MONITORING MATERNAL HEALTH SERVICE DELIVERY IN LIRA DISTRICT

A Civil Society Perspective

July 2009

Northern Uganda Coalition for Health Advocacy (NUCHA)

About Northern Uganda Coalition for Health Advocacy (NUCHA)

NUCHA is a coalition of 20 health civil society organisations (CSOs), community-based organisations (CBOs) and development partners in the northern region that coordinate their action and voice on health issues. It was founded in Lira in 2007 and is coordinated by HEPS-Uganda. Its membership includes: Africa Youth Initiative Network Uganda (AYINET), Northern Uganda AIDS Tuberculosis Malaria Program (NUMAT), Foundation For Integrated Rural Development (FIRD), Family Integrated Services for Health and Development (FISHD), Canadian Physicians For AID and Relief (CPAR-Uganda), PACE International, United Nations for Children's Fund (UNICEF), World Health Organisation (WHO), AIDS Information Center (AIC), Facilitation For Peace and Development (FAPAD), Marie Stopes Uganda (MSU), NGO Forum Lira, Reproductive Health Uganda (RHU), United Nations High Commissioner for Human Rights (UNOHCHR), United Nations Population Fund (UFPA), Pathfinder International Uganda, Rural Women Uganda (SHELTER), Coalition For Health Promotion and Social Development (HEPS-Uganda), Northern Uganda Anti Corruption Coalition (NUAC), and Medical Teams International (MTI).

NUCHA works through a seven-member Steering Committee and three Working Groups to champion and monitor improved service delivery; influence policy and legal processes; and promote increased health spending.

Acknowledgements

The survey team consisted of Denis Kibira (Survey Manager), Mrs Prima Kazoora (Research Assistant) and Richard Hasunira (Research Assistant). It included 13 data collectors: Hadline Okello, Diana Aroma, Sarah Awori, Juliet Akide, Barner Ongom, Joyce Lachol, William Acol, Josephine Aol, Loy Achola, Teddy Akullo, Richard Mugisha, Prima M. Kazoora, and Richard Hasunira. Bestason Aliyo and Sylvia Kimuli entered the data. Denis Kibira, Richard Hasunira and Prima Kazoora analysed the data and compiled this report. Richard Mugisha coordinated this study and managed the logistics. Rosette Mutambi supervised the entire project.

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EXECUTIVE SUMMARY

The performance of the Uganda government in facilitating women to realise their maternal and reproductive health rights as required under international and national instruments and laws has not been satisfactory so far. Expenditure on health and on reproductive health services is far below recommended levels, and as a result health infrastructure is poor, health centres are understaffed and emergency preparedness is low. Access to services remains poor and trends show Uganda may not achieve the maternal health objectives of the UN Millennium Development Goals. Uptake of family planning services in Lira stands at a paltry 25%, while the maternal mortality rate (MMR) is at 700 deaths per 100,000 live births, above the national average of 435[1].

This study adapted the standard WHO/HAI methodology to assess access to essential medicines, supplies and services for maternal and reproductive health in Lira district. A sample of 14 facilities was selected randomly: two level-two health centres (HC II's), seven HC III's, five HC IV's and the one regional referral hospital. Five focus group discussions (FGDs) were organised in the five sub-counties, and personal interviews conducted with key informants. The study team consisted of one survey manager, two research assistants and 13 data collectors.

The study found that the availability of maternal and reproductive health services varies widely from facility to facility, but are rarely comprehensive. There was poor availability of essential maternal and reproductive health medicines and commodities, including gynaecological gloves (27.3%), mama kits (27.3%), insecticide treated nets (36.4%), and vaccines for children (63.6%).

There is critical shortage of health workers to provide reproductive health services. Inadequate staffing, absenteeism and late coming have led to long waiting hours and undermined the quality of care. There is a shortage of skills among health workers in the administration of the various family planning methods, especially the long-term ones. There are strong misconceptions about family planning due to rumours that have exaggerated the side effects.

Taken together, the surveyed facilities have excess capacity for family planning and postnatal care services due to low uptake. The capacity to handle deliveries is too small.

The quality of client care and patient-health communication is low. Midwives and nurses harass women during labour and delivery. Women

[1] Lira statistics from Office of the District Health Officer; national figures from Uganda Bureau of Statistics

say this is the reason some prefer to deliver with the assistance of TBAs or relatives. Other sentiments indicated that women did not perceive a high level of risk in delivery.

