have access to reproductive health information, options and services that allow them to attain good health. Achieving these goals will help create an environment in which women are better able to contribute fully to the societies in which they live.

1.2 Strategies to improve Maternal and Child Health services:

Worldwide, over 500,000 women and girls die of complications related to pregnancy and childbirth each year. Over 99 percent of those deaths occur in developing countries such as Uganda. But maternal deaths only tell part of the story. For every woman or girl who dies as a result of pregnancy-related causes, between 20 and 30 more will develop short and long-term disabilities, such as obstetric fistula, a ruptured uterus, or pelvic inflammatory disease. Uganda's maternal mortality rate continues at an unacceptably high level. While maternal mortality figures vary widely by source and are highly controversial, the best estimates for Uganda suggest that roughly between 6,000 and 14,000 women and girls die each year due to pregnancy-related complications. Additionally, another 130,000 to

405,000 women and girls will suffer from disabilities caused by complications during pregnancy and childbirth each year. The tragedy and opportunity is that most of these deaths can be prevented with cost-effective health care services. Reducing maternal mortality and disability will depend on identifying and improving those services that are critical to the health of Ugandan women and girls, including antenatal care, emergency obstetric care, and adequate postpartum care for mothers and babies, and family planning and STI/HIV/AIDS services.

Efforts to reduce maternal mortality and morbidity must also address societal and cultural factors that impact women's health and their access to services. Women's low status in society, lack of access to and control over resources, limited educational opportunities, poor nutrition, and lack of decision-making power contribute significantly to adverse pregnancy outcomes. Laws and policies, such as those that require a woman to first obtain permission from her husband or parents, may also discourage women and girls from seeking needed health care services – particularly if they are of a sensitive nature, such as family planning, abortion services, or treatment of STIs.

Traditional practices that affect maternal health outcomes include early marriage and female genital cutting. Many women in sub-Saharan Africa marry before the age of 20. Pregnancies in adolescent girls, whose bodies are still growing and developing, put both the mothers and their babies at risk for negative health consequences. Female genital cutting, also known as female circumcision or genital mutilation, is a practice that involves removing all or part of the external genitalia and/or stitching and narrowing the vaginal opening (which is called infibulation). The practice is common in some parts of Africa and the Middle East. Social, cultural, religious, and personal reasons support the persistence of this practice. Some of these reasons include maintaining tradition and custom, promoting hygiene or aesthetics, upholding family honor, controlling women's sexuality and emotions, and protecting women's virginity until marriage.

Many women and girls who undergo female genital cutting, particularly those who undergo Type III cutting or infibulation, experience health problems including hemorrhage, pain, infection, perineal tears, and trauma during childbirth. They often also experience psychological and sexual problems. The consequences of maternal mortality and morbidity are felt not only by women but also by their families and communities. Children who lose their mothers are at an increased risk for death or other problems, such as malnutrition. Loss of women during their most productive years also means a loss of resources for the entire society. Ensuring safe motherhood requires recognizing and supporting the rights of women and girls to lead healthy lives in which they have control over the resources and decisions that impact their health and safety. It requires raising awareness of complications associated with pregnancy and childbirth, providing access to high quality health services (antenatal, delivery, postpartum, family planning, among others.), and eliminating harmful practices

1.3 Millennium Development Goal 5: Improve Maternal Health

More than 350,000 women die annually from complications during pregnancy or childbirth, almost all of

them —99 per cent — in developing countries. The maternal mortality rate is declining only slowly, even though the vast majority of deaths are avoidable. In sub-Saharan Africa, a woman's maternal mortality risk is 1 in 30, compared to 1 in 5,600 in developed regions. Every year, more than 1 million children are left motherless. Children who have lost their mothers are up to 10 times more likely to die prematurely than those who have not.

Maternal mortality remains unacceptably high. New sets of data show signs of progress in improving maternal health, the health of women during pregnancy and childbirth with some countries achieving significant declines in maternal mortality ratios. But progress is still well short of the 5.5 per cent annual decline needed to meet the MDG target of reducing by three quarters the maternal mortality ratio by 2015. Progress has been made in Sub-Saharan Africa, with some countries halving maternal mortality levels between 1990 and 2008. Other regions, including Asia and Northern Africa, have made even greater headway.

Most maternal deaths could be avoided. More than 80 per cent of maternal deaths are caused by hemorrhage, sepsis, unsafe abortion, obstructed labour and hypertensive diseases of pregnancy. Most of these deaths are preventable when there is access to adequate reproductive health services, equipment, supplies and skilled healthcare workers.

Large disparities still exist in providing pregnant women with antenatal care and skilled assistance during delivery. Poor women in remote areas are least likely to receive adequate care. This is especially true for regions where the number of skilled health workers remains low and maternal mortality high in particular Sub-Saharan Africa, Southern Asia and Oceania. HIV is also curtailing progress, contributing significantly to maternal mortality in some countries.

The risk of maternal mortality is highest for adolescent girls and increases with each pregnancy, yet progress on family planning has stalled and funding has not kept pace with demand. Contraceptive use has increased over the last decade. By 2007, 62 per cent of women who were married or in union were using some form of contraception. However, these increases are lower than in the 1990s. Some 215 million women who would prefer to delay or avoid childbearing lack access to safe and effective contraception. It is estimated that meeting the unmet needs for contraception alone could cut by almost a third the number of maternal deaths. Funding of reproductive and maternal health programmes is vital to meet the MDG target. Yet official development assistance for family planning declined sharply between 2000 and 2008, from 8.2 to 3.2 per cent. Other external funding has also declined. There is now less money available to fund these programmes than there was in 2000.

1.4 Uganda

Pregnancy and childbirth should be a cause for celebration and fulfillment. However, in Uganda on a daily basis, 16 women die in childbirth making their pregnancy experience a time for tears and mourning rather than joy and continuously perpetuating poverty and misery for families. Issues that are pertinent to women's health outcomes including access to family planning services, antenatal services, low girl-

child education, motivated skilled health-workforce and functional medical facilities have consistently been ignored. Lack of access to life-saving HIV treatment is another major contributor to maternal deaths and results in high rates of mother to child transmission of HIV often leading to death.

Uganda's Annual Health Sector Performance reports indicate that the percentage of supervised deliveries declined from 40% in 2008 to 33% in 2010. Additionally, only 45% of the health facilities in some parts of Uganda were providing emergency obstetric care in 2007 and there is no official Government data from 2005 to date on this matter. The ever-increasing maternal mortality that we are witnessing today points to poor or lack of these services. While Uganda has signed to many National, Regional and International commitments and guidelines on reduction of its high maternal and neonatal mortality and morbidity, improvements have not been forthcoming.

During the UN General Assembly held in September 2011 in New York, Uganda among many other member states, re-committed itself to implementing the Global Strategy for Women's and Children's Health; Uganda spelt out the following areas of focus:

1. Increasing comprehensive Emergency Obstetric and Newborn Care (EmONC) in hospitals from 70% to 100% and in health centers from 17% to 50%; ensure that basic EmONC services are available in all health centers; and that skilled providers are available in hard to reach/hard to serve areas.
2. Reducing unmet need for family planning from current 40% to 20%
3. Ensuring that Emergency obstetric and neonatal care services are available in all health centers
4. Increasing focused antenatal care from 42% to 75% with special emphasis on Prevention of Mother-to Child Transmission (PMTCT) and treatment of HIV.

However, we can only achieve the above targets by ensuring a well trained, motivated health workforce, working in a functioning health care system. Midwives and other priority health workers with midwifery skills are the answer. Uganda currently has a gap of more than 2,000 midwives.

1.5 Reproductive Health issues

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life. It covers the following inter-linked domains: (a) safe motherhood (b) family planning (c) reproductive tract infections and HIV/AIDS (d) gynaecology, including cancer and infertility (e) gender based violence or GBV (f) adolescent reproductive health, and (g) male reproductive health.

1.6 The importance of Reproductive Health

Reproductive health is a crucial part of general health and a central feature of human development. It is a reflection of health during childhood, and crucial during adolescence and adulthood, sets the stage for health beyond the reproductive years for both women and men, and affects the health of the next generation.

The health of the newborn is largely a function of the mother's health and nutrition status and of her access to health care. Reproductive health is a universal concern, but is of special importance to women particularly during the reproductive years. Although most reproductive health problems arise during the reproductive years, in old age general health continues to reflect earlier reproductive life events. Men too have reproductive health concerns and needs though their general health is affected by reproductive health to a lesser extent than is the case for women. However, men have particular roles and responsibilities in terms of women's reproductive health because of their decision-making powers in reproductive health matters. At each stage of life individual needs differ. However, there is a cumulative effect across the life course of events at each phase having important implications for future well-being.

Failure to deal with reproductive health problems at any stage in life sets the scene for later health and developmental problems. Because reproductive health is such an important component of general health it is a prerequisite for social, economic and human development. The highest attainable level of health is not only a fundamental human right for all; it is also a social and economic imperative because human energy and creativity are the driving forces of development. Such energy and creativity cannot be generated by sick, tired people, and consequently a healthy and active population becomes a prerequisite of social and economic development.

1.7 What is new about the Concept of Reproductive Health?

Reproductive health does not start out from a list of diseases or problems - sexually transmitted diseases, maternal mortality or from a list of programmes - maternal and child health, safe motherhood, family planning. Reproductive health instead must be understood in the context of relationships: fulfillment and risk; the opportunity to have a desired child or alternatively, to avoid unwanted or unsafe pregnancy. Reproductive health contributes enormously to physical and psychosocial comfort and closeness, and to personal and social maturation. Poor reproductive health is frequently associated with disease, abuse, exploitation, unwanted pregnancy, and death.

1.8 Reproductive Health Services

The precise configuration of reproductive health needs and concerns, and the programmes and policies to address them, will vary from country to country and will depend on an assessment of each country's situation and the availability of appropriate interventions. Globally, however, both the epidemiological data and the expressed wishes of diverse constituencies indicate that reproductive health interventions are most likely to include attention to the issues of family planning, STD prevention and management and prevention of maternal and perinatal mortality and morbidity. Reproductive health

should also address issues such as harmful practices, unwanted pregnancy, unsafe abortion, reproductive tract infections including sexually transmitted diseases and HIV/AIDS, gender-based violence, infertility, malnutrition and anaemia, and reproductive tract cancers. Appropriate services must be accessible and include information, education, counseling, prevention, detection and management of health problems, care and rehabilitation.

Reproductive health strategies should be founded first and foremost on the health of individuals and families. In the operationalization of the strategies all reproductive health services must assume their responsibility to offer accessible and quality care, while ensuring respect for the individual, freedom of choice, informed consent, confidentiality and privacy in all reproductive matters. They should focus special attention on meeting the reproductive health needs of adolescents.

1.9 Factors affecting Reproductive Health

Reproductive health affects, and is affected by, the broader context of people's lives, including their economic circumstances, education, employment, living conditions and family environment, social and gender relationships, and the traditional and legal structures within which they live. Sexual and reproductive behaviors are governed by complex biological, cultural and psychosocial factors. Therefore, the attainment of reproductive health is not limited to interventions by the health sector alone. Nonetheless, most reproductive health problems cannot be significantly addressed in the absence of health services and medical knowledge and skills.

The status of girls and women in society, and how they are treated or mistreated, is a crucial determinant of their reproductive health. Educational opportunities for girls and women powerfully affect their status and the control they have over their own lives and their health and fertility. The empowerment of women is therefore an essential element for health.

1.10 Who is most affected by Reproductive Health Problems?

Women bear by far the greatest burden of reproductive health problems. Women are at risk of complications from pregnancy and childbirth; they also face risks in preventing unwanted pregnancy, suffer the complications of unsafe abortion, bear most of the burden of contraception, and are more exposed to contracting, and suffering the complications of reproductive tract infections, particularly sexually transmitted diseases (STDs). Among women of reproductive age, 36% of all healthy years of life lost is due to reproductive health problems such as unregulated fertility, maternal mortality and morbidity and sexually transmitted diseases including HIV/AIDS. By contrast, the equivalent figure for men is 12%. Biological factors alone do not explain women's disparate burden. Their social, economic and political disadvantages have a detrimental impact on their reproductive health. Young people of both sexes are also particularly vulnerable to reproductive health problems because of a lack of information and access to services.

1.11 Conclusions

Sound reproductive and family health is essential to the health and welfare of women, to the stability of the family and thus to human and national security. Poor reproductive health especially, when it involves complicated pregnancies, unsafe and badly managed deliveries and poor pregnancy outcomes for women and their babies, disrupts family life, gives rise to social problems, and places a massive load on the health care system. Sexually transmitted infections and malignancies impose equally large demands on the family, the community and the health care system. Conversely, sound, rational and timely investments in reproductive health are likely to produce highly tangible health and social development outcomes.

1.12 Policy Recommendations

1. Increase access to reproductive health, sexual health, and family planning services, especially in rural areas. Due to the lack of access to care in rural areas, maternal death rates are higher in rural areas than in urban areas. In addition, many men and women in rural and urban areas lack access to information and services related to HIV/AIDS and other STIs.

2. Strengthen Reproductive Health and Family Planning Policies and improve planning and resource allocation. While the MNPI scores demonstrate that many countries have strong maternal health policies, implementation of the policies may be inadequate. Often, available resources are insufficient or are used inefficiently. In some cases, advocacy can strengthen policies and increase the amount of resources devoted to reproductive health and family planning. In other cases, operational policy barriers, barriers to implementation and full financing of reproductive health and family planning policies must be removed.

3. Increase access to and education about family planning. Another feature that relates closely to preventing maternal mortality is the provision of family planning. Family planning helps women prevent unintended pregnancies and space the births of their children. It thus reduces their exposure to risks of pregnancy, abortion, and childbirth. Reliable provision of a range of contraceptive methods can help prevent maternal deaths associated with unwanted pregnancies.

4. Increase access to high quality antenatal care. High quality antenatal care includes screening and treatment for STIs, anemia, and detection and treatment of hypertension. Women should be given information about appropriate diet and other healthy practices and about where to seek care for pregnancy complications. The World Health Organization's recommended package of antenatal services can be conducted in four antenatal visits throughout the pregnancy.

5. Increase access to skilled delivery care. Delivery is a critical time in which decisions about unexpected, serious complications must be made. Skilled health professionals such as doctors or midwives can recognize these complications, and either treat them or refer

women to health centers or hospitals immediately if more advanced care is needed. Women in rural areas live far distances from quality obstetric care, so improvements depend greatly on early recognition of complications, better provisions for emergency treatment, and improved logistics for rapid movement of complicated cases to district hospitals. Increased medical coverage of deliveries, through additional skilled staff and service points, are basic requirements for improving delivery care. Reliable supply lines and staff retraining programs are also critical.

6. Provide prompt postpartum care, counseling, and access to family planning. It is important to detect and immediately manage problems that may occur after delivery, such as hemorrhage, which is responsible for about 25 percent of maternal deaths worldwide. Postpartum care and counseling will help ensure the proper care and health of the newborn. Counseling should include information on breastfeeding, immunization, and family planning.

7. Improve post abortion care. About 13 percent of maternal deaths worldwide are due to unsafe abortion. Women who have complications resulting from abortion need access to prompt and high quality treatment for infection, hemorrhage, and injuries to the cervix and uterus.
8. Strengthen health promotion activities. Mass media should be used to educate the public about pregnancy and delivery, and community-level organizations should assist this through systematic programs. An important step for health promotion, in order to prevent negative maternal health outcomes, is to have the Ministry of Health supply adequate educational materials regarding safe practices.

9. Include the concept of comprehensive reproductive health in the curricula of all medical schools and technical health training

10. Strengthen maternal death audits

11. Ensure accessibility of RH services for adolescents who need it

12. Increase the training and recruitment of professional midwives

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Partners in Population and Development
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CHAPTER TWO

INNOVATIVE STRATEGIES FOR IMPROVING MATERNAL AND CHILD HEALTH SERVICES

2.1 Introduction:

Reproductive Health (RH) is a key facet of human development. Improved RH outcomes have broader individual, family and societal benefits, yet, improvement in RH have generally lagged improvement in other health outcomes. The Millennium Development Goal (MDG) for maternal and child health is one where the least among of progress of all MDGs has been made to date globally.

In recognition of this, the past two years have seen emerging global consensus refocusing attention on RH, offering an unprecedented opportunities to redress the neglect of RH through platforms such as partnership for maternal, newborn, and child health, campaign for health MDGs, and innovative financing. The Government of Uganda and Development partners are working towards ensuring that core interventions for addressing maternal and neo-natal health are addressed within the National Health Plans.

This chapter covers successful experiences with innovative approaches adopted by the Government of Uganda, Development partners and Non Governmental Organizations in collaboration with the District Local Governments of Dokolo, Soroti and Yumbe in addressing Reproductive Health issues by increasing access to and use of maternal and child health and family planning services.

2.2 MAKING PREGNANCY SAFER (MPS) INITIATIVE IN SOROTI DISTRICT

2.2.1 Background:

Making pregnancy safer is an initiative by the World Health Organisation (WHO) to highlight the organization's commitment to reduce the global burden of unnecessary death, illness and disability associated with pregnancy, childbirth and the neonatal period. Making Pregnancy Safer (MPS) initiative describes the contribution WHO intends to make during the next few years to the worldwide safe motherhood movement. Soroti district was the pioneer implementer of the MPS initiative in Uganda. Launched in 2001,the WHO supported initiative aimed at reducing the exceedingly high maternal mortality ratio (MMR) in the district through improved access and utilization of quality reproductive health services

In Uganda, Soroti district was chosen as a model district where the Making Pregnancy Safer activities were implemented. A baseline survey of the health units for maternal health services and an assessment of the community perceptions were done in Soroti. The constraints and weaknesses of these health units in the provision of maternal and new-born health services were documented. The knowledge gaps and needs of communities were identified.

Soroti district had high MMR at 885/100,000, a ratio much higher than the then national average of 505/100,000 in 2000. This high maternal mortality ratio was mainly due to obstetric complications such as obstructed labour, retained placentas, abortion complications, over-bleeding, pre-eclampsia, sepsis, ruptured uterus, ectopic pregnancy and indirect causes such as anaemia which were not being managed appropriately in the health care system due to various inadequacies

The implementation of the MPS Initiative was focused on the removal of these inadequacies and the weaknesses noted in the health system, it also addressed the community needs so that improved maternal and new born health services were offered.

2.2.2 Overall Project Goal:

The overall Goal of this project was to contribute to the reduction of maternal and perinatal mortality and morbidity in Soroti district.

2.2.3 Objectives of the project:

The MPS initiative was focused on reducing the high maternal and new born mortality through improved delivery and utilization of reproductive health services and consequently make pregnancy safer. The project objectives were the following;

1. To improve maternal health care across the levels of service delivery with special references to hospital services for safe pregnancy.
2. To increase the level of awareness amongst communities on the importance of ante-natal care, birth preparedness and delivery in health facilities, dangers of adolescent pregnancy, and importance of male participation in reproductive health.
3. To increase the number of people seeking reproductive health services in the district.

2.2.4 Methodology:

The baseline survey for the Making Pregnancy Safer project was conducted in September, 2001. It addressed service delivery components which included:

1. Physical infrastructure, equipment, drugs and supplies
2. Quality of care, Information, Education and Behavioural Change Communication.
3. Skills of health workers in regard to delivery of maternal and new born care services and emergency obstetric and new born care.

To ensure that no woman or baby dies as a result of pregnancy related complications or childbirth in the district, the MPS initiative equipped doctors, nurses and midwives with enhanced obstetric skills relevant for each level of health care. The Intra-venous(IV) plant at Soroti Regional Referral Hospital was renovated to enhance its production. Starter packs for Obstetric drugs were provided. In addition, the initiative focused on improving the referral system right from the communities and health centres up to Soroti Regional Referral Hospital. It equipped communities with bicycle ambulances; Health

Centre IIIs (HC III) with radio transmission sets and HC IVs with motorized ambulances. Theatre facilities were improved at Soroti Regional Referral Hospital.

These efforts were supplemented with reproductive health education to the community on the benefits of attending Antenatal Care (ANC), delivering in health units, avoiding early pregnancies, and understanding responsible fatherhood. Information, Education and Communication (IEC) campaigns both in the communities and at ANCs also tackled cultural barriers and practices that hinder safe pregnancy practices such as over-reliance on Traditional Birth Attendants (TBAs), use of herbs and delays in seeking skilled medical attention when in labour.

The Soroti District leadership under the able guidance of the Local Council 5 Chairman and the Chief Administrative Officer together with the entire District Health team took stewardship for implementation and supervision of the project activities. The Ministry of Health Officials also regularly visited the district for both technical and administrative supervision. This was very helpful in terms of regular clarification for both sides on roles and responsibilities

2.2.5 Strategy:

The main strategies that were used for improving maternal health included the following:

1. Advocacy and involvement of key policy and political leaders of the district.
2. Community mobilisation and empowerment.
3. Capacity building for health workers.
4. Information, Education and behavioural Change Communication.
5. Procurement of relevant emergency drugs, supplies and equipment.
6. Provision of transport and communication equipment for referrals of obstetric emergencies

Four wheel-drive motorised ambulance at Serere Health Centre IV, Courtesy of WHO Country Office, Uganda

2.2.6 Implementation:

The five-year intervention implemented throughout the district with support from WHO, Soroti District Local Government, Ministry of Health and other partners, followed an extensive Reproductive Health (RH) needs assessment survey conducted to establish the gaps and needs in responding to the problem of high maternal mortality in the health facilities and community level.

2.2.7 Achievements:

The strategy to prioritize emergency obstetric care, together with appropriate referral for women with obstetric complications led to dramatic outcomes. In a period of only five years the MMR was more than halved from 885/100,000 live births in 2000 to 221/100,000 in 2006, which was 50% below the 2006 national ratio of 435/100,000 live births as shown in table 1 and figures 2.1 and 2.2 below. This was associated with increased facility based deliveries from 19% in 2000 to 42% in 2006.

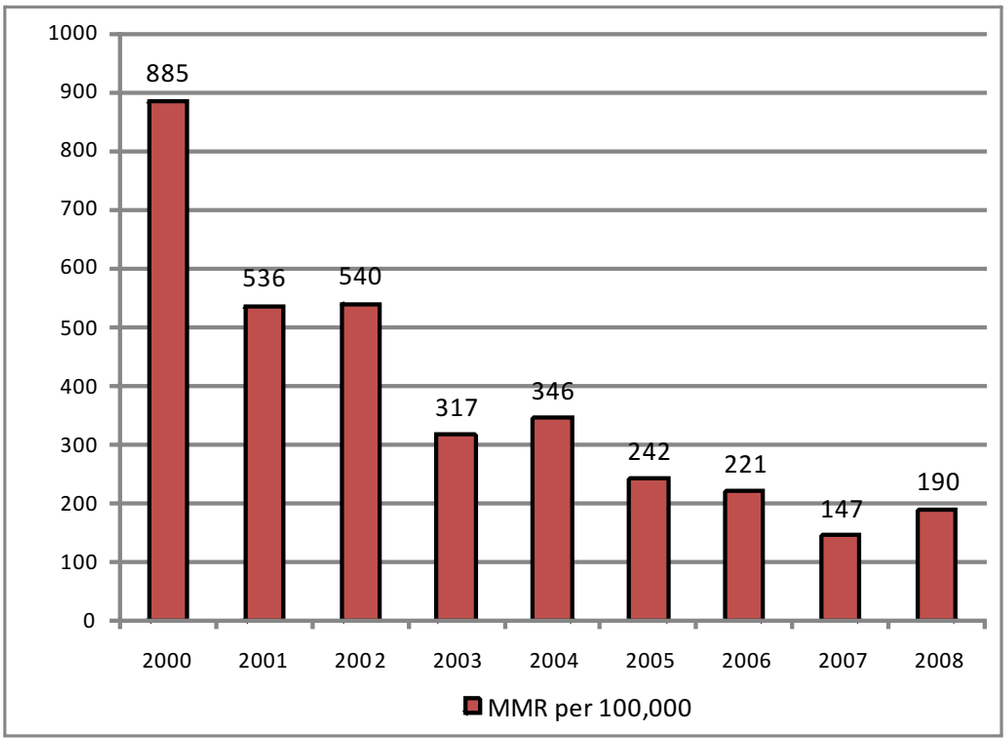
The Main Theatre in Soroti Regional Referral Hospital, Courtesy of WHO Country Office, Uganda

Table 1: Summary Statistics of Patients and Cases Handled in Soroti Districts from 2001 - 2005

Process Indicators	Jan-Jun 2001	Jun-Dec 2001	Jan-Jun 2002	Jul-Dec 2002	Jan-Jun 2003	Jul Dec 2003	Nov. '04 -Apr '05	May-Oct 2005
No. of Admissions.	1691	1857	1582	1965	1845	2,868	2338	2206
No. of Deliveries.	1153	1345	1303	1663	1637	2,459	1914	1744
No. of Caesarian Section	117	118	145	-	-	173	296	290
Direct Maternal Deaths	15	9	8	4	1	9	5	13
Direct Obstetric Complications	53	80	83	468	540	99	233	169
Case Fatality Rate.	28%	11.2%	9.6%	0.8%	0.1%	9.1%	2.1%	7.6%

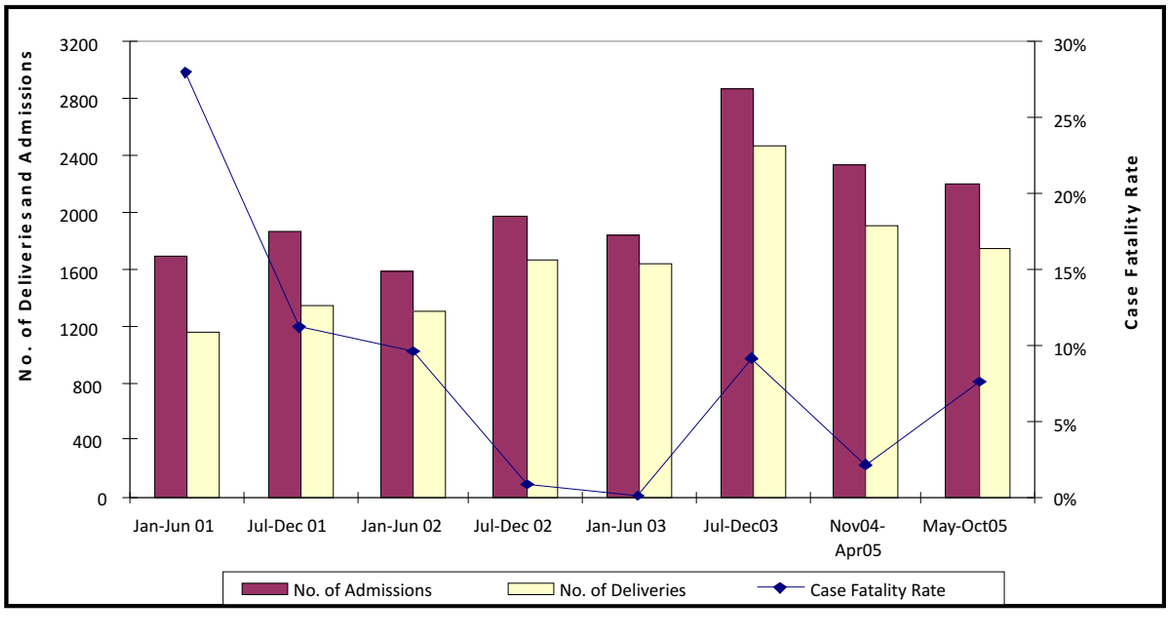
Source: *District Health Office, Soroti District Local Government*

Figure 2.1: Trends of Maternal Mortality Ratio Decline in Soroti District, 2000 - 2008



Service Statistics as monitored by the MPS Initiative up to 2005

Figure 2.2: Trends of Maternal Mortality Ratio Decline in Soroti District, 2000 - 2008



Service Statistics as monitored by the MPS Initiative up to 2005

2.2.8 Conclusion and Recommendations:

The MPS three components for service delivery for making pregnancy safer is a must investment for the entire country, if we are to reduce the needless deaths of mothers and new-borns and realise the set targets for Millennium Development Goals (MDGs) 4 and 5.

