Women's health and sexual and reproductive health in Uganda: A review of evidence

Training and Research Support Centre (TARSC)
Zimbabwe
and
Coalition for Health Promotion and Social Development (HEPS) Uganda

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Executive summary

Women's health issues have attained higher international visibility and renewed political commitment in recent decades. While targeted policies and programmes have enabled women to lead healthier lives, significant gender-based health disparities remain in many countries. With limited access to education or employment, high illiteracy rates and increasing poverty levels, women's health improvement remains a challenge.

The Training and Research Support Centre (TARSC), with HEPS-Uganda and Lusaka District Health Team, Zambia, and with Cordaid support, is implementing a two-year programme from 2012 to 2014 to scale up health literacy in Uganda and Zambia. As part of this effort, this paper focuses on the sexual and reproductive health situation and services for women in Uganda. The paper will be used as background to the development of a health literacy module on women's health and for enhancing the health literacy skills of community health workers.

According to the 2011 Uganda Demographic and Health Survey (UDHS), the health status of Ugandans has generally improved since 1995. This includes data in infant and under-5 mortality and maternal mortality. Nevertheless, the sexual reproductive health (SRH) care system is still deficient as far as appropriate responses to women's SRH needs are concerned. Many women, and especially young people, have unmet needs for family planning and, while HIV prevalence has declined since the 1990s, the epidemic continues with women carrying the major burden in terms of access to treatment and as care givers. Gender needs in policy and programmes are limited due to gender biases in choices and actions in programmes, and inadequate budgets fail to capture specific needs and interests of women and men.

Among the socio-cultural determinants of women's sexual and reproductive health are education, wealth status, occupation and wage employment. The 2011 UDHS shows that women from the poorest households are less likely to use preventive and curative sexual and reproductive health services and products than women from the wealthiest households. This also correlates with levels of education. In addition, women in informal employment have little access to sexual and reproductive health. Minimal health and safety regulations exist in these non-unionized sectors of the economy, and employer subsidies for health insurance are rare.

Cultural practices like bride price and gender relations affect a woman's self image, her sense of empowerment and her ability to control her fertility and method of contraception. The unequal power relations within households and communities predispose women to problems of gender-based violence. Women who are poor and illiterate are unable to take decisions compared to their male counterparts and require permission from their partners to access health care. All of these factors expose them to associated complications during pregnancy and childbirth.

Many complex and interlinking factors prevent women and girls from accessing appropriate sexual and reproductive health care. Tackling these barriers to SRH services from the woman's perspective is crucial to improving women's health. The Three Delays model (Thaddeus and Maine, 1994) is a globally accepted approach to identifying the points at which delays can occur and in designing programmes to address these delays. Together these three delays, represented as barriers to services, are: the supply of SRH services; access to care; and delays in decision-making.

The supply of SRH services is impeded by limited service delivery, lack of human resources, inadequate financing and a weak referral system. Despite improved coverage of health services in the

last decade, SRH services suffer from regular medical stock-outs, a lack of functional equipment and too few trained providers. Gender and equity issues are often not prioritised in resource allocation.

Access to care is often limited by a household's financial situation, and a weak-functioning transport system. In terms of finances, even though the government abolished user fees in public health facilities in 2001, the share of household expenditure on health – due to transport or cost of drugs – as a percentage of total household consumption remains high. This directly affects women's access to SRH services.

Delays in seeking care are often due to a woman's inability to make decisions about her own health in a household where the man is the primary decision-maker, her limited knowledge of her health rights, and her limited self-efficacy.

Government, and in conjunction with partner organisations, has determined policies and programmes for uptake of women's health and sexual reproductive health. To integrate women's health needs into service delivery, the government ratified and domesticated regional and international instruments on gender equality. With policy, planning and programme actions, Uganda has registered increased use of public health services. In 2007, the government, with support from its development partners, developed the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda as part of its effort to further consolidate and focus its efforts.

Government programmes include the National Minimum Health Care Package, and policies on AIDS, reproductive health, adolescent health and gender. The Uganda Health System Strengthening Project is a five-year government project rolled out in 2011 to meet challenges in the health sector. The project is intended to deliver the Uganda National Minimum Health Care Package to Ugandans with a focus on maternal health, newborn care and family planning.

Over the last few years, the Uganda Ministry of Health, in conjunction with partner programmes, has instituted some interventions to deal with the three delays. The maternal and child health intervention has shown a general improvement in health performance between 2003/04, although its output indicators fell short of targets.

In addition, the Ministry of Health has implemented sexual and reproductive health strategies to reduce prenatal, neonatal, infant and maternal mortality and morbidity.

Community participation is a missing link in all the strategies government and its partners have put in place. Regardless of the capacity of government and civil society, members of a community, and especially vulnerable groups, have an important role to play in the process of developing and implementing an SRH programme.

Non-governmental organisations can strengthen community-based organisations by supporting and training local service providers and community support groups, promoting civil engagement with government planning and budgeting cycles, and working with international and national development partners.

A multi-sectoral approach is necessary for planning and service delivery. All must understand each other's roles and create supportive relationships for integrated service delivery.

1. Background

Women's health issues have attained higher international visibility and renewed political commitment in recent decades. While targeted policies and programmes have enabled women to lead healthier lives, significant gender-based health disparities remain in many countries. With limited access to education or employment, high illiteracy rates and increasing poverty levels, women's health improvement is still a big challenge. In Uganda, women's reproductive health is threatened by limited access to effective contraception, untimely diagnosis and treatment of sexually transmitted infections, unsafe abortion, unskilled maternity care, and infertility treatments (UDHS, 2006).

Although the direct, first-level targets and beneficiaries of maternal mortality interventions by definition are always women, maternal mortality, and the conditions that heighten or diminish the problem, has a gender dimension:

1. Poor nutrition of girls and women due to gender discrimination can increase the chances of life-threatening complications at the time of pregnancy.
2. Societal norms that limit women's mobility, or that require women to obtain the consent of a male family member before seeking health care, can dangerously delay, or even prevent, women's access to life-saving care in the event of an obstetrical emergency.
3. Women's education is strongly correlated with positive maternal health outcomes. High rates of illiteracy/low rates of school attendance are likely to contribute to maternal mortality (WHO, 2003).

Gender roles, which are socially and culturally determined, influence the different behaviour, roles, responsibilities and expectations of men and women. These expectations influence access to resources and information, as well as the ability to make decisions, both individually and within communities. In relation to health, gender roles influence nutrition, educational opportunities, employment and income, which are all important determinants for good health. They also influence whose needs and priorities are addressed, and within health systems this can mean that the needs of women and girls are not addressed. Access to sexual and reproductive health is important for men and women. Provision of effective and accessible maternity services is vital to prevent women from dying during childbirth.

1.1 Purpose of the paper

In 2012-2014, TARSC is implementing a two-year programme with the Coalition for Health Promotion and Social Development (HEPS) Uganda and Lusaka District Health Team, Zambia, to extend health literacy in Uganda and Zambia and to promote dialogue and accountability among health workers and communities, including on women's health and sexual and reproductive health (SRH). As part of this work and the development of health literacy materials, this paper focuses on the SRH and women's health situation and services in Uganda. The paper will be used as background to the development of a health literacy module on women's health and for enhancing the health literacy skills of community health workers.

1.2 Methodology

Specifically the paper was commissioned to present information on

i. Public health trends and women's health, including important trends in women's health and SRH over the past decade
ii. The causes and determinants of the patterns above, including in relation to gender inequalities in norms, roles and resources, and social determinants
iii. The three delays and their causes in getting, accessing and using services

iv. The policies, services, personnel (and health workers) and programmes within and beyond the health sector, that aim to promote and respond to women's health and SRH, and the three delays
v. The implications for communities and health systems

This information was gathered through an extensive review of documents that included: national, regional and international SRH policies and action plans; health sector investment plans, ministerial statements in budget framework papers and annual progress reports; statistical reports from Uganda Bureau of Statistics (UBOS), Population Secretariat (POPSEC) and United Nations Population Agency (UNFPA) on Uganda. Academic and unpublished literature on women's SRH was also consulted as sources of researched data. A potential bias lay in the difficulties accessing grey material.

2. Trends in women's health and sexual reproductive health

The Uganda Demographic and Health Survey (UDHS) measures progress on the health status of the population in Uganda. Some of these health indicators include infant mortality rate (IMR), under-five mortality rate, maternal mortality ratio (MMR), total fertility rate (TFR), contraceptive prevalence rate (CPR) and prevalence on malnutrition disorders such as stunting, under-weight and wasting. *Table 1* shows the trends on these indicators for 1995 to 2011.

Table 1: Trends in selected health indicators in Uganda 1995 to 2011

Indicator	1995	2001	2006	2011	NDP Target 2014/15	MDG Target 2015/2016
Infant mortality rate (IMR) (per 1,000 live births)	81	89	76	54	41	41
Under-5 mortality rate (per 1,000 live births)	156	158	137	90	60	56
Maternal mortality ratio (MMR) (per 100,000 live births)	527	524	418	438	131	131
Total fertility rate (TFR)	6.9	6.9	6.5	6.2	6	N/a
Contraceptive prevalence rate (CPR)	15.4	23	24.4	30	46	N/a
Underweight prevalence	26	23	16	17	N/a	10%

Source: UDHS 2011 report.
N/a-Not applicable

Table 1 shows that between 1995 and 2011 the under-five mortality rate declined from 156 to 90 deaths per 1,000 live births; IMR decreased from 81 to 54 deaths per 1,000 live births; MMR reduced from 527 to 438 per 100,000 live births; and the CPR increased from 15.4% to 30%. The TFR has not changed much from 6.9 in 1995 to 6.2 in 2011. This high TFR contributes significantly towards the high population growth rates experienced in Uganda and will have implications on delivery of and access to health care. These indicators, although unsatisfactory, generally demonstrate that the health status of the people of Uganda improved over the reference period.

