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Access to Maternal Health Services in Rural areas of Uganda in the Decentralized Healthcare System in Conditions of increased Privatisation: A study Rukungiri District

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List of Acronyms

ANC	Ante-natal Care
CAO	Chief Administrative Officer
CESCR	Committee on Economic, Social and Cultural rights
DDI	District Drug Inspector
DHI	District health Inspector
DHV	District Health Visitor
DDHS	District Director of Health Services
DHT	District Health Team
EmOC	Emergency Obstetric Care
FGDs	Focus Group Discussions
HC	Health Centre
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immune Deficiency Disease
HMC	Health facility Management Committee
HSD	Health Sub District
HSSP	Health Sector Strategic Plan
ICPD	International Convention on Population and Development
IPT	Intermittent Presumptive Treatment
LC	Local Council
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
NCDs	Non Communicable Diseases
NGOs	Non Governmental Organisations
PFP	Private for Profit
PHC	Primary Health Care
PNFP	Private not for Profit
SAPs	Structural Adjustment Programmes
SSA	Sub –Saharan Africa
TFR	Total Fertility rate
UN	United Nations
UNMHCP	Uganda National Minimum Health Care package
UPE	Universal Primary Education
VHT	Village Health Team
WHO	World Health Organisation

Abstract

This paper presents and understanding of issues related to access to maternal health services in rural areas under the decentralised health system and increased conditions of privatisation. Rukungiri district was chosen because of its representativeness both in rural populations and extensive decentralisation that has taken place. This study espoused the human rights approach in understanding accessibility and argues that women have specific health needs related to pregnancy that must be provided for in the public health care system. In Uganda, maternal health care has been made priority in public provisioning and policies have been enacted to improve maternal healthcare. This paper argues that though decentralisation has brought physical health infrastructure to closer proximity in rural areas, specific services for maternal healthcare are not necessarily provided at these health centres. Also in this paper it is argued that privatisation has increased not only due to market forces but also due to failure in public sector to provide services pledged by government in its minimum healthcare package. This paper argues that this privatisation has led to proliferation of health service providers, but these have remained largely in urban areas and charge prohibitive costs and thus remain inaccessible to may poor women in rural areas. For this reason many poor women continue using services of TBAs who are untrained and pose increased dangers to the mothers they help deliver. This is a violation of the rights of women to access proper health and unless improvements are made in this area, Uganda will not register much progress towards the highly acclaimed MDG goal on maternal mortality.

Keywords

Maternal Healthcare, Access, Decentralisation, Privatisation

Chapter 1 Introduction

Maternal mortality is a problem that has continued to confront the population in Uganda. The Ministry of health designed a minimum health care package that guarantees universal access to a set of cost effective services of which maternal and child health services are a part. Available evidence shows that access to maternal health care can greatly reduce incidences of maternal mortality and morbidity. However, this access continues to be disproportionate in favour of urban areas. It is estimated that over 70% of women live in the rural areas and only half of them are within 5km distance from a health facility that provides antenatal care, delivery care and immunisation services. Decentralisation HC IV was intended to bring services closer to the people. This study aims to analyse the problems hindering accessibility to maternal health services in rural areas of Uganda from the view point of health providers in Rukungiri district. The rights approach is used to understand service delivery structure and how women get the services.

1.1 Background

Worldwide, approximately 525000 women die every year from complications related of pregnancy and childbirth, exacerbated by existing poor health and inadequate care. Many more suffer irreversible damage to their health. Most (99%) of these deaths take place in developing world making maternal mortality the health statistic with the largest disparity between the developed and the developing world. Perhaps this could be the greatest indicator of the stark differences between the developed and developing countries and of the inequality in access to proper health for the populations in those regions. All women can develop complications, even those who are educated, the healthy and those that access prenatal care. However the poor face the greatest risk because they are least likely to access the all important care that they need (Panos 2001).

Interestingly, most of the causes of maternal deaths are known and preventable, they include; severe bleeding, obstructed labour, eclampsia, unsafe abortion, infection and breach birth. The interventions required to mitigate and stop these conditions exist and are not technically complex if accessed in time (George 2007). Researchers agree that fighting these causes entails having not only an efficient maternal health care system but also addressing the gender related issues and women empowerment (Bhattacharya et al. 2008) This gives rise to the questions about the reasons why change for better is happening so slowly and inquiry in what is going wrong in the countries that have registered little improvement or even worsening conditions (Berer 2007)

By mid 1980s, awareness was growing and an article by Rosenfield and Maine "where is M in MCH" drew further attention. Their concern was drawn

by the increasing disparity in maternal mortality ratios and the risk of death due to maternal health issues between the developed and the developing countries. The Global Safe Motherhood Initiative was launched in Nairobi in the year 1987, which was charged with improving maternal health and reducing maternal deaths by 50% by the year 2000. A review of the progress indicated that many countries especially in Sub Saharan Africa were far and actually very far from achieving this, even when awareness was there to boost about as the major achievement.

The 1994 International Conference on Population and Development in Cairo (ICPD) further stressed on maternal health issues and thus initiated a programme of action which recommended that that countries move away from the traditional family planning (FP) to broader perspectives on reproductive health. It called upon all countries to expand provision of maternal health services in the context of primary health care as designed in the Alma Ata conference of 1978 (Mcpake 2008). This helped raise reproductive health agenda though it presented a conceptual problem to governments faced with competing priorities. Unlike most reproductive health services, obstetric complications require investment from governments (Mc Donagh and Goodburn 2000)

At the UN World Summit 2000, world leaders set eight Millennium Development Goals (MDGs) of which goal 5 is to improve maternal health with an indicator of reducing maternal mortality by 75% by the year 2015. Some low-income countries have made considerable progress though challenges still abound(Fariyal F et al. 2007)

Many countries where maternal health services are poor have signed the 1994 ICPD call of action and have since made reforms aimed at improving maternal healthcare provisioning. Sector reform interventions aimed at improving the health status of their populations by enhancing access, equity, quality, sustainability and efficiency in the delivery of health services especially to marginalized rural areas, women and other groups. There is no standard package of the reforms but the main strategies were to improve efficiency in public sector through decentralisation, essential packages of services, alternative financing , increasing involvement of private sector and sector wide approaches(Mc Donagh and Goodburn 2000)

1.2 Statement of the Problem

Uganda has one of the highest maternal mortality and morbidity ratios in the world. Estimates of 1990 figures were as high as 1200 deaths per 100,000 live births. Since 2001 these range between 500 and 600 deaths per 100,000 live births but may not portray a clearer picture because they were mostly based on small scale, health facility studies. Latest estimates show a decline in maternal mortality to 435 per 100,000 live births in 2006 which remains unacceptably

high (Uganda Population Secretariat 2007). In Uganda, only 38% of the deliveries are attended trained personnel. Given that the vast majority of Uganda's women live in rural areas and do not deliver in health facility, these figures would likely be much higher with variations between districts.

In 1980s maternal mortality would be blamed on the socio-economic and political instability that run for almost 12 years from late 1970s which destroyed infrastructure, forced staff to leave and cut off distant areas from essential supplies of medicines and equipment. Today, Uganda has expressed commitment to ensure access to health services to its population and has through its minimum health care package which forms the basic health guarantee to its citizens delivered under a decentralised health care delivery system (Ministry of Health 2005) The government and NGOs have put in place measures to increase health facilities, improve quality of services, increase midwives, and increase equipment and supplies(Ministry of Health 2004) However utilisation of especially emergency obstetric services has not increased, and nor has there been significant reductions in maternal deaths (Kyomuhendo 2003).

Uganda is a signatory to conventions on human rights, including the right to health. It thus claims to have adopted the rights-based approach that integrates the norms, standards and principles of the international human rights system into the plans, policies and processes of development (Uganda Population Secretariat 2008)

Public opinion shows doubts about commitment to quality of government's service to meeting the needs of pregnant women (Nalugo 2009), (Nabusoba 2008). Some study conclusions have questioned commitment in lieu the intentions of "rationing" in form of a "minimum package" and wonder what rights those persons in the populations hold in case the services they expect are not available under the government provisioning (Freddie 2006). The fact that many mothers still die in health units has a lot to speak about the availability of required services (Mbonye, Asimwe et al. 2007)

Private sector excludes the poor who are majority in rural areas of Uganda and therefore call for more government intervention. It was on this premise that reforms among which was decentralized health delivery were conceived to ensure access rural areas and in this case access emergency obstetric care during pregnancy and childbirth (Mayhew 2003,Mbonye 2001). For Uganda to achieving MDG goal 5 health care delivery system that responds to the needs of women in the countryside during pregnancy must be in place. Analysis of trends in maternal deaths showed that maternal mortality needed to reduce by 5.5% per annum between the years 1990 and 2015 to achieve the MDG on maternal health. However the decline was less than 1% in 2005 and it was 10 years away (Adanu 2008)

This study aimed to gain an understanding of how accessibility to maternal health services is configured in the current decentralised health care system and particular interest is in rural areas where the majority of the poor of whom many are women live. This study may refer to relevant literature and statistics before decentralization and privatisation but will not delve into a comparison of before and after situations. While the researcher recognises the value and important dynamics that such a comparison of time periods would bring, it was in the interest of time and ability to limit this research to the stated goal. This study looked at the current access in the rural areas by seeking to understand the point of view of service providers both in the public and the private sector in the district of Rukungiri.

1.3 Relevance and Justification

Many studies have considered decentralisation and how it works and others gone further to look at specific services but have either not addressed maternal health services in the decentralized system or have looked at the system without including the full account of providers themselves. Their findings have praised the decentralised system for taking services to the poor but minimal attention has been paid to the equity issues within the system.

As has been noted, women are functionally and biologically different from men. The functions of their bodies expose them to risks that call for services that are tailored. A good health system will not therefore ensure availability of services to the community but will also consider the needs that different groups need in relation to differences in their biology.

This study sought to create an understanding on how maternal health services are positioned in the current health system by taking the views of the providers and women about provisioning. Achievement of MDG target on maternal mortality by 2015 is high on government agenda and a clear understanding about how that translates to services to women especially in rural areas is paramount.

1.4 Research Objective

The main objective of the study is to establish the configuration of maternal health services available and how these are accessed by mothers in need in order to enhance approaches in promoting their right to health in childbirth from the understanding of health service providers in the district.

1.5 Research Question

How accessible are maternal health services in the rural areas of Rukungiri District in the context of decentralization and increasing privatisation of health service delivery?