To be able replicate this initiative and achieve better results, it is recommended that the following conditions must prevail:

1. There must be effective communication and good working relationships between the District Political leadership and the District Health Teams in the district.
2. Capacity building and skills improvement in Emergency Obstetric Care (EmOC) for health workers in the district must be undertaken.
3. There must be improved community trust for utilisation of the health care services in the district.
4. There must be improved transport and effective communication to enable mothers to reach the referral hospital in time for timely health care.

2.3 VILLAGE HEALTH TEAM STRATEGY FOR IMPROVING MATERNAL AND CHILD HEALTH SERVICES IN DOKOLO DISTRICT

2.3.1 Background

Maternal and child health conditions carry the highest total burden of disease. Perinatal and maternal conditions account for 20.4% of the total disease burden in Uganda. Some progress has been made in the improvement of the health of mothers and children in Uganda over the implementation of the HSSP II. The Road Map to Reduction of Neonatal and Maternal Morbidity and Mortality and the National Child Survival Strategy were formulated in 2007 and 2009, respectively. The effective implementation of these strategies will result into achievement of MDGs 4 and 5 by 2015.

Maternity ward in Dokolo District . Photo provided by courtsey of RHU.

In Dokolo district, Sexual and reproductive health (SRH) core interventions have been rolled out but the proportion of pregnant women delivering in GoU and PNFP facilities is still low at 26% by the end of 2010/11 against a target of 50%. The proportion of facilities providing appropriate Emergency Obstetric Care (EmoC) is still low and post natal care within the first week of delivery is at 26%. About 15% of all pregnancies develop life threatening complications and require emergency obstetric care (EmOC).

According to the emergency obstetric need assessment the national met need for EmOC is 23.9%. Only 11.7% of women deliver in fully functional comprehensive EmOC facilities. MMR for Dokolo is still high between 435-700 deaths per 100,000 live births and the leading direct causes of these deaths are haemorrhage (26%), sepsis (22%), obstructed labour (13%), unsafe abortion (8%) and hypertensive disorders in pregnancy (6%). The main factors responsible for maternal deaths relate to the three delays namely delay to seek care, delay to reach facilities and intra-institutional delay to receive care.

Slow progress in addressing maternal health problems in Dokolo district is due to inadequate human resource, medicines and supplies and appropriate buildings and equipment including transport and communication equipment for referral. Most of the HC IIIs are not providing comprehensive SRH services. Because of the above problems, MOH, Dokolo District Local Government and Partners adopted the VHT strategy to improve health of people at grassroots especially maternal and child health.

2.3.2 The Goal of VHT strategy

The overall goal of the VHT starategy is to improve the health of the people at the grassroot with special focus on maternal and child health in Dokolo district.

2.3.3 Objectives of VHTs

The objective of the VHT strategy is threefold;

1. To engage community leaders to participate in improving the health of the people through prevention practices and protecting the environment.
2. To mobilise communities by providing health information on the available health care services in the district.
3. To sensitise mothers to access information and maternal and child health services in the existing health facilities in the district.

2.3.4 Methodology and Strategy:

VHTs are community volunteers who are selected by communities to provide health information, mobilize communities and provide linkage to health services. They play a big role in mobilizing communities for better health, referral and follow-up of individuals in the community to the nearest health facility. The district has fully trained 960 VHT members distributed in 11 sub-counties. The VHT strategy adopted the following strategies:

- Community mobilisation to provide health information and services
- Advocacy by engaging community leaders at all levels to participate in preventive practices and protecting the environment which impacts on their health.
- Contacting mothers in their homes and linking them to the nearest health facilities for ANC and safe delivery.
- Capacity building for VHTs.

The Ministry of Health, Dokolo District Local Government and Partners adopted the above mentioned strategy to improve health of people at grassroots having identified the gaps/problems especially for maternal and child Health (see tables 2 and 3 below).

Table 2: Table Showing Gaps/Problems and VHT Strategies adopted MCH Services in Dokolo District

Gaps/Problems	VHT Strategies Adopted
1. High Maternal mortality rate- 435-700 per 100,000 live births. 2. High Infant mortality rate – 106 per 1000 live birth 3. High Total fertility rate – 7.5 children per women. 4. Low deliveries taking place at Health facilities - 26%. 5. Low contraceptive uptake - 9%. 6. VHTs tools are not yet available (Standard registers, books, pens, papers, files, bag, bicycles, Gumboots, rain coats for report and data collection). 7. Inadequate Referral systems (No Ambulance in most HC IVs). 8. Commodity stock out like LLINs, Coartem rampant in many Hcs.	1. Dokolo district is using VHTs to sensitize and encourage pregnant women and their partners to go for Antenatal Clinic (ANC), Postnatal Clinic (PNC) and PMTCT services. 2. Attaching 2 female VHTs at the ANC clinic to give Intermittent Presumptive Treatment with Fansidar and Directly Observed Treatment (IPT -DOT) services and health education. 3. VHTs also play a key role in advising and encouraging mothers to deliver in health units. 4. VHTs are promoting the utilization of family planning services. 5. The district is also using VHTs to distribute and disseminate IEC materials on Maternal and Child Health (MCH) and Reproductive Health (RH). 6. VHTs play a key role in mobilizing communities for health activities like immunization, Child Days Plus, Neglected Tropical disease (NTD) and ANC services. 7. VHT participates in reporting disease outbreaks in the villages 8. VHTs are also responsible for collecting and reporting vital data on MCH like Maternal death among others. 9. The district also engages VHTs in giving Mass Drugs Administration. 10. VHTs also play a role in linking Health units to the villages and villages to get health services it needs.

Table 3: Distribution of VHTs by Sub-county in Dokolo District

Sub-County	Total
1. Adok	84
2. Agwata	90
3. Okwalongwen	100
4. Bata	108
5. Amwoma	86
6. Dokolo	104
7. Dokolo TC	72
8. Adeknino	84
9. Kangai	88
10. Kwera	70
11. Okwongodul	74
Total	**960**

Source: HMIS Database 2011

2.3.5 The Strength of Voluntary Health Teams (VHT) in Dokolo District:

The following were identified as the strengths of the Village Health Teams in designing the MCH services approach in Dokolo District:

1. Most VHTs have high knowledge on Malaria, its cause, prevention and treatment, able to deliver the messages with confidence to their audience, gives time for questions and answers.
2. Most VHTs have good working relationship with the local leaders and health centre staff. They liaise with the local leaders for community mobilization for immunization, distribution of drugs, demonstration and reinforcement of sexual and behavioral change communication messages.
3. Information Education Communication (IEC) materials on malaria and referral forms have been given to the VHTs by the district and other development partners.
4. Reporting forms for VHTs were availed to all the health centres for quarterly data capture by MTI.
5. VHTs are making referrals of children and pregnant women to health facilities and a great progress has been registered in the health centre records.
6. VHTs make home visits to reinforce BCC messages and make referrals for further management in the health facilities.
7. Regular supervision of VHTs are conducted by the District Health Office (DHO) and MTI and quarterly review meetings are held at parish levels.

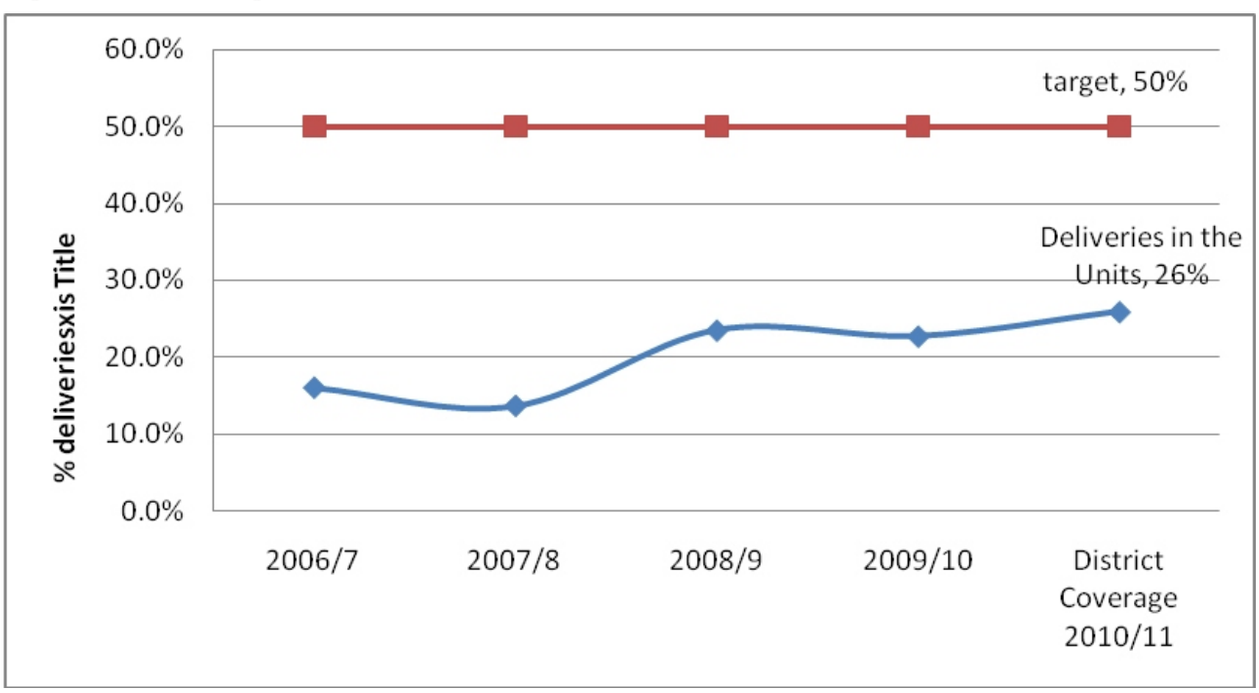
2.3.6 Achievements of the VHT:

The success of VHT approach in improving MCH services in Dokolo district is attributed to the support of the MoH, Dokolo DLG, Partners and the community. These achievements listed below and also graphically shown in figures 2.3, 2.4 and 2.5.

1. Total OPD utilization increased from 67% in 2007/08 to 89% in 2009/10.
2. Proportion of Deliveries taking place at the health facility increased from 13.6% in 2007/8 to 26% in 2010/11.
3. Proportion of pregnant mothers attending more 4 ANC visits has been increased from 42% in 2009/10 to 44% in 2010/11.
4. Percentage of children under 5 years treated with anti-malarials within 24 hours of fever onset increased from 49% in 2008 to 56% in 2011.
5. Percentage of pregnant women who have been given Intermittent Presumptive Treatment-second directly observed treatment (IPT - DOT 2) increased from 42% in 2007/08 to 69% in 2010/2011.
6. Percentage of households with any treated mosquito net increased from 71% in 2008 to 95% in 2010.
7. PMTCT coverage in Pregnant women increased from 43.2% in 2007 to 80% in 2011

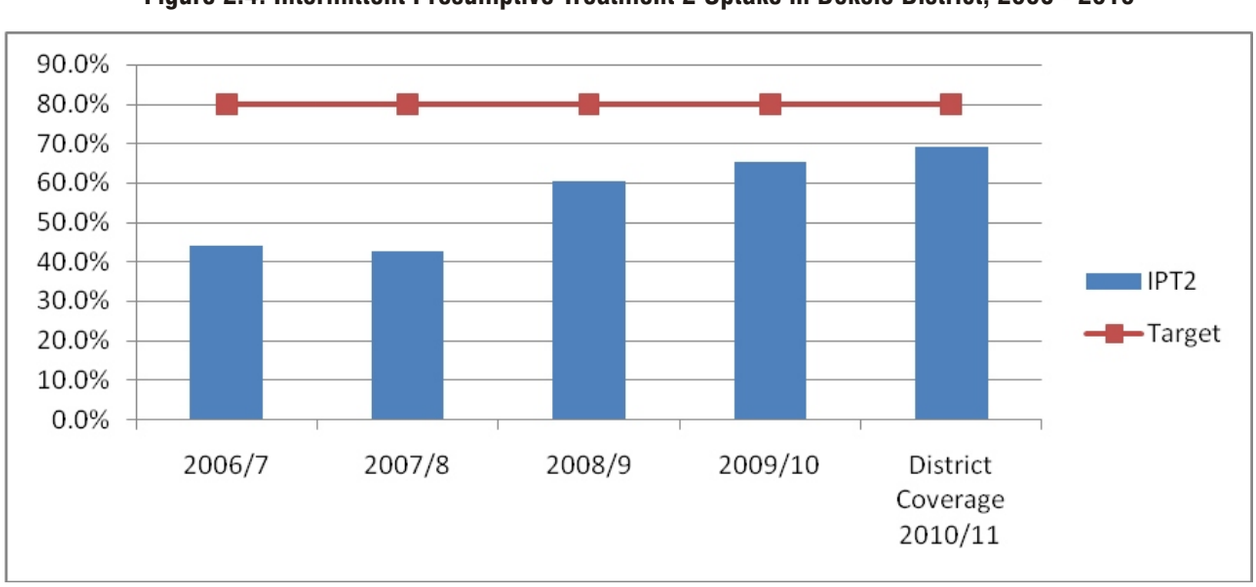
8. HIV Prevalence rate in pregnant women (Tested +ve from ANC) reduced from 5% in 2009 to 4.6% in 2011.
9. Latrine coverage increased from 56% in 2008 to 62% in 2011
10. Immunization coverages (on average for all antigens) increased from 87% in 2009/10 to 91% in 2010/11.

Figure 2.3: Percentage of deliveries in the Health facilities in Dokolo district, 2006-2010



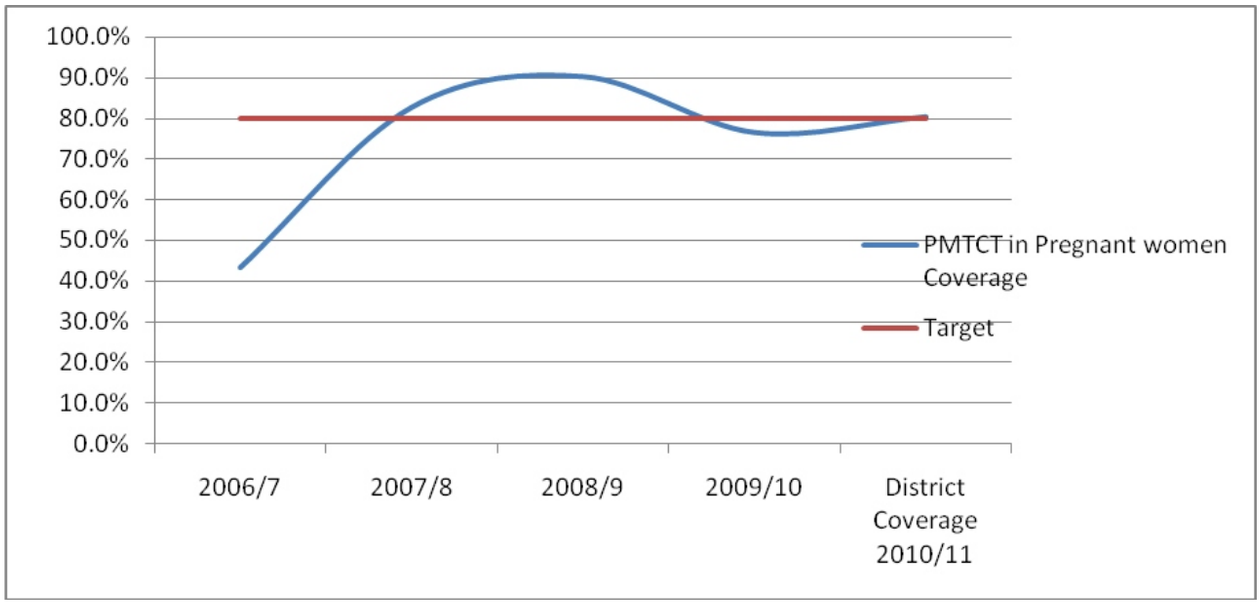
Source Dokolo District HMIS Data 2011

Figure 2.4: Intermittent Presumptive Treatment 2 Uptake in Dokolo District, 2006 - 2010



Source Dokolo District HMIS Data 2011

Figure 2.5: Prevention of Mother to Child Transmission (PMTCT) Services in Dokolo District, 2006 - 2011



Source Dokolo District HMIS Data 2011

2.3.7 Lessons Learned:

The success of the VHT Approach to MCH services in Dokolo district is due to the effective administrative structure that facilitated communication and mobilization of action at grass root level. The following lessons were learned from the VHT approach:

1. Involving female VHTs at the ANC clinic enabled the district to achieve a 4% increase in health facility deliveries.
2. The willingness of the VHTs to serve their community voluntarily is very vital.
3. The district was able to attain high coverage in health programs especially in immunization, ANC attendance and supervised deliveries in health units because of involvement of female VHTs.
4. Close working relations between the VHTs, Health Assistants and Health Inspectors at parish and sub county level is very vital.

2.3.8 Challenges of Voluntary Health Teams:

The VHT strategy in Dokolo district was faced with the following challenges in the course of executing their work:

1. The VHTs require additional motivation for the services they render on ANC days because they feel they are like Nursing Assistants and therefore deserve to be paid salaries.
2. There is low level of community mobilization especially during the period of cultivation.
3. There is limited supervision of VHTs by community leaders such as chiefs, religious

leaders, Health Assistants and the district.

4. The VHTs are not decently dressed and therefore need uniforms to enable them perform their work in the community.
5. There is no provision for coertem to be distributed in the community by the VHTs.
6. The district planning and budgeting guidelines do not clearly indicate allocation of resources for VHTs.
7. There is limited IEC materials distributed to the VHTs for community mobilisation.
8. VHTs are highly expectant of motivation, financially and materially from the MoH, DHO and partners.
9. Referrals are difficult where transport is needed by the community members to reach the Health Centres.
10. Most VHTs do not document their activities; have no work plans, hence poor record keeping.
11. Male involvement in community mobilization and ANC is still so low.
12. There is high demand for commodities by communities especially in terms motivation during meetings and in distribution of commodities.

2.3.9 Conclusion and Recommendations:

Engaging the community to actively take part in improving their own health by prevention practices and protecting their environment will improve the health of the people. The VHTs play key role in this approach by directly accessing individual households. This will enable MOH and the Districts to meet the targets of the Health Sector Strategic and Investment Plan and the Millennium Development Goals.

However, for the MoH and Districts to achieve the above mentioned targets, the following are recommended:

1. Ministry of Health and the District Local Governments should provide basic working tool kits for VHTs.
2. The District Local Governments should prioritise and monitor the activities of VHTs especially the community based health campaigns.
3. Ministry of Health and the District Local Governments should allocate resources for VHTs during their annual planning and budgeting.
4. There is need for continuous sensitization to be conducted on malarial prevention and control by VHTs.
5. VHTs should be regularly supervised and monitored to ensure that their work plans are drawn, followed and their activities well documented.
6. MoH and DHO should avail adequate and relevant IEC materials for VHTs on Malaria, PMTCT, Nutrition, Hygiene and sanitation to reinforce their messages on community mobilisation.
7. All the objective of training the Female VHTs on Goal oriented ANC by District and MTI should not be lost.
8. Mobilization and meetings be done and held with consideration of seasonal/ activity

calendars for each community; considering time, message, target audience and venue.

9. There is need to strengthen the logistics supply chain at the district level by following up request from MoH, and communities be encouraged to save money to bridge the stock out.
10. Strengthen coordination between the VHTs and health centre staff.
11. MoH and Development partners should train VHTs on reproductive health services and print and distribute VHT reporting tools.
12. VHTs should be trained in data management using the HMIS Community module.
13. The District Local Governments should incorporate VHT activities in the District Development Plan

2.4 A MULTI-FACETED STRATEGY FOR INCREASING THE DEMAND AND UTILIZATION OF FAMILY PLANNING SERVICES IN YUMBE DISTRICT

2.4.1 Background and Context:

Yumbe is one of the districts with poor health indicators the maternal mortality ratio is estimated at 600/100,000 live birth while infant mortality rate is at 115/1000 live birth. Contraceptive prevalence rate is 5% and total fertility rate is 7 children per woman.The district has 6 Government dispensaries (II), 6 health centres (III) at sub-county level, 2 health centre (IV) at sub-district level and a Government District Referral Hospital, Yumbe Hospital. Most reproductive health services are not available at HC II, which are closer to communities, meaning that women have to walk long distance to HC III or referral health centres to access the services they need. This problem is compounded by the bad road, which are sometimes impassable during the rainy season. The emergency obstetric care (EmOC) referral systems that enable pregnant women experiencing complications to reach health centers or hospitals with higher-level care were found to be particularly problematic.

The demand for and actual utilization of family planning services in Yumbe district is very low. The Government and Non Government Organizations have made interventions to address the low demand for family planning interventions to address this situation, which include: Training of service providers at health unit level, training of Village Health Teams at community level and equipping health units with logistics for service delivery. Women walk long distances to access maternal and reproductive health services and commodities.

IEC/BCC activities have been carried out through drama shows; community dialogue and radio talk shows. VHTs at community level have moved from house to house to educate eligible individuals and couples on family planning. The IEC/BCC interventions did not lead to significant changes in services utilization.

Surgical camps that were organized in Yumbe yielded very discouraging results. One of the medical officers who had been assigned to provide long term and permanent methods had this to say.

"Yumbe is a difficult area for family planning. Opposition from the political, religious and cultural leaders is very strong here. Men can't allow their spouses to use family planning. They want children. This is predominantly a Moslem community where polygamy is the norm. Women compete to have children. We are wasting our valuable time here"

RHU Health worker educating clients on Family Planning commodities.

It was realized that using a single approach at time could not produce the desired change in the utilization of family planning services. A number of communication challenges still needed to be addressed. They included wide spread roumours, myths and misconceptions that discouraged women and men from using the services, social cultural and religious norms that favour early marriages and large families

In a quarterly review meeting with partners, it was agreed upon that the communication challenges that were affecting family planning services should be addressed in order to increase the utilization of family planning by adopting different approach.

It was against this background that a multi-faceted strategy was developed with a focus on increasing demand and utilization for family planning services in Yumbe district. The team behind this strategy aimed at "*Turning challenges into success*".

2.4.2 Project Objective:

The project objective was twofold:

1. To increase access to family planning services; and
2. To Increase coverage of FP services in the under served areas of Yumbe district

2.4.3 Methodology, Strategy and Implementation:

This project was undertaken in partnership with the District Health Office, Village Health Teams, Uganda Muslim Supreme Council, Yumbe Branch and Yumbe Reproductive Health and Advocacy Network. A three pronged strategy of advocacy, social mobilization and IEC/BCC running concurrently was adopted. Advocacy was aimed at district and lower level councilors and men. Men were included because they make policies (unwritten) which start working the day they are announce

Health worker educating clients on Family Planning services in Yumbe district

and greatly influence family planning decisions. It was done to raise political and social support for family planning and was carried out by Yumbe Reproductive Health Advocacy Network which is currently housed in an office at the Uganda Muslim Supreme Council, Yumbe District headquarters.

District advocacy meetings targeting district councilors and Religious leaders were carried out to bring into perspective of the situation and to explain their role in improving the situation. They were organized by Yumbe Reproductive Health Advocacy Network with support from the District Health Education Department. The district political leaders and technical staff came out strongly to support family planning as an essential component of development on radio and community dialogue meetings.

Social mobilization was designed to provide a supportive social environment for decision making on family planning utilization. The target group for social mobilization included: political, religious and traditional leaders and extended family members. Messages were passed to audiences during prayers and through house to house approach that was implemented with the support of the District Health Office. These activities were reinforced with radio talk shows where selected themes on family planning were discussed and the responsive phone is attended to. IEC/BCC was carried out using drama, radio spots and community dialogue. The target group was women and men and their spouses/ partners. VHTs

RHU Health worker educating clients on Family Planning services in Yumbe district

were prepared and organized to make changes in knowledge, values, attitudes and behaviour, promote couple communication on family planning and empower individuals and couples to make informed decisions and choices to meet their family planning goals.

In addition, the use of a dynamic and result- oriented service provider who hails from the region was used to pass messages on radio and her counseling skills at the surgical camp contributed to the success of the mobilization of mothers and their spouses.

2.4.4 Challenges:

The key challenge was lack of funding for the advocacy network and negotiations were made with the District Health Office which agreed to have joint activities with the advocacy coalition using resources which they had received from UNFPA for IEC/BCC activities

2.4.5 Achievements:

The multi-facet strategy for increasing the demand and utilization of family planning services in Yumbe district had the following achievements that turned challenges into success for FP services:

1. After the intervention, there was an increase in the number of clients that were seeking for family planning services
2. Men came out strongly to support their partners to use long-term and permanent methods at surgical camp sites that were organized in the area
3. District political and religious leaders have integrated family planning in messages that they deliver to the community members during other development programmes.

2.4.6 Conclusion and Recommendations:

The Yumbe district experience is an excellent example of various key actors working in solid collaboration to achieve a common goal. This case study demonstrates how a systematic multi-faceted approach and a clear strategy can lead to desired results. A s a follow-up there is need to facilitate the key actors to form a community education working group which should also work on motivating clients for other reproductive health services. The project should also identify satisfied clients who will make living testimonies on their own experience with a particular method and can help reduce fears of side effects.

References:

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CHAPTER THREE

TRANSLATING MATERNAL HEALTH COMMITMENTS INTO ACTION

3.1 Introduction

The prevailing high rates of fertility (6.7 births per woman) in an environment of poor access to quality maternal and neonatal care continue to expose Ugandan mothers and infants to the highest risk of dying from pregnancy related causes. Every day, an estimated 16 women die from giving birth in Uganda as a result of pregnancy related complications. On average, that is one death every hour and a half and nearly 6,000 every year. A significant proportion of these deaths occur because women are not able to have healthy planned pregnancies. With the unmet need at 41% many Ugandan women bear children before they are ready to and have more than they can care for. About 755,000 women get unintended pregnancies each year, many of which end up in abortion. Every year about 297,000 women have unsafe abortions and 85,000 suffer complications.