The infrastructure is substandard at most health centres. Most facilities do not have running water and lighting. Preparedness for emergencies is low.

Access to reproductive health services and commodities is hampered by unaffordable charges, most of them illegal. Delivery services remain above the means of the poorest women and households, who fork out up to Ushs 180,000 to deliver by caesarean section during complications.

Women walk long distances to access maternal and reproductive health services and commodities. Most reproductive health services are not available at HC II, which are closer to communities, meaning that women have to walk long distances a HC III or referral health centres to access the services they need. This problem is compounded by the bad road, which are sometimes impassable during the rainy season.

The findings of this survey indicate that there have been efforts by government and the Ministry of Health through the district health office, as well as by non-government players to improve access to essential maternal and reproductive health services and commodities by women of reproductive age in Lira district. However, more is needed from all stakeholders to change this situation. The Ministry of Finance should allocate more resources to reproductive health services; the Ministry of Health should train, recruit, motivate health workers, and amend personnel regulations to strengthen discipline; the district health office must enforce existing disciplinary measures to fight unethical conduct and absenteeism among health workers; and the civil society should come out with innovative programmes to sensitise the public on reproductive health services, the responsibilities of women and men in reproductive health, and dispel fears and attitudes that affect access to reproductive health services and commodities.

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ABBREVIATIONS AND ACRONYMS

AAIU	ActionAid International Uganda
AIC	AIDS Information Centre
ANC	Antenatal care
ARVs	Antiretroviral drugs
CBOs	Community-based organisations
CSO	Civil society organisations
DFID	Department for International Development
FAPAD	Facilitation for Peace
HEPS-Uganda	Coalition for Health Promotion and Social Development
HMIS	Health management information system
ICPD	International Conference on Population and Development
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MSU	Marie Stopes Uganda
NGO	Non-governmental organisation
NUCHA	Northern Uganda Coalition for Health Advocacy
PHC	Primary healthcare
PMTCT	Prevention of mother-to-child HIV transmission
PRDP	Peace and Recovery Development Programme
RHU	Reproductive Health Uganda
Shelter	Lira Rural Women and Children Development Initiatives Shelter
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
UNCHR	United Nations Commission for Human Rights
WHO	World Health Organisation

1. BACKGROUND

1.1 Introduction

Pregnancy and childbirth-related complications are among the leading cause of death and disability in women of reproductive age not only in Lira district and the rest of post-war northern Uganda, but also in the country as a whole. The district has a high maternal mortality rate (MMR) of 700 deaths per 100,000 live births, far above the national average of 435[2]. At the national level, this translates into about 6,000 women dying every year due to pregnancy-related causes. Each of these deaths has a devastating effect on both the family and the surviving children. Studies have shown that the risk of death for children under age five is doubled or tripled after their mothers die.[3]

Like all other people, women and children have a right to health, and the state is obliged under various national and international legal instruments to ensure all Ugandans realise their fundamental rights.[4] At the national level, the National Objective and Directive Principle of State Policy No.XIV, as stated in the Constitution, gives government the responsibility to fulfil the fundamental rights of all Ugandans to social justice and economic development. This requires government to do everything in policy and law to ensure people access and afford health services of the best possible quality. It involves eliminating all avoidable maternal and child mortality by making sure, through planning, delivery and regulation, that all men and women of reproductive age have access to acceptable maternal and reproductive health services.

The performance of the Uganda government in meeting these obligations has not been satisfactory so far. Expenditure on health has been between 8-11% of total government spending over the years, far below the 15% level Uganda and other African countries committed themselves to spend on health in the Abuja Declaration. And out of this small proportion, only 28.7% of it is spent on reproductive health[5]. This implies that Ugandans, with a per capita income of only $ 256 per year and almost one third of whom (31%) live on less than a dollar a day, must pay out of pocket to access not only the maternal and reproductive health services but also the rest of the health care they need.