1.5.1 Sub questions

1. Is maternal health care given priority in provision of health services under the decentralised health system?
2. How are Health Centres in rural areas facilitated with human and other resources to care for mothers in need of maternal health services especially for complications during and after delivery?
3. How do lower level health centres respond to the need for referral in case of maternal health care that they are not equipped to handle?
4. What are alternatives to public maternal healthcare and how accessible are they to the rural populations?
5. What are the major challenges in the current system of provision of maternal health services and how can they best be overcome.

1.6 Research methods and strategy

1.6.1 The district of Rukungiri

Rukungiri district was chosen because it provides a good case for studying access to maternal health care to the poor in rural areas under the system of decentralization and increased privatization. Rukungiri, with a population of 301657 people has only 4.6 5% of its population in townships. About 33% of this population lives below the national poverty line of 1.45 US $ a day and most of them reside in rural areas. Rukungiri has an extensive physical health structure covering almost all rural areas with 80% of its population within 5km distance from a health facility. This is a good indicator that decentralization of health system has been able to reach the grass roots. The Uganda national population within 5km distance from health facility is 67% putting Rukungiri in a very good position country wide. The district has health facility supervised deliveries of 45% which is above the national average. With a doctor population ratio of 1: 1813, clinical officer population ratio of 1: 13464, nurse population ratio of 1:895 and midwife to child bearing women population ratio of 1: 987 the district has still been able to rank among the first 10 districts nationally based on the performance on PHC. The district has bad indicators on maternal health such as high mortality, high infant mortality, and low supervised deliveries. However, given its ranking in the country irrespective of all barriers; rural location it provides a good representation of the way the system works in the country.

1.6.2 Research Instruments, Sources and Data Collection Techniques

The study utilised various instruments for both secondary and primary data sources. Primary data was more qualitative and was collected by use of personal interviews, Focus group Discussions and Key Informant interviews. Secondary data was mainly through desk reviews. This triangulation of methods allowed a collection of rich data that ensured high quality of information collected.

1.6.2.1 Secondary data

This study relied a lot on secondary information especially published journals about the subject matter. Researchers and policy makers across the globe produce a lot of literature in both community and university libraries.

Government publications were used to access data on Uganda's health care system and specifically maternal health service provision both nationally and for Rukungiri district. It was important in obtaining statistics about available health facilities that provide maternal health services, human resources in those facilities, and numbers of beneficiaries in target communities.

Newspaper articles were reviewed to understand public opinion about the state of maternal health care provisioning in Uganda. District performance reports were used to draw conclusions about prioritisation of maternal health services.

1.6.2.2 Primary data

This was only qualitative data obtained from interviews with primary respondents chosen from the study area.

Input from midwives and nurses was obtained using semi structured interviews and FGD. A total of 4 midwives and 2 nurses in position of In-charge of maternity wards were interviewed to gather their views about the functioning of the health facilities in providing quality of maternity services to women. Two FGDs with nurses and midwives were held at two health facilities. Nurses and midwives have first hand experience about the interaction between pregnant women and the provisioning system. Their views on how the system can be improved are also considered valuable due to their first hand experience.

Views from women as clients were captured in 2 FGDs both at health centres in rural settings. Their experiences interacting with the service providers both private and public were important in providing information to this study. FGDs provided opportunity for participants explain their interaction with health facilities and how services are accessed there.

Input from HMT was also captured using FGD at the HSD. This committee oversees the management of the health facilities and represents the voices of the community holding the providers accountable. This FGD was important in getting their views about how decentralisation has led to better priorities for the services that they need most and whether there is priority given to maternal health care.

The study benefited from Key Informants (KIs) who for positions held were deemed knowledgeable about decentralised health services and maternal healthcare in particular in the district. Key Informant interview schedules were used. District Officials included the District health Visitor, District Drugs Inspector, District health Inspect, and District Planner. 2 Heads of health Sub-districts were interviewed and 2 in charge of HC IIIs.

1.7 Challenges of this research

Health providers both public and private perceived it as an evaluation exercise. Whenever people feel that they are being assessed there is a tendency to portray positive, while hiding negative aspects thus portray not the true situation. Proper introduction of purpose of study would array their fears and thus they co-operated.

Reports and statistics especially at district level were not readily available due to poor record keeping even as has been indicated as a problem in the third world(George 2007), (Orinda et al. 2005).Through personal acquaintances and good interaction skills, it was possible to compel officials to make effort to find the necessary records and reports. Even when all anticipated records were not obtained, enough was secured to give this study necessary reliability.

In the design of this study, functional VHT were to be first contact for mobilisation of respondents especially from the communities. Under the decentralised system, this team represents the first contact between communities and the health service providers. The VHT was not yet functional by the time of data collection. In part however mobilisation of women was done on days when they attend ANC and immunisation of children.

Chapter 2:
Decentralisation, privatisation and maternal health care; Review in Uganda

This chapter takes us through a review of the conditions of decentralisation and privatisation in Uganda with a view of how these affect service delivery. Particular interest is paid to understanding what these conditions influence maternal healthcare provision. Processes elsewhere in the world helps in bringing the greater picture to perspective in understanding how access to maternal healthcare is mobilised to reach the rural areas.

2.1 The Decentralised Health Care Delivery system of Uganda

The Local Government Act (1997) established decentralization in provision of health services to bring services closer to the people (Anders and Okuonzi 2000). The District Health Team (DHT) controls health service delivery, recruitment and management of personnel, passing by-laws related to health, planning, budgeting and allocation for health services. The Health Sub District (HSD) run by a management team mandated to provide overall day to day management.

2.1.1 Health Sub District structure

The leadership of HSD is located in an existing hospital or a Health Centre IV (HC IV) whether it is public or private not for profit (PNFP). They provide basic preventive, curative and rehabilitative care in catchment; act as second level referral services for HSD including life-saving surgical and obstetrical emergency care. Health Centre (HC) III located at Sub country level is designed to offer continuous basic preventive, promotive and curative care and provides support supervision of the community and HC II facilities under jurisdiction. There are provisions for laboratory services for diagnosis, maternity care and first referral cover for the sub-county. HC II presents the first level interface between formal health sector and communities. It provides only ambulatory services. The Village Health Team (VHT) facilitates community mobilisation for health action. It is comprised of 9-10 people one third of whom should be women. This team is supposed to keep record of community members, their health status and mobilise resources and also monitor performance of health centres.

2.1.2 Decentralised System and increased access to grassroots

With and extensive structure, the ministry, almost as a disclaimer, is quick to highlight the problems that affect the proper functioning which include; poor logistics, inadequate staffing, weak management capacity, poor working conditions, deployment and housing of personnel, high rates of turn over of

recruited staff, heavy work load due to combining of clinical and management functions, low levels of completion of and operationalization of infrastructure have all dictated the pace and effectiveness of this policy change. As such 29 out of 214 HSDs have been delegated to PNFP referral facilities (Ministry of Health 2005)

2.1.3 Decentralised system: Position of the private sector

Alongside public structure, there are many PNFP service providers especially faith based health centres. It is estimated that about 40% of health facilities in Uganda are of this category. Private for profit (PFP) providers are not widespread but increasing(Anders and Okuonzi 2000). Traditional herbalists, birth attendants, bone setters, and spiritual healers form the informal sector. The argument for decentralizing health care is the potential for improved service quality and coverage. However, how this can be realized and the specific impacts on different groups are not well understood.

Since decentralization in the health sector is often politically driven, the theoretical benefits tend to get more attention than the more concrete facts of actual experiences. Without proper planning and acknowledgment of the lessons learned by other countries, decentralisation of health care can be disappointing at best. The logic of decentralization is that the workforce can be distributed more equitably, with increases in rural areas. Decentralization remains a favoured means to increase efficiency and equity, although problems may arise especially in competing with the private sector (Isabelle and Gilles 1999). How these problems are recognised and addressed is of interest to this study. Private sector runs for profit and has to situate itself in this system where the public sector is reaching the entire population with a package of essential services. This research therefore comes in that dimension to understand the dynamics of how these two interact and affect services to the poor especially in rural areas.

2.2 The Minimum Health Care Package

In an effort to put in place a cost effective intervention, Uganda constituted a minimum health care package to address communicable diseases particularly malaria, acute respiratory tract infections, diarrhoea diseases, malnutrition, perinatal and maternal conditions. This is known as the Uganda National Minimum Health Care Package (UNMHCP).

This approach is used to divide clusters; cluster one comprised of crosscutting areas of health promotion, disease prevention and community initiatives, environmental health, and school health as well as gender and health. Cluster two represents integrated maternal and child health that emphasizes safe motherhood, newborn care and child survival. Cluster three groups together prevention and control of communicable diseases with accent

on HIV/AIDS, Tuberculosis, Malaria and diseases targeted for elimination or eradication. Cluster four addresses non-communicable diseases (NCDs) with emphasis on healthy lifestyles for prevention of NCDs and control of poverty producing conditions such as mental health, deafness, blindness, age and disability.

These are interlinked and contribute towards outcomes targeted for the year 2010. These include, reduction of maternal mortality from 505 to 354/100000 live births, reduced infant mortality from 88 to 68/1000 live births, under five mortality from 152 to 103/1000, total fertility rate (TFR) from 6.9 to 5.4 children per woman in the reproductive age, and reduction in the disparities for morbidity and mortality between lowest and highest socio-economic quintiles (Ministry of Health 2005). Specific targets for cluster two of UMHCP take cognisance of the fact that utilisation of maternal and child health services are inadequate and coverage is limited.

The government blames low education of women and cultural practices for the low levels of utilisation. While this may be true, it reveals but half the story because there must be supply factors such as satisfaction with the services that cause low utilisation as argued by some researchers (Parkhurst et al. 2005). The notion of minimum is questioned if it means least of the desirable or limiting availability, accessibility and utilisation. The minimum may be designed in such a way that any additional required services should be a responsibility of individual users. It is desirable to question the means and systemic conditions under which what is perceived as minimum reaches the intended beneficiaries and this is what this study is aimed at achieving especially for poor women in rural areas who have disadvantaged positions in relation to their counterparts in urban areas and other working class women.