Studies show that addressing the unmet need in Uganda could prevent 16,877 maternal deaths and about 1 million child deaths by 2015. If all Ugandan women needing modern contraception were able to obtain an appropriate method, unplanned births and induced abortions would each drop by as much as 85 per cent and maternal and infant deaths by as much as 40 per cent. This would improve

Hon. Rebecca Kadaga, Speaker of Parliament officiating at the SEAPACOH Regional meeting on Repositioning Family Planning and Reproductive Health in Africa at Munyonyo, Kampala.

the health and economic well-being of women and their families and the benefits would extend to the nation as a whole.

Despite the fact that maternal health is a priority service area that the Ministry of Health is investing in, these facts and figures pose a serious health scenario for maternal health in a country that is committed to major national, regional and international treaties, agreements and frameworks.

The poor maternal health outcomes are attributed to a number of factors including policy implementation, resource availability and service delivery challenges. The chapter presents a review of the maternal health policy framework and implementation issues relating to service delivery, providing analytical linkages between the policy implementation frameworks, the gaps in maternal health service delivery and financial allocations and expenditure. Given that accountability for financial resources and health outcomes is critical to the realization of the regional and international frameworks, this chapter analyses government commitment to meet the objectives of the treaties keeping in mind that accountability begins with national sovereignty and the responsibility of a government to its people and to the global community. Cognizant that all partners are accountable for the commitments and promises they make and for the health policies and programmes they design and implement, the chapter evaluates whether the commitments translate into action or remain broken promises. The chapter further attempts to answer the following questions; Are there mechanisms that keep those who commit accountable and how are those institutions that committed tracked or monitored?

3.2 Maternal Health situation

Uganda has experienced a slight improvement in maternal health indicators including slight reduction in maternal mortality rate over the years, from 505/100,000 live births in 1995 to 435/100,000 live births in 2006. Total Fertility Rate (TFR) reduced from 6.9 in 1995 to 6.7 in 2006, contraceptive prevalence rate increased from 15% in 1995 to 24% in 2006, the proportion of deliveries in the health facilities increased from 25% in 2004 to 32% in 2006 and Post Natal care (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) in 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 hemorrhage, 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 ; 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.

3.3 Maternal Health Policies

In Uganda, maternal health has 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 (Table 4).

Table 4: Policy Documents that articulate Government's Commitment to addressing Maternal Health in Uganda

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 aimed at providing an overarching framework to guide public action to eradicate poverty through increasing people's incomes, improving human development and reducing powerlessness. It has since been since been replaced by the National Development Plan
2010	National Development Plan (NDP)	This is the overall National Development framework that aims at guiding the development process that includes improving access to quality social services by ensuring universal access to quality National Minimum Health Care Package with a focus on maternal health care.
Health Policies, Plans, Guidelines		
1999	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 everyone 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 everyone 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 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 of 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 & 2010	National Health Sector Strategic Plan I & II and National Health Investment Plan III	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.
	Roadmaps	
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.

The Constitution of Uganda provides the basic legal framework for government commitment to reproductive health matters. Article 33 of the Constitution specifically provides for the rights of women: "Women shall be accorded full and equal dignity of the person with men and the state shall provide the facilities and opportunities necessary to enhance the welfare of women to enable them realize their full potential and advancement."

Commitment to address maternal health is also clearly articulated in the successive overall national development frameworks. Through the Poverty Eradication Action Plan (PEAP), which was the overall national development framework between 1997 and 2008/9, the government reaffirmed its commitment to achieving the MDGs and prioritized 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 recognized the significant contribution of maternal health conditions to the burden of disease in the country and identified inadequate RH services characterized by limited access to maternity services ; 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) 2008/9 – 2012/13 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) and reviewed (MOH Policy 2010). Maternal mortality and morbidity are key priority areas being addressed in an integrated manner through the Uganda Minimum Health Care package (UNMHCP). The main focus is on essential Ante-natal and Emergency Obstetric Care , Family planning , ASRH, VAW and improving nutrition for pregnant and lactating mothers, among others (MoH, 1999).The 2010 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 and the current HSIP III. One of the overriding priorities of HSSP II was the fulfillment 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 prioritized addressing life-threatening health problems, particularly pregnancy and birth-related deaths and childhood killer diseases. HSSP II worked 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.

The National Population Policy (2008) recognizes that all couples and individuals have the basic right to decide freely and responsibly the number and the spacing of their children, and to have access to information and education in order to make an informed choice; and the means to do so. It stipulates the promotion and expansion of comprehensive family planning services, 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. 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. It recognizes that health, in particular reproductive health, is a basic human right, and specifically points out the importance of RH commodity security and increased budgetary allocation for reproductive health.

Further 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 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.

3.4 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 in the NHP, HSSPII and NPP. 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 decentralization mechanism, where resources for service delivery are channeled directly to the districts and the Sector Wide Approach (SWAp) that promotes inter-sectoral collaboration and other stakeholders including civil society organizations and the private sector. 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.

It is also important to emphasize that it is impossible to have commitment to reproductive health without commitment to Reproductive Health Commodity Security (RHCS). Such commitment is empty and deceptive. "Trying to run sexual and reproductive health programmes without contraceptives and other reproductive health commodities is like trying to eradicate smallpox without vaccines. It simply cannot be done." The Ministry of Health underscores the critical role of RHCS in attaining better reproductive health status and sustaining services, as stated in the Strategy to Improve Reproductive Health in Uganda (2005-10), and the National Family Planning Advocacy Strategy. The second Health Sector Strategic Plan (HSSP II) targeted an increase in contraceptive prevalence rate (CPR) to 40% from the current 24%; full availability of condoms (100%); eliminate drug stock-outs, including RH commodities in 80% of health units; and provide emergency contraceptives in 60% of health units – all by end of June 2010.

In spite of these and other policy commitments and promises, stock-outs of all drugs, including RH commodities, occurred regularly, not until the amendment of policy to allow MoFPED to directly disburse funds to National Medical Stores under Vote 116 (Republic of Uganda 2010). Family planning was not a priority within the country's health agenda and health budget and the situation was made worse by the weak Public Accountability in the allocation and use of health resources earmarked for family planning.

3.5 Do Policy Commitments translate into Maternal Health Service Delivery?

While there are a number of policies, guidelines and service standards to address maternal health issues in the country, the apparent weak implementation of these policies has led to persistent poor maternal health outcomes, with many service providers unaware of their roles in effecting the existing policies. 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. Male involvement is highlighted as a cause of increased maternal deaths but no particular attention is paid to it as a priority area of focus. The discussion on maternal health largely focuses on gender as a "women-only-issue" with no comprehensive focus on men and their involvement in maternal and reproductive health, given the fact that men 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.

The policies also offer little discussion on the role of the community in maternal health issues; yet maternal health challenges are rampant in poor and rural communities. In addition, while unsafe abortion is identified as a major contributor to maternal mortality, the policies offer limited discussion on how it can be addressed. While 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. Most health units have limited capacity for post-abortion care. This is mainly due to the restrictive laws on abortion. 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.

Action is urgently needed for reproductive health commodity security. The population of Uganda, which was 24.7 million in 2002, is projected to reach 54.8 million by 2025, and if the trend is not checked, 103 million by 2050. This high population growth rate (3.2%) ranks among the highest in the world, and is attributed to the country's high fertility rate of 6.7 children.

RH commodities are starved of funding. Direct contraceptive funding from UNFPA and USAID represented about two-thirds of the total government budget for contraceptives, with government covering only 14% of the national contraceptive need. What is worse is that even this small government contribution was not fully forthcoming. For instance, government had allocated Uganda shillings 1.5 billion per year to reproductive health commodities since 2005/06, but much of this money was either not disbursed or diverted . For instance, spending on contraceptives has been between 2-6% of allocated funds! The MoH has estimated a 30% gap between contraceptive need and actual availability.

This raises the question of whether policy implementation depends too much on the interests or commitment of stakeholders, including donor interests and the capacities of the service providers. More concrete measures must be taken to ensure implementation of policies so as to achieve set targets outlined in the policy commitments.

3.6 The International Commitments

Despite being signatory to major regional and international agreements and frameworks including, the Declaration of Alma-Ata (1978), the International Conference on Population and Development in Cairo (1994), the Beijing Platform for Action, 1995; the Abuja Declaration (2001), the Maputo Plan of Action (2005), the Paris Declaration on Aid effectiveness (2005), the Accra Agenda for Action and the

Hon. Fred Jachan Omach, Minister of State for Finance (General Duties) officiating at EARHN Regional meeting on Repositioning Family Planning and Reproductive Health in Eastern Africa at Munyonyo, Kampala.

Millennium Development Goals, Uganda is plagued by poor health indicators .

Uganda is also party a signatory to a number of international and regional instruments 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 (refer to figure 3.1). Maternal mortality is a human rights issue in terms of the right to life, health, non-discrimination and equality .

Figure 3.1: Map of Africa showing the level of Commitment to Ratifying the Maputo Protocols to Improving Maternal Health

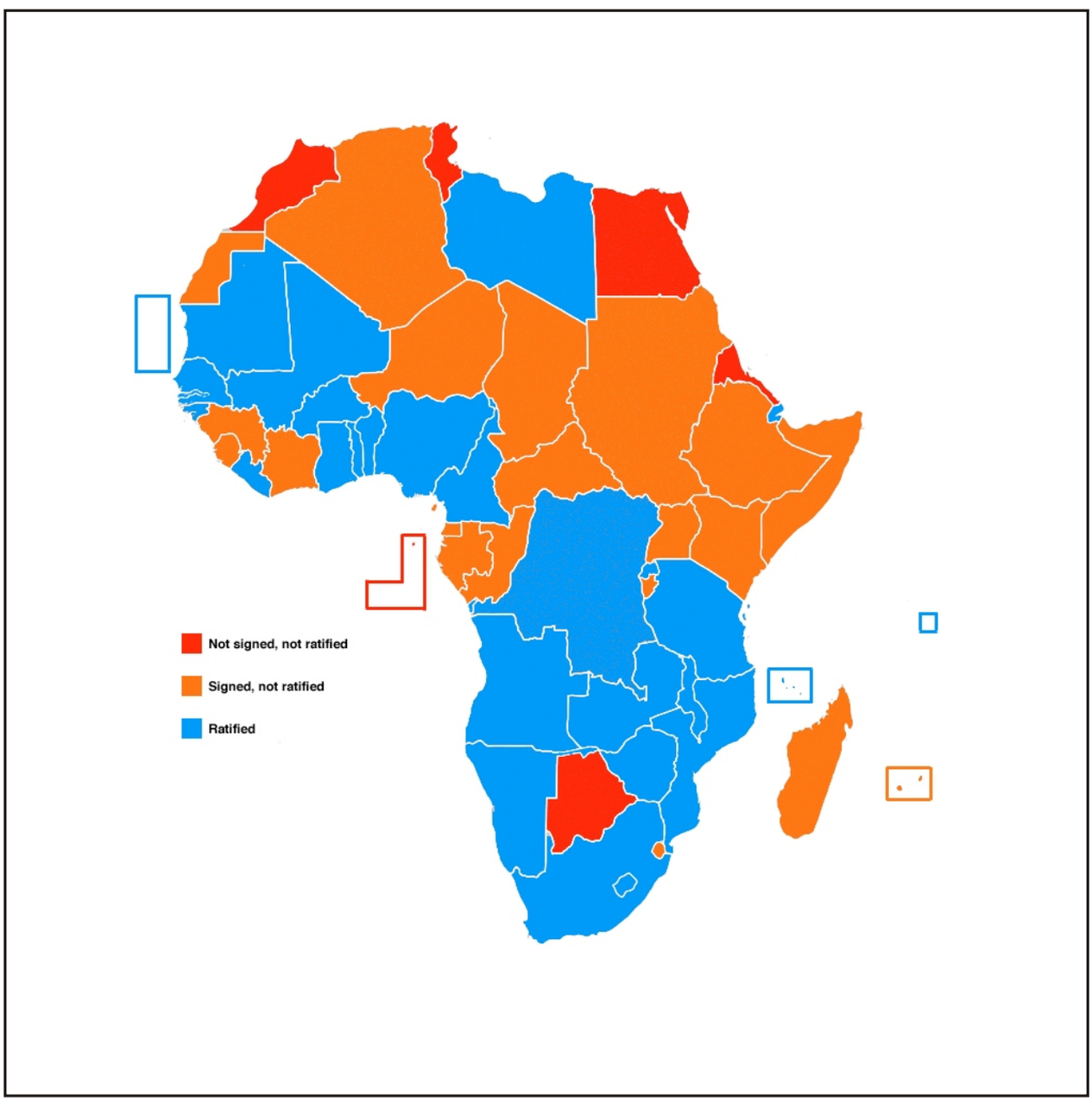

Figure 3.2: Maternal Mortality Rates in Uganda (1988-2006)

Source: UBOS, Uganda Health Demographic Survey2006

3.7 But how far has Uganda gone in achieving the international commitments?

The international treaties and frameworks reflect commitments towards equity in health and take a multi-sectoral approach. There is an assumption that all stakeholders are familiar with and use the plans to shape their work. However this may not be the case.

Attainment of the health-related MDGS remains the overarching means of government's commitments to addressing almost all the other international treaties and frameworks related to maternal health. In this regard, maternal health has seen the least amount of progress towards achieving the MDGs. Realizing that the Maputo Plan of Action was not adequately specific in some areas making it difficult to evaluate progress over time, Uganda like many African countries, developed the Road Map to accelerate the reduction of maternal mortality and morbidity as a way of domesticating the Maputo Plan of Action. However, bottlenecks in the financing, delivery and utilization of maternal health services impede the effective implementation of these interventions. Implementing the Road Map (2009 -2014) would cost about USD 80.0 million or USD 16.6 million per year but this is far from being realized. In addition, accessing emergency obstetric care country wide remains a challenge. Considering that all maternal health process indicators available have fallen short of targets, meeting the goals of maternal mortality by 2015 is unlikely as indicated in Figure 3.2 above.

In recognition of this, the past two years have seen an emerging global consensus on re-focusing

attention on reproductive health, offering an unprecedented opportunity to redress the neglect of reproductive health, through international partnership working with national governments to ensure that the national health plans address maternal and neonatal health. Uganda has hence forth, developed the MDG Acceleration Framework (MAF). The MAF facilitates prioritization of key interventions necessary for delivering effective maternal health services. The Framework also assists in the identification of bottlenecks that impede implementation of these interventions and solutions to break open these bottlenecks and sustain or accelerate impact on the ground.

The Abuja declaration and Plan of Action recommended that countries allocate 15% of their total domestic budgets to health by 2015. GOU has performed well on this compared to its East African counterparts because since 2008/9, government has consistently committed above 9% of its total budget to health, but it is still far below the Abuja target. In the Abuja Declaration, the tasks detailed assume that civil society, parliament and state relate effectively in policy engagement but this too may not always be the case.

Uganda has therefore, only signed and has not taken steps towards implementing most of the international treaties. Only few policy makers who control government budgets and spending have some knowledge of their government's commitments to internationally-recognized agreements and frameworks. Although health policies clearly align global targets with local priorities, a closer scrutiny however shows a clear mismatch between the policy priorities and financial commitments making it unlikely for Uganda to meet health related regional and global targets such as MDGs and Abuja Declaration.

3.8 Financing Maternal Health Policies

Budgeting in Uganda has been guided by the PEAP, Uganda's National Development Framework and Medium-Term Planning Tool since 1997 to 2009 and currently, the NDP. 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. There is a well-established finance management and monitoring mechanism which reinforces a similarly well established accounting system in ensuring expenditure is made against agreed work plans and outputs. 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 and further decline to 9.8% in FY 2010/2011. According to the Annual Health Sector Performance reports of 2007, 2008, 2009 and 2010, 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.

The belief that additional resources for health must come from outside Uganda is worrying. While there are a number of donors supporting the Health sector, the main development partners supporting maternal health initiatives 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).

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 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 specialized medical services surgical emergency and reproductive health services); referral hospitals (provision of specialized medical services surgical emergency and reproductive

The Parliament Building, Kampala, Uganda

health services) and local government (Primary Health Care).

According to the annual budget procedure in Uganda, the parliament has "the last word" with regard to the approval of the annual budget. Specifically, the Social Service Committee within the parliament and the Network of Women Ministers and Parliamentarians (NAWMP-Uganda Chapter) have had particular influence on the budget in the past two years for example, further to recommendations of the Committee, the budget has been rejected by the parliament for neglecting to include a budget for maternal health.

As a result of the advocacy of the MPs, Uganda has received a $30m (sh75b) loan from the World Bank for improving reproductive health including increasing access to EmOC, ensuring skilled attendance at birth, scaling up of family planning and providing antenatal care. Of these funds, $18,949,654 (sh42b) is allocated to procurement of reproductive health supplies including emergency obstetric care supplies and equipment, long term and permanent family planning methods and equipment, as well as procurement of oral contraceptives.

The Government has also committed sh24b for maternal health. But what is sobering is that allocations do not necessarily match expenditure. Information from the ministry of health shows that in 2008, of the sh1.45b allocated by the Government to purchase contraceptives, only 6.4% was spent. According to a study by United Nations Population Fund, 70% of maternal deaths could be prevented by investing in family planning and reproductive health services. Additional research shows that meeting just half of Uganda's unmet need for family planning would result in 519,000 fewer unintended pregnancies each year, which would lead to 152,000 fewer induced abortions and 1,600 fewer maternal deaths.

3.9 Do the Finances match Maternal Health Policy Implementation?

Inadequate budgetary allocation has been and is a major obstacle to improving maternal health. Putting in place finance management and monitoring mechanisms that ensures expenditure against agreed work plans and outputs will enhance effective and efficient maternal health service delivery. In the delivery of services, the infrastructure and equipment for the supply of maternal health services still needs further improvement. For instance, only 5% of facilities have a vacuum extractor for assisted vaginal delivery. Insufficient supplies and commodities, as well as limitations in transport and communication for referral, are also key bottlenecks in the supply of maternal health services. In utilization, there is high unmet need for, yet low use of the four above-mentioned priority interventions. Physical access, especially transportation for skilled attendance and emergency obstetric care, is a particular constraint here. Other bottlenecks affecting utilization and demand for maternal health services include indirect financial costs, such as those associated with transportation and access to drugs (despite the abolition of user fees), as well as cultural norms and social influences.

Many of the solutions identified for addressing bottlenecks in the delivery of emergency obstetric care

overlap with skilled attendance at birth, family planning, and antenatal care interventions. However, according to the HSSP Mid Term Sector Review (MoH, 2009), actual money released for the entire health sector was 84% of the entire approved 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 outstripping 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 off target of the HSSP (13.3%) and far below the Abuja commitment of 15% (MoH, 2006, 2008, 2009). Approved budget estimates for 2009/2010 indicate a significant shortfall of 86.1% of the proposed budget for the obstetric and gynecology department. This indicates a high budget off short which has implications for effective implementation of the Health sector activities and efficient maternal health service delivery.

There are also major 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.

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. One of the biggest challenges for maternal health highlighted in the Ministerial Policy Statement for the Health Sector, 2011 -2012 is the shortage of skilled health personnel, a challenge that poses major bottlenecks for the sector. 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. 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 also been noted in the budget 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.

On accountability and financial management, MoFPED experiences failure of the health sector 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. Delays in procurement of services such as procurement and distribution of essential drugs and health supplies have been common causing drug stock outs in most health facilities countrywide. It is not until government approved Vote116 for National Medical Stores with funds disbursed directly to NMS for the procurement of drugs and supplies that health centres are experiencing no stock outs. Further to this, not all allocations are fully aligned with the priorities laid out at the outset. In the annual health sector performance reports, 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.

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, continues to be common as government grapples with streamlining policy and financing mechanisms for National Medical Stores.

The MOH and RH advocates including MPs and CSOs have in the recent past advocated for increased financing for maternal health, but there is a conspicuous financing gap for maternal health related services (e.g., the Maternal Roadmap and RH commodities are expected to cost US$ 78.7 million per year, which exceeds estimates for the health sector non-wage budget by 80%). Prioritization of maternal health interventions is not uniform across the mushrooming districts, which affects budget allocation at the local level.

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

3.10 Conclusion

Government must translate national and international commitments into concrete action by increasing and guaranteeing financing, improving the logistics systems, procurement, and effective service delivery to enable Ugandans realize their reproductive health rights. Ensuring access to high quality maternal health information, products, and services requires commitment, not only in policy but in action as well. The existing policies and guidelines, are sufficient to improve access to RH commodities, and are being strengthened with new strategies such as the Road Map for accelerating reduction of maternal morbidity and mortality, the MDG Acceleration Framework and RH commodity security Strategy. But these policies and strategies count for nothing when they are not implemented.

In addition, the management of health systems is often weak and impedes direct measurement of achievements towards the health-related MDGs. There is also a lack of adequate universal instruments for accurately tracking both national and international financial commitments to women's and children's health and the subsequent disbursements as well as expenditures. This lack of attention is counterproductive and definitely requires well resourced budgets and collaboration with all key stakeholders.

3.11 Recommendation

1. There is need to step up efforts to implement the many policies that are in place. 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.
2. Political commitment and not the country's wealth is one of the most important factors in reducing maternal mortality. The lack of political commitment is further evidenced by the weak and uncoordinated approach to policy implementation and the low investment in reproductive health and the overwhelming reliance on donors to support RH programs. Uganda should therefore borrow leaf from Liberia and Rwanda that have only emerged from conflict recently but invested more in health, clearly out pacing bigger and richer nations.
3. Uganda must stop thinking that additional resources for health must come from outside the country and create additional resources for health by reprioritizing government expenditure most significantly, redirecting resources from expenditure of heavily funded sectors.
4. There is need to strengthen family planning services 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.
5. There is need to address human resource and capacity concerns in terms of recruitment and offering training.
6. Increasing resources to the Health sector and, in particular, government should honour the Abuja commitment while prioritizing and aligning available resources for basic service

delivery and especially increasing grants for local governments' health service delivery. This should include financial support for community participation with Village Health Teams (VHTs) as well as extending services to HCIIs which are nearer to the poor women.

7. While the importance of providing maternal health services is universally recognized, there is limited information available on the cost of providing these services. Cost information both measures of unit cost and cost-effectiveness serves as a critical input into the processes of setting priorities and allocating resources efficiently. Cost studies of maternal health interventions help to assess how well resources are used in different types of health facilities and can provide policymakers with information on how to improve the efficiency and effectiveness of service delivery as well as to assess how adequately funded these services are. There is a strong need, therefore, for the development of health financing schemes in-country.
8. 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.
9. Commitment to strengthen public private partnership that engages all stakeholders in national health development will enhance service delivery and promote participatory development and good governance.
10. Members of parliament (MPs) and CSOs should serve as a link to build accountability between government and citizens.
11. 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.

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CHAPTER FOUR

ADDRESSING SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF YOUNG PEOPLE

4.1 Introduction

The term adolescents and young people are sometimes used interchangeably; while the latter refers to people aged 10-24 years the former are those in the age group 10-19 years. Uganda has the youngest population in the world with a median age of 15 years, 56 percent of her population is below 18 years, 34 percent is between ages 10-24 (Uganda Bureau of Statistics, 2002). The current data show that Uganda will by 2016 have 10.4 million adolescents, will have become sexually active and thus predisposed to early pregnancy and STI infection including HIV. Adolescence is a transitional stage from childhood to adulthood and is characterized by physical, psychological, social and behavioral changes that subject young people to very high risk of STI infections. These changes make the sexual and reproductive health needs of young people unique and therefore call for more attention (UN, 2006 and 2005). Such reproductive health issues include early and unwanted pregnancies, unsafe abortion, STI/HIV/AIDS, female genital mutilation, sexual abuse, reproductive health infections, antenatal, prenatal and postnatal care. Some of these reproductive health issues have led to school drop out and increase in poverty among adolescents (Lancet, 2007).

Pan American Health Organization and World Health Organization (2001) define sexual health as the experience of physical, psychological, and socio-cultural well being related to sexuality. It is manifested in the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching the social life of young people. Sexual health needs a positive and respectful approach to sexuality and sexual relationship and possibility of having pleasurable and safe sexual experience that are free of coercion, discrimination and violence. The two organizations also have a common position that reproductive health 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 health system. The young people in Uganda are vulnerable to the socio-cultural and economic conditions are initiated into sexual relations at an early age, have low level of contraceptive utilization despite having high knowledge.

This chapter therefore presents the vulnerability of young people; gender roles, practices and their impacts on sexual reproductive health of adolescents; effects of early initiation of sex on sexual and reproductive health; effects of poor sexual and reproductive health; Uganda-global comparison of teenage pregnancy rate; knowledge and practice of sexual reproductive health; and strategies for addressing sexual and reproductive health needs.

4.2 Vulnerability of Young People

The negative outcomes of STI including HIV/AIDS and early pregnancy threaten the health of young

people the most compared to all other reproductive age groups combined because they have immature reproductive systems and low immunity making them susceptible to STI and HIV. This is worse for young girls who experience more difficulties in pregnancy and delivery than the older women since they have incomplete body growth (UN, 2007). The vulnerability of adolescents is compounded by the societal issues such as age differences between sexual partners, gender differences in norms for sexual behavior, early marriage that heightens the possibility of sexual coercion. Focusing on young people in the promotion of sexual health is therefore paramount due to multiple reasons:

1. Firstly, young people form a big percentage of Uganda's population. For example, adolescents constitute 25 percent of Uganda's total population.
2. Secondly, young people are vulnerable to sexual ill-health, which is why a high proportion of them suffer from STI including HIV. The latest information shows that 3.6 percent of the young people are HIV+, and the prevalence is higher among females (4.8%) than males (2.3%). This is partly linked to low level of condoms use by male (55%) and female (38%) adolescents (UNICEF, 2010).
3. Thirdly, young people experience high levels of sexual coercion, have high level of unwanted pregnancy and unsafe abortions, lack adequate access to health service and information. For example, between 2005 and 2009, only 38 percent of males and 32 percent of females had comprehensive knowledge about HIV.

4.3 Gender Role, Practices and their impacts on Sexual Health of Adolescents

In Uganda, there is deep rooted gendered attitudes, behaviors and gender power that have created inequalities. The basis of this is in patriarchy which is a systematic societal structure that has institutionalized male physical, social and economic power over women. This gives young men the power to decide in almost all aspects of life, including sexual relations. Young women's low power coupled with high male control has begotten violence. Violence and threats of violence affect many aspects of young people's sexual and reproductive health. Young women who live in violent relationships cannot make sexual and reproductive choices. This puts them at greater risk of early and unwanted pregnancy and STI/HIV infections because they have no control over or to negotiate for safe sex, and cannot also negotiate for the use of contraceptives. Violence during pregnancy has been associated with adverse pregnancy outcomes such as low birth weight, premature labor, preterm delivery, miscarriages, fetal injury and maternal mortality. These outcomes are as a result of high level of violence on young people, especially girls and it is almost socially accepted in the society.