2.1 Adult and maternal mortality

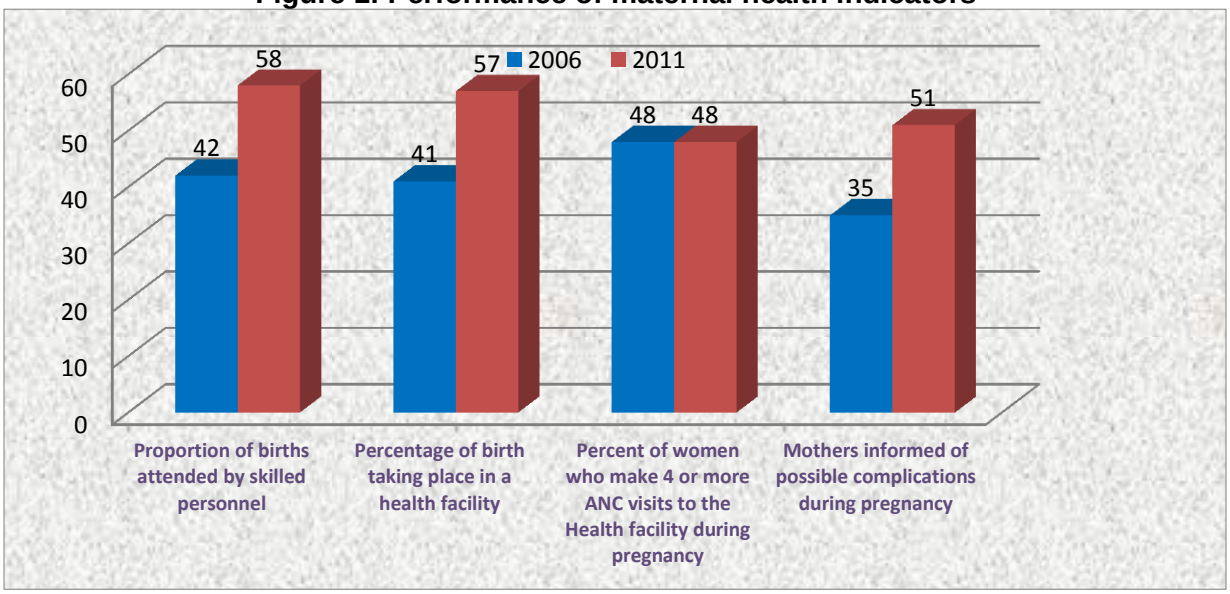
In the last two decades, the maternal health indicators for Uganda have generally remained poor. According to the 2010 Millennium Development Goals (MDG) report, an estimated 16 women die every day from giving birth in Uganda. On average, that is one death every hour and a half and nearly 6,000 every year, accounting for 18% of all deaths to women aged 15-49 years. The estimated maternal

mortality from the UDHS (2011) is 435 deaths per 100,000 live births, which means that to meet the MDG target, Uganda will need to reduce its mortality rate from 435 to 131 deaths per 100,000 live births by 2015. Clearly, improving maternal health is one of the key goals where progress has been too slow.

Levels and trends in overall adult mortality also have important implications for health and social programmes in Uganda, especially with regard to the potential impact of the AIDS epidemic, other infectious diseases, and non-communicable diseases. Adult mortality is slightly higher among men than among women (6.5 deaths and 5.3 deaths per 1,000 populations, respectively). Twenty percent of women and 25% of men are likely to die between ages 15 and 50. Estimates based on the 2000-2001 and 2006 UDHS also show that men had a higher probability of dying between ages 15 and 50 (37% and 35%, respectively) than women have (30% in both years).

The leading direct causes of these maternal deaths are hemorrhage (26%), sepsis (22%), obstructed labour (13%), unsafe abortion (8%) and hypertensive disorders in pregnancy (6%) (HSSP III). The main factors responsible for maternal deaths relate to the three delays – intra-institutional delay to provide timely and appropriate care, delay to reach facilities and delay to seek care. Slow progress in addressing maternal health problems in Uganda is due to lack of human resources, medicines and supplies and appropriate buildings and equipment, including transport and communication systems for referral. There is need to investigate the reversal or stagnation of trends in the maternal health services.

Figure 1: Performance of maternal health indicators



Source: 2011 UDHS report key

Figure 1 shows that 48% of women make four or more antenatal care visits during their pregnancy. This percentage has remained almost the same since 2006. Fifty-one percent of the mothers are informed of possible complications during pregnancy, an increase from 35% in the 2006 UDHS. A skilled provider assists in 58% of births, an increase from 42% in 2006. The percentage of births taking place in a health facility has increased noticeably from 41% in the 2006 UDHS to 57% in the 2011 UDHS.

2.2 Fertility rates

Currently, a Ugandan woman would bear an average of 6.2 children in her lifetime if her fertility were to remain constant at current levels. This represents a decrease of 0.5 children in the five years since the 2006 UDHS, when the TFR was 6.7 births per woman. Fertility is also significantly higher among rural women than urban women (6.8 and 3.8, respectively).

Parents may have a preference for male children on the grounds that sons are more likely to sustain familial and kinship ties following marriage, thus augmenting household income and providing old age parental support. Gangadhara and Maitra (2003) document the widespread literature on this phenomenon resulting in high fertility rates.

Table 2: Trends in age-specific and total fertility rates in Uganda

Mother's age at birth	2000-2001	2006	2011
15-19	178	152	134
20-24	332	309	313
25-29	298	305	291
30-34	259	258	232
35-39	187	190	172
40-44	76	94	74
45-49	40	26	23
Total Fertility rate	6.9	6.7	6.2

Source: UDHS 2011.
Note: Age-specific fertility rates are per 1,000 women.

In relation to trends in age-specific and total fertility rates in Uganda (*Table 2)*, the largest differences are observed in the age group 15-19. The age-specific fertility rate (ASFR) for this age group declined steadily from 178 in the 2000-01 UDHS to 134 in the 2011 UDHS, indicating a trend towards later age at marriage, first intercourse, and first birth. ASFRs in other age groups have changed more gradually. Teenage pregnancy and motherhood, however, remain a major health and social concern in Uganda because of their association with higher morbidity and mortality for mother and child. In addition to the physiological risks, there is a negative effect on the socio-economic status of the mother, and hence the child, because current school policy is to have pregnant girls terminate their education. The findings from UDHS show that the proportion of teenagers who have started childbearing has declined over time, from 43% in the 1995 UDHS, to 31% in the UDHS 2000-01, to 25% in the 2006 UDHS, and finally, to 24% in 2011.

2.3 Family planning

Over the last decade, the number of currently married women using contraceptives increased from 19% in 2000-01 to 30% in 2011. The increase is especially pronounced in the use of modern methods, increasing from 8% to 26% during the same period. The use of traditional methods has remained constant at 7% to 4% over the last decade.

One of the targets of the Ministry of Health in the Health Sector Strategic and Investment Plan is an increase in the contraceptive prevalence rate from 24% in 2006 to 35% in 2015. The results in the 2011 UDHS show that the government is on track to achieve this indicator (MoH, 2010). The most popular method of family planning is the injectable, because women can easily access it without the consent of their spouses and only have to be reinjected every 6 months. In many health centres drugs and other supplies are not consistent and this leads to inconsistency in utilisation of services.

In terms of unmet needs for family planning, these are lowest among the youngest women age 15-19 (31%) and those in the oldest age group 45-49 (24%) (UDHS, 2011). This could be a result of lack of youth friendly reproductive health services in Uganda. After menopause, a woman may not need to use contraceptives for family planning but rather as protection against sexually transmitted infections.

By region, the unmet need is higher in rural areas than in urban areas (37% and 23%, respectively). Generally, RHS are more accessible in urban areas than in rural areas, where information is easily accessed. Public and private health care services are more accessible in urban areas. A study by Koenig et al. (2004) found that the Ugandan rural population lacks integrated service delivery that can overcome the negative attitudes toward women seeking family planning.

2.4 Sexual behaviour

Findings from the recent AIDS Indicator Survey (MoH, 2011b) reveal gender differences that define the sexual behaviour of the population. In Uganda, the median age at first sexual intercourse is 17 for women and 18 for men. However, men are more sexually active, that is only 3% of women age 15-19 report having two or more sexual partners in the 12 months before the survey in contrast to 19% of men. The survey shows that this characteristic is similar in the general population: women have a mean of two sexual partners in their lifetimes compared with seven lifetime partners for men.

2.5 HIV and AIDS status

In sub-Saharan Africa, the region most affected by HIV, prevalence rates among women are already distinctly higher than those among men. The high prevalence rate is due to a combination of biological factors relating to the reproductive tract and social and gender norms that facilitate older men having sexual relations with much younger women (and men in general having more sexual partners than women).

According to the 2004-05 Uganda HIV/AIDS Sero-Behavioural Survey (Ministry of Health 2006), 6.4% (or slightly more than 800,000 people) of adult population in Uganda are infected with HIV. Overall, the trend of HIV infection has declined from a peak of 18% in 1992 to the current figure. The international target is to halt new infections by 2015 and begin to reverse the spread of HIV/AIDS. Uganda, therefore, seemed to be well on track on this target, but recent reports indicate that prevalence is increasing.

Effective prevention of mother-to-child transmission (PMTCT) may require involving both mothers and fathers, even though planners of such programmes may be tempted to address only women. Although it is women who must take PMTCT drugs, they may not have enough autonomy or financial resources to do so on their own, without their partners' consent and participation. Women and girls also bear the brunt of caregiving, which exposes them to infections.

3. Socio-cultural determinants of women's SRH status

3.1 Education and wealth status

Education and wealth status are key socio-economic determinants of the SRH status of women. The recent UDHS (2011) shows that several reproductive health indicators have high correlations with education and wealth. The proportion of deliveries in a health facility is more than twice as high among births to mothers with secondary or higher education (81%) as among births to mothers with no education (36%). A similar pattern is observed among women by wealth quintile: delivery at a health facility is less likely among births in the lowest wealth quintile (42%) than in the highest wealth quintile (88%). Low levels of education and lack of skills are mainly a result of high dropout rates, especially among girls in primary and secondary schools, leading to teenage pregnancies and early marriages.

