

UGANDA



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The Republic of Uganda is located in East Africa and lies on the equator (see map). It is a landlocked country bordered by Kenya, Tanzania, Rwanda, Democratic Republic of Congo, and Sudan. Uganda has an area of 241,038 square kilometers, with 18 percent open water and 12 percent forest reserve and game parks. Uganda is mainly tropical forest and savanna woodlands. Uganda has 54 tribes of Bantu, Nilotic, Nilo-hamitic and Sudanese origin.

Uganda had an estimated population of 21 million people in 1998 with a growth rate of 2.6 percent. It is estimated that

47 percent of the population is under age 15, while 23 percent are women of reproductive age (ages 15 to 49). About 90 percent of the Ugandan population lives in rural areas and depends on agriculture. About 66 percent of the population—a large proportion of whom are women—lives below the poverty level. Per capita GNP is US\$300.

The case study covers four districts, shown in highlights here: **Kampala**, **Jinja**, **Lira**, and **Kabarole**, in the central (capital), eastern, northern, and western regions of the country, respectively.

Summary



Only recently emerging from the devastation of a major civil war, the Ugandan government is committed to improving the health and well-being of its population by using the country's available resources. Uganda faces major reproductive health problems that include high infant and maternal mortality, high fertility, and high rates of teenage pregnancies and unsafe abortions. It is estimated that between 1.5 million and 2 million Ugandans are infected with HIV/AIDS.

In the last five years, Uganda has undergone many political, legal, and institutional changes that have influenced all development activities. Some changes have been conducive to improving the status of women and reproductive health. These include the new constitution, which guarantees women's political representation, and several national policies in the areas of population, gender equality, and universal primary education, which promotes girls' education.

Within the broad reproductive health framework adopted at the International Conference on Population and Development (ICPD), the Ministry of Health is focusing on the major priority programs that most affect the population. These programs include safe motherhood and child survival, family planning, prevention and management of sexually transmitted infections (STIs) and HIV/AIDS, capacity building, adolescent health, infrastructure development, and information education and communication (IEC). Though most programs have been in place since before the ICPD, most have changed focus to incorporate aspects of the ICPD Programme of Action.

IMPROVEMENTS IN REPRODUCTIVE HEALTH SERVICES

Family planning programs have helped to increase contraceptive use from 5 percent of married couples in 1990 to 15 percent of married couples in 1995. The rate is thought to be much higher today. Family planning programs have also begun to provide more comprehensive services, including care for STIs, prenatal care, and childhood immunizations, as opposed to "vertical" contraceptive services alone. This has led to obvious increases in service use, especially among under-served client groups such as men and adolescents.

Uganda has also adopted a multisectoral strategy to fight the high prevalence of HIV and STIs. The open government policy on the HIV problem has enabled national and international efforts to innovate and organize to address the problem at all levels of society. As a result of massive IEC campaigns, as well as research and voluntary counseling and testing, more than 90 percent of

adults know about HIV/AIDS. Most current programs are targeting behavior change, especially among young people. There are indications of a declining trend in HIV incidence and an increase in condom use in general.

More attention has also been given recently to safe motherhood, child survival and nutrition, and postnatal and postabortion care. Efforts to improve these services have included training and retraining of providers, equipping health facilities, and mobilizing communities. Systems are also being piloted to refer pregnant women to hospitals in the event of life-threatening complications of labor and delivery.

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REPRODUCTIVE HEALTH FINANCING

The government's contribution to the health sector has been increasing, but is still low given the low tax base in the country (per capita income is only about US\$300). The government spends only about US\$4 per capita annually on health, but surveys indicate that per capita health spending from both public and private sources increased from US\$8 in 1993-94 to US\$12 in 1996-97.

The government's creation and subsequent increase of a primary health care grant to local governments is testimony of its commitment to community health, which benefits mostly women and children. Reproductive health programs are primarily donor-financed—donors pay for about 90 percent of all investments. This raises serious questions about how programs will be sustained after donor funding ends.

Nevertheless, health programs currently attract about 22 percent of all development assistance to the country, an increase from 13 percent in 1993-94. Family planning, safe motherhood, and prevention of HIV/AIDS and STIs have attracted more funding in the last five years. More funding has also gone into universal primary education, agriculture, road construction, and poverty alleviation programs, which also have an impact on the population's health status.

ASSESSMENT OF PROGRESS AND OBSTACLES

The study reveals a supportive policy environment for reproductive health and rights whose benefits are yet to be felt at the community level. Major challenges to implementation include a lack of skilled manpower, infrastructure, and community awareness. There are few trained professionals at the national

and district levels who can implement health-sector reforms and reproductive health programs. The available manpower is not deployed in favor of the primary health care system that serves the majority of the population. Information provided to individuals seeking care and service choice and quality are unsatisfactory.

Reproductive health programs—and indeed all development programs—are now implemented in a decentralized fashion, with funding and management responsibilities in the hands of local governments. In this context, the coordination of donors, NGOs, and the commercial sector is essential to ensure donor funds are distributed equally to different communities and to ensure access to priority services. The study team observed weaknesses in coordination at both the national and local levels.

Universal access to reproductive health services can only become a reality when the entire system's capacity is strengthened. Efforts are needed to develop human resource capacity and infrastructure—in particular, roads and communications systems. In order for these changes to occur, resources must be made available and coordinated well in the health sector and other sectors that influence the health system.



Background



REPRODUCTIVE HEALTH IN UGANDA

Uganda faces many serious reproductive health problems, most of which are preventable. The major reproductive health problems in Uganda include high perinatal, infant, and maternal morbidity and mortality. The 1995 Uganda Demographic and Health Survey estimated that the maternal mortality rate is 506 deaths per 100,000 live births; perinatal mortality is 47 deaths per 1,000 live births, and infant mortality is 81 deaths per 1,000 live births.¹ Uganda has one of the highest adolescent pregnancy rates in Africa (43 percent). The majority of these pregnancies are unwanted. Consequently, there is a high rate of unsafe, induced abortion and associated complications. A 1994 study showed that unsafe abortion causes between 20 percent and 30 percent of all maternal deaths.² Women have, on average, 6.9 children, and only 15 percent of married couples use contraception. There is a high prevalence of reproductive tract infections and STIs, including HIV/AIDS. Between 1.5 million and 2 million Ugandans are infected with HIV/AIDS. Although little data are available, infertility and female genital cancers are major public health problems. Female genital mutilation (FGM) is less widespread, but exists in one tribe, the Sabiny in the Kapchorwa District. There are currently efforts to stop the practice, and the rate appears to be declining.

Several factors are believed to have led to the poor reproductive health profile in the country. These include civil strife, which ravaged the country for over 20 years, leading to the breakdown of the national economy, health infrastructure, and the

quality of health care. There is also a remarkable shortage of manpower in health units at all levels, poorly motivated providers in public health facilities, and insufficient drugs, supplies, and equipment.

This situation has led to communities being less able to afford and access health care, including reproductive health services.

Other factors associated with poor reproductive health are sociocultural practices, beliefs, values, and inappropriate attitudes. Examples are early age of marriage and high illiteracy rates, especially among women. Most ethnic groups in Uganda are polygamous, a practice that is increasingly associated with the spread of STIs and HIV infection. Early marriages and polygamy may also be responsible for the high fertility and population growth rates in Uganda.

Uganda is a patriarchal society. Men are the decisionmakers in the social, economic, and political spheres, and especially in households. This makes women very vulnerable. Among many ethnic groups, children are a means of social security for women. Having children allows them to secure their marriages, gain social status, and gain access to family property.

Most women marry before age 18, the legal age at marriage in Uganda. This promotes high fertility, as women start bearing children at a very early age and continue unabated until a late age. It is estimated that over 70 percent of Ugandan women have had their first pregnancy by age 19.

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The literacy rate in Uganda is reported to be 61 percent (50 percent among women and 73 percent among men). Illiteracy makes it difficult for women to access services, understand and conceptualize issues, and gain economic power and empowerment—especially regarding decisionmaking and controlling their reproductive and sexual health and rights.

For most women, access to quality reproductive health care remains elusive. Many rely instead on self-medication and traditional healers and birth attendants who operate outside the formal health system. For example, the majority of mothers do not benefit from trained health providers at delivery.

THE HEALTH CARE SYSTEM

Health care in Uganda is provided through the Ministry of Health (MOH), the local government, and the private sector, which includes NGOs, private medical clinics, drug shops and pharmacies, and traditional birth attendants (TBAs) and healers. Thirty percent of Ugandans are reported to use modern health services. Of those using modern services, 40 percent use public health facilities and 60 percent use the private sector.