- 39% of female adolescents have ever experienced violence compared to 11% of males
- 59.6% of young girls ever experienced physical violence
- 49% of sexually active primary school girls have been forced to have sexual intercourse
- 31% of school girls and 15% of school boys have ever been sexually abused
- 70% of adolescent girls and 69% of boys (15-19 years) feel it is justified for a man to beat his wife.

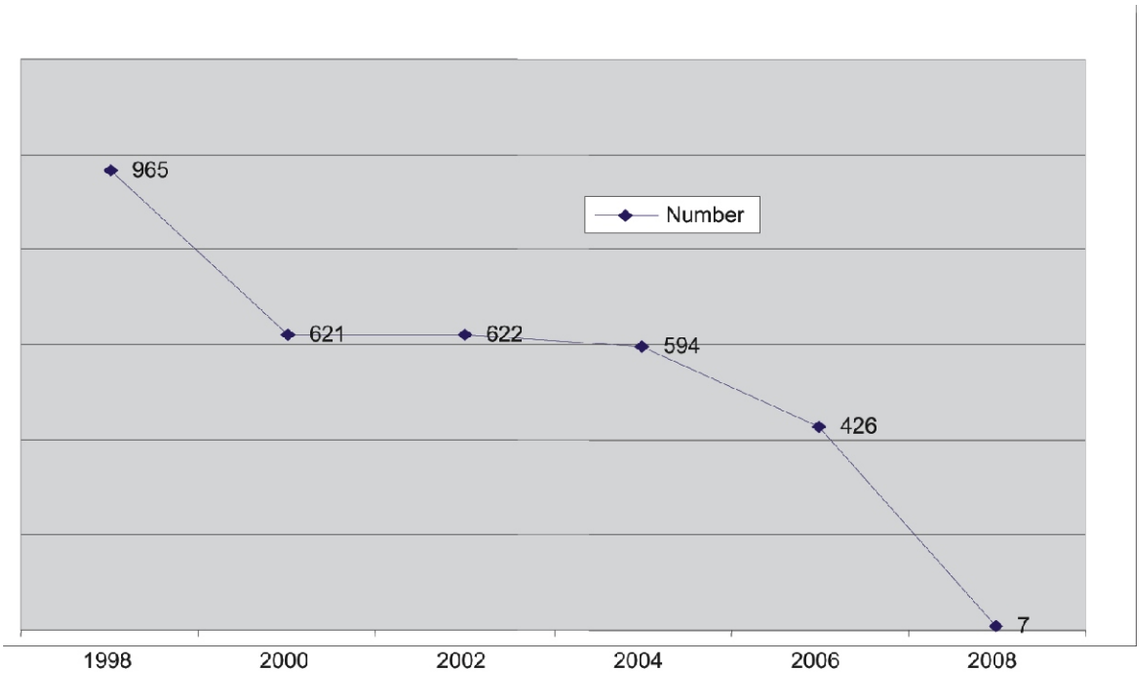
The most prominent forms of sexual violence in Uganda include female genital mutilation (FGM) and sexual coercion. Female Genital Mutilation (FGM) refers to a variety of operations that involve partial or total removal of female external genitalia. Female genital mutilation is practiced as a passage to adulthood among girls aged 10-15 years, preparing them for the tougher reproductive roles that the society expects them to undergo. It is also a process that integrates girls into the expectations of the dominant societal roles, the husbands and male patriarchy in general. In effect, FGM is preparatory phase during which girls are further socialized into their social identities, norm and expected behavior with husbands, respect and the wider society. It is a traditional practice found in some societies including those in Uganda (WHO, 2008; MoGLSD, 2009). WHO (2008) categorizes FGM into four:

1. Type 1 or Clitorictectomy: Involves partial or total removal of the clitoris and/or the clitoral hood.
2. Type 2 or Excision: is partial or total removal of the clitoris and labia minora with or without excision of the labia majora.
3. Type 3 or Infibulation: is the narrowing of the viginal orifice with creation of a covering seal by cutting and pacing together the labia minora and/or the labia majora with or without excision of the clitoris.
4. Type 4 or Unclassified: All other harmful procedures to the female genitalia for non medical purpose, for example, pricking, piercing, incision, scraping and cauterization.

Female genital mutilation is often done under unhygienic conditions and acute hemorrhage and infections are common. Some girls develop chronic morbidity, including urinary tract infections, reproductive tract infections, dyspareunia and sometime vescovaginal fistula, especially with type II and III mutilation. It is associated with obstetric morbidity, including perinatal problems. Adolescent girls with FGM type II and III are more likely to have caesarian section postpartum hemorrhage and long stay in hospital after delivery. Such women are also more likely to have babies that need resuscitation or may have still birth or early neonatal death.

The districts widely known for practicing FGM are Kapchorwa, Bukwo and Amudat. However, efforts have been made by different communities and NGOs to eliminate FGM. Such among others include Sabinyi Elders Association, partnering with UNFPA and Reproductive Education and Care for Health (REACH).

Figure 4.1: Trends in the Female Genital mutilation in Kapchorwa district



Source: Daily Monitor December 4, 2008.

The efforts resulted into a decline of the number of girls mutilated reported in Kapchorwa district from 1965 in 1998 to only 7 in 2008 as shown in figure 4.1 above. Ideally, the FGM practices would decline appreciably if cultural belief that encourages violence was not deep rooted in the thinking of both males and females. United Nations Children's Fund (2010) abridged report shows that 69 percent of the male adolescents in Uganda felt it is justified for a husband to beat his wife, and a similar belief was echoed by 70 percent of the female adolescents.

Sexual violence is also reflected in the coercion into sex that is still predominant in Uganda among adolescents, especially when the woman is younger than the sexual partner. In a study conducted in the country with a sample size of 4279 respondents, 31 percent and 15 percent of young girls and boys respectively in Kabale reported being coerced into sex. In Rakai district, younger female adolescents (girls below 15years) reported that their first sexual encounter with their current partner was coerced (Neema, Nakanyike and Kibombo, 2004). The drivers of sexual coercion include: Economic dependency, staying with opposite sex in closed places, leaving children by themselves, leaving children with other people such as houseboys and gender disparity.

Apart from other efforts, the government of Uganda has also specific laws in place to address sexual violence, and some of them have been used to solve the problem. The instruments include:

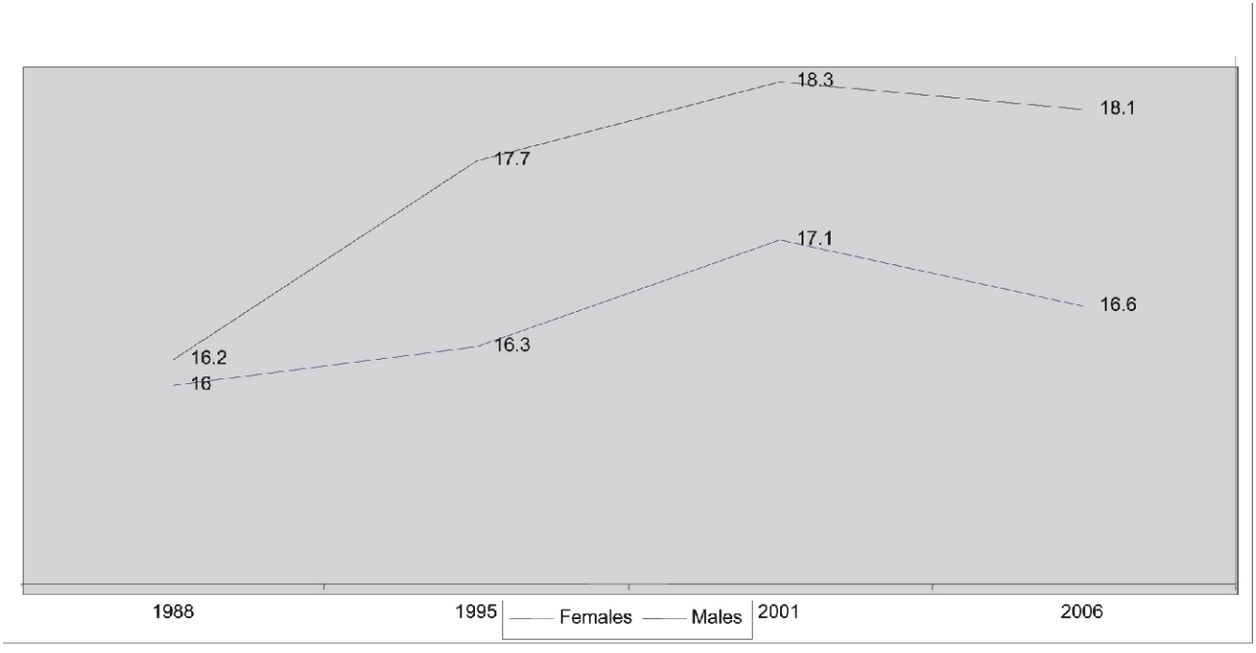
- The 1995 Constitution of Uganda
- The Penal Code Act CAP 120
- The Children Act CAP 59

- The Divorce Act CAP 249
- The Probation Department was established by an Act of Parliament.
- The Probation Act CAP 106 of 1964.
- The Local Council Courts Act Acts Supplement No 5
- Uganda Human Rights Commission Act CAP 24
- The Hindu Marriage and Divorce Act CAP 250
- The Marriage and Divorce of Mohammedans Act CAP 252
- The Marriage of Africans Act CAP 253

4.4 Effects of Early Initiation of Sex on Sexual Reproductive Health

Age at which an adolescent engages in sexual relations for the first time has an effect on their SRH outcomes. Inspite of the gradual increase in the median age, young people in Uganda start sexual relations early as reflected in the figure 4.2 below.

Figure 4.2: Trends in the Median Age at first sexual relations among Young People in Uganda



Source: UDHS 1988, 1995, 2001 and 2006, UBOS

The earlier sexual debut among females as the figure depicts can be linked to power relations that lead to coercion to sex. For example, the UDHS of 1995 indicates 23.4 percent of female adolescents were coerced into sex and this in itself affects the type of sexual partner a young person gets.

The type of sexual partner is a contributing factor to the infection and spread of HIV and other STI among young people. Several studies point out that some young people engage in sexual relationship with older people for economic favor. This was reported in Mubende and Rakai where traders and

salary earners formed the majority of sexual partners engaging with young girls (Neema, Nakanyike and Kibombo, 2004). Contrary to female adolescents who receive economic favors, their male counterparts pay for the services. Data from the 2000-2001 UDHS reveal that young men were more likely than older men to pay for sex (2 percent for young men aged 15-24 years compared to 1 percent of men aged 35-54 years). High poverty levels make it hard for adolescent girls to afford some of their basic needs, making sexual relations exchange for material gains more tempting.

4.5 Effects of poor Sexual Reproductive Health on the Development of Young People

The level of young people's development can be measured by their educational attainment, health and economic state. Health and education are important ends in themselves as well as means to reducing poverty as shown in figure 4.3 below. They are also core assets in human capital. Young people's education reduces child mortality directly through the ability and desire to obtain, understand and act on health related information, but also indirectly by increasing their respect and empowerment in within the family and outside family decision making (Green and Merick, 2005). Teenage pregnancy and childbearing are widespread in Uganda although the rates are gradually reducing. They are both causes and effects of poverty. According to Lloyd (2005), the potential channels through which they are linked include:

- Poor education outcomes for both the mother and her child, including dropping out of school and less schooling for the child,
- Lower or altered consumption patterns of the mother's immediate and extended family for rearing the child
- Lower labor force participation by the young parents, with less opportunity to contribute to household income
- Poor health outcomes for the young parents and their children, such as susceptibility to HIV infection that progresses to AIDS, higher risk of obstetric complications leading to likely maternal death and morbidity and low birth weight for the child.
- Reduced acquisition of social capital through reduced community participation and greater chances of divorces or single parenthood.

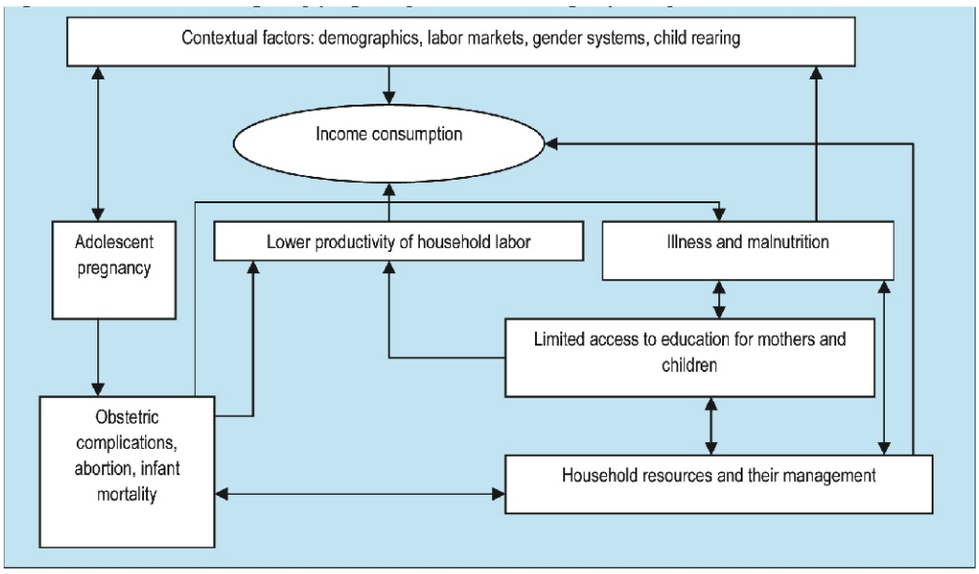
If adolescents are given proper health care, proper education and empowerment to their sexual health, they may not transfer poverty to their children. Educated girls are less likely to marry early and get pregnant, more likely to have correct and comprehensive knowledge of Sexual and Reproductive Health and have healthy children when they become mothers.

4.6 The Uganda-Global comparison of Teenage Fertility Rate

Uganda is one of the countries in the world with the highest teenage pregnancy and this is partly linked to early marriage and early sexual relations as sshown in figure 4.4 bel. Twenty percent of the adolescents in the age group 15-19 are currently married, 35 percent of the young people in the aged 20-24 years give birth before 18 years, and the number of births per 1000 girls in the age category 15-19 years is 159. The poor reproductive health practices have partly begotten negative health and

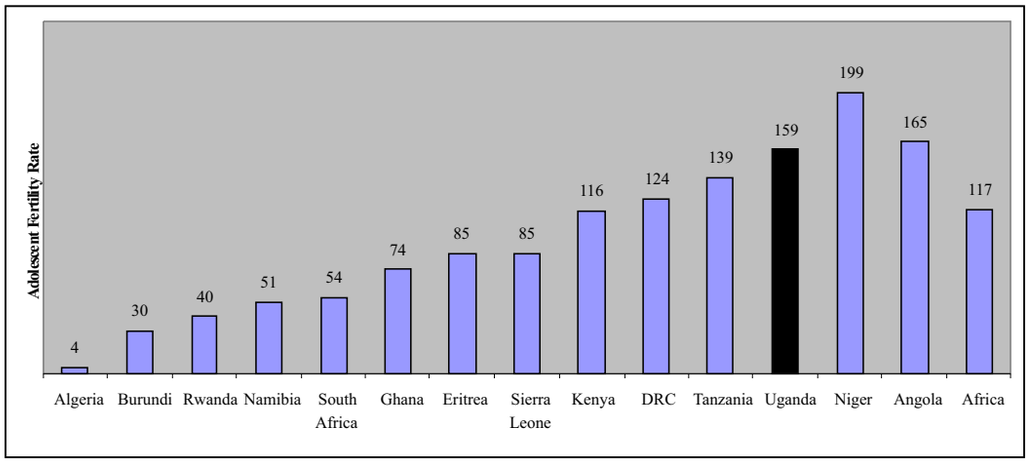
educational results. For example, 128/1000 children die before reaching the 5th birthday and Uganda takes 19th position out of the 128 countries with currently known childhood mortality rates, per capita income is only US Dollars 460, life expectancy is 53 years, 14 percent of infants are born with low birth weight (below 2500 grams), 16 percent of children under five years are underweight and 36 percent are wasted (UNICEF, 2011).

Figure 4.3: Channels linking early pregnancy and childbearing to poverty



Source: Greene and Merrick (2005)

Figure 4.4: Comparison of Adolescent Fertility Rates (per 1000 girls aged 15-19 years)



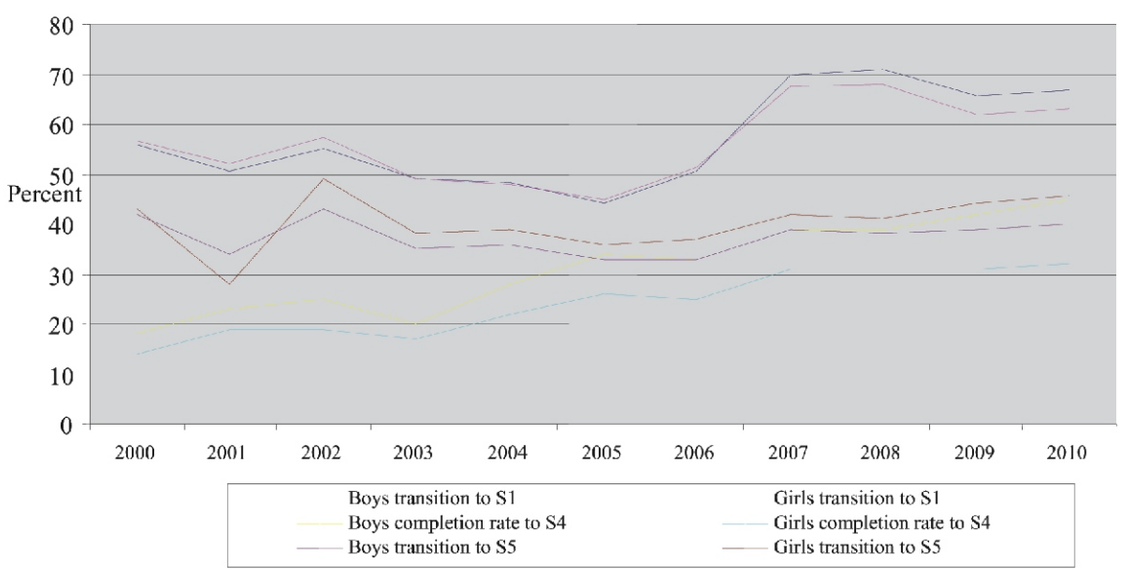
Source: WHO, 2009

Data from UNICEF (2010) indicate that literacy rate is high among males (89%) and females (86%), the transition rate to senior one (S1) and completion of senior four (S4) among adolescents is generally low. This is inspite of high expectation from the adolescents: 70 percent expected to complete secondary or higher education. The main thrust for lack of transition to S 1 and completion of S4 is financial difficulty attested to by nearly 67 percent of the adolescents. There has not been a

significant change in the improvement in the transition from P7 to senior one and completion of S4 since 2000 as the figure overleaf suggests.

More efforts should be taken by the Government of Uganda and the development partners to ensure that the transition and completion rates improve, lest the country risks not attaining skilled labor. High level of school drop-out will also lead to high early marriage, high fertility, high HIV/AIDS infection and prevalence, and this will lead to spiral of poverty among the population.

Figure 4.5: Trends in Schooling among Young People in Uganda



4.7 Knowledge and Practices of Sexual Reproductive Health

Knowledge and practices on Sexual and Reproductive Health is important if the SRH needs of the adolescents are to be addressed. In Uganda, 96.9 percent of the currently married adolescent females and 99.1 percent of the males know of at least one contraceptive method. However, the practice does not reflect knowledge. For example, only 11.4 percent of the currently married young women used contraceptive, and 8.3 percent used the modern method. More information shows that only 31.0 percent of young women (15-19 years old) had comprehensive knowledge about HIV/AIDS with a slight increase to 32.9 percent among those aged 20-24 years. The other aspect of concern is that 53.8 percent of the married young women do not discuss family planning with their husbands; and yet 51.7 percent have access to radio messages about on Sexual and Reproductive Health issues (UDHS, 2006).

A number of social, cultural and economic factors contribute to the above behaviors that predispose the young people to increased S&RH risks. Lack of access to RH information and services is often due to cultural and social norms and economic barriers that limit the level of capacity and willingness in communities to address S&RH issues. The other negative cultural contributor is rooted in the

gender differences and disempowering relationship. In Uganda, the young people are not free to use contraceptives, including condoms to prevent HIV infection. There is s till a general feeling among the young people that contraceptives can block the uterus, can lead to palpitation, dizziness, pills make people weak and therefore it is safer to get pregnant. The other societal feeling is that the role of a woman is to produce children (Nalwadda, 2010).

4.8 Strategies put in place by the Government

The government of Uganda recognizes the importance of young people in development. To this end, it has put strategies and programs in place to addresses their reproductive health needs. All these are put in different policy documents spelt out in Table 5.

Table 5: Government Policies on Adolescent Sexual Reproductive Health

Document	Goals, Objectives and Strategies
National Adolescent Health Policy 2000 and 2006	Goal: Mainstream adolescent sexual concerns in the national development process in order to improve their quality of life and standard of living. Objectives: • Provide and increase availability and accessibility of appropriate, acceptable, affordable quality information and sexual reproductive health services for adolescents • Influence positive behavioural change among adolescents • Influence individuals, community and leaders to support adolescent and sexual reproductive health • Provide policy makers and other key actors in the-social and development fields, reference guidelines for addressing adolescent health concerns. • Create an enabling legal and social-cultural environment that promotes provision better health information and services for young people. • Protect and promote the rights of adolescent to health education, information and care. • Promote the involvement of adolescent in conceptualization, design, implementation, monitoring and evaluation of adolescent health programs. • Promote adequate development of responsible health related behaviour amongst adolescent including relations based on equity and mutual respect between genders and to sensitize them to such gender issues as they grow into adulthood. • Provide legal and social protections of young people especially the girl child against harmful traditional practices and all forms of abuse including sexual abuse, exploitation, trafficking and violence. • Train providers and reorient the health system at all levels to better focus and meet the special needs of adolescents. • Advocate for increased resource commitment for the health of adolescent in conformity with their numbers, needs and requirements at all levels. Conformity with their numbers, needs and requirements at all levels. • Improve the capacity of local institutions in research, monitoring and evaluation of adolescent health needs and programs and to promote dissemination and utilization of relevant information to create, awareness which influence behaviour amongst individuals, communities, providers and leaders concerning adolescent health. • Promote co-ordination and networking between different sectors and among Non Government Organization/Youth Securing NGOs working in the field of adolescent health. • Promote intervention built on capabilities and resources of youth.

National Development Plan (2010/11 - 2014/15)	**Vision:** • Have A transformed Ugandan society from a peasant to a modern and prosperous country within 30 years **Objectives:** • Integrate population factors and variables at various levels of development planning • Promote improvement in the health status of the population. • Enhance Competitive skills building and human capital development • Promote positive health seeking behaviour. • Reduce the unmet need for family planning. **Strategies:** • Advocate for affordability, availability and accessibility of quality health services • Ensure that established population groups have functional and competitive skills and are increasingly participating in education, training and functional literacy programs. • Ensure that communities and individuals use available health service. • Enhance Competitive skills building and human capital development. **Intervention descriptions** • Promote awareness among men, women and communities on their roles and responsibilities in Sexual Reproductive Health and rights. • Promote the strengthening of youth friendly Sexual and Reproductive Health services. • Advocate for linking of Reproductive Health and HIV/AIDS programs and calling for increased budget allocation for RH. • Advocate for adherence to RH rights especially for women and girls including gender-based violence.
National Population Policy (2008)	National Population Policy first adopted in 1995 was revisited ten years after realizing some key issues needed to be addressed. The policy links population issues with broader development issues, such as Reproductive Health and HIV/AIDS; gender empowerment, especially women's higher education and capacity to make informed decisions that positively influence their reproductive health; responding to reproductive health needs of women that reduces their vulnerability to morbidity and mortality; and the role of communication and advocacy in promoting RH and rights such as family planning and HIV/AIDS prevention.
Guidelines for mainstreaming Gender in Reproductive Health (2007)	Ministry of Gender, Labor and Social Development under Gender Mainstreaming addresses the RH issues. It addresses the following: Family planning information and services; pre-natal, safe delivery and post-natal care; prevention of abortion and promotion of post abortion care; prevention and management of STDs and HIV/AIDS; prevention and management of infertility; screening for cervical and breast cancer; promotion, protection and support of breast feeding; discouraging bad practices, such as female genital cutting.
Health Sector Strategic Plan III 2010/11-2014/15 (undated).	The objective is to reduce perinatal, neonatal, infant and maternal mortality and morbidity. The plan tends to strengthen adolescent sexual and reproductive health services by integrate and implementing AS&RH in school health programs; increase the number of facilities providing adolescent friendly sexual and reproductive health services.

4.9 Conclusion:

Uganda's young people constitute a very high percentage of the country's population and would be the source of human capital development. Despite this potential, young people face the risk of HIV infection, sexual coercion, unfair gender relation and very high school drop out, early teenage pregnancy, and low level of contraceptive utilization. The government of Uganda should therefore

implement the national reproductive health policy, the 2008 population policy, and mobiles resources to protect, develop and sustain the quality of adolescents. Financing programs that target young people should be given priority, otherwise the existing RH policies from different ministries such Ministries of Health, Gender, Labor and Social Development, Finance can serve as guiding framework.

4.10 Policy Recommendations:

1. The government of Uganda must be guided by the principles enshrined in the population policy document of 2008. Respect for the rights of young people should be guaranteed. They should access better health services, education and be free of poverty. These poor conditions are responsible for early sexual debut that lead to STI/HIV infection, early pregnancy, poor health, poor nutritional status and ultimately leading to low of human capital formation.
2. Access to adolescent sexual reproductive health information should be guaranteed. Sexual and Reproductive Health education be taught at schools, provided by religious institutions, parents, peers, radios, newspapers, community and opinion leaders, and politicians.
3. Different communities should be sensitized about the danger of risky cultural beliefs, such as wife beating, female genital mutilation, and early marriage. Development partners such as UNFPA and WHO should provide financial and technical assistance to the local organizations such REACH in Kapchorwa district that are engaged in the promotion of healthy sexual and reproductive health behaviors.
4. The government of Uganda should train health workers with skills of SRH of young people and be deployed in rural areas where the majority of the adolescents stay.
5. There should also be legal frameworks that restrain the sexual abusers of young people.
6. More finances should be injected in SRH promotion. The financial resources can come from the government of Uganda as well as international organizations.