The health-seeking behaviour with respect to reproductive health services has improved over the past five years; in particular, the percentage of births assisted at delivery by a skilled provider increased from 42% in the 2006 UDHS to 58% in the 2011 UDHS, while the percentage of births assisted by relatives and others declined from 25% to 15%. The percentage of births attended by a traditional birth assistant dropped from 23% in the 2006 UDHS to 18% in the 2011 UDHS. In rural areas, delivery assistance by a skilled provider increased from 37% in the 2006 UDHS to 53% in the 2011 UDHS.

On average, women with no education have 6.9 children compared with 4.8 children for women with more than secondary education. Similarly, the TFR decreases from 7.9 children among women in the lowest wealth quintile to 4.0 children among women in the highest wealth quintile. Poor households tend to have children as security for old age due to the absence of appropriate insurance and social safety nets. In addition, most households employ children to provide labour for the family. This problem is exacerbated by high levels of infant mortality that drive couples to produce more children to cushion themselves against such risks.

3.2 Occupation and wage employment

Lack of employment is one of the major constraints facing women in accessing sexual and reproductive health. Most women in Uganda can only access opportunities that are limited to informal employment, characterised by high competition, unreliability, irregularity and great seasonal variance. Minimal health and safety regulations exist in these non-unionized sectors of the economy, and employer subsidies for health insurance are rare. There may be some implicit recognition of women's non-market contribution to household welfare, particularly over the childbearing and maternal periods, when women play an important role in fostering the well-being of the next generation. Thus while women may add less to the household monetary resource base than men, expenditure on women's health is arguably an important household investment.

The erratic and insecure nature of informal employment makes food purchases difficult yet critical in obtaining nutritional support for women and children. Patients on ART, for example, sometimes cannot afford public transport fares, thus hampering their adherence to treatment and ability to continue accessing RCT services. Although government-owned health centres are overcrowded, experience drug stock-outs and a shortage of specialized personnel, women cannot afford private health services due to high user charges.

In the face of these socio-economic constraints, women have devised coping strategies. Many of the households with HIV health care burdens, for example, have to rely on outside support from family or neighbours, reduce their consumption of basic utilities like piped water and electricity, or send children out to market food stuffs so as to contribute to the household income. It is mostly social capital and informal support networks, provided by the wider family and neighbourhood, that help poor women access treatment and housing and nutritional requirements.

3.3 Culture, gender relations and women's empowerment

A study on maternal health (Kyomuhendo, 2004)) documented that maternal illness is not necessarily a direct result of biomedical causes per se but may stem from other factors deeply rooted in culture and gender relationships. Bride price payment is a good example. A qualitative study (Kaye DK et al., 2005) found that respondents perceived a strong connection between bride price payment and domestic violence, age differentials between spouses, early marriage, poor sex negotiation, contraceptive non-use, high fertility, unwanted pregnancy and induced abortion. Bride price payment was perceived to worsen existing gender inequalities and inequities, especially regarding reproductive health decision-making.

Self-image and a sense of empowerment also affect a woman's ability to control her fertility and the method of contraception she uses. A woman who feels she is unable to control other aspects of her life may be less likely to feel she can make decisions regarding fertility. She may also feel the need to choose methods that are easier to conceal from her husband or partner.

According to the AIDS Indicator Survey 2011 (MoH, 2011b), there is widespread acceptance of the ability of women to negotiate safer sex with their husbands. Most women and men believe that a woman is justified in asking her husband to use a condom if she knows he has a sexually transmitted infection. However, both are least supportive of a woman's right to refuse sex if she knows he has sex with other women. In each situation, women were somewhat less likely than men to feel that a wife is justified in negotiating safer sex.

Urban women and men are more likely than rural respondents are to accept women's rights to negotiate safer sex. The proportion of women and men who support women's ability to negotiate in each of the specified circumstances increases with education level and wealth quintile.

3.4 Gender-based violence

Data from UDHS (2006)) show that 60% of women in Uganda have experienced SGBV, with one in four women reporting that their first sexual intercourse was forced. Violence against women by intimate partners is common, including during pregnancy when it is detrimental to the health of the mother and the foetus. This violence constitutes a major obstacle to improving women's health (WHO, 2003). The unequal power relations within households and communities predispose women to problems of gender-based violence. As most women are poor and illiterate, they are unable to take decisions compared to their male counterparts and require permission from their partners to access health care. All of these factors expose them to associated complications during pregnancy and childbirth.

4. The Three Delays

Many complex and interlinking factors prevent women and girls from accessing appropriate sexual and reproductive health care. Tackling these barriers to SRH services from the woman's perspective is crucial to improving women's health. The Three Delays model (Thaddeus and Maine, 1994) is a globally accepted approach to identifying the points at which delays can occur and in designing programmes to address these delays. The Three Delays model identifies the following barriers to accessing sexual and reproductive health care:

- barriers in supply of SRH services
- barriers in access to care
- delay in decision to seek care.

Together these barriers address socio-economic and cultural factors, accessibility of facilities and quality of care. Unless the three delays are addressed, no women's SRH programme can succeed. In practice, it is crucial to address barriers in supply of SRH services first, for it would be useless to facilitate access to a health facility if it was not available, well-staffed, well-equipped and providing good quality care (Hunt and De Mesquita, undated).

4.1 Delay One: Barriers in supply of SRH services

Service delivery: The SRH services commonly offered at Ugandan local health centres include PMTCT services, treatment for STIs, sterilisation, family planning services, post-abortion care and

routine counselling and testing for HIV/AIDS (RCT). The components under each of these services are determined by the central government annual budgets, which cascade into local-level health plans and services (Buyana, 2009).

Medicine stock-outs have long been a problem, as the percentage of health facilities registering stock-outs in essential medicines has consistently been more than 60% for the last 10 years. This implies that, although modern family planning services are available at 79% of the health facilities ((UDHS, 2011), the services may not be comprehensive. The procurement of medicines is done at the national level. The distribution system is based on 'pull' from lower levels of government health centres and hospitals, which are supposed to submit requisitions through the district health office to the National Medical Stores.

A lack of functional equipment is also a major problem at health centres. Investments in infrastructure and personnel cannot be put to optimal use if essential equipment is either missing or is not functional. It is particularly troubling if the equipment required for emergency obstetric care is either missing or broken. Evidence suggests (Ministry of Health 2011) that only 5% of facilities have a vacuum extractor (used for assisted vaginal delivery) and only 10% have a dilation and curettage kit (needed to remove a retained placenta). In some cases, equipment exists, but is incomplete. For example, while 92% of facilities offering delivery services report sterilisation of equipment for reuse, only 9% have all of the equipment and knowledge needed to sterilise or disinfect.

Human resources: Adequate staffing of health units is particularly important for offering skilled attendance at births, timely referral, and reliable, quality emergency obstetric care. The number of medical professionals in Uganda is below the WHO minimum target of 23 health workers per 10,000 population. For example, only 55% of facilities offering deliveries have a trained provider on site 24 hours a day, while 1% has a provider on call 24 hours a day (UDHS, 2011). In addition, the country has 15 health workers per 10,000, including 0.36 doctors, 0.71 clinical officers, 2.8 nurses and 1.4 midwives, a significant shortage. (UDHS, 2011) As a result of a limited wage bill, government has banned recruitment of staff, thus seriously hampering health sector efforts to maintain an appropriate workforce.

In addition to inadequate staffing, some districts face difficulties recruiting staff, particularly remote and hard-to-reach districts. Absenteeism of health workers is also exacerbated by hard working conditions. Beginning with financial year 2010/11, the government has prioritised staff accommodations in hard-to-reach and hard-to-stay areas and included them in all plans relating to health infrastructure.

Financing health: Like any other country in the world, Uganda is under enormous financial pressure to increase resources for health care services. The cost of health care service provision has gone up because of the expansion of services, increasing demand due to population growth, the adoption of new medical technologies, and changes in patients' choices and expectations. In 2007, the Government, with support from its development partners, developed the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (Muwange 2010). The Roadmap alone is estimated to cost about US$81 million over a four-year period, and the estimated cost of reproductive health commodities is $292 million, or about Ugandan shilling 157 billion, per year over five years. reference

An optimal balance needs to be struck between recurrent wage and non-wage expenditure. Government is addressing this imbalance through incremental restructuring of the national budget. Government interventions have followed a sector-wide approach and have been implemented through

Health Sector Strategic Plans, with donor funding going through the national budget in the form of basket funding.

Several development partners, however, continue to offer support outside this framework—so-called off-budget support. In such arrangements, the extent of harmonisation and alignment with government priorities is difficult to ascertain. International assistance for the health sector has been rising steadily in Uganda in recent years, driven in part by the off-budget component, which increased to a high of $460 million in 2006 (Muwange 2010) while on-budget support has declined. In terms of predictability, aid flows have remained volatile and, in recent years, this volatility has increased.

Budgeting is a political process that involves multiple competing demands on limited resources. In this process, gender and equity issues are usually not prioritised in resource allocation. Even when resources can potentially address gender and equity issues, ministries, departments and agencies tend to overlook them. Policies, plans and budgets often do not take into consideration the different needs of men and women, resulting in unequal participation, inequitable distribution of resources, opportunities and benefits. Uganda addressed gender in the budget cycle beginning in 2004/5 with the issuance of the National Budget Call Circular by the Ministry of Finance, Planning and Economic Development, which requires every sector to mainstream gender in plans and budgets.

Referral system: Public sector health services in Uganda are delivered through a seven-tier structure, starting with village health teams (VHTs). These teams are expected to provide information—although in other countries, they also provide family planning services. Health centres are graded as II, III, or IV, according to administrative zone and by the types of services they provide. Health centres II (HC-II) serve a parish and provide outpatient care, antenatal care, immunisation and outreach. Health centres III (HC-III) serve a sub-county and provide all the services of HC-II, plus inpatient care, maternal services and basic emergency obstetric care. Health centres IV (HC-IV) serve a health sub-district and provide all the services of HCs-III, plus surgery, supervision of the lower-level HCs-II and III, collection and analysis of data on health, and planning for the health sub-district. In addition, HCs-IV provide comprehensive emergency obstetric care, as do general, regional and national referral hospitals.