The public sector has different levels of care, including hospitals (at the highest level), health centers, dispensaries and maternity units, aide posts, and the community. All of these offer curative and preventive health services. Providers of these services have diverse training and specialization, which dictates the levels and type of services given. For example, most doctors and specialists serve in the hospitals and in the private sector in urban settings, while nurses and midwives serve in rural health facilities.

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The doctor to population ratio is 1:30,000, while that of midwives is 1:3,000. Use of maternal health services is low: Trained providers in health units deliver babies for only about 38 percent of mothers. TBAs deliver 15 percent, relatives deliver 35 percent, and 12 percent of women give birth by themselves. TBAs have received intensive training in a bid to provide mothers with safe maternity services. These efforts, however, have not reduced the national maternal mortality rate. The lack of effect could be partly due to poor targeting of the training programs. Relatives, for example, have not been included in training programs, although they assist about one-third of deliveries.

The national health policy promotes primary health care (PHC) by improving the quality and effectiveness of services and by improving sources of funding.

The government is working to encourage collaboration and coordination between health services and to improve guidelines.

Presently, Uganda is divided into 43 districts created to facilitate administration. The districts are subdivided into counties, parishes, and villages as the smallest administrative unit. The administrative structure is aimed at facilitating community-based problem identification and solving for priority areas like education, health, sanitation, agriculture, and roads, under the guidance and supervision of the government's line ministries.

ICPD PROGRAMME OF ACTION

The ICPD, held in Cairo in 1994, emphasized the importance of reproductive health to women's overall well-being and called for programs to increase the availability and equity of reproductive health services. The ICPD defined reproductive health as a state of complete physical, mental, and social well-being and not merely absence of disease or infirmity, in all matters relating to the reproductive system. The definition implies expanding access to quality services—especially family planning, prevention of maternal and newborn deaths, and disability and prevention and management of STIs and HIV/AIDS—to every individual. The program also calls for addressing other dimensions of reproductive health such as FGM, rape, domestic violence, forced prostitution, infertility, malnutrition and anemia, and reproductive tract infections and cancers.

STUDY OBJECTIVES AND DESIGN

This case study examines how central elements of the ICPD Programme of Action have been translated into action in Uganda since 1994. The specific study objectives were the following:

- ▶ to identify how family planning and health services have been modified to address individual health needs, as defined in the Programme of Action;
- ▶ to identify the steps that have been taken to improve the environment in which women and couples make reproductive health decisions;
- ▶ to examine how resources have been mobilized and allocated to support these changes; and
- ▶ to find out whether programmatic changes have made a difference to individuals seeking services.

The research team conducted a qualitative policy survey at the central government and district levels. The study is based on interviews with officials from the ministries of Health, Finance, Planning and

Economic Development, and Gender, as well as with major donors in the health sector. The team also reviewed current reproductive health literature, government policies, strategic plans, and program evaluation reports.

At the district level, the team visited major public, nongovernmental, and private service delivery points and conducted interviews with providers and with client groups wherever possible. Team members interviewed administrators, medical department officials, service providers, and clients. In all four districts, the survey covered 14 health centers, six hospitals, 46 providers, and 34 key informants at the national and district level. Three focus group discussions (FGDs) were held with clients and two with providers. The interviews followed a prepared questionnaire for different levels of personnel and a FGD question guide.

STUDY SITES

The team chose four districts—Kampala, Jinja, Lira, and Kabarole—to represent the central (capital), eastern, northern, and western regions of the country, respectively. These four regions have different ethnic groups, cultures, and behaviors, and therefore different health and service delivery challenges. The districts selected also have different donors who can affect the level of funding, priority programs, and services delivered.

Reproductive Health Policies and Programs

POST-ICPD ACTIVITIES

The MOH is conversant with the ICPD Programme of Action. Even before the ICPD, reproductive health services were implemented through the Maternal and Child Health and Family Planning (MCH/FP) Program. However, the MCH/FP commissioner observed that the services and programs had limitations: “The MCH/FP program and services before 1994 were provided in a disjointed manner. Since Cairo, efforts have been made to refocus the programs in a more holistic way. Under the ministry restructuring, the MCH/FP division is being renamed Reproductive Health Division. I hope it will do more and achieve more.”

Having endorsed the ICPD Programme of Action, Uganda is committed to its recommendations. Interviews revealed that the concept of reproductive health has support at the highest levels. The MOH has adopted the ICPD definition of reproductive health, which emphasizes addressing the individual in a holistic manner. Recognizing that ICPD goals are beyond national capacities, however, the MOH chose priority areas, including promotion of safe motherhood, capacity building, infrastructure improvement, family planning and reproductive health advocacy through IEC. These are given major emphasis in the five-year national strategic plan for MCH/FP. Although they have not received much funding, other reproductive health problems such as infertility and genital cancers are receiving

more attention. The practice of FGM is also being addressed in the one area of the country where it exists.

The health desk within the Ministry of Finance, Planning, and Economic Development is overseeing and coordinating planning and budgeting for health sector activities within the overall national programs. Within this ministry, issues related to reproductive health are perceived as important and influencing overall development strategies. The head of the National Execution Unit in the Ministry of Finance, Planning, and Economic Development said: “All issues of reproductive health are government priorities and are being re-emphasized in a more focused way. These are deserving sectors and need to be strongly funded.”

As part of government commitment to integrate the issues of population and reproductive health, the Population Secretariat has been created to link central government initiatives with local governments and other key ministries and players. This unit has had a major role in advocacy and promotion of ICPD recommendations that fall within its mandate. Interviews revealed that the concepts of reproductive health were familiar in the ministries of Health, Finance, Planning, and Economic Development, Gender, and among major donors in the health sector.

It is apparent, however, that there has been little dissemination of Cairo recommendations nor discussions with stakeholders to create a common vision on how to address reproductive health activities. Dissemination of ICPD recommendations is especially lacking at the district level. District

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managers are not aware of ICPD recommendations, although the key concepts have been integrated in training programs for providers.

POLICY ENVIRONMENT FOR REPRODUCTIVE HEALTH

Since 1993, the Ugandan government has enacted several policies that reinforce reproductive health efforts. One of these policies is the national population policy, which was in draft form at the time of the 1994 ICPD and enacted in 1995. The National Population Policy addresses the high annual population growth of 2.9 percent, high fertility, and related maternal morbidity and mortality. The policy goals are to improve these indicators through informed choices, service accessibility, and improved quality of care. The implementation strategies involve all sectors of development, such as education, health, agriculture, economy, and culture.

This policy benefited from the recommendations of the ICPD. It incorporated an emphasis on individual choice, reproductive rights, and the removal of family planning targets. Other aspects of the ICPD incorporated in the policy include more focus on adolescent health programs and the need to enhance collaboration with NGOs and the private sector in policy implementation.

The Uganda constitution guarantees the participation of women in decisionmaking processes at all levels of government by reserving 30 percent of the electorate seats for women. This is an effort to promote the status of women and to promote gender sensitivity at all levels. In addition, women are free to contest for other seats in their own capacity. This has enhanced women's decisionmaking at all levels and has helped women's voices be heard. Women in leadership have formed associations to train themselves and their peers in leadership roles and also to build awareness among women leaders about issues concerning women and development.

In 1997, the government adopted a National Gender Policy whose key aspects are to integrate gender into development efforts at all levels for planning, resource allocation, and implementation of development programs. The creation of a Ministry

of Gender is one of the hallmarks of the government's commitment to integrate gender concerns in development. The Land Act, enacted in June 1998, has established a platform for land ownership by the poor and women in particular. This is considered a major development in the empowerment of women.

In response to the high level of illiteracy and its impact on national development, the government launched a Universal Primary Education (UPE) policy to provide free primary education to four children per family. Half of UPE enrollment is reserved for girls. This is expected to raise school enrollment of girls and female literacy rates. It is hoped that this will empower women socially, economically, and politically and enable them to demand their rights and reproductive health needs. This program has received top priority in the government social sector spending since its inception in 1996.

An Adolescent Health Policy has been drafted and seeks to address adolescents' needs in a multifaceted way. As far as reproductive health is concerned, the policy calls for establishment of friendly, confidential young peoples' services. Though sex education has long been incorporated in the school curricula, its implementation has been questionable. The policy gives more impetus to implement health education programs in schools and out of school to equip adolescents with life skills before sexual activity. Adolescent programs are being piloted in urban areas, with the hope of being adopted eventually at the national level. In addition, the parliament set the minimum age of marriage at 18 years.