2.2.2 Minimum Health Care Package does it cater for all?

The overriding aim in setting an essential health care package is for the state to guarantee free access of its population to a set of health services it can afford. It is an insurance cover the state ensures with a purpose of helping to allocate resources in face of growing health burden with limited budget. Therefore government carries a commitment once such a minimum package to make it available to all those in position to benefit. This would mean that the government must bear the responsibility of financing all the requirements that are needed to deliver such a package, and failure to do so would be a failure on its commitment and should be held to account.

However it should also be noted that UMHCP is a direct rationing of health services by the state since services that fall out side the boundaries are not guaranteed to the population and therefore leaving them to private sector. The government is trying to provide the minimum package estimated at $28

per capita with only $8 per capita (Freddie 2006). Capacity to enhance emergency obstetric care is still lacking in many health units under the decentralised system (Ministry of Health 2005) just to confirm other studies that what is usually conspicuously missing is the element of emergency obstetric care that is either frequently omitted or "terribly" under resourced (Mc Donagh and Goodburn 2000)

According to the UNFPA (2002) twenty percent of the burden of disease globally among women is connected to reproduction. This situation is worse in SSA where the proportion is 40%. The average MMR in SSA is 1000 deaths per 100,000 live births. This sharply contrasts with the world total average of 400 deaths per 100000 live births. This applies the concept of equity between women and men in access to health services asking whether the health systems respond equally to men and women in equal need in view of the package that is determined. Women's health needs notably but not limited to the field of reproductive health as has been argued calls for prioritisation of the services in the package. There is need to take care to make sure that the package is relevant to the needs of the population that are known to address equity issues in the population. In this paragraph, the study argues that this may fail to be the case and thus sets out to inquire into this in Rukungiri.

2.2.3 The challenge in providing the package

Although HSDs are already working, government is still struggling with providing obstetric services. Unmet need for EmOC is 86%. Nationally only 38% of the deliveries take place under supervision of trained health workers (Ministry of Health 2005). Wilkinson (1999) argues that the essential package should include multi-skilled workforce in order to reduce maternal mortality.

As noted in this section a large proportion of morbidity among women is pregnancy related. Equity calls for treatment according to needs of different categories of people in the community and thus the UMHCP must fully address maternal services. There is however a tendency to disintegrate primary healthcare yet it is widely accepted that effective and universal access to reproductive health programmes produce major benefits to women's health and disintegration undermines access (Tangcharoensathien 2002). It has been argued that reproductive health is a basic human right and thus should not be dismissed as special pleading (Merrick 2002). This forms the backdrop from which this study proceeds to understand how maternal health issues are integrated in services of decentralised government.

2.3 Privatisation: Implications for maternal health care and the poor

Since 1980s, World Bank has been critical of size and function of government in the highly indebted and poor countries. They contended that budget deficits were brought by investment in social services which could well be left to the

private sector. The Structural Adjustment Programmes (SAPs) which were ushered in were embraced by many countries in developing countries which pursued privatisation policy. Functions formerly exercised by government are now mainly carried out by non-public entities, for profit and not for profit.

The national health policy is guided by the objective of making the private sector a major partner in national health development. This is already achieved with the PNFP subsector and a draft policy on PFP is in the making. The goal of these partnerships is to strengthen the national health system through full participation of private health sector to maximise the attainment of national health goals (The Republic of Uganda 2005). It is argued that by privatising social services such as health care, government can save and shift risk and liability to the private sector. Government has encouraged an increasing role by private forces including individuals and NGOs in health care delivery (Twinomugisha 2005).

As part of health sector reforms, proposed new mechanisms to finance the cost of care included user fees and community based health insurance. Results of studies carried in some poor countries showed that user fees were accompanied by decline in use of maternal health services particularly of the poorest(Mc Donagh and Goodburn 2000). The majority of the people affect by this failure to pay are found in rural areas. Uganda's 82% of the population is in the rural areas of whom more than 65% are women (Uganda Population Secretariat 2007). The maternal health disparity between rural and urban areas of Uganda can be explained by inability of poor women to purchase these services. In Uganda only about 15% is urban, it can be concluded that the vast majority of people have limited access to professional services. Inability to raise the user fees especially in rural areas where 80% of the poor live can have devastating consequences on the state of women's health in those areas (Melissa 2008). Without any remorse, Uganda is described as an economic star due to its privatisation policies but without explaining the persistently high maternal and infant mortality (Okuonzi 2004).

Scaling down of government towards a more regulatory and priority setting role, with responsibility for direct provision of services left to the whims of the market through privatisation, ensuring access to primary care for the poorest especially reproductive health becomes very hard. This type of behaviour by government during privatisation has led many writers to argue that welfare is postponed until an optimum economic growth has been reached without any clear timeline in view(Okuonzi 2004). Many have presented the public facilities for obstetric care in Uganda as pathetic (Mwenda and Platas 2009). This is because government has left its facilities with minimum resources while facilitating the private sector to expand under current privatisation policies.

2.3.1 Private Health care and the poor: Negligence?

Poverty and destitution is high especially among vulnerable and marginalised groups in rural areas of Uganda and especially among rural women (Ministry of Finance Planning and Economic Planning 2007). It is unrealistic to expect them to pay for maternal health services. Their access to markets where maternal health care is bought and sold is restricted .Women in the least wealth quintiles will therefore turn to members of the community like Traditional Birth attendants and healers who are not able to help in event of obstetric complications as was revealed in recent data that these constituted 23% of deliveries (Uganda Bureau of Statistics (Ubos) and Macro International Inc 2007). Accordingly, only 42% of the deliveries are attended by skilled providers and of these only 37% are residents of rural areas (ibid: 161)

Even with decentralisation, the philosophy behind the free market reforms is that as much health care as possible can be provided privately as a tradable commodity. Decentralized service delivery can only reach the people if it comes in the right quality and at the least cost for the marginalised poor and it is in this way that it can be judged. However this may not usually hold true and sometimes decentralization may proliferate the health facilities to increase physical access when economic access is reduced especially due to commercialization and privatization(Conyers 2007). This will lead to variance of expected outcomes and actual outcomes from the government programmes like health services.

Uganda still plans to recover 50% of the cost on the total health budget projections, with the help of "pro poor implementation of cost recovery" Success in health care in European social welfare models was related to strong governments that are able to intervene and control markets and by large scale progressive subsidies. In many countries like Uganda however, it has been argued, private provision of essential health services is encouraged while the regulatory capacities of governments to ensure quality and equity goals for the health system can be easily undermined (Verheul, E. and G. Cooper 2001 pp 15)

This type of shift reflects a prevailing ideological view of potentially greater quality and efficiency of private sector and the advantages of using competition as a way of shaking up the public sector. Much as this may achieve access to some poor, access for the very poor and marginalised groups becomes even harder under the same arrangements. This thinking has given rise to concerns of equity, efficiency and quality arguing that in reality privatization privileged efficiency over equity and quality (Standing 2002). Private markets have are not good in providing a cover against risk of mortality and morbidity, and therefore relying of them to offer maternal health services is an abdication of government from its responsibility to protect human rights. The view that maternal health care as a commodity that can be bought in the market to those able to pay excludes majority women especially in rural areas

from accessing them. There is need to be sensitive and ensure accessibility that guarantees the rights of those sections of the population to uphold and protect their rights to health (Melissa 2008). Many mothers who cannot pay to buy their right to health in the market arrangement are therefore abandoned by the state whose responsibility is to protect them in the face of the costs that they have to bear (Rath et al. 2007)

This section has taken us through the environment under which health care in general and maternal healthcare in particular is provided. The decentralisation is of a different nature from privatisation. While decentralisation was conceived to devolve powers of control and provision of services to local governments, privatisation calls for conception of the market as an efficient place to purchase goods and services with limited government intervention. It is within this environment that maternal health care accessed by women especially through the public sector which administers a minimum health care package that contains a set of services, free at delivery that the government has committed itself to provide for every citizen. The private sector provides services, are paid for at delivery by individuals. Private providers operate in the free market yet the exclusionary nature of markets rise questions about how majority of the poor, especially access them. Due to distance and economic inability, women in rural areas may not reach effectively the private sector. Decentralisation and privatisation may always overlap and sometimes leave gaps. The questions is what happens to those people whom the government may not reach with this service or who may need services beyond what minimum package has but is readily available in private sector as is always the case.

Chapter 3:
Understanding and Analyzing Women's Right to Access Maternal Healthcare

This chapter presents the frame to the approach for understanding and analyzing women's access to maternal healthcare as a right. It also conceptualises access to health care and thus sets the parameters in which the study understands how the health system is organised under conditions of decentralised health system and increased privatisation to provide health services to guarantee poor women's access to maternal healthcare as a right protected to ensure safe motherhood. This framework was therefore used to frame the research problem and to offer guidance in the investigation and analysis of findings to answer the questions of the study.

3.1 Women's right to health

Many people have been denied the right to health; realizing "health for all" as a basic human right should be the overall strategy of any health system (Verheul, E. and G. Cooper 2001). The WHO constitution states that it is one of the fundamental rights of every human being to enjoy the highest attainable standard of health. Every country is a signatory to one human rights treaty that addresses health-related rights, including the right to health and a number of rights related to conditions necessary for health. Several human rights treaties, including the convention on Elimination of all forms of Discrimination against women make specific identification of government responsibilities to prevent maternal mortality and thus must provide appropriate services for pregnant women (Panos, Institute 2001)

Maternal deaths in developing countries are often the ultimate tragic outcome of cumulative denial of women's human rights. The societies in which they live have yet to make decisions that their lives are worth saving, that is why they die. (Bhattacharya et al. 2008) further argues that maternity is not a disease but simply a social function.