According to the policy provisions, family planning services are referred from HC-II to the national referral hospital, while HC-IIIs attend to deliveries and offer basic emergency obstetric care. In Uganda, not all health facilities expected to provide certain services do so. Evidence from the Uganda Demographic Health Survey, 2011 suggests that modern family planning services are available in 79% of all health care facilities. Nearly 89% of government facilities offer family planning compared to 49% of private facilities. Family planning services are least likely to be available in hospitals (71%). Normal delivery services are available in 53% of facilities. Furthermore, emergency services are not widely available. Only 47% of all facilities can transport a patient to a referral site for maternal emergencies. The lowest-level health centres are also least likely to have transportation support for referrals (only 33%), although these centres are also least able to treat emergencies. The inadequacy of the referral system adds pressure to higher-level health centre units.

Although the government has made a deliberate effort to construct and upgrade health facilities, basic infrastructure such as electricity, water, communication, means of referrals, adequate staff quarters, and security (especially at night) remain obstacles to running 24-hour, quality emergency obstetric care services, especially in remote and rural areas. For example, only 31% have year-round water supplied in facility by tap or available within 500 metres of the facility; at HC-II level only 23% have regular water supply. The situation is similar with electricity. About 24% of health facilities—and only 14% of HC-IIs—have electricity or a backup generator with fuel routinely available during service hours. Finally, with respect to basic patient amenities, only 42% of the health facilities have a functioning client latrine, a waiting area protected from sun and rain, and basic cleanliness. (UDHS, 2011) Road networks and

transportation in some districts are so poor that women may not access RHS. This means that they only make an effort when they are in trouble or sometimes when it is too late to be helped.

4.2 Delay Two: Barriers in access to care

Financial barriers: The government abolished user fees in public health facilities in March 2001 to decouple payment from use of services. While the use of public facilities increased substantially after the abolition of fees, the share of household expenditure on health as a percentage of total household consumption remained high. A detailed analysis of the National Household Survey Data from 2009 indicates that, on average, almost 28% of sampled households faced health expenditures that were more than 10% of total household consumption expenditure.

The government is instituting a social health insurance system to harness out-of-pocket expenditures arising from expansion of the private sector as service providers and to other costs associated with seeking care. These factors combine to prevent women from accessing and paying for necessary medications, and to make women less likely to be able to access healthcare if associated prices rise. Research shows that when user fees are applied to health services, it is women, more than men, whose use of such services falls (WHO, 2003).

Physical barriers: The issue of physical access is related to financial accessibility. Due to sustained government investment in the expansion of the number of health facilities and the growth of the private sector, physical access is not considered a major hindrance for family planning and antenatal care. By 2006, 83% of households reported living within five kilometers of a health facility or hospital (UDHS, 2011).The transportation challenges from home to the facility are mainly related to physical barriers such as lakes, rivers, and mountains; difficulties of travelling at night; lack of communication; lack of availability of means of transport of a standby or easily accessible vehicle; and transportation costs. Poor roads are another challenge as mothers cannot be transported quickly in case of emergency.

For women, the opportunity cost of accessing health centres situated a long distance from where they live may be more burdensome than for men. Women's routine tasks typically including such central and uninterruptible jobs as childcare and food production may prevent them from travelling to health facilities for the medicines they need. In these situations, women often seek out less-expensive traditional medicines. In cases where the traditional remedy is less effective, this represents a net loss for women's health.

4.3 Delay Three: Delay in seeking care

Decision making in health: According to the DHS 2011, about two in five (39-42%) currently married women report that their husbands primarily make decisions on their wives' health care, major household purchases and visits to their family or relatives. However, 23% of the married women reported that they make solo decisions on their own health care and visits to family or relatives, and 16% reported making solo decisions on major household purchases. (Men disagreed, however, reporting that only 7% of women make decisions on major household purchases). Independence in decision-making on women's own health has not changed much since 2006. At that time, only about two in ten married women (22%) independently decided on their own health care; the percentage remains almost the same (23%) five years later. Men are increasingly accepting their wives' opinions in making decisions on major household purchases. Joint decision-making on major household purchases as reported by men has almost doubled since 2006 (47% in 2011 compared with 27% in 2006).

In many cases women are inadequately informed about how to use drugs because of lower literacy and by cultural norms that cause medical personnel to give information about the drugs to their *husbands*, rather than directly to the women themselves.

Knowledge of health rights: Uganda's health care policy has not fully integrated reproductive health rights into client perspectives. A woman's knowledge of her reproductive health rights is based only on information received from health care service providers. Recognising women's entitlements to family planning, antenatal care, immunisation, access to information and freedom to decide on the number of children she would like to have are crucial to the provision of a rights-based reproductive health service (Okiria, E 2011).

Decentralised health care is not adequately promoting community participation. Community health care campaigns have not been effective in using IEC materials to transmit knowledge about SRH rights. Most IEC materials are inappropriate for the targeted audiences -- they are in English and therefore not customised to the differences in language proficiencies amongst communities (Buyana, 2012).

Limited awareness and self-efficacy: Women's empowerment or self-efficacy to use available services adequately is a barrier to safe delivery. For instance, attendance at antenatal care visits may discourage delivery in health units if mothers are told that the pregnancy is normal. Mothers' experience of 'normal' versus 'abnormal' pregnancy affects their judgement and their decision about whether to seek skilled birth attendance.

Mothers' self-efficacy beliefs therefore constitute an obstacle to safe delivery. Improving care-seeking behaviours of pregnant women is clearly a critical function of the health system. Knowing when to seek care for potentially fatal childhood illnesses and knowing where to go are important. Pregnant women have a wide variety of choices once they make the decision to seek care outside the home. In addition to the marketplace, where they can purchase drugs without consulting professionals, they can also seek first recourse from traditional birth attendants or informal community services.

Cultural beliefs and social norms: Cultural factors like polygamy, bride price, preference of boys to girls, expectation of a woman as a strong and healthy being all the time, nutrition practices etc. contribute to high fertility and maternal morbidity and mortality. Some cultural and religious beliefs do not agree with the need for family planning and, therefore, limit the use of family planning services by some sections of the population.

The ways in which pregnancy and childbirth are managed within families and communities and the culturally articulated ideas that surround them often differ across societies in Uganda. Certain cultural beliefs and social norms prevent pregnant women from availing themselves of health care services and assurance of safe delivery. Successful maternal mortality reduction strategies and health care services will put local problem solving -- within facilities and within communities -- at the core of implementation and be adequate to their cultural need. These problems call for intensive, focused and well-ordinated collaboration between the Ministry of Health and other stakeholders.

5. National policies for uptake of women's health and SRH: dealing with the three delays

5.1 National policies and programmes for uptake of women's health and SRH

In 2006, the Uganda Demographic Health Survey highlighted the differences between women and men in development sectors like education, health, employment, and other important indicators of status, empowerment, and well-being. The survey indicated that while biology may help explain some differences between women and men, gender norms explain women's unequal status in society. To integrate women's sexual, reproductive and other forms of health needs into service delivery, the government ratified and domesticated regional and international instruments on gender equality. With policy, planning and programme actions, Uganda has registered increased use of public health services, with 46% of the female and 42% of the male population reporting ill health for treatment at government-run health centres (Ssewanyana and Kasirye, 2010).

In 2007, the government, with support from its development partners, developed the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda as part of its effort to further consolidate and focus its efforts.

Health Policy: The principles of the National Health Policy identify various issues, including the roles and responsibilities of women and men, equal participation and equal access, and presuppose gender mainstreaming in the health sector. However, key areas of the health sector do not reflect this picture or reveal a significant level of gender responsiveness. Even the objectives and components of the National Minimum Health Care Package are not explicitly gender responsive. Gender considerations feature only in scattered clauses in the Health Sector Strategic Plan. There is no plan for gender analysis and availability of gender disaggregated data for planning gender responsive programmes and support services. Of the 18 Health Strategic Plan monitoring indicators, only three are related to issues that cause high morbidity and mortality among women: contraceptive prevalence, percentage of deliveries in health facilities, and number of Caesarean sections per 1,000 deliveries. Elements of gender and women's health are not clearly articulated.

AIDS policy: The national AIDS Policy was formulated in 2003. Although the policy is not gender specific, it recognises the vulnerability of women to HIV and AIDS. Policy measures target specific women's issues such as promotion of the female condom to empower women to protect themselves against unsafe sex. It provides information for pregnant women living with HIV, AIDS-child bearing and PMTCT services. It recognises the vital roles of families and communities in treatment, care and support but does not highlight the prominent contributions of women as caregivers. While women dominate the general care and treatment for HIV and AIDS, men dominate the group receiving ARVs. The costs involved resources like time, information, decision-making and gender roles (socio-economic status) limit women's access to services.

Reproductive Health policy: Priority areas of the National Reproductive Health Policy guidelines are Safe Motherhood, including post-abortion care, family planning, adolescent sexual and reproductive health, STIs, including reproductive health cancers, and gender practices perpetuating poor reproductive health. Overall the guidelines are gender sensitive and responsive. The policy promotes user's reproductive health rights to information services and freedom to make choices without discrimination or coercion. This is an open policy in family planning in which a user does not require spouse, parent or guardian's written or verbal consent to access service in government health facilities.

Adolescent Health Policy: By mainstreaming adolescent health concerns in the national development process, the policy targets legal and social protection of girls against harmful practices, sexual abuse, exploitation and violence, and promotion of responsible health-related behaviours, including sensitisation on gender issues relating to adolescence. It pays particular attention to gender concerns relating to girls in programming and prioritising, gender-related qualitative and quantitative measures of women's health, pregnant girls' re-admission into the education system after delivery and increasing proportion of women receiving tetanus toxoid during pregnancy

Gender policy: Ministry of Gender, Labour and Social Development focuses on specific women's health issues with gender dimensions such as HIV and AIDS, high maternal mortality and fertility rates, gender-based violence, older persons and people with disabilities.

