Maternal Health in Uganda:
Understanding the Low Utilization of Skilled Attendants in Mukono, Uganda
Through Women's Experiences in the Health Care System

By

Ashley Gita Wallace

A Thesis Submitted to
Saint Mary's University, Halifax, Nova Scotia
in Partial Fulfillment of the Requirements for
the Degree of Masters of Arts, International Development Studies

August, 2012, Halifax, Nova Scotia

Approved: Dr. Peter Twohig
Supervisor

Approved: Dr. Suzanne Dansereau
Reader

Approved: Dr. Robert Huish
External Reader

Date: August 21, 2012

Library and Archives Canada

Published Heritage Branch

395 Wellington Street
Ottawa ON K1A 0N4
Canada

Bibliothèque et Archives Canada

Direction du Patrimoine de l'édition

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence
ISBN: 978-0-494-89997-7

Our file Notre référence
ISBN: 978-0-494-89997-7

Abstract

Maternal Health in Uganda:
Understanding the Low Utilization of Skilled Attendants in Mukono, Uganda
Through Women's Experiences in the Health Care System

By Ashley Wallace

This thesis explores the reality of maternal health services facing pregnant women in Uganda. It aims to understand the variety of issues surrounding women's utilization of skilled birth attendants in a weak and underfunded public health system. To explore this central objective, qualitative methods were used and women's narratives were collected through focus groups and interviews. This thesis contends that women's experiences of antenatal and delivery care reveal the systemic barriers of the health care system and the obstacles they face to reaching life-saving maternal care. The findings strongly indicate the complexity of the maternal health crisis and the barriers to accessible and acceptable maternal health care that must be addressed in order to improve maternal and child health outcomes across the country.

August, 2012

Acknowledgements

There are many organizations and individuals that deserve mention in making this thesis possible. The fieldwork that was central to this research was made possible with the financial support of Africa Initiative of The Centre for International Governance Innovation in 2011. I would also like to the Faculty of Graduate Studies and Research for their financial assistance during the two years of my studies.

Dr. Jean Chamberlain, Dr. Eve Nakabembe and the staff of Save the Mothers, who have dedicated their lives to improving the health of Uganda's mothers, have been a constant source of knowledge and inspiration. Thank you for partnering with me, facilitating my field research and shaping my understanding of maternal health in Uganda. Many thanks to my friends and roommates in Uganda for their encouragement, support and insight into Ugandan politics and culture. Thank you to my research assistants, who endured endless journeys to the hospital, for their translation skills during the data collection process. Finally, thank you to the hospital staff and new mothers who generously shared their stories with me. *Webale nyo!*

Thank you to Dr. Robert Huish at Dalhousie University for his helpful insights and comments in rethinking the maternal health crisis in Uganda. Thank you to Dr. Suzanne Dansereau, not only for her encouragement and contribution to this thesis, but also for her mentorship during my two years of study. Finally, special thanks to Dr. Peter Twohig for his support and guidance throughout this process. It was a privilege to work with such a dedicated, kind and patient professor from whom I learned very much.

Finally, thank you to my family and friends. Your love and support carried me through these last two years. To my colleagues in the program, thank you for the friendships and memories. They will last a lifetime.

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION

The iconic image of the African mother – a woman dressed in bright and vibrant *leso* cloth with a basket of produce balanced on their head and a baby strapped to their back – is a common sight in the markets and along the roads of Uganda. As these women blend into the backdrop of Ugandan life, the plight of pregnancy and childbirth experienced by these women on their journey to motherhood goes unnoticed by many people. In the developed countries outside Africa, Uganda has been known as a place of poverty, orphans and the HIV/AIDS crisis. Indeed, these problems are great and require an intense and united effort to solve. Speaking of the orphan crisis, a maternal health advocate said, "We become focused on caring for the constant flow of orphans that show up at our door, but we never consider looking upstream to see where all these children are coming from – the maternal health crisis." Maternal health draws out the connection between women and public health necessary to understand a large part of public health problems in Uganda.

During my first visit to Uganda, I was unaware of the maternal mortality crisis happening there. The maternal mortality rate measures the number of maternal deaths per 100,000 live births. In Uganda, 6,000 women die every year in Uganda from pregnancy or delivery complications. Canada has the same population as Uganda, but loses less than 10 women a year. In Uganda, the tragedy and scale of these deaths does not make headlines in newspapers. They happen quietly in maternity wards of busy hospitals, clinics of traditional midwives, or within the woman's home. They often go unnoticed by people outside her community, yet families are shattered by the loss of the mother. The impact of maternal mortality is well-documented. Mothers play a critical role in their

families and communities as breadwinners, educators, mainstays of families and caretakers of children and the elderly. A mother's death leaves her children in precarious emotional, social and economic situations. Maternal health is a fundamental part of national health and the future of a country, not only because "the death of mothers adversely affects her children, family, and community, but because women are intrinsically valuable" (Thaddeus and Maine, 1994, p. 1091).

Maternal health was listed as a Millennium Development Goal (MDG) in 2000 for several reasons: it is closely connected to neonatal and child health; it is critical for sustained economic development; and, the well-being of women is an important goal as an end in itself. Death and disability caused by pregnancy and childbirth is the source of great suffering of women, their newborns, and their families. This widespread suffering is needless since many causes of maternal death and morbidity are medically preventable. Maternal mortality and morbidity is a breach of women's right to health and safe motherhood, representing an injustice against new and expecting mothers. For these reasons, maternal mortality and morbidity is one of the most important challenges for development and human rights in Uganda.

1.a. Maternal Health: Problems and Strategies

Maternal mortality is a lesser-known issue in the developed countries partly because maternal deaths are almost unheard of there. Among common health indicators, however, maternal mortality shows the greatest disparity between the developed and the developing countries. The lifetime risk of maternal death for a woman in Africa is 1 in 16, while in developed countries it is 1 in 2,500 (Cook, 2003, 10). Uganda has one of the

highest maternal mortality rates in the world at 310 maternal deaths per 100,000 live births (World Health Organization [WHO], 2011). Improving maternal health is an objective of MDG 5, but has had the weakest improvement.

Though maternal mortality in Uganda is high, it is no longer one of the worst examples of maternal health. Other countries in Africa, Asia and the Middle East have far higher rates of maternal mortality. Maternal mortality rates in Congo (560), Angola (460) and Sierra Leone (890) are worse. Uganda's maternal mortality is comparable to its regional neighbours including Kenya's MMR at 320 and Rwanda at 340. Uganda has made some improvements to their commitment to reducing maternal mortality. In recent years, Uganda's maternal health related indicators have made improvement including a reduction in maternal deaths and an increased utilization of skilled birth attendants. Uganda's maternal health status is not the worst in its region or the African context, but their maternal mortality-related indicators remain unacceptably high.

There is international consensus on the interventions necessary to reduce maternal mortality ratios. Improving maternal health involves a set of relatively simple, well-known interventions. Antenatal care clinics provide women with opportunities to be assessed for their physical risks during pregnancy, childbirth complications and socioeconomic needs. As a method of reducing maternal mortality, many advocates recognize the vital role of a skilled attendant for delivery. A skilled attendant is someone who is able to identify the onset of complications, perform appropriate interventions when necessary, begin treatment and make referrals for procedures beyond their competence or particular environment (WHO, 1999, p. 31). The Millennium Development Goal to reduce maternal mortality measures the number of women who

deliver with a skilled attendant as an indicator of maternal health. Complications arise in 15% of pregnancies worldwide, some are unpredictable during the prenatal period, and are the leading cause of maternal death and morbidity. Therefore, it is essential that women have a skilled attendant during delivery in order to treat complications as they arise. Further, Emergency Obstetric Care (EmOC) are the life-saving components of maternal health. EmOC is the set of interventions in the health care centre that allow skilled attendants the capabilities to treat complications that cause the majority of deaths (Bullough et al, 2005). Without EmOC, skilled attendants cannot provide appropriate interventions to treat complications. These technologies, medications, and interventions to manage and prevent complications during childbirth are well known and accepted in the medical field.

The purpose of this study is not to undertake a comparative analysis of the maternal health or strategies to reducing maternal mortality across several countries. This micro-level study focuses solely on the Ugandan experience because most women who receive maternal health care in Uganda have no way of comparing it to childbirth in any other country. Though maternal health statistics in Uganda have been improving, the delivery and reception of maternal health care is not well understood in Ugandan context. Understanding the experience of pregnant women as they receive life-saving maternal health care can help Uganda continue to improve its maternal health status.

1.b. Skilled vs. Traditional Birth Attendants:

A key component of improving maternal health is to understand the reception of maternal health care. The experience of pregnancy and childbirth is most directly related

to the care women receive from both traditional and skilled birth attendants. Traditional birth attendants (TBAs) deliver 60% of births in some regions of Uganda. They are women who have no formal midwifery training, but learn their skills over time from more experienced TBAs or on their own. TBAs are the main providers of health care to women during delivery where maternal mortality rates are high (Costello, Azad, & Barnett, 2006, p. 1477). Some practices of TBAs are harmless or positive, while other practices may carry an element of risk of danger to the mother or newborn. This is especially true when they are unable to identify risks or refer women when complications extend beyond their competence. TBAs are trusted in their community, culturally appropriate, cheaper and more accessible than formal health care. They provide elements of personal care in attending to a pregnant woman.

Conversely, a skilled attendant is able to identify the onset of complications, perform necessary and appropriate interventions, begin treatment, and refer mother and baby for interventions that are beyond their competence or particular environment (WHO, 1999, p. 31). Skilled birth attendants are doctors, nurses and midwives with training in midwifery skills from a recognized school. Studies have shown that countries in which every women delivers with a skilled birth attendant have lowered rates of maternal mortality (WHO, 1999, p. 21). For this reason, the thesis will focus on the utilization of skilled birth attendants as an important strategy in improving maternal health.

Skilled birth attendants often work in health facilities with the necessary medical supplies, equipment and drugs to assist in a safe and clean delivery for the mother and the newborn. In Uganda, health facilities lack a reliable supply of necessary equipment and

drugs to treat women who reach the hospital for a delivery. Further, the shortage of medical staff places challenges on health facilities to meet the demand for services. Resources are stretched to the point of compromised quality of care in health facilities. How can more women be encouraged to seek care with a skilled birth attendant under these conditions?

Maternal health statistics paint an unclear picture regarding the state of maternal health in the country. The national health survey states that maternal mortality ratios have dropped from 505 in 2000 to 435 in 2006 (Republic of Uganda, 2006, p. 280). The World Health Organization reports that as of 2010 Uganda's MMR sits at 310 (WHO, 2011). The Lancet's recent publication of a worldwide decline in maternal mortality estimates Uganda's maternal mortality had dropped even lower, from 560.6 deaths per 100,000 live births in 1990 to 274 in 2011 (Lozana et al, 2011, p. 1148). Though the numbers may be improving, advocates and policy-makers in the Ugandan context know that much work remains for the health of mothers to improve. Access, utilization and quality of care are issues that remain for maternal health. Fertility rates, antenatal care coverage, and the percentage of women who deliver with a skilled attendant have stagnated over the years. One of the most startling comparisons of these maternal health statistics is the high level of antenatal care attendance and the low level of professional care during delivery. In Uganda, over 90% of women attend antenatal (also known as prenatal) care services, however about 59% return to health centres for delivery with a skilled attendant (UBOS, 2011, p. 13). This low utilization of professional attendants during delivery contributes to Uganda's high maternal mortality rate, since many women delivering without professional attendance delay seeking medical care until after complications arise. The

question guiding this thesis is the following: what are the reasons for, and basis of, women's behaviour regarding the low utilization level of skilled birth attendants in Uganda?

1.c. Women's Voices: What can women tell us?

Though women are considered the backbone of their families and communities and maternal health plays a key role in public health, the voices of Uganda's mothers are largely silent in maternal health-related literature. Economic structures, social norms, and cultural traditions bar women from access to resources and opportunities that improve their well-being and quality of life. As marginalized persons, the voices, opinions, perceptions, and experiences of women are often silenced, neglected, and ignored. Promoting gender equality refers, in part, to "the ability of men and women to equally influence and contribute to the political discourse and the development process." (Schuftan, 2008, p. 438) Women's experiences of health care services contribute to emic understandings of women's health-seeking behaviour and decisions. Ultimately, their stories can help inform public policy about the socio-cultural conditions that influence health status of women (Allen, 2004).

The experiences and voices of women are valuable to health and development because their stories provide much needed perspective from those who use these services. Hearing the experiences of women is important to development and health care because "women must be active definers of 'quality' and encouraged to voice their expectations and values" (Kitts, 1995, p. 11). Women's stories and perceptions can help identify context-specific issues that prevent safe motherhood. Though biomedical perspectives are

important to understand the immediate medical causes of maternal death, the ways in which social forces converge to deter safe motherhood and result in unsafe health care behaviour are important to consider. Additionally, women's experiences in health care can be compared their actual experiences with their preferences, maternity care policies and practices, and maternal health statistics. Finally, women's experiences and stories of maternal health care services reveal the reality of healthcare that faces pregnant women and new mothers in Uganda. Therefore, qualitative data and analysis of women's stories will provide a more complete picture of maternal health care in Uganda than Uganda's health policies and statistics.

1.d. Objective

In order to understand the low deliveries in health facilities, it is important to consider the experiences of women who use the services. This thesis will seek to explore and understand women's experiences of maternal health services and its effect on the low utilization of a skilled attendant delivery. It will document and analyze the reasons why women return to facilities for delivery with a skilled attendant or, alternatively, why they do not return. Through the experiences of women using maternal health care services in Uganda, this thesis aims to offer cogent reasons for explaining the discrepancy between antenatal throughout pregnancy and delivery attendance for childbirth in Uganda.

1.e. Thesis Statement

I will argue that the low use of maternal health care services can be revealed, in part, in women's experiences in maternal health care at public hospitals. Pregnant women's experiences health care will reveal the shortcomings of the health care system

and the obstacles they face to reaching life-saving maternal care. Physical, financial and social issues are important barriers that prevent women from reaching hospitals in time for their delivery. Additionally, women's experiences in maternal health care reveal the negative aspects of care provided in hospitals that deter women from accessing care on time.

1.f. Structure of Discussion:

Chapter Two presents a landscape of debate with a theoretical debate situated within health and development, as well as the gender inequalities that exist and their implications for safe motherhood. Following the literature review, Chapter Three presents the methodological approach to data collection of both the historical and political overview of health care in Uganda and women's experiences in maternal health care services. The fourth chapter outlines the history of health policy and systems in Uganda. It examines the health policies from Colonial Uganda (1935-1961), Post-Independence Uganda (1962-1971), The War Years (1972-1985), and the Period of Neoliberalism (1985-2010) and explores policy failures and inadequate funding that leads to maternal mortality. Through the stories of women, it outlines the consequences of the continual neglect of maternal health and women's health care needs. It connects their experiences in health care to the low utilization of life-saving skilled birth attendants. The fifth chapter presents a discussion and conclusion of the findings. Policy recommendations are offered.

CHAPTER TWO: LITERATURE REVIEW

Pregnancy and childbirth are not considered to be medical problems or diseases, but rather parts of a natural process that is necessary for the procreation of our species; however, in many parts of the world, the health and well-being of a mother and child are influenced by the care a woman receives during that time, or the lack thereof. Care can be structured in ways that build trust and familiarity, but limited resources can create environments for coercive or humiliating care. It is therefore important to examine how maternal health care is provided and received in order to further understand the utilization of such services.

In Uganda, women are encouraged to go to hospitals and health clinics to receive medical attention during their childbirth. Although almost all women in Uganda attend antenatal clinics, about 59% return to health facilities for the childbirth. This statistic masks regional disparities as over 90% of women in Kampala use a skilled birth attendant, that percentage drops to as low as 30% in Karamoja district (UBOS, 2011, p. 13). The discrepancy between antenatal clinics and skilled birth attendants creates a "care gap" leaving the majority of Ugandan women without medical assistance during childbirth. Though advocates encourage all women to use the formal health care system to improve pregnancy outcomes, there are few analyses that capture women's stories and experiences of maternal health care. Women's experiences can reveal the positive and negative aspects of maternal care in health facilities that hinder or encourage women from accessing and utilizing health care. These aspects of maternal care are important to consider because maternal health is a reflection of public health.

Most explanations of poor health status in Africa are linked to poverty and conflict. Unlike other African states in a perpetual state of political instability and conflict, Uganda has enjoyed political stability and growing economy for over two decades. More recent explanations of poor health outcomes in Uganda are linked to diseases such as HIV/AIDs and malaria. While these diseases have attracted high levels of financial assistance and political support from donors and governments around the world, maternal health has struggled to receive attention and resources to improve conditions for mothers and their newborns. Maternal health does not merit the attention that communicable diseases do because they do not pose a "threat" to national borders, nor do medications offer profit potential for pharmaceutical companies (Shiffman, 2006 p. 412). Unlike communicable diseases, maternal deaths do not threaten the borders of developed countries where mother receive the best health care during their pregnancies and throughout the delivery process. Maternal health in Uganda is a forgotten issue despite an exploding population; but these deaths happen too often and silently. They happen when women attempt to deliver their children at home alone without any assistance, in the rural clinic of a traditional midwife who lacks necessary training to treat complications as they arise, and in the chaotic wards of hospitals and health clinics. During a tour of the health facilities in the capital in 2009, one nurse says they had five maternal deaths that day. "It was a bad day," she explains.

The biological process of pregnancy alone cannot explain the global picture of maternal health. It cannot explain why 99% of maternal deaths occur in the developing world, even though 15% of all pregnancies and deliveries around the world will encounter at least one complication (WHO, 2012b, 3 para.). It cannot explain why, in

Uganda, the majority of the poorest women will deliver without a skilled birth attendant[1] or have limited access to quality health care services (WHO, 2010, p. 150). The current analysis focuses on the stories and perspectives of Ugandan women on the services they use during their pregnancies, their experiences with those services and views about how they can be improved.

Before exploring Ugandan women's experience and utilization of health services, the landscape of the debate that surrounds maternal health issues in the developing world is presented. Set within the framework of health and development, this chapter will outline the factors that influence maternal health status including gender and health, maternal morbidity, strategies to reduce maternal death, and the traditional versus biomedical health systems and perspectives that influence the experience of pregnancy and childbirth in Uganda. These discussions set the stage for the Ugandan context of health care and the stories of those who move through the system.

2.a. Health and Development

Health plays a critical role in development. The WHO defines health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1978, article 1). The implications of such a broad definition allow a discussion of the development frameworks that influence the health status of populations and individuals. Such a definition of health allows considerations of the economic, political, social, environmental, and cultural factors, as well as biological and genetic

[1] A skilled attendant is able to identify the onset of complications, perform necessary and appropriate interventions, begin treatment, and refer mother and baby for interventions that are beyond their competence or particular environment. (WHO, 1999, p. 31)

factors that influence the health of populations. Health and development are considered to have a symbiotic relationship in which a healthy population depends on economic development and economic development depends on a healthy population (Johnson, 2011). Thus, the health of a nation can reflect its overall level of development (Agobonifo, 1983, p. 2005). Therefore, it is important to examine the development framework and its approach to health. In tandem with the notion of health, "development" is a broad and contested concept. For the purpose of this thesis, development will be regarded as the social, economic, and political process whereby human potential is realised in improved living conditions, socioeconomic status, health, and freedom. As such, this thesis situates itself within the health and development paradigm.

Following the independence of colonized states in Africa and Asia during the 1950s and 1960s, development theorists focused on GDP growth to encourage development in the Third World. This approach to development was known as modernization as it assumed states would follow a path to development similar to that of the Western world (Johnson, 2011). Developing countries modeled the health care systems of their colonizers; however investment in health was limited in reach and purpose. Health was only considered a necessary investment in order to ensure that a healthy workforce could contribute to economic activities.

The development project to modernize the colonized world was considered a failure because states that achieved sustained economic growth had failed to improve the health of their citizens. Eventually, development theorists broadened their definition of development to consider life beyond GDP growth and developed the basic needs

approach to development (Agobonifo, 1983, p. 2004). Theorists began to draw the connection between development and public health by showing that a healthy population contributes to productivity and efficiency, leading to increased earnings (Agobonifo, 1983, p. 2003; Grosse and Harkavy, 1980, p. 166). Good health is considered essential for economic growth, as individuals with poor health can spiral deeper into poverty because sickness prevents them from earning the money they need to survive. At an individual or household level, poverty and sickness frequently coexist. Sickness is frequently a cause of poverty and an important obstacle to escaping it. Sickness can reduce household savings as families make costs for treatment, it lowers learning ability, reduces productivity, and leads to a diminished quality of life. The poor are, in turn, less able to access health information and health care, are less well nourished, and are more exposed to personal and environmental risks. Therefore, illness creates and perpetuates poverty (Dodd & Munck, 2003, p. 17). At the policy level, governments attempted to meet the basic social and economic needs of its population, such as comprehensive approach to basic health services, in order to ensure parallel improvements in both economic and social indicators (Magnussen, Ehiri, & Jolly, 2004, p. 168). Following the Alma Ata declaration in 1978, which declared health a human right that should be ensured by the state, some states invested in aspects of health. Many countries in sub-Saharan Africa and Asia committed themselves to universal access to health care as an essential part of nation building, but the commitment to "Health for All" was short-lived following the Declaration (Carpenter, 2000). Few developing countries came close to realizing their aspirations for universal access to health care. In the mid-1980s, many developing countries found themselves in the grip of an economic crisis, with mounting

foreign debt repayments and failing social services, including health care, that could not be maintained on domestic revenue alone (Freedman, 2005, p. 21).

While the WHO was encouraging a "Health for All" approach to health care, a neoliberal approach to development emerged in the early 1980s. Neoliberalism manifested in the developing world through structural adjustment policies. Under the neoliberal approach, it was argued that economic growth operating under a free market would increase human well-being. The logic behind this approach was that increasing GDP growth would allow a state to accrue more resources that, in turn, could be invested in social services such as the health sector; however, this has not happened in practice (Carpenter, 2000, p. 344-5) Debt servicing polices forced governments to cut expenditures on social services because they are not considered sectors that directly benefited GDP growth. The policies encouraged user-fees for health and education. Moreover, responsibility for a wide variety of services affecting health, including education and water supplies, shifted from the state to the private sector. It was argued that the commercial market was the most efficient mechanism for the distribution and production of health care. Such social services, including health care, had previously been considered public goods provided by the state but were now commodified. A neoliberal approach to development was said to have adverse effects on populations, especially the poor, who could not afford access to services that ensured their health needs would be met (Bond and Dor, 2000).

Current health and development discourse is attempting to broaden the narrow approach to health care outlined in the neoliberal agenda. Human development proponent Amartya Sen makes the case that development should be viewed as more than a means to

economic growth but also as the means to expand human freedom (Sen, 1999). Health enables one to achieve the true end of development, which is "to lead the kind of life he or she has reason to value" (Sen, 1999, p. 87) Ruger (2003) uses the human development approach in acknowledging the instrumental value of health to productivity and economic development, as well as the intrinsic value of health as an end in itself. Under this approach, health is not merely a means to economic development, it is also important for individuals' agency. Individual agency can be used to develop, improve and sustain effective health systems in which people "participate in political and social choice about public policies that affect them" (Ruger, 2003, p. 678). Health deserves special attention in development studies as it is considered a significant indicator of economic development, as well as individuals' well-being and agency. These approaches have been used to argue for increased investments in health.

A similar concept can be found in the human rights discourse that codifies the rights to health and health care. The Universal Declaration of Human Rights states "everyone has the rights to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services" (United Nations [UN], 2012, Article 25.1). The International Covenant on Economic, Social and Cultural Rights, written by the United Nations High Commissioner for Human Rights (UNHCR) recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." (UNHCR, 2012, Article 12.1) The Constitution of the WHO states, "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being." (WHO, 2012a, para. 1) Health as a human right has become acknowledged around the world as the WHO states

"every country is party to at least one human rights treaty that addresses health-related rights" (WHO, 2012a, para. 3). More importantly, the health and human rights discourse defines health as an inclusive right, not only pertaining to access of health care, but also to the underlying determinants of health that includes safe water, adequate sanitation and supply of safe food, nutrition, housing, access to health education and information, and a healthy environment (Cook, 2003, p. 37).

Lynn Freedman (2005) adds a third dimension to health and development. This dimension of the debate argues that poverty is not simply a lack of material resources or poor health, but also fundamentally relational. The experience of poverty is marked by marginalization, exclusion and voicelessness. Within this understanding of poverty, health and development, Freedman (2005) argues that "health systems are core social institutions that help define the experience of poverty, and must not by given equal weight in health policy" (p. 20). Social structures and institutions play a role in creating and shaping these relationships. Freedman (2005) point out human rights activists have long considered political institutions of the state – including prisons, judicial systems, and police forces – to be instruments that silence and control, but health systems are not approached with the same understanding. He argues that health systems should be regarded as institutions that create or reinforce poverty and, alternatively, in building democratic societies that provide the foundation for good health.

Health systems communicate a set of values and norms of society both in their structure and in the quality of care patients receive (Gilson, 2003; Freedman, 2005). They are inherently relational, socio-political institutions and "not merely a delivery point for bio-medical interventions" (Gilson, 2003, p.1463). Freedman (2005) asserts that

health systems "function at the interface between people and the structures of power that shape their broader society" (p. 21). Values embedded in health policy can include "equity, protection of life, compassion, human dignity and rights, justice, etc. (Okounzi and Birungi, 2000, p. 216) Health systems, "are not only producers of health or health care but they are also the purveyors of a wider set of societal values and norms" (Gilson, 2003, p. 1461). Gilson (2003) argues that trust, legitimacy, and equity in health care systems cannot be taken for granted, but must be actively produced.

Health systems that construct access to health care as a universal right will commit itself to inclusion and equity. Access and entitlement to health services is an important asset of citizens of democratic societies. The actions, choices, and resources that enable one to control their health allows one to participate as agents in their own life circumstances. These are important for individual capabilities and the experience of human rights. Conversely, health systems structured on market-based principles that favour privatized health care and access depends on the ability to mobilise resources "explicitly legitimates exclusion of the poor" (Freedman, 2005, p 22). Neglect, abuse, harassment and exclusion in the health care system are part of the experience of being poor and defines "their experience of the state and of their place in society." (Freedman, 2000, p. 21). Thus, understanding health systems contributes to our understanding of democracy, power, and poverty.

This approach to health and development examines the relationship between health systems and the broader social relations of power of health institutions. The quality of care received communicates the values of the health care system. A solely medical model of care means "scientific diagnosis, careful testing and charting, and treating parts

of the body that are sick, not relating to a person's social and emotional experiences or the overall quality of his or her life" (Cancian & Oliker, 2000, p. 80). A bureaucratic, capitalistic health facility can ignore or de-value the emotional or social aspects of care in the name of efficiency, hierarchical power relations and standardized rules. These aspects of medical and social care are illuminated in the experiences of those who move through the formal health care system.

The experience of health care is also affected by funding and resources in order to provide quality care. Funding can have a direct influence on the experience of health care, especially for the poor. Cancian and Oliker (2000) point out that, in the face of inadequate resources, health care providers can provide care that is humiliating, discriminatory and ultimately reinforces gender inequality (p. 142-3). Poor quality of care at health facilities, including abusive treatment by staff, exclusion, and difficulties accessing care, is a common complaint among the poor in developing countries (Dodd & Munck, 2003, p. 17). Inadequate resources, and its effects on people's experiences of health care, necessitates a discussion of health within the overall development framework.

The evolving development framework and its approach to health speak to the economic structures and political institutions involved in the provision of health care; however, it is still debated how health and development should be prioritized in resource-poor countries (Johnson, 2011). To achieve this broad definition of health, a number of factors have to be achieved including adequate shelter, nourishing food, clean water, peace, freedom, social justice, access to education and income-generating activities, and sustainable resources (Kitts and Roberts, 1996). Indeed, gains in material wealth and

economic activity have allowed populations to tackle threats to health through large-scale vaccination campaigns, but new threats to well-being have emerged such as infectious diseases, unsustainable national debt, and climate change. Public policies are required to improve and maintain a healthy population as Kemm (2001) points out that action taken outside the health sector can have a greater effect on health than others taken within the health sector (p. 79). Drugs and technologies alone will not lead to a reduction in disease or a healthier population until an integrated and multi-sectoral approach to health creates effective policies and programs. Challenges to policymakers remain such as ensuring basic needs, controlling communicable diseases, providing adequate levels of nutrition, and prioritizing health care and economic growth in the face of limited resources. In some cases, health sectors in developing countries have suffered from reductions in government spending, international debt repayments or have been de-prioritized against other sectors (Sweetman, 2001). As a result, many people in developing countries suffer from ill health, lack access to formal medical care, and poor treatment at health facilities.

The frequency of illness and disease in developing countries is compounded by a wider set of social, cultural and environmental factors called the social determinants of health. Social determinants of health influence the provision and experience of individual health (Fox and Meier, 2009). This is exemplified by the fact that the health needs of citizens extend to services beyond the health sector including "good nutrition, the elimination of poverty, a hygienic environment, infrastructural facilities such as good water supply and housing as well as efficient health services and medical personnel" (Agbonifo, 1983, p. 2003). Indeed, a complex set of social, cultural, political, and environmental factors influence health status of communities (Kitts and Roberts, 1996).

This broad consideration of health and its underlying determinants of health, allow for a discussion on gendered experiences of health and illness.

Women contribute significantly to development, yet suffer from a disproportionate level of disease and illness. The WHO says that women's health affects the broader community because they are the primary educators of children, mainstays of their families, caretakers and providers of healthcare, farmers, traders, entrepreneurs, and often the sole breadwinners. WHO recognizes that "a society deprived of the contribution made by women is one that will see its social and economic life decline, its culture impoverished and its potential for development severely limited" (WHO, 1999, p. 5). Indeed, development is dependent on women's health and necessitates a discussion on gender relations of health and illness.

2a.i. Gender, Health and Development

Health problems in men and women are the result of multiple factors and influences, representing an intersection between biological and social realms of life (Doyal, 2002). Biological differences between men and women predispose them to different risks for health problems, but social and cultural differences are also important for shaping health outcomes. The term "gender" is used to describe the socially constructed power differences between the sexes, as well as their social and cultural responsibilities and constraints (Kitts & Roberts, 1996). Most societies are hierarchical and unequal based on the theory that there are biologically determined differences between men and women (Kitts & Roberts, 1996) Moreover, cultures assign different responsibilities to men and women, including access to social and economic resources

and entitlements. As a result, men and women are exposed to different risks to their health and different access to health care throughout their lives. A gendered perspective on health is necessary to understand underlying factors that contribute to illness, disease, and death.

Though the health status of the general population in most developing countries is generally poorer than developed countries, women suffer the most from ill health. As a result of their gender, women have a greater chance of becoming ill and also delay seeking care. Typically, women will defer accessing health care for themselves in order to get care for their families (Dodd & Munck, 2002, p 11). Women's low social status restricts their "access to economic resources and basic education and thus their ability to make decisions related to their health and nutrition" (WHO, 1999, p. 15). Despite being providers of health care, they do not hold the power to make significant decisions regarding health-seeking behaviour (ie. to take someone to the hospital) or make changes to unhealthy living environments (Sweetman, 2002). While men are more likely to access formal health care, women are more likely to seek help from traditional healers (Dodd & Munck, 2002, p. 10). Some women are denied access to health care because of cultural practices of exclusion or because the decision-making falls on the shoulders of another family member, often the women's husband. The lack of decision-making power, poor access to education and good nutrition, and limited economic resources restricts a woman's ability to pay for health care or family planning services. Women have the worst nutritional status in malnourished communities partly because cultural preferences dictate that men eat first (Kundson, 2003). Excessive work coupled with poor diet also contributes to women's poor health status. These additional obstacles stand in the way of

women's access to health care services, which limits their opportunity to improve their health status.

The gendered nature of health care is revealed and reinforced in different and sometimes surprising ways. Women's reproductive function or potential is recognized as a key site of health care; however, the health of women is always linked to health of children, and their role as "mothers and future mothers." Men's health "is never defined from a family or fathering perspective." (Rathergeber and Vlassoff 1993, 514) This is manifested itself in programs for women geared towards their reproductive role such as family planning programs. Women's medical services are a lower priority and poorer quality than those for children and men. Udipi and Varghese (1995) state,

> Little effort is made by the health sector to help women realize that they are persons in their own right, with their own personal health needs. Women's health needs are given less attention within the structure of health-service provision than the health needs of children. Their quality is poorer, and more often than not, women's needs are subordinated to population-control programs. (p. 155)

Despite their vulnerability to poverty and ill health, health research, health care and health policies have largely bypassed women's health needs. This promotes the idea that women's needs are secondary to others. When addressed, women's health is considered a means (to children's health, population control) rather than an end in itself.

Women's sexuality represents the intersection of two of forms of oppression – gender and sexuality. Sweetman (2002) explains that "in many societies, social and economic inequality between women and men is played out through regulating women's bodies, to ensure chastity before marriage and fidelity within it" (p. 3). Women in many contexts have little or no power to choose when, where or how they will have sex. As such, they cannot negotiate safe sex, or the onset and frequency of pregnancies. As a

result of their low-status, many women are confined to a life of repeated child-bearing (WHO, 1999, p. 15). There is cultural pressure and expectation for women to provide children to their husbands. This pressure is compounded by the few economic options for women outside marriage. A woman's experiences of pregnancy and childbirth are shaped by their family's expectations because, in many places, the decisions about care for the mother and baby are left to others. This gender discrimination takes its toll on women as illustrated in various health statistics from resource-poor countries.

The tragedy of gender discrimination and the neglect of women's health needs resulted in the maternal mortality crisis. Maternal mortality is not only the result of biological events because these deaths can also be attributed to social, cultural, economic and political environment. The medical causes of maternal health issues are related to underlying factors that contribute to ill health including lack of power, lack of financial independence and low self-worth (Kundson, 2003). Gender inequality and health is most apparent in women's reproductive and maternal health.

2a.ii. Maternal Health and Mortality

Maternal mortality issues represent many of the health and gender inequality issues outlined above. It is the largest differential between the developed and developing world of any health statistic (Kruk, Prescott, & Galea, 2008). On a global scale, over 500,000 maternal deaths occur each year; 99% of these occur in the developing world (WHO, 2012b, para. 1). The leading medical causes of maternal death – hemorrhage, eclampsia, obstructed labour and unsafe abortion – are similar throughout the world (WHO, 2012b, para 2.). Though medical solutions to pregnancy and childbirth complications are widely

known, they are applied and used unevenly around the world. A high maternal mortality ratio (MMR) is viewed as an indicator of a weak public health care system that fails to meet the basic health needs of the population. This has occasioned a larger debate amongst scholars on the wider social and cultural obstacles to maternal health in developing countries.

The leading causes of maternal death are medically preventable, suggesting that maternal mortality is a social and cultural issue, not solely a medical one. This phenomenon is articulated by several maternal health researchers and advocates. Fleming (1994) states that "the chain of events that leads to a women's premature death or suffering related to childbearing is rooted in her social, cultural and economic environment" (p. 142). The WHO agrees saying that "maternal mortality is not merely a 'health disadvantage', it is a 'social disadvantage" (WHO, 1999, p. 2). A closer look at the issue of maternal death and morbidity in developing countries reveals this disadvantage.

Maternal mortality is a lesser-known issue in the Western world partly because maternal deaths are almost unheard of in developed countries. The maternal health of mothers in Europe and North America were of a similar magnitude a century ago as developing countries are today. In 1900, the United States had a maternal mortality rate of 700 deaths per 100,000 live births. Across the Western world, levels had dropped to below 100 by the 1950s (AbouZahr, 2003, p. 13). Today, Canada and other developed countries have a maternal mortality ratio below ten. Uganda has a very high maternal mortality rates at 310 maternal deaths per 100,000 live births. MDG 5 to improve

maternal health has had the weakest improvement, and Uganda has been slow progress to improving these statistics (WHO, 2011).