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[2] Lira statistics from Office of the District Health Officer; national figures from Uganda Bureau of Statistics

[3] WHO, UNFPA and PATH (March 2006): Essential Medicines for Reproductive Health: Guiding principles for their inclusion on national medicines lists," PATH, Seattle

[4] The Right to Health is enshrined in Article 25(1) of the Universal Declaration of Human Rights; Article 12(1) of the International Covenant on Economic, Social and Cultural Rights; and Articles 16(1) and 6(2) of the African Charter on Human and People's Rights.

[5] National Budget 2007/08

Over 70% of the estimated maternal deaths could be prevented if expectant mothers received proper care during pregnancy and delivery. WHO estimates that up to 100,000 maternal deaths in developing countries could be avoided each year if women who did not want children used effective contraception. Almost one in five maternal deaths is due to unsafe abortion. Uptake of family planning services in Lira stands at a paltry 25%, predisposing most women of reproductive age to unwanted pregnancies and their attendant need for abortion, which is usually carried out under unsafe conditions.

Maternal health services in Uganda (and more so in Lira and other post-war northern region) suffer from a high drop-out rate. The Ministry of Health recommends at least four antenatal care (ANC) visits in the course of a woman's pregnancy. In Lira and the rest of the country, almost all expectant mothers make their first visit. However, numbers progressively diminish over subsequent visits. In Lira, the proportion of expectant mothers who make the fourth ANC visit in Lira is only 54%.

This trend continues to the next stage, where only about 42% of expectant in Uganda deliver in health facilities under professional supervision. In Lira, this figure is even much lower, at just 26%. The majority of women (58% at the national level, and 74% in Lira) deliver at home or in the community under poor hygiene and without skilled care, predisposing them to death or severe complications. Haemorrhage, sepses or infections, complications of unsafe abortion, high blood pressure, and obstructed labour are the direct causes of maternal deaths. The risks they pose are compounded by malnutrition, malaria, anaemia, TB, HIV/AIDS, teenage pregnancies, unspaced births, and a high number of previous pregnancies.

In the end, only 10% of the women that deliver at the health facilities return health facilities for postnatal care.

This poor access to maternal and reproductive health services has kept national maternal health indicators poor over the past two decades, with the maternal mortality rate (MMR) stagnating around 505 deaths per 100,000 live births in the period 1995-2000[6], before reducing to 435 in 2006. In Lira, MMR is as high as 700 deaths per 100,000 live births.[7] About 6,000 women in Uganda are estimated to die every year due to pregnancy-related causes and for every woman who dies, six survive with chronic and debilitating ill health, while about 29% of all infant deaths occur in the neonatal period (within the first month). In order to meet the maternal health target set under the UN Millennium Development Goals (MDGs), Uganda will have to reduce its MMR further to 131 by 2015, which the United Nations Development Programme (UNDP) says is

[6] UNDP: "Uganda Millennium Development Goals Report," 2007
[7] Interview with Dr Peter Kusolo, District Health Officer, Lira

unlikely, considering that all process indicators available have fallen short of targets.[8]

1.2 Statement of the problem

The 1994 International Conference on Population and Development (ICPD) made reproductive and sexual rights a priority at both the national and international levels, and adopted a programme of action for universal availability of quality reproductive health services. At the national level, the Ministry of Health, through the "*National strategy to improve reproductive health in Uganda 2005-10*", has made various interventions to try to increase institutional deliveries and emergency obstetric care, strengthen family planning provision, and to implement goal-oriented ANC.

In spite of these interventions and others by the non-government sector, access to and utilisation of maternal health services remains a challenge in Uganda, especially in Lira and other districts in post-conflict north. Only 25% of women of reproductive age are estimated to have access to family planning services, leading to high numbers of unwanted pregnancies and unsafe, illegal abortions. While almost all expectant mothers visit a health centre for ANC at least once during pregnancy, institutional deliveries in Uganda average about 42%. In Lira, this figure stands at 26%, and other remote districts, institutional deliveries are much fewer. Access to postnatal care is estimated at only 10%.

1.3 Significance of the study

This study initiates an independent monitoring process for access to essential medicines, supplies and services for maternal and reproductive health, and is the first of a series of surveys that will constitute a mechanism for tracking district and national progress towards realising maternal and reproductive health rights.