Specific interventions on these frameworks and the targeted government-implementing partners are outlined in Annex 1.

5.2 Ministry of Health and partner programmes that deal with the three delays

Maternal and child health interventions
Over the last few years, the government has implemented a number of interventions aimed at improving overall maternal and child health. However, data available on a few output indicators show that although there was a general improvement in health performance over the year 2003/04, the Ugandan Poverty Eradication Action Plan (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 is unlikely.

The infant mortality rate, which measures child deaths before the age of one, improved to 76 deaths per 1,000 live births in 2007, from 122 deaths per 1,000 live births in 1991. However, the under-five mortality rate, which measures child deaths before the age of five, declined from 167 to 137 deaths per 1,000 live births during the same period. Given that most infants die before their first birthday, PEAP targets are unlikely to be achievable.

The Ministry of Health has been instrumental in changing the evidence and policy landscape, and has strengthened dialogue across the continuum of care for maternal, new-born and child health. The main issues include:

- High birth rates among Ugandan women and low deliveries in health facilities contributing to high maternal and infant mortality rates;
- Poorly equipped health facilities to provide for reproductive health care and access to safe drinking water and basic sanitation;
- Inadequate reproductive health personnel at all levels of health care; and
- High illiteracy levels among women.

Specific interventions co-ordinated by the Ministry of Health are outlined in *Table 3*:

Table 3: Population and location targets of maternal and child health interventions

Issue Addressed	Specific Intervention	Coverage
High birth rates and low deliveries in health facilities; high maternal and infant mortality rates	i. Implementation of the Roadmap for reproductive and maternal health including antenatal care and providing family planning services, and physiotherapy	All districts
	ii. Implementation of the child survival strategy, including immunisation and PMTCT of HIV	HC-IIs do not provide RHS-FP, HIV testing and counselling, antenatal care
	iii. Implementation of the multisector response to HIV/AIDS	
	iv. Improving supply chain management for essential medicines, vaccines and health supplies,	2062 HC-IIs and IIIs 170 HC-IV, 53 general hospitals, 13 referral hospitals, 2 national referral hospitals
Poorly equipped health facilities to provide for reproductive health and access to safe drinking water and basic sanitation	v. Rehabilitation of the referral system focusing on infrastructure development and continuation of inpatient, outpatient and other specialized services	National referral hospital; all regional referral hospitals
	vi. Investing in gravity flow schemes and extending piped water schemes, as well as rainwater harvesting	Some hospitals do not have running water and some districts do not have referral hospitals
Inadequate reproductive health personnel	vii. Implementing the motivation and motivation strategy for health workers: construction of staff houses and rolling out human resources for health management information system to provide information on staffing levels and distribution of health workers; viii. Recruitment and deployment of health workers; ix. Implementation of the hard-to-reach incentives	All hard-to-reach districts
High illiteracy among women	x. Sensitisation and capacity building of village health teams (nationally)	in 85% of the districts

Source: MoH Budget Framework paper 2012/13.

Sexual and reproductive health programmes: The Division of Reproductive Health at MoH is responsible for implementing this component of the HSSP III. It will be responsible for developing policies, providing overall co-ordination and guidance of SRH activities and providing technical support to district health services (DHS). It will work through the Maternal and Child Health (MCH) cluster to engage various stakeholders in planning, monitoring, evaluating and approving SRH policies, strategies and standards. District health officers (DHO), CSOs and health care providers at delivery points within the district will be responsible for implementation.

The existing strategies being implemented to reduce prenatal, neonatal, infant and maternal mortality and morbidity include:

- Strengthening IEC materials and activities on sexual and reproductive health;

- Building institutional and technical capacity at national, district and community levels for RH;
- Expanding the provision of SRH services;
- Strengthening adolescent sexual and reproductive health services; and
- Strengthening the legal and policy environment to promote delivery of SRH services.

Involving communities in promoting their own reproductive health care is key to improving infant and maternal health.

Sexual and reproductive health is among the four priorities identified in the Health Sector Strategic Plan 2010-2014(HSSP III) to be implemented and the budgetary allocations will also reflect the prioritised interventions in the HSSP III. Specific interventions co-ordinated by the MoH include the following:

Table 4: Ministry of Health interventions on sexual and reproductive health issues

Objective	Strategy	Interventions
To reduce perinatal, neonatal, infant and maternal mortality and morbidity	Strengthen IEC activities on sexual and reproductive health	• Develop, print and disseminate evidence based IEC materials • Through VHTs, create awareness about sexual and reproductive health, including family planning among community members • Sensitise communities about sexual and reproductive health rights • Advocate for increased funding for SRH activities • Promote deliveries by skilled attendants
	Build institutional and technical capacity at national, district and community levels for RH	• Train health workers in the provision of SRH services, including management of obstetric emergencies • Strengthen referral systems for SRH services • Provide quarterly technical support supervision to districts and lower levels
	Expand the provision of SRH services	• Procure and distribute contraceptives with minimal side effects to men and women of reproductive age groups, including adolescents • Conduct outreach SRH services from health facilities • Introduce deliveries in HC-IIs • Provide emergency obstetric care • Improve inter and intra-sectoral co-ordination and collaboration between actors in reproductive health • Conduct operational research aimed at improving the uptake of SRH services • Design programmes to encourage men to support women in using family planning services
	Strengthen adolescent sexual and reproductive health services	• Integrate and implement adolescent sexual and reproductive health in school health programmes • Increase the number of facilities providing adolescent friendly sexual and reproductive health services
	Strengthen the legal and policy environment to promote delivery of SRH services.	• Review SRH and related policies and address institutional barriers to quality SRH services • Review SRH policies, standards and guidelines and strategies as need arises

Source: Uganda Health Sector Strategic Plan 2010/11-2014/15.

Uganda Health Systems Strengthening Project (USSP): The UHSSP is a five-year government project rolled out in 2011 to meet challenges in the health sector. The project is intended to deliver the Uganda National Minimum Health Care Package to Ugandans with a focus on maternal health, newborn care and family planning. The project interventions are structured according to the Safe Motherhood pillars of:

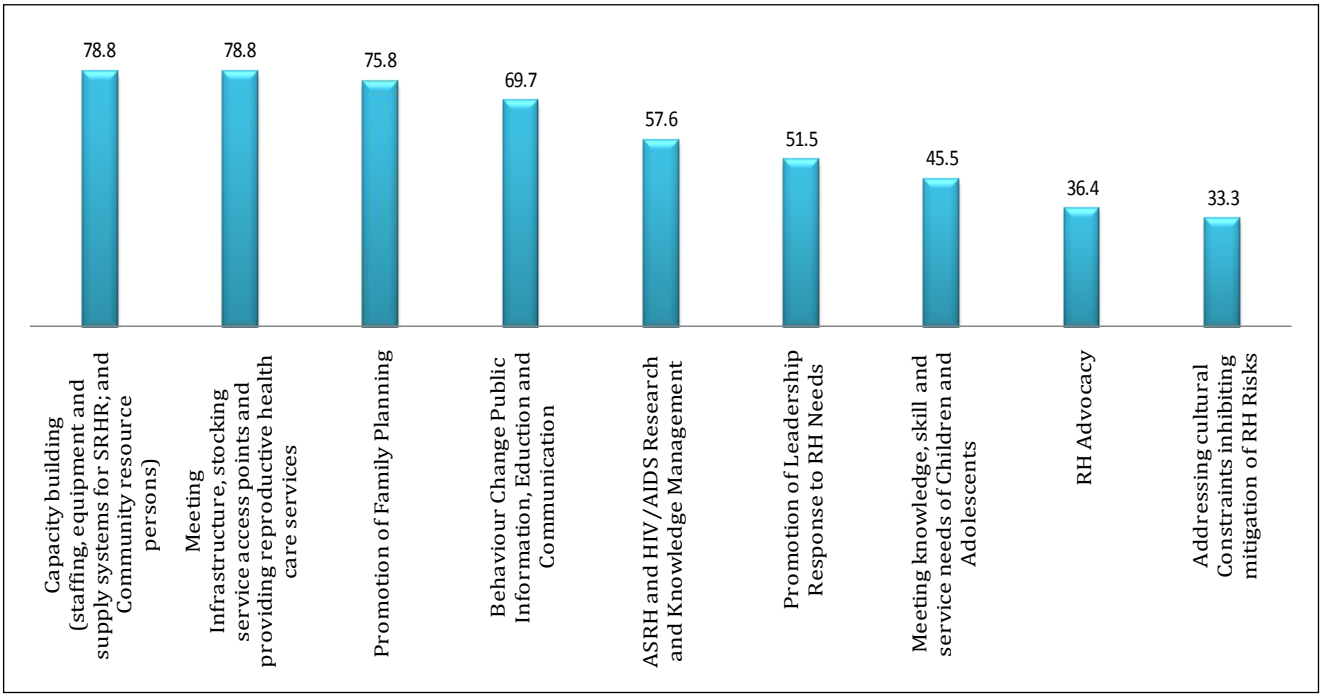
- Emergency obstetric and newborn care (EmoNc)
- Family planning
- ANC
- Post-abortion care
- Post-natal care
- Elimination of mother-to-child transmission of HIV.