Many maternal and child health (MCH) programs have neglected women's health needs relative to child health. Kitts and Roberts (1996) explain "more concern has been placed on children resulting from pregnancy than on women themselves" (p. 5). Maternal health was considered only as a goal of infant and child health and survival, based on the assumption that what is considered good for the child will also be good for the mother. Though women had different health needs from their infants, funding for maternal health measurement and data did not come through until 1985 when the WHO and the United Nations Population Fund (UNFPA) provided support for the necessary research (Rosenfield & Maine, 1985, 83). This international agreement on improving maternal health led to what some call a "motherhood and apple pie" status for maternal mortality whereby governments agree in public that something must be done but do not followed through with strong and effective actions (Sen & Ostlin, 2007, 3). Women's health advocates realised that women's health was not considered a value in and of itself, and presented the issue in a political context. Araugo and Diniz argued, "To cure the health problems of women is to acknowledge that oppression—and health problems—are not determined by biology but by a social system based on the power of sex and class" (as cited in AbouZahr, 2003, p. 17). The social system surrounding maternal deaths is outlined in the various barriers that prevent women from accessing life-saving care.

Thaddeus and Maine (1994) outline the environmental, social and cultural barriers that lead to maternal mortality in a conceptual framework that is the result of three delays: first, there is a delay in deciding to seek care on part of the individual, family or

both. Factors that shape this delay include the status of women, physical characteristics of symptoms, distance to heath facility, financial costs, previous experience in the health care system, and perceived quality and need of care. Second, there is a delay in reaching an adequate health care facility due to cost and availability of transportation and travel time to health facility. Finally, there is a delay in receiving adequate and appropriate care at the facility. The shortage of qualified staff, a lack of essential drugs and blood, malfunctioning equipment and clinical mismanagement of patients can inhibit an individual's access to lifesaving treatment.

An important note of reflection is the difference between the medical language surrounding maternal mortality, and the social, economic and cultural context in which maternal deaths occur. In North America, feminists have argued that pregnancy and childbirth are natural events. They have pointed out medicine's tendency to define normal biological events, such as pregnancy and childbirth, as pathological *and in need of* medical attention and expertise (Barker, 1982; Riessman, 1983; Morgan, 1998). This conceptualization of pregnancy, treatment of complications and maternal mortality privilege medical explanations. However, another body of research rejects this medicalization, and appeals to the 'natural' or 'normal,' does not address how to deal pregnancy complications that require medical intervention (Purdy, 2001; Kurkla, 2005; Lyerly, 2009). Purdy (2001) points out that preventative action against maternal mortality is not considered morally intrusive (p. 254). Further, helping women be healthy is primarily a moral and political task, not solely a medical one. Though pregnancy and childbirth should not be excluded from the medical realm, the medicalization of

pregnancy, in this view, should not deflect attention away from the social conditions that discriminate or oppress women.

Gender equality, female education, eradicating poverty and mitigating its effects, and social programs that uphold these values help ensure women have safe pregnancies and healthy newborns. Where no such programs exists, skilled medical help with delivery can save women and their children from death or disability. This argument applies to the current maternal mortality crisis. It is the social, economic, and political context of maternal mortality crisis exacerbates pregnancy complications and compromise pregnancy outcomes, and strategies to reduce maternal mortality are aimed increasing access to these medical interventions. For these reasons, maternal mortality ratios are considered a basic indicator of women and child's health, as well as the performance of the health care system. Therefore, this thesis focuses on strategies that increase access to and utilization of public health services that reduce maternal mortality and morbidity. Health systems, and their accommodation of maternal health needs, play an important role in saving women and their newborns from death and disability.

2a.iii. Maternal Health and Health Systems

Many systems in society have a bearing on health including agriculture, education, housing, transportation, and the economy. For this reason, the WHO defines health systems as "all the activities whose primary purpose is to promote, restore, or maintain health" (WHO, 2000, p.5). This involves a wide array of interventions including health facilities, household and community level interventions, and public health messages such as campaigns. It includes all levels of providers including public and private, formal and informal, for-profit and not-for-profit, biomedical and traditional. Mechanisms of

finance, regulatory authorities and professional bodies are also part of the system. Cook (2003) explains that health care systems are considered, "the mechanism in any society that transforms or metabolizes inputs of knowledge, and human and financial resources, into outputs of services relevant to the health concerns in that society." (p. 36) Health care systems are a complex interconnection of these various actors in health. Maternal health is linked to many aspects of society, including health care, education, and nutrition. For this reason, a country's maternal health status is considered a basic indicator of the public health system.

It is well understood that that a functioning health systems is necessary for reducing maternal mortality (Parkhurst et al, 2005; Bullough et al, 2005). Maternal health care falls within reproductive health care, an important component of the public health care system, however, it "differs from other types of medical care in that it is not an occasional need for an unfortunate few" (Cook, 2003, p. 41). Reproductive health services must meet a universal need for safe motherhood, fertility regulation, protection and treatment of sexually transmitted infections, among others. For instance, timely treatment of obstetric complications is necessary to ensure a healthy pregnancy outcome. The authors state that functioning systems must include, "providing basic equipment, supplies and referral systems, financing and human resource organizations." (Bullough et al, 2005, p. 1181) The availability and functioning of these aspects of the health system will facilitate appropriate treatment of complications if they arise. Thus, maternal health is dependent on and sensitive to the functioning of health systems.

The sensitivity of maternal health outcomes to health systems is demonstrated in developing countries where women face a series of obstacles to receiving appropriate

treatment for pregnancy complications. Sundari draws the connection between health systems and maternal mortality by saying "inadequate health care systems characterized by misplaced priorities contributes to high maternal mortality rates" (Sundari, 1992, p. 513). Ronsmans and Graham (2006) state that "delays in recognition and treatment of life-threatening complications, as well as substandard practices, contribute directly to maternal deaths." (p. 1196) A number of obstacles stand in the way of a woman receiving adequate care at a health facility including lack of life-saving equipment, skilled personnel, and functioning patient management. The poor quality of medical care can be summed up as providing women with "too little, too late." For this reason, poorly functioning health systems causes delays that lead to maternal death.

Maternal health is considered a key indicator of public health and the quality of the health care system. Maternal health depends on a strong capacity of public health, including education and nutrition, human resources, infrastructure, referral and communication systems, supplies and equipment, etc. (Sundari, 1992). Thus, improving maternal health care is a sign of a strengthening health system, since many of the necessary components of maternal health care provision will have benefits for the rest of the population (World Bank, 2006). For instance, a hospital that can perform caesarean section can also perform other abdominal surgeries. The solutions to maternal mortality must be situated in the context of broader health programmes. Therefore, the provision and reception of maternal programmes and services must be discussed.

2a.iv. Health Systems, Maternal Health, and Care

Health care systems provide maternal health services by bringing together both the technical and medical aspects of care with the social and emotional aspects of care. Quality of care can be measured in two dimensions. Technical care is the extent to which services comply with minimum standards. The technical aspects of maternal health care are the components of a functioning health care system discussed above, including communication and referral systems, the availability of medical supplies and drugs, and skilled birth attendants. Consumer assessed quality is the extent to which patients are satisfied with the services they receive. (Okuonzi & Birungi, 2000 p. 214) Gilson (2003) points out that poor consumer assessed quality can offset the satisfaction of good technical care. Therefore, quality of care is an important consideration of health care system, notably the acceptability of health services by patients.

The relationships between patients and health care workers are important component of consumer assessed quality of care. This micro-level relationship brings together the medical and the social or emotional aspects of care. Cancian and Oliker (2000) argue the social and emotional aspects of care or caregiving are a reflection of the institutions in which we participate. They explain that though women fill many paid and unpaid caregiving roles, it cannot be assumed that it is considered women's responsibility or their natural talent. Instead, good caregiving is dependent on the organization or institution in which they work. They explain "good paid care depends on highly trained and well-motivated workers who have time to provide responsive care" (Cancian & Oliker, 2000, p. 100). Quality of care in health systems is dependent on adequate resources and workplaces that value caregiving. Health facilities that create a positive

culture of caring can communicate equity, compassion, and human dignity to patients, but negative care is also common.

A negative culture of caring has been studied in health care systems of developing countries. Though nursing discourse emphasises "caring" as an important part of the profession, but Jewkes, Abrahams and Mvo (1998), nursing practice in developing countries is characterised by power differentials, humiliation and abuse. Their study in South Africa finds that nurses and midwives used humiliation, physical abuse or verbal coercion to control or punish patients. This behaviour was justified by an underlying ideology of patient inferiority (Jewkes et al., 1998). It is notable to point out that the academic literature on these social situations involve health services for women, specially family planning and maternity services (Jeffery et al., 1989; Mernissi, 1975; Sargent & Bascope, 1996). Women's inferior status in society is compounded at maternal health services within a system that operates on limited resources, power differentials, and a neglect for women's health. Therefore, this culture of caring pervades strategies to improve maternal health in developing countries.

2a.v. Strategies to Reduce Maternal Mortality

Maternal health advocates encourage women to use the formal health care system to monitor pregnancies and ensure safe deliveries (Thaddeus & Maine, 1994; Bullough et al, 2005; Gabrysch & Campbell, 2009). Three interventions to improve maternal health that will be discussed in this thesis are antenatal care, emergency obstetric care, and skilled birth attendants for every birth. Ideally, health systems will offer universal access to all maternal health services, but the lack of resources to reduce the maternal mortality

ratio in the developing world has led to considerable debate with respect to the most effective methods to prioritize.

Antenatal Clinics

Antenatal care plays a significant role in improving maternal health, as it provides opportunities to discuss with women the risks of pregnancy and delivery, as well as their options for place of safe delivery. Antenatal care should include the following essential elements: monitoring of the pregnant woman and her expectant child; recognition, management and treatment of pregnancy complications; screening for diseases or conditions; preventative measures; advice and support to the woman and her family; and, helping the woman and her family develop healthy home behaviours and birth preparedness (Lincentto, Monthebesoane-Anoh, Gomez, Munjanja, 2006, p. 53) A study in Bangladesh suggests that women who attend antenatal care are more likely to seek professional assistance for delivery (Vanneste, Ronsmans, Chakraborty, & de Francisco, 2000). The push to encourage antenatal care throughout pregnancy was based on the belief that early detection of risk factors for complications can lead to appropriate interventions at the time of delivery. Further, antenatal care attendance is important because it can be used as an indicator for access to health care services throughout pregnancy.

The role of antenatal care to reduce maternal mortality has been questioned in weak health systems. Antenatal care utilization is very high in developing countries indicating access to maternal health services, but it has not been associated with lowered risk for complications (Bullough et al, 2005). For instance, complications such as hemorrhage during delivery cannot be predicted during pregnancy. The inability to identify adverse

maternal outcomes through antenatal care has led to a shift in global maternal health priority from universal antenatal coverage to emergency obstetric care and universal skilled attendants for delivery (Vanneste et al, 2000; Bullough et al, 2005).

Emergency Obstetric Care

The availability of emergency obstetric care (EmOC) is an important part of maternal health strategies. EmOC is a series of "interventions focused on the direct obstetric complications that cause the majority of maternal deaths" (Bullough et al, 2005, p. 1184) This is considered a priority for maternal care because the ability of skilled attendants to provide appropriate interventions for pregnancy complications is compromised without adequate supplies, equipment, and referral systems (Sundari, 1992). Though not all complications can be predicted or prevented, some can be managed with these interventions. There are difficulties implementing EmOC in developing countries, especially rural areas, where access to reliable electricity and running water in hospitals is limited.

Despite the encouragement of EmOC provision in developing countries by the WHO, there are some critics of this approach to reducing maternal mortality. Costello et al (2006) argue that many maternal deaths occur outside the period of labour and delivery, "by no means would all be prevented by having delivered in a facility" (p. 1478). Some proponents of EmOC base their opinions in part on the mortality trends in low and high-income countries that reduced their maternal mortality rates by following this approach. Critics point out that the causes of maternal mortality in other countries could be attributable to the unavailability of antibiotics or high rates of HIV/AIDS. (Costello et al., 2006, p. 1478) Overall, the cost-effectiveness of this approach has been

questioned and weakened in its overall priority in international maternal health strategies (Costello, 2006; Bullough et al, 2005).

Skilled Birth Attendants

Many advocates for maternal health recognize the importance of having a skilled attendant at every birth as a primary means of reducing maternal deaths (Kurk, et al., 2008; WHO, 1999). A skilled attendant is able to identify the onset of complications, perform necessary and appropriate interventions, begin treatment, and refer mother and baby for interventions that are beyond their competence or particular environment. (WHO, 1999, p. 31) The WHO (2012b) defines skilled birth attendant as

> an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns." (para.2)

Millennium Development Goal number five is measured, in part, by the number of women who deliver with a skilled attendant as an indicator of maternal health. Skilled attendants are trained midwives who can identify and treat complications that are unpredictable, arise during and after pregnancy, and could be damaging or fatal for the mother and her baby. Skilled attendants play a significant and vital role in ensuring the survival of pregnant women and their babies "since timely treatment of complications is critical" (Republic of Uganda, 2010a, p. 64).

Studies have identified that regions with the highest coverage of skilled attendants during deliveries have the lowest maternal and neonatal mortality rates (Narayanan, Shaver, Clark, Cordero, & Faillace, 2004). Historical records of European countries (Sweden, Denmark, Netherlands and Norway) demonstrate the significant reduction in

maternal deaths that took place as a result of professional midwifery care for all births (WHO, 1999). Some question the feasibility of this option for resource-poor countries with inadequate numbers of skilled attendants and weak health care systems (Mathole & Lindmark, 2005).

The effectiveness of skilled birth attendants in developing countries is exemplified by Sri Lanka which witnessed significant reductions in maternal mortality in correlation with the expansion of the health facilities, midwifery training, and family planning. Between 1940 and 1985, Sri Lanka's maternal mortality rate dropped by 1,400 maternal deaths per 100,000 live births (WHO, 1999, p. 21). The effectiveness of this strategy can also be seen in China, Cuba, and Malaysia (UNFPA, 2012, 2 para.). In every case, ensuring a skilled attendant for every delivery was a key intervention for saving the lives of mothers and their children. For these reasons, this thesis will focus on the utilization of skilled attendants as an important strategy to reduce maternal mortality.

In the context of the above research, however, an important issue arises concerning the WHO-promoted approach to maternal health care and indigenous, traditional forms of health provision, especially in rural areas of Africa. This dimension of rural African maternal health care must be reviewed, especially in the case of Uganda, since there remains an important question whether such traditional systems are complementary or oppositional with regard to perinatal maternal health care, and, therefore, whether they enter as a factor into the discrepancy between prenatal attendance and delivery attendance mentioned above.

2.b. Traditional vs. Biomedical Perspectives on Health

Cultural perspectives of sickness, disease and illness are expressed in the management of different health systems. Traditional medicine is "the sum total of knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures that are used to maintain health, as well as to prevent, diagnose, improve or treat physical and mental illnesses" (WHO, 2008, para.1). It is a spiritual-based structure founded on knowledge that varies between cultures and has been used in some societies for thousands of years (Dove, 2010). Traditional medical practitioners (TMP) seek to cure illnesses by understanding the spiritual causes of pain using herbal or animal-based remedies, animal sacrifices, or monetary donations to a shrine (Wilkinson & Callister, 2010). For instance, some sicknesses may be seen as punishment for a spiritual offense. TMPs embody cultural and spiritual knowledge and have built up a relationship of trust with the communities they work and live in. Traditional medicine is used by many people in Asia and Africa, especially when modern, biomedical health care facilities are inaccessible or unaffordable (WHO, 2008, para. 4).

In contrast, the biomedical model is based on the scientific discipline of molecular biology. It assumes that disease is caused by measurable biological variables that deviate from the norm (Engel, 1977). This model of health care developed alongside broad social and historical changes in Western civilization. Max Weber referred to this paradigm shift as "a process of 'rationalization', in which the central theme is persistent emphasis on calculable and predictable concrete evidence" (Hewa & Hetherington, 1995, p. 130). The paradigm shift to rationalization ultimately undermined the spiritual and traditional values of society. For Weber, this led to "a total alienation of the human spirit from the

scientific and rational world" (Hewa & Hetherington, 1995, p. 131). Within the bio-medical model, disease is treated independently from social and spiritual behaviour. This model has shaped understandings of disease in the Western world. However, the limitations of this model are that it leaves little room for social, cultural and psychological dimensions of disease (Engel, 1977). These limitations have led critics to conclude that the biomedical model is "incomplete or useless" (Hewa & Hetherington, 1995, p. 129). Despite these limitations, the authority of the medical profession has allowed the biomedical model to dominate (Dove, 2010). As a result, it has become mainstream and internationalized.

Though Weber believed that this process of rationalization was irreversible, Hewa and Hetherington (1995) argue that there is a process of understanding the limitations of rationalization. The awareness of the biomedical model's limitations is mirrored in wider political, social, and cultural aspects of society. The alternative concept of the whole person, or a holistic view of human life, stems from a reunification of the relationship between body and mind that are allowing for alternative directions in development to unfold. Engel (1977) proposes a *biopsychological* model that accounts for the missing dimensions of the biomedical model. Under this model, the definition of health is not the mere absence of disease, but takes into account the social, psychological, and cultural causes of illness. The shift toward the biopsychological model is evident as doctors find themselves treating diseases that are not responsive to biomedical treatment. Instead, doctors must go beyond the boundaries established by the biomedical model and consider a patient's lifestyle, living environment, cultural beliefs, social interaction and economic condition because all these aspects of life contribute to an individual's well-being.

In spite of the limitations of the biomedical model, this model has been introduced and maintained in non-Western communities around the world. The intersection of the biomedical and traditional health systems is a site of contention in the African context. Though the biomedical model was adopted in Western civilization that reflected more general changes in the larger society over a significant period of time, this model was introduced to developing countries during the relatively brief period of colonization. As such, the biomedical model is critiqued as "an instrument of empire, as well as an imperializing cultural force in itself" (MacLeod & Lewis, 1988, p. 32). As an important tool of the imperial project, Konadu (2007) explains that the biomedical model embodied "the intimate relationship between disease and empire, in terms of ailing African bodies constructed as vectors of infection, [and] allowed for African exploitation and colonial imposition" (p.2). As the biomedical model is introduced to non-Western communities and developing countries, the traditional medical systems have been undermined and the role of traditional healers limited (Mathole & Lindmark, 2005). This debate between traditional and biomedical systems plays out on the ground both within and outside health care facilities.

Underutilization of health services is a distressing occurrence in developing countries. Services that are culturally inappropriate, alien and social irrelevant to societies are often contested. This is especially true in societies who have methods of healing, interpretation of sickness and disease prevention that contrast with biomedical health care. Health care providers may blame patients for not understanding the importance of their services and conclude that health care utilization will be improved with better education. Cook (2003) points out that this underutilization of the health care system is

the fault of the health care system. She says, "the question should not be why patients do not accept the services they offer, but rather why health professionals do not offer services that patients will accept." (p. 43) Cultural understandings of health and disease embedded within the biomedical model have clashed with traditional cultural, spiritual and social values especially in the area of pregnancy and childbirth.

2b.i. Pregnancy and Childbirth in Traditional and Biomedical Systems:

The medical management of pregnancy and childbirth represents a crossroads between traditional and biomedical systems because childbirth is a significant cultural event. It is surrounded by various cultural practices, beliefs, fears and expectations (Wilkinson & Callister, 2010). Many women in developing countries use traditional birth attendants (TBAs) to deliver their babies, especially in resource-poor communities where access to a trained medical birth attendant may be unfeasible. TBAs are informally-trained village midwives who are not considered skilled birth attendants by the WHO (WHO, 2012c, para. 2). TBAs can vary in their range of skills, but lack a recognized accreditation for midwifery skills of skilled birth attendants. Kamal (1998) defines TBA as "a person (normally a female) who assists mothers during childbirth and initially learns her skills delivering babies by herself or with another, more experienced TBA." (p. S43) A TBA can be a woman who practices midwifery for a living; but, the term also includes the rural or family birth attendant who is sometimes called upon to deliver as a 'favour' or a 'good deed' (Kamal, 1998, p. S46). This classification includes a large number of people including a relative who may occasionally assist a delivery, to government-trained TBAs who have some connection to the formal health care system

(Parkhurst et al., 2005, p. 133) While some TBA practices are positive or harmless, there are some that carry an element of risk and contribute to maternal or infant mortality or morbidity. Though they are considered unskilled by medical standards, TBAs are the main providers of health care to women during delivery where maternal mortality rates are high (Costello et al., 2006, p. 1477).

The traditional practices, skills, and roles of TBAs are as varied as the cultures and communities they work and live in. They are generally considered by their community as experts in women's health and share the same "childbirth ethos" of the women they assist (Fleming, 1994, p. 143). TBAs are trusted in their community, culturally-appropriate, cheaper, and more accessible than professional health care services (Mathole & Lindmark, 2005). Studies show that "women tend to have a more equal relationship and socially acceptable dialogue with TBAs compared to biomedically-trained midwives" (Ssengooba, Neema, Mboyne, Sentubwe, & Onama, 2004, p. 26). For these reasons, some women may prefer to use TBAs over health facilities. In many places, TBAs may be the only access women have to care for delivery.

From a biomedical perspective, many TBAs are unable to identify risks during pregnancy or complications that arise during childbirth and often seek professional help after it is too late to save the mother and baby (Ssengooba et al., 2004). Tuguminize (2005) explains that TBAs enjoy a positive reputation in the communities, but they do not know how to identify risks during antenatal care, complications during pregnancy or practice referral to trained health professionals early on. The traditional practices of untrained attendants such as TBAs contribute to, or even compound the problem of maternal mortality. For instance, Fleming (1994) outlines some of these practices in the

Ugandan context. During antenatal care visits, TBAs rarely take a history from their patients, even though patient histories can reveal women more likely to have high risk pregnancies. In the case of severe tears, some women are sent to the hospital for repair while others are left to heal on their own. Finally, women who are distressed during labour or experience excessive bleeding are considered cowards or reacting "according to their nature" (Fleming, 1994, p. 145). Overall, it was found that TBAs offered unhygienic childbirth practices, poor infection control, and delayed referral with potentially fatal consequences for the mother and baby.

TBA-training programs have been introduced in some countries as a method of integrating the biomedical and traditional health models and mobilizing this available human resource in countries that suffer shortages of professional health workers; but the success of these programs has been limited and methods of integration are currently being debated (Walraven & Weeks, 1999; Smith et al, 2000; Mathole & Lindmark, 2005). Training programs have been developed to train TBAs to identify problems during delivery, and guide women to and through the formal health care facility when the need arises, but the WHO (1999) reports that there is no evidence that TBA training can lead to lower maternal mortality rates without support from the broader health system. Kamal's (1998) survey of TBA training programs suggests that the failures of these programs are poor TBA curricula, weak supervision of trained TBAs, accessibility to emergency obstetric care, community sensitization to training, and a lack of a replacement strategy. (p. S52) Unsupervised TBAs tend to slide back into their traditional methods. Further, TBA-training is rendered ineffective when TBAs are unsupported from a wider, functioning healthcare system. Despite these challenges, TBAs remain

influential actors who can be channelled toward improving maternal health by offering "culturally appropriate nurturing in the community setting, offer a first-line link with the formal health care system and provide some simple services such as distribution of nutrition supplements" (WHO, 1999, p. 26). TBA-training must be situated within the biomedical health care (ie. a functioning referral system) with professional medical personnel in order for a reduction in MMR to be achieved.

In Uganda, the government has had a turbulent relationship with traditional birth attendants. The health minister, Steven Malinga, issued a report in 2009 from the Uganda Ministry of Health to all development partners to incorporate TBAs into the work of village health teams (VHT)[2], but this approach was short lived. Today, TBAs are considered to be a contributing factor towards maternal mortality and receive negative attention in the national newspapers and radio programs. In 2010, the story of Salome Nakitanda made headlines when complications arose the delivery of her 11th child (Murigi and Ford, 2010 Mar 30). She could not afford hospital care or transportation so sought the help of a TBA. The newspapers explain the harrowing accounts that followed. The TBA performed caesarean section using a kitchen knife after Salome fell unconscious during labour and stitched together using tailoring thread. During the procedure, Salome's uterus and bladder were sliced open. Her baby did not survive, and Salome was brought to the hospital where she required major reconstructive surgery and long-term treatment. Her story exemplifies the ways in which TBAs' lack of knowledge and traditional practices can be harmful to pregnant women and their newborns.

---

[2] VHT offer advice to their communities on basic health care and prevention including registering pregnant women, identifying danger signs among pregnant women and encouraging them to deliver in health facilities

This story added weight to the government's decision to ban TBAs because of their failure to refer women to health centres. Most maternal health advocates acknowledge that some traditional birth attendants are skilled enough in normal labour and birth. Though they are dedicated and professional, "they may not possess the nuanced ability to know when it's time to stop depending on their own skill and call on mainstream health professionals." (Nakkazi, 2012, p. 19) Despite the ban, TBAs are still the providers of choice for many women who deliver outside a health facility either with a TBA or an elderly female relative. TBA practices still persist in Uganda because of the lack of transportation, uneducated clientele, substandard care at health facilities, and health workers who are rude and insensitive to patient needs.

Maternal and public health advocates, including the WHO, encourage women to use the formal biomedical health care system to monitor pregnancies and ensure a successful delivery. Western medicine has the ability to treat common maternal complications and lower MMR from their current levels in developing countries. As such, maternal health advocates are eager to apply various biomedical interventions to reduce maternal death (Thaddeus & Maine, 1994; Gabrysch & Campbell, 2009). For instance, hemorrhage can be treated with a single dose of *oxytocin* (Bullough et al., 2005). There has been a call for cultural competence in the formal health care system in order to bridge the gap between traditional medicine and biomedical healthcare to encourage utilization of skilled attendants (Walraven & Weeks, 1999; Smith et al., 2000; Wilkinson & Callister, 2010); however, obstacles to the utilization of skilled attendants and traditional birth attendants arise beyond the cultural expressions of formal and

traditional health care to more practical and logistical problems regarding access to skilled attendants.

2.b.ii. Utilization of Skilled Attendants vs. Traditional Birth Attendants:

Gabrysch and Campbell (2009) have identified various determinants that affect women's delivery with a skilled attendant. Grouped into four categories, these determinants are economic feasibility, physical accessibility, socio-cultural factors and the perceived benefit/need of skilled attendance. Economic feasibility of using maternal health services is related to the mother and husband's occupation and ability to pay. Secondly, physical accessibility is dependent on rural or urban location of the mother, as well as distance, availability of transport and road infrastructure (Gabrysch & Campbell, 2009). In correspondence with the barriers identified by Gabrysch and Campbell (2009), various studies have identified logistical obstacles that prevent women from accessing health facilities to deliver their children Regarding financial accessibility, Levin et al. (2003) outline the monetary burden of delivering in a health facility in four African countries including Uganda. Further, the lack of physical accessibility due to poor roads and lack of transportation is an obstacle to reaching medical services in a timely manner (Kundson, 2003). Physical accessibility issues are more problematic in rural, rather than urban settings.

Socio-cultural factors associated with a decision to seek a skilled birth attendant may include ethnicity and traditional believes, the mother and father's level of education, and a women's autonomy (Kundson, 2006; Gabrysch & Campbell, 2009). The perceived need for medical attention involves information availability, health knowledge, perceived

quality of care, antenatal use throughout pregnancy, and previous facility delivery. These socio-cultural factors may hinder or delay the decision for women to deliver at a formal health facility, opting instead to seek health care from traditional birth attendants.

Women's preference to deliver outside a health facility can be attributed, in part, to their adherence to traditional birthing practices. Kyomuhendo (2003) finds that traditional beliefs and practices dictate that pregnancy is childbirth is a test of endurance and as such, rural women are more likely to choose high risk options of delivering with a TBA. Tuguminize (2005) states that women use TBAs because the women can choose the positions of delivery, TBA services are inexpensive, women identify with TBAs and share their beliefs, TBAs are kind and tolerant to women, and are well-respected in their communities. (Tuguminize, 2005, p. 278) For these reasons, the use of formal health centres is considered and pursued as a last resort. These findings suggest that women's experiences of childbirth under traditional care differ from that of formal health facilities and may influence them to deliver without a skilled attendant.

2.c. Experiences of Pregnancy and Childbirth in Uganda's Healthcare Systems

Despite the encouragement of skilled attendants by maternal health advocates, there are institutional and logistical reasons for the low utilization of these attendants in Uganda. Economic feasibility and physical accessibility along with socio-cultural preferences for TBAs can deter women from using skilled attendants for delivery in Uganda (Knudson, 2003). Indeed, several factors that influence a women's place of delivery in the developing world have been identified by researchers and health practitioners. In their review of maternal health in Uganda, a report by several public and

maternal health advocates states, "it is important to disentangle the web of access barriers to identify the way these various factors are interrelated" (Ssengooba et al., 2004, p. 13).

High quality medical care brings together two components of care: the quality of care in terms of service and the system, and quality of care as experienced by the users. van den Broek and Graham (2009) point out that "the use of services and outcomes are the result not only of the provision of care but also of women's experience of that care" (p. 19). Some services may be considered high quality in terms of standards of care, but unacceptable to women. Conversely, some aspects of care may be popular with women, but may be ineffective or harmful to women's health. In Uganda, quality maternal health care is compromised by understaffing, gaps in knowledge in aspects of midwifery, inadequate job supervision and an absence of standard guidelines (Kaye, 2000, p. 558).

Maternal health advocates in Uganda recognize the varying experiences of maternal health care in traditional and biomedical systems. Women find their experiences of pregnancy within the biomedical system in Uganda to be unacceptable. A small study in Uganda found that women feared inappropriate handling, rudeness of medical staff to mothers, unacceptable delivery posture, and inappropriate assessment of labour process by medical staff in the formal health care system. (Ssengooba et al., 2004) Women who used hospital services for delivery were concerned about hygiene, privacy and lack of medical supplies. This study suggests that medical practices surrounding childbirth in hospitals conflicts with the expectations of women who use them.

Cultural and social preference for TBAs, combined with inappropriate and inaccessible care provided in health facilities, may affect the utilization of skilled attendants in Uganda. The high level of antenatal coverage across the country indicates

some level of access to health facilities. Cook (2003) writes, "the voices of women, and their perspectives, have often not been taken into consideration in laws, policies, and regulations governing sexual and reproductive health care for women" (p. 39). Investigating women's experiences in antenatal and delivery services can explain the extent to which maternal health care services are acceptable and to what extent they effect the utilization of skilled attendants.

2.d. Conclusion

At the onset of labour, time is of the essence. A woman must know when and how to seek a skilled birth attendant who can assist her with the delivery. Necessary medical equipment and supplies must be on hand including everything from gloves and medicines to blood supplies and monitoring equipment. A woman must be healthy and well-nourished to have energy for the labour and also to deliver a infant of healthy weight. She must have social network to provide logistical and emotional support for childbirth before, during and after the delivery. In developing countries such as Uganda, this process of pregnancy and delivery is sensitive to both social, cultural, and biological factors that obstruct a healthy pregnancy. This chapter summarizes the wide variety of issues surrounding maternal health in the developing world that lead to low utilization of skilled attendants and high maternal mortality.

These issues are important for development because maternal health is a key indicator of development, public health, women's health, and child health. Health plays a key role in development as both a means to development and also an indicator of development. Despite this importance, historical approaches to development have favoured economic growth over the provision of a strong, well-functioning public

healthcare system. Women offer an important contribution to development, and their health owes significant consideration for development discourse; however, gender plays an important role in the experience of health as cultures assign different roles to men and women that affect both their exposure to health risks and access to health care throughout their lives. The literature explains that women are differently affected by ill health because they have less access to, control of and authority over financial resources, which are needed to cover the costs of medical care. As a result, women suffer from a disproportionate level of illness.

As the health measure representing the largest differential between the developed and developing world, maternal mortality encompasses the health and gender inequalities discussed above. The leading causes of maternal death are medically preventable, but are unevenly applied and used around the world. Safe pregnancies depend on a strong capacity of the public health system that is accessible, functioning, and safe to assist with the labour and provide care to the mother and child before, during and after the delivery. As such, maternal deaths are attributed to their social, cultural, political, and economic environments in which they occur.

The strategies to reduce maternal deaths are well-established. Antenatal clinics allow health professionals to monitor the health of the mother and child, assess and discuss risks, and place of safe delivery. Emergency Obstetric Care (EmOC) allows health professionals to provide appropriate and safe interventions for complications that arise during the delivery; however, some critiques do not consider EmOC a cost-effective approach in resource-poor countries as it does little to encourage utilization by the poor. Finally, skilled birth attendants are considered a primary means of reducing maternal

deaths. These are trained midwives who can identify and treat problems that are damaging to the health of the mother and her baby. These interventions are based on a biomedical system to manage pregnancy, and do not incorporate pre-established, traditional methods of childbirth in non-Western cultures.

The cultural and social significance of pregnancy and childbirth requires an understanding of traditional medicine within the context of rural African maternal health care. The intersection of biomedical and traditional health systems is a site of contention in the African context because the cultural, spiritual and social values of indigenous cultures have clashed with the understandings of health and disease in the biomedical model. Several women use traditional birth attendants (TBAs) to deliver their babies. TBAs develop their skills overtime, and are informally-trained village midwives who lack recognized accreditation of skilled birth attendants. There is significant variation in their level of skill which can contribute to the high rates of maternal mortality in some cases. Though the WHO does not consider them to be skilled birth attendants, they are culturally-appropriate, cheaper and more accessible than formal health services. TBAs may be the only feasible access to assistance during childbirth in rural areas.

Utilization of skilled birth attendants over other methods of childbirth assistance is the primary interest of this thesis. Literature points to various factors that affect a woman's likelihood of seeking and accessing a skilled attendant for birth. These include economic feasibility, physical accessibility, perceived need for care, and socio-cultural factors such as adherence to traditional practices. Further there is some indication that the experience of childbirth with TBAs differs significantly from deliveries in the formal health care system. TBAs are preferred by some women because they are inexpensive,

they can choose positions of delivery, they are kind and tolerant, and are well-respected in their communities. On the other hand, childbirth in the formal health system is unacceptable by some women because of lack of privacy, poor handling and attitude of staff, lack of medical supplies and poor hygiene are concerns for some women. These varied experiences suggest that institutional factors could deter women from delivering at a hospital with a skilled attendant.

In Uganda, skilled birth attendants are located in health facilities across the country. Uganda's national health survey reports that almost all women in Uganda attend antenatal clinics, but only 59% return to health facilities for the childbirth (UBOS, 2011, p. 13). This discrepancy between antenatal clinics and skilled birth attendants creates a "care gap" leaving the majority of Ugandan women without have skilled assistance during childbirth. Though advocates encourage all women to use the formal health care system to improve pregnancy outcomes, most literature focuses on the barriers to use and not women's experiences within the system. Though the literature and data are extensive, questions still remain: What are women's experiences within the system they are encouraged to use? Do institutional factors affect women's utilization of skilled attendants? How can more women be encouraged to use skilled attendants for childbirth?

Therefore, the primary focus of this thesis draws on women's experiences of childbirth within and outside a health facility. Though women are considered the backbone of their families and communities and maternal health plays a key role in public health, the voices of Uganda's mothers are largely silent from the literature. Women's experiences moving through maternal health care services, from antenatal clinics to delivery, can help us understand the "care gap" that emerges from their

utilization pattern. These experiences can only be understood by hearing the stories of women moving through the system. Women who use the system are the primary subjects of this thesis who share their experiences, address the research questions and offer methods of improving the system.

CHAPTER THREE: METHODOLOGY

"Stories can be used to disposes and malign, but stories can also be used to empower and humanize. Stories can break the dignity of a people, but stories can also repair that broken dignity." - Chimamanda Adichie, author, 2009

The methods of this thesis were inspired by some of my first encounters with Ugandan mothers. During one of my first trips to Uganda in 2009, I traveled with Save the Mothers (STM) students to the Nakifumwa health clinic in Mukono district. They conducted focus groups with hospital staff and community members including men, women and adolescents. Following the discussions, the STM staff offered to drive one of the focus group participants, an adolescent mother and her young infant, closer to her home on our way back to town. The conversations with our staff revealed her opinions on her community's reaction to her out-of-wedlock pregnancy. With the help of a translator, she shared her story of being a pregnant adolescent girl in Uganda, the damage of the social stigma of the adolescent pregnancy, and the impact it had on her life. Here was a young woman who is articulate, opinionated, capable, and willing to share her experiences of adolescent pregnancy.

The story of this young woman was unlike many of my other encounters with Ugandan women. In the presence of men, authority figures, or foreigners, women rarely speak up in groups. After spending a year in Uganda, I became convinced that women's voices were not being heard. English-speaking doctors, nurses, researchers, and administrators are considered to be go-to consultants who kept a pulse on local maternal health trends. Members of Uganda's educated and political elite are sought after for funding and solutions to the maternal health crisis. Poor and rural women who use the

maternal health services are rarely called upon to answer questions about these trends, hold those in power accountable to the maternal health crisis, and fill in the gaps were empirical knowledge falls short.