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CHAPTER FIVE

EMERGING SEXUAL AND REPRODUCTIVE HEALTH ISSUES

5.1 Introduction

This chapter focuses on the emerging sexual and reproductive health issues in Uganda. It brings to the fore the salient matters that have not been given adequate attention and yet have a great impact on the sexual and reproductive well being of Ugandans. The chapter starts off by discussing the debilitating effects of alcohol and drug abuse on individuals and the country as a whole. It uses statistics from Butabika National Referral Mental Hospital's Alcohol and Drug Unit as a case. This chapter also discusses the emerging issue of multiple concurrent sex partners as an obstacle in the fight to prevent the spread of HIV/AIDS. It concludes by saying there is need to have an innovative communication strategy capable of reversing the current rising HIV/AIDS prevalence figures. The Health Sector Strategic Plan of the Ministry of Health notes that forty three percent (43%) of new infections in the country occurred among people in long term relationships calling for an increased focus on HIV prevention among couples and other high risk groups such as Commercial Sex Workers(MOH,2010). Among the other salient issues is obstetrics fistula which falls in the area of safe motherhood. The latter is defined as the state of ensuring all women receive the care they need to be safe and healthy during pregnancy and childbirth. Involved in this effort of safety is the need to have access to a full range of quality, affordable sexual and reproductive health services, especially maternal care and treatment of obstetrical emergencies to reduce maternal death and disability according to the Interagency Gender Working Group (IGWG, 2011).

5.2 Access to and Use of Information on STI including HIV/AIDS:

The level of awareness on HIV/AIDS in Uganda is quite impressive at over 90% according to findings from documents review of the Delivery of Improved Services for Health (DISH) Projects (2008).Most people, including the youth and adolescents, know about HIV/AIDS, its modes of transmission and available preventive options. However, according to surveillance reports from the Aids Control Program, over 80 percent of new HIV infections are through sexual intercourse.

RHU Gulu Branch providing Outreach services to clients.

However, the downside is that this high awareness level has not translated into the successful prevention of the spread of HIV/AIDS. Uganda's prevalence rate now stands at 6.5% (Sherard, 2008) and available information shows that infection rates are now higher among the married couples. One of the explanations for this is the practice of having many sexual partners concurrently which raises the risk of infection.

5.2.1 Multiple concurrent sexual partners

There are a number of reasons as to why Ugandans are engaging in multiple concurrent partnership as pointed out in a pilot study undertaken by Panos Eastern Africa for Panos GAP(2011).Among the reasons advanced include: long absences from home in the migrant labour system, female vulnerability, ease of opportunity and social cultural factors. Women are particularly singled out as active participants in the phenomenon because they stand to benefit things like cash, material resources, social status, sexual satisfaction, love and security.

5.2.2 The Communication gap:

The gap in communication has been identified as an emerging issue especially after realizing the best weapon in the fight against the spread of HV/AIDS is prevention through the dissemination of relevant information to the general public. The realization and belief that HIV/AIDS can be successfully prevented than cured has had a plethora of communication strategies adopted over the years but there still appears a lacuna in the manner of delivery. What is beginning to emerge from all these studies on HIV/AIDS prevention is that people seem not to be heeding the call to engage in safe sex behaviors, the communication strategies were meant to elicit from the intended targets. This therefore begs such questions: Are Ugandans no longer scared of dying of HIV/AIDS? Are the social or economic pressures so much so that risky sexual behavior is the lesser of the two evils of poverty and social failure?

While listing possible reasons as to why people engage in multiple sexual relationships, there is a danger of ignoring the undercurrent that is yet to be given the appropriate attention it deserves. First of all, freely discussing sex and sexual matters honestly and candidly in our bedrooms is more or less taboo (Neema and Bataringaya: 2000). It might have been mentioned in passing but the issue of sexual satisfaction or the lack of it looms big on the question of having multiple sexual partners which has been identified as one of the channels through which HIV/AIDS is being abetted to spread unabated. Any communication strategy being sought in the effort to prevent the spread of HIV/AIDS needs to creatively target opening up among couples and encouraging that private communication in bedrooms. While a communication strategy is important in helping the fight on the spread of HIV/AIDS, Uganda as a country faces other reproductive health challenges especially in the area of safe motherhood.

5.3 Safe Motherhood

It has been estimated that every year, on average, over half a million women die in pregnancy or childbirth, and a further 1.4 million barely survive life-threatening complications in developing countries(Mehta and Maggie et.al:2007). Five major causes of maternal death have been identified as: hemorrhage, sepsis, hypertensive disorders of pregnancy, unsafe abortion and obstructed labor. This final cause—obstructed labor—is principally responsible for obstetric fistula, a devastating injury sustained by women during childbirth.

According to UBoS (2006) Demographic and Health Survey figures in Uganda, an estimated 2.6% of women of reproductive age (15-49 years) had experienced obstetric fistula. Based on the population of women of reproductive age from the most recent census, this equates to a national prevalence of over 142,000 women. When the numbers are added up, an estimated 3.5 million women are suspected to be living with the condition.

5.3.1 Obstetric Fistula

During prolonged obstructed labor, the head of the fetus, compresses the soft tissues of the mother's vagina, bladder, and rectum against the maternal pelvic bones. The impacted tissues of the mother's vaginal wall sustain pressure necrosis, slough off, and leave a hole between the vagina and the bladder (vesico-vaginal fistula) or between the vagina and the rectum (recto-vaginal fistula). If a prompt caesarean section to relieve the obstruction is not done, the fetus suffocates and dies.

5.3.2 The Socio-Cultural and Economic context of Obstetric Fistula

Obstetric fistula that first presents as a medical condition is deeply rooted in women's social, cultural, and economic vulnerability. Previous studies in this area reveal that most women with fistula are young, poor, live in rural communities, and have low social status, little or no formal education and no political influence. Constrained by poverty and subservient roles in society, women face numerous barriers in accessing adequate health care:

Lack of knowledge to recognize pregnancy and labor complications; powerlessness to seek care; distance from facilities; lack of transport and poor roads; prohibitive costs of transport and health services; and low expectations of the care they deserve. Serious shortages of medical supplies and equipment, theater space, and particularly trained personnel, further undermine the

A patient undergoing examination at Mulago National Referral Hospital

timeliness and quality of the care they receive.

For the same socio-economic reasons, once they have fistula, many women are unaware that surgical treatment is available, or cannot access or afford the treatment. As a result, they often live with the condition for years or decades. Lastly, even basic repair services are unavailable in most developing countries where the capacity to treat fistula cannot meet the demand for services.

5.3.3 The Effects of Obstetric Fistula

As a result, of obstetric fistula, a girl or woman is left with uncontrollable leaking of urine and/or feces from her vagina, and constant and humiliating odor and wetness. Without treatment, women are frequently ostracized or withdraw from their communities out of shame. Some are rejected or abandoned by husbands and families. Many are unable to work or earn a living, driving them deeper into poverty.

5.3.4 The Challenges of ensuring Safe Motherhood:

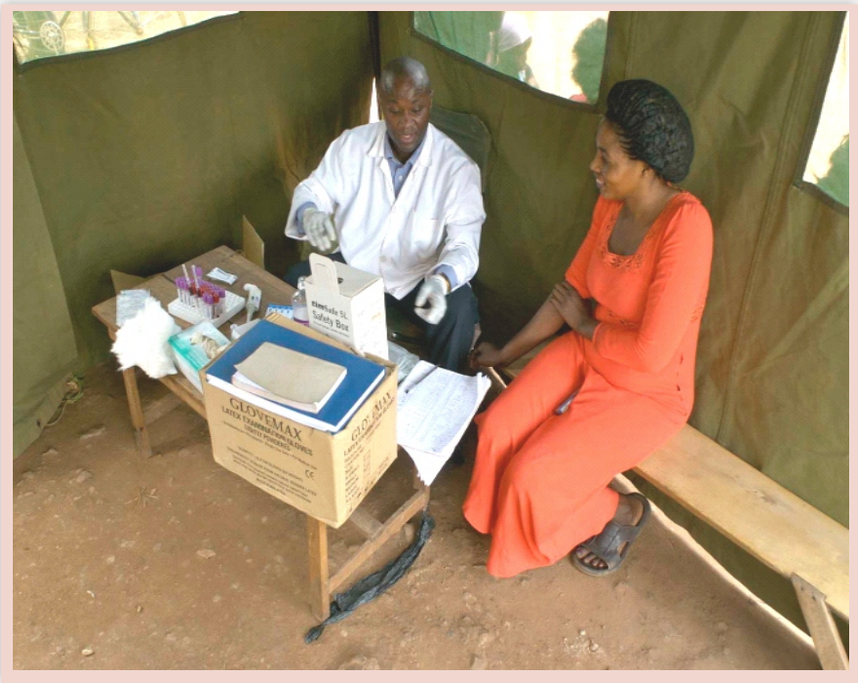
While it is true safe motherhood is not only about our glaring inability to prevent obstetric fistula, it is important for purposes of this report to give it the attention it deserves. Maternal mortality and disability is a phenomenon that points beyond our health systems and delves into our cultural and traditional norms in as far as gender relations are concerned. This can further be understood in the context of women's acute socio-economic vulnerability in developing countries like Uganda which denies them access to timely and appropriate health care. Women are powerless in most cases, to control their sexual and reproductive lives and to decide on their own healthcare; lack of education on pregnancy and child birth amidst poverty that makes it next to impossible to attain quality medical care. To add onto the plethora of challenges is the chronic shortage of qualified health workers and adequately equipped health facilities.

5.3.5 Antenatal Care (ANC)

ANC services are an important opportunity for women to receive information and counseling on pregnancy, labor, and delivery. It also provides the opportunity for healthcare providers to diagnose serious problems that women may face during pregnancy, such as pre-eclampsia. Officially, ANC is a free service in public facilities in Uganda; in private facilities, clients may have to pay. However, the challenge is whether the ANC services are helping in the fight against unsafe motherhood. Where the services are below expected quality, the challenges of safe motherhood continue to be exacerbated.

5.3.6 Constraints in Planning Facility Based-Delivery

According to findings by Mehta and Maggie et.al. (2007), the constraining factors in ensuring women delivered from health facilities were the lack of money, high transport costs and hospital charges. Insufficient knowledge about labor and fear of treatment at health facilities were mentioned as encumbrances as well. The reputation of nurses and mid wives regarding care for delivering women was not good and many women avoided health facilities due to fear of being insulted, verbally abused



RHU Health Worker providing FP service to a client at Mengo Kisenyi, Kampala

and humiliated.

Another practice was for women to avoid going to health facilities due to peer influence. Since the majority in the neighborhood never gave birth from such facilities, it would look preposterous if one went ahead to give birth from a health facility. Such cases and more, especially where discussing issues of pregnancy are considered taboo, keep women continuously vulnerable in as far as their sexual and reproductive health is concerned.

5.3.7 Institutional weaknesses in providing Safe Motherhood:

In a 2003 assessment on obstetric fistula, it was noted that because nothing was being done for fistula patients, they tended to keep away from hospitals and stay in the communities making it difficult for them to be identified. The situation eight years later seems not to have improved either. The baseline assessment on obstetric fistula report highlighted a number of constraints that hospitals face in attempting to treat women with the condition. Among these were: inadequate skills among health workers as well as a lack of equipment, medication, and other supplies. Doctors interviewed agreed they lacked the confidence and skills necessary to perform fistula repairs. Nursing staff cited a shortage of nurses, pointing out that one nurse would be expected to look after 70 or more patients (Kiapi, 2004).

Eight years ago, the cost of repairing obstetrics fistula was on average 300,000 Uganda shillings (US$150), a price that is beyond the reach of most patients. Even the 40,000 shillings (US$20) that rural hospitals charge is too high for many people. Patients complain that even when the treatment is free, they incur expenses in the form of gifts to "motivate" medical personnel.

5.3.8 What can be done?

Efforts to prevent fistula, and to promote maternal health overall, can be significantly strengthened by utilizing the testimony of girls and women to develop effective recommendation and interventions. Appropriate policies and interventions rely on solid evidence of the socioeconomic and cultural contexts within which mothers die or are left severely disabled without the prospect of treatment or

rehabilitation. Once this effort is taken seriously, Uganda should be among the countries soon to consider obstetric fistula an affliction of the past.

5.4 Access to and Use of Family Planning:

The need to access family planning services arises especially in light of the need to have manageable numbers of children. Managing a country's population should start from the smallest unit of administration which is the family. Once numbers in the family can be adequately managed through the provision of easily accessible and user-friendly family planning services, it becomes easier to plan nationally for population whose number is manageable.

5.4.1 Early Marriages:

One of the factors that affect population growth rate is the proportion of people that get married and their age among others. By marrying early in life, chances are high that the number of children such a couple will have will be high, income levels low and the incidence of poverty exasperating. More so with the incidence of obstetric fistula not receding, it is likely to affect a poor household.

5.4.2 Why Early Marriage occurs at all

Available literature indicates that young girls get married early not out of their own volition but it is brought upon them by their socio-cultural setting. In this domain we have the desire by parents to have cattle as dowry in order to help the males in the family also marry, during famine, girls are exchanged for food, those who get pregnant out of wedlock are forced to marry the one responsible for the pregnancy, poverty looms large in all this.

5.5 Conclusion:

A nation's most important asset is its citizens who need to be mobilized and supported in their efforts to ensure there is holistic development in all their spheres of life. The Government must be seen to prioritize the health concerns of its citizens by adequately funding the health sector to enable the purchase of badly needed drugs and equipment, infrastructure development, training of more health workers and ensure an enhanced pay structure specifically for health workers. Uganda's sexual and reproductive health concerns can appropriately be managed where there is commitment from both the policy makers and implementers. More specialized training can be funded for health workers such as in the case of obstetric fistula repair, which is currently lacking. Meanwhile, the effort to prevent the spread of HIV/AIDS should seek to address the issues regarding communication gaps among the most vulnerable groups. In all this, there should be as much participation as possible with the concerned communities for the intended interventions to have meaningful impact.

5.6 Policy Recommendations:

1. While a country with an unhealthy population jeopardizes its development efforts, it is important that health workers are attracted, motivated with attractive packages

and retained in the health sector to offer this vital service.

2. The communication strategy on the prevention of the HIV/AIDS calls not only for a holistic approach but should attempt to address the basic issues in marriage by encouraging the traditional/cultural input of dealing with intimate matters.
3. For purposes of ensuring service delivery in remote and hard to reach and work in areas, a policy to motivate and encourage service providers in such places should be put in place. The policy could look at having benefits like housing, water, electricity, transport or even food basket benefits and allowances.
4. Girls and women need fistula repair services that are available, accessible and affordable. There should be fistula repair centres set up and publicized as government trains more health personnel in this area. Expanded accesses to fistula services are required to reach those in need. Referral systems managed by local authorities, communities and all concerned groups can mobilize transport or funds or both to help the affected persons reach health facilities for remedial medical action. Also recommended is that repair services must be provided free.
5. What can be done today is to start a vigorous health education campaign through outreaches in the most vulnerable communities. Health educators need to involve men in their communities if the outreaches are to have impact and avoid resistance. Visual aids like videos depicting some graphic details can have a far greater impact on the psyche of viewers.

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CHAPTER SIX

THE ROLE OF FAMILY PLANNING IN SOCIO-ECONOMIC DEVELOPMENT

6.1 Introduction

Family planning is sometimes used in the wrong way, as a synonym for birth control, though it often includes birth control, family planning concerns with when a couple chooses to have children and how well they wish to space those children. It is most usually applied to a female-male couple who wish to limit the number of children they have and/or to control the timing of pregnancy (also known as spacing children). Family planning may encompass sterilization, as well as abortion. On the contrary birth control is narrower in scope and aims to prevent unwanted pregnancies. The Family planning association of Uganda formed in 1957, now known as Reproductive Health Uganda (RHU) pioneered the organizational provision of family planning services in Uganda. The association has in the past put much emphasis on vertical family planning campaigns, but has now made a strategic shift towards Integrated Sexual and Reproductive Health and Rights.

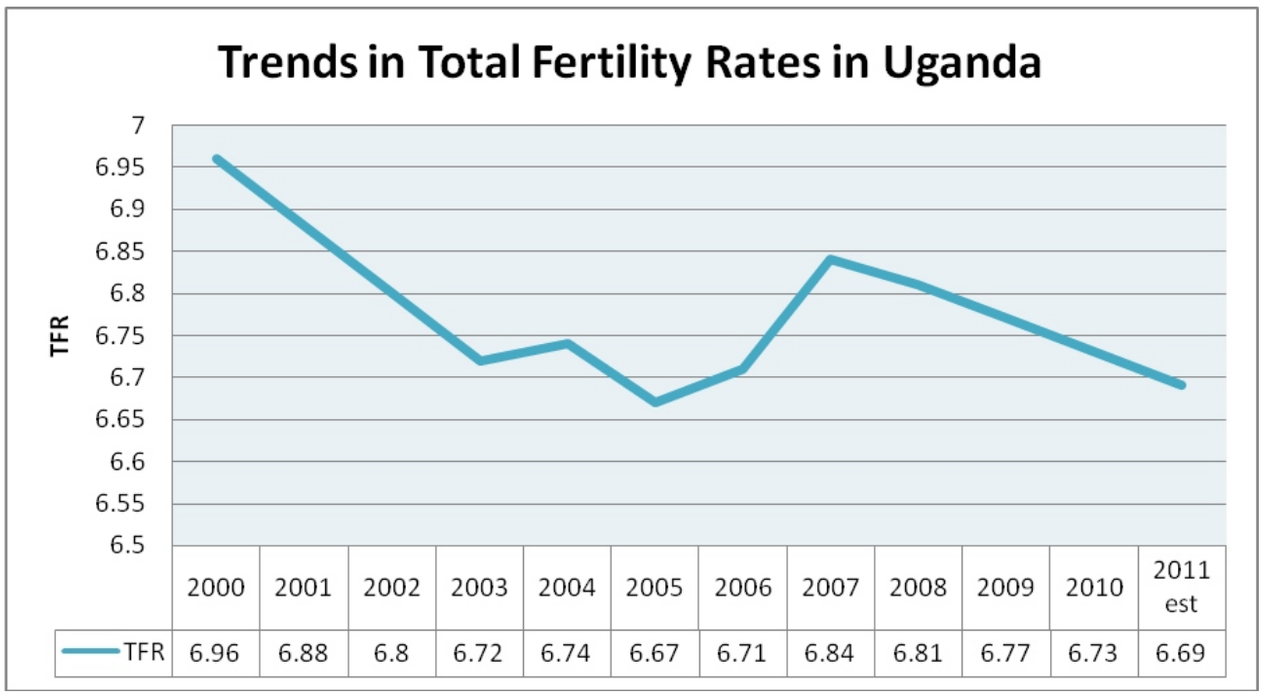
The concept of family planning draws its relevance from the Malthusian theory. Malthus a 16th century British political economist and demographer in his essay "The Principle of Population" argued that human population increases exponentially due to the natural urge to procreate, while food supply can only increase arithmetically. This he thought would create a real danger of starvation, famine and slow socio-economic development. The resulting mismatch between population growth and food production would in the end result in chronic food insecurity, poverty and slowed socio-economic development in the affected nation. Malthus concerns still provide the theoretical underpinning for the need for family planning today. Family planning is in no doubt important for economic and social sustainability; it allows couples to have children when they need them and to have the number of children they can manage. Improving the availability and effectiveness of family planning services in the developing world is one of the best ways to stem population growth and achieve sustainable socio-economic development. Experts have predicted that unchecked exponential population growth will add about 3 billion more people to the planet in the next 50 years, they note that the planet today has already surpassed its natural carrying capacity, and there are few options left to extend that capacity. If population growth is not controlled, this could result in a significant population and socio-economic crisis.

6.2 The Contextual Relevance of Family planning in Uganda

Uganda's population growth estimated at a rate of 3.2% is one of the fastest in the world. The population grew from only 5 million persons in 1948 to 24.2 million in 2002 . In 2010, the population was estimated to be around 32 million persons, and is projected to reach 55 million in 2025 and 130 million in 2050 if the current growth rate is not checked . The high growth is in part, because Uganda has a total fertility rate (TFR) of 6.7 (Figure 6.1), making Uganda only second to Niger in the world

rankings. This represents one of the highest total fertility rates in the world with an estimated 50% of the population being economically unproductive and dependent , this has major implication to socio-economic development. In a land locked country like Uganda, the implications can be dire as more resources will be channeled to supporting the high dependent population at the expense of savings and investments necessary to drive economic growth. This has also the effect of stretching the resources needed to deliver social services to a population growing faster than the delivery capacity of the nation which will impact on the quality of life of the people.

Figure 6.1: Trends in Total Fertility Rates in Uganda, 2000 - 2011



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011 est
TFR	6.96	6.88	6.8	6.72	6.74	6.67	6.71	6.84	6.81	6.77	6.73	6.69

Promoting the use of contraceptives for both birth control and child spacing is one of the key interventions the government and development partners have adopted in Uganda. Recent survey results indicate increases in contraceptive use in many sub-Saharan African countries, this notwithstanding the fact that Africa is the only region in the world that has not realized a contraceptive revolution leading to fertility decline. In Uganda the fertility rate appears to have stagnated at 6.7 over the last nine years in spite of the sustained efforts guided by the National Population Policy (1995) and the new National Population Policy and Action plan 2010 which have increased the contraceptive prevalence rate (CPR) from 24% in 2006 to 33.4% in 2010 .

6.3 The Policy Framework and Trend in TFR

The Government of Uganda through the National Population Policy and Action Plan, 2010, has prioritized family planning services and set the agenda to integrate population growth management interventions into national and sub-national socio-economic development frameworks. This strategic agenda calls for improved prioritization of population management initiatives such as provision of

family planning and reproductive health services. The budgetary allocation for Family Planning services was increased in FY 2010/11to 28% from 12% of the Health Sector budget . In spite of the good policy commitments, there is political ambivalence in implementing the family planning programs characterized by inconsistent messages from senior officials and political leaders, this together with other factors have undermined efforts to achieve the policy objectives. For example while Uganda under the 2008 population policy planned to increase the CPR to 40% by 2010, including RH commodities in 80% of health units; and provide emergency contraceptives in 60% of health units, observations show that, the increase in CPR is skewed towards the highly educated career women professionals and urban dwellers, who may be motivated by career demands and economic pursuits rather than the need for small size families. The majority rural and less literate women folks appear to show the opposite trend in TFR. The gains from the one end are being undermined from the other side of the divide which explains why Uganda's TFR appears to have stagnated at 6.77 in the recent years. Despite the efforts invested towards family planning and increasing contraceptive prevalence, population modeling studies indicate a danger that fertility rate will continue to stagnate over the next 30 years, other modeling studies however paint a more optimistic picture, that remarkable gains leading to TFR of 2.2 can be achieved over the next 30 years if family planning uptake increases to 65%. This positive outlook requires a radical rethink of the entire policy structure to address the salient factors that have impacted on the success of family Planning programs in the country. These factors can be summed as Political, Economic, Social and Cultural in Nature.

From the economic point of view poverty is a major factor in Uganda's high fertility rate, while no studies have been done to make a direct link between poverty and the high fertility rate, the most poor rural communities of Uganda have the highest TFR, with the war torn North and North eastern Uganda registering the highest TFR in the country. Anthropological evidence points to the fact that in such poor communities children are regarded as a means of economic insurance especially in old age , to these communities, there is safety in numbers. Secondly conflicting political statements from leaders has created a contradiction between policy and practice in policy implementation. This puts to question the level of political commitment at both high and low levels of government to address the problem of high TFR. Thirdly children are a means of social security and having or lack of them determines the level of respect and position one is accorded in society. Couples consider children a security for marriage, a means to attain bragging rights in the community and the more children one has the more respect they draw from the community. The culture of bride price appears to be at the heart of the demand for children, in words of Mr. Otim Boniface a trader in Lira Municipality "*….the worthy return for the bride price paid to get a wife is children, the more the children the more satisfying the return…*" This sentiment is shared across Uganda's society even among the elite members of society.

The public pronouncements from some of Uganda's leaders pledging to offer rewards for whoever can produce a given number of children only helps fan these sentiments. Finally the demand for children is driven by cultural factors and social beliefs which favor large families and put emphasis on

preserving and furthering lineage, high fertility rates are therefore a security against high child and maternal mortality that would otherwise disseminate a family line or name. In general these factors have prevailed partly as a result of a large population living in rural areas, low levels of socio-economic development, high levels of infant and maternal mortality and the social and cultural values that glorify large family sizes for self preservation. These factors together with the greater focus on women and less emphasis on the role of men in family planning underline the short comings in the current policy and practice which targets the elite women, puts more emphasis on reduction of family sizes and less to address the underlying causes of high fertility, the motivations for child spacing, the lack of sufficient infrastructure to deliver family planning services in the rural areas and access factors leading to the low CPR among the rural women and men .

The above policy challenges translate into the large unmet family planning need among both the educated and the uneducated women. According to the UBOS 2009 statistical abstract, the unmet family planning need increased from 35% to 41% between 2000 and 2006. The Uganda demographic health survey (UDHS) of 2006 reported a contraceptive prevalence rate (CPR) of 24%, the recent findings from the 2009/10 national panel survey put CPR at 33.4%. CPR refers to the percentage of married women who are using any method of family planning. At 33.4% CPR and with 41% unmet need for family planning, Uganda has the highest level of unmet family planning need in East Africa and the second highest in the world with less than half of women (47%) making the recommended four antenatal care visits.

6.4 Historical Factors leading to High fertility in Uganda

In general terms human fertility falls considerably short of its biological maximum, even those communities where contraception is not practiced, biological fertility rates are not attained due to cultural practices or physical impairments that constrain reproduction. Such constraints in Ugandan societies include prolonged breastfeeding coupled with long periods of postpartum abstinence as a means of birth spacing. In some areas, where high levels of sterility prevail, these further reduce fertility. Although there may be considerable regional variation, the mean length of postpartum abstinence period in Uganda before the 1980s which followed each live birth was commonly on the order of 1.5-2.5 years, due primarily to postpartum taboos on sexual relations. Alongside such taboos, other practices worked in support of this prolonged abstinence for instance in some cultures a woman was required to return to her native village at the time of the baby's birth and remain there until the child was 1 to 2 years old. Similarly, the practice of polygamy provided males with alternate sexual partners during the postpartum abstinence period. According to Caldwell and Caldwell, (1981) women who fail to observe this practice of postpartum abstinence in some communities may find themselves the target of scorn or ridicule by other members of the community. Although birth spacing in the African context results in a delay in pregnancy, the motivation has not been one of achieving a smaller family size. To the contrary, spacing appears to be used as a measure to reduce infant mortality and increase the probability that each child would survive through childhood and beyond. This is contrary to the Western view of family planning as a means of achieving a small family size, in

Africa birth spacing is a means of attaining the ideal large number of healthy children. This same sentiment seems to permeate the current use of family planning services in Uganda and it might be of great interest for policy makers and program implementers to examine the motivation behind the use of contraceptives for birth control in Uganda in order to explain the discrepancy between the growing CPR and the stagnated fertility rate.