The Ministry of Health roadmap for accelerating reduction in maternal mortality and morbidity of 2007 acknowledges inequity in access and quality problems in care. Incomplete reports from the districts have left gaps in the national health management information system (HMIS) of the Ministry of Health. The findings of this series of studies fill-in such gaps and validate the official data, and provide evidence for civil society advocacy for improved access to maternal and reproductive health medicines, supplies and services.

[8] UNDP: "Uganda Millennium Development Goals Report," 2007

1.4 Study objectives

This study assessed access to essential medicines, supplies and services for maternal health in Lira district. It has analysed and documented:

(1) The availability of essential medicines, supplies and services for maternal health in Lira district;

(2) The affordability of essential medicines, supplies and services for maternal and reproductive health in the district;

(3) The acceptability of maternal and reproductive health medicines, supplies and services provided at health facilities;

(4) Individual (men, women) and community perceptions that affect access to essential medicines, supplies and services for maternal and reproductive health.

1.5 Study questions

This survey sought to answer the following questions:

- What essential medicines, supplies and services for maternal and reproductive health are available in health facilities?
- What are the prices of essential medicines, supplies and services for maternal and reproductive health? What other costs do women pay to access medicines, supplies and services?
- What proportion of facilities have maternal and reproductive health-friendly infrastructure, equipment?
- What is the proportion of mothers who have to walk more than an hour (more than 5kms) to the health facility?
- What is the percentage of expectant mothers who have to wait for more than one hour to get served?
- What attitudes in the community affect access to and utilisation of maternal health medicines, supplies and services?

2. METHODOLOGY

2.1 Study design

The study adapted the standard WHO/Health Action International (HAI) methodology for assessing access to essential medicines, and combined both qualitative and quantitative approaches.

The study focused on access to essential medicines, supplies and services for maternal and reproductive health. These included family planning, pre-conception services, ANC, deliveries and neonatal care; and postnatal/postpartum care. Others were prevention of mother-to-child HIV transmission (PMTCT), immunization, health education and post abortion care.

2.2 Sample selection

The study population was randomly sampled from the 43 public, non-government/mission and private facilities that provide maternal health services in Lira district. These were classified into levels (HC II to hospital) and into sectors (government, private-not-for-profit, and private-for-profit) before a sample of 14 facilities was selected randomly. The sample included two level-two health centres (HC II's), seven HC III's, five HC IV's and the one regional referral hospital.

In addition, five focus group discussions (FGDs) were organised in the five sub-counties of Ogur, Aromo, Orum, Omoro and Amach. Each FGD consisted of between 9-12 women of reproductive age. The FGDs were constituted with the help of local leaders in randomly-selected sub-counties in the district. In each of the sample sub-counties, FGD participants were selected from one parish, to keep costs in the affordable range. During the discussions, the participants were assigned other names other than their own for purposes of confidentiality. Each FGD had a discussion moderator and a notes taker.

2.3 Data collection

The study team consisted of one survey manager, two research assistants and 13 data collectors. The research assistants provided a one-day training to the data collectors at the HEPS-Uganda offices in Lira town before assigning them to the field. In the field, data collectors undertook a medicine availability check and conducted an accompanying interview at each sampled health facility. They interviewed midwives, doctors and officers-in-charge at each health centre visited using an interview guide. Data collectors also directly observed maternity wards to assess acceptability of services and facilities. The same data collectors

also worked in pairs to moderate and take record of the proceedings of the FGDs.

This study also carried out interviews with six key informants within the district. The research assistants carried personal interviews with the district health office (DHO), the Lira offices of the World Health Organisation (WHO), United Nations High Commission for Human Rights (UNHCHR), United Nations Population Fund (UNFPA), and Reproductive Health Uganda (RHU), Marie Stopes Uganda (MSU), and Medical Teams International (MTI).

2.4 Data analysis

The quantitative data collected were sorted, entered into the WHO/HAI Excel Workbook for analysis. Results from the qualitative process, including interviews and FGDs were manually coded and analysed along the WHO/HAI key themes of access to essential medicines/services: availability, acceptability, affordability and geographical access.

2.5 Working definitions of key terms

2.5.1 Availability

For purposes of this study, availability is used to mean the physical presence of medicines and other medical products on the shelf or in the dispensary of a health facility, where they can be readily dispensed to or accessed by clients. In the case of health services, availability was used to refer to services that health facilities routinely or ordinarily offer their clients.