DECENTRALIZATION

The government is pursuing a policy of decentralization with the objective of strengthening local governments and empowering communities to govern and mobilize their own resources. The process is still in its infancy, however. Constraints

include political conflicts in some communities, which have occurred because of competition for influence.

In some cases, inconsistent government actions may have undermined local leadership capabilities. More often than not, the central government releases funds that fall short of requirements or are cut to accommodate certain unplanned activities. Technical deficiencies, as well as lack of human capacity, are also a real challenge. Successful decentralization requires a strong, capable central government to mentor, monitor, and regulate activities without undue administrative interference.

In spite of the government's commitment to ICPD goals, implementation is constrained by lack of community awareness, skilled labor, and infrastructure, as well as poverty and sociocultural barriers. Many observers have noted that most of the policies enacted have not filtered to the household/family level. In order to bridge the gap between national policies and household practices, the government is attempting to communicate more with local leaders. The government is also trying to enhance economic empowerment through poverty alleviation programs. On another front, a domestic relations bill is currently being debated and seeks to address family issues such as property rights and polygamy, among others. This bill has been widely debated by the public and has met some resistance from certain religious denominations.

PROGRAM PRIORITIES

Given resource constraints in Uganda and the breadth of the ICPD recommendations, the government has prioritized reproductive health programs to include safe motherhood, family planning, STI/HIV prevention and treatment, child survival, and adolescent

health. Other priority areas include capacity building, infrastructure rehabilitation and expansion, postabortion care, IEC, and reproductive health advocacy. These programs are receiving major emphasis in the Five-Year National Strategic Plan for Health 1997-2001. The strategy aims at having a phased approach to the comprehensive reproductive health package. This approach ensures that progress is made in priority programs before new ones are added. Peter Savosnick, chief of party, Delivery of Improved Services for Health (DISH) project, said, "We could not take Cairo wholesale, even if we wanted to ... until the systems are ready and people are in place to handle the workload."

Lack of capacity at the local level is a major constraint in the implementation of reproductive health services. The MOH and donors perceive manpower resources to be an even greater constraint than finances.

The process of decentralization has given the responsibility of planning, decision-making, and implementation of all programs to the districts. Unfortunately, the awareness and capability at the district level was found to be seriously lacking. "Decentralization has given us more responsibility than both human and financial resources to implement programs," said Betty Rwigare, chief administration officer, Jinja District.

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SERVICE INTEGRATION

The team found that health centers offered comprehensive and integrated reproductive health services. Family planning, prenatal care, delivery and postnatal care, STI/HIV care and counseling, nutrition education and childhood immunizations are provided daily by the same providers. The move from providing separate “vertical” services to integrated services is a new development in the last three to five years. Most health centers are training and supervising TBAs and offering community outreach clinics for all services except delivery care.

Unlike health centers, both NGO and government hospitals still provide reproductive health services in a vertical manner—in special clinics, by specialized providers, and on specific days. In some NGO hospitals and health centers, there is little or no specific focus on reproductive health. The director of a Catholic hospital in Kabarole admitted, “I can’t say that we are doing much about reproductive health.”

FAMILY PLANNING

The national goal for family planning is to increase the contraceptive prevalence rate from 15 percent to 30 percent by the year 2001. The strategies include efforts to improve the quality and accessibility of contraceptives and to diversify the range of methods and distribution outlets available. Access has been increased through community-based distributors (CBDs), social marketing programs, and use of mobile clinics. Family planning training programs have also targeted nontraditional providers such as pharmacists, private practitioners, drugshops, bar attendants, and community health workers to increase service access.

The team found family planning services offered in all institutions visited, including public and NGO hospitals and clinics of the Family Planning Association of Uganda (FPAU). While family planning programs have focused on women for a long time, recently some programs have made efforts to involve

men. Most programs provide information, education, and counseling to men. Some health centers are promoting male contraceptive methods such as surgical contraception (vasectomy). Midwives in FPAU clinics and medical attendants in health centers said they are promoting condom use. Some health center staff members reported that they encourage men to support women to use family planning. The Association for Voluntary Surgical Contraception (AVSC) initiated a program to ensure quality surgical contraception. The scope of AVSC has been broadened to include HIV/STI counseling and testing, postabortion care, infection prevention, and support supervision.

Most women use injectables, such as Depo-Provera[®], because of the method’s convenience and privacy. Oral contraceptives and intrauterine devices (IUDs) are less common and more closely associated with misconceptions and myths. One client expressed her fears about using an IUD: “The piece is said to cause a lump in the tubes leading to cancer, also may get pushed up by the man and disappear inside during sexual intercourse.”

Oral contraceptives and condoms are second to injectables in popularity. Inadequate supplies of other contraceptives in health centers leave clients

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with few choices. Surgical contraception was available at all hospitals visited, while Norplant® was offered in only two. In any case, many clients do not want to be referred to hospitals for methods not offered at the health center. They are discouraged by transport costs, the unfamiliar hospital environment, and the need to keep their search for a method secret from disapproving husbands.

The Uganda Demographic and Health Survey estimates current unmet need for family planning at 29 percent. (Unmet need is the percent of women expressing a desire to space or limit childbearing, but not using contraception.) Although it is believed that one of the major reasons for nonuse of family planning is the desire for large families, about 27 percent of women are not using contraception because of myths and misconceptions about methods, indicating a significant need for more education about contraception.

Physical access to family planning services is a major barrier to those in need. The median distance to the nearest facility with family planning services is estimated to be 20 kilometers. This is too far for most women, since the main mode of transport is walking or cycling.

CBD programs distribute mainly contraceptive pills and condoms. The success of CBDs, which are staffed by community volunteers, indicates that availability and accessibility strongly influences the choice of method. Their influence as peers was found to be an important determinant of method choice. Interviews revealed, however, this approach may not be sustainable. CBDs in one focus group complained about the lack of incentives, and some had dropped out due to lack of remuneration. The only compensation they receive is the status of their role as CBD.

Overall, there is evidence of increasing use of contraceptives. Nonetheless, there is a need for greater male participation in family planning and

reproductive health issues. Condom use continues to be low; this method is chosen mainly for HIV/STI control rather than for family planning.

THE SAFE MOTHERHOOD PROGRAM

Maternal mortality is unacceptably high in Uganda, at an estimated rate of 506 deaths per 100,000 live births. Although rates of disability are undocumented, there is evidence that this is also exceptionally high. The safe motherhood program aims to reduce maternal deaths by 20 percent by the year 2001. The major components of the program are provision of quality prenatal care, ensuring availability and accessibility of emergency obstetric care, safe and clean delivery, postnatal care, and family planning. Activities include training of midwives and other health providers, including TBAs, in life-saving skills to provide quality delivery care. A training program for comprehensive reproductive health has also been instituted. The program is trying to standardize training through the development of common curriculum guidelines, supervisory tools, and a team of trainers. The program is also attempting to develop a functional, sustainable referral system to prevent maternal deaths. In Kabarole, the 1997 district health report states that about 10 percent of Caesarean sections are due to a ruptured uterus, which results from a late referral.

The MOH is working on the safe motherhood program in collaboration with donors, NGOs, the private sector (especially private midwives) and community health providers. The MOH is carrying out training programs to build awareness among district and subcounty administrations and communities about safe motherhood issues. At the community level, programs are training health workers such as TBAs, pregnancy monitors, and traditional healers to identify women with potential complications for appropriate referral. Due to the acute shortage of midwives, TBAs are being trained and equipped to provide safe and clean maternity services in the communities. IEC materials have been developed in the form of pamphlets and videos to address issues faced by fathers and adolescents.

Abortion in Uganda is a major public health problem. Although induced abortion is against the law (except where the life of mother or her unborn child is at risk), unsafe abortion is common. Abortion complications lead to between 25 percent and 30 percent of maternal deaths and are linked to problems such as hemorrhaging, infections, ectopic pregnancies, and infertility. A postabortion care program has been developed that trains and supervises doctors and midwives in both public and private sectors in postabortion care and the use of manual vacuum aspiration technology.

THE HIV/STI PROGRAM

The HIV/AIDS epidemic is a major challenge to social and economic development in Uganda. An estimated 1.5 million Ugandans are infected with HIV, and 1 million children are orphaned due to HIV/AIDS. The age group most affected by AIDS (ages 15 to 50) occupies a critical position in family support systems, community development, the labor force, and leadership in society. HIV therefore touches every aspect of national life and development. Due to the nature of transmission, HIV cuts across different cultures and economic classes, intermingling issues of poverty, inequity, culture, and sexuality. As early as 1986, the government recognized the disease's impact on national development and began fighting its spread.