The state and health care system are the most important entities in realizing women's rights to maternal health services. The state should ensure that the right to health of all women is met and thus must be accessible, available and affordable at all times of need. The quality should be sufficient not to compromise the health of the individual. Public health and health care facilities , goods and services as well as programme have to be available in the right quantities if we are to say that terms of availability are met (George 2007)

It is also very importance that the available goods and services are accessible to everyone. Four dimensions are needed when ascertaining to this

which include; 1) non discrimination in provision, 2) physical accessibility especially to the vulnerable, 3) economic accessibility wherein payment for health service should be based on principle of ensuring equity whether publicly or privately provided, and 4) information accessibility (Casimiro 2007)

> *"The right to health obligates governments to ensure that health facilities, goods, and services related to sexual and reproductive health are available in sufficient quantity, accessible to everyone without discrimination, acceptable (respectful of medical ethics and culturally appropriate), and of good scientific and medical quality (CESCR Paragraph 12)"(Erdman et al. 2008) The state therefore has obligations to make sure that the rights are guaranteed through a system that allows women access the most important services that are necessary for preserving their lives in pregnancy and child delivery.*

> *"Reproductive rights are guaranteed to everyone without discrimination on the basis of marginalized status, including poverty, age, sex, race, ethnicity, disability, health or marital status, geography, and sexual orientation. CESCR recognizes that, where services are not provided on principles of substantive equality, states are in violation of the right to health. CESCR, Art. 12)."(Erdman et al. 2008)*

Governments are therefore accordingly obliged to make comprehensive reproductive health services available and remove barriers to care in order to fulfill rights to life and health. This principle is crucial in reducing maternal mortality, infant and child mortality. Globally, 20% of the burden of disease among women of reproductive age is connected to reproduction and this situation is much worse in sub-Saharan Africa where Uganda is where the proportion is 40%. The right to non discrimination and respect requires governments to ensure equal access to health care for everyone and address the health needs of women especially the vulnerable poor women in rural areas in order to reduce both morbidity and mortality among these people (U.N.F.P.A 2002)

3.2 Conceptualising and Analysing Access

Hand in hand with women's right to health is the issue of access. Access has been used more as a political term than operational and a few attempts have been made to provide empirical definitions that would enable policy makers and consumers to actually monitor effectiveness of various programs who state access as their goal.

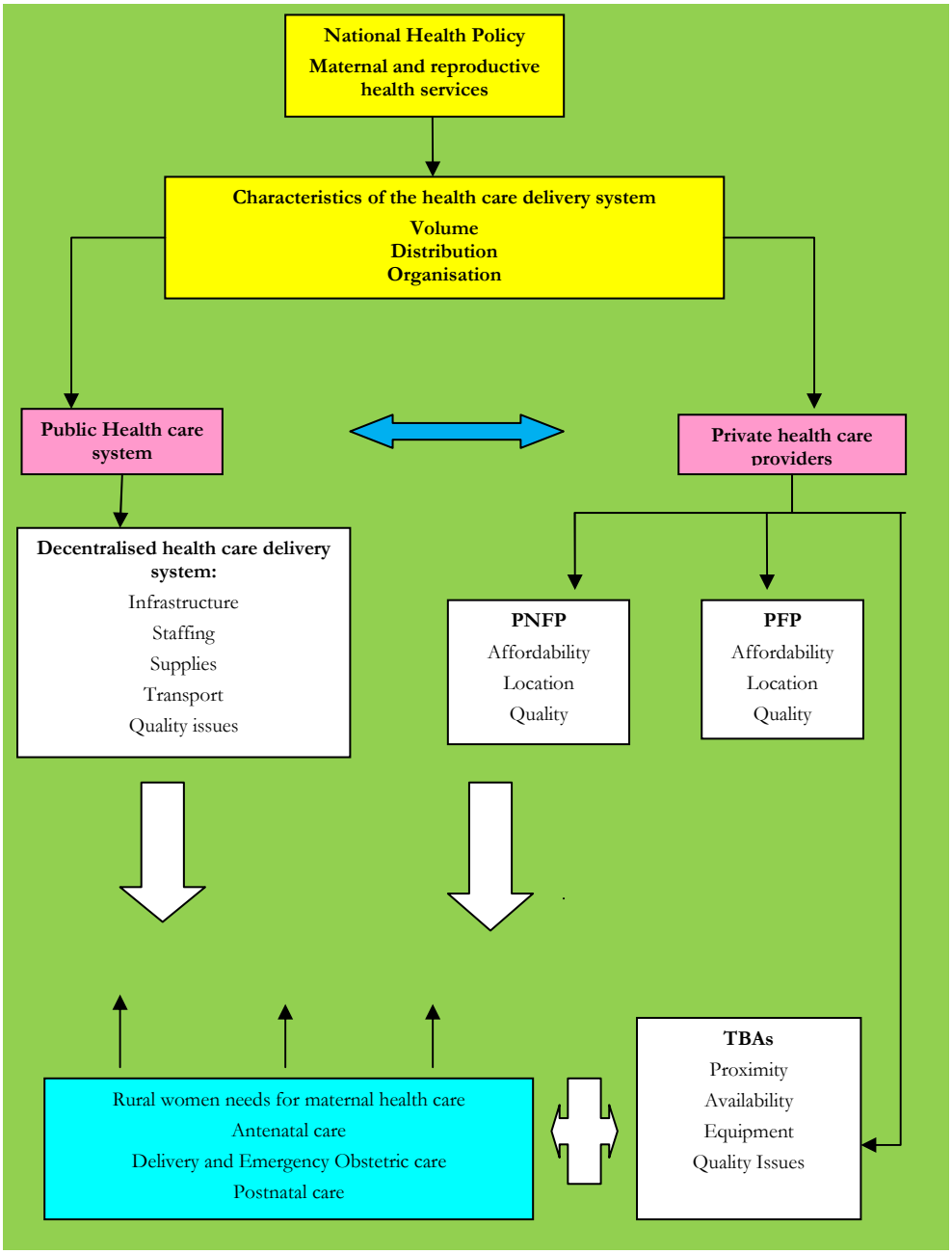
Access has been taken to be synonymous with availability of financial and health system resources in an area. It would thus be easy to assert that rural areas are deficient in professional medical personnel and ability to afford financial costs of illness. Also, the concept of access can be looked at in two main aspects; socio organizational and geographic accessibility (Culyer et al. 1992) Both perspectives are pertinent in this study because while decentralization brings health facilities within physical reach of the women in rural areas, the organizational issues of how the service is made accessible can actually be the final determinant of access to the services. Commercialization and privatization of health services including maternal health care also

becomes another barrier to rural women especially the poor even when the facilities are within reach. In conceptualizing the barriers of access by women to health services 3Ds approach has been explained, delay in recognizing the problem and seeking care, a delay in reaching care and delay in receiving adequate treatment once a woman has arrived at the right health facility. The first delay maybe caused by cultural factors within the larger social system but the second delay and the third reflect on the accessibility of the health system itself and more importantly how it functions to give proper treatment to those in need (Panos Institute 2001). Decentralized health system largely addresses the second delay by bringing health facilities closer to the people at the grass roots, but may not be enough when the facilities do not have the right treatment, personnel and equipment.

It should be understood that the major concern about health care stems from a concern about utilization of health care, which in turn stems from a more fundamental concern about health itself. Understanding access is important for reaching equitable distribution of health care since factors like costs will influence people's consultation behavior and compliance.

Focusing on access alone offers partial picture, and one needs to analyze utilization of the available services. However, this paper research concentrates on the provision of services though some utilization aspects are addressed from clients' perspectives. Many women especially the poor die because they tend to be excluded from available health care by barriers that hinder access. It is important that these issues presented in this conceptualization below should be viewed in terms of the women's rights to access and utilize quality maternal care services.

Fig 1: A framework for understanding the concept of access



Source: Own construction.

Access to health services is conceptualized by looking at the objectives, which determine the characteristics of health care system in addressing population at risk , the outcomes which are actual utilization of the health services and consumer satisfaction with these services (Aday and Andersen 1974)

The general policy on maternal health will inform financing, education and manpower related to health are all planned at this level, and "improved access" is always the goal of health policy. This policy translates into those arrangements for potential rendering of maternal health care. Organization reflects on what the system does with the resources thus co-ordination among providers.

In Uganda, a two tier system of health care exists; public sector financed from general tax revenues and donor aid; with services free at the point of service and the private sector, largely market oriented where health care is paid for through fees at the point of service. A partnership system has been developed especially for public health services where free services from government and donors are provided in private health sector to protect the health of the public. This type of arrangement (shown by left-right arrow) though is with the PNFP sector rather than the PFP sector. The TBA system is much informal and operates from within the communities themselves, flourishes in rural areas where majority of the poor live and depend on it when it's the only reachable immediate source of maternity services. TBAs are readily available, but have poor quality and technical know how to handle complications.

This type of arrangement raises even more the issues of accessibility which become even more pertinent especially for the poor rural populations. The private sector usually operates in main cities and towns and is perceived to provide services at a cost that can not be afforded by the lower income groups in society. The private sector also is perceived to provide higher quality services than government providers. These services however are not accessible to the poor and necessitate availability of comprehensive services in the public sector health facilities to cater for those who cannot afford. This framework access enables us to look at the configuration of services and how they are made accessible to the poor women in rural areas where private provisioning exists but some segments of the population cannot afford them. This would then leave the burden to the public sector as the only source protect the rights of access to maternal healthcare to those women excluded by exorbitant costs.

This study though with some elements of other factors considered in the framework, emphasizes the organizational system and the various health service providers to understand how rural women access the services provided under this configuration in the current system. The perspective of the providers and policy makers supported with some views from clients enabled to understand how the services that are supposed to ensure rights of women to maternal healthcare is guaranteed. Therefore views about priority of maternal healthcare under the decentralized local governments, supply of equipment and routine supplies, functioning of referral system and staffed norms are gathered in this with the view of understanding rights to health and how these rights are

being protected. Also in this study we will be able to provide recommendations on how to make the services under the decentralized system work better to ensure access to maternal healthcare by women in rural areas.

Chapter 4: Presentation and Discussion of Findings

This chapter focuses on presenting and discussing the findings from the investigations carried out in the field and documents identified through desk study to answer the 5 questions of the study. It provides a view into maternal health service provision from the point of view of service providers in the health care delivery system and also the views of beneficiaries and office bearers in the department of health that oversee the district's health service delivery. These findings lead the study to make conclusions about how accessible maternal health services are in the system where service delivery has been decentralised and also private practitioners in the sector has been increasing due to the privatisation policies that have led to liberalised markets in social service delivery.

4.1 Priority given to maternal health care in Rukungiri District

Government policies and actions impact on health services and henceforth assess to the same. Policies recognise that maternal health status as one of the indicators of human development tend to prioritise maternal health services and access to these services as one key of the key targets to reflect the integrity and effectiveness of service provision.

In Uganda the national health policy considers safe motherhood as one of the priorities of the health care system (Ministry of Health 2004), however policies that explicitly target access to maternal health care are lacking. While governments have in the last years of HSSP concentrated on expansion of health infrastructure, there has been less political commitment on ensuring provision of the practical equipment, supplies, human resources and drugs which are all major facets of the actual delivery of services that reduce maternal morbidity and mortality.