The previous chapter explained that gender and health issues are often neglected or ignored in Ugandan society and politics. The connection between women, health and development is well established. Despite the wealth of research on the issues of maternal health and mortality in the developing world, little is known about the discrepancy between high antenatal care and low utilization of skilled attendants. The current research moves beyond the statistics to reveal the stories that account for women's patterns of utilization. More importantly, women's voices are largely absent from academic research addressing this issue. Few studies consider qualitative analyses of women's experiences with the maternal health system as a source of understanding for the underutilization of skilled attendants for delivery. Listening to women not only makes their voices heard but provides insight into the complexity of their circumstances and the health care issues that matter most to them.

The purpose of this thesis is to understand their utilization, or lack thereof, of such services by documenting the lived experiences of Ugandan women using maternal health care services in Uganda. The thesis aims to explore women's experiences about systems that surround childbirth and delivery, specifically women who delivered within the past six months with or without the assistance of a skilled attendant. It will document and analyze the reasons why women return to facilities for delivery with a skilled attendant or, alternatively, why they do not return. Their stories will personalise these issues and emphasize the problems that surround their use or non-use of skilled attendants. How can

the richness of their voices, the complexity of their circumstances and the variety of their experiences be captured and translated into academic research?

3.a. Epistemology

For the above reasons, this research involves a mixture of qualitative research methods. Qualitative research methods are the most appropriate approach to capture the voices, experiences, and stories of Ugandan mothers and critique the strengths and weaknesses of the health system they use. The goal of qualitative research is "understanding of specific circumstances, how and why things actually happen in a complex world." (Rubin & Rubin, 1995, 39) Quantitative researchers deliberately reduce their studies down to measurable variables, but qualitative research embrace methods of investigating the complexities of the 'real world.' In this project, qualitative methods will illustrate the rich descriptions of life events, capture the participants' point of view, and direct attention to the constraints of their everyday life.

Postmodern researchers consider quantitative approaches to be sterile because they use empirical methods that contributes to only one story and "silence too many voices" (Denzil and Lincoln, 1994, 12). Indeed, a multiplicity of voices can expose similarities and contradictions in the discussion of one event. Denzil and Lincoln (1994) contend that the field of qualitative research is "defined by a series of tension, contradictions, and hesitations." (27) Postmodernists, refusing to privilege one method, find "truth" and "reality" lies in the core of those tensions. Expressing this postmodern view, Nigerian author Chimamanda Ngozi Adichie explains the importance of story-telling, writing, and sharing experiences. She says, "the danger of a single story is that we miss critical understanding... The single story creates stereotypes, and the problem with

stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story." Falling within this approach, this thesis favours narrative form to draw out the complexities that surround utilization of skilled attendants in Uganda.

The narrative paradigm encompasses qualitative research methods that study story-telling, or giving a report of events in order to communicate and comprehend the conflicts, characters, values and beliefs that shape life experiences. Narratives are sometimes used to represent the lives of subgroups in societies defined by gender, race, class, etc. Due to their class and gender, rural women in Uganda "are discriminated-against minorities whose narratives express their unheard voices." (Lieblich, Tuval-Mashiach & Zilber, 1998, p. 5) The narrative paradigm does not take the side of total relativism which views all stories as fabrication, nor does it consider stories should be taken at face value. Instead, the narrative paradigm considers stories to be constructed around a core set of facts. As well, this thesis situates the stories of women's experiences in health care to be a valuable collection of facts. Interviews and focus group guidelines allowed women to recount the stories that led up to their last childbirth experience, whether in a hospital, at home, or with the assistance of a TBA.

In maternal health, there is a need for research that places the spoken word at the centre of social science research. Narratives are an effective method of addressing the research questions because they allow "a wide periphery for the freedom of individuality and creativity in selection, addition to, emphasis on, and interpretation of these 'remembered facts." (Leiblich et at, 1998, 8). There is a wide variety of issues connected to maternal health (politics, gender relations, education systems, etc.). The only way to figure out what women are experiencing, the issues that affected them most, and the

reasons for their utilization of skilled attendants for delivery is to talk to them. Only the narrative form would reveal their experiences in health care and allow a wide variety of their reasons for choice of delivery site. Falling within the narrative paradigm, this thesis considers the experiences of women as valuable accounts of the inner-workings of health care systems and its affects on utilization of services.

This research project veers away from a pure narrative form by adding a comparative element to the methodology. Collecting stories of the lived experiences of Uganda's mothers allows the researcher to explore the health care system through the eyes of those who use it. The methodology and analysis link and compare their stories for similarities of experiences and commonality of issues. The analysis involves finding and creating narratives in the interviews and focus groups transcripts (Kvale, 1996, p. 201). Looking for narratives and moulding them together allow us to combine the stories of the women. Focus groups allow women to share their individual stories, placing emphasis on the issues that mattered the most in their eyes. Individual in-depth interviewing allows women to further elaborate their stories, their experiences, their criticisms and their acclaim. Together, women's stories create a collective narrative that helps us answer the question of utilization of services.

Critical social researchers argue that the purpose of research is to expose flaws in society and propose ways to eliminate those flaws (Rubin & Rubin, 1995, p. 35). These researchers tend to study and give voice to oppressed and powerless groups. Feminists, focusing their lens on the problem of dominance and submission that affect women, shape one variety of this approach. They reject the idea of a neutral researcher who often ignores women, assumes a position of dominance over the researchers, and disempowers

the interviewees in the process. Instead, feminist critical social researchers call for a loosely structured research methodology that allows us to "learn about women, to capture their words, their concepts, and the importance they place on the events in their world." (Rubin & Rubin, 1995, p. 35). Regarding the maternal health crisis in Uganda, this thesis turns to Ugandan women for answers. They will tell us what is wrong with the poor state of maternal health care in the country.

3.b. Research Methods

In keeping with the overall hypothesis that women's negative experiences in maternal health care are linked to poor utilization of skilled attendants for delivery, it is important to speak with women who use these services. I occasionally use observations of Uganda's maternal healthcare that I made during the 10 months I worked as a volunteer in Uganda and an intern for a maternal advocacy organization, Save the Mothers and during the three months I spent doing fieldwork in 2011; however, my main source of information comes from the stories shared and collected from focus group and interviews with Ugandan mothers.

During the fieldwork, I conducted one focus group with women who delivered with a skilled attendant in the past year and another focus group with women who did not deliver with a skilled attendant in the past year. These women informed me of their preference for health care or home delivery and the factors influencing their decision of place to deliver. The benefits of a group interview including helping women feel comforted by each other's presence. According to Berg (2009), focus groups places the interviewer on equal footing with the women, and understand how group members

"arrive at, or alter, conclusions" about maternal health choices. (p. 165) Focus groups are beneficial for exploring socio-cultural issues as they allow "unanticipated topics [to] arise in the course of the group's discussion." (Berg, 2009, 165) These two groups were not be mixed into a single group interview because women's negative view of recent deliveries in a hospital may have detered other women from seeking the life-saving care they offer. Overall, this focus group provided me with general social and cultural issues that influence women's decision for place of delivery and will inform the interview guidelines for individual in-depth interviews with new mothers in the community. Limitations of focus groups, such as gaining only group opinions and hearing from dominant personalities, are thwarted with a facilitator that draws out opinions from each woman in the group. Also, conducting separate in-depth interviews with other women will diversify and triangulate the data from these focus groups.

I conducted individual in-depth interviews with ten women who delivered a baby in the past six months year with and without a skilled attendant. The age groups for the women would be between age 21-45 to exclude the adolescent and older generations whose experience with pregnancy and childbirth could differ greatly from the majority mothers in the community. Unstructured, open-ended question interviews are appropriate for new mothers because the conversational style would help them feel more comfortable. Denzin and Lincoln (2005) explain that these interviews "provide greater breadth of information" and help provide insight into "the complex behaviour of members of society without imposing any a priori categorization that may limit the field of inquiry." (p. 705) These unstructured interviews allowed me to probe beyond their initial answers to uncover the thought processes and attitudes toward reproductive health

knowledge and rights, cultural beliefs surrounding childbirth and delivery and their perceptions of seeking skilled attendants for delivery. In these interviews, women provided information regarding their decisions, perceptions, and experiences delivering at home or at the hospital. More importantly, this interview style would allow unexpected topics, thoughts and attitudes to be discussed. Overall, the interviews with these women will help me uncover the thoughts behind Ugandan women's decision to deliver their babies with or without a skilled birth attendant.

3b.i. Historical and Policy Overview

A historical overview of Uganda's health policies is necessary in order to understand the current conditions of maternal health care in Uganda. This documentary review included Uganda's national development policies, national health policies, loan agreements and policy recommendations from international financial institutions, research studies, and books. These sources provided insight into the formation of Uganda's health system, health policies that organize and manage health care delivery, as well as the effects of health policies on the Ugandan population through the decades. This historical and policy overview, outlined in chapter four, situates the focus group and interview data in a broader context of health care services. This overview is necessary to help understand Uganda's general health care system and the maternal health services that are provided to pregnant women and new mothers.

3b.ii. Participants and Procedures

Based on this study's ethical guidelines stipulated by the Research Ethics Board at Saint Mary's University, participants were selected based on three criteria: all women had

delivered a child in the past six months, all women had attended at least one antenatal clinic, and had either delivered with or without the assistance of a skilled birth attendant. No other personal, socio-economic, and lifestyle data was collected from participants outside the data disclosed by participants during the interviews and focus groups. Data were collected from women who have recently used delivery services with and without a skilled attendant, as well as women who were currently attending antenatal clinics for a subsequent pregnancy. Methods of data collection included focus groups, and individual in-depth interviews with the help of research assistants fluent in Luganda and English. Data was collected from 26 women in total over the age of 21 regarding the birth of their second child. One focus group of eight (8) women was conducted with those who delivered with a skilled attendant in the past six months; and another focus group was conducted with eight (8) women who delivered without a skilled attendant in the past six months. The focus groups lasted between 1 and 1.5 hours. The data gathered from these focus groups was used to develop interview guidelines for in-depth individual interviews with other women. Ten (10) interviews were conducted in total: five (5) interviews with women who delivered with a skilled attendant in the past six months; and, five (5) interviews with women who delivered without a skilled attendant in the past six months. Participants were recruited from immunization clinics at the district hospital just after their babies were immunized, or while they waited to be seen by a nurse. Interviews lasted about 30 to 40 minutes each. They were not reimbursed for their transport costs. Topics of discussion health seeking behaviour, experiences with maternal health care services within and outside the hospital, and the impact of these experiences on their

choice of services during pregnancy and childbirth. One woman declined to participate the focus group of women who delivered without a skilled attendant.

Three research translators were recruited from MICAH, a community outreach student-run group on the campus of the Uganda Christian University. They were trained to help conduct and translate focus groups and interviews. The focus group discussion (FGD) and individual interview guides (see appendices A and B) were translated from the original English version into the local language (Luganda) by one research assistant. Another research assistant translated the Luganda versions back to English to compare. This was done to ensure consistency of meaning. The informed consent form was read aloud for both focus group and individual interviews when participants who were illiterate. Those who could not write were asked to mark an "X" in place of a signature. Verbal consent was given so the sessions could be recorded. Participants were guaranteed anonymity and asked not to disclose their responses or the responses of others with people outside the discussion groups. One research assistant translated for the researcher and helped moderate the focus groups, while the others took notes to aid translation.

3.c. Analysis

Categorical-content analysis was used in order to explore the narratives surrounding experience and utilization of services shared among the group of women. Categorical-content analysis is two-dimensional in form. The categorical dimension of the analysis approaches the text by "the original story is dissected, and the sections or single words belonging to a defined category are collected from the entire story or from several texts belonging to a number of narrators." (Leiblich et al, 1998, p. 12) The content dimension

of this analysis focuses on the content of the narratives, namely, "what happened, why, who participated in the event, and so on, all from the standpoint of the teller." (Leiblich et al, 1998, p.12). Together, these two dimensions form an approach similar to content analysis.

This method of analysis was employed in the following process. Data was translated into English and transcribed for analysis. Transcripts were read multiple times to gain a sense of the overall messages being communicated. Data was condensed to reveal underlying meaning and messages in the text. Coding was used to help identify words and concepts mentioned in the discussions belonging to the categories regarding utilization and experiences of services. These categories included various issues with health care, characters that affected utilization of services, limitations on access to services, etc. Codes were grouped into categories and subsequently into themes. Themes were identified and will be linked to literature review. Quotes that best summarised common issues or highlight the views of multiple women were chosen to share in the next chapter. Some of the data analysis was completed in Uganda, and some of the language used by the women is carried into the writing of this thesis. Notably, men and women in Uganda call the unborn, infants and toddlers "babies". The word "baby" is used in this thesis in similar way.

Due to the abstract nature of women's experiences and stories of their last pregnancy, the process of analysing the data into codes, categories, and themes requires further unpacking. Some codes and categories have more clear connections. For instance, women who explained 'they demanded money' or 'gave them bribes' were coded as

"bribery" and generated categories as 'medical costs'. Other concepts discussed in the focus groups and interviews were more abstract.

Many women shared stories about their treatment in the hospital by staff. Data was analysed using both in vivo codes and constructed codes from sentences, paragraphs or stories about their interactions with hospital staff. For example, one of the codes is "poor communication" constructed when women explained a nurse or doctor "barked at me." Another code entitled "lack of compassion or empathy" was constructed from women's stories in which they explain a staff member treating them poorly, neglecting to show sympathy in their state of labour . One woman says, "I was from the [operating] theatre with my baby and the nurse told me to go out, yet I was supposed to rest a bit. Also, some nurses force us to clean when we have just given birth." All of these codes were categorised into "hospital staff attitude and behaviour."

Multiple codes were grouped into topics or categories. Categories were constructed describe a group of codes that shared a similar idea or concept. For example, "overcrowding" best described the group of codes that described the busy maternity wards and staff shortage. Other categories were more difficult to construct on my own, so I borrowed some concepts from previous research studies on maternal health. For example, several maternal health researchers explain that women are dependent on family members to make and facilitate health care choices for the pregnancy (Thaddeus & Maine, 1994; Kyenmundo, 2003; Parkhurst & Campbell, 2009). The literature describes these issues as a woman's lack of autonomy or decision-making power. Similar language was applied describe codes or concepts in this research. Thus, category entitled "lack of

independence/autonomy" was used to encompass codes that described women's dependence on husbands or family to access skilled birth attendants.

Two overarching themes were identified from the focus groups and interviews. First, women were asked to share their stories about their experiences within the hospital or health facility. These stories included interactions with hospital staff, waiting times, availability of beds, and medical costs. These discussions revealed the obstacles within the health care system to access care from a skilled attendant. Secondly, women were asked to share their reasons for using a skilled birth attendant or not. For these questions, women discussed their ability to access the hospital or health facility and the benefits of going to the hospital. The topics that were discussed were physical access, time constraints, or lack of autonomy. The categories were then placed into these distinct groups.

Codes	Categories	Themes
- no beds - long waiting times - few doctors/nurses	Overcrowding	Obstacles in the Health Facility Effecting Utilization:
- payment for medical supplies - payment for medicine - bribes	Medical Costs	
- rude staff - poor communication - lack compassion and empathy - poor patient care - busy staff - neglect	Health workers' attitude	
- risks at private/TBA clinics - medical needs/ testing - expertise at hospitals, especially in case of complications - useful information	Benefit/Need of Hospital Services	Obstacles in the Community to Reaching a Skilled Attendant for Delivery
- husband's consent for care - alone in labour - caregiver in hospital - husband's monetary support - husbands' responsibility	Lack of independence/autonomy	
- labour pains quickly - private clinic/TBA nearby - boda-boda uncomfortable - delays in referral process - bumpy terrain	Time constraints and transportation issues	

Ethics

Ethical approval was received from Saint Mary's University and the Uganda National Council for Science and Technology. The study was conducted in partnership with Save the Mothers and the public hospital from where participants were recruited. Written consent was obtained from the participants. Doctors and nurses in the antenatal and maternity wards gave permission for the researcher and translators to approach patients before or after they received services.

3.d. Setting:

Uganda is divided into four administrative regions that include the Central, Eastern, Western and Northern regions. Currently, Uganda is divided into 111 districts. Research has taken place in the Mukono district of Central region in Uganda. Mukono is a neighbouring district of Kampala. The transnational highway runs through the main town, but Mukono is largely rural. In this region, 90% of women receive antenatal care from a skilled provider at least once, while almost 49% of women deliver their baby with a skilled attendant (Republic of Uganda, 2006, p. 120). Research participants were recruited from a district hospital in which about 24,000 women attend antenatal clinics and only one-third return for delivery at a health facility. Key informant interviews were conducted with the public health nurse, a nurse from the antenatal clinic and a midwife in the maternity ward. The name of the hospital will not be disclosed to protect the identity of health care workers at this hospital.

The responses were recruited from a district government hospital. The state of hospitals in Uganda vary depending on funding and location. This hospital was built in

1968, but has not undergone expansions and renovations to accommodate the growing population in its 32 years of operation. It is funded by the government, but the infrastructure shows its years of wear and tear. It serves a population over 420,000 people, but its location on the main highway means it serves people traveling to and from Kenya, road accident victims, and those who become sick traveling on the highway. It consists of 7 wards in total and it's one and only operating theatre is shared among all wards. The theatre is stocked with malfunctioning equipment dating back from the 1960s.

The entire hospital lacks consistent electricity and running water. Daily power outages have been common in several districts, including this one, in recent months. The generator consumes fuels to generate power for the hospital, but was broken at the time of writing. Hospital workers must use lamps and flashlights to see patients at night. Large black basins for collecting rain water sit beside each ward; water must be transported to individual wards via bicycle during the dry season. There is one covered, open-air corridor that connects the wards and is usually lined with people and children waiting for their family members to recover. These people must accompany those admitted to the hospital to act as their care-takers.

This hospital consists of 2 major wards for maternal health including an antenatal and a maternity ward. The antenatal ward sees over 2,000 women per month and employs 20 trained nurses. Across from the antenatal ward lies the maternity ward. The maternity ward employs over 20 trained nurses, midwives and doctors. The initial capacity of the ward built in 1968 is 24 beds, plus 6 private rooms; however, there is, on average, an occupancy of 36-40 women some of whom take space on the floor. The maternity ward

will assist with 270 deliveries per month, with about 1 maternal death and 10 neonatal deaths per month.

It is important to note that my presence in the hospital, as a foreigner wishing to speak with patients, was a rare and odd occurrence for the hospital staff. Some may have considered it intimidating. In entering the antenatal and postnatal clinics, women sat silently listening to the nurses. There was no talking amongst them. It was noted that some nurses wanted to listen in on the focus group discussions, but were asked not to. As the researcher, it was important that the women felt confident to speak openly about their experiences in the hospital without fear of repercussion or reprisal from the staff.

CHAPTER FOUR: HEALTH POLICIES IN UGANDA

The importance of persistently high [maternal] mortality is profound; it defies and questions the basis of any social or economic progress a country may claim to have made.
– Sam Agatre Okuonzi, 2004, p. 1633

Women's stories and experiences of childbirth and pregnancy are largely shaped by the care they receive. The literature establishes the need for universal maternal health care in order to achieve healthy pregnancy outcomes. This means access to medical interventions and skilled birth assistance during pregnancy and childbirth that meet the standards of care for both medical professionals and potential clients. Utilization of skilled birth attendants and emergency obstetric care depends largely on the accessibility of a functioning public health care system. The structure of the health system, the services offered and the care provided all stem from the health system developed and managed through health policy. The creation of Uganda's health system, the evolution of health policies, and the availability of services provide context to the care women receive during their pregnancy and childbirth.

Uganda's latest national health policy, released in 2009, paints a devastating picture of Uganda's malfunctioning health system, including lack of access to health facilities in some areas, low utilisation, poor infrastructure, lack of drugs, medical supplies and equipment, and low staff morale. (Republic of Uganda, 2009, p. 3) While the maternal mortality ratio has dropped since the mid-1980s, other important and related health indicators, such as fertility rates, utilization of antenatal clinics, and deliveries with a skilled attendant have failed to improved since the mid-1990s (Republic of Uganda, 2009, p. 1-2). Overall, Uganda's maternal health status remains very poor. Considering

the international consensus on strategies to improve maternal health through basic health services, the sub-par health condition of Ugandan's mothers begs a question as to why the country has failed to meet the maternal health needs of its population.

This chapter examines the history in Uganda's development models and health policies, beginning with a brief look at the health care system and policies established by colonialism, the disintegration of health policies during the War Years between 1971 and 1985, followed by the influx on international aid, expertise, and services from the mid-1980s until today. Finally, the chapter will conclude with a close look at Uganda's efforts to improve maternal health through both policy and implementation. The chapter will highlight the gap between Uganda's health policy and the maternal health needs of the population, a connection that offers an explanation as to why maternal health indicators have been slow to progress over the years.

4.a. Colonial Uganda (1935-1961):

Uganda under colonialism, in common with most African countries during this time, is often described as "a poor and backward country." (Mugaju, 1990, p. 99) This was due to the economic structure of the country which mainly consisted of subsistence agriculture. As described by Mugaju, the 1959 Ugandan census reported that "96% of the people of Uganda lived and worked in rural areas as peasant farmers or pastoralists." (Mugaju, 1990, p. 99) In 1946, 82% of Uganda's total exports were from coffee and cotton alone, and the country was "overwhelmingly dependent on coffee and cotton as the primary source of foreign exchange." (Mugaju, 1990, p. 99) It is not surprising that

Uganda's economy was sensitive to the fluctuations in prices for these products on the world market.

The World Bank has highlighted that coffee and cotton crops were exported to Allied countries during the war under state-controlled prices paid to growers. The government continued to provide fixed prices to farmers after the war. Coffee and cotton world market prices crashed in the 1950s, so government introduced export taxes to both products to generate revenue. These funds allowed the government to finance new industries – textile, cement, and copper. As a result of these measures, GDP grew over 20 percent between 1954 and 1960. (World Bank, 1962, p. 25) As of 1960, the majority of Ugandans were still working in the agricultural sector, followed by manufacturing industry and the civil service.

Infrastructural development and modernization schemes began in the 1940s by the colonial government, as "no fundamental economic modernisation could be accomplished without a programme of rapid industrialisation." (Mugaju, 1990, p. 100) Though coffee and cotton were the main agricultural exports, the development plans emphasized the need for diversification. Import-substitution was used to protect and guide domestic manufacturing industries. Uganda's imports between 1947 and 1951 reflected the country's plans for industrialization to improve economic growth. The World Bank (1962) describes the type of imports by stating, "Two-thirds consist of machinery, transport equipment and various manufactured products, the rest of chemicals, fuels and certain food items." (p. 28) The industrial sector, along with export and import trade, banking, large-scale commercial agriculture was mainly owned by

Europeans and Asians. (Mugaju, 1990) Most Africans were absent from executive positions in the private sector.

Britain's development strategies designed to encourage economic growth involved several infrastructure projects. These state-driven initiatives included a railway between Kampala and Kasese, the Jinja Dam, road infrastructure, the creation of the Uganda Development Corporation and the development of textile and cement factories. The cheap electricity provided by the Jinja Dam was hoped to "usher in the era of rapid industrialization" but it did not become profitable until 1964. (Mugaju, 1990, p.104) Uganda made significant investment in social services prior to Independence, "By far the largest part of investment was to provide schools, hospitals, government quarters and special government housing." (World Bank 1962, p. 35)

Colonialism and the Health System (Pre-Independence 1935-1961)

The current health care system in Uganda was established under British colonial rule. Along with colonial-driven initiatives to expand infrastructure across all sectors in an effort to modernize the economy, the health care system was heavily supported for the goal of achieving economic growth. Initially, the British colonial office established a medical department in 1894 to provide health care for their colonial staff. A series of tropical disease outbreaks, including sleeping sickness, malaria, and the plague, forced the office to address the health needs of the greater population. (Okuonzi and MacRae 1995, p. 125) The main concern of colonial staff was to maintain a healthy and productive population that would lead to economic growth. The official Colonial Medical Advisory Committee memos from this period note that "it can be pointed out that a

healthy population can produce more than an unhealthy one." (Great Britain, 1934, p. 4) Eventually, the colonial administration became involved in health care training and expanded health facilities.

The colonial government introduced a western model of health care based in urban areas, out of reach to the majority of the population living in rural areas. Health care infrastructure consisted of hospitals and health centres located in urban areas and rural capitals, along with "a network of health inspectors for the promotion of home hygiene."(Okuonzi and MacRae 1995, p. 125) As described by Mugaju (1990), the 1959 census finds that "96% of people of Uganda lived and worked in rural areas as peasant farmers or pastoralists." (p. 100) The large number of people living in rural areas and the concentration of health services located in urban areas suggests that the majority of the population had limited geographical access to health services.

Along with a paternalistic approach to health promotion through home hygiene, the health policy under colonialism was based on a curative as opposed to preventive orientation to health care. This policy is defended by the medical department which stated, "the Department had been purposely directed so as to gain the confidence of the Native population by curative measures in the first place." (Great Britain, 1934, p. 1) Though the Medical Department also recognises their "duty to raise the standard of health conditions over the whole of the Protectorate," it is clear that the curative system was implemented as a political strategy to manipulate the Ugandan population so they would see the presence of the colonial government in a more favourable light. (Great Britain, 1934, p. 1)

4.b. Post-Independent Uganda (1962-1971)

Uganda's independence in 1962 was regarded with optimism for the future. The political backdrop of independence united traditional and modern leadership through an alliance between the Kabaka of Buganda and the Uganda People Congress led by Milton Obote on Independence Day October 9, 1962 (Gukiina, 1972, p. 117). However, the country faced challenges of uniting the country's multiple ethnic groups and addressing the economic disparities that existed between them.

The development plans for Uganda were outlined in a World Bank five-year plan in 1962. The World Bank proposed development plans to increase economic growth to improve the standard of living for Ugandans. By increasing investment in sectors that offer a high rate of return for the economy, the government would increase national income to afford investment in the expansion of social services. As stated by the World Bank (1962), "Vigorous promotion of economic growth is at this stage an essential part of successful self-government... The major emphasis should be on increasing production - the direct wealth-producing activities." (p. 34) Government investment, they argued, should be allocated to "favourable sectors" such as agriculture and education, as these sectors were seen as producing the greatest short-term returns for the economy.

In addition to economic growth, Uganda's 5-year Development Plan entitled *Work in Progress* addresses plans to develop economic and social justice. Mugaju (1990) explains the government's awareness that "in the interests of national unity and political stability, the government could not 'afford to neglect the economic development of certain areas where the yields to investments in purely economic terms may not be the

highest available" (p. 99). The plan goes on to describe targets for increasing primary school facilities, university enrolment, hospital bed capacity, and job creation.

These development plans reflected the belief that modernization and economic growth would lead to national development. Modernization of the agricultural sector would increase the national revenue and allow investment in social services and development of other industries. To expand production and increase agricultural output, "the government planned to introduce new farming methods and techniques, to provide subsidized farm inputs and to encourage mechanization and group farming" (Mugaju, 1990, p. 100). Such modernization schemes would improve the output of cash crops and increase national revenue.

Following independence, Obote's government engaged a series of political and economic policies that diverged away from the national development recommendations of the World Bank. Obote's government moved toward a mixed economy, but Bigsten & Kayizzi-Mugerwa (1999) highlight the socialist policies of his government. They explain, "The definitive move towards total control of economic activity by the state was made when Obote presented his Common Man's Charter in 1969, the Ugandan expression of a leftist tendency." (p. 11) Obote's government took on an increasing role in the economy, with restrictions placed on currency and property transfers. The sectors that moved under government control included finance, industry and agriculture. In an attempt to allow the people of Uganda to control the economy, "The government acquired a controlling stake in all the major enterprises in the country." (Bigsten & Kayizzi-Mugerwa, 1999, p. 11)

Within the agricultural economy, import-substitution and the expansion of cash-crop production had provided Uganda with a period of economic growth. Economic

growth in the 1960s was impeded by the decline in coffee prices from 80 cents per pound in 1957 to 43 cents per pound in 1965. (Bigsten & Kayizzi-Mugerwa, 1999, p. 12) The increase in production during this time was a sign of incorporation of the countryside into market economy; however regional disparities and income inequalities persisted. Socialist policies discouraged private investment, as Bigsten & Kayizzi-Mugerwa (1999) states, "The emphasis on national, government-controlled institutions meant that no new private financial institutions would be forthcoming." (p. 17) These state-controlled industries may have scared away foreign investment and impeded the movement toward diversification.

Mugaju (1990) states these socialist policies "stressed distribution rather than the creation of wealth, which was like putting the cart before the horse." (p. 100) Despite the criticism, GDP growth averaged 5.2% per annum between 1962 and 1971. (International Monetary Fund, 2010, p. 1) Significant investment in social infrastructure allowed to services to expand rapidly, "medical services have more than tripled since independence in 1962. Primary and secondary education has been extended to most parts of the country." (Gukiina, 1972, p. 138) Economic disparities and unequal access to social services between rural and urban areas "increasingly politicized the role of the military." (Bigsten & Kayizzo-Mugerwa, 1999, p. 17) Before many of these measures were given a chance to operate, Obote's government was toppled by a coup in 1971.

Health and Development in Post-Independent Uganda

A public health care system, funded by national revenue and taxes, was established by Independence in 1962. During this decade, Uganda was considered to have

one of the best health care systems in Africa. It was a comprehensive referral system based on numerous rural dispensaries, health centres, maternity units, district and regional hospitals, and a national referral hospital. Complementing government services were private medical services run by missionaries and licensed medical professionals. These health units were run by trained medical professionals, and services were free of charge at government facilities (Birungi, 1998, p. 1456)

Uganda's national economic development plans entitled First-Year Development Plan (1961-1966) and Second Five-Year Development Plan, Work for Progress (1966-1971) were based heavily on the recommendations put forth by the World Bank; however, Uganda's policies regarding social service took greater significance. (Mugaju 1990, p. 105) As outlined in Uganda's first five-year development plan, the government recognized "promotion of social service and distributive justice objects as valid national development goals." (Mugaju 1990, p. 106) Instead of following the World Bank's recommendations for growth, the new Ugandan government maintained the colonial system of health care provision and infrastructure expansion.

The post-independence period, lasting between 1962 and 1971, remained identical to colonial health system already established. Structurally, the Medical Department was converted into the Ministry of Health in 1961. (Okuonzi and MacRae 1995, p.125) The national development policies for Uganda included plans to build 22 rural hospitals and increase hospital bed capacity by 85%, leaving a total of over 400 health unites (including sub-dispensaries to large hospitals) across the country by the end of the decade. (Mugaju 1990, p. 106; Scheyer & Dunlop, 1985, p. 29) These health facilities offered curative services, while preventative services were the responsibility of the local

government (Scheyer & Dunlop, 1985, p. 28). Treatment in government facilities was free of charge, but private practices and mission hospitals charged fees. Significant investment in social infrastructure allowed services to expand rapidly, with Gukiina (1972) reporting that "medical services have more than tripled since Independence in 1962." (p. 138) It was assumed that economic growth would continue and national revenue would increase to afford the maintenance a publicly-funded health care system. (Okuonzi & MacRae 1995, p. 125) Further, little attention was paid to incorporating preventative or traditional health care into the system. By the end of the decade, Uganda had the best health indices, including crude birth rate and crude death rate, in the sub-region (Uganda Bureau of Statistics [UBOS] 2000, p. 8; Bennett, 1985, p. 43). Infant mortality rate fell between 1959 and 1969 (Scheyer & Dunlop, 1985, p. 29) Overall, Uganda maintained the trajectory of health care development established by the Western model introduced by Britain.

4.c. The War Years Under Idi Amin and Obote II (1971-1985)

A coup led by Idi Amin toppled Obote's government in 1971. What followed was a series of ad hoc economic policies implemented by Amin's military regime that would reverse the economic progress in the 1960s. Initially, state participation in major businesses fell from 60% to 49% to the satisfaction of businessmen and multinationals. (Bigsten & Kayizzi-Mugerwa, 1999, p. 20) Amin's leadership quickly became a military dictatorship, leading the country into political turmoil and economic decline that would last for over a decade. Ugandans lived in state of fear as "Amin began to eliminate, often by extra judicial executions, real and potential enemies, including key members of his

initially civilian-dominated government." (Bigsten & Kayizzi-Mugerwa, 1999, p. 21) Along with living in political oppression under Amin's military regime, Ugandans suffered from the consequences of economic turmoil under his government.

Amin's "Economic War" began with his expulsion of Asians in 1972. Asian-owned businesses became operated by the government and managers were replaced by unskilled and inexperienced members of the military. Much of these small businesses were driven into the ground and had devastating impact on national revenue. Bigsten and Kayizzi-Mugerwa (1999) explain, "Previously they generated government revenue in the form of corporate taxes, rent, licences and fees, but now they became dependent on government subsidies to meet running costs." (p. 22) The public sector employment increased as private sector declined.

As national expenditure began to exceed revenue, the government began to search for new ways to increase national revenue. Amin's government introduced licenses for importers and exporters, which reduced the supply of goods in the country to the point at which basic commodities became scarce. As budgetary revenues suffered, the government turned to domestic bank financing that consequently increased inflation. Sharer, Zoysa and McDonald (1995) note that growing inflation led to an increased exchange rate that discouraged exports, further lowering government revenue. Economic resources could not support his civil service, military and political activities. Even expenditure in the military fell by 1978, "reflected in increasing pauperisation of the soldiers and deterioration of their equipment, perhaps explaining the relative ease with which they were defeated," by Tanzanian and Ugandan exiled troops in 1979. (Bigsten & Kayizzi-Mugerwa, 1999, p.25)

Bigsten and Kayizza-Mugerwa (1999) sum up the downward spiral of adhoc economic and political policies under Amin's administration:

> The state found itself in a vicious circle. Its mismanagement of the economy led to economic decline and lower tax revenues, which forced it to devise new ways, such as increased export taxation, to collect revenue which however, further accelerated the decline and made it even more difficult to collect taxes. (p. 30)

The economy suffered greatly throughout Amin's dictatorship as demonstrated by economic indicators. Investment fell from 11 per cent of GDP in 1972 to 6 per cent in 1976, remaining at this level until 1980. (Bigsten & Kayizzi-Mugerwa, 1999, p. 27) Between 1978 and 1980, Uganda experienced a "population growth of about 3 per cent per year, and GDP per capita fell by more than 25 per cent." (Bigsten & Kayizzi-Mugerwa, 1999, p. 25) Inflation reached 100% by 1981. (World Bank, 1983, p. 2) Amin's bizarre personality and irrational political and economic policies isolated his government regionally and internationally. By the end of Amin's dictatorship, the country was economically and politically devastated.

Health and Development in the War Years

Health services experienced a breakdown during the war years. Health policy development during the war years was hindered by political oppression and economic instability. The Alma Ata Declaration for Primary Health Care (PHC) was signed in 1978 but was not implemented into policy due to political insecurity. MacRea, Zwi, and Gilson (1996) quote a former Ugandan health policy advisor who explains that "no one knew what health policy really was; over the years it had become an *ad hoc* collection of declarations, rather than an integrated legal framework for government action". (p. 1097)

Policy development was essentially stagnant during the 1970s and early 1980s due to fear under the military regime.

Uganda's health care system disintegrated under Idi Amin and the health progress made during the decade following independence ended. Amin's administration lacked a clear health policy as military rule outweighed the provision of social services; however his economic policies had serious effects on the health care system as a whole. Firstly, his expulsion of the Asian population in 1972 severely reduced the number of doctors and pharmacists in the country. Other professions fled the country as political oppression mounted under Amin's regime. During the course of his regime, the population-to-physician ratio decreased from 15,050 to 1 in 1960 to 20,690 to 1 in 1975 and 26,810 to 1 in 1980. This is contrasted with neighbouring Kenya which experienced an increase in population-to-physician from 10,000 to 1 in 1960 to 5,800 to 1 in 1975 and 7,890 (World Bank, 1978, p. 108; World Bank, 1984, p. 264). This political move severely limited access to medical services.