The government instituted a multisectoral strategy involving all relevant ministries, including Health, Labor, Gender, Defense, Education Information, and Agriculture; as well as private citizens. The goals of the national program are to (1) stop the spread of HIV infection; (2) mitigate the health and socioeconomic impact of AIDS; (3) strengthen national capacity to respond to the epidemic; (4) establish an effective information base; and

(5) strengthen national capacity to undertake research on HIV/AIDS control and prevention.

The main programs include IEC, research, voluntary testing and counseling, safe blood transfusions, school health programs, and home-based care for people living with AIDS (PLWA) and for orphans. Recognizing that STIs were responsible for the fueling of the spread of the epidemic, the government has made available nationwide treatment campaigns through a World Bank program. They have also integrated the AIDS control and the STI programs.

The program is currently extending services to underserved groups such as youth, women, and PLWA. In order to target youth before they start having sex, sex education programs are being instituted in schools.

The program encourages parents and community leaders to get involved in these efforts. In

addition, UNICEF and UNFPA are piloting several programs in essential life-skills training to provide sex negotiation skills.

The government formed the Uganda AIDS Commission (UAC) to harmonize policies and plans for the AIDS response in the country. Members of the Commission include parliamentarians and representatives of ministries and religious organizations. The Commission's mandate also includes efforts to improve treatment, vaccine development, and promotion of behavior change. The deliberate government openness to the HIV/STI problem has facilitated collaborative research in HIV/AIDS care and control.

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The national strategic framework for HIV/AIDS activities in Uganda estimates that HIV/STI-related spending from 1994-96 was US\$117 million.³ From 1998 to 2001, estimates indicate that the cost of critical activities is equivalent to the entire annual health budget of US\$130 million. This means allocating over 25 percent of the health sector budget to HIV/STI activities in the next four years. The critical areas include HIV testing and counseling, STI screening and treatment, home-based care of PLWA, and capacity building at the district and national levels for epidemic response and control.

Resources are not adequate enough to put even this modest package into action. It does not include ambitious programs with prohibitive costs such as the retroviral therapy now available in developed countries at US\$15,000 per patient per year. John Rwomushana, who works with the AIDS Commission, said: "More needs to be done to bring comfort to the lives of people sick from HIV-related illness. Painkillers, anti-diarrheals, and basic medicines to treat opportunistic infection are not affordable to the majority of people in the poorest communities."

Despite serious constraints, HIV control efforts are showing a declining trend in HIV prevalence. Of the 20 sentinel surveillance hospitals in the country, five report a declining trend from 1991 to 1995. For example, in Nsambya hospital, rates among prenatal women have decreased from 28.8 percent to 16.8 percent.⁴ Public awareness of HIV is over 90 percent in the adult population, though behavior change is seriously lagging behind. Only

11 percent of men and 2 percent of women are reporting the use of condoms for the control of HIV and 53 percent and 55 percent of women and men respectively report having restricted their sexual activity to one partner.⁵

There is still a need to link the success achieved at the national level to grassroots and community-based organizations. Though still weak, community efforts to cope with the HIV epidemic have been commendable. The threat of HIV has transformed the communities into groups to prevent HIV, support victims, and provide care for orphans. Youth organizations and social groups are taking care of victims and helping to mobilize against the spread of HIV. By 1994, over 4,000 NGOs were registered and operating in the area of HIV/AIDS care, prevention, and orphan support.

The AIDS Information Center (AIC) is now offering counseling, testing, and treatment for STIs, as well as offering family planning. Traditionally, AIC offered anonymous testing and counseling as a strategy to curb HIV/AIDS transmission. There has been a move to integrate AIC services by adding family planning and STI counseling and treatment in order to serve clients better. The benefits of these efforts are evident as increasing numbers of youth come for services. Josephine Kalule, the Information and Evaluation officer of the AIC, said: "This is a new aspect of integration that we have just adopted. A need has been felt to have these additional services incorporated in the clinical package in order to service a wider clientele and also reduce the stigma attached to the traditional vertical HIV services. We want to evaluate how service integration reinforces the utilization of each of the services provided."

Despite serious constraints, HIV control efforts are showing a declining trend in HIV prevalence. Of the 20 sentinel surveillance hospitals in the country, five report a declining trend from 1991 to 1995.

In order to reach the poor, AIC has set aside one free clinic day each week to provide services to those who can not afford the user fees of US\$3. The client package includes family planning, HIV counseling and testing, and screening and treatment of STIs. The free clinic days are popular with youth and poor residents who live near AIC clinics. In 1997, when the AIC in the capital city relocated to a highly populated peri-urban slum, service use by poor and young people increased.

ADOLESCENT PROGRAMS

Uganda has one of the highest rates of adolescent pregnancy in Africa (43 percent). By age 17, about one-third of girls had given birth. The majority of adolescents between ages 15 and 19 are sexually active (68 percent for females and 75 percent for males). The UN-supported Basic Education for Childcare and Adolescent Development (BECCAD) and the Program to Enhance Adolescent Reproductive Life (PEARL) programs are focusing on improving reproductive health information for adolescents. BECCAD covers 29 districts with the focus on STIs, sexuality, postabortion care, family planning, early pregnancy, rights of children, and the prevention of defilement and rape. Their strategies include creating “adolescent-friendly” services and recreation activities. They offer training in psychosocial life skills to promote behavior change.

In general, these outreach programs are small, community-based efforts that provide reproductive health information and counseling to teens. They are yet to be integrated in mainstream health services. Often, adolescents do not seek care or will not use the same services as adults. Or health providers may be too overworked to reach out to young people and may not approve of their

behavior. The government now has a draft adolescent policy to provide guidance to all health providers and to integrate adolescent programs into mainstream health services.

INFORMATION AND ADVOCACY ACTIVITIES

Every program component of reproductive health has an IEC component. IEC programs are trying to involve all afflicted communities, i.e. adolescents, women, men, and PLWA in their information networks. Though instituted to combat HIV, IEC programs have now been diversified to promote broader reproductive health issues. This has been done mainly through the mass media. Popular FM radio programs cover topics such as sexuality and STI prevention and control. Newspapers, special youth magazines, pamphlets, awareness-raising workshops, and drama shows have targeted different levels of society, including the grassroots level. The STI project is leading in this effort, due to its nationwide coverage and involvement of as many stakeholders as possible.

Advocacy for reproductive health is not yet very strong. There is, however, a multisectoral reproductive health advocacy committee, as well as women’s groups and activists who advocate for women’s reproductive health. There is a Ministry of Gender, Community Development and Labor that has the mandate to advocate for women’s health, rights, and empowerment.

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INFRASTRUCTURE AND CAPACITY BUILDING

One of the major constraints in service delivery, expansion, and quality remains the lack of trained manpower. The doctor and midwife to population ratios are 1:30,000 and 1:3,000, respectively.⁶ In order to improve this dismal situation, much effort has gone to in-service training and retraining of health providers to enable them to provide up-to-date care and to address more health needs, especially in reproductive health. There are also efforts aimed at improving management information systems for better health planning, budgeting, and accounting.

There have been obvious efforts to train in comprehensive reproductive health services in most districts. This is particularly evident among the rural health center providers. Nontraditional reproductive health providers, such as general nurses and clinical officers, have been trained to provide reproductive health services, which were traditionally provided by midwives. The team found that between 40 percent and 50 percent of staff in health centers were trained in comprehensive reproductive health service provision. In addition, the trained staff were training their colleagues, a practice not found in hospitals.

Though hospitals serve as district referral centers and are responsible for supervision of rural health networks, they have benefited less from the recent training efforts. In the hospitals, only one or two people have been trained in comprehensive reproductive health services. This is largely because the rural health center networks are directly under the decentralized district health systems, while the

hospitals are directly under the MOH. Hospital budgets do not make allowances for provider training, yet the district budgets reserve a significant amount of funds for this purpose.

Selective training of providers in health centers without training hospital staff may have serious implications for the management of referred clients and the supervision roles of the hospital. Due to the current shortage of trained manpower, TBAs, CBDs of contraceptives, community counseling aides, and many other groups have been trained as a short-term strategy to improve the quality of care at the community level.

Due to the prolonged period of neglect and infrastructure deterioration, the government has financed major renovations of health facilities with help from many sources, especially the World Bank and the European Union. In some health facilities, the World Bank project (District Health Services Project) has procured and distributed new equipment. The general state of equipment at all levels, however, is unsatisfactory.⁷

Strong coordination is also desirable due to the multitude of donors and NGOs trying to implement programs in a decentralized environment. It is necessary to avoid variability in service standards and messages getting out to the communities.