Similarly, in Rukungiri, there even when there is some political support towards committing resources to strategies that have shown to be critical in accessing mothers to maternal health care. The DHI, he was more direct at tacking the issue,

> *"Maternal health issues are prioritised, look at the structures and the improvements. Everything has been put in place and goes as planned. We have a maternity ward at every health facility as per the national priorities. Even when some of them are not functional yet, at least they are planned. But you should know that we are an aid-dependent country, when ambulances are broken down, we wait for donors to come in. So it should be expected that those problems culminating from that are just natural. When our maternity wards and TBAs were connected with a mobile communication gadget system, it was great, but when it broke down and the donors withdrew, there is no more money to repair the system according to the money sent by the national government. We should not and do not expect everything if we do not have the money and the people will frustrate themselves by expecting any better!!" (Interview, DHI)*

Indeed a lot of questions are raised as to whether this support for maternal health care is implemented with due diligence or just for political lip-service. Especially there has been a lukewarm attention paid to provision of emergency obstetric care as aptly expressed by a senior midwife;

> *"When we look at the national priorities, yes, we can see that at least something is done, in line with the internationally agreed MDG 5, the county is planning something. But whether maternal health care is a major priority will remain questioned, because things that are prioritised are not just written on paper, but we see strong political commitment with action to support the strategies that are developed. For example, funding comes to the district when it is earmarked for PHC and the national government instructs the district to budget according to the lines given, then what would you make of that? The funding brings out the whole truth about what kind of priority. Look at the staffing chats and the supplies and equipment, then you will know where the priority is! The strategy is there, well written, but responsibility to operationalize the strategy lies at the district and health sub district. However the activities agreeable in the funding lines do not reflect the strategies in the national priority areas for maternal health. The there is the controversy" (Senior Midwife, and In-charge Maternal and Child health, Rukungiri district)*

Community members do not know whether any priority in attention to maternal healthcare exists and many believe that the issue has not been given any priority to say the least. This came out clearly when in an FGD one noted

> *"Not a lot is meant by all the government talk about maternal health when they are doing nothing. It is hard to say what they are prioritising when all we see here is neglect. When we talk to our nurses here and they say, we have nothing, we send patients and they have to be referred to private clinics of individuals, what have we to show priority. Maybe other things are priority, even malaria and HIV/AIDS comes first if you are to put the priorities we see in a line. Haven't many women delivered in our homes when the health centre is closed or lack equipment?" (HMT Bwambara)*

However, the district has shown commitment towards improving maternal health. The department of Maternal and Child health out of the desire to see the outstanding gaps in the number of trained midwives needed in the delivery of maternal health care, did present in its budget a request to train midwives who would then be bonded to the district for 7 years. This has been ongoing for the last 4 years and has boosted the number of midwives available for hire within the district who are not at liberty to move anywhere for employment. This has gone along way in reducing the gaps in available skilled providers in the district. However, this is an incidental gesture and not an instruction from government. The head of the department did not hide her pessimism about sustainability of this project she commented thus;

> *"The budget allowed this project as long as we get the donor aid that has been coming separate from the central government conditional grants for PHC funds. Once the donors who are not necessarily predictable get a mishap, even the students that are now enrolled can have their scholarships cancelled. We have seen such excellent projects die a natural death especially in this department. We had mobile contacts with Traditional Birth Attendants (before the current scenario when they are not allowed anymore) and a mobile van for maternity purposes. It is all now broken down and history because when the funders of the project stopped, the district did*

not have money, not even for repair. Now the system has broken and we rely on private mobile phones of our staff to communicate any essential information in referral and also other work related needs. (Head MCH division, Rukungiri district)

As rightly argued above, incidental gestures without proper structural incorporation into planning system always face sustainability and could be basis for questioning commitment to the cause maternity care.

The district health visitor in another attempt to highlight local government's commitment to prioritising maternity care strongly affirmed that they are working hard to makes sure that HC IIs get fully functional at the level of all parishes albeit with an embedded disclaimer to cover up for the current failure of the system to provide at that level

"Physical infrastructure which is much needed will be built and this is our current priority. We need to have structures were staff can be accommodated so that we have stationary staff all the time. At this moment you cannot require one to stay there when there is no staff housing. We need to make sure that the structures are there and we are moving to that. After that then we can think about the necessary supplies and equipment for the services to be effective" (Rukungiri DHV)

These statements portray a blurry picture about the status and future as far as maternal health care is concerned. For example, while it is clear that the district is pushing for the construction of HC IIs, no reference is made in as far as maternal health is concerned. Many a times, mere existence of a health facility has been used a justification when in actual sense these are not equipped for antenatal and delivery care. At health centre IIs for instance, there is no maternity ward planned though the structure allocates a midwife to it. Effort to get the district health visitor to comment about that disparity triggered an answer that was actually revealing of the more neglect, even though unintended may be existing,

"We as the district will not choose one service to give; we try to give all health services. If some seem to receive less attention, it is because the resources are limited. We do not have the money to provide for the services that are required by everybody in the district. If we had all the money we would be glad to give everybody the services they want for free. And it is because the country cannot afford to pay that they have allowed private clinics and hospitals for people to go and pay" (DHV Rukungiri)

This means that even when there are many government publications showing that maternal mortality is a priority area as per the MDGs, questions still remain about the seriousness and commitment given to it, and how that is going to be achieved under circumstances where it does not receive the due priority till the lower levels of service provision from where it can be implemented.

It should therefore be noted that unless maternal health care needs are looked at as a priority, a lot of injustice will be done to women.

In summary though local governments have been running health service delivery through the years under the decentralised system, there has not been

explicit show of priority attention to maternal health care. In principle while the government is trying to ensure that right to health is met, there has been yet little to show for the effort, as the decentralised system itself is still struggling to reach to the grass root communities at parishes especially as far as maternal health is concerned. The most impressing attempt at promoting maternal care in Rukungiri has been the local governments initiative to train own midwives whom they will bond to the district for a period of time. The continuity of this project however will depend on other exogenous factors especially funding from outside. Attention has been concentrated on putting up physical structures for now and once that is in place, the necessary services will be looked into. In the next section, we will see what happens on ground where the physical structures for maternity care are already in place.

4.2 Facilities and staffing of Health Centres for maternal health services

For a health system to offer effective maternal health services, a number of its components need to be fully functional. Uganda has identified one of the major components is essential health supplies and equipment and human resources in the delivery of health services. Even when health providers are skilled, their ability to provide maternal health care can be greatly hindered at any level in the health care system if the essential equipment , drugs and supplies are not supplied regularly and in sufficient amounts. Shortage of drugs is one of the main problems in health service delivery and can be partly due to inadequate funding and partly due to poor management.

4.2.1 Supply of essential drugs and equipment for maternal health

In Rukungiri district supply of essential drugs and equipment for maternal health care in public health facilities continues to be a big challenge even if claims of improvement are made. Many times, especially due to drug and other basic utilities stock-outs, it has become a common practice to refer women or their attendants to private clinics and drug shops to purchase whatever supply they need that is missing in the hospital before they can be attended to even when the services are supposed to be free. The District Drug Inspector did not hide the problem when he aptly points to the problem the health sector is facing in purchasing drugs especially those that are recommended as crucial in saving mothers in pregnancy and child birth. In the interview, he beckoned thus;

> *"The district faces strict funding guidelines for PHC and drugs that are must be available for mothers are not always available. Fansider and Iron tablets are important but when we make orders, the National medical Stores inform us that they are not available. We are always offered with Non- availability certificates, and yet after hat there is nothing to do. The women who are prescribed those drugs have to buy them from the private clinics and drugshops." (DDI Interview)*

In Uganda, the leading cause of mortality and morbidity is malaria and it becomes even more fatal to pregnant women. Anaemia is identified as a one of

the leading causes of mortality among mothers. However as has come out in the case above constant shortage of these drugs is common phenomenon. At one public facility, iron tablets and fansider was missing for 4 months and 2 months respectively at the time of the study. Inefficient supply remains a big limitation in the provision of public maternity care services.

Basic supplies for carrying out sufficient ANC and a normal delivery like gloves and delivery kits are not guaranteed even where maternity wards are available separate from other regular illness wards. At a HC III which is supposed to provide comprehensive care, the midwife complained poor facilities when she commented;

> *"In this facility we have no weighing scale. It was broken by the time I was posted here, there is no BP machine, there is no thermometer and even the bed used for testing mothers was broken we now improvise with the table as u can see! Pregnant mothers need their pressure to be checked regularly because if it fluctuates frequently it signals need for emergency preparation and caution. Now I can only rely on guess work and encourage them to take a lot of fluids without any measurement of truth!" (Midwife, interview HCIII)*

Such comments in a working system speak volumes about the situation of provisioning of maternal health services. In commenting about an incident where a mother was reportedly neglected and died in hospital, one writer cautioned the public against heaping blame on the midwives, perhaps they were missing basic supplies as has become a common problem in all public facilities or even worse the case may have been above their competent when competent doctors were absent from duty (Wokuri 2009). She raises the doubts about the availability of simple basic supplies concerning maternal healthcare as is the case in the case above of Rukungiri.

Pregnant mothers visiting for ANC do away without enough medication when it is not provided by public health facility. This was revealed in the spontaneous response when asked about what happens when the drugs prescribed are not available at the facility. They responded in chorus;

> *"When the nurse (actually midwife, but they call her nurse) gives me some medicine and tells me to buy more, I just go and take the ones she has given me, when they are over I come back. It is usually hard to go to buy the medicine in town (23km away) because not even the drug shops here have the medicines they usually give us. Many times somebody does not even have money to buy salt, and at home children are eating food without sauce, then how do you tell your husband that you want money to buy medicine? (FGD Bwambara)*

The midwife decried this situation because it can be with fatal consequences especially during delivery if the precautionary medicines are not taken. Poor drug supplies at health facilities go unanswered or with simplistic but weak explanations that ensuring efficient supply of drugs is not within what the district can do.

On a good note, physical infrastructure is in place especially at HC IIIs with good labour wards. However, it was found among nurses and midwives that they did not have enough the basic supplies for adequate maternity care.

Women have to purchase these basic equipments to the health centre and in cases needing complicated equipment not available in drug shops, the only remaining option was to refer the patient to a PNFP hospital.