Amin's economic policies that introduced taxes on imports and exports had two effects on the health care system. First, it led to an overall decline of national revenue, which imposed cutbacks to the health care budget. National expenditure on health was only 6.4% of its 1970 levels. (MacRea et al., 1996, p. 1097) Secondly, the taxes imposed on imports increased the price of goods and, along with the rising inflation, discouraged the flow of goods into the country. Basic commodities, including medical supplies such as gloves and syringes, became scarce. Health facilities were looted of supplies and equipment and some were damaged due to war or neglect. The Ministry of Health became preoccupied with maintaining the status quo amidst the political unrest and

declining budget. Government hospitals could not afford to provide free drugs, maintain supervision of health professionals, and pay health workers a living wage (Birungi, 1998, p. 1456).

There are only a few health indicators for this period, as systems for monitoring broke down during the early 1970s. (World Bank, 1988, p.1) Conflict brought about the breakdown of the few preventative initiatives in the country, resulting to a spread of diseases such as malaria, tuberculosis, and measles. The health system struggled with low staff morale, lack of running water and electricity, lack of laboratory and sterilization equipment, damaged beds and mattresses, and a lack of drugs and supplies. (World Bank 1988, p. 3) The country also faced a breakdown of management and support services of the health sector during this time.

The poorly-functioning health care system gave rise to a number of new local solutions. There was an increase in the number of unlicensed private oriented health care providers, home providers, and drug shops. Conversely, there was growing distrust of the government facilities and confidence of the public health care system was undermined as the morals and values of the health professionals changed. Birungi (1998) states that during this time, "professionals could only survive by ignoring their standard ethics" (p. 1456). Health workers survived by opening drug shops and clinics, treating patients at home, misappropriating drugs and medical equipment for personal gain, and demanding informal fees from patients that were initially free.

4.d. Post-Conflict Period (1985-1988)

Uganda faced new challenges to development as the country emerged from a decade of military dictatorship, political instability and economic chaos. Milton Obote gained power again in 1980 for his second term in government and began to turn around the decade of economic decline. The government sought international assistance to stabilize the country. Economic reform began in 1981 when Uganda "sought and received technical and financial support from the IMF and the World Bank." (Bigsten & Kayizzi-Mugerwa, 1999, p. 32) The IMF and World Bank provided financial assistance under conditions that would change the trajectory of Uganda's economic policies, moving away from state-led interventions toward neoliberal policies.

Uganda implemented an IMF-supported Economic Recovery Program, which changed the development model in Uganda and set its path toward neoliberal economic reform. Sharer sums up the assistance from IMF and WB during this time, "The [IMF] stabilization program included the introduction of a more flexible exchange rate policy, the decontrol of many prices, and regular reviews of producer prices. Much of the World Bank funding was in areas of reconstruction, industrial and agricultural rehabilitation, and technical assistance." (Sharer, DeZoysa, & McDonald, 1995, p.1) These economic reforms helped stabilize the economy. The World Bank reports that GDP grew 5% per year between 1981 and 1983, export volume increased by 45% and inflation decreased from 100% in 1981 to 30% in 1983. (World Bank 1988b, p. 5) These reforms were short-lived, however, due to political insecurity caused by the eruption of civil war in 1985.

The National Resistance Movement (NRM) led by Yoweri Museveni took control of government in 1987. Museveni was not eager to accept assistance of

International Financial Institutions (IFIs) who offered what he said was "an imperialistic imposed policy package'; instead of 'the invisible hand of market forces', he preferred the 'visible hand of the government." (Craig & Porter, 2006, p. 160) The challenges of emerging from a long period of political instability inclined the new NRM government to maintain a state-oriented approach to economic growth and stabilization. (Bigsten & Kayizzi-Mugerwa, 1999) His administration embarked on a series of state-controlled measures for stabilization including, "fixed exchange rates, price control, deficit financing, and state monopolies over external and internal trade." (Craig & Porter, 2006, p. 160) Uganda introduced new currency notes to devalue the shilling and stabilize inflation, while industrial production grew in response to stabilization of foreign exchange.

Economic growth was obstructed for two reasons: coffee prices fell on the world market which decreased national revenue, and political instability increased military expenditures. The Ugandan economy suffered from fluctuations in world market prices for coffee. Less foreign exchange currency was earned from the decreased exports, and what was earned went into debt repayment and petroleum imports. Further, unplanned expenditures on military due to insurgencies in the east and north and relief for displaced persons stretched the national budget. Peace and security allowed most farmers to return to their land, but GDP increased by only 3% in 1987. (Bigsten & Kayizzi-Mugerwa, 1999) The World Bank (1988) blamed the weak institutional capacity of the Ugandan government to deal with these unforeseeable impediments to economic growth. The report states that the government's "constrained resources and incomplete information" hindered their response to the domestic and external challenges and that this

"overestimation of institutional capacity last year underscores the importance of corrective action in this area in 1988/89" (p. vii)

Health System and the Post-Conflict Period (1985-1988)

The period following the war years represented a shift toward significant international influence in the health policies and initiatives in the country. Obote's return to power in 1981 was met with international assistance to reverse the decade of economic decline under Amin, but health care policies between 1981 and 1985 were considered a secondary priority rate in the face of political instability. High military expenditures, combined with an inadequate budget, limited expenditures on public health (MacRea, et al., 1996, p. 1097). The health budget was constricted as most of government revenue was directed towards quelling political uprisings. Despite the increasing health needs following the decade of civil war, including displaced people, hunger and malnutrition, emergence of AIDS and damaged infrastructure, the health budget was insufficient to meet the health needs of the country. In the absence of a nationally integrated and functioning health care system, international assistance and aid relief flooded the country. For example, the World Bank noted that UNICEF provided resources to revitalize immunization programs in the country. (World Bank 1988, p. 3) Several other international NGOs and aid relief organizations stepped in to assist with the immediate health needs to the population.

When the National Resistance Movement (NRM) led by Yoweri Museveni took hold of the government in 1985, the country's devastated economy left few options to rebuild the economic and social sectors. As a result, the NRM government turned to

International Financial Institutions (IFIs) to help stabilize the economy and became dependent on international financing and personnel to revive the health sector. The national and international response to the emerging HIV/AIDS crisis was especially substantial, and will be revisited later in this chapter to demonstrate the significant influence of external forces on national health policy and uneven health outcomes.

Primarily, development of a national health policy during the post-conflict period was slow due to the lack of political interest and capacity of the Ministry of Health. Macrae et al (1996) explain that "the absence of a clear national health policy framework in 1986 meant that donors could neither conform, nor fail to conform, with government goals." (p. 1103) Instead, international donors offered financial assistance in their own areas of expertise and interest. Many donors and NGOs had representatives or technical supporters in the Ministry of Health to design and implement specific programmes rather than develop a national health policy. Projects with long-term recurring costs, such as capacity building within the Ministry of Health, are not preferred by donors. (Macrae et al 1996, p. 1104) Many donors funded and implemented rehabilitation strategies that did not contribute to an integrated health system. Instead, these post-conflict initiatives created a high dependency on external aid.

On the ground, international relief agencies and NGOs became the forefront of health service delivery in Uganda during the initial years of the NRM government. For example, Macrae et al explain that in 1986 UNICEF, Save the Children Fund and the Ministry of Health entered a tripartite agreement to initiate a national immunization campaign. (Macrae et al 1996, p. 1098) Other interventions financed by international donors focused on physical restoration, rather than institutional development. The World

Bank provided a $50.7 million USD loan to Uganda outlined in the First Health Project report in 1988 to address the immediate needs of health system: drugs, equipment health education programs, and reconstruction of damaged health facilities. (World Bank 1988a, p. 3) Physical rehabilitation and construction were favoured because they produce "quick and tangible results compared to other health problems." (Macrae et al 1996, p. 1104) In the absence of a clear health policy, donors were in a position to strongly influence projects and priorities in the Ministry of Health.

Overall, the post-conflict period in Uganda was comprised of a number of donor-funded programmes and initiatives that were not designed to increase the government's capacity to design and manage a functional health care system. Many rehabilitation programs concentrated funds to urban areas and rural training centres, further reinforcing the urban bias established during the colonial period. The brain-drain during the civil war of doctors and policy managers led to an influx of expatriate health experts representing a variety of external agencies' interests. The persistence of economic problems inhibited health facilities from operating at their previous state. Health workers' morale continued to be low due to inadequate salaries (Birungi, 1998, p. 1457). Drug supplies were especially susceptible to mismanagement and misappropriation due to illicit sale of drugs from the local health facilities. The fear of AIDS, coupled with the mismanagement of government health facilities, also contributed to the mistrust of public health care. These actions following the civil war did not provide a strong foundation for establishing a strong health care system heading into the 1990s.

4.e. Embracing Neoliberalism: Health Policies Under the Structural Adjustment Program (SAP) and Poverty Reduction Strategy Paper (PRSP) (1988-2010)

Uganda's weak financial situation in 1987 pushed them into the arms of the International Monetary Fund and the World Bank. Craig and Porter (2006) explain that Uganda "faced liquidity crisis, runaway inflation, an insolvent banking system, and foreign exchange reserves to cover only two weeks of imports... [Museveni's] regime desperately needed donor support." (p. 159) Loan assistance from International Financial Institutions (IFIs) was accompanied with conditions that would drastically change the role of the state in development and economic affairs.

With IFI assistance and the implementation of the Economic Recovery Program, Uganda embarked on a pro-market model of development that transformed the country "into one of the most liberal economies in Sub-Saharan Africa." (World Bank, 1993, p. 137) Conditions for the structural adjustment program and IFI assistance included the liberalisation of trade and exchange, agricultural pricing and marketing, and privatization. The country privatized agricultural monopolies for coffee, tea and food, allowing "private traders [to be] the driving force behind the penetration of the European and Middle East markets." (World Bank, 1993, p. xvi) Privatization and trade liberalisation that affected the agricultural industry generally dominated this development policy. Uganda implemented the Structural Adjustment Program (SAP) by expanding their tax base, increasing coffee revenues, increasing the interest rate, permitting the expansion of credit to the private sector. The government decreased the civil service budget through job cuts of some 30,000 'ghost' employees. (World Bank, 1988, p. xi) Overall, state involvement in the market decreased considerably, while privatization and

trade liberalization were given a priority to balance the budget and ensure economic growth.

The report recommended that cost-effective investment in social service sectors would benefit the poor. The report states that Uganda's poor will be targeted with "a set of cost-effective interventions in the areas of health, education, and employment-generating infrastructure rehabilitation." (World Bank, 1988b, 64) These programs and initiatives will be financed through government and external aid. There is no mention of role of the state in these areas, despite the brief explanation of the state of disrepair of health and education facilities. The African Development Bank (1994) mentioned that "The underfunded budget does not allow much scope for expenditures on social services." (p. xv) Little is recommended for state involvement and public investment in the crumbling social service sectors such as health care and education. On the other hand, transportation infrastructure was given a high priority to facilitate to serve the development of industry. The World Bank (1988b) report states, "In the short term, road, rail and ferry services must continue to meet a growing demand while infrastructure constraints persist." (p. xi) State funding of the social services was not considered a priority for economic growth.

The World Bank evaluated the progress of the SAP in 1993. Five years after the implementation of the program, the World Bank notes the primary sector in Uganda remains agricultural industry, followed by the service sector and industry. Regarding employment, 80% of all workers were engaged in the agricultural sector in 1993. Services employ 16% of working Ugandans, while industries employ 3% of all workers. (World Bank, 1993, p. ii) Economic indicators note the progress of economic growth in

Uganda during that time. The African Development Bank (1994) states that inflation declined from 365% in 1986 to 3% in 1993 (p. 3). The SAP set the GDP growth rate on a path of positive growth in 1988 that would continue until 2006 (Republic of Uganda, 2007).

Despite economic growth, Uganda became saddled with debt. "From 1987 to 1992, the IFIs provided $1 billion through 25 policy-based loans to the Economic Recovery Program." (Craig & Porter, 2006, p. 160) The focus on these economic numbers, very little is discussed regarding the impact of HIV/AIDS on the economy, the health sector and quality of life. Further, Craig and Porter (2006) note that "the removal of price and wage controls, the abolition of subsidies and devaluation hit the poor before the rich." (p. 160) National debt and the ERP was undertaken to improve the standard of living for Ugandans, but it had failed to improve poverty indicators.

The neoliberal policies introduced with SAPs continued to take deepen in Uganda throughout the 1990s. The SAP in Uganda has made the country a favourable country for donors who "rewarded the government generously for its economic reform programme in recent years." (Economist Intelligent Unit, 1996) Agriculture remained the main engine behind economic growth. Real GDP growth rates fluctuated between 6-10% between 1994 and 1997, despite internal security issues in Northern Uganda. (Economist Intelligence Unit, 1998) Further, the percentage people living below the poverty line have decreased since 1992 from 56% to 31% in 2006. (Republic of Uganda, 2000b, p. 8) The SAP was considered a success in Uganda as the economy grew and lifted some Ugandans out of poverty.

In 1997, the Ugandan government implemented a national development plan called the Poverty Eradication Action Plan (PEAP) to address the challenges of alleviating poverty. Though it sets the broad policy development framework for long-term development plans in Uganda, it follows within the neoliberal development policy trajectory determined by the SAP. PEAP argues that wealth creation, measured with GDP, will lead to the alleviation of poverty. On the other hand, it argues that state is ineffectual for alleviating poverty. It explains the national budget is an inadequate tool for reducing poverty. PEAP notes, "Over 75% of GDP is contributed by the private sector which means most potential to reduce poverty rests outside government policy." (Republic of Uganda, 2007, p. 8). The neoliberal fiscal and monetary policies in the past 15 years have stabilized the economy, decreased inflation rates, attracted investment and cut public spending. Based on the success of these neoliberal policies, PEAP believes that market-oriented development and economic growth will lead to poverty alleviation.

The Poverty Reduction Strategy Paper (PRSP) was introduced in 2000 with revisions for the PEAP. The report summarises the success of the PEAP through various human development indicators – including life expectancy, maternal mortality, and child mortality – while also noting the need for improvement of human development. Good governance is introduced as a new element of development, and explains strategies for eradicating poverty that include encouraging economic growth and improving incomes and quality of life of the poor.

Overall, the plan calls for a withdrawal of the state from social services. Though the plan states the public sector's responsibility to intervene "in areas where the markets function poorly or would produce very inequitable outcomes," it also states that the

public sector should use cost-effective methods to intervene through the use of NGOs for service delivery. (Republic of Uganda, 2000b, p. 13) This represents the shrinking role of the state from the public service delivery, allowing NGOs to delivery essential services that would improve human development indicators in Uganda.

Along with the shrinking role of the state, the report recommends that the private sector expands to encourage economic growth. Based on projections that Uganda could grow GDP by 7% be annum, the report affirms "economic growth in Uganda requires a framework within which the private sector can expand." (Republic of Uganda, 2000b, p. 14) It goes on to note that Ugandan government should take measures to encourage private sector competitiveness by improving urban infrastructure (ie. electricity and roads) that allow private businesses to function at full capacity.

Finally, the PRSP introduces the concept of "good governance" in the development strategy. Decentralization, which transfers responsible to a district level, is encouraged to develop democratic structure of the state. The report expresses a need for transparency and efficiency of public expenditure, regulated by a new Ministry of Ethics and Integrity. The report does not address the contradiction of allowing the state to regulate itself. It does mention the necessity a free and independent media or third party to regulate the actions and integrity of the state.

Health Policies under the SAP and PRSP

Under the SAP, the Ministry of Health was not immune to macroeconomic neoliberal principles that saw a retreat of the state from the market and social services. State involvement in economic and social affairs decreased as the country moved toward

a pro-market model of development. The World Bank report explained that a set of cost-effective investment in social services, including health, would be used to target the poor. Finance and delivery of the social services would involve both the national government and international organizations. Overall, state funding for social services was not considered a priority for economic development.

The policy process surrounding the ten-year National Health Policy Plan is a testament to the role of IFIs in health policy design. As outlined by Okuonzi and MacRae (1995), this plan introduced a number of changes to the health care system. Structurally, it organised the health care system in to four levels of referral: primary (health centres); secondary (district and rural hospitals); tertiary (general referral hospitals based in regional capitals); and quaternary (two national hospitals). (Okuonzi & MacRae 1995, p. 127) The plan also involved decentralization of the health care system to local governments who would be allocated responsibility for primary health facilities. The plan promoted collaboration and coordination between ministries, NGOs and donors for health service delivery.

Initially, this health plan sparked opposition from donors because it exceeded the health budget. After providing expertise to the health policy development process, the World Bank proposed five major recommendations to the plan: no major expansion of health care infrastructure; existing health facilities should be restored; basic health care should be based on local needs and available resources; and, a user-charge policy should be implemented to boost income of the health sector. (Okuonzi & MacRae 1995, p. 128) The recommendations directed the Ministry of Health to provide policy guidance, coordinate the private sector and NGO activities and "ensure that government

bureaucracy did not get in the way." (Holt, 1997, p. 30) These recommendations were used as a condition of a new loan by the World Bank to ensure they would be put in place. Through this plan, the Ministry of Health began to resemble the privatized and decentralised national government structure set in place by the SAP.

The freeze on the expansion of health infrastructure, user-fees and decentralization created barriers to health care. Firstly, health infrastructure was not expanded to accommodate the increasing population and this stretched existing health facilities beyond capacity. Patient waiting times were documented at between 30 minutes and six hours because of the overcrowding of units. (WHO, 2005, p. 5) Secondly, the introduction of user-fees to pay for consultations, diagnostic tests, hospitalization and drugs discouraged poor families to access health care needs. In some cases, user-fees were "high enough to push households into poverty." (WHO, 2005, p. 5) Lastly, decentralization allowed local governments to determine to levy user fees for their health services. There was variation between districts on how and what services were levied. Overall, these fees created another obstacle to health care access even though user fees generated less than 5% of total health expenditure. (WHO, 2005, p. 7) Economic growth during this decade was not followed by improved health, which was evaluated toward the end of the decade.

Under the SAPs, the primary concern was to create market-based health system, and not to improve health status. The concern for efficiency and cost-effectiveness was so strong that it was considered inefficient to expand health infrastructure, but Okuonzi and Burungi (2000) point out, the resources directed at creating a market-oriented approached to health "could have been used to expand basic infrastructure and health

care, near universal access to very basic health care would have been possible." (p. 207). Quality of health care, including technical quality (the extent to which services meet minimum standards) and client satisfaction, did not improve.

Despite economic growth of during the 1990s of 6.5% per annum between 1995 and 2000, the barriers of access to the health care system reflected poorly in health indicators. At the end of the 1990s, Uganda had some of the worst health indicators in the region. (Republic of Uganda 2000, p. 8) Health status disparities between Ugandans grew, as demonstrated by the under-three mortality rates between 1988 and 1995 "fell by 6 percentage points for the poorest 20 percent, it declined by almost 60 points for the richest quintile." (Republic of Uganda, 2000) Five years after the implementation of the SAPs, only 27% of the population lived within 10km of a health centre. Over the course of ten years, neoliberal policies enforced by IFIs prevented the health care system from making significant impact on the health status of Ugandans.

Uganda introduced the five-year Health Sector Strategic Plan in 2000 (HSSP I), operating within the framework of the PRSP to address the compounding health issues during the 1990s. The development of this plan involved all stakeholders including the government, donors, private sector and communities, but provided greater responsibility to the state. In an effort to alleviate poverty, the plan introduces the Ugandan National Minimum Health Care Package (UNMHCP) to establish universal access to basic medical needs. The programmes in the minimum plan were considered to be cost-effective because they "have the highest impact on reducing morbidity and mortality from the major contributor to the disease burden using existing resources." (Republic of Uganda, 2000a, p. 15) Essentially, it identified "a list of interventions... that provide the

best value for money in achieving the most reduction in the disease burden." (Ssengooba, 2004, p. 2) Some of the health needs in the plan covered the control of communicable diseases (malaria, TB and STDs), childhood illnesses, immunization, and essential clinical care. The plan sets out goals to increase access to health facilities by constructing more health facilities across the country and to improve the infrastructure of existing facilities. Better coordination and partnership with other governmental ministries and the private sector were considered priorities to implement this plan. The Ministry of Health deems itself responsible for "policy development and overall coordination and guidance" of health care system and service delivery. (Republic of Uganda 2000a, p. 45) Though not listed in the plan, user-charges in first-level government health centres were eliminated in 2001. (WHO 2005, p. 1)

Uganda's improved ownership of the HSSP I allowed the government to address some of the health needs of the country. The abolition of user-fees and improved geographical access to services dramatically increased the usage of public health services. Despite these successes, only 30% of the HSSP I was funded. The push for market-driven development within the PRSP national development plan meant that "additional funds for the [health] sector... have been constrained by macroeconomic concerns and rigid sector ceilings." (Republic of Uganda, 2005, p. xi) The UNMCHP became compromised under budget ceilings for the sector, which led to rationing of quality and services as the minimum package costing $28 per capita was implemented with only $8 per capita. For this reason, funding "remains the single most important constraint facing the health sector in Uganda" (Odaga and Lochoro, 2006, p. iii).

In 2005, the government introduced the Health Sector Strategic Plan II (HSSP II) for 2005 to 2010. The goals of the HSSP II were the same as HSSP I: to attain universal delivery of the UNMHCP. In addition, the priority of this plan was to reach the Millennium Development Goals of reducing maternal and child mortality and fertility and malnutrition; addressing the burden of HIV/AIDS, TB and Malaria; and addressing health outcome disparities between the lowest and highest income levels by 2010. The HSSP II stressed focus on health promotion and prevention. Despite the goals outlined in the report, it acknowledged the "big resource gap to finance the requirements of the HSSP II." (Uganda 2005, p. xi) Priority was given to interventions that impacted maternal and child health, but the lack of funding inhibited national goals to improve health indicators and the overall health status of Ugandans.

Uganda's HIV/AIDS Campaigns and Neglected Maternal Health (1985-2010)

Before moving on to the next decade of Uganda's health and development history, it is helpful to understand the government's approach to HIV/AIDS between 1985 and 2010. During this time, the government became dependent on foreign aid and health policies were heavily influenced by donor institutions; however, the government's restrictions on social expenditures such as health led to the neglect of other health needs such as safe pregnancy and childbirth. The neoliberal health environment led to the fragmented health provision. Referral pathways, infrastructure and health providers were not strengthened during this time, despite large amounts of foreign aid funnelled into HIV/AIDS awareness campaigns and treatment programmes.

The HIV/AIDs crisis was one of the greatest threats to Uganda's development emerging from the civil war. In 1988, The World Bank reports that "about 25% of pregnant women attending Kampala hospitals have tested positive for HIV. It has been reported that nearly 60% of the population of Rakai district has HIV infection." (World Bank 1988, p. 2) Before a new health policy emerged under the new government, the NRM took a direct and open approach to the HIV/AIDs epidemic across the country. The AIDs crisis was placed high on the national agenda as all groups were called to prevent it. President Museveni "talked openly about the AIDS as a problem that all Ugandans must face." (Parkhurst and Lush 2004, p. 1918) In 1986, the government created two groups within the Ministry of Health to tackle the crisis: the National Committee for the Prevention of AIDS comprised of ministers and AIDs experts, and the AIDS Control Programme (ACP) to coordinate national activities using the ABC approach[3] to HIV prevention. (Holt 1997, p. 28) The roles of these organizations changed as more and more international NGOs and donors became involved in the Uganda's HIV/AIDS campaign.

The country's overall approach to HIV/AIDS was driven by the government's lack of capacity to undertake a nation-wide prevention strategy for HIV prevention; it relied on outside support to cope with the HIV/AIDS problem. HIV/AIDS policies were heavily influenced by external donors with the capacity to fund and implement programmes. To accommodate the variety of actors, the health policy did not implement strong policy lines or a "right way" to prevent HIV. (Parkhurst and Lush 2004, p. 1920) The WHO provided a number of expatriate staff to supplement the shortage of Ugandan

[3] ABC approach is an HIV prevention strategy promoting the message "abstain from sex, be faithful, and wear a condom." (Avert 2010)

staff in the ACP. (World Bank 1988, 6) Networks of organizations were involved in AIDS-related activities including church-based groups, international NGOs, and community-based organizations. Each created their own prevention and awareness messages. The Ministry of Health also developed education and awareness campaigns. Funding for many programs was supported by bilateral and multilateral donors. Screening and testing facilities were established early on with support of international donors. During this time, the Ministry of Health became one aspect of HIV/AIDS prevention along with a variety of groups who supported diverse HIV-related programs.

The government's overall retreat from health service provision and delivery under the SAP led to the proliferation of external agencies' involvement in the response to the AIDS epidemic that together reduced the HIV/AIDS prevalence rates. Behaviour change programs, political leadership, condom use and HIV testing – were all part of a comprehensive approach to HIV/AIDS prevention that reduced rates in the 1990s. Uganda has been regarded as a leader of AIDS treatment in Africa as national prevalence rates dropped through the 1990s from 15 percent in 1992 to 6% in 2002. (Human Rights Watch 2005, p. 5) The Human Rights Watch argues that a myriad of factors and initiatives collectively helped reduce HIV prevalence rates in the 1990s. Further, Bass explains that "Uganda's varied approaches to treatment make it a staging ground for choices that face ARV treatment programmes all over the world." (Bass 2005, p. 2077) Avert agrees that the decline of prevalence rates in the 1990s cannot be attributed to one campaign, but "likely to have been a result of both a fall in the number of new infections (incidence), and a rise in the number of AIDS-related deaths." (Avert 2010, para. 12)

Though there was greater governmental involvement in health sector provision in the HSSP I and II between 2000 and 2010, Uganda's HIV/AIDS policies were inclined to suit international donor interests. In 2004, Uganda and the US Presidential Emergency Plan for AIDS Relief (PEPFAR) entered a partnership in which PEPFAR would fund HIV prevention programs and ARV medication to HIV/AIDS patients in the country. Bass says, "As of mid-2005, the money had helped support nearly 40% of the country's accredited ARV centres, and roughly 75% of all Ugandans receiving these drugs." (Bass 2005, p. 2077) As Uganda's largest donor, PEPFAR had significant influence on AIDS policies in Uganda. In 2004, the government shifted its policies during this period to compliment the PEPFAR's preference for abstinence only programs; the Uganda AIDS Committee (UAC) released the "abstinence and being faithful" (AB) policy during the same year PEPFAR partnership was established (Human Rights Watch 2005, p. 25) This new policy established a prevention message for young people that abstinence was the only way to prevent HIV/AIDS; promoting the use of condoms, a common prevention message used in the 1990s, now was seen as undermining the abstinence-only messages. These abstinence-only messages became highly controversial because they discouraged organizations from providing complete information about reproductive health and various methods of the HIV prevention.

PEPFAR also funded a program to provide all primary and secondary schools with abstinence-only messages of HIV prevention. Primary school teachers were instructed by PEPFAR trainers to omit messages about condoms, so students were informed that abstinence was the only method of HIV prevention. This narrow message did not address the fact that as of 1997, the government funded universal primary

education and, since then, saw an influx of teenagers completing primary education across the country. (Human Rights Watch, 2005, p. 29) These abstinence-only messages did not address the reproductive health situation of teenagers who may have already been sexually active. Overall, the Human Rights Watch criticises these messages saying, "an exclusive focus on sexual abstinence as an HIV prevention strategy failed to account for the lived experiences of countless Ugandans." (Human Rights Watch 2005, p. 4) Regarding the success of the PEPFAR programs, the PRSP reports, "HIV prevalence reduced from 30 per cent in the 1980s to 6-7 per cent in 2008." (Republic of Uganda, 2009, p. 261); however, Avert reports that in 2009, the number of new infections exceeded the number of AIDS deaths which could be attributed to the shift towards "abstinence only" messages on reproductive health as well as complacency towards HIV/AIDS campaigns. (Avert, 2010)

The evolution of HIV/AIDS policy in Uganda exemplifies the gap between interests of international donors and the health needs of Ugandans. As with the majority of health sector programmes and initiatives, Uganda's response to HIV was "was created to match the needs of the donors, doing little to improve the existing structures, but rather to create new ones." (Holt 2007, p. 34) A BBC report on the politics of international funding for HIV/AIDS explains that Uganda receives more money from PEPFAR for HIV/AIDS programs alone than exceeds their national health budget, while malaria is the most frequent cause of death. (Villadsen, 2009 Oct 9) Given the rising prevalence rates in 2008, HIV remains a major threat to Uganda and it is feared HIV could be on the rise again.

4.f. Looking forward – National Development in 2010s and beyond

The National Development Plan was created in 2010 under the development framework established by PEAP. The PRSP maintains "the poverty eradication vision, but with an additional emphasis on economic transformation and wealth creation thereby intertwining sustainable economic growth with poverty eradication." (Republic of Uganda, 2010b, p. 3) The PRSP favours investment in sectors that return economic growth, social services such as health and education have not improved since the onset of SAPs. The PRSP points out that health and education shares of GDP have remained at their 1988 levels. Further, the labour force in health and education decreased from 1988 amidst the rapid population growth. Outlining other social development indicators, the PRSP indicates the progress toward reaching the Millennium Development Goals (MDGs). Most of the MDG targets are unlikely to be met by 2015.

In 2006, the agriculture sector represents the biggest labour force (75%) and exporter in the economy. The manufacturing/industry sector engages 20.7% of the labour force, while the service sector represents only 4.2% of working Ugandans (Republic of Uganda, 2010b, p. 12). Through 2000 to 2008, agriculture contribution to GDP fell, while the industry and manufacturing industry grew. Exports in primary growth sectors are largely primary commodities. A key goal outlined in the PRSP notes the government's intention to encourage value-added exports from the manufacturing and industry sector.

Looking Forward: Health and Development

Heading in to the next decade, the Ministry of Health released the National Health Policy Plan in 2009 to guide the next ten years of the health sector. Though it provides no

additional funding for the health sector, it maintains significant reliance on NGOs and the private sector for health service and delivery and it places greater emphasis on preventative health care. (Republic of Uganda 2009, p. 1) Despite the inadequate budget to meet their goals, the Health Sector Strategic Policy III states,

> The responsibility for health primarily lies with individuals, households and communities. The elaborate structure of the National Health System is in place to facilitate the individuals, households and communities to attain and sustain good health. The individuals, households and communities therefore need to be empowered to take their due role as health producers and consumers (Republic of Uganda, 2012, p. 93).

The minimal role of the government in the latest national health policy is the result of decades of reliance on international aid and expertise to meet basic health needs of the population. Though health status of Ugandans has improved, they remain very poor. The country struggles to provide quality health care for preventative health issues, including strategies to reduce maternal health.

4.g. Maternal Health Policies in Uganda

Uganda has committed itself to meet the MDG targets that improve the standard of living of Ugandans, including the reduction of maternal mortality by three quarters from 505 out of every 100,000 live births to 131 between 1990 and 2015 (Republic of Uganda, 2010b, p. 22). In order to meet these targets, Uganda has introduced a number of initiatives to improve maternal health outlined in Uganda's health and development policies. Uganda has provided a conducive policy environment that involves various stakeholders including a number of government ministries, private health care providers and NGOs. Along with introducing several policies concerning various aspects of

maternal health, Uganda has introduced an implementation framework from the national to local levels to put policies into practice (East African Sub-Regional Support Initiative for the Advancement of Women [EASSI], 2010, p. 11); however, there are vast irregularities and gaps regarding the extent to which various policies, especially those concerning maternal health, are implemented across the country.

Some of the most notable effort to meet MDGs are outlined in Uganda's National Development Plan. Within this framework, Health Sector Strategic Plans help guide investments in the health sector over five year periods, as well as contribute to MDG goals. In 2000, Ugandan National Minimum Health Care Package (UNMHCP) was introduced to establish universal access to basic medical needs and help meet the health-related MDGs. Some of the health needs in the plan covered the control of communicable diseases (malaria, TB and STDs), childhood illnesses, immunization, and essential clinical care. The plans sets targets to reduce maternal mortality rates by 30% by increasing contraceptive prevalence rates, the number of women supervised by a skilled health care provider, and the coverage of medicines for pregnant women (Republic of Uganda, 2000a, p. 24). The plan also covers free services for maternal and child health.

Additionally, the National Policy Guidelines and Service Standards for Reproductive Services was released in 2001 in order to establish policy guidelines and service standards related to safe motherhood, family planning and adolescent health more specifically (Republic of Uganda, 2001). It outlines information and basic services to be provided for all aspects of maternal health care including preconception care, antenatal care, labour and delivery, newborn care, immediate pueperium care, emergency obstetric care, post-natal care, referrals, and community outreaches. Another policy includes the

National Adolescent Health Policy of 2004 which addresses prevention of adolescent pregnancy and access to maternal and reproductive health care to Uganda's large adolescent population (Republic of Uganda, 2004). Finally, the government launched the Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality in 2008 to improve the health care system in maternal and neonatal care, but maternal health issues have not received the required level of prioritization in policy and implementation stages.

Uganda has made success in financial commitment to improving maternal health through budgetary allocations. In June 2010, the government announced $122 million for maternal and reproductive health over the next five years (Kagumire, 2010, p. E685). Maternal and neonatal health was also represented in the budget for the 2009/10 fiscal year to cover health care improvements such as basic obstetric care, medicines and supplies (including those for safe motherhood), staff training, and family planning would be addressed. Funds for mosquito net distribution and increasing patients receiving treatment for Prevention of Mother to Child Transmission of HIV (PMCT) were also allocated in the budget that year. Funding for medicines was introduced and staff training was conducted (Republic of Uganda, 2011, p. 22). Such efforts for maternal health have helped reduced the maternal mortality rate from 560 in 2000 to 310 in 2010 (WHO, 2011); however, researchers predict Uganda will not meet MDG target for maternal health by 2015 (Lozana et al, 2011, p. 1161).

Insufficient funding has prevented many of these policies from being fully implemented across the country. Uganda's total government spending on health stagnates at around 10%, thus failing to allocate 15% of its budget to health as promised in the Abuja declaration (Republic of Uganda, 2010c, p. 22; Kagumire, 2010, p. E685). The

HSSP III notes that inadequate funding has prevented the government from delivering the UNMHCP with a budgetary shortfall of over 50% (Republic of Uganda, 2010c, p. 22-23). The government's 2011/2012 budget has allocated funds to reduce maternal mortality for the first time, but these funds remain insufficient to meet the current needs. According to the health sector budget report, there is an "unmet national need for Reproductive Health Supplies estimated at Ushs 7.5 billion [over 3.3 million USD]" (Republic of Uganda, 2010b, p. 255). This represents the single largest unmet need for medicines and supplies in the 2010/2011 budget. This unmet need met stems from the recent planned withdrawal of foreign donor support for the health sector; however, the Ugandan government has failed to take necessary steps to address the funding shortfall as the overall budget allocation for the health sector remains low. According to the Centre for Reproductive Rights (2010), maternal and child health receives the least funding within the health sector (p. 3).

Plans for the expansion of the Road Map in 2010 include the establishment of maternal mortality audits to identify causes of death, emergency obstetric facilities in 50 hospitals, and basic equipment; it remains to be seen whether these plans will be realised given the budgetary constraints on health. A cursory review in 2010/2011 budget states that only 34% of targeted districts received the intended allocations without any mention of specific goals or strategies to reduce maternal mortality (Republic of Uganda, 2010b, p. 242).

As a result of this funding shortfall, consistency and quality among health care services offered across the country vary greatly. Few health centres offer basic emergency obstetric care, services for adolescents are low despite high rates of

adolescent pregnancy, and women who deliver in hospitals remains low (Republic of Uganda, 2005, p. 6). Further, foreign donors provide some of the only health care services for underserved populations. For instance, the UNFPA funds corrective surgery for obstetric fistula, a condition with devastating socio-economic consequences in which women become incontinent of stool and urine after prolonged obstructed labour (Manyire, 2010, p. 20). Not only do several health care centres lack funding to meet objectives outlined in national policies, they suffer from overcrowding, overworked health care staff, under-stocked pharmacies for medicines and supplies, and a crumbling infrastructure. Complaints of bribery are common in maternity wards, as well as other areas of the public facilities, for services that should be free of charge (Kyomuhendo, 2003, p. 25).

Underfunding has affected the essentials for basic health care interventions including human resources, drugs, and equipment. Human resources suffered due to the failure to recruit staff because of lack of capacity and funds for recruitment, as well as poor deployment strategies. Uganda continues to suffer from staff shortages and a mal-distribution of medical personnel favouring urban areas. (Odaga and Lochoro, 2006, p. 7) Further, there is an inadequate network of health facilities and fully-functional infrastructure, as well as a common lack of drugs and equipment. Drug shortages in leave Ugandans will continue to have to pay for health care as they retrieve necessary drugs and supplies before receiving care at public health centres and hospitals.