Table 5: Strategies and interventions under the UHSSP

Strategy	Interventions	Indicators
1. Increase the number of health centres and hospitals providing EmoNc to reduce the number of health facilities with no stock-outs of essential reproductive health medicines and supplies	Procuring emergency obstetrics and neonatal care equipment and supplies for health centres and regional referral hospitals	• Number of health centres and hospitals providing EmoNc • Number of health facilities with no stock-outs of essential reproductive health medicines and supplies
2. Provision of hands-on training and mentorship on EmoNc	Training health service providers on the provision of better reproductive health services	• Number of health service providers trained
3. Increase access to family planning services	Procuring long-term family planning methods and mentoring service providers in the provision of family planning services	• Number of women accessing family planning services • Proportion of the population informed about the benefits of family planning and other reproductive health services
4. Improve newborn care	Providing protocols to help integrate HIV/AIDS and eliminate mother-to-child transmission of HIV	• Number of newborn deaths in the first week of birth
5. Improvement in the provision of post-abortion care	Training health workers in general and referral hospitals in the use of manual vacuum aspiration (MVA) for managing abortion complications	• Number of health workers trained in use of MVA

Broad interventions. The broad interventions categorised by thematic area reflect clearly how districts are implementing population actions and interventions (see *Table 3).* Based on a 33-district survey, capacity building, servicing reproductive health service points, promoting family planning and behaviour change education are the key areas where districts note significant interventions.

Figure 2: Percent of districts implementing reproductive health interventions



Source: Uganda Demographic Health Survey, 2011

6. Implications for community action and health systems to improve women's health

Given the factors that enable, and largely disenable, women's access to and supply of quality SRH services, a multi-sectoral approach is needed for planning and service delivery. Government, development partners, the private sectors, NGOs and local communities must all understand each other's roles and create supportive relationships for integrated service delivery throughout the cycle of planning, budgeting and programme action.

NGOs can use their advocacy role and neutrality to advantage local communities through the following strategies:

- Continuing knowledge-based advocacy by creating long-term partnerships with research institutions to obtain and package relevant information on SRH;
- Supporting local health system development by training local service providers and community support groups and offer financial and technical support where possible;
- Promoting civic engagement with government planning and budgeting cycles based on knowledge about the SRH realities in regards to delays in deciding to seek care, barriers in access and supply of quality SRH goods and services; and
- Working with international and national-level development partners to influence government policy and priority-setting standards in the health sector, with a focus on integrated planning and service delivery and increasing investment in the health sector.

Community participation is a missing link in all the strategies in place. Regardless of the capacity of government and civil society, the community's role is a means to the end that really matters - that of

building capacity for individuals to realise their potential for better lives. Limitations of local government create the space frequently occupied by community-based organisations (CBOs). The CBOs typically possess expert understanding of the needs of local people and are best placed to create the sense of community ownership and a feedback mechanism so important to development projects.

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List of abbreviations and acronyms

ANC	Antenatal Care
CBO	Community Based Organization
CPR	Contraceptive Prevalence Rate
CSOs	Civil Society Organisations
DCDO	District Community Development Officer
DHE	District Health Officer
DPO	District Population Officer
EmoNc	Emergency Obstetric and Neonatal Care
GBV	Gender-based Violence
HEPS	Coalition for Health Promotion and Social Development
HSSP	Health Sector Strategic Plan
IEC	Information, Education and Communication
MoH	Ministry of Health
MMR	Maternal Mortality Rate
MSNGOs	Non-Government Organisations
MVA	Manual Vacuum Aspiration
NPA	National Planning Authority
NPC	National Population Council
PNFP	Private-Not-For-Profit
POPSEC	Population Secretariat
RCT	Routine Counselling and Testing
RHU	Reproductive Health Uganda
PMTCT	Parent and Mother To Child Transmission
SDS	Strengthening Decentralisation Services
SGBV	Sexual and Gender Based Violence
SRH	Sexual Reproductive Health
STAR-EC	Strengthening AIDS and TB Response in Eastern Central Uganda
STAR-SW	Strengthening AIDS and TB Response in South Western Uganda
STI	Sexually Transmitted Infection
SURE	Securing Uganda's Rights to Essential Medicines
TARSC	Training and Research Support Centre
TFR	Total Fertility Rate
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UHSSP	Uganda Health System Strengthening Project
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
VCT	Voluntary Counselling and Testing
VHT	Village Health Team

Annex 1: Interventions on women's health and SRH in national development frameworks

Strategy	Intervention	Implementing Partners
Promote access and use of population and health information	• Design and implement community awareness programmes on health rights especially reproductive rights and improved quality of health services delivery.	Ministry of Health Ministry of Gender, Labour and Social Development Population secretariat and all districts
Advocate for affordability, availability and accessibility of quality health services	• Promote awareness among men, women and communities on their roles and responsibilities in sexual and reproductive health and rights. • Advocate for development and appropriate deployment of skilled human resources for reproductive health through dissemination of UDHS, Population Census and HMIS reports. • Advocate for reproductive health (RH) commodity security. In this regard, HMIS reports, Labour Market Information system (LMIS) reports, and Ministry of Health sector reports will be produced and disseminated. • Promote the strengthening of youth friendly sexual and RH services. This will include advocating for institutionalisation of youth friendly services. • Advocate for linking reproductive health and HIV/AIDS programmes. To facilitate this, advocacy for increased budgetary allocation for RH will also be intensified. • Advocate for adherence to RH rights especially for women and girls including gender-based violence (GBV). • Revise, disseminate and enforce public health and environment standards for communities and households. Community and household guidelines for public health and environment sanitation standards will be developed. • Advocate for improvement of maternal and child mortality through campaigns to reduce teenage pregnancies, proper spacing of pregnancies and improve quality of maternal care.	Ministry of Health Ministry of Gender, Labour and Social Development Population secretariat and all districts
Ensure that communities and individuals utilise available health services	• Promote awareness among men, women and communities in their roles on sexual and reproductive health and rights. • Promote community utilisation of safe motherhood and child survival services. • Promote awareness among men, women and communities on their roles and responsibilities in sexual and reproductive rights.	Ministry of Health Population secretariat and all districts
Reduce the unmet need for family planning	• Advocate for affordability, availability and accessibility of family planning services. • Promote provision of family planning information	Ministry of Health Population secretariat and all districts

	and increased utilisation of family planning. • Promote efficient commodity security logistics. • Focus on making family planning services available for women and girls, especially in rural areas.	
Reduce gender based violence and promote women's rights	• Develop and implement sensitisation and awareness programmes and put in place clear reporting and administrative mechanisms for handling the cases. • Ratify, domesticate and report on regional and international protocols, conventions and principles on women's rights and gender equality. • Support survivors of gender-based violence to engage in income-generating activities and provide access to professional psychosocial counselling services. • Reduce incidences of sexual and gender-based violence among men and women. • Ensure total elimination of female genital mutilation (FGM).	Ministry of Gender, Labour and Social Development all districts
Promote economic empowerment of women	• Promote women's full participation in economic decision making at all levels. • Develop and implement gender sensitive policies and programmes aimed at enhancing women's access to full and productive employment. • Develop programmes that support and develop women's technical, managerial and entrepreneurial capacities and initiatives. • Implement initiatives that translate educational achievements of women into employment opportunities. • Invest in labour saving technologies, affordable energy sources and ensure access to productive resources for women	Ministry of Gender, Labour and Social Development and all districts

Source: National Development Plan 2010/11-2014/15.

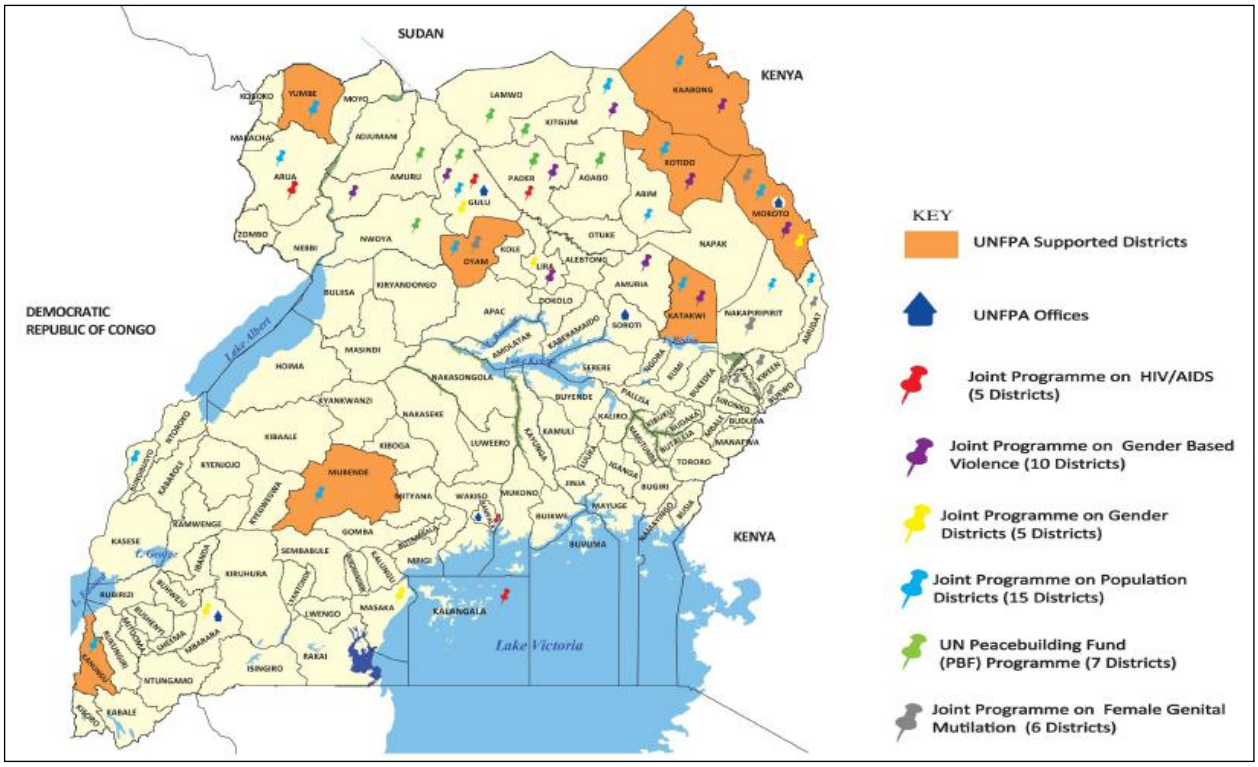
Annex 2: Programmes for international agencies and civil society organisations

The programmes funded by international agencies and civil society are broad in nature and tend to cover different elements of health-seeking behaviour. In particular, they have programmes handling delays to seek care, those which address barriers in access to care and barriers in supply of SRH services. Below is a description of these programmes.