Midwives have tried to improvise and make basic supplies within reach of health facility but their efforts backfired when it created misunderstanding. They privately procured some drugs and basic supplies like gloves and delivery kits, which they would then provide to patients both for ANC and delivery at a price. With time, women accused staff of soliciting illicit money for government provided services. In an interview, one midwife explained the situation;

> *"We made a request for gloves but they brought 50 pairs! A single delivery can use almost 4 pairs, and that's when everything goes smoothly well. We deliver more than 30 mothers a month, therefore, we cannot keep the stocks for all deliveries, and we have to send the mothers to buy their gloves! We used to have a box of gloves which I would keep at my home so that in case the government stocks run out, I can help them to buy from me, with time they started spreading rumours that I sell to them the government gloves. I had to stop" (Interview HSD)*

This is typical of what challenges midwives go through if they feel they can do better but necessary supplies and equipment are not availed sufficiently. Privatisation in this is driven not by market forces but by failing public system to the disadvantage of the poor.

A midwife in a show of frustration at the inefficiencies burst out during an FGD and shouted in a voice aptly presents the dilemma that they face to which others nodded in approval,

> *"If a woman comes for delivery without her own utilities, I know the facility is out of supply, I will tell her to go, or refer he as a way of getting her away from me! I can not seat and wait with her for the baby to start coming out when I am well aware that I do not have the equipment to help her deliver. I cannot feel bad as a person, because we do what we can! It's not our fault that these things are not there, the women will not know anything that happens in here but God will be our judge. No one can serve food that has not been cooked. It is the government that cooks and for us we serve, how can we serve food that we have not been given? TBAs up to now they do it without gloves or anything and many of them have acquired HIV AIDS in the process! We as professional workers cannot allow putting our lives at risk and those of our families. Unfortunately the politicians keep deceiving people that the services are free and have and that drugs and everything necessary has been provided" (FGD Midwives and Nurses)*

Chronic shortages of equipment, basic supplies and drugs, typify a system that becomes hard not only for the patients but also for the workers within the system. Unfortunately, like noted above, politicians responsible for the running of local governments seek political capital by informing the public that all services are provided free. True to their word, that is on paper in government documents and policy statements but what goes on at the point of delivery tells a different story. The reports showing improving maternal health indicators are good but should not blind our sight of the dynamics on the ground. This is specifically true where the private sector extensive and can bring service to many women who can pay. This should not diminish the responsibility of government especially to avail services to those not able to pay the prices in

the private sector. Attention should be paid to the majority especially in rural poor households who cannot compete for services in private sector.

4.2.2 Human Resource for maternal health care

Health services are highly dependent upon skilled human resources, its availability, quality, commitment and performance. Maternal health services especially emergency obstetric services are even more dependent on highly skilled human resources as they need complex procedures like caesarean section which require competence. Ensuring quality maternal health services including emergency obstetric care in a challenge in absence of adequate skilled health personnel (Gerein et al. 2006).

In Uganda, obstetric care is mainly provided at health centres with hospitals providing a back up referral care services. As is expected, in health centres, enrolled midwives form the back bone for obstetric care delivery while general practitioners compliment their work at Health centre IV and hospitals. There is however shortage of midwives and doctors in rural areas where most women who need obstetric care live (Ministry of Health 2005). There is an urban bias in availability and distribution of health practitioners in general. Following the same trend, it has been observed that over 80 % of the doctors and 60% of the midwives and nurses are located in hospitals which mostly serve urban populations.(Mbonye, Mutabazi et al. 2007)

The quality of health-care facilities available in any area has been found to influence maternal health by determining the rates and frequency of their utilisation (Thaddeus and Maine 1994)In Rukungiri District being a largely rural district, there is a lot to be desired from the situation faced on human resources especially for maternal health. In an interview with one of the respondents, she had this to note,

> *"Conditions of work are not good at all.. There are no free days because the staff are few, then u need time for your family. Imagine my children will soon need to be in school, which school will I put them? UPE (Universal primary Education school) I need to put them in good schools which are far away in town, therefore I will have to move my home there. That will limit how long I can stay at the duty station and if it becomes totally impossible I go to work in town in a private clinic, just for the sake of my children"(Midwife, rural health facility)*

This is common in all health facilities that serve rural areas. The providers are usually urban oriented people who cannot adjust and move their families to stay with them at the station of duty. For instance, since the upgrading of Bugangari Health Centre III to HSD, the position of medical officer was approved. However, the holder of that office has never stayed in Bugangari but choose to stay in Rukungiri town 13 km away which means, availability at post of duty is according to his/her own convenience and not as needed by patients. This certainly raises questions of the speed at which women are able to access the services of the doctor especially in case of emergency

complications that develop after normal working hours. They would end up being referred to the health centres in town which is far and may contribute to the delays in accessing service a big challenge among other factors that ultimately culminate in the unfortunate loss of life at worst and at best permanent disability to the mother.

There is more to that than actually may just meet the eye, as can be revealed from an interview with one of the medical officers posted to a rural health facility, but chose to reside in the urban centre far away from post of duty.

> *"I would stay at the centre where I work, but there is no proper accommodation for me and my children and I have a good house in town. In relation to maternal health care, there maybe not much I can do, since the theatre I would use is not yet functional because there is no equipment necessary to run it, no power (electricity) and not even running water. Many necessary tools that are supposed to be in theatres for example to carry out a caesarean section were requested but the district has not yet procured them citing funding issues. This renders me redundant at least in that issue of maternal care which would be very easy to do once the theatre is working. Choosing to stay in the filed would mean having to move my whole household which is not possible at this time" (medical doctor, HSD)*

Notably the choice not to stay at the provided work housing is supported by poor facilitation for the doctor to offer required services. Even when this should not be the reason, he argues that the theatre is available but not operational for him. Under utilisation of hired staff is not uncommon in the local government especially due to poor facilitation with equipment and other supplies. This renders the staff redundant and perpetuates the laxity in their motivation for service. In all health Centre IVs in Rukungiri, there is a position of a medical doctor to carry out especially caesarean section while delivering mothers. However their services are rendered redundant because not of the operation theatres are functional.

A close look at the distribution of the most critical human resource for maternal healthcare, midwife has important revelations about it and the seriousness of human resource for this service in Rukungiri.

Table 1.1 Availability of midwives per facility in Rukungiri District

	Facility level	Per facil-ity	Approved	Filled	Gap
1	**Hospital**		*25*	*39*	*+19*
2	**HCIV**	*3*	*9*	*12*	*+3*
3	**HCIII**	*2*	*18*	*17*	*-1*
4	**HCII**	*1*	*23*	*6*	*-17*

Source: Own construction

Table 1.2 Clinical officers available in health facilities in Rukungiri

	Per facility	Approved	Filled	Gap
Hospital		5	14	+9
HCIV	2	6	7	+1
HCIII	1	9	6	-3
HCII	Na	Na	Na	Na

Source: Own construction

Tables 1.1 and 1.2 illustrate not only the existing urban bias in the distribution of human resources for maternal health but also the bias towards the human resources that are not directly and primarily needed in providing care in childbirth. Urban facilities get more personnel far and above the approved positions. Lower level health centres which also happen to be located deeper in rural areas do not have the required or approved potions filled. This maybe understandable for the hospitals which are PNFP and may have the liberty adopt staffing norms different from what the government sets since they do not rely on government payrolls to remunerate their staff. However for HC IV to have 3 extra midwives than the approved and the lower level HC III and HC II lack 1 and 17 midwives respectively leaves a lot to be desired from the way in which staffing is planned and implemented in the district. Also noteworthy is the fact that while many health centres under the decentralised health system that are responsible for delivering comprehensive maternal health care are under the supervision of medical assistant, these are not trained to address issues of pregnancy and delivery.

When the issue was raised to the Deputy LCIV chairperson who doubles as a member of the Local council for one of the sub-counties in the district, her answer left more questions than could address the issue;

"My thinking is that because the HC IVs are in town, some untouchables want to keep posted there so that they can concurrently run their private clinics and the government facility. That is part of the politics of work and employment that run in your country. I think that question should be asked the directorate of health services in the district. If we as politicians want to enter such details, we get out down fall in the process because you do not understand what powers are involved in case of such contradictions" (Deputy LCV Chairperson)

This is an accountability and governance issue, because the law does not allow government workers to serve in the private sector. Also, having extra personnel at one facility, and a deficit of the same positions in another facility shows lack of transparency in the whole system. Any fatalities that result from this negligence especially in maternal health can and should indeed be blamed on this lack of oversight.

In Rukungiri district the bulk of maternity services are provided at health centre IIIs which in many cases mainly serve the rural populations. Although there are midwives as shown in table 1.2 above some of them have not acquired the required staffing levels. While these midwives carry out normal deliveries and manage simple obstetric complications, day to day supervision of the midwives at the Health centre III is done by a clinical officer in charge of the health centre who unfortunately lacks both knowledge and skills in midwifery. The gap between the approved positions and the filled becomes even bigger at the lower health facilities in the decentralised system with shortage of midwives in HC IIs a staggering 17 midwives. This actually means that out of 26 government health centre IIs, 17 lack services of a basic midwife, which indicates the problem of maternal health service provision in further rural and remote areas.

Rukungiri district has moved to improve its health staffing levels by training personnel, whom they later bond to work with the district for a number of years. This has led to increase of midwives in health centres under the district. However the problems still remain!

"Much as we as the district have tried to work hard, we have chronic understaffing! The staff ceiling for health structures are appalling. For example when you look at the structures, there are supposed to be two midwives at Health centre III, 1 at Health centre 2 and 3 midwives at HCIV. But these are few in relation to the burden. Antenatal care, home visits, family planning education, post natal care maternity ward delivery, escorting for referral, and domiciliary care! If the midwives are to provide all these services, then it is impossible for them when they are just two at a station. Remember they work day and night because you cannot control the times of pregnancy related cases" (Head Maternal and child health department Rukungiri District; Interview)

Further more; Rukungiri faces a challenge of retention of staff in rural health facilities. General practitioners and midwives are reluctant to work in rural areas owing not only to physical hardships but also due to lack of professional growth opportunities. Also at HC IIIs and HC IVs, there are clinical officers who are usually more available but even when they are charged with the role and responsibility to supervise midwives and other nurses and oversee the provision of all primary health care services; they have a notable lack of midwifery and obstetric surgical skills in their training.