Recent studies show a waning trend in postpartum abstinence since 1980s in Uganda and across Africa. This has been attributed to increased female education and urbanization which have affected patterns of union, making prolonged periods of sexual abstinence more difficult to observe. For example, with urbanization, returning to one's village for childbirth may be logistically or economically difficult. Some women reduce the abstinence period in an effort to keep their husbands closer to home (Lesthaeghe et al., 1992). The changes in postpartum practices therefore imply that any further decreases in TFR will depend on the scale of contraceptive use. This might also explain the increased CPR among the educated and urban women who seem to have shifted to the use of contraceptives as a means of child spacing in place of postpartum abstinence. It is important to understand the motivations for increased contraceptive use, to determine the extent to which this is motivated by a desire to limit family size versus the desire to space children.

6.5 The Importance of Family Planning in reducing Maternal Mortality Ratio

Studies show that at least half a million women die each year of pregnancy-related causes. Ninety-nine percent live in developing countries; similarly the maternal health indicators for Uganda have generally remained poor in the last two decades . Over the period 1995-2000, maternal mortality stagnated at about 505 deaths per 100,000 live births. The estimated maternal mortality from the Uganda Demographic and Health survey is 435 deaths per 100,000 live births. To meet the MDG target, Uganda will need to reduce its mortality rate from 505 to 131 deaths per 100,000 live births by 2015. Over the last few years, the government has implemented a number of interventions aimed at improving overall maternal and child health care. However, data available on a few output indicators shows that although there was a general improvement in health performance over the year 2003/04, PEAP output indicators fell short of its targets. Considering that all process indicators available have fallen short of targets, meeting the goals of maternal mortality by 2015 requires an aggressive intervention program. In trying to reduce the levels of maternal mortality two likely approaches could be adopted. One approach is to reduce these deaths, by making pregnancy and delivery safer once women become pregnant; secondly, reduce the number of pregnancies through family planning. Family planning reduces maternal mortality in several ways:

1. For the individual, family planning reduces the number of times a woman becomes pregnant. A woman who has been pregnant six times has twice the risk of dying a maternal death as a woman who has been pregnant only three times.
2. Family planning reduces the number of unintended and unwanted pregnancies which are far more likely to end in induced abortion, and are far less likely to receive adequate prenatal care than wanted pregnancies. The potential for family planning to

reduce these deaths is very great.

3. At the national level, family planning reduces the number of pregnancies and births. Studies have shown that even without any improvement in obstetric care, a 10% reduction in the number of pregnancies will produce a 10% (or greater) reduction in the number of maternal deaths.
4. Family planning can be targeted to reduce the number of pregnancies to women in groups at increased risk of maternal death, that is women who are too young (<20), too old (>35 or >39), or women who are high parity (more than 5 previous births).

Studies in Bangladesh have shown that family planning is far more effective (in terms of preventing maternal mortality) to prevent births to young (<20) women than to prevent births to older women. The noted that whereas only 2.5% of the death and 2.1% of the births occurred to women older than 39, 32% of the deaths and 21% of the births occurred to women younger than 20; demonstrating the vulnerability of younger women to increased risk of dying in childbirth and during pregnancy. Secondly studies have also shown that obstructed labor is more likely to occur in early child bearing which can lead to increased disability like fistula. About 80% of patients with vaginal fistula are under 20 years old. Considering the challenges faced by African countries in improving obstetric care, it would be cheaper to prevent a majority of death by increasing the uptake of family planning as a control measure to reduce unplanned pregnancies and early pregnancies among young married and non married couples. These statistics show that the greatest impact of family planning on maternal mortality can be achieved with those women who are <20 years of age. While it is a sensitive issue in many cultures, delaying pregnancy by increasing family planning use among both married and unmarried women <20 could save many lives. In a country like Uganda where the average age of first sexual encounter is 16 and women provided nearly 70% of the farm labor force, reducing maternal mortality and risks of pregnancy related complications can have a profound effect on national productivity and socio economic development. Family planning is therefore an important factor in the success of national socio-economic development programs.

RHU Health Worker providing ANC services at comunity level

6.6 The role of Family Planning in Socio-Economic Development

Africa is the only region of the world which has not yet undergone a contraceptive threshold that can result in fertility decline; and a lot of debate has been going on about the implications to socio-economic development in Africa. To understand the relationship between family planning and socio-economic development we shall examine the factors affecting contraceptive use, and looking at a comparative analysis of why use has risen in some areas and not in others even within Uganda. The effect of family planning to socio-economic development in Uganda is dictated by key factors which include; the demand for children and the supply of contraception. Whereas improvements in socio-economic development elsewhere in the world has resulted in fertility decline, Uganda's high fertility rate can be explained in terms of the general African context where sustained high fertility can be viewed from the point of factors that inhibit economic development more generally. Sub-Saharan Africa in particular is considered as being different from the rest of the world in its support for high fertility. This stems from the unique features of social organization structures that are not easily modified by economic development. Some of these structures are so deeply embedded and immutable that high fertility will continue to persist unless specific interventions are carried out to ensure that these pro-natalist values and constraints can give way in the face of new socio-economic influences as was the case in Latin America. Among the factors that have contributed to sustained high fertility in Uganda are the large percentages of the population living in rural areas, low levels of socio- economic development, and high rates of infant and child mortality, patterns of social organization and deeply ingrained cultural values that maintain the demand for large families.

The lack of any empirical studies to examine the link between, the levels of per capita income, child mortality, educational attainment among adults, and the costs and benefits of having children makes it difficult to determine the actual linkage between these factors to fertility on the one hand and the role of family planning on socio-economic development in the Ugandan context. The Latin American experience shows that the association between these factors and fertility is not strong but nonetheless they were found to be important and indicated receptivity to smaller family sizes among particular groups. While countries like Kenya, Botswana and Zimbabwe have had substantial increases in contraceptive use, it still remains that the diverse nature of the linkages with socioeconomic indicators suggests that features of African social structures remain the important determinants of the demand for children (refer to figure 6.2). This is because of the high value attached to the perpetuation of the lineage; the importance of children as a means of gaining access to resources, particularly land; the use of kinship networks to share the costs and benefits of children, primarily through child fostering; and the weak nature of conjugal bonds are some of the factors that have inhibited contraceptive adoption and fertility decline in Uganda. While there is evidence that these factors are being affected by changing economic conditions in some settings, for instance changes in child rearing costs and educational aspirations, as well as deteriorating economic conditions, are resulting in increased conjugal closeness and shared decision making. Many of these changes are observable in urban areas and among the educated couples or populations that exhibit higher contraceptive prevalence.

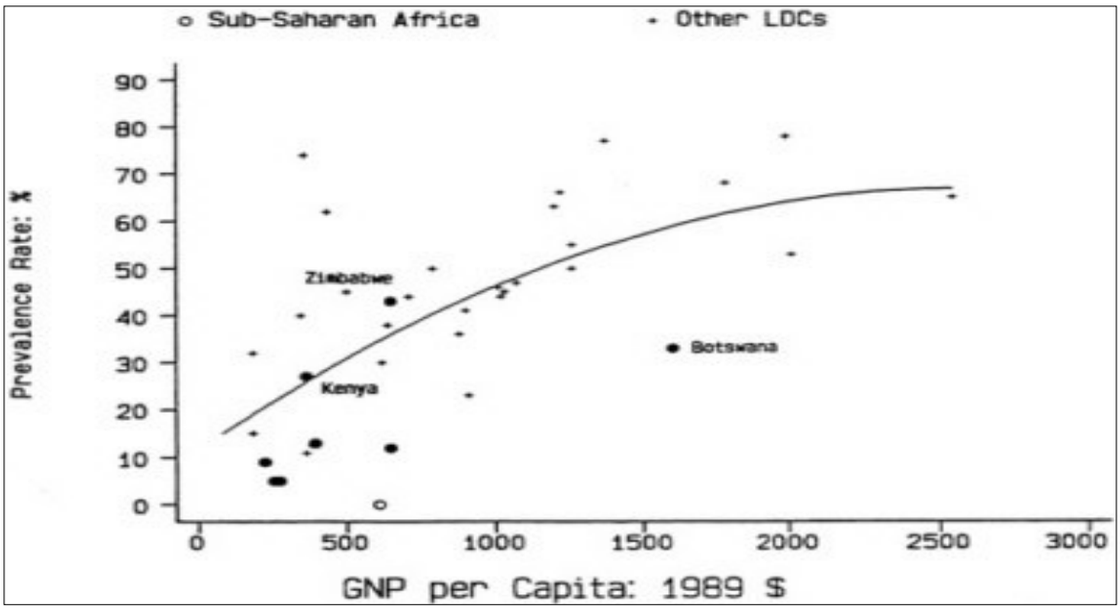
There is also an observed linkage between the implementation of family planning programs in Uganda and contraceptive use. The political commitment and the development of National Population Policy (1995) and the National Population Policy and Action Plan (2010) resulted in the increase in CPR from 15% to 24% in 2006 and 33% in 2010. It clearly shows that a supportive family planning policy framework can create an environment for the successful implementation of programs. While the private organizations can play a significant role promoting the acceptability of contraception in Uganda and make further investments in this sector, countries that have shown substantial increases in national prevalence all have well-developed public sector service family planning delivery programs.

Prof. Ephraim Kamuntu, Minister of State for Finance (Planning) officiating at the launch of the National Population Policy Action Plan accompanied by Ms. Sylvia Taleka, Board Member of NPA and looking on is Ms. Janet Jackson, UNFPA Representative.

An empirical examination of the recent Uganda National Panel Report by UBoS 2010 shows that among factors affecting modern contraceptive use, female education emerges as an important determinant of prevalence at the individual, regional, and national levels. Urbanization and the nature of religious affiliations are shown to affect schooling levels and thus contraceptive use. On the other hand Polygamy, a proxy for aspects of the high-fertility rationale, negatively affects contraceptive use where it is prevalent , lending anecdotal support for the view that African social organization continues to influence the demand for children and the trends in socio- economic development. A review of the theoretical relationship between variables linking fertility levels to a set of socioeconomic determinants: income per capita, child mortality, educational attainment among adults, and the costs and benefits of child schooling shows that (World Bank, 1984), growth in income levels is associated with lower fertility in a long run. This seems to contradict economic theory which suggests that fertility may rise with increase in income, because additional resources allow the family to afford more children. Adopting this view is however simplistic, because the income-fertility relationship is

complicated, mainly because changes in income are related to other aspects of economic development, which include educational opportunities, the participation of women in the work force, accessibility of consumer goods, and the value of time. The effects of income on fertility are both direct and indirect, and may show both negative and positive associations with fertility (Mueller and Short, 1983).

Figure 6.2: Contraceptive Prevalence Rate versus Per Capita GNP in Developing Countries.



Source: World Bank (1991), and Demographic and Health Survey data tapes for sub-Saharan Africa

There are competing hypotheses as to the effects of economic hardship on contraceptive use. On one hand, it has been argued that low levels of socioeconomic development (which are generally accompanied by low levels of female education, high infant mortality, and large percentages of the population living in rural areas) work to sustain the demand for a large number of children. On the other, it has been hypothesized that the current economic crisis in many parts of Africa may cause Africans to respond by altering their attitudes regarding family size and increasing their receptivity to family planning. Unfortunately there is very little empirical evidence on the effects of economic downturns to contraceptive use. However what is at the heart of the decisions regarding child bearing is the motivation for producing the children and the desired number of children. To the extent that these motivations reflect any of the above schools of thought will determine the actual actions couples take in responding to social economic factors.

6.7 Conclusion

While it is evident that the social support for high fertility has a strong influence on fertility rates, countries like Zimbabwe, Botswana, and Kenya have demonstrated that increase in contraceptive use can be achieved and future fertility decline is likely to occur if provision of family planning services, improvements in child mortality, and progress in female education is achieved. More

women getting into employment would also create an increased demand for contraception, reduce fertility and improve the socio-economic indicators.

6.8 Policy Implications and Recommendations

It will be essential to note the several factors that are relevant to achieve future increases in contraceptive use and reduce TFR: continued improvements in female education, reduction in infant and child mortality, and strengthening of family planning programs have been the traditional areas of emphasis, continued progress in these areas should provide the impetus for further uptake of contraception in Uganda. However on the basis of the evidence showing the strong influence of the social organizational structures and the motivations for child spacing among communities in Uganda, policy makers and program implementers will have to factor in interventions that will address the social structures and clearly address the motivational factors behind the current use of contraceptives and uptake of family planning programs. Specific policy recommends should pay attention to;

1. Strengthening the monitoring and trucking systems: Attempts to evaluate and quantify the family planning supply environment have been limited to date. Although some information is available at the national level, there is a need for sub-national data that indicates not only the quantitative but also the qualitative aspects of service delivery. Without this data, it is impossible to determine the effectiveness of family planning programs and the effect to socio-economic development in Uganda. Government needs to develop a functional mechanism for continuously monitoring and trucking as opposed to sporadic surveys so as to determine specific usage trends and socio-economic changes resulting from family planning intervention which in turn should be used to inform and refocus future policy and actions to promote socio-economic development and reduce the TFR.

2. Build in policy mechanism to include the social organization and motivational factors that determine the use for modern family planning services; The current approaches to family have put more emphasis on reducing family sizes and more recently to addressing issues of reproductive health as a strategy to increase the CPR, little has been done to understand the motivations for the use of modern contraceptive methods as a key to reducing fertility rates and the influence of social structures in Uganda on the demand for children. In this discussion it has been demonstrated that these have significant policy implications to the campaign to reduce TFR, there is need for all government institutions and development partners promoting modern contraceptive methods to examine the current philosophy driving the family planning approaches and design policy interventions that will address the motivational and social organizational factors in order to achieve a positive influence towards reducing fertility rates.

3. Strengthen the infrastructure and networks for delivery of family planning services to address the unmet need; The significantly high differences in CPR between the urban and rural centers, the educated and uneducated women, the employed and the unemployed women demands a critical rethink of the service delivery structure to ensure increased availability of knowledge, contraceptive services and support systems in terms of counseling, infrastructure and supply of modern contraceptive services aimed at reducing the unmet need for family planning which currently stands at 41%. Government and programmers must integrate the local social organizational networks and use them to provide information and legitimize modern contraception.

4. There is need to mainstream family planning services into all socio-economic development programs; On account of the evidence from this discussion the link between the CPR and socio-economic development and the changes in the socio-economic environment can have a profound effect on the demand for and spacing of children which in turn will result in increased CPR. Government and development organizations should consider integrating family planning activities into all economic development programs like "Prosperity for all" programs, NUSAF and NAADS programs, as the best and cheaper way to increase the reach and use of contraception in order to create a positive influence on fertility rates from the resulting changing socio-economic environment.

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CHAPTER SEVEN

WHY POPULATION ISSUES COUNT IN DEVELOPMENT

7.1 Introduction

This chapter broadly discusses how population factors affect development by exploring the implication of population factors on development both globally and nationally. It further provides insight into the Ugandan scene, justifying why Uganda should position population issues at the heart of its development agenda. It focuses on the implications of the demographic projections to socio-economic development. The central question here is whether the rapid pace of population growth is in pace with the level of development and how this is likely to affect economic growth and poverty reduction in Uganda. Based on insights from the theoretical and empirical (cross-country) growth literature, and an assessment of the impact of household size on poverty and inequality in Uganda, it's important to understand how high rates of population growth and related population indicators are likely to undermine efforts to sustain economic development. The Population issues being explored in this chapter include: Population growth rate and size; Population age and structure and Population quality and productivity.

This chapter thus draws insights into the global and national background to population and development issues and highlights the importance of addressing population issues as fundamental to any development state. It also highlights key findings, conclusions and key policy implications as well as recommendations.

7.2 Global context:

Journalist Martin Wolf of the Financial Times has called population "the most important issue confronting humanity in this century." Important new books on the future of development have devoted significant attention to it. Debates about population policy continue to stir and columnists and academicians argue about what lies ahead if global population challenges are ignored. Population; the study of people using the tool of demography is now appearing across development discourse, with policy implications that reach far beyond family planning and reproductive health.

7.2.1 The World at 7 Billion: What does Global Population Growth mean for People and the Planet?"

By the close of 2011, the global Population will reach 7 billion. A world of 7 billion has implications for sustainability, urbanization, access to health services and youth empowerment. It is also an opportunity to renew global commitment for a healthy and sustainable world. Many of the world's social and economic problems can be directly attributed to population growth. Issues such as poverty, hunger, child mortality, insufficient health care and diminishing natural resources are a result of too

many people competing for limited or misdirected resources. The strain that this rapidly growing Population places on all the available natural and human resources and services is far too high for the needs of all citizens to be satisfactorily met.

7.2.2 Population Structure:

The composition of the Population age structure can have significant impacts on countries' stability, governance, and social well-being. Rapid population growth may make many developing countries more vulnerable to civil conflict, especially when combined with high rates of urban population growth and shortages of cropland. 80 per cent of civil conflicts between 1970 and 1999 occurred in countries where 60 per cent or more of the population was under age 30, and these countries are most likely to face autocratic governance.

7.2.3 Access to Social Services:

Many poor countries struggle to ensure access to health care, education, and economic opportunities in the face of rapid population growth. Governments are often unprepared to meet the needs of disproportionately large populations of young people that result from this growth. Studies have shown that Countries with the most rapidly growing populations are often also the least prepared; for example, Niger has the highest total fertility rates in the world, and currently has the third lowest registered Human Development Index and the third lowest adult literacy rate.

7.2.4 Food Security and Nutrition:

Per capita supplies of both fresh water and crop land are falling as population grows. The United Nations Food and Agriculture Organization estimates that 925 million people worldwide were undernourished in 2010. That number has increased by nearly 15 million between 2002 and 2007, and by nearly 77 million since then. Rapid population growth is intensifying food insecurity in parts of the developing world, particularly in Sub-Saharan Africa where some countries' populations are doubling and tripling every 30-50 years. Niger, whose current population is 14 million people and projected to nearly double to 26 million by 2025, is having 25 per cent of its population facing chronic food shortages. The situation in Haiti is even worse as 40 per cent of Haitian households face daily food insecurity; with 25 per cent of the population not affording the minimum 2,240 daily calories recommended by the World Health Organization. With one of the world's worst daily caloric deficits per inhabitant, the Haitian population suffers from widespread and chronic malnutrition. About 42 per cent of children under age 5 are severely or moderately stunted in growth.

Rapid (and unhindered) population growth is a significant factor in exacerbating food shortages in Ethiopia-the second most populated country in Africa-according to a 2003 report by the UN Emergencies Unit for Ethiopia. That year, 20 per cent of the population was dependent on foreign-supplied food aid. Of the country's current 77 million people, an estimated 12 million Ethiopians are facing serious threats of food insecurity and famine. With one of the highest birth rates in the world, Ethiopia's population is projected to increase by 20 million in the next 10 years and double by 2025.

7.2.5 Natural Resources:

Population growth is putting unprecedented and increasing pressure on vital natural resources, including crop land and fresh water. Today, around 2 billion people live in areas of water stress or scarcity, and this number is expected to rise. By 2035, around 3.6 billion people worldwide are projected to live in countries where water scarcity threatens public health and constrains food production and economic development. Water shortage is likely to grow especially acute in the Middle East and in much of Africa.

Dozens of countries already have reached alarmingly low levels of available cropland. Currently, 465 million people live in counties with less than 0.07 hectare of cropland per person the minimum cropland capable of supplying a vegetarian diet for one person. The number of people living in such critically land scarce countries-including Egypt, Bangladesh and Jordan is projected to increase to as many as 740 million in 2025.

7.2.6 Linking Population Issues to Development

This section explores how population issues count in development and justifies the need for putting population dynamics at the heart of any development agenda. The discussion is mainly based on a study, focused on a cluster of population variables including: Population growth rate and size; Population age and structure and Population quality and productivity. These variables are discussed in relation to the broader socio-economic development context, highlighting three key development indicators of per capita economic growth, poverty and inequality.

7.2.7 Population Growth versus Economic Growth and Poverty Reduction

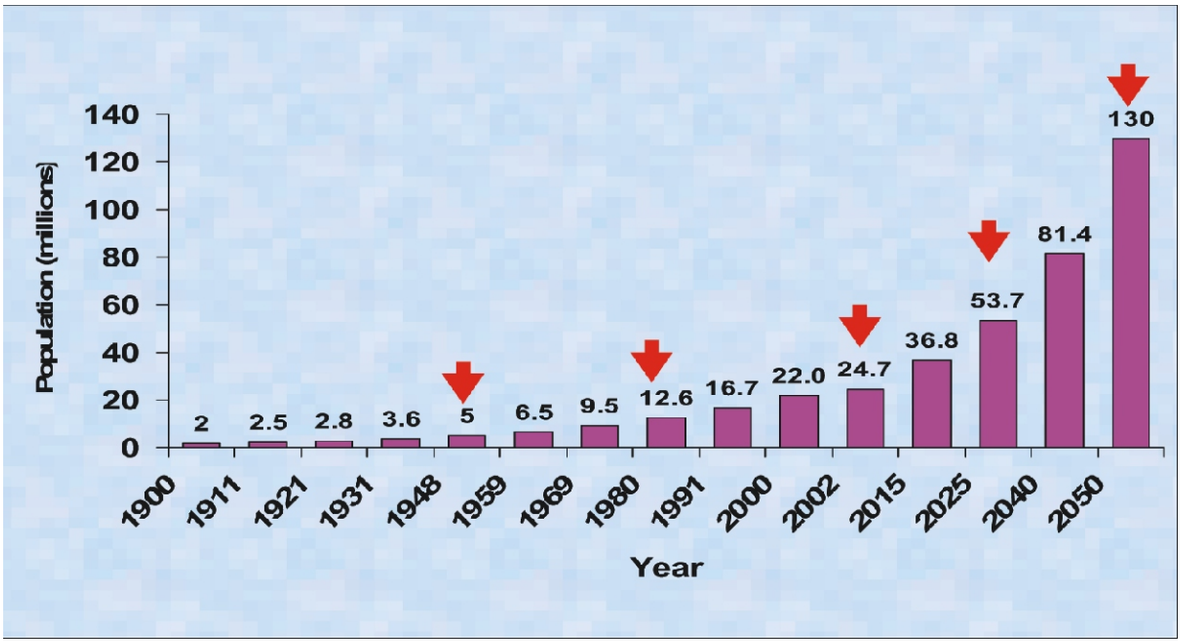
Before embarking on an analysis of the impact of population growth on economic growth, two preliminary considerations are critical to bear in mind. First, this analysis focuses on the impact of population growth on per capita economic growth (rather than overall economic growth), as this is the relevant indicator most responsible for changes in income poverty and many non-monetary measures of deprivation.

Secondly, we examine primarily the causality between population growth and per capita economic growth. It should be stated upfront that the two variables are closely related to each other, with causality going in both directions. Considering the causality from per capita economic growth to population growth it is likely that in the short term, high per capita growth in a poor developing country like Uganda will increase population growth, mainly through reducing mortality rates. This is the typical process of a country beginning a demographic transition which initially increases population growth rates. In the long term, however, it is very likely that per capita economic growth will reduce population growth rate as wealthier parents choose smaller families which will over time reduce the rate at which the population grows. This is well documented in richer countries and has been studied extensively theoretically and empirically (Becker, 1981).

7.3.0 National Context:

Ugandan's population has been growing rapidly over the last two and a half decades. Population grew from an estimated 16 million in 1991 to 24.2 million in 2002 and was estimated at 30.7 million in 2009. At a growth rate of 3.2 per annum (1991-2002), the population increased to reach 31.8 million in 2010 and is projected to reach 38 million in 2015. At this rate, a total of about 1.2 million people is added per year to Uganda's population (refer to figure 7.1 below).

Figure 7.1: Population Growth Projections for Uganda from 1900-2050



This rapid growth of population is largely attributed to a high fertility rate. Uganda is ranked among countries with the highest fertility levels in the world. Uganda's fertility rate stands at 6.7 children per woman. This has resulted in a young population as nearly half of the population in Uganda is under the age of 15, and the population will continue rising even if fertility declined. The demographic implications of this high population growth rate as seen in demographic projections from the United Nations Population Division based on the medium (and thus most probable) variant of the 2002 revision, reveal that; Uganda's population is expected to reach 103.2 million people in 2050. This projection is based on considerable fertility decline from presently about 7 to only 2.9 in 2045-50. Whether this will be achieved is far from certain and will likely depend on overall economic development in coming decades as well as government efforts to support a fertility decline. But even with this considerable fertility decline, population growth will still be over 2 per cent per year in 2045-50 and Uganda's population is projected to stabilize at a population of 200 million in the 22nd century.

The net effect of this population structure is a high level of dependency by the young and less productive population group on a small number of productive Ugandans. This will further create a built

in momentum for future growth.

The above described national population growth rate, size and structure have a powerful impact on the achievement of socio-economic development goals. Population growth is cited as a major contributing factor to shortages of agricultural land, the loss of forests and wetlands, and poverty (State of the Environment Report for Uganda, 2006/07). Over 80 per cent of Ugandans rely directly upon land, agriculture, and fishing for their livelihoods, but environmental indicators reveal trends of degrading agricultural lands, soil erosion, deforestation, drainage of wetlands, loss of bio-diversity, reduced range land capacity, and increased pollution.

The growth of urban populations throughout Uganda is placing particular stress on municipalities that already lack the infrastructure to meet current water and sanitation needs. Even in densely populated Kampala, 85 per cent of households rely on pit latrines. In these urban areas, flooding, poorly constructed latrines, and the resultant run-off of solid waste contaminate water ways and further exacerbate diarrheal disease outbreaks. As such if the trend persists, there shall be several challenges to future growth and structural transformation unless serious measures are taken to convert it into a population dividend.

7.3.1 Population Dynamics and Economic Growth:

While Uganda is unlikely to fall into a Malthusian trap of population growth leading to subsistence crises, growth theory suggests that there are serious negative impacts of high population growth for Uganda's per capita economic growth. In the most simple growth model, the Harrod-Domar model which assumes a production function with fixed proportions of factors and constant marginal returns to each factor, a one percentage point increase in population growth reduces per capita economic growth by one percentage point. This fixed proportions assumption is also the main criticism of the model which is the reason why it has been largely abandoned, although simple cross-country regressions reveal considerable support for this rather simple formulation

In Uganda, gross investment rates have been rising in recent years, mainly due to foreign savings transferred by aid. Domestic savings have stagnated as a share of GDP, Bevan et al. 2003. With this higher investment rate, it was possible to do some capital deepening as the growth in investment was faster than population growth. But had population growth been slower, much fast rates of capital deepening would have been possible.

Apart from the impact of steady-state population growth on economic growth, the age structure of the population can also matter for economic growth. The age structure of the population is largely determined by the stage of a country in the demographic transition from high to low fertility levels. A population such as Uganda's which has not yet entered the demographic transition has a very young population, comparatively few working age people, and even fewer elderly. This is born out by the dependency rate which shows that each working age person currently has to take care of more than

one dependent. Once it enters the demographic transition, the growth rate of the number of young will slow, while that of the working age population will remain high for some time. In that phase of the demographic transition, a country has a particularly low dependency burden.