Underfunding in the health sector affected the equity, quality and access maternal health care services within the UNMCHP after it was implemented. Regarding equity, health facilities offer different health services according to their capacity and referral

level, and the coverage of the UNMHCP was far from universal. For instance, a study found that only 33% of health facilities offer maternal health care services, 57% of hospitals are able to administer general anaesthesia, and only 40% can handle complications from abortions. (Ssengooba, et al, 2004, p. 7-8) The implications of this inequity means that women in need of a caesarean section must be referred to health clinics or hospitals that can handle complications. This increases the delays between onset of complications and receiving appropriate treatment, which can be fatal for women and their babies.

Secondly, the quality of maternal health care services was impacted as cost-effective approaches were used to implement programs that had little effect on improving health. Ssengooba (2004) explains that the "minimum package is set before its costs (and presumably its effectiveness) are fully understood." (Ssengooba, 2004, p. 3) For instance, the Ugandan government invested heavily in programs to train traditional midwives which have a limited effect on improving maternal health, rather than training and distributing more midwives for rural areas which have been proven to reduce maternal mortality rates. (Ssengooba, 2004, p. 3) In addition, a survey of emergency obstetric facilities found that 3.9 to 41 per cent of health facilities complied with minimum standards of medical inputs and procedures. (Okounzi, 2006, p. 1174) These examples demonstrate that current approaches to health care management do not increase the quality of maternal health services offered.

Finally, the budget constraints affected physical and financial access to maternal health care. The UNMHCP was only available from functional high-level health centers and hospitals located in major urban/township centres. Since the majority of the Ugandan

population live in rural areas, the coverage of the UNMHCP was far was universal. In 2003, the average distance to a health facility in rural areas was 13km, compared to 6km in urban centres. (Ssengooba et al, 2004, p. 3) Okuonzi reports that as of 2004, about half the population can physically access and health facility. Regarding obstetric care, he explains that there is "a deliberate policy not to expand such services countrywide, because they are thought to be expensive, and by extension, wasteful, since they do not directly lead to export-oriented investment." (Okuonzi, 2004, p. 1653) This physical access had severe implications for maternal health, as pregnant women were required to travel long distances, sometimes in labour, to reach facilities that can assist them with delivery.

The effects of these policies on maternal health care can be seen in maternal health statistics. Though the World Health Organization reports the maternal mortality indicator sits at 310, Uganda's latest national Demographic and Health survey reveals an uneven use of Uganda's maternal health care services (WHO, 2011). According to this survey, approximately 95% of Ugandan women use antenatal care services from a skilled provider, and 59% of women are assisted by a skilled attendant up from 42% in 2006 (UBOS, 2011, p. 13). These numbers hide regional disparities. While over 90 percent of women in Kampala are likely to make use of a skilled birth attendant, the percentage of deliveries in other districts are well below 50 percent (UBOS, 2011, p. 13).

Uganda's health care performance is rated one of the worst in the world, ranking 186th out of 191 nations by the WHO (Sisay, 2009 Apr 3). Government spending on health increased since 1995 from $3.45 to $9 per capita, but has decreased over that time as a percentage of total government spending. The current health budget for 2010-2015

falls short of US $29 per capita and therefore does not have adequate funding to provide all of the facilities outlined in the UNMCHP (Government of Uganda, 2010, p. 24). Thus, the government continues to struggle to make good quality health care accessible to the majority of the population.

Overall, it is the poorest of the poor who carry the burden of this inequity. Public health services offered by the government are 50% more likely to be used by people from the poorest quintiles (Hutchinson & Akin, 1999). Regarding maternal health care services, about 41% of women in the poorest quintile gave birth in government facilities, and 20% were assisted by untrained personnel or TBA compared to 7% of women in the wealthiest quintile. The WHO reports that 38% of Uganda's poorest 20% of the population were attended by the skilled birth attendant for delivery, compared to 77% from the wealthiest 20% of the population (WHO, 2010, p. 150).

The effect of underfunding means that the capacity of the health care system cannot accommodate maternal health needs in the country. The lack of skilled medical personnel at health facilities, frequent stock-out of drugs, and malfunctioning health facilities compromises the quality of care received at health facilities. Overcrowding in maternity wards in urban centres remains a problem and obstacle to maternal health care. National hospitals and local health clinics frequently run out of basic supplies, put up with faulty equipment and are at the mercy of blackouts and lack of running water. Hospitals lack necessary drugs to treat basic health needs, including antibiotics and blood supplies, and suffer from a chronic shortage of skilled medical personnel.

4.h. Conclusion:

The Ugandan state has implemented a variety of development models to address the external and internal challenges to balance political stability, economic growth, and prosperity. Mugaju states, "Africa has become renowned as 'a continent of economic plans." (Mugaju, 1990, p. 99) Since independence, Uganda has experienced periods of stability and prosperity, as well as devastation and economic decline. The development trajectory in Uganda represents the external and internal influences for prosperity, economic growth and political stability. The level of state involvement in economic activity changed considerably since Independence from a high level of state involvement toward a withdrawal of the state from economic activity and social needs of the country. The brief period of growth following Independence was largely due to a state-led model of development. Idi Amin's military regime and ad hoc economic policies reversed the economic progress made after Independence. The country emerged from over a decade civil war in political and economic ruin. Following the civil war, Uganda's economic and development policies became heavily influenced by the World Bank and the International Monetary Fund.

Uganda has experienced steady economic growth since the early 1990s. Although Uganda has preformed well economically, it is difficult for those who praise its economic growth to convincingly explain their stagnating and poor maternal health statistics throughout this period. The poor social-welfare situation is epitomized by the high rates of maternal and infant mortality. Okounzi (2004) states, "The importance of persistently high mortality is profound; it defies and questions the basis of any social or economic progress a country may claim to have made" (p. 1633). The uneven health improvements

between HIV prevalence and maternal mortality ratios exemplify the inability of the state to provide basic health services across the country. As a result, the barriers to maternal health care – financial, physical, and socio-cultural – remain unchallenged after more than two decades of relative political stability. Even as maternal mortality ratios begin to decline, these statistics hide the reality of maternal health care across the country. Women's experiences of maternal health care uncover the reality for pregnant women that policies and statistics fail to explain.

CHAPTER FIVE: EXPERIENCES OF MATERNAL HEALTH CARE

5.a Introduction:

My first visit to Mulago hospital, Uganda's National Referral hospital in Kampala, revealed a world of health care that I was not familiar with in Canada. The maternity ward, deemed one of the busiest in East Africa, delivers 27,000 mothers every year (Mulago Hospital, 2012, para. 3). A nurse quickly gave us a tour of the facilities. The ward consisted of one dimly lit corridor and a handful of rooms. Hospital staff rushed between rooms stepping over patients. Women waited with their belongings on the floor along the main hallway – some were in labour, others were nursing their newborns. The smell of fluoride lingered. It was clear there were not enough beds for each patient, or enough hospital staff to attend to every need. I could not help but think, "I would never want to end up in a place like this."

As it turns out, I am not the only one in Uganda who thinks this way. The *Daily Monitor*, one of Uganda's national English newspapers, reported that about $125 million dollars is spent on health care services for top government officials overseas every year (2010, Apr 26). This is enough money to construct 10 hospitals that, if built, would bring high quality health care services to ordinary Ugandans. In Uganda, most foreign researchers, politicians, and academics are not the users of the public health care centres. Health insurance plans and a favourable exchange rate means that the wealthy in Uganda will get access to the best health care offered in private hospitals, whether within the country or outside of it. A major issue of Uganda's health inequity is that those who influence health policy and secure health funding are not the ones using the public health

system. That is, those responsible for creating and maintaining the public health system are not reliant on it. How do the voices and experiences of those who move through the system get taken into consideration during health policy formation?

Maternal health care is a basic public health need in every country. Universal coverage of antenatal care, skilled attendants at birth, and basic emergency obstetric care are key ingredients to ensuring every woman has healthy pregnancies and pregnancy outcomes. These components of maternal care are widely accepted in the international field, but Uganda has struggled to improve its maternal mortality ratio during the last two decades. In this period, Uganda has made improvements to maternal mortality rates, but the statistics present an unclear picture of what is really going on. Uganda's maternal mortality ratio fell from 506 in 1995 to 435 in 2006 (Republic of Uganda, 2006: 280). The World Health Organization reports that Uganda's MMR in 2011 is 310 (WHO, 2011). The Lancet's recent publication of a worldwide decline in maternal mortality estimates Uganda's maternal mortality had dropped even lower, from 560.6 deaths per 100,000 live births in 1990 to 274 in 2011 (Lozana et al, 2011, p. 1148). At first glance, this may appear to be a great improvement for maternal health, but advocates and policy-makers in the Ugandan context know that much work remains for the health of mothers to improve.

Access, utilization, and quality of care provided by skilled attendants remains a challenge for Uganda. Related indicators that measure the percentage of birth assisted by a skilled attendant, antenatal care, and deliveries in a health facility show very modest improvement in the past 10 years (UDHS, 2006, p. 282). Since 1989, skilled attendance at birth rose only slightly from 38% in 1989 to 42% in 2006 (Minca, 2011, p. 2). The

latest national Demographic and Health survey reveals an uneven use of Uganda's maternal health care services. According to this survey, approximately 95% of Ugandan women use antenatal care services from a skilled provider, and 59% of women are assisted by a skilled attendant (UBOS, 2011, p. 13). When births in private facilities are excluded, it was found that only 30% of the remaining births took place in a public health facility (UBOS, 2006b, p. 12). These numbers hide regional disparities. While over 90 percent of women in Kampala are likely to make use of a skilled birth attendant, the percentage of deliveries in health facilities are well below 50 percent (UBOS, 2011, p. 13). The high use of antenatal care among Ugandan women and low utilization of skilled attendants at birth raises questions regarding women's access to and utilization of life-saving maternal health services, especially outside of Kampala. Women's stories will help us understand the discrepancy between their use of antenatal care and skilled attendants at birth. Many factors can contribute to this "care gap," and women's experiences with these services will reveal the problems within the health care system and why the majority of the population does not use these essential maternal health services.

Chapter two shows the international consensus on the importance of skilled attendants for maternal health care, and the low use of this service across Uganda. The history and evolution of Uganda's health is outlined in Chapter four and shows that Uganda's health care systems is underfunded, heavily reliant on NGOs for essential services, and suffers from poor infrastructure, staff shortages, insufficient human resources, and unreliable access to electricity, water, drugs and medical supplies. Maternal health services are some of the most underfunded in the system. It provides

context for the following discussion of women's experiences with maternal health care services. This chapter will provide a deeper understanding of the factors that lead to women's utilization of skilled attendants for delivery by hearing the voices of women who use services at a government health facility.

5a.i. Introduction to Fieldwork:

The goal of my fieldwork is to understand the factors behind women's utilization of maternal health services. I wanted to understand women's experiences of these essential services and, in particular, the reasons behind their low use of skilled attendants for deliveries. The results of this project will capture the intrinsic value of experiences of women using Uganda's health care system surrounding childbirth and delivery. The experiences of women reflect the various obstacles to accessing safe delivery services, including transportation, medical costs, perceived need/benefit and socio-cultural barriers. By using the experiences of women, we are able to see a snapshot of the quality of maternal health care and the factors that influence their decision and access to skilled attendants for delivery.

I collected qualitative data from women using postnatal clinics government health facility in the district of Mukono. The participants for the focus groups and interviews were at the health facilities for immunization services for their newborns. I spoke to patients who had used at least one antenatal clinic, and either used a skilled attendant for the delivery of their last child or did not use a skilled attendant for their last delivery. The voices of these women shed light on the conditions of health facilities, obstacles to accessing basic life-saving maternal health care, and offer new perspectives on the

underlying factors affecting women's utilization of maternal health services and access to delivery with a skilled attendant.

5.b. Women's Experiences of Maternal Health Care:

During the course of the focus groups and interviews with new mothers, major themes were identifiable among the responses and experiences shared. Women's reasons for using a skilled attendant during their last delivery are presented in two over-arching themes effecting utilization of a skilled attendant: "Obstacles in the Community," and "Obstacles in the Health Facility". From these two themes, the following five categories are identified: "Overcrowding;" "Medical Costs;" "Health Workers' Attitude;" "Benefit/need of Skilled Birth Attendants;" "Independence and Autonomy;" and, "Time Constraints and Transportation Issues". Quotations from focus groups and individual interviews are used to validate the findings.

5b.i. Community Obstacles Effecting Utilization of a Skilled Attendant

Almost every participant, regardless of where they delivered, understood some of the health benefits (including receiving medication, education on healthy eating and behaviour during pregnancy, and testing for HIV) and need of delivering with a skilled attendant at the hospital; however, the women's desire to deliver in a health unit with a skilled attendant did not directly translate into a hospital delivery. Though a number of factors affect the place of delivery and type of assistance a woman will have to deliver her child. Those who delivered without a skilled attendant gave a wide array of reasons and obstacles to delivery outside the hospital. These reasons were categorised under two groups "lack of support at home" and "time and transportation constraints."

5b.i.1. Benefits and Need of Skilled Birth Attendants

For these participants, the benefits hospital delivery and need of having a skilled attendant during delivery is an attraction to health care facilities. The majority of participants found antenatal care helpful and know the risks of delivering outside a health facility. They cited the main difference between a traditional birth attendant (TBA) and the hospital, as the TBA may not know how to help if a complication arises during childbirth. Additionally, the benefits of delivery with a TBA include comfort, privacy, and patient care; but the benefits of a hospital delivery outweigh those of the TBA.

Many of the women understood that their best chance of a healthy childbirth is to deliver at a hospital. In one interview, a woman explained why it is important for her to deliver in a hospital. She says, "You may fail to produce and no one can help you and you die, so that's why it's better for someone to come in the hospital." (Interview #8) This woman's response summarizes that of most participants. It is important to note that most women in this study understand the fatal risks of unassisted childbirth and that maternal mortality can be prevented with the assistance of skilled birth attendant.

As expressed in the maternal health literature, TBA's offer limited knowledge and expertise for childbirth complications. A woman who delivered at home explained the difference between TBA and hospital deliveries. She says,

> When the baby has refused to come out, the doctors help you very quickly. They can advise you to be operated or they can comfort you and you deliver. When you deliver from a TBA you can get problem for example the baby may fail to come out very well and no one can help you to push, but when you in the hospital the doctors can put you on drip and you deliver your baby. (Interview #6)

TBA training is informal and though they may know how to handle a normal pregnancy and childbirth, they may not know how to their medical expertise varies between each

one. Some TBA clinics could be stocked with more medical equipment and drugs than others. One woman explains her experiences with a traditional birth attendant.

> [The TBA] helped me to deliver very well. The problem I saw is that when I was giving birth the baby was big and I got a cut. The TBA doctor didn't help me to sew it back. It was yet that TBA told us that I had not got a big problem that I will be fine but now I am suffering... [With the] TBA they don't fix you in case you got a cut like me but in the hospital they can and you get healed at once. (Interview #7)

Most of the women understand that the hospital offers help from skilled birth attendants that cannot be found outside a health facility. One woman summarises the limited knowledge and medical expertise of the TBAs. She delivered without a skilled birth attendant and says,

> I gave birth in the village and those people in the village don't have experiences. That is, they don't tell you whether the baby is ready they just tell you to push. So it's better and come here [to the hospital] so that you can know everything about the pregnancy. (FG2)

TBAs include traditional midwives who learn their trade from other TBAs, as well as less experienced friends or relatives. Traditional midwives would have experience delivering babies because this is their job; however, TBAs can also include a relative or friend who occasionally delivers a baby in her village as a "favour" or "good deed" (Sibley et al, 2003, p. 51). In these cases, being assisted by an inexperienced TBA is possible. Some will have experiences with routine births, but not with complications that arise. This participant is pointing out that she has more confidence in in the skill and range of experiences available in the hospital.

Another woman points out the difference between TBA and facility-based deliveries. She delivered her first three children in a hospital, but her last delivery was

with a TBA. She says TBAs lack the necessary medicines and supplies to ensure a safe delivery. She states,

> The equipment these people [at the hospital] have, the TBA doesn't have. When you produce from the hospital, immediately afterwards they give you vitamins and medicine. And TBA, you just produce. When you pass blood, some women pass too much blood and the TBA will have nothing to stop that blood. So it's better to produce from the hospital. (Interview #10)

This woman, like many others, understood the benefits of deliver their children with a skilled birth attendant. Other factors, which will be discussed below, inhibited her from accessing a skilled birth attendant for her last delivery.

The women understood the best chance of delivering a healthy baby is to attend antenatal care in order to monitor the health of the mother and baby. Attending antenatal care allowed women the chance to ask questions about their pregnancy, acquire medication for malaria or other illnesses, learn about proper nutrition and practices, and check that the baby is in the proper position to ensure a health pregnancy and delivery. Even women who did not deliver with a skilled attendant agreed. One woman in the second focus group noted, "We went for check-up from the doctor. That's to say a doctor used to tell us to go for screening to see whether the baby is well, and also they tell us to take some medicine." (FG2) Another woman in the same focus group agrees saying, "They gave them medication for de-worming, malaria and they tell you the date you are supposed to come back." (FG2)

Antenatal care is even more important for women with HIV/AIDS. In one case, a woman learnt her HIV status when she attended antenatal clinics. She explains the importance of using hospital services over private clinics. She delivered with a skilled attendant and shared in the focus group discussion, "In some clinics they don't test for

HIV/AIDS blood but here they test and they tell you your status and they counsel you so you can start taking medication." (FG1) Women with HIV/AIDS came for antenatal care and hospital delivery to prevent transmission of the virus to the baby. Another woman delivered her last baby with a skilled attendant after HIV was unknowingly transmitted to her first baby. She says,

> I encourage other women to come in the hospital because for me it helped me to save my baby from getting HIV/AIDS so, she is alive but for us we [my husband and I] are affected. But the elder one I didn't go to the hospital and I delivered from home. It's my neighbours who helped me to deliver the baby, but we didn't know that we are HIV positive. And they delayed to cut the umbilical cord and the blood entered the baby and he got affected. He is on treatment with me. (Interview #5)

The benefits of such care allow women to encourage others to attend antenatal and delivery services at the hospital. Some of the women explained that friends or family encouraged them to attend antenatal clinics. One woman who delivered with a TBA says, "When I was pregnant my friend told me that when you are pregnant you have to go in the hospital and they check on you. That's why I also had to come for antenatal. (Interview #7)

The women were aware that attending antenatal care clinics will assist with the delivery process at the hospital. When a woman attends antenatal care clinics, they receive a small booklet that documents their medical history, immunizations and any medical concerns that could result in complications and adverse pregnancy outcomes. Women explained that when they show up for delivery without an antenatal card, they will face verbal abuse and poor care from hospital staff.

One woman explains why not attending antenatal clinics can be a problem for women who wish to deliver at the hospital. She says,

> You find a problem because they cannot find where you begin. And it might be maybe to late for you to deliver. When you have a problem they may ask you 'Now where is your antenatal card? Where have you been attending antenatal care?' So you may not find help from there. (Interview #10)

This stress of not having an antenatal card was reason for one woman to deliver outside the hospital. Speaking of a previous pregnancy, she says, "I had not attended antenatal care from any hospital and I used to hear that if you have not attended antenatal, the nurse will abuse you and not pay attention to you... still they can work on you, but the nurses say that it's difficult to identify your problem quickly. (Interview #4) These women explain that failure to attend antenatal care clinics can deter women from seeking a hospital delivery.

Conclusion: Benefits and Needs of Skilled Birth Attendants

The women explain that the services found at antenatal clinics include HIV/AIDS testing, medication for malaria and other illnesses, education on nutrition. These services cannot be found at the home of a TBA or private clinic. This may explain why attendance for antenatal clinics is high. Regarding delivery, the women have confidence in the skill of hospital workers over that of TBAs. Thus, skilled birth attendants can offer help in the case of a complication, but the expertise of TBAs varies and their knowledge is incomplete. Regardless of a woman's place of delivery or type of assistance, the majority of participants stated there are benefits to delivering with a skilled attendant and would encourage others to use hospital services for delivery. Considering the low use of skilled attendants outside the capital city of Kampala, it is possible that there is a potential for 'respondent bias' in which the participants state this because they believe it to be the 'correct' answer. It is also possible that these women, who have some previous

experience using maternal care services, represent a cluster of the population who favour these services over others who have never or rarely accessed maternal health services in hospitals. A final thought may be that these women represent a select group who value health care at health facilities because this is the site they were recruited.

5b.i.2. Lack of Independence and Autonomy:

Each day I visited the hospital to speak with women and nurses, the antenatal and maternity wards were full of women and very few men were present. There was little room in the hospital's maternity and antenatal wards to accompany all the women seeking medical care, let alone men who are not seeking care. Though the presence of men in the hospital was small, it became apparent in my discussions with the women that their reasons for delivering without a skilled attendant were often linked to a woman's independence and autonomy from her family and husband. Though men did not accompany women to the hospital, the women in both groups expressed the need to consult their husbands in order to seek health care during the pregnancy. In the focus group among women who delivered their last child with a skilled attendant, one woman explains, "I bring myself [to the hospital] because sometimes people may not be around at home, so you just need to prepare yourself anytime and then call your husband." (FG1) After several women mentioned consulting their husbands before seeking health care for the pregnancy, I asked the focus group why they must consult their husbands. The women in the focus group explained in agreement saying, "we have to go to our husbands when we are pregnant... When you tell your mother that your pregnant she has to ask you who is responsible for it." (FG1) Another woman in the same group explained, "When

you're married you have to tell your husband, who is responsible." (FG1) As explained by the women, their husbands must take "responsibility" for the pregnancy. The general consensus in this focus group is that women must consult their husband prior to going to the hospital. This data suggests that women do not can make decisions for their health and seek care independently.

Though the husband are expected to take responsibility for the wife during pregnancy, the women who delivered without a skilled attendant explain what happens when husbands are not around when labour begins. One woman who delivered with a TBA says in the focus group, "My husband had not come for work and my in-laws are far from my place. For me I don't have anyone I know because my village is in Mbarara and at that time I had only that woman to help me." (FG2) Another woman in the same focus groups explains why she visited TBA to deliver her last child. She says,

> For me, the problem was there was no one to be with me in hospital because I was staying alone at home and my husband used to travel long distances and my mother stays very far in Jinja, so I had no one to help me. That's why I decided to stay at home. Near my home there is a certain old woman who could help me ... that's why I delivered from home. (FG2)

This data suggests that accessing a skilled birth attendant in a hospital is inhibited when a woman is alone and in labour. Women who were alone at the onset of labour had no one to help them get to the hospital.

Most importantly, having no support at home can result in negative health and pregnancy outcomes for the mother and newborn. This became evident in some of the most devastating stories shared by in the new mothers, in which their husband showed no or little concern for their health. One woman in the focus group of women who delivered

with a skilled attendant openly explained the situation she experienced with her husband. She says,

> "When I was in antenatal care I tested and I was HIV positive. I went to my husband and I asked him whether he knew that he was affected. He said that he didn't know because he had never been tested for HIV/AIDS. Later I started medication from the hospital after experiencing bad conditions. I was emotionally disturbed." (FG1)

This data illustrates that the level of a husband's involvement can effect maternal and child health. The health of the mother and the baby is compromised when the husband is disengaged from health concerns. This is most clear in the story of a mother of two whose husband left her. She delivered without a skilled attendant. She shares,

> I delivered from home because I didn't have money to transport myself from home up to the hospital. My husband got another woman and he left me without anything and after he chased me from his home. Now I am staying with my father... My husband does not give me any support. I am the one suffering with my children. I had hopes of producing in the hospital. When my husband had refused to give me money I lost hope. I expected him to give me money for the things needed in the hospital. And also, I needed him to be in the hospital for help like when the nurses are asking the husband is there to respond for her and also [for] the company. At the first pregnancy he used to care about her but the second one he didn't care. (Interview #6)

These stories reveal that women's health is tied to her relationships at home. This data suggests that a husband's approval is a key step before women can access the hospital for a skilled attendant at delivery. A husband's disapproval or lack of presence severely limits a women's ability to access health care during the childbirth.

Independence and Autonomy: Conclusion

In order for women to utilize hospital services and a skilled attendant, women need to have adequate support at home. They are dependent on the presence of their husbands at home to assist them with financial support for supplies and materials and for access to a

hospital during the time of delivery. Women were primarily dependent on their husbands or a relative to take them to the hospital, but those who did not deliver at a health facility with a skilled attendant often disclosed that they were alone at the time labour pains began. Even when women have prepared for a hospital delivery, they may find themselves in a situation where no one can assist go to the hospital at the onset of labour pains. This data is supported by literature that states that women's lack of autonomy, such as financial independence and decision-making power regarding her own healthcare, is an important barrier to delivery with a skilled birth attendant (Parkhurst and Campbell, 2009).

The women explain that men play an important role in seeking a skilled birth attendant for delivery. Though husbands are not likely to join women at antenatal and immunization clinics, or the delivery, the women explained that husbands are key consultants for women with respect to seeking care. In the group who delivered with a skilled attendant, husbands were sometimes noted as attending the hospital with the mother. This data suggests that husbands are expected to make decisions about health care without accessing information or resources about his wife's condition during pregnancy. This data is supported by literature on male involvement in maternal health care in Uganda. Even though men play a central role in a woman's reproductive health by paying for costs associated with hospital visits, men are not expected to accompany women to antenatal or postnatal clinics with women, or attend the labour or birth of their child (IPPFARO, 2008, p. 6). The lack of support at home is an important determinant of facility use and, therefore, the use of a skilled attendant.

5.b.i.3. Transportation and Time Constraints:

One of the first observations of my arrival in Uganda is the state of the road system. Even in Kampala, the capital city, the condition of roads is very bad. On paved roads, large potholes damage cars and cause them to swerve towards pedestrian traffic. Uganda has a limited network of paved roads throughout the country, and most of the rural population are inaccessible by car due to the poor conditions of roads. According to the CIA World Factbook, Uganda has a paved road network of 16,300km in a land area of 200,000 km. According to a survey by the World Bank, about 80% of Uganda's population reports living within 5km of a health facility, and about 10% of people do not seek health care assistance due to distance from facilities (Okwero et al, 2010, p. 22). Gollin et al (2010) report that about 77% of people walk to those clinics (p. 10). In rural areas across Uganda, roads are mostly unpaved while paved roads in urban areas are in poor condition. Streetlights are few and far between. During the rainy season, unpaved roads become as slick as ice. Transportation problems are exacerbated for a pregnant woman as her ability to reach a facility is constrained by the time between the onset of labour and the delivery.

Obstacles to delivering outside a health facility were expressed by the group who did not deliver with a skilled attendant. The main difference between responses of those who delivered with a skilled attendant and those who did not were the time constraints, distance and transportation problems. Distance to the health facility and transport delays were commonly cited as reasons for delivering outside a health facility without a skilled attendant. Several of the women explained the challenges of reaching the hospital from the onset of labour pains to the delivery of the baby. Simply put, many women did not

make it in time. As such, some women delivered on the way to the hospital, resorted to home deliveries, or opted for assistance with a TBA.

One young woman explains her intention to deliver at the hospital. She moved from her home village to her mother's house to be closer to the hospital before it was time to deliver. When her labour pains developed quickly, she decided to deliver at her home with the help of her sister and mother. She says,

> I got labour pains from home so when they brought the *boda-boda* [motorcycle taxi] I was already about to deliver and they thought that I may deliver on the way... We had prepared for everything to come in the hospital but the pains came rapidly and I delivered from home. I was not happy to deliver from home just because it just came rapidly. " (Interview #2)

Another woman shared a similar experience. With the help of her mother, she intended to deliver at a hospital. By the time their transportation was ready, the distance to the hospital was too far to make it there in time. She explains,

> "We got on the *boda-boda* [motorcycle taxi] to bring us in the hospital but on our way I felt bad and I told my mother that I may not reach the hospital because I was in severe pains. I was coming to the hospital, but the *boda-boda* man [motorcycle driver] told us that there is a lady called Nalongo[4]. She helps women to deliver and so we went to her." (Interview #7)

Transportation issues were a problem for some women as transportation options are limited for poor women. Common means of transportation include private cars, *boda-bodas* [motorcycle taxis], *matatus* [public buses] and walking; however, several women explained that these methods of transportation are difficult and uncomfortable when one

[4] Sometimes new mothers identified TBAs by their name, or described them as "some old woman in the village" who helps deliver babies. Women also use "private clinic" to describe small, independent pharmacies and store fronts that sell medications and offer a few medical services such as HIV testing or administer drugs.

is in labour. The difficulty of transport is compounded when labour pains begin at night because safe and reliable transportation options are limited or non-existent after dark.

In the focus group with women who delivered without a skilled attendant, several of the women explained that issues with transportation created an obstacle to reaching the hospital. Walking was not an option for women in labour who lived far away from the hospital. The most common method of transportation for women in this focus group was a *boda-boda*, an uncomfortable option for women in labour. One woman who delivered at a private clinic explains, "No one was at home, and I started bleeding heavily, but I couldn't sit on the *boda-boda* and I decided to go to the nearby clinic." (FG2) The others in the focus group agreed and sympathized with this statement, as another woman who delivered at home explains, "They may bring the motorcycle but you may even fail to sit on it at that time so you end up delivering at home." (FG2) Safety is also an important transportation issue. The youngest and most vocal in the group explained why she delivered at a private clinic of a TBA instead of the hospital. She says, "I was in the labour pain and I had no transport and when I had to look for transport the *boda-boda* men were drunkard[s]." (FG2) These statements highlight the importance of finding safe and reliable transportation to a health facility, but that these options are limited for women in labour.

Linked to the limited methods of transportation are the time constraints of reaching the hospital. Some women who delivered with a TBA for the birth of one of their children expressed time constraints as the main reasons for going to a clinic instead of a hospital. During one interview, a woman who delivered with a skilled attendant for her last birth explained the circumstance of a previous pregnancy. She says, 'The first

born was born in the clinic because it was the nearest and I got labour pains at night." (Interview #9) Another woman explains a similar situation. Her previous pregnancies were delivered in a hospital, but her most recent labour was too. "For me I used to produce my babies from the hospital, but it's just because this time the labour pains were abrupt that I produced with the TBA." (Interview #10) Several of the women who delivered without a skilled birth attendant were clear that with the onset of labour pains, they had few options. They lacked transportation support to make it to the hospital before the child was delivered. They therefore sought assistance from a "nearby clinic"; however, the state of the clinic, the quality of care, and the expertise of those assisting women are unknown. Parkhurst et al (2005) explain that the private sector in Uganda consists of "a large number of different actors, both medically trained and unqualified undertaking private practice" (p. 130). Although women are initially seeking care at a hospital, physical access to hospitals is a major reason why they cannot access hospitals or health facilities. With nowhere else to turn, women end up at the clinics of TBAs. This data is shared by Dodd and Munck (2002) who state that inaccessible formal health care leaves people to turn to traditional medicine (p. 17). Time constraints, transportation, and distance problems were not expressed in the groups who delivered at the hospital.

Transportation and Time Constraints: Conclusion

These stories from women echo some of the long-standing problems with health care system in Uganda. This data suggests that physical access to health facilities is a serious and major obstacle for women seeking skilled birth attendants. For the new mothers in this study, it was one of the most common determining factor for delivery with a skilled attendant or not. Physical access and time constraints are more important during delivery

than antenatal care because "providing access to care during the relatively short period of labour and delivery is logistically much more difficult than making services available during the antenatal period" (Tann et al., 2007, p. 10). This data also explains the high attendance to antenatal care relative to the utilization of skilled attendance because physical access to facilities is extremely limited for women in labour who cannot safely walk, sit on a motorcycle or reach a public bus. These constraints are compounded by labour occurs at night. This data is supported by Thaddeus and Maine (1994) who state that a delay reaching the health care facility is one of three major delays that cause maternal mortality around the world. This delay is due to poor road conditions, lack of safe transportation, or distance to the health facility in developing countries. Researchers in the Ugandan context also state that physical barriers, such as distance from health facilities and lack of safe transportation, are one of the most important obstacles for a women in search of skilled attendants for care (Parkhurst et al, 2005, p. 440). This physical barrier to maternal health care is important because without reasonable access to health care, complications will worsen. Overall, the stories of new mothers note that they struggle to reach the facilities can prevent women from accessing a skilled birth attendant in time for the delivery.

Conclusion: Community Barriers Factors Effecting Utilization of a Skilled Attendant

The women's stories explain that several barriers exist before they can access a skilled attendant in the hospital. Those who delivered without a skilled attendant did so because a hospital delivery was not possible considering the circumstances that led up to the childbirth. This data suggests that the circumstances beyond the control of the women can

dictate whether or not she is able to access and use hospital services and a skilled attendant for the delivery. First, husbands are key consultants for women to seek health care during pregnancy, but women who lacked financial support or were alone during labour had difficulty making their way to the hospital when labour began. Secondly, many participants who delivered without a skilled attendant lacked safe and reliable transportation options to take them to the hospital. Several of the women explained these situations provided them with limited options for place of delivery at the onset of labour pains. One women who delivered without a skilled attendant explained in the focus group, "Its not our own decision to deliver from home but because of the situation we are passing through and you have no option." (FG2) These sentiments are echoed by Kyomuhendo (2003) who says "Mothers do not deliberately choose the option of home-based, unskilled care; rather, the environment in which they live to a great extent limits their choices." (p. 24). Therefore, obstacles within a women's community, including the lack of support at home and transportation and time constraints, at the onset of labour can inhibit her ability access a skilled attendant in time for the childbirth.

5.b.ii. Health Facility Obstacles Effecting Utilization of Skilled Attendants

All participants in the study had some experiences in the health care system through antenatal clinics. All the women attended at least one antenatal clinic. Their experiences varied – some women had positive experiences while other women's experiences were very negative. Once they reach the hospital, women are met with a series of obstacles as they interact with health workers and other patients. According to the participants,

overcrowding, medical costs and bribery, and the poor attitude of health workers strongly shape their experiences in health care.

5b.ii.1.Overcrowding

For women who reach the health facilities, the women explained there are a series of barriers to accessing a skilled attendant. Once women reach the health facilities, overcrowding creates a barrier for women seeking health care services. Several of the women noted long wait times in the formal health care system for antenatal care and, more critically, delivery services. Indeed, during the course of the interviews and focus groups, women expressed that they spent hours waiting for care. Commonly, women experienced situations in which they were asked to wait for assistance when they were in labour. In some cases, the labour ward was operating beyond its capacity. In both focus group discussions, women explained that overcrowding can prevent women in labour from receiving care. A woman in one focus group who delivered in the hospital says, "You may find that five women want to produce at the same time. So, the doctors can tell you to first wait to push because he/she may be attending to somebody else." (FG1) A women in the second focus group who delivered from home is also aware of overcrowded hospitals, " You may come in the hospital when you are in labour pains and they tell you to first sit down hence not giving you attention yet you can be in a lot of pain." (FG2) This data illustrates that overcrowding in hospitals is a barrier to receiving care upon reaching the hospital.

In some cases, women witnessed women who delivered on the floor because no beds were available. One woman explains the situation,

> We only have 5 beds and of which three beds are the ones we use to deliver on. The two are used to transport those who have failed to deliver yet the population is high. They use those beds to transport those who are in severe condition and some of us we find problems when the beds are full which forces some to deliver on the floor. (FG1)

In a couple cases, women witnessed or experienced delivery in the hospital without a skilled attendant. A woman in the focus group who delivered in the hospital explains her own experience with childbirth in the hospital:

> I called the doctor to help my delivery but the doctor barked at me, "We have seen may deliveries so, you are not the first one. It's not yet your time." But I was in pain and I was on the bed and I delivered without any help from the doctors because they had refused to turn up in time. (FG1)

As exemplified in the following case, overcrowding can have fatal consequences for the mother and the baby. In one interview, a mother of two explains that she had a positive experience in the hospital and a healthy pregnancy outcome, but witnessed another woman with a very different experience than her own. She explains:

> For me the day I came to deliver there was a woman who delivered from the floor because she had nothing like gloves and the nurses could not help her deliver... For me they take care of me because I come with money... I had money to give them but my colleagues were treated badly like the woman who produced on the floor the baby first came with the head and it fell on the floor and later the baby died. (Interview #9)

This mother of two explains there is an informal system that dictates who gets a bed during labour and who does not, who receives attention and care and who does not. The women who delivered in the hospital explain the overcrowding can encourage health staff to ask for bribes and shout at patients in order to manage the demand. This data suggests that overcrowding can prevent women from accessing help from a skilled attendant once she reaches the hospital. Additionally, the overcrowding can compromise the quality of care a woman receives in the hospital, as women who deliver on the floor could risk

delivering in unsanitary conditions. These cases emphasize the lack of care and inability of staff to monitor the labour process of individual mothers in face of overcrowding and working beyond capacity.