COORDINATION AND COLLABORATION

Given the breadth and diversity of ICPD recommendations and the number of stakeholders, successful implementation of reproductive health objectives requires strong coordination among donors, ministries, district managers, and services. Strong coordination is also desirable due to the multitude of donors and NGOs trying to implement programs in a decentralized environment. It is necessary to avoid variability in service standards and messages getting out to the communities.

In order to distribute donor funding equitably among districts in the country, the Ministry of Finance, Planning, and Economic Development

registers and assigns donors to different districts. The assignment of a donor to a particular district depends on the district's needs, resource gaps, and donors' desired programs.

The donors have formed a forum where they meet regularly to share experiences and information. At such meetings, different donors' roles have been mapped out to avoid duplication of efforts, especially in the procurement of drugs. The United Kingdom's Department for International Development (DFID) is currently procuring most STI drugs and injectable contraceptives, while the United States Agency for International Development (USAID) procures all oral contraceptives, and the Danish International Development Agency (DANIDA) provides general essential drugs. There have been discussions on the "sector-wide approach," which aims to harmonize planning and strengthen coordination among the government and donors. Most donors, however, express the desire for stronger leadership and guidance from the MOH—especially in policy formulation, defining standards of care, training curricula development, and supervision. Given the decentralized health systems, ongoing reforms, and restructuring processes, the MOH has to define its roles and develop the capacity to set and supervise standards, and develop and evaluate policies—in addition to playing its traditional role of directing health service delivery.

DONOR INFLUENCE

Despite their efforts to honor national priorities, donors more or less dictate programs. The bargaining power of district decisionmakers is minimal because of the inadequate funds at their disposal. Because they depend so heavily on donors for funds, they tend to accept projects as they arrive. Decentralization means that standardization of programs in different districts is difficult. There is, therefore, a strong need for appropriate guidelines for all districts.

Lack of coordination at different levels still leads to duplication of efforts. For example, donors rarely share training materials and monitoring tools. Fortunately, central training manuals are being developed. Another important issue is the need to

maintain standards and quality, which is difficult in an uncoordinated environment. Improved coordination would reduce duplication of efforts, save resources, and build on different programs' strengths.

ROLE OF NGOs

The NGO health delivery sector is broad, consisting of religious groups who manage health units, private medical clinics, and other specialized reproductive health organizations. Examples of the latter category are the FPAU, Marie Stopes, PEARL, RESCUER (Rural Extended Service and Care for Ultimate Emergency Relief) and REACH (Reproductive, Educative and Community Health). PEARL is a program for adolescents while RESCUER and REACH are programs for maternal referral and communication systems and FGM control respectively.

The government has long recognized the need for partnerships with NGOs in health delivery, but following the ICPD, collaboration with NGOs has been revitalized and strengthened. The main objectives of collaboration are to improve quality of care, increase cost-effectiveness of services, and make optimal use of the limited manpower available for health programs. Since the ICPD, the private sector has been incorporated in government activities for reproductive health services. Private midwives, TBAs, and traditional healers are being supported and supervised to provide quality services in the community.

Collaboration between governments and NGOs has taken place in the development of policies and collaborative training, provision of grants, and sharing of trained staff. The government is moving toward contracting service delivery to NGOs. District administrations are also increasingly supporting NGOs and the private sector. For example, the MOH is giving FPAU clinics funds for community outreach and NGO hospitals block grants for their operations. The government has also developed

formal relationships with the traditional sector. Traditional birth attendants have been trained on the job in public health units and are being supervised upon return to their communities. Although all health providers of government, NGOs, and private medical clinics are required to report directly to the district medical officer, this is far from being realized. As such, there are inadequate statistics on the use of specific services. Sharing information is paramount for meaningful planning, budgeting, and coordination at the district level.

PROVIDERS' PERSPECTIVES

The team found that providers' attitudes depend on whether they work in public, private, or NGO settings and whether they work in hospitals, family planning association clinics, or health centers. Attitudes also depend on the providers' training, skills, and understanding of reproductive health concepts.

About 40 percent to 50 percent of providers in the rural health centers have recently been trained or retrained in reproductive health and STI care. This improves providers' knowledge and skills to handle reproductive health problems with confidence. A few trained providers are passing on the skills to their colleagues on the job. A midwife at Kawempe Health Center said: "The two of us have been trained in comprehensive reproductive health by DISH. We are treating the mothers better. We counsel and give treatment for HIV, STI, and family planning. Mothers go away with everything they need at the same visit."

However, most providers in public hospitals had not had training or refresher courses in reproductive

health provision and were unmotivated. Due to the shortage of staff in public hospitals, there is a "run through and clear the line" attitude by midwives, making the quality of care provided to clients and patients unsatisfactory. "[Pre]natal care is still a problem. Although a significant number of mothers attend, the quality is low," said Dr. Kabagambe, the district director of Health Services in the Kabarole District.

Hospital providers see integration of services as additional work and, unlike their counterparts in the health centers, they do not appreciate how to link up services to provide a holistic reproductive health package. As a consequence, reproductive health service components are fragmented, with intra-hospital referral practices creating some missed opportunities for family planning and STI treatment. "We are few and already overworked," said a midwife in the Lira District Hospital. "Imagine attending to 100 plus (prenatal) mothers a day, then EPI (childhood immunization), family planning and STIs. We need more staff to do all this at once."

Providers in the health centers, FPAU, and NGO hospitals reported that integration had revolutionized the services they provide and that they worked better as a team. They have added new services. For example, the FPAU clinic in the Kabarole District, with the support of district health department, has started immunizing children at the clinic and at outreach sites. Missionary facilities provide surgical family planning services or invite FPAU to provide family planning services at their facilities. A woman in charge of the Mission Health Center in Kabarole District said: "The District medical office supports the FPAU to come and offer family planning from here every Thursday. We counsel the mothers about family

About 40 percent to 50 percent of providers in the rural health centers have recently been trained or retrained in reproductive health and STI care. This improves providers' knowledge and skills to handle reproductive health problems with confidence.

planning, especially the natural methods. Since we serve everybody in this area, we tell those interested in other methods to come and see the FPAU people.”

A midwife in the Kampala District said: “It was evident that the providers saw the process of integration as addressing the client needs in a holistic manner. Providers were happy with the integration since they claim it saves time for both the provider and the clients. We used to have fully packed clinics every day, but the same mothers were coming for the different clinics.”

Overall, integration of services has helped to increase the number of clients, especially for family planning. Mothers use health center visits (immunizing their children, in particular) as opportunities to obtain family planning secretly. This practice is partly due to a lack of cooperation from husbands regarding family planning. The method of choice for these women is Depo Provera® injections because they can conceal the method from their disapproving husbands. In addition, more people are being treated for STIs due to the integration of STI screening in the reproductive health services.

A midwife in the Kampala District said: “Clients are more encouraged to come for STI now than before due to a couple of reasons: The clients need not undergo the dehumanizing process of laboratory investigation or the need to tell the story to the whole hospital staff. I remember we used to call our friends to see a male with gonorrhea at the clinic. Few of the clients would come for the whole course of treatment due to the stigmatization of STI. Now all this is history.”

Providers regarded HIV/STI and fertility-related problems as very important. They routinely provide

information about family planning and HIV/STI during health education talks and counseling. Providers feel this has slowly helped their clients make decisions about child spacing, sexual behavior, and family planning method choice. Male interest in these issues is generally poor. Although rarely, some men do accompany their wives to the family planning clinics. Providers think this is due to the wide range of services now provided, especially STI treatment and the system of partner notification. Men were also said to accompany their wives to give moral support, especially when the family planning method chosen is sterilization. The few men seeking vasectomies, however, are said to come alone and prefer to keep the procedure a secret from their wives.

Providers noted that few clients request HIV counseling and testing. They felt there is still a lot of denial regarding HIV/AIDS risk and infection by the community. One provider in Lira said, “Although we see many patients on the wards, most people in the communities regard HIV/AIDS as witchcraft.”

Communities need more information about HIV/AIDS and STIs. Providers noted that they see many STIs. People openly talk about them and seek treatment. One provider in the Lira District health center said: “Our patients do not know the relationship between HIV and STI. When you try to counsel and relate the two disease entities, the patients get annoyed that we think they have AIDS—some go away without further investigations and treatment.”

A midwife in the Kampala District said:
“It was evident that the providers saw the process of integration as addressing the client needs in a holistic manner. Providers were happy with the integration since they claim it saves time for both the provider and the clients.”