Uganda currently has a broader base of the population at the base called the 'demographic burden' and the second phase a 'demographic gift'. The quicker the fertility declines in that phase, the larger the demographic gift. East Asian countries achieved a particularly quick fertility decline in the 1960s to 1980s and thus had a particularly large demographic gift and up to 50 per cent of their high per capita growth in these decades has been traced by Bloom and Williamson (1998) to the demographic gift. The mechanisms for high growth in the demographic gift phase relate to a higher share of workers to the total population (thus mechanically lifting per capita growth rates), higher savings rates in that phase as the working age population can build up capital and has to spend relatively few resources on the declining numbers of young people (and the still small number of elderly), and an investment-demand led boom for housing, infrastructure, and other adult population sensitive services (see Bloom and Williamson, 1998 and ADB, 1997 for a detailed discussion).

The demographic gift, particularly the high savings and investment rates, are not automatic but will depend on sound economic policy that ensures high employment. Also, it is clear that the phase of the 'demographic gift' will be temporary and it will be replaced by another phase of a demographic burden when the share of workers is falling and that of the elderly rising. But in the case of Uganda 'temporary' refers to a period of 30-40 years so that there is ample time to capitalize on this opportunity while preparing for the inevitable ageing of society that will begin in mid-century.

One variant of an endogenous growth model (e.g. Kremer, 1993) would, conversely, suggest that population growth might lead to higher growth as a larger population increases the number of innovators, and with innovations being a public good and thus available to everyone, would boost technical change in a society.

Focusing on the more plausible Solow Model estimates, they suggest that if Uganda succeeded in reducing its population growth rate from the current 3.2% to 2.4% (which, given the inherent demographic momentum, would only be possible in the medium term), its annual growth of per capita GDP could rise by between 0.5- 0.6%. If we additionally consider the impact of the population dynamics such a reduction would entail, per capita economic growth could increase by between 1.4 and 3.0 percentage points per annum as long as Uganda would be in the phase of the 'demographic gift' with falling population growth but still substantial labour force growth.

7.3.2 Population Growth and Poverty:

Kremer and Chen (2002) show theoretically and empirically that countries with high income inequality will have a high fertility differential between the educated rich and the uneducated poor. The few children of the educated rich will have a much greater likelihood to become educated themselves,

while the many children of the uneducated poor have a much lower chance. This then reproduces (and possibly worsens) inequality over time.

The clear policy implication would be to push for high education of the poor to allow them to break out of this poverty trap. Bourguignon (2001) has shown that the income distribution dynamics in Latin American countries are heavily influenced by differential fertility. De la Croix and Doepke (2003) additionally show that this mechanism of differential fertility is, according to them, a major reason why such large inequality appears to reduce economic growth. If the poor continue to have such large families, improvements in the (average) human capital of the population are difficult, and growth will be lower as a result.

Uganda has an unusually large discrepancy in fertility between the highly educated (3.9) and the women with low education (7.8) and is therefore particularly prone to this dynamic of the poor being caught in a demographic poverty trap which keeps poverty high, widens inequality and reduces economic growth. This is one of the reasons why Eastwood and Lipton have suggested that sustained reductions in fertility are one of the most important ways to generate pro-poor growth in countries such as Uganda (Eastwood and Lipton, 2001, see also Klasen, 2004). Of the general poverty dynamics literature, other things being equal, increased household size has been found to also consistently place extra burden on a household's asset/resource base and in general is positively related to chronic poverty (McCulloch and Baulch 2000, Jalan and Ravallion 1999, 2000, and Aliber 2001). A similar logic applies for increased dependency ratios, number of children (McCulloch and Baulch, 2000, Jalan and Ravallion, 1999, 2000). We examine such relationships in a Uganda specific environment in this next section.

Analyses of household surveys from many African, and other developing, countries have shown that larger families are generally poorer. We can see this is generally the case for Uganda, Angemi (2003) finding that large families, which consist of many dependent children, face an additional increase in poverty. A reduction in fertility of one child for example would reduce the likelihood of a household to fall below the poverty line by 3-4%. In addition, it would lower the dependency burden that would have the effect of reducing household poverty by another 1%. To some extent, such quantitative findings are also supported by Uganda's Participatory Poverty Assessment found that a large share of respondents saw large families as one of the most important causes of poverty (MoFPED,2003).

However, given the wealth of Uganda's household data, we have the potential to substantially add to this analysis by using panel data. In particular, we can establish if household size and changes in household size, relative to other important characteristics, are associated with movements into poverty, persistent poverty, or slower per adult equivalent growth levels. We notice that those households persistently below the poverty line have a higher average household size in both 1992 and 1999 (6.2 and 6.7 persons respectively, compared to an overall average of 5.48 and 6.07).

However, perhaps most noticeable are the changes in household size over the period. Households that move into poverty have household size increases of almost 35%, compared with a decline for those households that have moved out of poverty. Sachs, Radelet and Lee in ADB (1997) find a negative coefficient of population growth of 0.77 and a positive one for labourforce growth of 1.13 in a growth regression that also controls for many of the commonly found determinants of economic growth. They also test one channel of this link and particularly find that high dependency rates lead to greatly reduced savings rates, with further implications for economic growth. Households that are persistently poor (chronic poverty) are made up of children below the age of 15 years. There appears therefore, to be both a link between family size and static based poverty measures and an association between having larger families being more likely to be chronically poor, or move into poverty. Examining the aforementioned trends econometrically allows us to establish with greater certainty the statistical association between the aforementioned variables. Every person added to a household, it raises the likelihood of moving into poverty by 3% and being in persistent poverty by 2.5%, relative to never being poor. Therefore, although household size and changes in household size are important, other factors such as the region and the types of jobs have a greater marginal impact.

The importance of the impact of population growth is exemplified by other Uganda specific evidence. MoFPED (2004) projected that approximately 28% of the total population will live below the poverty line by the year 2013, assuming the current population growth rate of 3.2% p.a. In addition, Ssewanyana et al. (2004) found that the differential family size between rich and poor had an impact on widening inequality in Uganda (as shown by the impact of household size on poverty in Uganda has increased between 1992 and 2002). As a result, differential fertility and its effects are responsible for about 10-12% of the level of inequality in 1992 and in 2002, and for about 20% of the increase in inequality between 1992 and 2002. Moreover, there is a close linkage between large families and high infant and child mortality. Klasen (2003) found that high fertility is one of the main reasons for high child mortality in Africa. This has also been found to be the case in Uganda (MoFPED, 2002). In fact, the non-improvement in infant mortality is to a large extent driven by the strong fertility-infant mortality linkage (MoFPED, 2002). MoFPED (2002) find that a reduction of one birth (within a five year period) would reduce the risk of infant mortality by about 30%. It would therefore appear that high fertility is preventing improvements in the human capital of the Uganda's population.

7.3.3 Population Growth versus Quality:

At the household level, a large number of children are associated with low human capital investment in each child. This is what Becker called the quantity-quality trade-off. As a result of many children, households have fewer resources to send children to school, they have fewer resources to afford health care, and they have even fewer resources to save or invest in productive activities. This is not only true at the household level, but similarly applies to the provision of public services. In a high population growth environment, it is extremely difficult to extend services to the rapidly rising population. This is particularly the case for education and health services for children.

In 2000, there were about 9 million children for whom one would need to provide education to ensure universal primary and secondary education. By 2050, this number will have increased to over 34 million. At the same time, the tax base in a country with many young people is particularly small as only working age people are contributing to taxes (particularly income and consumption taxes). Thus in a high growth scenario, the state will be hard-pressed to assist parents in investing in human capital. Uganda embarked on a policy of free universal primary and secondary education and to date, the cost of this has mount rapidly and affected quality standards in the education sector. Options to extent it to tertiary education will not be fiscally possible given current population growth rates. Thus not only households, but also public services, will face a quantity-quality trade-off. If large families are poorer and worse off in terms of health and savings, the obvious question arises why families choose to have many children given that they appear to be well aware of these connections (MoFPED 2003). To some extent, they may not have chosen such large families if access to family planning is not available (at costs affordable to the poor).

Findings from the Uganda Demographic Health Survey (UDHS) show that the high unmet need for family planning is playing a role. It shows that the Wanted Fertility Rate (based on fertility preferences) stood at 5.3 in 2000, compared to an actual TFR of 6.9 (UBoS, 2001). This differential is particularly large among poorly educated women in rural areas. In addition, there are other factors that relate to the importance of children as 'investment goods.' Parents want a certain number of surviving children to ensure support as workers and in old age. Given the high prevailing infant and child mortality, they must, ex ante, plan to have large numbers of children to achieve their reproductive goal with a high degree of certainty. Ex post, however, many parents will find themselves with more surviving children than anticipated. So the number of children ex post is too high for many families.24 It may also be the case that social norms maintain high fertility rates even if everyone would be better off if all couples simultaneously chose smaller family sizes.

A third reason for having large families, despite the negative effects, are externalities. Parents can, to some degree, pass on the costs of raising children to others within the larger household (e.g. older relatives) and thus will have more children than is optimal, if they themselves had to incur all the costs. Parents will rationally adjust their fertility behaviour to prevailing patterns, particularly in the case of rationed resources where each child is like a 'lottery ticket' for access to scarce public and private resources. If all parents decided to lower the number of children, they would collectively be better off. Thus in this sense, high fertility persists due to a failure of coordination (in which case a family planning program can help to establish new norms).

7.3.4 Market Size Arguments:

As higher population growth will, in time, deliver a higher population, the question arises whether the resulting larger market will be a benefit for Uganda. In particular, a larger market is likely to increase foreign direct investments that want to service such a market. In addition, the scope for import-competing industries might be larger if the domestic market to be served is bigger. While these

arguments are of some relevance, a few points are worth noting. First, market size depends more on the purchasing power of the people, rather than their numbers.

There is a variant of this argument proposed by Kremer (1993). If innovations are a public good, a country with a large population innovates more and the country benefits as a result. While this might also have been a factor in explaining technological change over the very long haul (Kremer's time horizon is from 10 million B.C. to 1990), in today's world technological change does not primarily depend on population, but is much more related with the level of economic development, technology policies, etc. Moreover, technological development is increasingly a public good at the global level so that a country like Uganda can benefit from technological improvements elsewhere.

Having 100 million poor people is not much of an inducement to set up industries to serve that market. Second, with falling trade barriers all across the world, the relevance of a national market for foreign direct investment is becoming smaller as such markets can be well-served through imports. Third, regional integration provides another means to enhance market size and the East African Community is one such way to enhance the attractiveness for foreign direct investment and import-competing industries to locate in the region. Thus it is far from clear that there are great benefits to get from an increasing population size, especially given the costs involved.

7.3.5 Why Uganda must put Population Dynamics at the heart of her Development Agenda

Although Uganda has recently experienced excellent economic growth and poverty reduction, it currently has one of the highest population growth rates in the world which, due to the inherent demographic momentum, will persist for some time to come. The currently high population growth rate puts a considerable break on per capita growth prospects in Uganda.

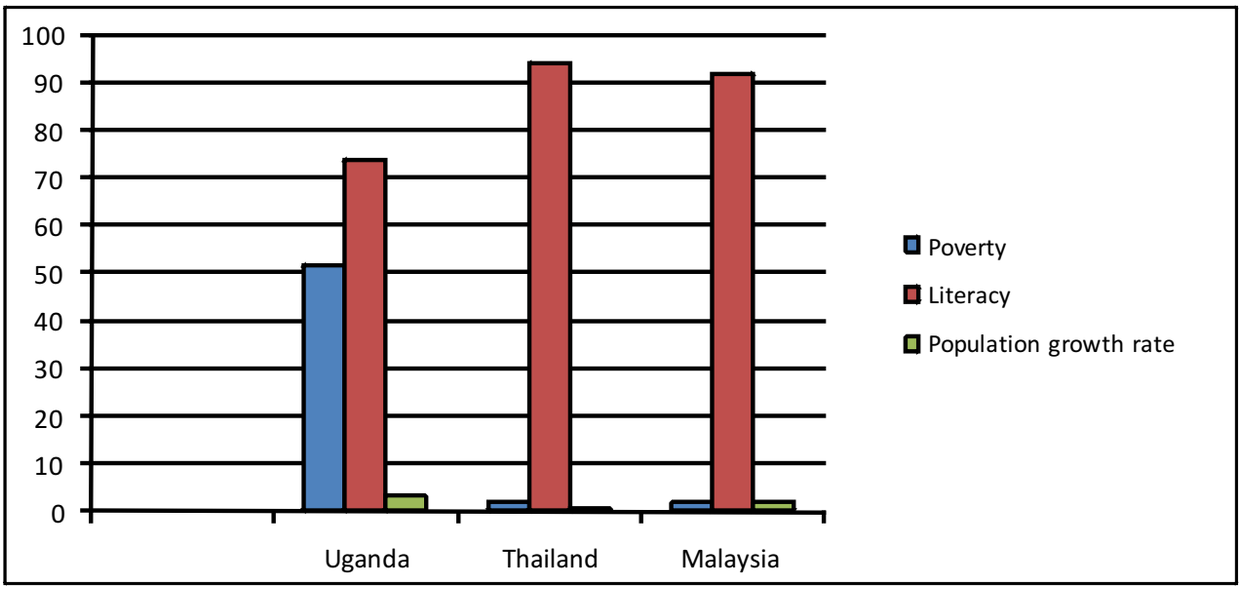
Moreover, it contributes significantly to low achievement in poverty reduction and is associated with households being persistently poor and moving into poverty. This is therefore likely to make substantial improvements in poverty reduction and per capita growth, very difficult.

The central question here is whether this rapid pace of population growth is likely to affect growth of per capita incomes and thus poverty reduction in Uganda. Based on insights from the studies undertaken and an assessment of the impact of household size on poverty and inequality in Uganda, it's important to understand how high rates of population growth are likely to undermine efforts to maintain and boost economic growth rates and poverty reduction.

7.4 Comparison of Uganda's Socio-Economic indicators with other Developed Countries

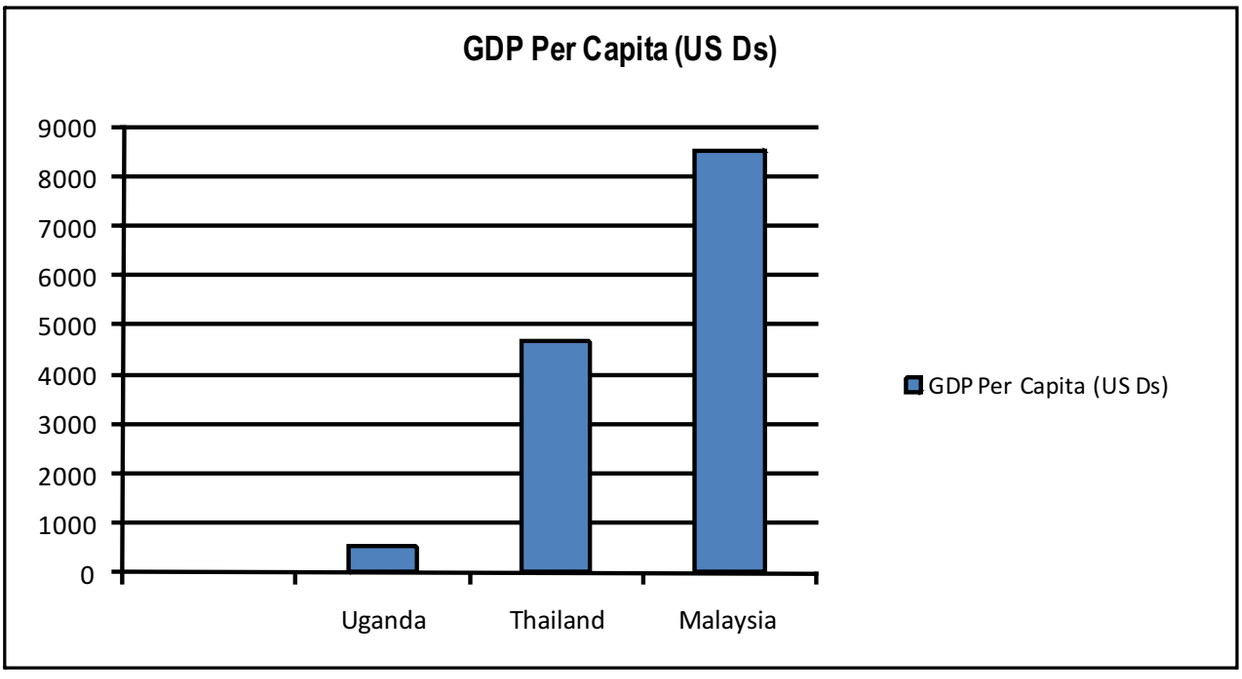
Figure 7.2 above confirms that there is a significant relationship between the population growth rate, poverty and literacy. The high population growth rate in Uganda exacerbates poverty and constrains household and Government efforts to provide quality social services such as education and health.

Figure 7.2: Comparision of Uganda's Population Growth, Poverty and Literacy levels with Thailand and Malaysia



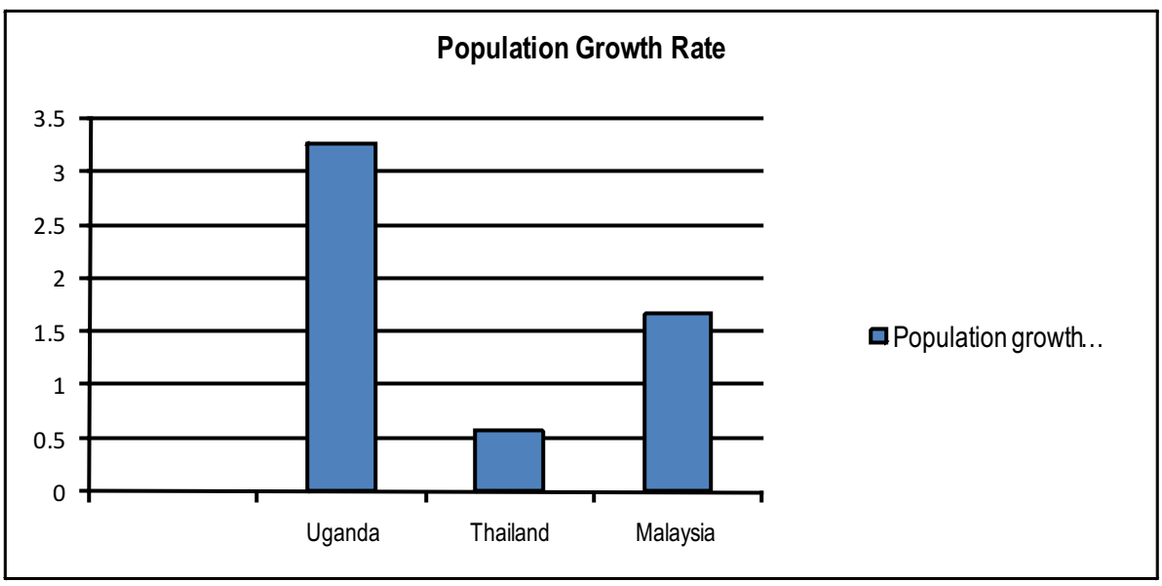
Source: World Bank (2000-2007):

Figure 7.3: Comparison of Uganda's GDP Per Capita with Thailand and Malaysia



Source: World Bank (2009)

Figure 7.4: Comparison of Uganda's Population Growth Rate with Thailand and Malaysia



Source: World Bank (2009)

Deducing from figure 7.2, 7.3 and 7.4 above and Table 9 below, we conclude that there is a strong relationship between population growth rate and GDP per Capita. A higher population growth constrains savings and investment not only at national but also at household level, thus lowering economic growth. Uganda particularly requires strong focus on family planning initiatives (including mostly information, education and the spread of a variety of low-cost reproductive and family planning services) to achieve a more rapid fertility decline given the slower expansion of female education and the low income growth.

Table 6: Socio-Economic Development Indicators of Uganda Compared with other Countries.

Indicator	Country						
	Uganda	Ghana	Thailand	Botswana	S.Africa	Gabon	Malaysia
GDP Per Capita (US $)	500	1,287	4,679	7,513	7,280	8,667	8,519
Life Expectancy (at birth) (years)	51.5	60	70.6	50.7	49.3	56.9	74.2
Literacy (UNDP Report 2009). (%)	73.6	65	94.1	82.9	88.0	86.2	91.9
Poverty (percentage of population with income under $ 1.25 per day) (%)(2000-2007)WB	51.5	30	02	31.2	26.2	04.8	<2
Income inequality (Gini coefficient) UN Gini index(2008)	45.7	40.8	42	60.5	57.8	N/A	49.2
Population growth rate World Bank(2009)	3.27	2.06	0.56	1.48	1.07	1.81	1.66
Unemployment rate (%)	5 (2002)	11 (2000)	1.2 (2010)	7.5 (2007)	23.3 (2010)	21 (2006)	3.5 (2010)

Source: World Bank Data

7.5 Conclusion

"People are a critical asset in development;" because they provide the human capital, a key factor for socio-economic development. This capital is contributed through production as well as consumption of the products of their labour. However, to achieve this, the country must possess a quality and healthy population. The problem with a fast-growing population is not the growth itself, but "rapid, unplanned growth". It is conceded that growth is a natural process that guarantees continuity of existence of living things. However, the process of growth is determined by important variables, which include; age structure,sex and distribution. The decisions and policies we make today, and the options available to young people, will ultimately determine the quality of the population in 2050. The impact of population growth on overall (not per capita) economic growth is neutral. Overall growth is entirely determined by the amount of capital available. In Uganda, gross investment rates have been raising in recent years, mainly due to foreign savings transferred by aid (domestic savings have stagnated as a share of GDP. With this higher investment rate, it was possible to do some capital deepening as the growth in investment was faster than population growth. Had population growth been slower, much faster rates of capital deepening would have been possible.

Among the most important factors affecting fertility levels are, in order of importance, female education, female employment opportunities, greater female bargaining power at the household level, higher incomes, good access to reproductive health services, and a family planning effort that tries to establish norms of smaller families and assists in making reproductive and family planning services available at low cost to everyone in society (e.g. Schultz, 1994, 1997; Summers, 1994; Murthi and Dreze, 2001, ADB, 1997; Pritchett, 1995).

The high fertility rates are not the cause of the security problems, but they complicate existing economic and resource challenges. Reductions in poverty depend in large part on finding innovative and integrated solutions to the complex population, health and environment problems affecting Uganda's poorest people. Meeting this challenge requires a multi-sector policy framework, with evidence from various disciplines feeding priority setting, planning and implementation.

In addition, there appears to be societal influences that affect fertility decline that are not well-understood, such as the role of the media that project positive images of small families. These factors are also the most important ones that ensured rapid fertility decline in East Asia, and the onset of the demographic transition in some of Uganda's neighbours, such as Tanzania and Kenya.

In the Ugandan case, there is also a strong impact of female education on fertility. As shown by the UDHS, women with no education have 7.8; those with some primary education have 7.3; and those with some secondary education or more 3.9 children (UBoS, 2001). This clearly shows that the impact of education on fertility is relatively small below completed primary education and some secondary education. Similarly, more educated women have better access to family planning information and services, have a much lower likelihood for teenage pregnancies (this is already true for girls with only some primary education) and have a lower 'unmet need' for family planning

services.

Here it is interesting to note that the desired number of children is at 5.9 for those women with no education, 4.8 of those with some primary education, and 3.8 with some secondary education. This suggests that the relatively small fertility difference between women with no and with some primary education is largely due to the unmet need for family planning services in the latter group. Higher incomes and greater urbanization also affect fertility levels. Moreover, greater female status and decision-making within the household is associated with reduced fertility levels.

As discussed in Klasen (2003), here Uganda is lagging behind with women having little control over resources and decision-making within the household. There is a remarkably strong linkage between high fertility and high child mortality. This suggests that parents in Uganda are replacing lost children and 'hoarding' children in anticipation of loss. Through its UPE policy, Uganda is already embarking on a strategy to promote female education. While this is likely to assist with fertility decline, it must be accompanied by great efforts to reduce drop-out rates, and particularly ensure completion of primary education and continuation to secondary education. As shown by the DHS and the 2002 household survey, there remain large persistent problems (UBoS 2002).

Reproductive and child health services are still quite inadequate and prevent families from reducing their number of children and investing more in each of them (MoFPED, 2001). Given that child mortality and fertility are so closely linked, it is critical to tackle the issue from both ends. Success in one area will then promote success in the other.

Measures to assist households with alternative ways to smooth consumption over the life-cycle would clearly assist in reducing fertility. Uganda national household survey indicated that almost two out of every 10 children were conceived against the parent's will. “Over 40 per cent of women conceive more children than they want because they have no access to contraceptives.

7.6 Policy Implications and Recommendations:

1. The Ugandan population does not in its current form possess the ingredients to stimulate effective demand and ignite socio-economic transformation and development. To believe that the current structure, quality, age and form of Ugandan population will foster socio-economic transformation is more of a myth than reality. Thus government must invest in the human capital development in form of education, widening opportunities for all, and elimination of all forms of inequalities, improve access to credit finance for people to start up Small Medium Enterprises (SMEs), open up avenues for people to access all forms of information to facilitate and improve their methods of production among other needs.

2. One clear policy implication is to push for high education of the poor to allow them to break out of this poverty trap. Income distribution dynamics are heavily influenced by

disparities in fertility among the rich and poor and this is a major reason why large inequalities appear to reduce economic growth. If the poor continue to have such large families, improvements in the (average) human capital of the population are difficult, and growth will be lower as a result.

3. Similarly, to improve on the competitiveness of the population, the Government needs to increase funding in education (formal and vocational) to improve on its quality, and increase both its local international competitiveness. . Through this the government will reap on its unit per investment on human capital in terms of remittances from labour exports and widened tax base.

4. In the longer term, policies that generate alternative old-age security arrangements (e.g. financial markets and the build-up of pension systems) are likely to help. It is no coincidence that South Africa's fertility decline appears to have accelerated markedly in recent years after a non-contributory social pension was introduced.

5. A concerted effort by the Government (similar to the effort to halt the spread of AIDS) to focus on the population question by providing an integrated approach and political leadership is needed to highlight the issues and coordinate solutions. As argued above, high fertility is often simply the result of a social norm resulting from a coordination failure. Government leadership can bring about a change in those norms that make a substantial contribution to lower fertility levels and increased demand for family planning services. Here the issue is not so much providing information about family planning options, which, according to the DHS, is very widely available, but increasing its acceptability through promoting norms of smaller families.

6. Access to contraceptives is a strategic need that the government should direct its resources toward availing and increasing access to acceptable services for reproductive health in that every woman in need of contraceptives gets access to it. By so doing, Uganda's fertility rate would decrease by 30 per cent and bring the average household from seven to four children per woman. “This would give women an opportunity to provide more for their children and Government to provide more quality services. If we spent more in this area, this would lead to a four-fold return on investment. Every dollar invested in family planning returns $3 (Talemwa 2010).