5.b.ii.2. Medical Costs and Bribery

According to Uganda's health policies, maternal health care services are to be delivered free-of-charge to women seeking care (Republic of Uganda, 2010, p. 5). These policies, however, do not translate into free care in government facilities. There are several informal costs associated with hospital deliveries and considering the additional burden against an inflation rate in 2011 of 13.7%, these financial expenses were an important part of the women's stories (CIA World Factbook, 2012) It was only by sitting down with women that the system surrounding informal medical costs in the hospital was revealed.

A woman who delivered at the hospital explains that she paid bribes for services that were supposed to be free. She says,

> I used to know that they are for free but I was surprised when they demanded me that money. I used to hear it from women who came to attend antenatal care from here. I had [brought] money because [the women] told us that when you come to the hospital, they ask for money. That's why I came with money. (Interview #8)

Requests for bribes were a common and expected occurrence in the hospital, but is a major source of frustration among the participants. The standard bribe fee paid for antenatal care among these participants is 1,000 Ugandan shillings (about 0.50CAD), as summarised by one women who delivered in the hospital, "Every time you come in the hospital they have to tell you to give them 1,000 [shillings] for check-up, yet some are poor and cannot afford them." Most women explained they paid 1,000 shillings for the

antenatal check-up. A few women explained they did not have to pay for the same services, but theses care were extremely rare.

The overwhelming number of women in both groups was asked to pay for services they expected to be free. In nearly all discussions with women, it was mentioned that nurses asked for money for both antenatal and delivery services. Women were asked to pay varying amounts of money in order to get assistance during antenatal and delivery care. This money was requested from the women in order to be issued a discharge from the hospital, but in other cases bribes were requested in exchange for care. In the first focus group, one woman who delivered her last child in the hospital says, "[The hospital staff] pay attention to the people who have given them more money than those who have not paid them." (FG1) Another woman of three confirms saying, "They asked from us 2,000 [shillings] for the bed. After delivery they asked for me 6,000 [shillings]. A lot of us we pay because they first ask for money. They tell us that if you don't have money you move out and they don't check on you." (Interview # 9) Women explained that the women who can afford to pay a higher bribe will receive care during their delivery, especially in cases where more than one women is delivering at the same time.

Even women who did not deliver at the hospital expressed their frustration with bribery and abuse within the system. Though their experiences within the system are limited to antenatal care and immunization clinics, they are familiar with the obstacles within the hospital especially the conduct of health workers. The amount of money charged by each patient varied. In the second focus group, one woman explains the informal nature of bribe requests. She delivered at home, but explains the experiences of her friends and family. She says,

> We also talked to our friends whether they pay money and they told us that they do, but it depends. You're not the one who decides. Even me I brought my sister but the nurse told us to pay 20,000 [shillings]. My friend came to deliver from here but the nurse told her to pay 50,000 [shillings]. So it varies. (FG2)

Indeed, the bribes asked by hospital staff are inconsistent. A woman who delivered with a skilled attendant explains in one focus group, "They [doctors and nurses] sometimes don't give us medicine yet they make us pay for it. It helps the baby after delivering but they give you half doze and they don't give you the receipt for medication. So, they should change because we are poor." (FG1) Due to their nature, bribes are unregulated and this puts women's health at the mercy of the hospital staff.

For deliveries in the hospital, women are required to bring their own medical supplies for doctors and nurses to use so they can be assisted with their delivery. A woman who delivered in the hospital lists the necessary supplies for hospital deliveries. She says, "The nurses used to teach us to be having the facilities which the hospital needs. For example 6 pairs of gloves, 3 polythene [sheets], a packet of razorblades, basin, bed sheets, clean clothes, etc. When you have not come with what they want, they cannot work on you." (Interview #9) Other woman confirmed her statement explaining that a woman lacking these supplies will find difficulties getting assistance for her delivery. One woman who delivered in the hospital says, "I had everything they needed. When you don't have the property the nurses can be rude to you. Still they work on you when they are abusing you. They tell you next time you come you have to bring everything." (Interview #8) A women who delivered in the hospital explains her frustration saying,

> If they tell you to come with 6 pairs of gloves and you come with 3 pairs of gloves they cannot work on you... For me, I was in labour, but I had three pairs of gloves and the nurse told me that she wants the other 3 pairs. I pleaded for her to help me

> deliver, but she insisted that she wants the other pairs. She made me pay 3,000 [shillings], yet I didn't use them at all. (FG1)

The women explained that health care workers would sometimes sell these medical supplies to women. In the focus group of women who did not deliver in a hospital, another woman who delivered from home explains her sister's experience in the hospital. She shares her experience accompanying her sister in labour,

> We didn't have any property apart form the polythene and the doctor told us to bring gloves (6 pairs) and 4 razorblades. We did not have money. During the antenatal visits they told us that things are there in the hospital but the doctor told us to buy those things that if we refuse to buy them she could not help my sister who was in labour pain. Another thing she told us that if you cannot find them for me I have them here and I can get them to you because I am selling them. We told her to help us to bring them for us until she delivers well and we will bring money for the hospital. We shall pay you. She refused and she told me I will not touch on your patient but she was in severe pain (FG2)

Another woman in the same focus group agreed saying "They should stop selling us medicine because it's from the government. It sends it for us for free not to buy it. So, they should change that since it's a government hospital and also, the government gives them for free." (FG2) The interviews and focus groups revealed that there are several costs associated with accessing care from a skilled birth attendant upon reaching a health facility.

Conclusion: Medical costs and bribery

These data suggest that women must pay for supplies when they are not available in the hospital, but it also reveals that some hospital staff may be involved in selling medical supplies or drugs to patients. A study by McPake et al (1999) that states most health workers in Uganda levy informal charges in exchange for medicine or medical care. Medical costs and bribery associated with maternal health care in Uganda act as a barrier

to receiving care within the hospital (McPake et al, 1999, p. 857). Shortages of medical supplies and medicines for reproductive health are common across the country. Nationwide, the government budget only funds 30 percent of requirements for essential medicines, and 72 percent of government health units are out of at least one medicine every month (Republic of Uganda, 2010, p. 22). The Ministry of Health's budget line item for reproductive and maternal health supplies is often vastly under-spent against what is allocated, with less than ten percent of designated funds actually disbursed. With no other budget from which to draw, hospitals usually reverse the free maternal care policy and ask patients to purchase medical supplies when they are running short (Madison et al, 2010 p. 5). As a result of these funding shortfalls, women and their families must cover the costs of medical supplies upon accessing health facilities for delivery.

Many of the women encounter informal costs in the form of bribes, medical supplies, and drugs. In many cases, these informal costs for maternal health care are expected, but are a major source of frustration for women who arrive at the hospital in labour and ready to deliver. Cases of bribery in the health care system are common in Uganda. Another study confirms this data by stating,"medical attention at public hospitals and health units can only be obtained in exchange for payment despite the official abolition of user fees at health units." (Hunt, 2012, p. 700) Patients must pay for medical attention, as well as medical supplies, no matter how small. For women in labour, the lack of medical supplies and drugs are a barrier to acquiring help from a skilled attendant even upon access to the hospital.

5b.ii.3. Health Workers' Attitude:

The experience of childbirth in the hospital was mainly shaped by the conduct of the health workers. The attitude of health workers encompasses examples of hospital staff expressing empathy, care or lack thereof in verbal form or behaviour towards the women. Verbal coercion from health care workers in the hospital was a common complaint among women in both groups for delivery services, but not for services acquired in antenatal care. Personal experiences of abuse and lack of care were shared among women who delivered with a skilled attendant, but women who delivered without a skilled attendant were also familiar with the conduct of health workers towards patients.

Among those who delivered in a hospital, participants expressed their frustration toward nurses who failed to give attention, empathy and care to women in the maternity ward. A woman in the first focus group explains her experience with a nurse right after a caesarean section operation. She says, " I was from the [operation] theatre with my baby and the nurse told me to go out, yet I was supposed to rest a bit. Also, some nurses force them to clean when they have just given birth." (FG1) Calling for help in the hospital is also reprimanded as shared by another woman in the same focus group. She says, "Some nurses tell you to call your husband to deliver because you did it together with him. So [there will be] no need to shout for her." (FG1) Those who did not deliver their last child in a hospital were aware of this behaviour. In the second focus group, a woman says, "They should handle people with care when they come... Also the nurses should stop being rude to us when we come to deliver." (FG2) These accounts of staff behaviour, physical or verbal abuse, and neglect were common among the new mothers regardless of there last place of delivery.

Interestingly, one woman associates physical abuse with a positive pregnancy outcome. Speaking of another friend, a woman who delivered her last child out of the hospital says, "The doctor got annoyed and she slapped her two times and she told her she wanted to kill the baby. After being slapped, she followed the rules and produced well." (FG2) This new mother may have been monitoring her response out of fear from being overheard by the staff during the focus group.

Some participants who were treated by kind nurses explained that most women do not come back for a delivery because of mistreatment and lack of respect from health workers. This fear of health workers causes women to attempt deliver at home without a skilled attendant. A woman who delivered at the hospital shared her experience with childbirth in the hospital. She was asked to pay 10,000[shillings] for the delivery, and brought all the necessary supplies to the hospital. She says, "The [nurse] who was working on me was very kind to me but they are rude to others... They should respect the women who have come to deliver from the hospital. They should stop being rude." (Interview #1) Another woman explains a similar experience. Though her experience with childbirth in the hospital was positive and nurses were kind, she witnessed another women treated poorly and experiencing with a fatal pregnancy outcome. She says,

> For me the day I came to deliver there was a woman who deliver from the floor because she had nothing like gloves and the nurses could not help her deliver. I had money to give them but my colleagues were treated badly like the woman who produced on the floor the baby first came with the head and it fell on the floor and later the baby died. (Interview #9)

The data suggests that hospital staff behaviour can lead to fatal pregnancy outcomes. This story highlights that quality of care within a hospital is compromised by hospital staff behaviour.

The issue of hospital staff attitudes was one of the most important issues that affected a woman's experience of childbirth in a hospital. When asked what would encourage more women to return to the hospital for their delivery, most women gave a response similar to this woman who delivered at home, "The nurses should stop being rude to the pregnant women." (Interview #2) This simple statement was echoed by almost every woman, regardless of place of delivery or individual rapport with nurses.

Conclusion: Health Workers' Attitude

The experiences are primarily shaped by the hospital staff who work on them. Some women are satisfied with the services they received, while other women's experiences are very negative. These experiences within the health care system can hinder some women to deliver without a skilled attendant for a subsequent pregnancy. The majority of participants expressed desire to deliver their next baby at a hospital, but some women pointed to their negative experiences in the hospital as a reason they will not come back to the hospital. In the focus group, one woman says, "I rather give birth from home than here or I go to a private clinic, or unless they chase some of the rude nurses from the hospital." (FG1) Another woman disagreed saying, "Yes, you have to come back because it's the only hospital and not all the nurses are rude, some are kind to us." (FG1). Maternal health literature in the Ugandan context supports this data concluding that the negative attitude of health workers can affect utilization of skilled birth attendants and the quality of care they offer (Kyomuhendo, 2003; Kaye, 2000).

Conclusion: Health System Obstacles Effecting Utilization of Skilled Attendants

Most women expected to come back to the hospital to deliver their next child. In most cases, women develop a feared respect of health care workers. Women know they must

obey health care workers, including attending antenatal care, bringing necessary supplies for delivery, following their "rules" or instructions during delivery, and payment of bribes. Failure to do so will result in a series of consequences – including verbal and physical abuse, and lack of medical care – that are critical to the health of the woman and baby. A mother of three said, "I expect to produce from here because I know how they are working that's you have to be having money" (Interview #9). Overcrowding, medical costs and bribery, and negative attitude of health workers all create barriers to a woman's access to skilled birth attendants within a hospital. These barriers to care within the hospital are recognized by maternal health researchers. Thaddeus and Maine (1994) consider hospitals as the last and final delay toward receiving adequate and timely treatment of complications that can lead to maternal mortality or morbidity (p. 1102).

4.c. Impact of Women's' Experiences on Utilization of Skilled Birth Attendants

Participants indicated negative experiences of health care in hospitals is a reason why women do not return to deliver their children with a skilled attendant. The stories of women illustrate the poor quality of services available to them during pregnancy and childbirth. Women who access antenatal care during pregnancy are familiar with the obstacles within the health care system: bribery, overcrowding, and poor attitude from hospital staff. Those who reach a hospital in time for a safe delivery face the same, familiar obstacles to accessing care with a skilled attendant. A mother of two who delivered without a skilled attendant says, "We come here for help but they instead shout at us, abuse us, they ask for money yet not everyone is having money to give them. (FG 2) Her statement echoes the inequalities and the lack of understanding among policy

makers who encourage women to deliver with skilled attendants, yet fail to address these important issues that prevent women from getting the help they need and seek.

Having experience within the system, most women did not expect free and satisfactory services from a public hospital. Verbal and physical abuse, lack of patient care, and bribery made the health care experience a challenge for women in the formal system. Such an environment generated a sense of fear among the women of hospital staff. Most women expressed an understanding of the need to pay bribes, bring all materials and supplies necessary for delivery, and obey the instructions of hospital workers in order to receive kind treatment and some degree of attention and care. Stepping outside of bounds of these parameters put women at the mercy of hospital staff. Participants in the interviews and focus groups identified the number one way to enhance the services was to improve the attitude of the hospital staff. This was also the main reason participants gave as to why other women do not return to the hospital for delivery with a skilled attendant. The poor attitude of health care workers, limited patient care, and bribery all negatively affect the quality of care women receive. The treatment women receive at hospitals makes an impact on their opinions of health services and is an important indicator for improvement.

Outside the health facility, women lack decision-making power and resources to seek care independently at a hospital. Husbands enable a women's ability to pay for official and unofficial costs of medical care, transportation, and medical supplies necessary for delivery with a skilled attendant (Gabrysch & Campbell, 2009, p. 11-12). This study finds that women learn about the health needs during pregnancy during antenatal clinics, but must seek approval from her husband in order to access care during

childbirth. In cases where male involvement in health care was limited, women found more difficulties reaching appropriate care for the health facility. The husbands play an important role in encouraging women to attend health care services, but they are not likely to receive maternal health care information along with their wives at antenatal clinics. Transportation constraints and lack of independence and autonomy are the two most cited reasons for delivering without a skilled attendant among women's personal accounts of their last pregnancy.

Overall, the experiences in the system generate a poor reputation of services at the hospital. Though women who want to access to a skilled attendant who can assist them with their delivery, women must navigate the unpleasant experiences of being a patient within the formal health care system. Their obstacles within the system include overcrowding, bribery, verbal and physical abuse, and a lack of care. As a result, women do not feel welcome in the hospital environment where they seek to ensure the health of themselves and their newborn.

5.d. Responses of Skilled Attendants

The research participants' childbirth experience is largely shaped by those from whom they seek medical care. Although the objective of this research is not to demonize hospital workers, they have a negative reputation in Uganda as stories of negligence, bribery and harassment frequent national newspapers and radio programs. National outcry was trigged on September 20, 2011 by the story of Cecilia Nambozo who died during labour after she was left unattended at the hospital for failing to pay 300,00 shilling (Mafabi, 2011 Sept 20). Six doctors from Mbale's referral hospital were arrested

for charges of negligence. The Anti-Corruption Coalition of Uganda (ACCU) states that negligence can result in 10 years imprisonment, but women Members of Parliament demanded that the hospital staff be charged with murder (ACCU, 2012, online; Mubiri, 2011 Sept 20). Maternal health advocates in Uganda considered these measures to be an ineffective method of combating maternal mortality because punishing doctors and nurses ignores a larger systemic problem of health care in Uganda. Dr. Chamberlain, a Canadian obstetrician and Executive Director of Save the Mothers, states "the truth is that without the needed tools, even the most skilled obstetrician in the world cannot save a dying mother." (Chamberlain, 2011 Sept 22) Hospital workers in Uganda face serious consequences for corruption, and they have a lot to loose if they are caught. This puts skilled attendants in a precarious position, as they are required to save mothers without always having the necessary drugs and equipment to do so.

Given the women's negative views of hospital staff, I thought it was important to hear their views on the quality of care they administer to women seeking maternal health care. One does not have to look far to find some understanding behind the poor attitude and behaviour of hospital staff. In fact, some explanations lie in the limitations in their work environment. A lack of electricity, running water, proper supplies and drugs, malfunctioning equipment, few staff, and several patients creates unpleasant and, in some cases, dangerous circumstances for a mother and baby. The behaviour of staff as described by many of the participants, though inexcusable, could be attributable to their difficult working conditions. Even so, I wanted to hear the perspectives of the hospital staff who shape the experiences of pregnant women in health facilities and can speak to some institutional deficiencies of the hospital and health system. Several issues were

explained for their limitations as skilled attendants including working environment, human resources and workload, funding, and its overall impact on the provision of maternal health care.

5.d.i. Limitations of Skilled Birth Attendants

5d.i.1. Working Environment: Infrastructure

Discussions with the nurses were important in order to hear the staff's perspective on overcrowding and the limitations of their work environment. Two nurses graciously agreed to speak with me at the hospital. The first is the head of the Public Health department and is responsible for the maternal and child health departments. The second is a Midwife and Nursing Officer who supervises the midwives in the maternity ward. It was difficult to find spare time and a private space to conduct the interviews in the hospital, which led to discussions of the work environment. As the Public Health (PH) nurse and I walked down the main corridor of the hospital, she offered a historical perspective on the hospital after 30 years working in the district as a nurse. She said the hospital was built in 1968, but,

> The hospital has remained the same. We have not improved on the structure of the hospital. It has remained entirely the same. The same wards, and the capacity is the same. It was a 100-bed hospital, and it is remaining a 100-bed hospital." (PH Interview)

According to the Ministry of Health, district hospitals serve a population of 500,000 and the current population of the district is 568,000. The number of health facilities stands at 77 health centres of varying levels of service. Other health facilities in the district include Health Centres I, II, III and IV located at the Local Council, Parish Council, Sub-County Level and County levels respectively.

The hospital's maternity ward is also subject to constraint. The maternity ward is an open concept room with beds lined along the walls. Some beds have mosquito nets, while others do not. There are no curtains or partitions separating patients from each other. New mothers curl up next to their newborns with their belongings tucked away neatly below their bed. The delivery ward consists of 3 beds and no curtains offering privacy between them. A midwife-nursing officer (MNO) in the maternity ward explains the operational capacity and over-capacity of the maternity ward.

> We have a bed capacity of 24 beds, but we have 36 [patients]. It is a 24-bed ward. That's how it was constructed. But we go up to the extent of 36 or 40, because sometimes we get floor-cases. The occupation is 36 to 40, but by building, it is supposed to be 24-bed ward. (MNO)

"Floor cases" are cases where the mother does not have a bed. These situations of a mother delivering on the floor was confirmed by the new mothers who explained that overcrowding leaves some women no space on the beds. The public health nurses also explains the situation of overcrowding in the maternity ward whereby the demand for services outweighs the availability for beds. She says,

> You see, the capacity now even for the beds, there is supposed to be 25 only in the ward, and like in the private rooms there's supposed to be 6 beds. So, what we do is we put some others on the floor. That is to increase the capacity. (MNO interview)

At the time, the hospital was operating over its capacity. The solution to the high demand for services is to put some women on the floor during their visit. The lack of beds in the maternity ward is also reflective of a wider problem of the availability of beds in the district. Though there are 77 health units in the district, there are 682 beds among them (UBOS, 2010, p. 133). Out of these beds, government facilities within this district account for 100 beds and the rest belong to private not-for-profit hospitals (UBOS, 2010,

p. 133). It is difficult to find statistics on the number of maternity beds in the district. For this reason, reports of "floor cases" and operating beyond facility capacity are common across the country (Mwesigye, 2012 Apr 12).

The problem of overcapacity is an important issue for Uganda's health care system because the country's population has sky-rocketed in the past 50 years. Though early population growth figures could not be found for the district of Mukono, the population of Uganda grew from 8.5 million in 1968 to 33 million in 2010 (World Bank). This growth is not slowing down, as it is the world's third fastest growing population with a fertility rate of 6.9 children per woman (Sibbald, 2007, p. 245). The growing population has strained the capacity of the hospital, and the maintenance of the hospital has also fallen behind needs. She explains,

> All the systems, they are old. The hospital is built in 1968 and the system for water carriage and sewage system were installed in 1968 up to now. It is 2011. They have no been replaced... So it's the sewage system, the water and the electricity? On, off. On, off. On, off. So we have to use fuel to put on the power. Always very costly for the power... you can see? (she points to cracks in the concrete wall) This hospital has never been renovated.
>
> Like for my department, we don't have a data bank. Always we have to write. And, transport, we don't have a vehicle. Because like now I'm in public health, and we don't have a vehicle for the community health." (PH Interview)

This is not an uncommon state of public health facilities in Uganda. Crumbling hospitals and rural health centres are scattered throughout the country. Private hospitals in the capital city, Kampala, offer some privately funded services. After visiting the overcrowded and decrepit maternity ward in Kampala's national referral hospital in Kampala, Mulago hospital, my colleagues explained the top floor offers private maternity services that could rival Canadian or American hospitals. "It would be like stepping into

a Canadian hospital. It would be like going home," they explained to me. For the majority of the Uganda's population, hospitals that resemble those in Canada are simply out of reach because they are unaffordable and only located in Kampala.

Reports from hospitals elsewhere in the country paint a similar picture, but these accounts have more significant meanings beyond aesthetics of the facilities. Pregnancy and childbirth can also be considered indicators of public health, as women are located throughout the country and become pregnant throughout the year. Meeting the needs of women at the onset of labour becomes a test of how well the health care system functions. Functioning health systems "provide basic equipment, supplies and referral systems, financing and human resource organizations." (Bullough et al, 2005, p. 1181) The availability and functioning of these aspects of the health system will facilitate appropriate treatment of complications if they arise. Thus, maternal health is dependent on and sensitive to the functioning of health systems.

Indeed, maternal health care relies heavily on a well-functioning health care system. Health system performance has serious consequences for the quality of care a mother can receive in the hospital. The public health nurses explains the deficiencies in the infrastructure of hospital that prevent staff from offering services to those seeking or in need of care.

> We are supposed to go home visiting, but those are some of the weaknesses. We are supposed to do home visits, but if we do not have money, we do not go. There are lots of activities we cannot do if there is no money. We don't have transport.
>
> The labour ward... ok here we got some strength. Some donors gave us incubators. But now, the maternity ward is very squeezed. No privacy. Beds are not standard and they are few. Delivery beds, and on the wards. They are in poor state. They don't have lockers to keep their whatever. The toilets in the wards are broken. The water system now is not functioning. (PH Nurse)

At the time of research, electricity supplies throughout Uganda were not reliable. Power outages for hours or days at a time were a constant occurrence at the time. These power outages prevented normal operation for businesses, universities, NGOs and hospitals. A power deficit made way for load shedding, whereby the power was cut in one part of the grid to prevent a complete shutdown. Most public outrage was directed at Umeme, the biggest power distribution company in the country. Also contributing to the blackouts, newspapers reported that a fire at the sub-station in Mutundwe as well as the government's failure to pay its subsidies for power generators. Though there was confusion as to the exact source of power outages, most public outrage was directed at Umeme.

The frequent outages resulted in the loss of productivity in the manufacturing and business sectors, but the effect of these outages has unique and fatal consequences for hospitals across the country. The midwife explains the situation in the maternity ward of this hospital. She says,

> The load shedding whereby Umeme puts off the lights... The whole night there is no light. We use lamps. At the moment the generator is faulty, the whole night we are in darkness. Then, how are we to expect midwives to deliver in darkness and Umeme is off and the generator is spoiled. Sincerely. We have poor lighting systems. Some of us, our eyes in the dim light is giving us occupational hazards. (MNO interview)

Without consistent electricity, especially at night, midwives struggle to attend to their patients. Their ability to monitor women and assist them during childbirth is inhibited by the lack of lighting. The hospital cannot sanitize equipment for surgery without electricity, which prevent the staff from performing caesareans and attending to other

childbirth emergencies. This data suggests that the poor quality of care received by mothers can, in part, be attributed to neglected infrastructure in the hospital.

5d.i.2. Working Environment: Drugs and Medical Supplies

The new mothers spoke of bribes for supplies and equipment. Having delivered in the past 6 months, most of the women experienced a lack of drugs and/or supplies in the maternity ward. I wanted to ask the nurses about the stock of supplies. The Government of Uganda acknowledges the stock-outs of essential Reproductive Health medication are common and only 35% of facilities had no stock-outs of medications (Republic of Uganda, 2010, p. 87). I wanted to ask the hospital staff if and how the supplies of drugs and medicine affect their work. The public health nurse said, "Blood supplies, now they are there... Previously they have not always been there. But these days they are always there... I cannot tell you [why] but I can tell you they are there now." (PH Interview). The midwife also confirmed this statement of the full stock of supplies available in the maternity ward. She says,

> At the moment, the advantageous thing right now [is that] we have enough supplies of gloves, we have the Maama kit. That one helps. You give her Maama kit. There is a polythene paper, so you give her. At the moment, the surplus is okay. Drugs, we have enough drugs. The very few that we have, especially the emergency drugs, we have them. We have the Maama kit. We have enough drugs.... Since about.... It's coming to a year, we're having enough supplies.

Maama kits are a cost-effective measure to ensure that childbirth is conducted in a safe environment. They consist of the basic supplies required for childbirth including sterile gloves, plastic sheets, cord ligature, razor blades, tetracycline, cotton, soap and sanitary pads (WHO & Ministry of Health, 2004 p. 1). These kits were devised in response to the challenges of improving maternal health in low-resource settings, especially rural areas

where the majority of the population lives, as it was found women who did not bring supplies to facilities for childbirth would be discouraged from seeking life-saving medical attention available there. Various international aid organization and private companies in Uganda have supported the distribution of these Maama kits to hospitals around the country. The WHO and Ministry of Health state that the kits have helped reduce rates of sepsis (infection) in mothers, and helped improve the relationship between midwives and patients (2004, p. 18). According to the midwife, the stock of Maama kits is just short of demand. She says,

> The Maama kits we received on Monday, we received a few some months ago. Which were over. For instance these are the mama kits we received in august, we received 24 in October in November we received 20. And then on Monday we received 40.
>
> *If there is 270 women delivering a month, and there's 40 mama kits...*
> At the moment, they give us 60 per week. That is the average.
>
> *Is that enough?*
> Per month, that's 240. Which may not be enough, but it's close.

This exchange is confusing because of the dramatic shift in her answer. The midwife was insistent that they received a reasonable amount of Maama kits to meet the demand of mothers who seeks delivery at the hospital. Though she did not have her records on hand, she concludes that there is no severe shortage of Maama kits; however, her statement suggests that a shortage of medical supplies does exist. These responses that medical supplies are now available does not correspond to the responses from focus groups and interviews where participants claimed that they were asked to bring or pay for medical supplies. Further, the women explained that those without enough supplies could not be helped. Even though the nurses state medical supplies and drugs are now available and

have been available for the past year, the statements from the women who delivered in the past year conclude that they are not getting access to them. Whether drugs and medical supplies for pregnancies and childbirth are in the hospital or not, this data suggests that they are not accessible to women. This contradictory data also suggests that maternal health services fall short of women's expectations, but also suggests that the stories of women's access to medical supplies in a hospital is very different from the accounts given by staff. It highlights the importance of hearing women's voices in the field of improving maternal health to understand how exactly services are being rendered.

The impact of these limitations has direct influence on women's experiences of childbirth in the hospital. The midwife draws the connection between the limitations, rude staff, and quality of care. She says,

> Because of the limitations, and our overwhelming work, there are some staff who are rude to [the women]. That is what I have observed. And the quality care, they don't get it... For instance, it's a topography [that is used] to monitor a mother. But you when you admit a mother you may find because of the overwhelming work, we are monitoring another mother and another mother. So the topograph does not go to where it is supposed to go. To monitor this mother after two hours, or every four hours, like that. Because quality care. And what you have realised also there are midwives who say, 'What can we do? Let's perform what we can. What we can't perform, we leave it." (Midwife, interview)

The nurses were able to explain some of the limitations from the lack of medical equipment available in the maternity ward. The impact of the working environment has serious effects on the quality of maternal health care that women receive. The midwife explains,

> If I am skilful, than I need to work in the maternity ward with all the facilities I need – resuscitation, enough equipment, enough beds with privacy, you see? Where I can sit if the workload is too high. At least where I can sit and monitor my mother. Where I can have a fetoscope to monitor, the electronic fetoscope. A good

> working environment. That one would boost me. Though there is workload, if all those things are there, it would be okay.

The challenges of shortages on medical supplies and poor infrastructure limit a skilled birth attendant's ability to monitor a woman through labour and apply necessary interventions to assist her through the childbirth. This insight is confirmed by others in the field of maternal health who note the vital relationship between skilled birth attendants and an enabling work environment (Bullough et al, 2005; Sundari, 1992). A skilled person who does not have the tools and supplies to perform interventions is limited in how they can help a woman. This disabling work environment limits the ability of skilled birth attendants from applying their skills to assist a woman in labour. Overall, this compromises the quality of care a woman receives, and the ability of a skilled birth attendant to properly monitor and attend the childbirth in a hospital setting.

5d.i.3. Working Environment: Human Resources and Workload

Every time I visited the hospital, not once did I see any nurse or doctor sitting down doing nothing. Always on their feet, the nurses and midwives were engaged with the women conducting antenatal clinics, administering drugs, doing check-ups, or assisting with the births. Somehow, they managed to allocate some time for an interview with me at the hospital. Both interviews were held in a small and quite office to bide time away from the hectic pace of the maternity ward; but the room did not stop us from being disturbed. There was a knock on the door a few times from other nurses looking for the assistance and guidance of the midwife and public heath nurse. Additionally, the nurses were pressed for time as the needs of the ward did not stop for the sake of my interview.

Based on the busy work environment, and the discussions with the mothers about overcrowding, I was not surprised to hear from the nurses that lack of staff and workload were important limitations for their work. The midwife explains that the challenges of the hospital go beyond infrastructure problems. She adds to some of the weaknesses noting the lack of human resources affects the ability of staff to attend to all patients. She says,

> There are few midwives, as compared to the capacity. So we have a workload, and the quality suffers... whereby you find a mother is being monitored by one midwife. You concentrate on one mother, but you have others apart from her (about 4) that you are managing in labour. So we have some limitations of that kind. (MNO, interview)

The public health nurse confirms her statement. Though she did not know why, she says that additional staff has not been recruited to accompany the expansion of people using the services and leads to burn out.

> The workload is overwhelming. Because the facilities was 100-bed. It has not yet expanded. And the workload again is overwhelming. So the midwives at the end of the day they get burn out. (PH nurse, interview)

"Burn out" was a phrase commonly used by the nurses. The hospital staff do what they can to accompany the overwhelming numbers. When asked how the staff cope with the capacity, the public health nurse says, "The health workers, they have to squeeze them. They try, they try. That's why I say they have to burn out. They overwork." (Interview) The midwife expressed the same sense of frustration to the number of patients in needs of care. When asked how they cope with the overcrowding, she answered,

> It is a kind of crisis. We do it because we need to help the mothers. But also we get a burned out. Copping out it is only certain things that have not been done. You see the emergencies at that time, and then maybe you even document when you work on the mother, she delivers. Or if it is treatment she is treated, and then you move on. But... the capacity is overwhelming. (MNO interview)

This crisis has become the norm in maternity wards across the country. Midwives at this hospital have some techniques to deal with constant flow of mothers in need of assistance.

> What we do, if we are one midwife because midwifery is a two-nurses procedure. But you may find you are in labour ward alone. What you do is you put on gloves, two pairs, so that when another mother is delivering... okay you deliver this mother tie the cord tightly or you clamp the cord. You remove the gloves, put on other gloves and you deliver. (MNO, interview)

In some cases, they ask for assistance from other departments to help in the maternity ward, too. She says,

> If there is need more [patients] than expected, we always call on from other departments to help us. But you may find that you always call them from antenatal but antenatal is also a busy unit... So we always say that at least you can do what you can, then if you expect you do more than that. We call on others to assist. (MNO interview)

This data suggests that staff have some methods to help cope with the high number of patients and low numbers of staff to assist them.

Nevertheless, the midwife explains these methods are not enough. She says, "There are all these limitations are sort of a burden. Limitations are felt by the midwives who cannot do their job because of the work environment and the overwhelming capacity." (MNO, interview) The lack of staff at this hospital can be linked to women's accounts of lack of attention during delivery. The lack of staff can also inhibit the ability of the supervisors to monitor the behaviour and conduct of subordinate staff. The ability of one midwife to monitor the occurrence of bribes and rude conduct, and to apply various approaches to address these problems, is also limited.

Staff have a direct influence on a women's experience in the hospital, but the lack of staff creates a constant state of crisis in the maternity ward. The Joint Learning

Initiative established the connection between adequate staffing levels and good health care outcomes. This Initiative measured health outcomes and the number of health workers in the population, finding that countries need at least 2.5 health workers per 1,000 population for minimal health care coverage (Chen et al, 2004, p. 1985). This case of staff shortage is not unique to Mukono district. Human resources in health facilities are low across the country. In Uganda, ratio of health workers (doctors, nurses, and midwives) to patients is 1:1,818, far below the recommended WHO minimum of 1:439 (Republic of Ugnada, 2010, p. 20). With 990,000 women becoming pregnant every year and only 15,184 trained midwives in the country, there are serious limitations in the capacity of skilled birth attendants (Murigi and Ford, 2010 Mar 30) The effect of low staff on health is expressed by Dr. Michael Oscinde from the referral hospital in the neighbouring direct of Jinja. He says, "Monitoring or delivering more than one woman at a time is prone to inefficiency, high risk and mistakes yet this is what happens." (Wanyera, 2011 Jun 16). One skilled attendant can only do so much, be in one place at a time, and relies on the availability of her coworkers to offer assistance when needed.

It is clear that more midwives, doctors and nurses are needed to provide adequate care for a mother during delivery. Before recruiting more staff at the hospital can be addressed, there remains a challenge for retaining the little staff they have. The midwife explains that remuneration in Uganda is very little, leading to lack of motivation for staff. Their jobs are connected to other areas of their lives, including finding a good home and sending their children to good schools. The midwife explains that even dedicated, hard-working staff struggle to make ends meet at home, some having to take up jobs outside their health care profession to supplement their income.

> I love my job, though with the limitations which would make me to have a different mind. For in the first case even the pay itself in Uganda is little. To compare to what you perform. Even if you fill out an appraisal form, and then your supervisor says well done. There is no increase in what you are paid. If it could be that what you do is also valued, even in form of allowances, or in form of motivation, which can push me on. By the end of the month, you get little money. Compared to the economic status. Then you have to make sure that at least you make ends meet elsewhere because most midwives do not depend on only salary here. They are either farmers and they supply the markets with foodstuffs. Others are in business, then they can also to meet their level of expectation because all our children to go to better schools. You need to live in a good house. You have to have land... And also, by the end of the 60 years at retirement there should be something tangible that you have gained out of it.

This nurse expresses that allowances and payment are considered to be an important motivation for the work they do in the maternity ward, but low wages for health workers in Uganda do not meet daily living costs (VSO, 2010, p. 7). The average monthly pay for nurses and midwives in Uganda during 2009/2010 was 353,887 Ugandan shillings (US$191), 657.490 UGX (US$354) for a medical officer and 840,749 UGX (US$453) for a senior medical officer. Compared to high court judges who receive 6.8 million Ugandan shillings (US$3,664) per month, health worker salary is not thought to be financially satisfying (Nguyen et al, 2008, p. 8). Uganda was found to have the lowest wages for nurses within a comparable set of sub-Saharan countries (Nguyen et al, 2008, p. 8). This low wage not only makes it difficult to cover one's own daily living expenses, but there are extended families to support. These worries about finances can "add to the stresses of long hours and little rest, the burden of too many patients, and the frustrations of not enough medical supplies or the lack of appreciation in the workplace." (VSO, 2010, p. 7) This data is an important reminder that health care workers are struggling to make ends meet in their personal lives, as well as their workplace.