Providers are very concerned about infection—especially HIV—as they provide reproductive health services. A midwife in Jinja said: “Because our patients are not tested, neither most of us, we need to keep absolute barriers between ourselves and the patients. We have a big problem of gloves and Jik (chlorine solution) to ensure absolute sterility, but we try our best.”

Providers also expressed concerns over other general issues such as lack of training to deliver the expected services, heavy patient loads for too few providers, lack of consistent supplies and equipment, and low and erratically paid salaries. The providers trained in comprehensive reproductive health were happy about their new skills, but expected regular supervision from the trainers as well as better salary benefits and promotions with their new roles.

CLIENTS’ PERSPECTIVES

The researchers interviewed family planning clients, mothers in maternity wards, and relatives of patients. The team found that clients are more satisfied with providers’ services and attitudes in lower-level health centers than in hospitals. In hospitals, clients feel they wait for too long for services. Clients expressed a desire to have more information on their conditions, instructions on care, and follow-up care.

The team also found that women were more positive than men about using contraceptives. Most women believe that their partners are not supportive. However, there was evidence that couples rarely discuss family planning and sexuality.

In interviews and FGDs, men felt that women should take responsibility for family planning, since they are the ones who endure childbirth, while women complained that their husbands prevent them from practicing family planning. Men prefer their wives to have surgical contraception (tubal ligation) instead of having vasectomies themselves. Neither men nor women seem to understand how vasectomy works. Indeed, women prefer undergoing a surgical procedure themselves instead of asking their husbands to have a vasectomy.

The discussions also revealed that men are the decisionmakers in many reproductive health matters. In most cases, couples do not seem to decide together when to have the next child. Because most women are not using contraception, they find themselves repeatedly pregnant. One 30-year-old woman in a maternity ward in Kabarole was suffering from maternal depletion syndrome as she prepared to have her eighth child. She said she had not discussed family planning with her husband, but she assumed he would be opposed. Continued use of family planning is dependent on the approval and support of men.

The FGDs revealed that most participants want a minimum of five children. Also, there is a preference for boys, indicating that couples will continue producing in search of male babies. Peer influence affects the method of choice for family planning. In one clinic in Kabarole, every woman wanted injectables because friends/neighbors had successfully used the method. The role of information and counseling was also weak and resigned to the “pre-determined” choice in the community. In an FPAU clinic in Kampala, clients said their choice of method depended not just on counseling but also on peer influence and husbands’ attitudes toward certain methods.

In two health centers, clients were happy and more satisfied with the way services were provided. “These days it is much better coming here because they treat for everything daily. Those days, you would have to come many times, now we come once for ANC, my immunization and also they see those children who are sick. It saves money,” said a pregnant mother with a 2-year-old child.

Service clients pay user fees with no reservations. One woman in an FGD in a client group in the Jinja District said: “We pay something for treatment, but not much—Shs. 500 or Shs. 1,000 (US\$.50-US\$1). Most of us can afford it and we get better treatment. The nurses care. They are very friendly.”

Funding for Health Services

The Minister of Finance reported in a 1998 budget speech that Uganda is considered successful in improving its economy through the structural adjustment program. Uganda's apparent success with structural adjustment has attracted donors. Uganda is experiencing economic growth as it undergoes reforms. Inflation is about 5 percent.

The government commits 7 percent to 9 percent of the total budget, or currently about \$4 per capita, to the health sector. Considering total health expenditures from the government, private sector, and donors, per capita spending on health was about US\$8 in 1993. The Social Dimensions of Adjustment (SDA) survey showed that this increased to US\$12 in 1996.⁸

RECURRENT EXPENDITURES ON HEALTH

The private, government, and donor contribution to recurrent health expenditures is about 75 percent, 17 percent, and 10 percent respectively.⁹ Most government spending is on operational costs like salaries and materials, rather than on particular programs. However, operational costs are still grossly underfunded, as illustrated by low salaries and inadequate materials and drugs.

Underfunding of health programs is principally attributable to a low tax base. Tax revenue in the financial year 1996-97 was only 11.5 percent of gross domestic product (GDP). While government revenue will increase with economic growth, it is not projected to rise above 17 percent of GDP by 2001.¹⁰

Table 1 summarizes recurrent expenditures in the health sector between 1994-95 and 1997-98.

DONOR FUNDING OF HEALTH PROGRAMS

Health programs in Uganda are largely dependent on donor financing. In recent years, the donors' contribution to development expenditure has been in excess of 90 percent. Much of this is in the form of grants and loans. A proportion of what is counted as development expenditures actually contributes to recurrent costs such as drugs and supplies and, in some instances, staff salaries. The health sector has attracted about 13 percent of the total aid allocation to Uganda, and this share

Table 1

Recurrent health expenditures, 1994-98, Uganda (in billion shillings)

	1994-95	1995-96	1996-97	1997-98 ¹
Private expenditures (SDA survey and projection)	132.75	159.31	183.20	210.68
Public expenditures (health) ²	32.13	37.12	54.67	46.50
International donors	20.70	23.10	21.28	21.28
Total health expenditures	186.08	219.98	259.89	278.55
Per capita (Uganda shilling)	10,489.00	12,350.00	14,641.00	15,265.00
Per capita (US dollar)³	11.22	12.19	13.84	14.27
Total public recurrent expenditures	524.00	592.00	675.00	733.00

Notes:

1. Uganda budget estimates 1997-98.
2. Health planning unit, MOH.
3. Average exchange rate: US\$1 = 1,000 Uganda shillings.

increased to 22 percent in 1996-97, from US\$60 million to US\$110 million.¹¹ Similarly, donor support to the health sector and to reproductive health has increased over the years as illustrated by

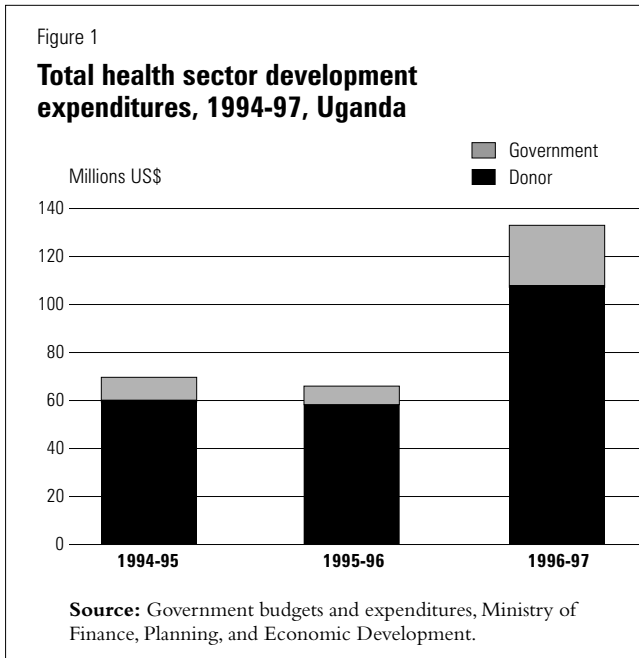
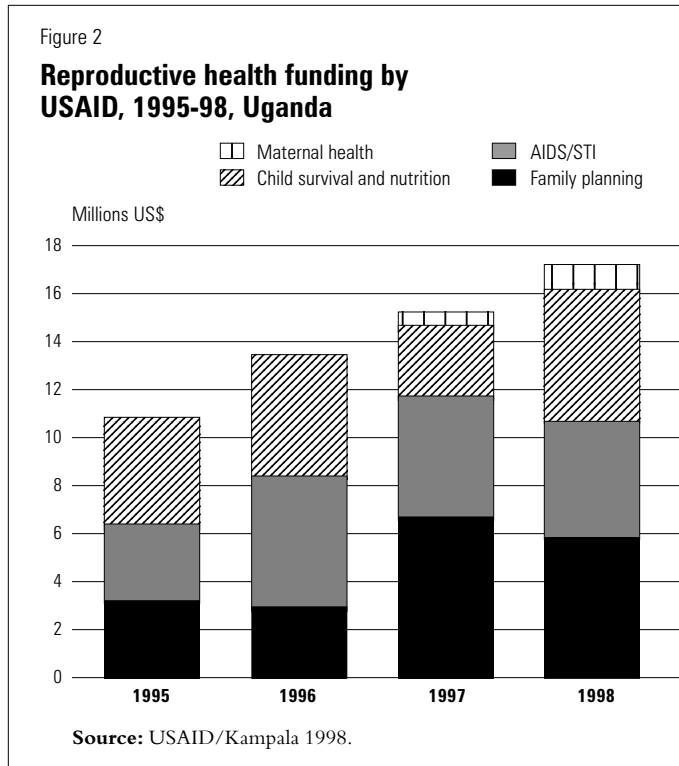


Figure 1 above. The donor requirement for government counter-funding has increased the government's allocation of funds to the health sector. However, given the dominant contribution by donors to health programs and low counter-funding from the government, this raises serious questions about sustainability.