2.5.2 Acceptability

Acceptability of a medicine or medical product/commodity is used to refer to its quality in terms of its expiry status, side-effect profile and any other aspects that may influence its usability by consumers. As far as heath services are concerned, acceptability is used to refer to the quality of services in terms of adequacy of the health workers' attention to clients and of the equipment used, convenience of service schedules, client waiting time, and staffing and skill levels.

2.5.3 Affordability

The WHO/HAI methodology defines affordability in terms of the number of days the lowest-paid government worker has to work to raise enough money to buy the medication they need per month for a typical chronic condition such as diabetes or hypertension. The meeting of stakeholders that reviewed the tools ahead of data collection however, relaxed this definition for several reasons, including the fact that the lowest-paid

government worker is obviously not the poorest or even the typical health consumer in Lira district, and in any case, most women of reproductive age are not government workers, and in fact, they are not income earners. This study therefore did not measure affordability in quantitative terms, but used the proxies from qualitative data to determine whether the cost of medicines and other medical products/commodities and services was an issue to them.

2.5.4 Geographical access

A person is considered to have geographical access to a health facility if they are within a radius of five kilometres, estimated to be a one-hour walking distance.

3. DISCUSSION OF FINDINGS

This section discusses the key results of the study. The discussion is aligned to the four thematic areas of access: availability, acceptability, affordability, and geographical access.

3.1 Availability

3.1.1 Availability of essential services

The range of essential services for maternal and reproductive health that the surveyed facilities reported to provide include family planning, ANC, deliveries and neonatal care, and postnatal care. Other services identified were PMTCT, immunisation, health education, and post-abortion care. None of the facilities reported providing pre-conception care.

The availability of these services however, varies widely from facility to facility both in terms of the service range and in comprehensiveness. All facilities surveyed, except one, had at least one of the services. ANC was the most available service; 13 out of the 14 surveyed facilities provide ANC. It is followed by family planning. Facilities operated by the Catholic Church, which is known to be opposed to birth-control, do not provide family planning services. There is a marked dependence on non-structured, non-governmental service providers RHU and MSU, which provide family planning services during outreach missions to health centres and at the reproductive health units they operate in Lira Municipality. Postnatal care is the least available service.

At most facilities, the available services are not comprehensive. Comprehensive family planning, for instance, should include sexuality education, prevention and management of sexually transmitted infections (STIs), pre-conception counselling and management, contraception, and infertility management. Out of this range, only contraception and testing and treatment of HIV and other STIs were found at the surveyed facilities; the rest were not available. And even within contraception, the most available options were male condoms, oral pills and injectable Depo provera. The delivery of these is affected by stock-outs of supplies and limited uptake. Most facilities that offer family planning services do not have long-term contraceptives like implants and IUDs.

ANC services, while generally widely available, findings show they are in most cases not comprehensive. Cervical cancer screening was for instance, not available at any of the surveyed health facilities. ANC, PMTCT, immunisation and family planning are provided once or twice a week at most health centres, meaning long queues on such days.

It is also worth noting that the availability of services does not necessarily follow the recommended structure. Some second level health centres (HC II's), such as Anyangatir HC II, have emergency delivery rooms and handle deliveries, provide family planning and immunisation services, which are not available at some HC III's (such as Lira Barracks HC III). HC IIs were supported to have emergency delivery rooms after realising that some of them were being forced to deliver women who were turning up with advanced labour pains when it is too late to refer them to health centres with the requisite facilities and personnel.[9]

Postnatal (postpartum) care is the time between delivery of the placenta and 42 days following delivery (UDHS 2006). This care is important for both the mother and child to treat any complications arising from delivery and provide information to the mother on how to care for herself and the baby. It includes treatment of the mother after childbirth, newborn care, nutrition and infant-feeding counselling and support, immunisation, and post-delivery family planning. Postnatal care that was reported to be provided includes: PMTCT, treatment after child-birth, immunization and new born care, infant feeding counselling, post-delivery family planning, and nutrition counselling. Most of the postnatal care is offered immediately after delivery.