UNFPA Uganda

UNFPA is currently supporting implementation of the 7th Government of Uganda/UNFPA country programme, providing support in three components: reproductive health, population and development and gender. Reproductive health interventions supported by UNFPA are implemented in eight districts and seven civil society organisations. Partners are the Ministry of Health (Reproductive Health Division and AIDS Control Programme); Ministry of Education; Population Secretariat; Ministry of Gender, Labour and Social Development; Mulago Hospital, Fistula Department; and Uganda AIDS Information Centre. The district local governments are: Kaabong, Kotido, Moroto, Katakwi, Oyam, Yumbe, Mubende, and Kanungu. The civil society organisations are: Reproductive Health Uganda (RHU), Uganda Red Cross (URC), Marie Stopes Uganda, Pathfinder International (PFI), Uganda Private Midwives Association (UPMA), Association of Obstetricians and Gynaecologists of Uganda, and Uganda Nurses and Midwives Associations.

Figure 4: Map of United Nations population interventions in Uganda



Source: UNFPA, 2012.

UK Department for International Development (DFID)

DFID Uganda provides support for improved monitoring and evaluation of government services and performance, and supports the implementation of national surveys, including the national census. This is intended to help improve the quality of administrative data provided by line ministries and districts. DFID envisions supporting Uganda in its transition to a prosperous and stable democracy, positioned to exploit the benefits of oil for all Ugandans and able to protect the interests of the most vulnerable. The programme will tackle the barriers to equitable, sustainable and inclusive growth, and help Uganda meet the Millennium Development Goals (MDGs). DFID creates opportunities in particular for girls and women. DFID empowers the private sector to drive future prosperity and provides financial support directly to government. It focuses on embedding the technical reforms necessary to manage future challenges. DFID creates partnerships with others where combined expertise can add value and where shared impact is expected to be greater.

Specific areas in line with the NPA that are supported under the DFID plan for the period 20011/12 - 2014/15 are provided in Table 6.

Table 6: Women and sexual reproductive health intervention areas

Pillar/ Strategic Priority	Specific Areas Targeted
Reproductive, maternal and neonatal health	Modern use of contraception by women
Reproductive, maternal and neonatal health	Skilled attendants at births
Wealth creation	Access to financial services by both men and women
Poverty, vulnerability, nutrition and hunger	Provision of unconditional cash transfers
Education	Returning to school of primary school drop-outs (with support from GEM)
Wealth creation	Food/cash for work projects in Karamoja

Source: DFID Uganda (2002).

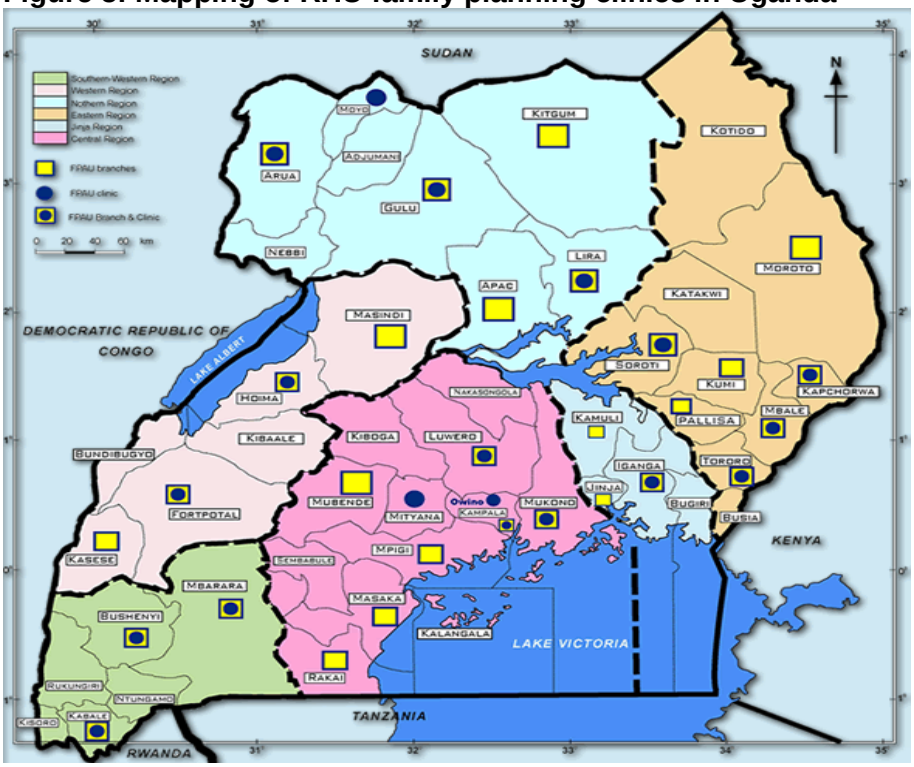
German Foundation for World Population (DSW)

DSW is implementing sustainable health projects and integrated projects that address reproductive health, population and development issues. It focuses on strengthening the capacity (training, financial and material support) of CBOs and promoting the potential of young people's (youths aged 10 to 24 years) initiatives. The focus districts are: Buliisa (Biiso and Buliisa TC sub-counties), Busia (Buteba sub-county), Kampala (Kawempe and Rubaga divisions), Jinja (Buwenge and Mafubira sub-counties), Kamuli (Nawanyago sub-county), Masindi (Masindi town council and Budongo sub-county), Pallisa (Apopong and Kaboloi sub-counties), Tororo (in Merikit, Mukuju and Mella sub-counties). The youth are targeted through peer-to-peer education and appropriate VCT services. Under the civil society funding, DSW enhances the capacity of HC IIIs to offer youth friendly VCT services and builds the capacity of youth clubs.

Reproductive Health Uganda (RHU)

RHU is a national, voluntary, not-for-profit, grassroots, non-governmental organisation founded in 1957 as Family Planning Association of Uganda. It is affiliated to the International Planned Parenthood Federation (IPPF) and is one of the leading organisations in the provision of high quality sexual and reproductive health services in Uganda.

Figure 5: Mapping of RHU family planning clinics in Uganda



Source: RHU website (http://www.rhu.or.ug/).

RHU addresses the unmet needs and demands for quality sexual and reproductive health services and promotes SRH with the primary focus on youth 10-24 years. RHU operates 19 family planning clinics country wide, as shown on the map in *Figure A1*. Interventions by RHU fall in the following thematic areas: access to SRH information and services, safe motherhood/post-abortion care, adolescent reproductive health, and HIV/AIDS.

PACE

PACE is a local organisation and an affiliate of Population Services International (PSI). PACE has programmes in malaria, reproductive health, safe water, child survival and HIV/AIDS. PACE promotes products, services and healthy behaviours that enable low-income and vulnerable communities to lead healthier lives. PACE partners with Ministry of Health, Uganda AIDS Commission, Ministry of Water and Environment, universities, CBOs and NGO's in implementing interventions in its programme areas, including those on:

- Sex workers
- Uniformed services personnel
- Intrauterine devices (IUD)
- Clean delivery kits
- Male condoms
- Basic HIV care and prevention packages
- Female condoms
- Cross-generational sex
- Long lasting insecticide-treated nets
- Behaviour change communication for malaria control

The target populations of Pace interventions are: in the case of HIV, the people living with HIV/AIDS and vulnerable populations including rural populations and women; in the case of malaria, the rural populations; while in the case of safe water, the parents with children under-five years of age.
PACE receives funding from USAID, DFID, UNICEF, The Global Fund To Fight AIDS, Tuberculosis and Malaria, Procter and Gamble - Children's Safe Drinking Water, CDC, PEPFAR, NORAD, CSF, UNFPA, Youth AIDS, and Johnson & Johnson.

Annex 3: Organisations in Uganda working on women's health and SRH by district

District	Project/Organisation	Problems Addressed	Specific Interventions	Affected Population Groups	Location / Coverage
Amuria	1. None	Not applicable	Not applicable	Not applicable	Not specific
Amuru	1. Back to School Campaign (UNICEF) 2. Immunisation days plus (GoU/UNICEF) 3. Providing youth with SRH services (Straight Talk/Amuru DLG/GoU)	Lack of support for resumption of school for girl dropouts New infections of HIV/AIDS/STI Re-emergence of polio and other immunisable diseases Teenage pregnancies		Adolescents, children below 5 years, young girls	Kilak County, Amuru, Atiak, Lamogi, Pabbo, Amuru Town
Apac	1. HIV/AIDS reduction Maternal and infant mortality 2. NUMAT/AMREF/TASO/RH-Apach	High maternal and infant morbidity Inadequate HIV /AIDS counselling and testing New infections of HIV/AIDS/STI	Circumcision, HIV/AIDS counselling Testing and treatment, immunisation PMTCT Providing family planning services	All males for circumcision Children below 5 years, Females of reproductive age	All sub-counties
Bugiri	1. Birth and death registration data collection 2. LOGICS	Lack of data for planning Lack of vital statistics	Coordination of vital registration Routine data collection		Bugiri TC, Buluguyi, Bulesa, Iwemba, Nabukalu, Buwunga, Nankoma, Bulidha, Muterere, Budaya, Kapyanga
Bukedea	1. APOOLO NA ANGOR OVc and PLWAS 2. Community Information System 3. Community Linkages with VHTs (THETA) 4. Education - Building Africa (GoU/Bukedea), 5. Keep Children Learning (UNICEF) 6. Kumi PAG Planning and Development , PREFA (PREFA/Bukedea LG) 7. Reproductive Health and	Discrimination of the girl child in schools High poverty levels Inadequate capacity of staff Inadequate HIV /AIDS Counselling and testing Lack of data for planning, Limited skills among VHTs Mother-to-child transmission of HIV New infections of HIV/AIDS/STI Poor maternal health	Data processing and dissemination HIV/AIDS counselling Testing and treatment Livelihoods support at community level PMTCT Promotion of income-generating activities and community infrastructure Referring pregnant mothers to health facilities Sensitisation of	Children under 5 years, children in primary school, general community, local government employees, pregnant mothers, village health teams	All sub-counties