An important part of departure from the discussion of remuneration for services is the topic of bribery. During interviews and focus group discussions, women drew the connection between medical attention and bribery. They explained that bribes were asked in exchange of medical supplies, delivery beds, or medical attention. Since bribes were brought up by many of the new mothers, I wanted to inquire the occurrence of bribery from the staff's perspective. According to the midwifes, bribes are not a severe problem at the hospital. She says,

> At the moment, [bribery] is not so common, especially during this time where government has got an intervention in corruption. It is not so common. And then too, the community itself has already had a corrupted mind because [the hospital] used to ask money from them. There are those who can say no, so that I can give you so much. But if you find someone who is sensitive and at the same time has genuine things. You say, but surely, rendering a service -is it quantifying the service to the money you want to give me? Surely, to the extent of somebody's life? I don't think. So some mothers say thank you very much. There are those who are genuine who say thank you very much. Since the intervention of government especially in government institutions such as this and they carry out what they call anti-corruption, it is not so common. And when they see the problem in the community they say, "We go there for gloves. You don't expect a midwife to deliver a child barehanded." So they tell them [in the community] to bring gloves. Those who used to come without gloves they go to the shops and by them. But sometimes it's challenging when it is in second stage [of delivery]. But now it is not so common.
>
> *How do you monitor that?*
>
> Yea, being a supervisor I monitor. Because one, we have enough supplies. Enough. Or maybe there are stock-outs where maybe we find we don't have certain things. Btu we have Grade A [pharmacy] which is in operation. So as a supervisor you have to be very careful at whatever others do.
>
> You can know. And it's very easy. Because you're everywhere, you are going everywhere.

This section of interview lacks clarity, but my sense of her response during the interview is that bribery is not common, although some women give money to staff as a token of appreciation. The hospitals' actions against corruption and bribery are vague. The

midwife recognizes there was once a problem, but not any more, although women who offer money as a sign of gratitude is welcome. This data suggests that money is exchanged in an informal and unpredictable way. More significantly, this data is contradictory to the stories shared by women using the services who insisted that they were asked for money in exchange for medicine, attention, and a delivery bed during their childbirth experience in the hospital. Considering the study by McPake et al (1999) that states most health workers in Uganda levy informal charges in exchange for medicine or medical care, it is possible that there is a potential for 'respondent bias' in which the midwife is stating what she believes to be the 'correct' or appropriate answer.

The staff do not divulge information on the occurrence of bribes as openly as some of the new mothers. Drawing on literature, some studies have indicated that bribes are elicited at the facility-level by individual staff in exchange for salaries. Hunt (2010) states, "public sector bribery represents a facility-level extortion policy to raise revenue from patients exempted from payment by government policy. This suggests that well-intentioned policies to reduce healthcare fees for the poor may be thwarted by health workers seeking to supplement their own income" (p. 700). Though data from my research cannot draw this conclusion, the connection between poor remuneration and demanding bribes from patients is a common problem in the country.

The impact of staff shortages, heavy workload and low wages has an effect on the experiences of childbirth in a hospital. The lack of supplies, working equipment and functional infrastructure can affect the care that staff are able to give to a woman. This data suggests that women's experience in childbirth is connected to structural and institutional issues that surround health care workers who are expected to save their lives.

Their health care providers are given inadequate pay, unreliable access to medications and malfunctioning equipment, and a poor working environment. The limitations of the midwives mean that each women's quality of care is compromised or neglected. How can women be encouraged to deliver in health facilities that lack basic equipment, supplies, and motivated staff?

5d.i.4. Funding and Donors

The nurses briefly discussed funding and donors during the interviews. Their knowledge on the impact of funding on the operations of the maternity ward are limited, and the data from these interviews is not extensive enough to be conclusive as it was it not triangulated in the field; however, a discussion on funding can help lend some understanding towards the state of maternal health care at the hospital and across Uganda.

The government is the main funder of this hospital and public health facilities in Uganda (PH Interview). As discussed in Chapter Three, Uganda's ability to implement its maternal health policies are not sufficiently reinforced by financial commitments and implementation strategies. Uganda has consistently fallen short of providing enough funding for a functioning public health system across the country. In 2009, Uganda spent 8.2% of its GDP on health, short of the commitments outlined in the Alma Ata Declaration that state at least 15% of national GDP should be spent on health (WHO, 2012d, para. 1). As a result of the small health care budget, health care infrastructure remains poor, equipment is old or broken, health worker vacancies are found across the country, access to health facilities is limited, and deliveries with skilled attendants in health facilities is low.

The Ugandan government contributes only 25% of total health expenditure (WHO, 2009, p. 114). Uganda's small health care budget is one of the reasons why foreign donors have played a large role in the health care system. The government's failure to provide comprehensive and universal health care provision has left "growing gaps to be filled by the profit and non-profit sector" (Verheul and Rowson, 2002, p. 392). This has made donor coordination one of the major roles of the Ministry of Health in Kampala. As explained by the midwife, all donors are coordinated at the Ministry of Health. She says,

> Mostly things are done by government, though we are also implementers of the policies they put in place. Even the energy has to come through Ministry of Health. If I have a friend who is supportive of this place, it may not be direct. It must come through the ministry of health to help the midwives. It is very hard because mostly it is the administrators who can decide (MNO, interview).

An example of donor interests and funding for health was expressed by the public health nurse. She explains there are currently no partners for maternal health needs at the hospital.

> There are some partners, who fund some activities of their interest. Like they fund HIV, whatever. PMCT [Prevention of Mother to Child Transmission]. There are some partners in health. At the district-level, there are some partners who are interested in funding children's health. World Vision. Some few partners.
>
> *Is there any partner who is interested in maternal health?*
> None at the moment, except that one who does the PMCT.
>
> *Who is the key partner for PMCT?*
> I think that one is PEPFAR [President's Emergency Plan for AIDs Relief]. (PH Nurse)

There is not enough data from this research to conclusively state that funding and donors do not favour maternal health because it could not be triangulated in the field; however, this data adds to the growing body of literature stating that funding partners and donors can influence the services and equipment that are provided at the hospital and at the

district level. Policy makers in developing countries often have a number of issues to address and limited resources to deal with them. Health initiatives find themselves in competition for attention and scare resources which have led to rationing of services and prioritizing health targets and initiatives. As a result, preventable death, such as maternal death, remain a major challenge for developing countries (Magnussen et al, 2004).

Advocates for maternal health are frustrated with the neglect of maternal health funding in the global health agenda. Well-intentioned international donors fund projects of their own interests, sometimes using a cost-benefit analysis fuelled "by a growing sense that more lives would be saved by fighting other, cheaper diseases." (McNeil, 2010, May 10) The major criticisms of such selected approaches to health are summed up by Magnussen et al (2004) who say, "although one disease might be controlled or eliminated, recipients of that intervention might die of another disease or its complications" (p. 167). Project-based funding from donors created "islands of better resources programmes and services" (Standing, 2002, p. 22). Unfortunately, maternal health has not benefited from sustained international funding. For instance, the WHO's assessment of the maternal health supplies and medications in Uganda attributes some of the storages to a lack of international donor support. It states, "Unlike family planning, donors have not provided dedicated, sustained and large-scale funding for maternal health supplies in Uganda" (Madison et al, 2010, p. 6).

Uganda's health care system is a perfect example of this as the country receives more money from PEPFAR for HIV/AIDS programs alone than exceeds their entire health budget (Villadsen, 2009 Oct 9). These funding allocations translate directly into the reality on the ground for women seeking maternal health care. For instance, men can

access male circumcision – an approach to reducing HIV/AIDS transmission that shows some benefit to decreasing men's susceptibility to infection – for free because it has sustained international support. It is advertised nationally on radio campaigns and billboards, is allocated additional staff, and time in the operating theatre (Chamberlain, 2012 May 14). This means that women requiring caesareans must wait for time in the operating theatre and cover its cost in full because other procedures are given a higher priority in the limited space.

Impact on women's experiences in facility-based childbirth

Women suffer the effects of the limitation of the health care system. Cost-effective measures to improve some health statistics over others do little to address the institutional and infrastructural limitations of maternal health care such as improved infrastructure, maternity wards and operations theatres that have reliable supplies of electricity and water, a steady flow of accessible drugs and medical supplies, and adequate presence of motivated skilled birth attendants. Women seeking safe pregnancies and childbirth need physical and financial access to health facilities that are adequately equipped with staff, medicines, supplies, and working equipment. A number of obstacles stand in the way of a woman receiving adequate care at a health facility including lack of life-saving equipment, skilled personnel, and functioning patient management (Ronsmans and Graham, 2006, Sundari, 1992).

Conclusion: Responses of Health Staff

This section shows that health care staff are part of a bigger institutional structure of the national health care system. The interviews with hospital staff help make the connection between limited resources in the hospital and limited amount of time and care they can

provide to the patients. Their interviews helped reveal a connection between limited resources in the hospital and limited amount of time and care they can provide to the patients. The efforts of the hospital staff in the maternity ward are constantly stretched beyond their limit and cannot make up for the structural issues that remain in the public health delivery. These structural issues include poor infrastructure, lack of functional equipment and supplies, staff shortages, an overwhelming workload, poor remuneration for staff, and little avenues for motivation.

4.e. Who is responsible?

Women and families

The stories of women shed light on the conditions of maternal health care services and the obstacles for accessing a skilled attendant for delivery. It is important to establish that most of the women recognized some benefits of delivering with a skilled attendant such as health care information, monitoring of foetal development, or healthy pregnancy outcomes. Recognition of these benefits of maternal health care does not translate into skilled attendance for delivery. Instead, women face a series of obstacles to reaching skilled attendants at the onset of labour. Those who did not deliver with a skilled attendant did so for a reason. Their most common reasons were time constraints, distance problems, few transportations options, or lack of autonomy in health care decisions. A women who delivered at home summarises this predicament stating, "It's not our own decision to deliver from home but because of the situation we are passing through and you have no option" (FG2). The stories of women who did not deliver with a skilled attendant emphasize that the barriers to accessing health facilities are difficult or impossible to overcome when the services are needed.

These experiences of maternal health care emphasize the various factors that are beyond a women's control will determine her access to and utilization of a skilled birth attendant. The barriers to accessing a health facility in time for delivery tell us that many women are simply unable to deliver with a skilled attendant. These findings can be linked to other researchers in the maternal health field who conclude various physical, social and economic barriers to health care contribute to maternal health mortality and morbidity (Thaddeus and Maine, 1994; Kyomuhendo, 2003; Parkhurst et al, 2006; Parkhurst and Campbell, 2009). All these barriers limit women's access to skilled birth attendants, and overall, their choices for delivery are limited to traditional birth attendants, a friend or relative, or at home alone (Knudson, 2003). Further, these barriers tell us that social determinant of health, such as women's status, limited resources, and socio-economic status play a large role in determining a woman's place of delivery. Pregnant women do not operate independently, but are dependent on a number of external factors to help facilitate their health care choices for a skilled birth attendant.

Their stories have serious implications for health's instrumental and intrinsic contribution to development. First, a woman's inability to access a skilled birth attendant for delivery compromises her pregnancy outcomes. This inability to access formal health care compromises maternal health outcomes, placing a mother and baby at risk for death or disability because she cannot access appropriate medical care in a timely manner. These barriers help explain the high rates of maternal mortality in Uganda effecting the overall economic development of Uganda. As noted in the literature review, Ugandan women play important roles in their families and communities as mothers, teachers, primary care givers for children and the elderly, sole breadwinners and entrepreneurs.

Treatment for disabilities or death takes time away from contributions to work and family care, threatening to drive women and their families deeper into poverty. More importantly, there is an intrinsic value of a woman's health as an important end in itself. A woman at risk for mortality or morbidity during pregnancy and childbirth due to inaccessible health care diminishes her quality of life.

Secondly, women's experiences reveal a series of obstacles reaching health facilities and acquiring skilled attendance for delivery in hospitals. The data suggests that women cannot translate their own health care choices into reality. Women lack agency in their health care decisions because a women's desire to deliver with a skilled birth attendant at a health facility is sometimes not fulfilled. Women in Uganda lack control or choice of where they will deliver their child, as well as the quality of care they receive during the delivery. The efforts of these individual women and their families are unable to challenge the multiple barriers to quality maternal health care. At the individual level, women alone cannot be responsible for failing to reach health facilities that are physically and economically inaccessible. It suggests that changing individual behaviours, such as encouraging more women to deliver with a skilled attendant, does not translate into more women delivering in health facilities. Instead, these barriers pose collective challenges to accessing and navigating the public health system.

Finally, the major contribution of this thesis lies within women's experiences of maternal health care. Women's experiences of maternal care force us to look beyond health statistics and pregnancy outcomes to reveal the internal dynamics of health facilities. Women's stories and experiences of maternal health care are marked by bribery in exchange for care, neglect of health needs, a lack of sympathy and empathy, as well as

verbal coercion and physical abuse. The relational aspects of medical care provided in health facilities have important impacts on clients of maternal health care. As expressed by the participants, the poor quality of care received at hospitals is a major reason women do not deliver their children in health facilities. This is an important indication that the health care offered to reduce maternal mortality is unacceptable to its potential clients. Further, this research helps understand the underutilization of skilled birth attendants for delivery in comparison to antenatal care (Cook, 2003). Time constraints and few transportation options pose greater challenges to a woman in labour than a pregnant woman who can make plans and arrangements to attend antenatal clinics. Participants who endured the system experienced neglect, abuse and exclusion from hospital staff. Although women who access skilled birth attendants at health facilities are more likely to have positive pregnancy outcomes, their experiences of health care create and reinforce poverty (Freedman, 2005). The women experience maternal care in government hospitals that is dehumanizing and coercive. These relational aspects of maternal care point to the structure of health care provided and the health care system in which these services are offered.

Woman and families cannot be held solely accountable for inaccessible health centres, lack of transportation options, and poor quality of care offered at health centres. A woman cannot be responsible for her health when she relies on her husband to make the health care decisions or make payments for costs associated with a safe hospital delivery. A woman cannot be responsible for accessing a hospital for delivery when there are few safe and reliable transportation options in her community. These barriers to care threaten the health and safety of pregnant women and their newborns.

Health care system, health providers, and society

Although the government and international organizations acknowledge the importance of skilled attendants for maternal health, the public health care system falls short of meeting the needs of women using the system. Women's experiences of health services during pregnancy and childbirth reveal systemic problems of maternal health care. Their stories contribute to health system analyses of health services that reveal "the extent to which services are available, accessible, acceptable, and of the highest possible quality" (van den Broek & Graham, 2009, p. 19). The data for this thesis, women's experiences in hospitals, tell us these services are inaccessible, unacceptable to clients, and poor quality.

The stories of women who delivered with a skilled attendant, and participants who shared stories of other women who did, not emphasised the barriers to receiving care within health facilities. These barriers to care included overcrowding, bribery and medical costs, and rude or insensitive staff. Their experiences of health facilities bring to light the poor quality of care they receive. A mother of two who delivered without a skilled attendant says, "We come here for help but they instead shout at us, abuse us, they ask for money yet not everyone is having money to give them" (FG 2). Many of the women shared their stories and experiences with anger at the treatment they receive at the hands of medical staff. These stories reveal the internal dynamics of health care facilities whereby women are faced with obstacles to receiving help and poor quality of maternal care. They explained that several women in their communities do not seek care at health facilities because of the poor quality of care offered there. Taking place in a public hospital that caters to the rural, poor communities, these interviews and focus groups shed light on the poor quality of maternal health care available to the majority of

Uganda's population. One study finds the facility-based maternal death rate to be as high as 671/100,000 live births, much higher than the national average (Mboyne et al, 2010, p. 289). This high mortality rate indicates a problem with the quality of care women receive once they reach health facilities is common in facilities across the country.

Uganda's health care providers often shoulder the responsibility of the poor maternal health care provided to women in health facilities. Indeed, health care workers shape women's experiences at the hospital, but staff face constant exhaustion and burn-out being over-worked and under-paid. The stories of health care providers reveal the systemic problems in providing quality maternal health care to their clients. Statements from nurses draw our attention to their poor working environment that lacks running water and reliable electricity, functioning equipment, as well as adequate levels of trained and motivated staff. Though there is no excuse for their poor treatment of clients, their working environment limits their ability to provide quality maternal care to their clients. Hospital personnel are few and overloaded with other activities that take time away from caring for mothers. Health facilities and medical equipment are old and mal-functioning. Salaries and work conditions are very poor. Hospital staff do what they can to make ends meet in an over-crowded and under-funded hospital, but the limitations of their ever-demanding work environment makes it difficult for trained midwives, nurses and doctors to do their jobs with skill and empathy. Their coping strategies in a poor work environment do little to encourage women to use the services that are essential for maternal and newborn health.

Uganda's method of addressing poor maternal health care misses the point on improving the health of mothers across the country. In September 2011, Uganda's

national newspaper reported that two medical officers were arrested for charges of negligence leading to the maternal death of two women at a hospital in Mbale district (Koytalengerire, 2012 Mar 8). Placing the burden of blame on hospital staff, we miss the broader, structural issues that lead to maternal deaths. Some of these structural issues include functioning health facilities with working equipment, drug supplies, and sufficient and motivated staff. Without functioning health facilities, health workers will be limited in the quality of care they can provide to pregnant women and new mothers. Without enough skilled birth attendants, health facilities will be unable to meet the demand for maternal health care.

Government and Policy

As part of the public health care system, this hospital is the site of Uganda's public health care policies in practice. Uganda has provided a conducive policy environment that involves various stakeholders including a number of government ministries, private health care providers and NGOs; however, there is vast irregularity and gaps regarding the extent to which various policies, especially those concerning maternal health, are implemented across the country. Stakeholders are in agreement that the gap between high antenatal care rates and low facility-based deliveries is "a priority for Uganda's maternal health program." (Madson et al, 2010, p. 5) The National Health Policies states a goal to increase the number of women who deliver in health facilities from 40 to 60 per cent (Republic of Uganda, 2010, p. 86-87). The plans also include targets to increase the contraceptive prevalence rates, the supplies of life-saving medication, and improvements to basic obstetric care coverage. The preliminary findings of the latest health survey state that 59% of women accessed a skilled attendant for their last delivery, a major

improvement from five years ago. Looking at these health policies and statistics alone, it would appear Uganda is committed to toward improving maternal health, but the voices of women tell us there exists an obvious gap within the stated goals of the public health system and its ability to deliver them.

The government's approach to health fails to acknowledge that women's experiences of childbirth are shaped by a variety of factors beyond their control. The National Health Sector Strategic Policy states, "The responsibility for health primarily lies with individuals, households and communities" (Republic of Uganda, 2012, p. 93). This research points out that women are aware of the benefits of the skilled birth attendants and facility-based deliveries, but the women's stories reveal multiple barriers beyond their control that prevent them from practicing safe deliveries. These barriers include a lack of autonomy over health decisions, physically inaccessible health facilities, unreliable and unsafe transportation options, informal medical costs in the form of bribes and purchasing of medical supplies, dealing with unpleasant hospital staff, and overcrowding. Their stories tell us that the demand for quality maternal health care is not provided to women to seek it. How can individuals and communities be responsible to their health when health facilities are inaccessible and quality of care is unacceptable?

The shortage of skilled birth attendants and poor quality of care is not the responsibility of women who use the services, but of the Ministry of Health and local governments who manage health care in their district. The Health Sector Strategic Plan tells us various organizations are responsible for the delivery of health care. For instance, the recruitment of staff in district hospitals is the responsibility of the local district government (Republic of Uganda, 2010, p. 111). Further, the policy states that the

Ministry of Health is responsible for "the setting of standards and quality assurance" (Republic of Uganda, 2010, p. 3). The National Drug Policy is responsible for "ensuring the availability and accessibility at all times of adequate quantities of affordable, efficacious, safe, and good quality essential medicines and health supplies (Republic of Uganda, 2010, p. 21). Finally, plans for the repair and renovation of health infrastructure are currently being redrafted under the National Medical Policy and Guidelines, but inadequate staffing and funding to manage and maintain infrastructure remain serious challenges for implementing these policies. These policies allocate responsibility for providing quality maternal health care primarily lies with the government.

Though the government seeks to encourage more women to deliver in a health facility in policies, hospitals such as this struggle to encourage their patients to return to health facilities for the delivery of their child given the limitations of the facilities and hospital staff. The experiences of women in this project point out that poor hospital conditions strip women of dignity and respect, and access to quality maternal health care for poor and rural women remains a huge area of improvement in the public health system. Their stories explain that multiple barriers exist for women wanting safe pregnancies. Therefore, improving one area of maternal health care, such as physical access, will not necessarily improve utilization of services. Acceptability of services was another important aspect of maternal health care that affects the use of skilled birth attendants, but improving the quality of care provided in health facilities will not make them physically accessible to pregnant women. Therefore, cost-effective measures that target one area of maternal health will fail to improve overall maternal health status and pregnancy outcomes.

The needs are clear and ever-present, but the Government of Uganda falls deaf to the maternal health needs of women. Despite 65 percent of health worker positions unfilled across the country, the Ugandan parliament failed to reallocate part of the government's budget to hire more doctors, nurses and midwives in October, 2011(IRIN, 2011 Oct 27). The failure to reallocate much-needed funding for human resources in the health sector angered maternal health advocates who point out that a lack of trained birth attendants is a key reason about 16 women die everyday in Uganda. Sam Lyomoki is the chairman of the social services committee states, "I know we shall access this money over time. Of course, as we wait, we lose more mothers." (IRIN, 2011, Oct 27). Further, there is an unmet national need for Reproductive Health Supplies represents the single largest unmet need for medicines and supplies in the 2010/2011 budget. This means that skilled birth attendants may not have access to affordable drugs and supplies for women who seek safe deliveries in health facilities. Finally, inadequate funding for improved infrastructure means that staff and clients will have unreliable access to fully functioning health facilities the offer quality maternal health care.

f. Conclusion: Experiences of Women in Maternal Health Care

This data reveals the lived-reality for women seeking safe pregnancies in Uganda. Though Uganda's maternal mortality statistics show that maternal health is improving, women's experiences tell a different story. The dynamics of health facilities create several barriers to receiving quality care. The current state of public health facilities compromise the care a woman receives throughout her pregnancy and during delivery. Their experiences are the result of a poorly functioning public healthcare system in which

skilled birth attendants are poorly paid, unmotivated and lack necessary equipment and resources to administer life-saving medical interventions for women and their newborns. This leaves one of Uganda's most vulnerable groups, pregnant women, with few places to turn to for quality health care at the time of their labour.

The key findings of this study are based on the priorities of the research participants. The opinions of these women point to maternal healthcare services that are accountable to them. The injustices of the healthcare system, as explained by the women, are the series of barriers they face in the hospitals where they seek help and from the skilled birth attendants from whom they receive care. These barriers ultimately prolong their suffering and that of their newborns. Eliminating rude staff, ensuring drugs and medical supplies are available for their delivery, and receiving medical care and attention without bribery were some important ways their maternal health care could be improved.

Women seek maternal health services in health facilities because it offers them and their newborns the best chance of a healthy childbirth. Their priorities emphasize that women are not looking for alternative sources for maternal healthcare. Instead, women wanted better care from health facilities. The women who participated in the interviews and focus groups discussed the importance of receiving good quality maternal health care that upholds their dignity and respect. Good quality maternal care not only offers safe and effective services to treat complications and ensure good pregnancy outcomes. It also includes providing services that are acceptable to potential users. Ideally, the experience of good maternal health care should be readily accessible, safe, effective and acceptable to patients and staff. Good quality maternal health care should provide comprehensive care, or linkages to other reproductive health services. It should provide a continuity of

care where staff are helpful, respectful and non-judgmental. This research reveals that most women in Uganda do not have physical or economic access to good quality maternal healthcare.

In a country that fails to provide well-functioning health facilities, women's experiences with maternal health care reveal the appalling state of maternal health in Uganda. Eliminating physical barriers that lead women to maternal health care will not improve utilization of skilled birth attendants if negative aspects of care remain unaddressed. These negative experiences in heath facilities do little to encourage them to use skilled attendants for delivery and explain the underutilization of skilled birth attendants in Uganda. Ultimately, women using maternal health services bare the brunt of the system that fails to meet their needs during pregnancy and childbirth. Maternal healthcare services are remain the responsibility of the government who must eliminate physical and economic barriers to maternal health care for Ugandan women. Therefore, the government, health ministries and local governments must provide maternal health services are acceptable and represent the best possible care of mothers, and their newborns, in Uganda.

CHAPTER SIX: CONCLUSION

6.a. Discussion and Conclusion:

This thesis set out to explore the reality of maternal health services in an effort to understand women's low utilization of skilled birth attendants in Uganda. The research question that guided this study is what are the reasons for, and basis of, women's behaviour regarding the low utilization level of skilled birth attendants in Uganda? The answers were sought from the very women who are encouraged to use skilled birth attendants. First, literature surrounding health and development, maternal mortality, and strategies to improve maternal health was examined. Second, the creation and structure of Uganda's health care system and provision of maternal health services was studied. This overview, outlined in chapter four, was necessary to understand the broad context of women's experiences of health care services. Finally, women's narratives of their experiences with maternal health care were investigated including their obstacles to accessing health facilities, the circumstances that led up to their place of delivery, and their experiences within health care facilities.

Literature on health, gender and development explains that women play important roles in their communities as mothers, wives, teachers, sole breadwinners and caregivers of the young, elderly and sick. Their health needs, however, are often neglected due to a mix of gender norms, social expectations, cultural traditions, and a lack of political and economic power. As a result of this neglect, high rates of maternal mortality are common in developing countries where the status of women is low. Strategies to reduce maternal health are concentrated on the provision and utilization of health services such as skilled

birth attendants, antenatal care, and emergency obstetric care. These health services can treat pregnancy complications and ensure a safe delivery. For this reason, maternal health is dependent on a functioning health care system that is accessible, affordable and acceptable to women across the country. Barriers to accessing this care include economic feasibility, physical accessibility, and socio-cultural expectations. These barriers affect utilization of maternal health care, but literature does not explain the patterns of utilization in Uganda where over 90% of mothers access antenatal care, but less than half return to health facilities to deliver with a skilled attendant.

Uganda's history of health care, health policies and the structure of the health care system provide context for the women's experiences of these services. Health care in Uganda was structured on a curative system that catered to urban areas and townships. Though services expanded after Independence in 1962, the civil war lasting 15 years deteriorated much of the health care systems and policy formation. Uganda has enjoyed stabled economic growth since the end of the war in 1985, but the country struggles to create a public health care system that meets the needs of the population. Specifically, the government struggles to garner the will and funding to support maternal health care services. The lack of funding to strengthen public health care provision is part of the reason why maternal health statistics have failed to improve.

Maternal health statistics show that maternal mortality rates and as the percentage of deliveries with a skilled attendant are improving, but access, utilization and quality of care remain important barriers to life-saving care in many regions. Uganda's national health policies make commitments to improve services for maternal health care, but women's narratives explain how maternal health care is provided to them. The

significance of women's stories is that they provide a more complete picture of the state of maternal health services in Uganda and the reasons behind the patterns of utilization.

The research provides insight into the low utilization of skilled birth attendants. It has shown that the low utilization of skilled birth attendants is due to multiple barriers that prevent access to quality maternal health care. These barriers included time constraints and long distances to health facilities, lack of safe and reliable transportation options, and lack of autonomy of care regarding freedom of movement and decision-making power. Women's experiences within health care facilities show obstacles to accessing skilled birth attendants. Women explained problems of overcrowded facilities, bribery and medical costs, verbal coercion, and physical abuse are additional barriers to accessing quality maternal health care. Nurses attribute some of these problems to poor staff remuneration, staff shortages, and a disabling working environment. These internal dynamics of the hospital generate a negative reputation of the hospital that accounts for the low use of skilled attendants by women in the surrounding communities and the poor quality of care available to them.

Women's experiences of health care are important for development because they indicate a series of systemic barriers to basic maternal health care. Skilled birth attendants are physically inaccessible for many women, offer care that is coercive and humiliating, and discourages future use. These barriers within health facilities compromise the care offered to women. This poor quality of care threatens their pregnancy outcomes because women who do not have skilled medical care in a safe and clean environment are at risk for mortality of morbidity. Not only do ensuing health problems diminish women's productive contribution to their families, communities and society. Their health is

intrinsically valuable because it improves their quality of life. These experiences of poor treatment in health facilities, however, create and reinforce their experience of poverty. As a social institution, health care in Uganda excludes rural and poor women from accessing quality maternal health care. The barriers to maternal health care are a breach of women's right to safe motherhood and prolong the suffering of pregnant women and their newborns.

Women and their families do not have the resources to overcome these barriers. Even skilled birth attendants in health facilities lack the medical resources and support they need to assist women with skill and empathy. In its current state, the public health care system in Uganda does not offer quality maternal health care to the majority of the population. Responsibility for eliminating these barriers to basic maternal health care lies with the central government, the Ministry of Health and Local District Governments who govern and manage these health care facilities. The national health policy attributes many of these problems to inadequate funding in the health sector. The large number of barriers that exist between women and quality maternal health care means eliminating one barrier or improving one aspect of care will do little to improve utilization of skilled birth attendants and improve pregnancy outcomes.

6.b. Recommendations for Improvement

According to the research participants, the most important way to encourage women to use skilled birth attendants for delivery is to improve the care they receive at health facilities. Vertical programs that operate outside the public health system to improve one aspect of maternal health provision will not encourage women to use skilled birth

attendants in health facilities for their next delivery. There are no cost-effective strategies to improving the delivery of maternal health care services. Uganda's health system is in need of more staff who are able to do their jobs with skill and empathy, health facilities that does not operate on bribery where medical supplies and drugs are available and accessible for all to use. The following recommendations are not an exhaustive list of methods to improve utilization of skilled birth attendants, but address some of the major barriers to improving women's access and acceptability of maternal health care.

Strengthen Public Health Care Services

Uganda's underfunded health care system hinders the implementation of policies and strategies that can be used to improve maternal health. The currently underfunded system relies on infrastructure built 50 years ago to deliver services to a population that has since almost tripled in size. Staff are poorly paid and unmotivated to provide quality care in hospitals that lack basic equipment, medicines, and supplies. Health facilities are inaccessible because good roads and safe transportation methods are uncommon, especially in rural areas. As the government has consistently underfunded the health sector, the government relies on non-governmental organizations (NGOs) to provide some of the only maternal health services (such as fistula repairs) for women. International donors have funded health services of their interest, often through vertical programs, that do not create a cohesive health care system. This method of health care delivery helps improve some health statistics, but it leaves pregnant women seeking safe delivery with few places to turn. This is especially true for the poor and those who live in rural areas.

A strong public health care system commits itself to the notion that access to health care is a universal right. Maternal health is dependent on a functioning public health care system, but it must be everyone's concern. Several ministries of Uganda's government, including the ministries of health, transportation, and education, have an important role to play in helping to facilitate a healthy population. Education campaigns are needed to create a supportive culture for maternal health. Roads are needed to access health facilities. Of course, the Ministry of Health needs to improve the provision of services so they are accessible and acceptable to pregnant women. They must provide care in health facilities that are respectful of women's dignity and offer services that ensure they have a safe pregnancy and delivery.

Consider women's experiences of health care:

Women are not passive recipient of medical services. Their experiences in health care reveal the internal dynamics of the health care facilities. Their stories tell us if and how they are received in antenatal and maternity wards, their access to medicines, drugs, and medical services, and the quality of care they receive. Currently, their experiences in health facilities are unacceptable and compromise the quality care they seek. They can explain the most important barriers to receiving hospital care are the systemic issues that have been ignored, neglected and underfunded for decades.

Descriptions from women using maternal health services are rarely shared or discussed in Uganda, but women can answer important questions for improving maternal healthcare: Are women accessing maternal health services? How are services being received? Are drugs, beds, and supplies readily available at health facilities? How can care be improved? If Uganda is to improve maternal health, they must consider women's

experiences of care in order to create maternal health care services that are acceptable to them. Well-written policies with no funding to implement them are useless, but even funded health policies that do not consider the various physical, social and economic barriers to maternal care will be ineffective.

Exercise legal right to health:

This thesis reveals that these women want maternal health care services that are accountable to them. They want better access to medical services in public hospitals that ensures the health of themselves and their newborns, and care that upholds their dignity and respect. The experiences of these women also reveal that their experiences of maternal healthcare is characterised by neglect, unmotivated staff, and dysfunctional healthcare facilities. An effective way of drawing attention to their plight and demanding their right to health is to utilize Uganda's legal system. Civil society groups in Uganda have recently banded together to sue the Ugandan government for the current maternal mortality crisis (Kasasira, 2012 Aug 9). These groups are demanding that the Ugandan government be held accountable for preventable maternal deaths that are a breach of their right to health, and ultimately call into question the state of maternal healthcare across the country. Exercising their right to health could be an effective way for women to make their voices heard, and ultimately improve the availability and quality of maternal health services for Ugandan women.

CHAPTER SEVEN: APPENDICIES

7.a. Focus Group Discussion Guideline

This focus group is interested in exploring your shared experiences of health services during pregnancy and childbirth. There are no right or wrong answers to our questions, as individuals will have different experiences. The purpose of the focus group is to hear as many different opinions as possible. In this way, people can listen to and respond to the other participants.

Tell me about what services you used during the pregnancy of your last child.

Did everyone attend antenatal clinic here? Where did everyone deliver?

How did you address health problems or concerns throughout your last pregnancy?

What are the advantages and disadvantages of the services that you used?

What did you think about the services you used during the pregnancy?

What are the main reasons for delivering at home, instead of the hospital?

Could services be improved to encourage more women to deliver in a health clinic? How?

Who has influenced your decision regarding the services you used in pregnancy?

Where would you prefer to deliver your next child?

Is there anything else you would like to say about the experiences with delivery services of your last child?

7.b Interview Guidelines

Questions for individual interviews were designed based on responses from the focus group.

Individual Interview Questions

Tell me about the delivery of your last child.

Antenatal Clinic

In your previous pregnancy, did you attend antenatal clinics?

If yes, how many antenatal clinics did you attend?

Who encouraged you to attend an antenatal clinic?

Why did you attend an antenatal clinic?

What did you expect during the antenatal clinic?

Were your expectations met?

Was the staff kind during the clinics?

Were you able to ask questions about your pregnancy?

Did you get satisfactory answers?

Were the facilities clean?

What did the staff discuss with you at the prenatal clinic?

Did you feel comfortable during the clinic?

Would you encourage other women to use antenatal clinics?

Will you use prenatal services for your next pregnancy?

Delivery Services

Where did you give birth to your last child?

What did you expect from the delivery services you attained?

Did the delivery services meet your expectations?

Was your privacy respected?

Did you feel comfortable during the delivery?

Would you like to use the same services again? Why?

Will you use delivery services for your next pregnancy?

Trained/Untrained Midwives

Who assisted you with the delivery?

How long did you know this person?

What were the events that led to your delivery with a skilled attendant?

What were the events that led to your delivery with a relative? OR, what were the events that led to your delivery with a traditional birth attendant?

Have your views on trained midwives changed? How?

Will you use a skilled attendant for your next pregnancy?

7.c. Participant Profiles

Interview No.	No. of Children	No. of Antenatal Care Visits	Assistance During Last Childbirth	Method of Transportation	Cost of Last Delivery (Ugandan shillings)	Will use Skilled Birth Attendant for Next Delivery
1	2	1	SBA	Boda-boda	10,000	yes
2	2	3	Mother and sister/TBA	walked	0	yes
3	2	1	TBA	walked	10,000	maybe
4	3	0	SBA	Taxi	0	yes
5	5	4	SBA	Boda-boda	0	No plans for more children
6	2	1	alone	n/a	n/a	No plans for more children
7	2	1	TBA	Boda-boda	5,000	yes
8	3	4	SBA	Boda-boda	7,000	maybe
9	3	4	SBA	Boda-boda	8,000	yes
10	4	4	TBA	walked	20,000	No plans for more children

REFERENCES:

AbouZahr, C. (2003). Safe Motherhood: a brief history of the global movement 1947-2002. *British Medical Bulletin*. 67(1), 13-25.