Rural populations therefore are at more disadvantage of getting skilled attendance when in need of these services at facilities nearer to them. When access to nearest health facility however is measured, the district will come up with a wonderful figure of 80% within 5km as is the case in Rukungiri now (Rukungiri District Local Government 2009). This figure tends to portray a distorted image of the truth as it holds on ground especially for maternal health services that are not necessarily the same as other clinical services required for other different groups and gender in society. In the light of this shortage of health workers, especially in rural areas, provision of 24 hour, 7 days a week access to maternal health care especially emergency obstetric care service remains a big problem in Rukungiri.

4.3 Referral in maternal health cases

As has been argued before that properly functioning referral system is an essential component of access to health care and is particularly important during pregnancy and delivery for providing access to emergency obstetric care and to provide back up for delivery care in the first line facilities (Rath et al. 2007); Uganda has emphasised its commitment to improving these services albeit at policy level. The government has recognised the importance and therefore in its reproductive health strategy pledged to improve by providing and equipping fully functional HC IVs across the country as first referral level for obstetric emergencies.

In Rukungiri District, according to the report and common knowledge in the health an office, every Health Centre IV has been given an ambulance to ease the transportation of cases that cannot be managed at that level and need referral. Transportation being one of the major factors contributing to delays to reach health facility, the gesture and intention of providing these ambulances cannot be over emphasized. However, the workings of these ambulances as the first major resource needed have problems that need to be understood as far as Rukungiri district is concerned.

Situated at HC IVs, questions that appear to every researcher is whether these ambulance services are accessed at other lower levels especially where according to the structure the referral cases are supposed to be coming from. Many lower level health facilities in remote areas where they are needed most do not access them. As a first eye opener, the radio call network system that used to exist between the hospitals and health centres but it has broken down since 7 years ago and the districts do not have so far failed to repair them. Thus, without a functioning communication system, health centres that do not have ambulances cannot call for emergency ambulance evacuations when there is need.

Probing into the same issue revealed more flaws in the functioning of ambulances. In an interview with one In-charge of the maternity ward, she lamented that the Ambulance for the health centre was taken by the district health officials.

"Nobody recognises the car as belonging to patients, officials from the district just make a call and it is taken to drive them around" (Senior midwife, HSD)

That notwithstanding, when the vehicle is finally made available to use, a lot is left desired in the way it is facilitated to run. In one focus group discussion (FGD) with nurses and midwives a health unit, they expressed dissatisfaction at the way ambulance operates,

"The ambulance is not fuelled, every patient must fuel it. When one tell a mother that she needs to be referred to the hospital, she has to pay for fuel which is about 70,000/= (26 Euro) and these are poor mothers. Some of them cannot afford and they think that services are supposed to be free, because that's what politicians tell them. They end up going back home or going to hire a private car which is cheaper because it charges one way fare." The biggest problem with that is that under normal referral circumstances one of the midwives is supposed to escort the mother, but when we are not sure of transport back, then we cannot go, and we just give a referral letter. Many times the mothers refuse to go and what happens to them is what we can only speculate about. Some who are from nearby die others lose their children as a result" (FGD nurses and midwives, HSD)

Just like other supplies to the health centres, this too is not without insufficiencies. In a system which aims to guarantee universal services with a minimum package, one would expect that the service does not put undue expenses on the local people especially those that are clearly not able to raise the funds. With average monthly salary of a school teacher being about Uganda shs 140,000 (51 EUR), any cost sharing that would require unemployed citizens especially in rural poor populations would be rather too much.

One of such uncomfortable facts reveals with the experience of one woman who had recently gone through the process of pregnancy and birth at the health centre. In an FGD her story reveals what such ill prepared health facilities cause for women going through pregnancy,

"I visited the health centre for all ANC, when I came to deliver I was told that I had to deliver at hospital because the foetus was in bad position. I didn't have money to hire a car or fuel the ambulance. I sent for my husband, but when he instead took me back home to look for the money. A day later, I got the birth pains. With the help of a local birth attendant, I delivered a baby who died during the process, and I was rushed back to the health centre where I was admitted even when the nurses insisted I needed to be referred to the hospital. We resisted because we had no money and I was lucky to have recovered because they found nothing was wrong with my womb. Many women would have died in this situation" (FGD women)

The midwives, even aware of fatal consequences to the mother and the foetus could still not prevent her husband from taking her back home because they did not have what to help her with. It just unacceptable that poor women are asked to pay for services and supplies that government has promised to

deliver at no cost to the consumer. It makes the services inaccessible to the most needy that cannot pay as in the case above.

In Rukungiri district, all pregnancy complications are referred to a PNFP hospital where user fees are charged. The existing co-operation between this hospital and the local government has not put in place modalities to waive any kind of user fees for any reasons. In an interview with private provider, she arguably explains the fear of referral among the poor when she commented,

> *"Actually the problem with referral is not the cost of transport. Where they are taking them is also a private hospital and they charge almost 200.000/= for caesarean section and other theatre based procedures. If the government operation theatre was working, these services would be available and most problems with referral would be done away with" (Private provider, Bugangari)*

Given the type and speed with which pregnancy complications come, having no ready remedy for them in the nearby government structures is a neglect of responsibility. Other illness can be referred to regional and national hospitals but pregnancy complications come first and don't give time for travel to the next free government hospital 100 km away. Rukungiri therefore faces a challenge to meet the needs of women especially those that suffer complications in delivery and must do so without turning the burden of care to the family if it is to guarantee the right to health of poor communities and provide fully the minimum health package without discriminating women.

Referral also has to do with availability of staff to go with the patient to the next facility if it is done properly. Because of poor staffing norms, health staff cannot accompany the women who are referred. In an interview with one midwife, she tried to put blame the patients and do not see it as their responsibility to try and do what they need to do.

> *"These women are lazy, they do not prepare, for the whole year they have been pregnant and they cannot even put aside some money or come to health unit on time. Then they wake you up at 8pm in the night and you are supposed to travel with a patient to the hospital. Will that be the work I will do for the rest of my life? She continued, 'you see, for us we see these women everyday, we live with the problem, my job is not going to be travelling with delivering mothers everyday to Nyakibaale(the district hospital) and leave my infants at home with nobody to care for them!" (Midwife, HSD)*

The issues raised in her concern deserve understanding, but blaming the poor for not saving enough money is rather a disregard for the complexities of gender related issues in society. Accompanying the referred women on their way is legitimate because sometimes complications can increase on the way. However, without an ambulance, midwife cannot join the patients in their private transport. More complicated is the situation where there is only one midwife as is the case when one of them is off duty.

According to the in-charge of the health sub district, the ambulance is the same car that is supposed to transport nurses and midwife to carry out community outreach program. There are 4 outreaches in a month and each takes about 5 litres. At the end of the month, the 50 litres of fuel which are given for the ambulance to go for 3 months end up used within a month even if no referral is made. This is a problem of government giving the minimum to a sector that it considers priority.

4.4 Alternative sources of maternal health care.

4.4.1 Public and Private not for Profit (PNFP)

In Uganda in general, the public and the private not for profit sub sector have almost an equal stake and are dominant providers of health services. Similarly in Rukungiri district, PNFP sub sector is a major partner to the public sector in the delivery of maternal health care.

Table 1.3 Formal Health Units by ownership in Rukungiri District

Type of Facility	*Govt*	*PNFP*	*PFP*	*Total*
Hospital	0	2	0	2
HC IV	3	0	0	3
HC III	6	7	0	13
HC II	26	21	0	47
Clinics	0	0	17	17
Total	35	30	17	82

Source: (Adapted from Rukungiri District Health facilities inventory 2008/2009)

Out of a total 82 facilities, 30 are PNFP owned and that includes especially the only two hospitals in Rukungiri district. These hospitals serve as centres for comprehensive emergency obstetric care is provided. To sustain themselves financially, PNFP facilities charge user fees paid by individuals who utilise the services. The government has sought to strengthen collaboration and partnership between the public and private sectors in health as part of their guiding principal (Ministry of Health 2001). This has seen some funding going to PNFP hospitals as part of effort to strengthen service delivery. This subsidy from government is able to reduce their operational cost but the impact is not usually big enough and they have to continue heavily relying on out of pocket fees from clients. The DHV decried the situation that faces the district when he commented in an interview,

> *"In other districts, there are operational government district referral hospitals, but not for us, we have to meet the needs within the conditions which we find ourselves. Mothers referred from out public health facilities have to raise the fees to pay at the hospitals we have with operation theatres. The costs for the treatment are about 220,000 Uganda shillings for a caesarean section and for normal delivery it is about 70,000. This is extremely high if you look at the poverty levels especially if you go down to the rural areas and see the appalling situations that people have to leave through. The costs push them away and they die in their homes trying to get support form friends and TBAs" (District Health Visitor)*

Costs for emergency obstetric care in these facilities in case of a major intervention like caesarean section can go up to $91 a cost that can be too high for the majority of 38% of Uganda's population living below 1.45$ a day. Women form the biggest population of the poor, most of who are also in rural areas, sometimes very remote.

4.4.2 Private for Profit Provider (PFP)

Uganda has since 1980s embarked on policies that increase private provision of goods and services while seeking to reduce on the government size in the same field. This has invited a lot of private investment in the area of health services to cover the functions formerly provided by the public sector. The World Bank led supporters of market mechanism and liberalisation believe that privatisation will lead to improved welfare of the poor. They further argue that by relying on market forces, private persons and NGOs can deliver services with much more efficiency and yet at a lower cost than government. However this turn of events and approach to service delivery practically turns provision of maternal health care from a covenant on the side of the state to a business contract (Twinomugisha 2005). Relying on market forces ignores the reality that rural women do not usually have the ability to control market returns on their labour therefore lack sufficient income with which they would access the market where quality maternal health care is bought. Maternal health care is not like any other ordinary commercial goods that can be left to the market forces because of the complex issues involving gender, and negative cultural practices (ibid:81)

Rukungiri district, being a largely rural district does not appeal to many investors. The district has about 17 PFP facilities (see table 1.3) of which 7 are in Rukungiri Town Council and the rest at Sub county headquarters with little or minimum access to rural areas. These clinics are operated as private businesses and have been left out of any collaboration with government yet they play a major role in providing maternal health care services. In an interview one midwife commented,

> *I worked with the government health facility for 28 years. I know what essential supplies are many times missing in public facilities and that's what I stock in my clinic. Women end up here looking for them. And I sell them at retail price, so u cannot expect the same price as pharmaceutical shops in Kampala. Some women also come to me telling me that they will sell their goats after I have delivered them, I just allow if I know them properly. If I cannot handle any of the complications I receive, I go with the patient with my car to hospital and explain to the doctors the problem (Private midwife, Bugangari)*

In an interview with, the DHV lamented the poor distribution of private providers when he commented,

> *Almost all the private clinics and maternity homes that offer services similar or better than what Government offers are located in towns and trading centres. The rural areas and remote areas are shunned by the private sector because people there do not have money to pay. The district has nothing to do on this; it can be dealt with by the central government under the ministry of health (District Health Visitor)*

The private sector cannot be directed where to invest by government. And as noted earlier, when the public sector fails to deliver, the private sector expands to those who can pay. The fact that they do not reach the rural areas calls for more concentration of government service to make sure that the accessibility is not skewed more to the urban areas by government actions.