The major programs funded by donors include safe motherhood, family planning, STI/HIV, adolescent health, IEC, infrastructure development, and training of providers. The major donors supporting reproductive health programs are the World Bank, DFID, UNFPA, USAID, DANIDA, UNICEF, and the World Health Organization (WHO). Many recent donor-funded programs did not start implementation until 1996-97. This time period marked a big leap in the health expenditure contribution from the donors and in government counter-funding. All programs supported by donors fall within national policies and priorities. Figure 2 provides an illustration of the various programs and levels of funding supported by USAID.



Some donor funding supports activities in the MOH, such as development of policies and training curricula, research, and technical assistance. Most donor funding is disbursed at the district level, where programs are planned and implemented. In some districts, decentralization appears to have increased the recurrent resources available for health services. In a study of 13 districts covered by the World Bank project, government, donor, and private spending increased in total from US\$7.37 to US\$9.41 per capita.¹²

FUNDING AT THE DISTRICT LEVEL

Due to the enormous responsibility given to districts as a result of decentralization, the local district administration is the operational level for health planning, delivery, and program evaluation. District administrators receive funds through central government funds, local revenue, and donors. The central government provides funding for salaries and materials. However, the experience of the past five years of spending in the districts made clear that

some national priority areas were not taken as district priorities. The central government has therefore created conditional, primary health care (PHC) grants to the districts to ensure that government priorities are served at the district level.

The PHC grant is about \$60,000 per year, per district, to guarantee funding for services, including reproductive health. This funding mechanism, however, has created tensions between the central government and the districts over the extent of central control of district-level allocations and priorities. In the current financial year, 1998-99, the PHC grant has been increased about three times. In the districts investigated in this study, the team found that about 50 percent to 60 percent of the PHC grant goes to reproductive health services. In the Kabarole District, where the presence of a comprehensive health sector budget lent itself to analysis, 55 percent of the financial resources (excluding salaries and the costs of essential drug kits*) were allocated to reproductive health services, as shown in Figure 3.

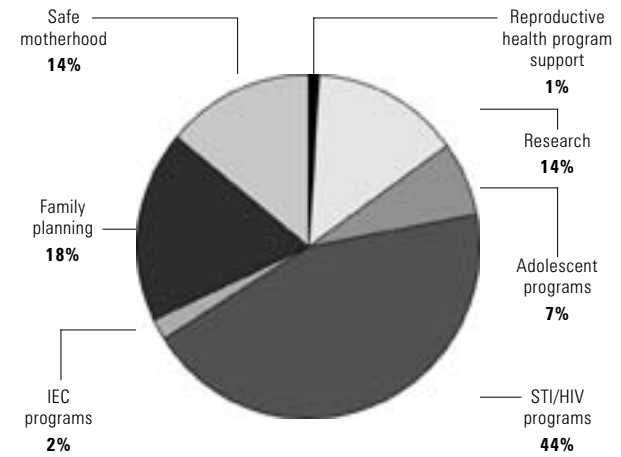
STI/HIV, family planning, and safe motherhood programs receive the most funding at the district level. Donor funding contributed substantially to recurrent costs such as staff salaries, drugs and supplies, and short-term training workshops. In every district the team visited, several donors were providing funding. In some districts, donors have experienced poor program performance by depending on poorly paid staff. The German agency, GTZ, has pioneered an effort in the Kabarole District to improve staff performance through substantial contributions to staff salaries.

The district-level, recurrent budget allocations to health services are in principle about 10 percent to 12 percent of the projected internal district revenue. However, given the low level of tax collections, the actual funds released to the health sector was found to be only 1 percent to 2 percent, which translates to about US\$2,000 to US\$5,000 annually. On the other hand, considering both recurrent and development budget allocations, the health sector

*District budgets did not allow for allocation of staff salaries and drug costs to various health programs. This is due to nonprogram budgeting of these items and the integrated nature of health service delivery.

Figure 3

Reproductive health budget allocation, Kabarole District, 1997-98



Total district health budget, US\$3.83 million
 Total reproductive health budget, US\$2.08 million

receives 30 percent to 40 percent of the total district budget. This indicates that donors have a huge input in the health sector at the district level. Districts cannot sustain their health programs without donor and government funding.

Local district managers believe that the health sector is relatively well funded by donors compared to other priority sectors like primary education, roads, and agriculture extension. With few resources available, the district management therefore focuses on areas other than health.

Donor funding at the district level varies according to each donor. Though in principle the districts have the mandate to negotiate the programs to be funded, the experience in practice is that the district administration has little negotiating power, because most decisions about funding, programs, and operating conditions are centrally determined. Donor funds at the district level are often not fully used. In the Lira District, for example, less than 50 percent of the funds available for health programs were used, mainly due to lack of personnel to put the programs into action.

FUNDING OF SERVICES

Staff salaries and other operational costs of public health facilities are paid from local district administrations, which receive them as an earmarked fund from the central government. Delays and salary arrears of up to three months were common among the providers interviewed, however. Salary shortfalls result in low morale among health providers in public institutions. The director of the Kabarole

Due to the small amounts charged and inefficient collection systems, very few funds are raised by this scheme. User fee collections currently have little impact on recurrent hospital costs or provider attitudes. In rural health centers, user fees have a greater effect in improving running costs and provider incentives. Of the user fees collected in a health center, 50 percent goes toward operations and maintenance, while the rest is shared as staff incentive.

Table 2

Client charges by service and level of care (in US\$)

SERVICES	HOSPITALS	HEALTH CENTERS	FPAU	MARIE STOPES
Prenatal care	2.5 – 5.0	0.5 – 1.5	1.5	n/a
Delivery care (Normal)	5.0 – 30.0	2.5 – 30.0	n/a	n/a
Delivery care (C-section)	20.0 – 40.0	n/a	n/a	n/a
Family planning Pills (3 month)	0.0 – 0.5	0.3 – 1.0	0.3	1.0
Depo-Provera®	0.5 – 5.0	0.3 – 1.0	0.3	0.5 – 1.0
Sterilization	5.0 – 30.0	n/a	n/a	25.0*
Norplant®	Limited	n/a	n/a	25.0
Condoms (for 3)	0.0 – 0.03	0.01	0.01	0.02
IUD	0.5 – 20.0	n/a	0.5	1.0 – 5.0
Jelly/foam	0.0 – 0.5	n/a	0.5	0.5

Notes:

* Subsidized at no cost to the client
n/a = not available

Given the small number of providers in health centers, the user fee contribution to their benefits is substantial compared to hospital providers. User fees are also playing a crucial role in supplementing the essential drug kits, as well as filling other needs in health centers, like repairs and equipment replacement. A study done in one district found that health centers were recovering 10 percent to 23 percent of their recurrent costs.¹³

Most NGO hospitals that the team visited were charging user fees to recover their costs and were self-sustaining, except Kakira Hospital, where services were “free” to the factory workers. Two NGO facilities visited in Kabarole and Lira were recovering about 95 percent or more from user fees. Kakira Hospital operated through a direct insurance scheme for its industrial workers.

Hospital described his dilemma: “I have not been able to pay salaries of my staff for three months now. I cannot have the moral authority to ensure their diligent service.”

District hospitals are funded by the central government. Because this funding is insufficient, the hospitals have introduced alternative sources of funding, such as user fees. Health facilities charge clients a nominal amount for most services, including reproductive health (see Table 2).

Having realized the role played by NGOs in health care provision and the obvious decline in donor support to hospitals, the government is providing support through grants and salaries of doctors and midwives. NGO facilities use fewer and better paid staff. Most public hospital workers, though full-time, spend part of their working time in private practice to supplement the low salaries.

Policy Implications

There has been tremendous change in Uganda in the last 10 years, in particular following the ICPD. Major reforms are underway in all sectors—social, economic, development, and health. The government has developed a Population Policy, a Universal Primary Education Policy, Gender Policy, Adolescent Health Policy, and others that create a positive environment for reproductive health services.