Adichie, C.N. (2009). Chimamanda Adichie: The Danger of a Single Story. In *TED Conferences*. Retrieved from: http://www.ted.com/talks/chimamanda_adichie_the_danger_of_a_single_story.html

African Development Bank. (1994). Uganda Economic Recovery Loan: Project Performance Evaluation Report. Retrieved from: http://www.afdb.org/fileadmin/uploads/afdb/Documents/Evaluation-Reports/05550218-EN-UGANDA-ECONOMIC-RECOVERY.PDF

Agbonifo, P.O. (1983). The state of health as a reflection of the level of development of a nation. *Social Science and Medicine*. 17 (24), 2003-2006.

Allen, D.R. (2004). *Managing Motherhood, Managing risk: fertility and danger in Central West Tanzania*. Ann Arbor: University of Michigan Press.

Anti-Corruption Coalition Uganda. (2012). Mbale doctors held over death of woman in labour. Retrieved from: http://www.accu.or.ug/index.php?option=com_content&view=article&id=578:mbale-doctors-held-over-death-of-woman-in-labour&catid=7:in-the-media&Itemid=21

Avert. (2010). HIV & AIDS in Uganda. Retrieved from: http://www.avert.org/aids-uganda.htm

Bangser, M., Mehta, M., Singer, J., Daly, C., Kamugumya, C., & Mwangomale, A. (2011). Childbirth experiences of women in Tanzania and Ugandan and the need for fistula program development. *International Urogynecology Journal*. 22, 91-98.

Barker, K.K. (1982). A ship upon a stormy sea: the medicalization of pregnancy. *Social Science and Medicine*. 47(8), 1067-76.

Bass, E. (2005). The two sides of PEPFAR in Uganda. *The Lancet*. 365(9477), 2077-2078.

Bennett, F.J. (1985). A comparison of community health in Uganda with its two East African neighbours in the period 1970-1979. In C.P. Dodge & P.D. Wiebe (eds.), *Crisis in Uganda: The Breakdown of Health Services* (pp. 43-52). Toronto: Pergamon Press.

Berg, B. L. (2009) *Qualitative Research Methods for the Social Sciences.* (7th ed.) New York: Allyn & Bacon.

Bigsten, A., & Kayizzi-Mugerwa, S. (1999). *Crisis, Adjustment and Growth in Uganda: A Study of Adaptation in an African Economy.* New York: St. Martin's Press, Inc.

Birungi, H. (1998). Injections and Self-Help: Risk and Trust in Ugandan Health Care. *Social Science and Medicine*, 47(10), 1455-1462.

Bond , P. & Dor G. (2003). Uneven health outcomes and political resistance under residual neoliberalism in Africa. *International Journal of Health Services*. 33(3), 607-630.

Bullough, C., Meda, N., Makowiecka, K., Ronsmans, C., Achadi, E.L., & Hussein, J. (2005). Current strategies for the reduction of maternal mortality. *International Journal of Obstetrics and Gynaecology*, 112, 1180-1188.

Cancian, F.M. & Oliker, S. (2000). *Caring and Gender*. Thousand Oaks: Pine Forge Press.

Chamberlain, J. (2012, May 14). Jean Chamberlain Froese on Ugandan health care: Women and children last. *National Post*. Retrieved from: http://fullcomment.nationalpost.com/2012/05/14/jean-chamberlain-froese-on-ugandan-health-care-women-and-children-last/

Carpenter, M. (2000). Health for some: global health and social development since Alma Ata. *Community Development Journal*, 35(4), 336-351.

Chen L, Evans T, Anand S, Boufford JI, Brown H, Chowdhury M, Cueto M, Dare L, Dussault G, Elzinga G, Fee E, Habte D, Hanvoravongchai P, Jacobs M, Kurowski C, Michael S, Pablos-Mendez A, Sewankambo N, Solimano G, Stilwell B, de Waal A, Wibulpolprasert S. (2004). Human Resources for Health: Overcoming the Crisis. *The Lancet,* 364 (9449), 1984-90.

Centre for Reproductive Rights. (2010). Supplementary Information on Uganda. Letter to The Committee on the Elimination for Discrimination against Women. Retrieved from: http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/CRR_Uganda47.pdf

Cook, R.J. (2003). *Reproductive Health and Human Rights*. New York: Oxford University Press.

Costello, A., Azad, K., & Barnett, S. (2006). An alternative strategy to reduce maternal mortality. *The Lancet*, 368, 1477-1479.

Craig, D., & Porter, D. (2006). *Development Beyond Neoliberalism? Governance, poverty reduction and political economy.* New York: Routledge.

Denzin, N.K. & Lincoln, Y.S. (2005). *The Sage Handbook of Qualitative Research.* (3rd ed.) Thousand Oaks: Sage Publications.

Dodd, R. & Munck, L. (2002). *Dying for Change: poor people's experience of health and ill-health.* World Bank and Word Health Organization. Retrieved from: http://siteresources.worldbank.org/INTPAH/Resources/Publications/Dying-for-Change/dyifull2.pdf

Dove, N. (2010). A Return to Traditional Health Care Practices: A Ghanaian Study. *Journal of Black Studies*, 40, 823-853.

Doyal, L. (2002) Putting gender into health and globalisation debates: new perspectives and old challenges. *Third World Quarterly*, 23(2), 233-250.

Dugger, C.W. (2011, Jul 30). Promising Care; Maternal Deaths Focus Harsh Light on Uganda. *The New York Times*. Retrieved from: http://query.nytimes.com/gst/fullpage.html?res=9807E6DE123EF933A05754C0A9679D8B63&pagewanted=all

EASSI. (2010). Monitoring Maternal Health and Safe Motherhood Policies. Policy-Making in Practice: What can be learned from Uganda's National Budget Implementation?

Economic Intelligence Unit. (1996). Uganda Finance: Possible Debt Relief. Country Alert. *The Economist Intelligence Unit*. Retrieved from: http://www.eiu.com/index.asp?layout=VWPrintVW3&article_id=1694529569&printer=printer

Economist Inteillgence Unit. (1998). *EIU Country Report: Uganda 2nd quarterly review.* London. Retrieved from: http://www.eiu.com/report_dl.asp?issue_id=1914088591&mode=pdf

Engel, G.L. (1977). The need for a new medical model: A Challenge for biomedicine. *Science*, 196(4286), 129-136.

Fleming, J. (1994). What in the world is being done about TBAs? An overview of international and national attitudes to traditional birth attendants, *Midwifery*, 10, 142-147.

Freedman, L.P. (2005). Achieving the MDGs: Health systems as core social institutions. *Development.* 48(1), 19-24.

Fox, A.M. & Meier, B.M. (2009). Health as Freedom: Addressing Social determinants of global health inequities through the human right to development. *Bioethics*, 23(2), 112-122.

Gabrysch, S. & Campbell, O. (2009). Still too far to walk: Literature review of the determinants of delivery service use. *BMC Pregnancy and Childbirth*, 9(34), 1-18.

Gilson, L. (2003). Trust and Development of Health Care as a Social Institution. *Social Science and Medicine*. 56, 1453-1468.

Gollin, D., Rogerson, R., & College, W. (2008). Agriculture, Roads, and Economic Development in Uganda: Working Paper No. 15863. *The National Bureau of Economic Research*. Retrieved from: http://www.nber.org/papers/w15863

Grady, D. (2010). Maternal Deaths Decline Sharply Across the Globe. *New York Times*. 13 April 2010. Available at: http://www.nytimes.com/2010/04/14/health/14births.html

Great Britain. Colonial Office. Uganda Medical Department. (1934) Minutes of the Three Hundred and Forty-Sixth Meeting. *Uganda. Medical and sanitary conditions.*

Grosse, R.N. & Harkavy, O. (1980). The role of health in development. *Social Science and Medicine*, 14(2), 165-169.

Gukiina, P. (1972). *Uganda: A Case Study in African Political Development.* Notre Dame: University of Notre Dame Press.

Hewa, S. & Heatherington, R.W. (1995). Specialists without spirit: limitations of the mechanistic biomedical model. *Theoretical Medicine*, 16, 129-139.

Holt, J. (2007). Multisectoral HIV/AIDS Policy and Education: Case Studies of Uganda and Tanzania. (Masters dissertation). Stanford University, Stanford.

Human Rights Watch. (2005) The Less They Know, the Better: Abstinence-only HIV/AIDS programs in Uganda. *Human Rights Watch*, 17(4). Retrieved from: http://www.hrw.org/en/reports/2005/03/29/less-they-know-better

Hunchinson, P. & Akin, J.S. (1999). Health-care facility choices and the phenomenon of Bypassing. *Health Policy and Planning*, 14(2),135-151.

Hunt, J. (2010). Bribery in Health Care Uganda. *Journal of Health Economics*, 29(5), 699-707.

International Monetary Fund. (2005). *Uganda: Poverty Reduction Strategy Paper: Poverty Eradication Action Plan (2004/5-2007/8). IMF Country Report No. 5/307.* Washington, International Monetary Fund.

International Monetary Fund. (2010). *Uganda: Poverty Reduction Strategy Paper: National Development Plan (2010/11-2014/15).* IMF Country Report No. 10/307. Washington: International Monetary Fund.

IPPFARO. (2008). Promoting the Involvement of Boys and Men in Reproductive Health and HIV/AIDS: Findings from a Review of IPPF projects in Lesotho and Uganda. Retrieved from: http://www.ippf.org/NR/rdonlyres/AC62ECC6-0555-454A-BEBF-F8605EB6040A/0/IPPFmaleInvolvementReport.pdf

IRIN. (2011, Oct 27). UGANDA: Mothers-to-be most at risk from inadequate health budget. UN Office for the Coordination of Humanitarian Affairs. Retrieved from: http://www.irinnews.org/Report/94083/UGANDA-Mothers-to-be-most-at-risk-from-inadequate-health-budget

Jeffery, P., Jeffery, R., & Lyon, A. (1989). *Labour pains and labour power: women and childbearing in India.* London: Zed.

Jewkes, R., Abrahams, N., & Mvo, Z. (1998). Why do nurses abuse patients? Reflections from South African Obstetric Services. *Social Science and Medicine*, 47(11), 1781-1795.

Johnson, S.A. (2011). *Challenges in Health and Development: from global to community perspectives*. New York: Springer.

Kagumire, (2010). Pregnant and Alone in Uganda. Canadian Medical Association Journal. Vol. 182. (1): E685-686. Available at: http://www.cmaj.ca/content/182/14/E685.full.pdf+html

Kamal, I.T. (1998). The Traditional Birth Attendant: A reality and a challenge. *International Journal of Gynecology and Obstetrics*. 63(1), S43-S52.

Kasasira, R. (2012, Aug 9). Uganda: Government sued over maternal healthcare. AllAfrica. Retrieved from: http://allafrica.com/stories/201208091159.html.

Kaye, D. (2000). Quality of Midwifery Care in Soroti District, Uganda. *East African Medical Journal*. 77(10), 556-561.

Kemm, J. (2001). Health impact assessment: a tool for health public policy. *Health Promotion International*. 16(1), 79-85.

Kipp, W., Tindyebwa, D., Rubaale, T., Karamagi, E., & Bajenja, E. (2007). Family Caregivers in Rural Uganda: The Hidden Reality. *Health Care for Women International*. 28, 856-871.

Kitts, J. (1995). Quality of Health Care for Women: report of a workshop held in Budapest, Hungary, October, 1994. *UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases*. Retrieved from: http://www.who.int/tdr/publications/documents/quality-of-health-care.pdf

Kitts, J. & Roberts, J.H. (1996). *The Health Gap: Beyond Pregnancy and Reproduction*. Ottawa: International Development Research Centre.

Knudson, L.M. (2003). Limited choices: A women's access to health care in Kiboga, Uganda. *Women's Studies Quarterly*, 31(3), 235-260.

Knudson, L.M. (2006). *Reproductive Rights in a Global Context: South Africa, Uganda, Peru, Denmark, United States, Vietnam, Jordan*. Nashville: Vanderbilt University Press.

Konadu, K. (2007). *Indigenous Medicine and Knowledge in African Society*. New York: Routledge.

Kruk, M.E., Prescott, M.R, & Galea, S. (2008). Equity of skilled birth attendant utilization in developing countries. Financing and policy determinants. *American Journal of Public Health*, 98(1), 142-147.

Kvale, S. (1996) *InterViews: An Introduction to Qualitative Research Interviewing*. London: Sage Publications.

Kyomuhendo, G.B. (2003). Low use of rural maternity services in Uganda: impact of women's status, traditional beliefs and limited resources. *Reproductive Health Matters*. 11(21), 16-26.

Ladu, I.M. (2010, Apr 26). Money spend on VIP treatment abroad can build 10 hospitals. *The Daily Monitor*. Retrieved from: http://www.monitor.co.ug/News/National/-/688334/1394344/-/item/0/-/11m5eppz/-/index.html.

Levin, A., Dmytraczenko, T., McEuen, M. Ssengooba, F., Mangani R., & Van Dyck, G. (2003). Costs of maternal health care services in three Anglophone African countries. *International Journal of Health Planning and Management*, 18, 3-22.

Lieblich, A., Tuval-Mashiach, R., and Zilber, T. (1998). *Narrative Research. Reading, Analysis, and Interpretation*. Thousand Oaks: Sage Publications.

Lincetto, O., Mothebesoane-Anoh, S., Gomez, P., & Munjanja, S. (2006). Antenatal care. In J. Lawn & Kerber, K. (eds.) Opportunities for African Newborns: Practical data, policy and programmatic support for newborn care in Africa (pp. 51-62). The Partnership for Maternal, Newborn & Child Health. Retrieved from: http://www.who.int/pmnch/media/publications/oanfullreport.pdf

Lozano, R., Wang, H., Foreman, K.J., Rajaratnam, J.K., Naghavi, M., Marcus, J.R., Dwyer-Lindgren, L., Lofgren, K.T., Phillips, D., Atkinson, C., Lopez, A.D., and C.J.L. Murray. (2011). Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis. The Lancet. Vol. 378: 1139-65.

Macrea, J., Zwi, A. B., & Gilson, L. (1996). A Triple Burden for Health Sector Reform: Post-conflict rehabilitation in Uganda. *Social Science Medicine , 42* (7), 1095-1108.

MacLeod, R.M. & Milton, J.L. (1988). *Disease, medicine, and empire: perspectives on Western medicine and the expansion of European expansion.* Routledge: London.

MacKian, S.C. (2008). "What the papers say: Readings therapeutic landscapes of women's health and empowerment in Uganda," *Health & Place.* Vol 14: 106—115.

Madson, E.L., Bergeson-Lockwood, J., & Bernstein, J. (2010). Maternal Health Supplies in Uganda. *Population Action International.* Retrieved from: http://www.who.int/pmnch/activities/commodities/2010_maternal_health_uganda.pdf

Mafabi, D. (2011, Sept 20). Uganda: Mbale Doctors Held Over Death of Woman in Labour. *The Daily Monitor.* Retrieved from: http://allafrica.com/stories/201109200148.html

Magnussen, L., Ehiri, J., & Jolly, P. (2004). Comprehensive versus primary health care: lessons for global health policy. *Health Affairs*, 23(3), 167-176.

Manyire, H. (2010). Financing Maternal Health: A Gender Budget Analysis of Safe Motherhood in Uganda, edited by Mwaka Victoria Nakibaneko. Kampala: Forum for Women in Democracy.

Mathole, T. & Lindmark, G. (2005). Competing knowledge claims in the provision of antenatal care: a qualitative study of traditional birth attendants in rural Zimbabwe. *Health Care for Women International*, 26, 937-956.

Mavalankar, D. (2003). Quality of care in institutional deliveries: the paradox of the Dominican Republic: a commentary on management. *International Journal of Gynecology and Obstetrics*, 82, 107-110.

Mbonye, A.K., Mutabazi, M.G., Asimwe, J.B., Sentumbwe, O., Kabarangira, J., Nanda, G., and V. Orinda. (2007). Declining maternal mortality ratio in Uganda: Priority interventions to achieve Millennium Development Goal. Journal of Gynecology and Obstetrics. Vol. 98: 285-290.

McNeil, D.G. (201, May 10). At Front Lines, Global War on AIDS is Falling Apart. *The New York Times.* Retrieved from: http://query.nytimes.com/gst/fullpage.html?res=9E07E7D71638F933A25756C0A9669D8B63&ref=uganda&pagewanted=1

McPake, B., Asiimwe, D., Mwesigye, F., Ofumbi, M., Ortenblad, L., Streefland, P., & Turinde, A. (1999). Informal Economic Activities of Public Health Workers in Uganda: Implications for Quality and Accessibility of Care. *Social Science and Medicine*, 49, 849-865.

Mernissi, F. (1975). Obstacles to family planning practice in Morocco. *Studies in Family Planning*, 6(12), 418-425.

Milio, N. (1986) *Promoting health through public policy.* Ottawa: Canadian Public Health Association.

Minca, M. (2011). Midwifery in Uganda: an in-depth country analysis. The State of the World's Midwifery. Retrieved from: http://www.unfpa.org/sowmy/resources/docs/country_info/in_depth/Uganda_SoWMYInDepthAnalysis.pdf

Morgan, K.P. (1998). Contested bodies, contested knowledge: Women, health, and the politics of medicalization. In S. Sherwin,, and Feminist Health Care Ethics Research Network (Eds) *The Politics of Women's Health: Exploring Agency and Autonomy* (pp. 83-121). Philadelphia: Temple University Press.

Mubiri, R. (2011, Sept 20). UWOPA-Charge Mbale Doctors with Murder. *UgandaRadioNetwork.* Retrieved from: http://ugandaradionetwork.com/a/story.php?s=36987.

Mugaju, J. (1990). Development Planning Versus Economic Performance in Uganda, 1961-1971. *Transafrican Journal of History*, 19, 99-116.

Muhumuza, R. (2012, Jun 13). Stunning childbirth mortality rate in Uganda sparks human rights court case. *The Toronto Star.* Retrieved from: http://www.thestar.com/news/world/article/1210688--stunning-childbirth-mortality-rate-in-uganda-sparks-human-rights-court-case

Mulago Hospital. (2012). Gynaecology Department. Retrieved from: http://www.mulago.or.ug/gynaecology.php

Murigi, S. & Ford, L. (2010, Mar 30). Should Uganda ban traditional birth attendants? *The Guardian*. Retreived from: http://www.guardian.co.uk/katine/katine-chronicles-blog/2010/mar/30/traditional-birth-attendants-ban

Mwesigye, S. (2012, Apr 12). Gulu hospital on road to recovery. *The Observer*. Retrieved from: http://observer.ug/index.php?option=com_content&view=article&id=18147:gulu-hospital-on-road-to-recovery&catid=42:sizzling-entertainment&Itemid=74

Nabiruma, D. (2012 Mar 12). Why we are rude – Midwife. *The Observer*. Retrieved from: http://www.observer.ug/index.php?option=com_content&view=article&id=17796:why-we-are-rude-midwife&catid=57:feature

Nakkazi, E. (2012). Traditional birth attendants outlawed in Uganda but practice persists. *The Health Digest*. 1. Retrieved from: http://www.whiteribbonalliance.org/index.cfm/linkservid/F79F2DC9-1CC0-70AB-CB8F72A270FB2AE0/showMeta/0/

Narayanan, I., Shaver, T., Clark, A. Cordero, D., & Faillace, S. (2004). *Entry into this World: Who should assist? Birth attendants and newborn health*. Arlington: Basic Support for Institutionalizing Child Survival Project (BASICS II).

Nguyen, L., Ropers, S., Nderitu, E., Zuyerduim, A., Luboga, S., & Hagopian, A. (2008). Intent to migrate among nursing students in Uganda: Measures of the brain drain in the next generation. *Human Resources for Health*, 6:5.

Odaga, J. and Lochoro, P. (2006). Budget ceilings and health in Uganda. Wemos Foundation. Retrieved from: http://www.who.int/rpc/evipnet/uganda_report%20Budget%20ceiling%20and%20health.pdf

Okuonzi, S.A. (2004). Evidence of a flawed economic policy in Uganda. *The Lancet*, 364,1632-37.

Okounzi, S.A. & Birungi, H. (2000). Are lessons from the education sector applicable to health sector reforms? The Case of Uganda. *International Journal of Health Planning and Management*, 15, 201-219.

Okuonzi, S. A. and Macrae J. (1995). Whose Policy is it Anyway? International and national influences on health policy development in Uganda. *Health Policy and Planning*, 10 (2), 122-132.

Okwero, P., Tandon, A., Sparkes, S., McLaughlin, J., & Hoogeveen, J. G. (March 2010). *Fiscal Space for Health in Uganda – World Bank Working Paper No. 186.* Washington, D.C.: The International Bank for Reconstruction and Development & The World Bank.

Parkhurst, J. O. & Lush, L. (2004). The Political Environment of HIV: lessons from a comparison of Uganda and South Africa. *Social Science and Medicine*, 59(9), 1913-1924.

Parkhurst, J.O., Penn-Kekana, L., Blaauw, D., Balabanova, D., Danishevski, K., Rahman, S.A., Onama, V., & Ssengooba, F. (2005). Health Systems factors influencing maternal health services: a four-country comparison. *Health Policy*. 73, 127-138.

Parkhurst, J.O., Rahmen, S.A., & Ssengooba, F. (2006). Overcoming Access Barriers for Facility-based Delivery in Low-Income Settings: Insights from Bangladesh and Uganda. *Journal of Health, Population, and Nutrition*. 24(4), 438-445.

Parkhurst, J.O. & Ssengooba, F. (2009). Assessing access barriers to maternal health care: measuring bypassing to identify health care needs in rural Uganda. *Health Policy and Planning*, 24(5), 377-384.

Rathgeber, E.M.; Vlassoff, C. (1993). Gender and tropical diseases: a new research focus. *Social Science and Medicine*, 37(4), 513-520.

Republic of Uganda. Ministry of Health. (2000a). *Health Sector Strategic Plan I 2000/01 – 2004/05.*

Republic of Uganda. Ministry of Health. (2001). The National Policy Guidelines and Service Standards for Reproductive Health Services. Available from: http://www.k4health.org/system/files/Uganda%20National%20Policy%20Guidelines%20and%20Service%20Standards%20for%20Reproductive%20Health%20Services.pdf

Republic of Uganda. Ministry of Health. Reproductive Health Division. (2004). National Adolescent Health Policy for Uganda. Available from: http://www.k4health.org/system/files/Uganda%20National%20Adolesecent%20Health%20Policy_0.pdf

Republic of Uganda. Ministry of Health. (2005). *Health Sector Strategic Plan II 2005/06 – 2009/2010 Volume I.*

Republic of Uganda. Ministry of Health. (2009). *National Health Policy: Reducing poverty through promoting people's health.*

Republic of Uganda. Ministry of Health. (2010c). *Health Sector Strategic Plan III 2010/11-2014/15*. Retrieved from: http://www.health.go.ug/docs/HSSP_III_2010.pdf

Republic of Uganda. Ministry of Finance, Planning and Economic Development. (2000b). *Poverty Reduction Strategy Paper. Uganda's Poverty Eradication Action Plan Summary and Main Objectives.*

Republic of Uganda. Ministry of Finance, Planning and Economic Development. (2007a) 5-year National Development Plan for Uganda: PEAP Revision Process 2007/8. Concept Note on Revision Process.

Republic of Uganda. Ministry of Finance, Planning and Economic Development. (2010a). Millennium Development Goals Report for Uganda 2010: Special theme accelerating progress towards improving maternal health. Kampala: Ministry of Finance, Planning and Economic Development.

Republic of Uganda. Ministry of Finance. Ministry of Finance, Planning and Economic Development. (2010b). *National Budget Framework Paper FY 2010/11 – FY 2014/15.* Retrieved from: http://www.finance.go.ug/index.php/national-budget/budget-framework-papers/doc_view/9-national-budget-framework-paper-fy2010-11-fy2014-15.raw?tmpl=component

Riessman, C.K. (1983). Women and medicalization: a new perspective. *Social Policy.* 14(1), 3-18.

Roberts, J. & Hatcher, J. (1996). *The Health Gap: Beyond Pregnancy and Childbirth.* Ottawa: International Development Research Centre.

Ronsmans, C., & Graham, W.J. (2006). Maternal mortality: who, when, where, and why. *The Lancet*, 386, 1189-1200.

Rosenfield, A., & Maine, D. (1985). Maternal Mortality – a Neglected Tragedy: Where is the M in MCH? *The Lancet.* 2(8446), 83-83.

Rubin, R.J & Rubin, I. (1995). *Qualitative Interviewing: The Art of Hearing Data.* Thousand Oaks: Sage Publications.

Ruger, J.P. (2003). Health and Development. *The Lancet*, 362, 678.

Sen, A. (1999). *Development as Freedom.* Oxford: Oxford University Press.

Sen, G., Ostlin. P., & George, A. (2007). Unequal, Unfair, Ineffective and Inefficient. Gender Inequality in Health: Why it exists and how can we change it. Field Report to the WHO Commission on Social Determinants of Health. *Women and Gender*

Equity Knowledge Network. Retrieved from: http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf

Sargent, C., & Bascope, G. (1996). Ways of knowing about birth in three cultures. *Medical Anthropology Quarterly*, 10, 213-237.

Schuftan, C. (2008). "Gender Equality is not Just a Women's Issue, but a Development and a Human Rights Issue." In Murthy, P. & Smith, L. (Eds), *Women's Global Health and Human Rights* (pp. 437-440). Toronto: Jones and Bartlett Publishers.

Sibbald, B. (2007). Uganda government makes maternal health a priority. *Canadian Medical Association Journal*, 177(3), 244-245.

Sharer, R. L., DeZoysa, H. R., & McDonald, C. A. (1995). *Uganda: Adjustment with Growth, 1987-94.* Washington, DC: International Monetary Fund.

Shiffman, J. (2006). Donor funding priorities for communicable disease control in the developing world. *Health Policy and Planning*, 21(6), 411-420.

Shiffman, J. (2007). Generating Political Priority for Maternal Mortality Reduction in 5 Developing Countries. *American Journal of Public Health*, 97(5), 796-803.

Shiffman, J. & Smith S. (2007). Generation of political priority for global health initiatives: a framework and case study of maternal mortality. *The Lancet*, 370, 1370-79.

Scheyer, S. & Dunlop, D. (1985). Health Services and Development in Uganda. In C.P. Dodge & P.D. Wiebe (eds.), *Crisis in Uganda: The Breakdown of Health Services* (pp. 25-42). Toronto: Pergamon Press.

Short, C.W. R. (1961). Causes of Maternal Death Among Africans in Kampala, Uganda. *BJOG: An International Journal of Obstetrics and Gynaecology*, 68(1), 44-51.

Smith, J.B., Coleman, N.A., Fortney, J.A., Johnson, J.D., Blumhagen, D.W., & Grey, T.W. (2000). The impact of traditional birth attendant training on delivery complications in Ghana. *Health Policy and Planning*, 15(3), 326-331.

Ssengooba, F. (2004). Uganda's Minimum Health Care Package: Rationing Within the Minimum? *Health Policy and Development Journal*, 2(1).

Ssengooba, F., Neema, S., Mboyne, A., Sentubwe, O., & Onama, V. (2004). *Maternal Health Review*. Health Systems Development Programme. Makarare University Institute of Public Health. Retrieved from: http://www.dfid.gov.uk/r4d/Output/179742/Default.aspx

Standing, H. (2002). An Overview of Changing Agendas in Health Sector Reforms. *Reproductive Health Matters*. 10(20), 19-28.

Stekelenburg, J., Kyanamina, S., Mukelabai, M., Wolffers, I., & van Roosmalen, J. (2004). Waiting too long: low use of maternal health services in Kalabo, Zambia. *Tropical Medicine and International Health*, 9(3), 390-398.

Strong, M.A. (1992). "The health of adults in the developing world: The view from Bangladesh." *Health Transition Review* 2(2), 215-224.

Sundari, T.K. (1992). The untold story: How the health care systems in developing countries contribute to maternal mortality. *International Journal of Health Services*, 22(3), 513-528.

Sweetman, C. (2002). *Gender, development and health*. Oxford: Oxfam.

Tann, C.J, Kizza, M., Morison, L., Mabey, D., Muwanga, M., Grosskurth, H., & Elliott, A.M. (2007). Use of Antenatal services and delivery care in Entebbe, Uganda: a community survey. *BMC Pregnancy and Childbirth*, 7(23), 1-11.

Thaddeus, S. and Maine, D. (1994). Too Far to Walk: Maternal Mortality in Context. *Social Science and Medicine*, 38 (8), 1091-1110.

Thornton, P. (2012). Our side of the story: Ugandan health workers speak up. VSO International. Retrieved from http://www.vsointernational.org/Images/our-side-of-the-story-2_tcm76-35533.pdf

Tuguminize, L. (2005). The role of TBAs in midwifery care: the Ugandan experience. *British Journal of Midwifery*, 14(5), 276-278.

Udipi, S.A. & Varghese, M.A. (1995). Improving women's quality of life: enhancing self-image and increasing decision-making power. In J.H. Roberts, J. Kitts, & L.J. Arsenault, L. (Eds.), *Gender, health, and sustainable development: perspectives from Asia and the Caribbean: Proceedings of workshops held in Singapore, 23-26 January 1995, and in Bridgetown, Barbados, 6-9 December 1994* (pp. 151-160). Ottawa: International Development Research Centre.

Uganda Bureau of Statistics. (1989). *Uganda Demographic and Health Survey 1988-1989*. Kampala: Uganda Bureau of Statistics and Macro International Inc.

Uganda Bureau of Statistics. (1995). *Uganda Demographic and Health Survey 1995*. Kampala: Uganda Bureau of Statistics and Macro International Inc.

Uganda Bureau of Statistics. (2001). *Demographic and Health Survey 2000-2001 Key Findings*. Kampala: Uganda Bureau of Statistics and Macro International Inc.

Uganda Bureau of Statistics. (2007). *Uganda Demographic and Health Survey 2006.* Kampala: Uganda Bureau of Statistics and Macro International Inc.

Uganda Bureau of Statistics. (2010). *2010 Statistical Abstract.* Retrieved from: http://www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/2010StatAbstract.pdf

Uganda Bureau of Statistics. (2012). *Uganda Demographic and Health Survey 2011: Preliminary Report.* Kampala: Uganda Bureau of Statistics and Measure DHS.

UN. (2012). Universal Declaration of Human Rights. Retrieved from: http://www.un.org/en/documents/udhr/

UNHCR. (2012). International Covenant on Economic, Social and Cultural Rights. Retrieved from: http://www2.ohchr.org/english/law/cescr.htm

UNFPA. (1996). Support to traditional birth attendants. *Evaluation Finding.* 7. Retrieved from: http://www.unfpa.org/monitoring/pdf/n-issue7.pdf

UNFPA. (2012). Skilled Attendance at Birth. United Nations Population Fund. Available at: http://www.unfpa.org/public/mothers/pid/4383

UNICEF. (2009). *Maternal and Newborn Health.* UNICEF. Retrieved from: http://www.unicef.org/health/index_maternalhealth.html

UNICEF. (2010). *Uganda Statistics.* UNICEF. Retrieved from http://www.unicef.org/infobycountry/uganda_statistics.html#70

van den Broek, N.R. & Graham, W.J. (2009). Quality of care for maternal and newborn health: the neglected agenda. *BJOG.* 116 (Suppl. 1), 18-21.

Vanneste, A.M., Ronsmans, C., Chakraborty, J. and De Francisco, A. (2000). Prenatal screening in rural Bangladesh: from prediction to care. *Health Policy and Planning,* 15(1), 1-10.

Villadsen, J. (2009, Oct 9). Uganda's misplaced health millions. *BBC Focus on Africa.* Retrieved from: http://news.bbc.co.uk/2/hi/8275713.stm

VSO. (2010). Ugandan Health Workers Speak: The Rewards and the Realities. VSO International. Retrieved from: http://www.vsointernational.org/Images/ugandan-health-workers-speak_tcm76-30142.pdf

Walraven, G. & Weeks, A. (1999). Editorial: The role of (traditional) birth attendants with midwifery skills in the reduction of maternal mortality. *Tropical Medicine and International Health*, 4(8), 527-529.

Wanyera, D. (2011, June 16). Uganda: Hospital Staff Shortages, Lack of Equipment Causing the Highest Number of Stillbirths. *The Monitor*. Retrieved from: http://allafrica.com/stories/201106160381.html

Wilkinson, S.E., & Callister, L.C. (2010). Giving Birth: The voices of Ghanaian women. *Health Care for Women International*, 31, 201-220.

World Bank. (1962). *Economic Development of Uganda: Report of a mission organized by the International Bank for Reconstruction and Development at the request of the Government of Uganda.* Baltimore: The Johns Hopkins Press.

World Bank. (1978). World Development Report 1978. Pub-2080. Available at: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2000/12/13/000178830_98101903334595/Rendered/PDF/multi_page.pdf

World Bank. (1982). *Uganda – Country Economic Memorandum.*

World Bank. (1984). World Development Report, 1984. Pub-5003. The World Bank. Oxford University Press. Retrieved from: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2000/12/13/000178830_98101903341963/Rendered/PDF/multi0page.pdf

World Bank. (1988a). *First Health Project. Staff Appraisal Report. Report #7203-UG.* Retrieved from: http://documents.worldbank.org/curated/en/1988/06/738898/uganda-first-health-project

World Bank. (1988b). Uganda: Towards Stabilization and Economic Recovery. Report # 7439-UG. Retrieved from: http://documents.worldbank.org/curated/en/1988/09/739344/uganda-towards-stabilization-economic-recovery

World Bank. (1993). *Uganda Growing Out of Poverty.*

WHO. (1978). *Declaration of Alma Ata.* International Conference on Health Care. Alma Ata: World Health Organization.

WHO. (1999). Reduction of maternal mortality: a joint WHO/UNFPA/UNICEF/World Bank statement. Geneva: World Health Organization.

WHO. (2000). *The World Health Report 2000. Health Systems: Improving Performance.* Geneva: World Health Organization.

WHO. (2005). The Elimination of User Fees in Uganda: Impact on utilization and catastrophic health expenditures. Geneva: World Health Organization.

WHO. (2006). Constitution of the World Health Organization. Basic Documents. Forty-fifth edition. Retrieved from: http://www.who.int/governance/eb/who_constitution_en.pdf

WHO. (2008). Traditional Medicine. Fact Sheet no. 134. Retrieved from: http://www.who.int/mediacentre/factsheets/fs134/en/

WHO. (2009). World Health Statistics 2009. Retrieved from: http://www.who.int/whosis/whostat/EN_WHS09_Table7.pdf

WHO. (2010). World Health Statistics. World Health Organization. Retrieved from: http://www.who.int/whosis/whostat/EN_WHS10_Full.pdf

WHO. (2011). Global Health Observatory Data Repository. World Health Organization. Retrieved from: http://apps.who.int/ghodata/?vid=20300&theme=country

WHO. (2012a). Health and Human Rights. Retrieved from: http://www.who.int/hhr/en/

WHO. (2012b). Why do so many women still die in pregnancy or childbirth? Retrieved from: http://www.who.int/features/qa/12/en/index.html

WHO. (2012c). Health services coverage statistics. Retrieved from: http://www.who.int/healthinfo/statistics/indbirthswithskilledhealthpersonnel/en/

WHO. (2012d). Countries: Uganda. Retrieved from: http://www.who.int/countries/uga/en/

WHO & Ministry of Health. (2004). *Maama Kit: Making childbirth clean and safer.*

WHO, UNICEF, UNFPA, and the World Bank. (2010). Trends in Maternal Mortality: 1990 to 2008. World Health Organization.

SAINT MARY'S UNIVERSITY SINCE 1802
One University. One World. Yours.
PATRICK POWER LIBRARY

Department Office
T 902.420.5534
F 902.420.5561

Research Ethics Board Certificate Notice

The Saint Mary's University Research Ethics Board has issued an REB certificate related to this thesis. The certificate number is: 11-109 .

A copy of the certificate is on file at:

Saint Mary's University, Archives
Patrick Power Library
Halifax, NS
B3H 3C3

Email: archives@smu.ca
Phone: 902-420-5508
Fax: 902-420-5561

For more information on the issuing of REB certificates, you can contact the Research Ethics Board at 902-420-5728/ ethics@smu.ca .