4.4.3 Traditional and Alternative maternal health Practices

Many studies have found out that traditional medicines are commonly used during pregnancy and after birth in Uganda. Indigenous medicines have persisted for a long time and become more common in areas where there are inadequate modern medical services and inadequate drugs in health facilities. While some of the medicines have well known remedies for different groups in Uganda, others have been tested to be dangerous due to the toxic elements that they contain (Neema 2001).

There are a range of local herbs for different purposes ranging from stimulating labour contractions at birth, widening birth canal, preventing miscarriage and stomach upsets and cleansing the baby that are commonly used in the societies. These herbs are used and re-enforced by different beliefs held by different traditional groups and sub cultures (Nydomugyenyi et al. 1998)

Traditional birth attendants (TBAs) are very common in the provision of maternal health care especially to poor and rural women where services from the formal health care breaks down. TBAs are members of the community with no formal training but who have acquired skills through apprenticeships and are well known by people in society. Studies have indicated that most women in Uganda deliver in their homes assisted by relatives and TBAs.

From late 1980s, government of Uganda started mainstreaming the services of TBAs into the main service delivery as a strategy to increase care and reduce maternal mortality. However, with time, studies indicated that they tend to have little knowledge on danger signs in complicated pregnancies which lead to loss of both lives of the baby and of the mother.

> *It is on a daily basis that you go to a health centre and they do not give you anything. Every time, they tell you to go and buy the medicine. They give us some drugs and tell us to go and buy the rest. It is very expensive in the shops and we cannot buy it. When we have problems at night it is very hard to go to the health centre or sometimes one is told that the midwife has gone to town. TBAs know how to help and even if one finds them in the garden or in a party and she will allow checking you. And they tell you exactly like what those who go to hospital are told (FGD, Women)*

It is believed that women tend to have more equal relationship and socially acceptable dialogue with TBAs compared to formally trained midwives in formal health facilities. It is for this reason that many mothers still find solace in them, especially when they are not able to pay the high costs of maternal care (Nydomugyenyi et al. 1998) However they have since the

HIV/AIDS pandemic been outlawed, but the irony is that without a successful replacement for their services, TBAs have remained popular even as health facility deliveries have remained below 45%.

4.5 Major challenges in the current system of provision of maternal health services in Rukungiri District

From the study, it was noted that all the HC IVs were not fully functional. As a result, pregnancy cases with complications are referred to PNFP facilities which charge fees. These fees have made accessibility to these life saving services especially by the poor much harder. They end up delivering from else where and when they develop complications they are brought when it is too late to save their lives. The DHV in commenting about this situation noted,

> *"HC IVs will soon be functional, but the challenge is the funding from the centre. All things would be done according to plan if money was available. For now, we cannot lie about any meaningful intervention" (Interview, DHV)*

Funding is definitely a big challenge and many claim it has been chronically small compared to the needs. Even when funding as a percentage of national expenditure has been increasing, the population has increased even faster to new and more.

> *The government must make sure that all its health structures are working and that maternal health issues are put high on agenda while planning services. On paper it is all good, but in practice, we have a dilemma. The commitment is lost as services come down to the people. In an interview with the district in charge of MCH issues, she had a very interesting recommendation when she noted, "If the effort made in partnerships with PNFP providers could also cover delivery and other post delivery complications, more than 70% of pregnancy related problems could be eliminated. Government health centres are not equipped to handle most of the cases, and mothers continue to die. The private sector is not free, and yet has been brought on board in providing services like immunisation and ANC. When it comes to delivery the policy is silent, and yet that's where many mothers face problems (In charge MCH)*

The suggested partnership between government and PNFP to provide delivery services would indeed extend more delivery services to the poor. In Rukungiri, there is no public hospital and this is the biggest challenge that is keeping away mothers from accessing some maternal health services. Partnership to provide all pregnancy related services would be a great step in ensuring that many of the poor who feel excluded from services of the private sector can benefit. Such an arrangement would go a long way in ensuring that the decentralised system as it is now in Rukungiri and the private sector provisioning work for the safety of women through childbirth.

Chapter 5:
Synthesis and Reflections

5.1 Introduction

This chapter presents a synthesis of the findings of the study in answering the research questions. At the end of the synthesis it gives reflections on what can be done to make maternal health service provisioning better in Rukungiri and also situates the recommendations to the country context.

5.2 Synthesis

The objective of this study was to establish the configuration of maternal health services available and how these are accessed by women with a bias to rural women in the district of Rukungiri.

The study did not find explicit evidence to show that maternal health services become a priority in the district. Priority to maternity services the ministry of health which directs the funding. Rukungiri district has an impressing innovation to increase the number midwives through bonding personnel, but the gesture is incidental and cannot be attributed to the fact that it is running as a decentralised system. However the district health officials are confident that there is enough priority given to maternal healthcare the big funding challenges notwithstanding. The district has made sure that physical structures are improved at every centre especially maternity wards.

The facilitation of health facilities is poor in general and in particular supplies and equipment for maternal healthcare in frequent stock-outs. Health personnel are usually available but the equipment in providing especially emergency obstetric care is lacking. No single government facility can do caesarean section and simple basics like gloves, delivery kits and drugs used for pregnancy related precautionary measures like IPT of malaria are not readily available. Women with pregnancy related complications are referred to a private hospital where they have to pay exorbitant prices that are not affordable to the majority poor in rural areas. As a result, many women attend only ANC services but deliver at home with assistance of relatives and TBAs. Inadequate facilities with full knowledge of consequences to lives of women and their unborn babies amounts to disregard at best and at worst violation of the rights of these women.

Human resource for maternal health care but their distribution is biased against rural areas where majority of poor live. Distribution of midwives to health centres showed a very large disparity between those required and

available at health centres between urban and rural areas. While urban areas had more than expected personnel especially midwives, rural areas had less than needed. This raises serious issues of accountability and governance if government payroll workers can be overstaffed in some areas when there is shortage in other areas under the same jurisdiction.

The referral system in the district of Rukungiri health service delivery is not satisfactory. First of all, the maternity ambulance vehicle was reported to be used as an administration car for government officials and it is not fuelled. Mothers who need maternity ambulance have to fuel the government car themselves. The ambulance is situated at a central point, but there is no communication link between this point and other lower level health facilities where it may be required. Referred women are not accompanied by a trained midwife exposing them to danger in case complications occurred. In Rukungiri, the only referral hospital for pregnancy related cases is a PNFP facility which charges fees that are costly. Many poor women tying to avoid the costs hope to avoid the costs and attempt to deliver in their homes but in case of complications they lose their foetus, and sometimes unfortunately their lives too.

Three different systems of provisioning for maternal healthcare; government, private and traditional has worked to exclude more the poor. While private practitioners always have good stocks of the necessary equipment and supplies to deliver good quality maternal healthcare services, fees are prohibitive to the poor. Even without satisfactory services, many poor women continue to utilize government services sometimes with disappointment. Public facilities still charge money and also make women in need of maternal care to buy basic utilities. The conditions of poor and sometimes unreliable service in government health centres especially further in rural areas, and the exorbitant costs of transport and services in the private sector relegate the poor to the services of untrained TBAs.

5.3 Silent factor

Roles of men in ensuring access to maternal healthcare of women remained a silent factor. Husbands are mentioned by both midwives and women only when referring to failure or refusing to pay costs for delivery of maternal services to their wives. In one case, a woman was taken back home by her husband because he could not pay, and a day later she lost a baby at birth attended by a TBA. Men are portrayed men as barriers to access by failing to avail the resources necessary for women to access services. In major decisions involving women's access to healthcare during pregnancy men were referred to. This shows that paternity is yet another significant dimension to issues of maternity that should be brought fully on board in discussions about access to maternity services. Though this tends to be addressing more of social issues and not the provision side, the thin line dividing social dimensions should be

explored to see how much of male involvement can improve access to maternal health care by women.

5.4 Conclusions

Decentralisation and privatisation as ongoing processes still have space to be studied and improved in the quest for improved service delivery in select sectors like maternal healthcare. Decentralised health service delivery has brought especially physical health services structures closer to the rural areas where the majority of poor women live. However, this should not be confused with actual availability of services that are supposed to be in those services according to the policies. Many problems still exist in the actual maternal health services and how to make sure that they are accessible to women in rural areas.

Privatisation process also has led to proliferation of many maternity homes and clinics offering maternity services. This increases availability of the services in the community, as the private service providers run their business for profits. However, there is a clear evidence that private provisioning does not work in favour of majority poor; one because they cannot afford to pay the costs, and two, these private providers shun rural areas, where statistics show is where the poor live. Also private providers invest wisely in services that bring quicker returns and may not prioritise targeted services like for pregnant women. Thus far, the private sector cannot be relied upon to deliver sufficiently on issues on national priorities and to guarantee the rights of all citizens to health without discrimination.

Pregnancy is not a disease but a function, and when women risk their lives to carry out functions of society they deserve to be guaranteed services that make their risk less thus making pregnancy safer. The society through public provisioning or otherwise has the obligation to make pregnancy safer by ensuring full and quality maternal health care provisioning to women especially those marginalised by poverty and remote settlement. For Uganda to achieve its goals in line with the MDG goals 5, it should take into account the specific needs of pregnant women. It should also take into account the capacity of local governments to implement maternal care especially in rural areas that may be having specific needs. While private service delivery may help address maternity needs of middle income women in society, there are the majority women who are not able to cope with those needs unless the government commits itself to its obligations to provide those services under the minimum health care package. Poor people do not deserve poor services, and the government should champion the fulfilment of poor women's right to health.

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