7. The demographic gift, particularly the high savings and investment rates, are not automatic but will depend on sound economic policy that ensures high employment. Also, it is clear that the phase of the 'demographic gift' will be temporary and it will be replaced by another phase of a demographic burden when the share of workers is falling and that of the elderly rising. But in the case of Uganda 'temporary' refers to a

period of 30-40 years so that there is ample time to capitalize on this opportunity while preparing for the inevitable ageing of society that will begin in mid-century. Uganda thus needs to exploit demographic windows of opportunity. Countries that have benefited from large populations have done so because their governments have invested in the population (education and training, health and skills-mix formation). In fact, some countries such as Malaysia, Irish republic and recently Mauritius have now advanced to what we call reaping from the demographic window of opportunity.

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GLOSSARY

Family Planning
Refers to the planning of when to have children, and the use of birth control and other techniques to implement such plans.

Birth Control
Refers to techniques used to prevent unwanted pregnancies

Contraceptive Prevalence Rate
Refers to "the percentage of women of reproductive age, married or living in union that use some type of contraceptive method.

Gini Coefficient
This is a measure of the difference between a given distribution of some variable like population or income, and a perfectly even distribution. It tells us how evenly the wealth is spread or distributed in the regions of the country

Growth rate
The rate at which the population is increasing (or decreasing) in a given period of time due to natural increase (or decrease) and net migration. The growth rate take into account all components of population growth, birth, death and migration.

Gross Domestic Product (GDP)
The sum value added by all resident producers in the economy plus any product taxes (less subsidies) not included in the valuation of output

Gross National Income (GNI)
This is Gross Domestic Product plus net receipt of primary income (compensation of employees and property income) from abroad

Human Development Index (HDI)
A composite index measuring average achievement in three basic dimensions of human development; Life expectancy, Adult literacy and combined primary, secondary and tertiary gross enrollment ratio and GDP per capita (a measure of decent standards of living.

Infant Mortality rate
The number of infants under one year of age per 1,000 live births in a given year

Life Expectancy
An estimate of the average number of additional years a person can expect to live based on the age-specific death rates for a given year.

Maternal Mortality Rate
The number of maternal deaths per 100,000 live births in a given year. A maternal death occurs during pregnancy or with in six weeks of delivery from any cause directly or indirectly related to the pregnancy or its management.

Total Fertility Rate (TFR)
The average number of children that would be born alive to a woman during her life time if she were to pass through all her childbearing years conforming to age-specific fertility rates of a given year. It is the most useful indicator of fertility


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APPENDIX

MAP 2: MAP OF UGANDA SHOWING CURRENT DISTRICTS

A: TRENDS OF SELECTED NATIONAL DEMOGRAPHIC, SOCIAL AND DEVELOPMENT INDICATORS FROM 2002 - 2010

Indicator	Year		
Demographic	**2002**	**2005**	**2011**
Total Population (million) (projection)	24.4	26.7	32.9
Total Male Population (million)	11.9	13.0	16.1
Total Female Population (million)	12.5	13.7	16.8
Total Urban Population (million)	3.0	4.0	4.9
Population Growth Rate (%)	3.2	3.2	3.2
Urban Population Growth Rate (%)	5.1	5.1	5.1
Population Density(Persons per Sq. Km.)	123	*134	*165
Health	**2002**	**2005/06**	**2009/10**
Infant mortality rate (IMR) per 1,000 live births	88	76	76
Under five mortality rate per 1000	152	137	137
Maternal mortality ratio per 100,000 live birth	505	435	435
HIV Prevalence rate (%)	6.4	6.4	6.4
Immunization rates for DPT3 (%)	72	85	85
Percentage of births delivered by a skilled provider (%)	39	42	42
Immunization rates against measles (%)	83	85	85
Total Fertility rate (TFR)	6.9	6.7	6.7
Children Age 6-59 months with Vitamin A deficiency (%)	27.9	20.4	20.4
Social			
Literacy rate (Aged 10 Years and above) (%)	70	69	73
Access to toilet facilities (% of Households)	83.8	88	91.3
Access to safe drinking water (% of Households)	60.9	68	73.8
Pupil teacher ratio (Primary School)	53	57	49
Pupil classroom ratio (Primary School)	87	72	68
Primary school Pupils with adequate sitting space (%)	-	64	-
Student teacher ratio (Primary School)	-	19	18
Student classroom ratio (Secondary School)	-	-	35
Economic			
Gini Coefficient (Inequality measure in household consumption)	0.428	0.408	0.426
Urban Unemployment rate (%)	12.2	6.9	9.5
Mean per capita consumption expenditure (Ushs)	26,663	40,550	47,150
GDP per Capita (US $)	280	370	-
Human Development			
Human development index	0.488	0.581	-
Life expectancy (years)	50.4	-	50.4
Percentage of population below the poverty line (%)	38.8	31.1	24.5
Human poverty index (%)	36.0	25.2	-
Gender Empowerment			
Gender Empowerment measure	0.549	0.583	-
Female Adult literacy rate (%)	59	58	61
Burden of Diseases			
Children age 6-59 months that are anaemic (%)	65	73	-
Prevalence of fever in Children under five years (%)	43.9	40.9	57.1

* *Population densities computed from projected population by UBoS*

B: TRACKING NATIONAL PROGRESS IN ATTAINMENT OF ICPD GOALS USING SELECTED INDICATORS (1CPD +15 YEARS) FROM 2000 - 2010

Indicators		Year of Data Collection and Analysis		
Mortality		**2000/2001**	**2005/06**	**2009/10**
Infant Mortality Rate per 1,000 live births		88	76	-
Maternal Mortality Rate per 1,000 live births		505	435	-
Life Expectancy (years)	Male	48.8	48.8	-
	Female	52.0	52.0	-
Education				
Gross Primary enrollment (%)	Male	130	118	121
	Female	124	117	120
Gross Secondary Enrolment (%)	Male	38.2	36.8	-
	Female	30.4	33.3	-
Percent Illiterate (age above 15 years)	Male	22.2	20.5	21
	Female	42.3	41.3	34
Reproductive Health-				
Births per 1,000 women aged 15-19 years		-	203	-
Contraceptive Prevalence (%)	Any method	23	24	24
	Modern Method	18	18	18
Unmet Need for Family Planning (%)		35	41	41
HIV Prevalence Rate 15-49 years (%)	Male	-	5.0	-
	Female	-	7.5	-
Women Age 15-19 that have began child childbearing (%)		31.4	24.9	24.9

C: TRACKING NATIONAL PROGRESS IN ATTAINING OF MILLENNIUM DEVELOPMENT GOALS (MDG +10) FROM 2001 - 2010

Millennium Development Goal (MDG)	Millennium Development Goal (MDG) Indicator	Progress since 2000				Progress towards MDG Target	MDG Target 2015
		2000	2003	2006	2010		
1. Eradicate extreme poverty and hunger	Percent of Population that is living below the poverty line	38.8	37.7	31.1	24.5	On track	28.0
	Poverty gap	10.0	11.3	8.7	6.8	-	-
	Percent of underweight children (moderate and Severe under 5 years)	22.8	-	20.4		On Track	12.5
2. Achieve universal primary education	Net enrolment ratio in primary education	84.0	90.0	81.8	83.2	On Track	100.0
	Literacy rate of 15-24 year olds	78.8	80.0	84.0	-	-	-
3. Promote gender equality and empowerment of women	Ratio of girls to boys in primary schools	-	*0.95	0.95	-	On Track	1.00
	Ratio of girls to boys in secondary schools	0.79	-	0.81	-	On Track	1.00
	Ratio of girls to boys in tertiary education	-	0.55	-	-		1.00
	Ratio of literate women to men 15-24 years	-	0.99	0.92	-	On Track	1.00
	Proportion of seats held by women in parliament	19.0	25.0	30.1	-		50.0
	Percent share of women in wage employment in the non agricultural sector	-	30.7	28.9	43.7		-
4. Reduce infant and child mortality	Infant mortality rate per 1,000 live births	88.4	-	76.0	-	Slow	31.0
	Under-five mortality per 1,000 live births	156	-	137	-	Slow	56.0
	Percent of 1 year old children immunized against measles	56.8	-	68.1	-	On Track	90.0
5. Improve maternal mortality	Maternal mortality ratio per 100,000 live births	505	-	435	-	Slow	131
	Percent of births attended by skilled health personnel	39.0	-	41.1	-	Slow	90.0
6. Combat HIV/AIDS, malaria and other diseases	HIV prevalence rate among 15-49 year pregnant mother	-	-	6.4	-	-	-
	Condom at last higher- risk sex among 15-24 years old	49.8	-	52.9	-	-	-
	Contraceptive prevalence rate among married women 15-49 years	23.0	-	23.6	-	-	-
	Proportion of 15-24 year old who have comprehensive knowledge of HIV/AIDS	28.0	-	32.1	-	-	-
7. Ensure environmental sustainability	Proportion of land area covered by THF forest	21.3	-	18.3	-	-	-
	Proportion of population with access to an improved water source (Urban)	87.0	84.0	86.8	92.2	On Track	100
	Proportion of population with access to an improved water source (Rural)	57.0	-	63.6	69.5	On Track	70
8. Develop a global partnership for development	Debt relief committed under HIPC initiative (US$ millions)	69.7	-	-	-	-	-
	Debt service as percent of export of goods and services	-	20.4	15.8	17.1	-	-

D: NATIONAL LEVEL SOCIAL AND ECONOMIC INDICATORS FROM 2005 - 2010

SECTOR	INDICATOR	YEAR	
		2005/06	2009/10
1. Education	National Literacy rate (%)	69	73
	• Male Literacy rate	76	79
	• Female Literacy rate	63	66
	Urban Literacy rate	86	88
	Rural Literacy rate	66	69
	Adult Literacy rate (%)		
	• Female Adult Literacy rate	80	8
	• Male Adult Literacy rate	58	61
	Enrolment in Schools:		
	• Primary School (million)	7.5	8.7
	• Secondary Schools (million)	0.9	1.5
	• Primary School GER (%)	-	120
	• Primary School NER (%)	84	83
2. Labour force and Employment	Annual Labour force Growth rate (%)	-	4.7
	• Male Labourforce Growth rate	-	4.7
	• Female Labourforce Growth rate	-	5.3
	Urban Labourforce Growth rate (%)	-	4.1
	Rural Labourforce Growth rate (%)	-	7.6
	Labourforce Growth rate by Age Group (%)		
	• 15-24 years	-	5.9
	• 18-30 years	-	6.7
	Labourforce participation rate (%)		
	• National	-	78.7
	• Urban	44.3	60.3
	• Rural	76.8	85.6

	Total Working Population (million)	9.3	11.0
	• Increase per annum (%)	-	4.2
	• Male Working Population Growth rate	-	3.7
	• Female Working population Growth rate	-	4.6
	Industry of the Working Population (%)		
	• Agriculture, Hunting	71.6	64.6
	• Sales	9.1	9.8
	• Manufacturing	4.5	6.0
	• Education	3.0	3.5
	• Transport and Communication	2.2	2.7
	• Others	8.9	12.4
	• Note stated	0.7	0.1
	Key Sectors of Employment (%)		
	• Primary Industry	72	66
	• Secondary Industry	5	6
	• Service Industry	23	28
	Unemployment rate (%)		
	• National	6.4	9.5
	• Urban	1.1	3.0
	• Rural		
	Youth Unemployment rate (%)	1.9	4.2
	• 15-24 years	4.4	5.4
	• 18-30 years	3.4	4.7
3. Health	Burden of Diseases (%)		
	• Malaria/Fever	56.3	52.1
	• Respiratory Infection	14.3	14.8
	• Diarrhea	4.1	3.1
	• Urinary Tract Infection	0.3	0.2
	• Skin Infection	3.2	1.6
	• Injury	2.7	2.7
	• Others	19.2	25.5

	Burden of Diseases for under (5 years (%)		
	• Malaria/Fever	-	57.1
	• Respiratory Infection	-	17.8
	• Diarrhea	-	6.5
	• Urinary Tract Infection	-	0.2
	• Skin Infection	-	2.5
	• Injury	-	1.1
	• Others	-	14.8
	Availability of Government Health Units within Communities (%)	6.7	14.3
	Proportion of Population using Mosquito nets (%)	16.8	41.1
	Proportion of Population using Mosquito nets by age groups (%)		
	• Under 5 year	18.7	44.3
	• 15-49 years	22.5	49.3
	• Below 18 years	13.9	36.1
	• Above 18 years	21.7	47.9
4. Economy	Population Living below Poverty (%)	31.1	24.5
	• Monthly Household Expenditure (%)		10.0
	• Urban Household Expenditure (%)		11.8
	• Rural Household Expenditure (%)		3.0
	Household Expenditure by Item (%)		
	• Food, Drinks and Tobacco	45	45
	• Clothing and Foot wear	4	3
	• Rent, Fuel and Energy	16	16
	• Household and Personal Goods	5	5
	• Transport and Communication	7	9
	• Education	10	9
	• Health	7	6
	• Other Consumption Expenditure	3	3
	• Non Consumption Expenditure	4	5
	Consumption Expenditure per Household (Ushs.)		
	· National	210,750	232,700
	· Rural	176,600	197,500
	· Urban	372,500	384,350

	Mean Per Capita Consumption Expenditure (Ushs.)		
	• National	40,550	47,150
	• Rural area	33,150	38,200
	• Urban area	81,450	97,750
	Population of Poor Persons (million)		
	• National	8.4	7.5
	• Rural area	7.9	7.1
	• Urban area	0.57	0.42
	Income Inequality (Gini Coefficient)		
	• National	0.408	0.426
	• Rural area	0.363	0.375
	• Urban area	0.432	0.447
	Poverty Status by Source of Income to Household by share of Population (%)		
	• Agriculture	57.3	51.5
	• Wage Employment	17.0	21.3
	• Non Agricultural Enterprises	18.1	20.4
	• Remittances	3.4	4.5
	• Others	4.2	2.3
	Average Monthly Household Income (Ushs.)		
	• National	170,800	303,700
	• Rural area	142,700	222,600
	• Urban area	306,200	660,000
	Average Monthly Household Income (Ushs.)		
	• Male Headed	170,300	336,900
	• Female Headed	106,200	226,300
	Average Income of Household by Education Level (Ushs.)		
	• No Formal Education	54,400	160,300
	• Some Primary Education	102,400	175,500
	• Completed Primary Education	141,100	293,100
	• Some Secondary Education	219,100	326,200
	• Secondary/Post Secondary Education	308,400	969,700

	Household Main Source of Earning (%)		
	• Subsistence Farming	49.2	41.8
	• Commercial Farming	2.7	3.7
	• Wage Employment	20.8	25.3
	• Non Agricultural Enterprise	19.0	20.9
	• Remittances (Transfers)	4.9	0.23
	• Others	3.5	8.1
5. Social	Households with Access to Improved Water (%)		
	• National	67.6	73.8
	• Rural area	63.6	69.5
	• Urban area	86.8	92.3
	Households by Type of Toilet Facilities (%)		
	• Pit Latrine	85.8	85.5
	• V.I.P Latrine	2.5	3.7
	• Flush Toilet	1.1	2.2
	• Bush/No Toilet	10.6	8.7
	Main Sources of Energy for Lighting in Households (%)		
	• Tadooba	70.6	66.2
	• Lantern	14.2	14.6
	• Electricity	10.5	12.1
	• Others	4.6	7.8
	Main Sources of Energy for Cooking in Households (%)		
	• Fuel wood	77.8	73.0
	• Charcoal	18.2	21.5
	• Kerosene	1.2	2.3
	• Electricity	0.2	0.6
	• Others	2.6	2.6

E: REGIONAL/SUB-REGIONAL SOCIAL AND ECONOMIC INDICATORS FROM 2005 - 2010

E1: KAMPALA SUB-REGION SOCIAL AND ECONOMIC INDICATORS FROM 2005 - 2010

SECTOR		INDICATOR	YEAR	
			2005/06	2009/10
1.	Education	Literacy rate (%)	91	92
		• Male	91	95
		• Female	90	90
		Primary School Enrolment GER (%):	-	110
2.	Labour force and Employment	Annual Labour force Growth rate (%)	-	5.9
		Unemployment rate (%)	8.3	11.4
3.	Health	Burden of Diseases (%)		
		• Malaria/Fever	-	44.6
		• Respiratory Infection	-	19.0
		• Diarrhea	-	0.8
		• Urinary Tract Infection	-	0.2
		• Skin Infection	-	0.8
		• Injury	-	2.5
		• Others	-	32.2
		Proportion of Population using Mosquito nets (%)	46.9	59.2
4.	Economic	Population Living below Poverty (%)	29.2	26.4
		Consumption Expenditure per Household (Ushs.)	462,550	475,500
		Household Expenditure by Item (%)		
		• Food, Drinks and Tobacco	30	30
		• Clothing and Foot wear	3	5
		• Rent, Fuel and Energy	20	25
		• Household and Personal Goods	7	6
		• Transport and Communication	13	15
		• Education	11	9
		• Health	4	2
		• Other Consumption Expenditure	4	4
		• Non Consumption Expenditure	8	6
		Mean Per Capita Consumption Expenditure (Ushs.)	109,200	131,600
		Average Monthly Household Income (Ushs.)	347,900	959,400
5.	Social	Households by Type of Toilet Facilities (%)		
		• Pit Latrine	85.2	87.4
		• V.I.P Latrine	4.6	7.6
		• Flush Toilet	9.1	3.2
		• Bush/No Toilet	1.1	1.8
		Main Sources of Energy for Lighting in Households (%)		
		• Tadooba	13.1	8.1
		• Lantern	20.5	15.6
		• Electricity	60.6	67.4
		• Others	5.7	9.0

	Main Sources of Energy for Cooking in Households (%)	5.8	2.4
	• Fuel wood	77.7	74.5
	• Charcoal	5.2	7.8
	• Kerosene	1.4	3.4
	• Electricity	9.9	11.9
	• Others		

E2: CENTRAL REGION SOCIAL AND ECONOMIC INDICATORS FROM 2005 - 2010

SECTOR		INDICATOR	YEAR	
			2005/06	2009/10
1.	Education	National Literacy rate (%)	80	83
		· Male	82	84
		· Female	78	81
		Primary School Enrolment GER (%):	-	113
2.	Labourfore and Employment	Annual Labour force Growth rate (%)	-	4.6
		Unemployment rate (%)	1.7	5.7
3.	Health	Burden of Diseases (%)		
		• Malaria/Fever	-	52.3
		• Respiratory Infection	-	15
		• Diarrhea	-	1.8
		• Urinary Tract Infection	-	0.1
		• Skin Infection	-	1.5
		• Injury	-	2.2
		• Others	-	26.3
		Proportion of Population using Mosquito nets (%)	16.4	38.4
4.	Economy	Total Population of Poor Persons (million)		
		Population Living below Poverty (%)	-	26.5
		Consumption Expenditure per Household (Ushs.)	253,800	291,250
		Mean Per Capita Consumption Expenditure (Ushs.)	51,650	67,450
		Average Monthly Household Income (Ushs.)	209,300	389,600
		Income Inequality (Gini Coefficient)	0.417	0.451
		Household Expenditure by Item (%)		
		• Food, Drinks and Tobacco	38	43
		• Clothing and Foot wear	3	3
		• Rent, Fuel and Energy	17	17
		• Household and Personal Goods	5	5
		• Transport and Communication	11	8
		• Education	10	10
		• Health	6	6
		• Other Consumption Expenditure	4	3
		• Non Consumption Expenditure	7	5
4.	Social	Households by Type of Toilet Facilities (%)		
		• Pit Latrine	90.4	75.9
		• V.I.P Latrine	4	10
		• Flush Toilet	0.6	14.1
		• Bush/No Toilet	5	0.0
		Main Sources of Energy for Lighting in Households (%)		
		• Tadooba	64.6	56.1
		• Lantern	17.6	8.6
		• Electricity	15.1	19.4
		• Others	2.8	5.9

	Main Sources of Energy for Cooking in Households (%)	70.2	57.8
	• Fuel wood	24.5	36.4
	• Charcoal	2.0	1.7
	• Kerosene	0.2	0.4
	• Electricity	3.2	3.7
	• Others		

E3: EASTERN REGION SOCIAL AND ECONOMIC INDICATORS FROM 2005 - 2010

SECTOR		INDICATOR	YEAR	
			2005/06	2009/10
1.	Education	Literacy rate (%)	64	68
		• Male	71	75
		• Female	56	60
		Primary School Enrolment GER (%):	-	126
2.	Labour force and Employment	Annual Labour force Growth rate (%)	-	6.9
		Unemployment rate (%)	0.7	3.0
3.	Health	Burden of Diseases (%)		
		• Malaria/Fever	-	53.9
		• Respiratory Infection	-	12.9
		• Diarrhea	-	3.7
		• Urinary Tract Infection	-	0.3
		• Skin Infection	-	1.8
		• Injury	-	2.9
		• Others	-	24.5
		Proportion of Population using Mosquito nets (%)	17.2	47.0
4.	Economy	Total Population of Poor Persons (million)	2.45	2.20
		Population Living below Poverty (%)	25.2	29.5
		Consumption Expenditure per Household (Ushs.)	178.900	193,400
		Mean Per Capita Consumption Expenditure (Ushs.)		
		Average Monthly Household Income (Ushs.)	155,500	171,500
		Income Inequality (Gini Coefficient)	0.354	0.319
		Household Expenditure by Item (%)		
		• Food, Drinks and Tobacco	50	54
		• Clothing and Foot wear	4	3
		• Rent, Fuel and Energy	15	15
		• Household and Personal Goods	5	5
		• Transport and Communication	6	6
		• Education	9	5
		• Health	7	6
		• Other Consumption Expenditure	2	2
		• Non Consumption Expenditure	4	3
5.	Social	Households by Type of Toilet Facilities (%)		
		• Pit Latrine		
		• V.I.P Latrine		
		• Flush Toilet		
		• Bush/No Toilet		
		Main Sources of Energy for Lighting in Households (%)		
		• Tadooba	81.2	80.2
		• Lantern	12.3	12.7
		• Electricity	5.0	3.5
		• Others	1.6	3.7

	Main Sources of Energy for Cooking in Households (%)		
	• Fuel wood	86.1	85.2
	• Charcoal	11.4	11.3
	• Kerosene	0.7	1.7
	• Electricity	0.1	0.4
	• Others	1.7	1.0

E4: NORTHERN REGION SOCIAL AND ECONOMIC INDICATORS FROM 2005 - 2010

SECTOR		INDICATOR	YEAR	
			2005/06	2009/10
1.	Education	Literacy rate (%)	59	64
		• Male	74	77
		• Female	45	52
		Primary School Enrolment GER (%):	-	120
2.	Labour force and Employment	Annual Labour force Growth rate (%)	-	4.9
		Unemployment rate (%)	3.3	4.1
3.	Health	Burden of Diseases (%)		
		• Malaria/Fever	-	49.3
		• Respiratory Infection	-	13.8
		• Diarrhea	-	5.1
		• Urinary Tract Infection	-	0.2
		• Skin Infection	-	1.4
		• Injury	-	3.3
		• Others	-	26.9
		Proportion of Population using Mosquito nets (%)	17.4	45.5
4.	Economy	Total Population of Poor Persons (million)	3.25	2.84
		Population Living below Poverty (%)	19.7	20.1
		Consumption Expenditure per Household (Ushs.)	111,700	150,200
		Mean Per Capita Consumption Expenditure (Ushs.)	21,500	28,400
		Average Monthly Household Income (Ushs.)	93,400	141,400
		Income Inequality (Gini Coefficient)	0.350	0.387
		Household Expenditure by Item (%)		
		• Food, Drinks and Tobacco	55	52
		• Clothing and Foot wear	3	4
		• Rent, Fuel and Energy	14	17
		• Household and Personal Goods	6	7
		• Transport and Communication	5	4
		• Education	8	7
		• Health	6	6
		• Other Consumption Expenditure	2	1
		• Non Consumption Expenditure	3	3
5.	Social	Households by Type of Toilet Facilities (%)		
		• Pit Latrine	75.4	72.9
		• V.I.P Latrine	3.2	1.9
		• Flush Toilet	0.1	0.3
		• Bush/No Toilet	21.2	24.9
		Main Sources of Energy for Lighting in Households (%)		
		• Tadooba	79.9	66.7
		• Lantern	7.6	10.9
		• Electricity	1.4	1.7
		• Others	11.7	10.8

	Main Sources of Energy for Cooking in Households (%)		
	• Fuel wood	88.3	87.6
	• Charcoal	10.7	10.6
	• Kerosene	0.4	0.8
	• Electricity	0.0	0.2
	• Others	0.7	1.0

E5: WESTERN REGION SOCIAL AND ECONOMIC INDICATORS FROM 2005 - 2010

SECTOR		INDICATOR	YEAR	
			2005/06	2009/10
1	Education	Literacy rate (%)	67	71
		• Male	74	77
		• Female	60	65
		Primary School Enrolment GER (%):	-	122
2	Labour force and Employment	Annual Labour force Growth rate (%)	-	2.2
		Unemployment rate (%)	0.7	2.1
3	Health	Burden of Diseases (%)		
		• Malaria/Fever	-	52.2
		• Respiratory Infection	-	17.9
		• Diarrhea	-	2.1
		• Urinary Tract Infection	-	0.2
		• Skin Infection	-	1.6
		• Injury	-	2.4
		• Others	-	23.6
		Proportion of Population using Mosquito nets (%)	11.3	41.1
4	Economy	Total Population of Poor Persons (million)	1.44	1.60
		Population Living below Poverty (%)	25.9	24.0
		Consumption Expenditure per Household (Ushs.)	205,250	210,450
		Mean Per Capita Consumption Expenditure (Ushs.)	38,400	42,150
		Average Monthly Household Income (Ushs.)	159,100	303,200
		Income Inequality (Gini Coefficient)	0.342	0.375
		Household Expenditure by Item (%)		
		• Food, Drinks and Tobacco	48	50
		• Clothing and Foot wear	4	3
		• Rent, Fuel and Energy	14	13
		• Household and Personal Goods	5	5
		• Transport and Communication	6	7
		• Education	9	9
		• Health	9	6
		• Other Consumption Expenditure	2	3
		• Non Consumption Expenditure	3	3
5	Social	Households by Type of Toilet Facilities (%)		
		• Pit Latrine	93.5	95.7
		• V.I.P Latrine	0.9	1.2
		• Flush Toilet	0.4	0.8
		• Bush/No Toilet	5.2	2.3
		Main Sources of Energy for Lighting in Households (%)		
		• Tadooba	76.0	77.4
		• Lantern	16.1	12.7
		• Electricity	4.2	6.2
		• Others	3.7	3.6

	Main Sources of Energy for Cooking in Households (%)		
	• Fuel wood	89.5	84.2
	• Charcoal	7.8	10.8
	• Kerosene	0.5	3.1
	• Electricity	0.1	0.4
	• Others	2.1	1.5

Source:

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