COMMUNICATING HEALTH POLICIES

The policies are well articulated at higher and central levels of government; however, the benefits of these policies have not filtered through to the grassroots level. This is mainly due to lack of awareness and capacity to implement policies. In addition, there are major reforms in all sectors, which means that the frameworks within which the policies are to be implemented are not yet in place or are in their pilot stages. Decentralization at the district level, for example, is a new process in Uganda. As the districts are trying to cope with the responsibilities of decentralization, there is even a push for further decentralization at lower levels.

Women's rights are also receiving increased attention. The Ministry of Gender, Labour and Development, the Uganda Women Lawyers Association (FIDA), and other women NGOs and activists are strong advocates. These groups are championing the causes of economic rights, education of girls, abolition of FGM, and the prevention of rape, defilement, and domestic violence.

DONOR DEPENDENCY

The government has worked with donors to identify the priority reproductive health problems. Despite the government's efforts, however, health services are still strongly dependent on donor financing. Therefore, donors are playing an influential role in determining Uganda's reproductive health agenda.

The major donors in the reproductive health field are UNFPA, World Bank, DFID, International Planned Parenthood Federation (IPPF), USAID, UNICEF, and WHO. These donors are funding STI/HIV, safe motherhood, family planning, IEC, and others such as post-abortion care, adolescent health, and child survival. While infertility, female genital cancers, and menopause are being addressed, they are not yet well-funded.

Despite the government's efforts ... health services are still strongly dependent on donor financing. Therefore, donors are playing an influential role in determining Uganda's reproductive health agenda.

CHARGING USER FEES

While not a national policy, most local governments have required public health facilities to charge user fees in an effort to improve service quality and sustain services. The fees are very small, and the majority of patients and clients can afford them. Although the collections are small, they contribute substantially to operational costs, which include drugs, supplies, and infrastructure maintenance, particularly in rural health centers. The additional income also has a positive effect on providers' attitudes.

NGO AND PRIVATE-SECTOR COLLABORATION

NGOs play an increasingly important role in health services provision. The government and donors are beginning to support them to provide services to underserved and underprivileged groups and communities. Private-sector providers, however, seem to operate in a parallel universe. Most private-sector providers are unaware of ICPD goals or of their potentially collaborative role in the health care system. The private sector is growing fast and has better prospects for recovering a high proportion of operational costs through user fees. As the quality of services improves, the private sector will increasingly provide more reproductive health services with better prospects for sustainability.

TRAINING FOR REPRODUCTIVE HEALTH CARE

The training of nontraditional reproductive health providers such as nurses and clinical officers, and the retraining of midwives and doctors in specific reproductive health skills has increased the number of providers and consequently increased access to services. The comprehensiveness of the reproductive health training has greatly improved providers' skills, confidence, and attitudes toward clients seeking services. There is evidence that these changes have led to greater use of reproductive health services as well as increased client satisfaction. Clients perceive providing integrated services as cost-effective.

Many providers are still untrained, meaning that many clients are offered inadequate reproductive health care services. The lack of trained manpower is the most significant obstacle to implementing reproductive health programs. Training institutions are responding to this challenge by strengthening their curricula.

ACCESS TO QUALITY REPRODUCTIVE HEALTH CARE

The team found the quality of services to be unsatisfactory in many units. In particular, the districts lack skilled and trained manpower. There is an overall shortage of midwives in all districts, with an apparent concentration working in the district hospitals. This is a major constraint in the provision of reproductive health services in the PHC network. Staff deployment is not yet in line with the government's policy of reorienting the health services delivery to primary health care. Whereas 70 percent of the district-trained midwives are in the hospitals, only 5 percent of the population has access to these facilities.

CLIENT INFORMATION

Though not systematically assessed, the team found that the information provided to clients and spouses was still weak. Discussions with some family planning providers during the survey revealed that they did not give information routinely about the range of services available. Instead, all clients were given Depo Provera[®], including a client who had had recurrent abortions who should have been referred, and another with 12 children who had a strong desire for permanent surgical methods.

CONTRACEPTIVE METHOD MIX

There is a limited method mix in both public and NGO facilities, which means that clients have to take what is available or be referred. Intrauterine devices, tubal ligation, and Norplant[®] are not commonly available, except at the district hospital, because of staff skills, equipment, and space. Doctors in hospitals are trained in surgical contraception methods, but physical distance and the US\$25 fee has limited use of this service.

Pilot efforts with community-based providers of reproductive health services are contributing substantially to the distribution of contraceptives, but are limited to providing pills and condoms. Access to a full range of reproductive health services remains a major constraint in all districts visited.

DELIVERY CARE

While most mothers receive some form of prenatal care, most deliver without the benefit of a skilled provider. Over 80 percent of mothers make at least one prenatal visit during pregnancy to a health facility. The majority of mothers start prenatal care in the second and third trimester, although only 32 percent make three or more visits. Very few of these women receive trained care at delivery, however. Nationally, trained health providers with midwifery skills attend only 38 percent of the deliveries. Instead, women deliver with untrained assistants—often relatives.

Late referral of women with complications to the hospital is still a major issue. Poverty and poor road networks discourage hospital deliveries. Most peripheral areas visited had only a few transport vehicles that were over-loaded with people and goods making one route per day to the town, where the hospital is located. The situation is worse during the rainy seasons, when most roads become impassable.

MALE INVOLVEMENT

There have been some efforts to involve men in family planning decisions. In the Kabarole tea estates and in a Jinja sugar factory, male work groups have been used to raise awareness of children's rights to education and quality of life in the home, and the rationale for a smaller and manageable family size. The workers reported seeing more men accompanying their wives to the family planning clinics than before. Most women feel, however, that men are not supportive of family planning. More male youth are using the private sector to obtain condoms and STI treatment.

SUSTAINABILITY OF PROGRAMS

The government faces a strong challenge in crafting policies that address Uganda's diverse population. Certain programs—especially family planning, HIV/AIDS control, and adolescent pregnancy—do not easily attract community support. It is difficult, for example, to advocate for smaller families in an environment of high infant mortality, or to advocate for HIV/AIDS prevention in a polygamous community.

The government is attempting to create sustainable programs by involving communities in programs and by using community volunteers to provide reproductive health services (community-based distribution of contraceptives and home-based care for AIDS patients and orphans).

Programs that are predominantly donor-supported face the issue of sustainability. When donor support ceases, programs collapse. In an effort to alleviate this situation, government counter-funding has been built into most donor-supported programs. There are efforts to raise internal revenue to support

priority programs. For instance, there is an earmarked fund for PHC, 60 percent of which is devoted to reproductive health. Since this fund was introduced, it has been progressively increased.

The government is attempting to create sustainable programs by involving communities in programs and by using community volunteers to provide reproductive health services (community-based distribution of contraceptives and home-based care for AIDS patients and orphans).





Recommendations



► DISSEMINATE POLICIES

The supportive policies for reproductive health need to be translated and disseminated at the community level in order to create awareness for informed decisionmaking and for overall community and women's empowerment. The reproductive health status of the country stands to benefit as individuals make informed decisions and demand their reproductive rights.

► PROMOTE COLLABORATION

Reproductive health service coverage is still a big challenge. Program managers with new innovations will have to identify and work with competent NGOs and the private sector to improve service coverage to rural women and men with unmet needs for contraception. The private sector capacity to expand, especially given incentives to extend services to rural areas, offers a more sustainable alternative. Initial financial incentives to NGOs to provide a comprehensive reproductive health services package is strongly recommended. Collaboration between the MOH and training institutions is essential in developing sound reproductive health programs.

► INCREASE TRAINING FOR BETTER SERVICES

Staffing levels in both the public and private sectors are very low. More rational staff deployment and better pay will enhance staff morale to provide friendly services. Midwifery training needs to be given long-term priority as a strategy to improve service coverage. This needs to be integrated in all existing paramedical training programs for

comprehensive manpower development. Aggressive training at all levels of services, and in particular for family planning services, is necessary. The MOH needs to develop guidelines and protocols, especially regarding the information given to clients and standards of care, to ensure appropriate client decisionmaking and care.

► STRENGTHEN COORDINATION

Planning, coordination, and overall use of health management information systems need to be strengthened. The MOH needs to strengthen its coordination role with the different national and district-level stakeholders. Information sharing at the national and district level is important for meaningful planning and management.

► IMPROVE HOSPITAL CARE

Hospital activities need to be seen in the light of a comprehensive PHC system. Hospital services need not lag behind in quality or coverage. Though the referral system for maternal care is a major problem in Uganda, hospital services should remain attractive and contemporary to those that use them.

► STUDY SERVICE INTEGRATION

There is need to study the process of service integration. It seems to have preliminary success, but there is not complete understanding of the issues of services costs, quality, and use of individual services.



Endnotes



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