District	Project/Organisation	Problems Addressed	Specific Interventions	Affected Population Groups	Location / Coverage
	HIV Project (BAYLOR Uganda/Bukede LGa) 8. SAO Agribusiness (SAO/Bukedea LG) 9. Support to POPDEV Integration (POPSEC), 10. SWISS CONTACT - YOUTHS	Prevalence of GBV in the community	communities		
Busia	1. Primary Health Care (GoU)	Lack of community awareness of available RH services Poor health-seeking behaviour	Promoting behaviour change Providing family planning services Stocking service points for RH	General community	All sub-counties
Butaleja	1. Gender mainstreaming 2. Maternal and infant mortality 3. Routine data collection Support to population and development (GoU/UNFPA)	Gender inequalities and limited access to diverse opportunities Lack of data for planning, Misconceptions in family planning	Providing family planning services Routine data collection Sensitisation of communities	Females of reproductive age General community, women Youths	All sub-counties
Buyende	1. GBV prevention at Community level (CFI) 2. Gender equity and diversity (CARE International/CARE Uganda) 3. HIV/AIDS reduction, routine data collection	Gender inequalities and limited access to diverse opportunities Lack of data for planning New infections of HIV/AIDS/STI	HIV/AIDS counselling, testing and treatment, Routine data collection Sensitisation of communities	Children, general community	All sub-counties
Dokolo	1. Child protection (CFI) 2. GBV prevention at community level (CFI) 3. GBV prevention in schools (IDF)	Discrimination of the girl child in schools Low completion rate of girls in primary schools Prevalence of GBV in the community	Not specified	Children in primary school General community, orphaned and vulnerable children	IDF in Agwata, Kangai and Kwera Rest in whole district
Ibanda	1. ANC Care PMTCT 2. Supervised male circumcision	High maternal and infant morbidity Inadequate HIV /AIDS counselling and testing Inadequate options for	Mentorship Supervised male circumcision camps/sites Training	All males for circumcision Mothers with infants, pregnant mothers, village health teams	All sub-counties

District	Project/Organisation	Problems Addressed	Specific Interventions	Affected Population Groups	Location / Coverage
		reducing chances of contracting HIV			
Iganga	1. Advocacy and training of local leaders 2. Community Information System 3. Community sensitisation	Inadequate consideration of community problems in district plans Lack of community awareness of available RH services Lack of data for planning	Routine data collection Sensitisation of communities Training	Households, local government employees, local leaders especially LCI, LCII, parish and S/C chiefs, political leaders, pregnant mothers	All sub-counties
Jinja	1. Lot Quality Assurance Sampling Survey, (PACE, STAR-E)	None Identified	HIV/AIDS counselling Testing and treatment Providing family planning services Sensitisation of communities Support to POPDEV Integration	Children under 5 years, females of reproductive age, men aged 24-54 years, mothers with infants, youths	All sub-counties, all Town councils
Kaberamaido	1. None	1. Not applicable	Not applicable	Not applicable	Not applicable
Kalangala	1. None	1. Not applicable	Not applicable	Not applicable	Not applicable
Kaliro	1. Community Case Management (PACE), 2. HIV and TB Reduction (USAID/STAR-EC/KDLG) 3. Reproductive Health, CS and FP -STRIDES (USAID) 4. Support to HIV/AIDS, TB and Malaria (GLOBAL FUND/USAID 5. Systems and Structures Strengthening - SDS (USAID)	High incidence of malaria and child morbidity High maternal and infant morbidity Ignorance of reproductive health, immunisation, hygiene and sanitation Inability of community to plan and implement interventions Limited supplies of contraception materials Low access and utilisation of LLINS Low access to and utilisation of quality HIV and TB services Low male involvement of male in RH Misconceptions in family	HIV/AIDS counselling, Testing and treatment Mobilisation Outreach services PMTCT Promoting behaviour change Promoting condom use Providing family planning services Routine data collection Sensitisation of communities Stocking service points for RH Support to reproductive health, training	ART adherence groups (PLHW), community structures SMC (14years), village health teams	All sub-counties

District	Project/Organisation	Problems Addressed	Specific Interventions	Affected Population Groups	Location / Coverage
		planning Mother-to-child transmission of HIV Weak community structures			
Kapchorwa	1. Support to Population and Development (GoU/UNFPA) 2. Support to reproductive health (RHU)	Inadequate data for evidence-based RH planning Lack of community awareness of available RH services Lack of data for planning	Promoting behaviour change Promotion of income-generating activities and community infrastructure Providing family planning services Routine data collection Sensitisation of communities	Adolescents, children, general community, women, youths	All sub-counties
Kasese	1. Family Health International (FHI360/Kasese DLG) 2. Poverty Reduction Programme (BTC/Kasese DLG) 3. Strides Uganda for Family Health (USAID/Kasese LG)	High poverty levels,Inadequate capacity of staff Inadequate popularity of family planning methods Limited skills among VHTs Limited supplies of contraception materials Weak information systems	Commemoration of child and malaria days Dissemination of planning and decision making information Immunisation Mitigating environmental degradation Promoting condom use Training	Children, households, mothers of age 15-54, mothers with infants, pregnant others, village health teams, women, youths	Maliba, Kyarumba, all sub-counties
Kisoro	1. Strengthening HIV/AIDS and TB Response in South West	Inadequate HIV /AIDS counselling and testing Limited availability of skilled workers Mother-to-child transmission of HIV	Advocacy, HIV/AIDS counselling, Testing and treatment PMTCT Promoting behaviour change Providing family planning services Provision of Mama Kits Sensitisation of communities Skilled delivery Stocking health Units with drugs	Children under 5 years Females of reproductive age General community MARPS Pregnant mothers	Busanza, Bukimbiri, Chahi, Nyarusiza, Murambo, Nyakihana, Kisoro TC, Nyarubuye, Kirundo, Nyabwishenya, Nyundo, Nyakabande, Kanaba, Murora

District	Project/Organisation	Problems Addressed	Specific Interventions	Affected Population Groups	Location / Coverage
			Stocking service points for RH Training		
Kitgum	1. None	1. Not applicable	1. Not applicable	Not applicable	Not applicable
Kotido	1. None	Not applicable	Not applicable	Not applicable	Not applicable
Kumi	1. Strides	Low male involvement in RH Misconceptions in family planning	Antenatal care Outreach services Provision of Mama Kits Sensitisation of communities Skilled delivery Stocking health units with drugs	Children, general community, women, youths	7 sub-counties
Kween	1. Support to POPDEV Integration (POPSEC)	Inadequate consideration of community problems in district plans Inadequate data for evidence based RH planning Lack of data for planning	Routine data collection Sensitisation of communities		All sub-counties (12 LLGs)
Lamwo	1. None	1. None identified	1. Not applicable	Not applicable	Not applicable
Luuka	1. None	Not applicable	Not applicable	Not applicable	Not applicable
Mayuge	1. Community Information System 2. Prevention of gender-based violence 3. HIV and malaria control	GBV against women and girls Inadequate data for evidence-based RH planning Lack of data for planning Mother-to-child transmission of HIV	Data processing and dissemination Mediation in GBV cases Routine data collection, Training	Local government employees, village health teams, women	All sub-counties
Namayingo	1. Routine data collection	Lack of data for planning	Co-ordination of vital registration, mentorship Routine data collection	General community	All sub-counties
Namutumba	1. Child Protection (SDS/Local Govts/GoU), GBV Prevention (GoU/Irish Aid) 2. HIV and malaria control	Child neglect and violation children rights, GBV against women and girls Mother-to-child transmission of HIV	Advocacy Mediation in GBV cases Medication, Mobilisation Prosecution Support to POPDEV Integration, Training	Children, women, young girls	All sub-counties

District	Project/Organisation	Problems Addressed	Specific Interventions	Affected Population Groups	Location / Coverage
Ngora	1. None	Not applicable	Not applicable	Not applicable	Not applicable
Otuke	1. Community Action Planning (NUREP/World Vision) 2. Family Planning (USAID/Marie Stopes) 3. Gender Equity and Diversity (CARE International/CARE Uganda)	Gender inequalities and limited access to diverse opportunities Inadequate consideration of community problems in district plans		Females of reproductive age General community, local leaders especially LCI, LCII,Parish and S/C Chiefs	Whole district, Okwang S/C for Comm. planning
Oyam	4. Support to Population and Development (GoU/UNFPA)	Gender inequalities and limited access to diverse opportunities Inadequate consideration of community problems in district plans		Children, orphaned and vulnerable children, women	Aber, Minakulu, Otwal, and Ngai sub-counties
Rubirizi	1. Lot Quality Assurance Sampling (USAID/Rubirizi DLG)	Inadequate consideration of community problems in district plans	Routine data collection Training	Men of age 24-54, mothers of age 15-54, mothers with infants, young people (15-24 years old)	Ryeru, Kichwamba, Katerera and Katunguru sub-counties
Rukungiri	1. Maternal and Child Health (USAID/STAR-SOUTH WEST) 2. Promoting Reproductive Health Rights for Socially Deprived Women (IDF/RUGADA) 3. Sexual Health Improvement Project - SHIP(POPSEC/ISREAL)	High maternal and infant morbidity Inadequate data for evidence-based RH planning Limited availability of skilled workers Limited supplies of contraception materials	Advocacy HIV/AIDS counselling, testing and treatment PMTCT Providing family planning services Sensitisation of communities Stocking health units with drugs Stocking service points for RH Support to reproductive health Training	Children under 5 years Females of reproductive age General community, men aged 24-54, mothers of age 15-54 Young people (15-24 years old)	All sub-counties
Sironko	1. None	Not applicable	Routine data collection Support to reproductive health	Children, men of age 24-54, women, youths	All 19 sub-counties and 2 town councils