There is limited follow-up after the mothers are discharged and very few come back to the health centre. Those who mainly come back are mothers on PMTCT programme. Most women seek postnatal care after getting problems after delivery. A 40-year old mother of eight in Amach subcounty reported that sometime after she delivered her fifth child, she felt a swelling inside the cervix, itching, a burning feeling, a foul smell and a discharge from her private parts, which prompted her to visit a health facility, where she was advised to maintain hygiene, bathe three times a day, and change cotton pants often. She has maintained similar hygiene standards after each of the two subsequent deliveries she has since had and experienced no related problem.[10]

Other women who participated in the focus group discussion in Adyaka (Amach subcounty) however, reported failure to get adequate attention. In Ogur, 22-year old mother of two said, "*I was not attended to after delivery; I was left alone. The good thing my relatives were around.*" Other women agreed with her, saying the health workers gave them the impression that it is the mother's responsibility to take care of the baby and themselves after delivery, claiming that "the major thing health workers do is to vaccinate the baby."

[9] Interview with DHO Dr Peter Kusolo in his office on July 1, 2009
[10] Focus group discussion in Adyaka, Amach subcounty

3.1.2 Availability of essential medicines and commodities

The supplies of essential maternal and reproductive health medicines and commodities for the district come through three channels – the primary healthcare (PHC) grants from the central government, the credit line system, and from donors. Most of the medicines procured through the PHC grant are curative due to the high disease burden, giving little attention to reproductive health commodities, i.e. family planning products. Under the credit line system, which works through National Medical Stores (NMS), caters for some reproductive health supplies but supplies are low. Most supplies come from donors, including RHU, MSU, Medical Teams International (MTI) and other NGOs; UN agencies, particularly WHO, UNICEF, WFP and UNFPA; and other bilateral donors such as USAID.[11]

The survey team assessed the availability of essential medicines and commodities for maternal and reproductive health at the sample health facilities, including contraceptives, gynaecological gloves, obstetric care kits (mama kits), insecticide treated nets and anti-malarials, antiretroviral drugs (ARVs) for PMTCT, and vaccines for infants, among others. The results of the assessment are summarised in Table 1.

Table 1: Availability of selected reproductive health medicines at surveyed facilities

Medicine	Percentage availability	
	Public	Mission
Albendazole tab 200mg	72.7	66.7
Amoxicillin cap/tab 250mg	63.6	100.0
Contraceptives	100.0	33.3
Ferrous sulphate/folic acid	72.7	100.0
Gynaecological gloves	27.3	100.0
ITNs	36.4	100.0
Magnesium sulphate 500mg/ml amp	72.7	100.0
Mama kit[12]	27.3	33.3
Metronidazole 200mg tab	81.8	100.0
Nevirapine 200mg tab	72.7	66.7
Oxytocin 10IU/ml amp or Methylergometrine 200µg/ml amp	72.7	100.0
Sulphadoxine/Pyrimethamine 500/25mg tab	54.5	0.0
Tetanus toxoid	72.7	100.0
Tetracycline eye ointment 1%	72.7	100.0
Vaccines for babies	63.6	100.0

[11] Interviews with DHO Dr Peter Kusolo, RHU, MSU and MTI

[12] A mama kit was defined to include six items; the non-availability of anyone of them amounted to non-availability of kits

The highlights of the findings are:

- Availability of at least one type of contraceptive at public health facilities was 100% compared to only 33.3% in mission health facilities. However, this does not take into consideration acceptability of the various contraceptives found.
- There was poor availability of gynaecological gloves (27.3%) in public health facilities. These are used in delivery and check up during ANC and their absence puts the life of health workers at risk.
- Mama kits, which are important commodity during delivery, were also poorly available in public health facilities (27.3%) as well as mission health facilities (33.3%).
- Prevention of malaria which is a major cause of deaths and miscarriages has received poor attention. This is due to the poor availability of insecticide treated nets in public health facilities (36.4%), and Sulphadoxine/Pyrimethamine in both public and mission facilities (54.5% and 0% respectively).
- Nevirapine for PMTCT was in 72.7 % of public facilities and only 66.7% of mission facilities.
- Availability of vaccines for children in the public sector is still inadequate (63.6%) which may explain why infant and child mortality rates are far below targets set by the MDGs.

3.1.3 Availability of human resources for maternal and reproductive health

On average, most health facilities surveyed – both government and non-government – had one staff on duty or available to attend to all categories of maternal and reproductive health clients. The only exceptions were Lira Medical Centre, a private facility, where there were eight midwives and three doctors; and the government-owned Lira Hospital, with 15 nurses and nine midwives. Pentecostal Assemblies of God (PAG) HC IV also had more midwives and doctors.

The shortage of health workers has affected access to essential maternal and reproductive health services. At the time of the survey, Lira Barracks HC III had suspended maternal and reproductive health services because the only midwife had gone for maternity leave.

The bigger problem however, is the high degree of absenteeism in government facilities. The general level of motivation is low due to poor remuneration, poor working conditions (including long walking distances to work and lack of housing at health facilities), weak supervision systems, absence of a strict disciplinary mechanism, and a general feeling of impunity (caused by the “permanent and pensionable” employment terms and the political patronage occasioned by the

decentralisation system). This has left programme managers feeling frustrated.

> *I feel it's time (for me) to retire; we all seem to be helpless! We have said the same things everywhere. People know the problem and the solutions but nothing is done. The budget has just been read and they increased salaries by only 5% well-knowing the inflation rate is 14%. Even NGOs come and interview me about these problems and disappear without giving any help or sharing with us their reports.*
>
> *Management of personnel involves more than personnel. I have discovered that health workers who work in mission facilities are paid even lower salaries, but they love their jobs more than our people do. It has something to do with the conditions of service and the feeling that their jobs are permanent and pensionable. Disciplinary measures are difficult to implement and decentralisation has made matters worse because health workers are mostly from the district and they are linked to politicians who want to impress voters. I have been summoned (by superiors) more than once for trying to take disciplinary action against stubborn health workers. They don't take warning letters seriously because they know there is nothing else the system can do, and their salaries go straight to their accounts even if they take months without reporting for duty.*[13]

This frustration was echoed by other key informants. In an interview with the survey team, a source at WHO Lira Office said government had made one of the organisation's staff apologise for revealing that WHO warned the Ministry of Health of a possible resurgence of polio in northern Uganda three months before it eventually happened. The source said it had been part of a mission that had recently visited a facility which officially has 18 health workers but found only four who were manning all departments. The source said WHO had worked with the district to recruit more midwives but that the effort was not generating the full benefits because of high levels of absenteeism.

[13] Interview with Lira DHO Dr Peter Kusolo at his office on July 1, 2009

3.2 Acceptability

This subsection discusses findings on acceptability of the available medicines, commodities and services for maternal and reproductive health, including quality issues and health worker and consumer attitudes that affect access to them. The indicators of quality for purposes of this study relate to the side-effect profile of medicines and commodities; acceptability and adequacy of facilities and equipment; convenience of service schedules; client waiting time; and staffing and skill levels.

3.2.1 Acceptability of family planning commodities and services

Lira faces a critical shortage of staff, to the extent that most health facilities surveyed had one staff on duty or available to attend to all categories of maternal and reproductive health clients. As a result of inadequate staffing, women wait in queues to be served. For most women, waiting time ranges between 15 minutes at health centre II's, where the range of services is limited, to indefinitely at referral facilities, where some clients even go back home without being served if the health worker is not available or the available staff are unable to serve all clients before the day ends.

The waiting time tends to be shorter for family planning clients and longest for ANC clients. At health centre IVs, respondent health workers and clients alike indicated women seeking ANC services have to wait for more than an hour to be served. Waiting time was found to be longer at government facilities than at private-for-profit and private-not-for-profit facilities, apparently because more women depend on government facilities, but also because government facilities tend to have a higher degree of late-coming and absenteeism.

Most health centres surveyed depend on outreach services from MSU and RHU for family planning services because of a shortage of trained, experienced staff with adequate skills in the various family planning methods, and the requisite commodities. The lack of adequate skills among health workers involved in the provision of family planning and other reproductive health services has undermined the quality of services provided. Nursing school curricula do not include modern family planning options, and as a result, most health workers involved in family planning only know about injectables, oral pills and condoms. RHU and MSU have undertaken limited capacity building by training serving health workers in the district in family planning, but the numbers they train – about 40 per year – are few compared to the unmet need.

There are strong misconceptions about family planning among women due to rumours that have exaggerated the side effects of contraceptives.

Both providers and consumers agree that most family planning consumables (contraceptives) have side effects of varying magnitude, and that, even for a single commodity, side effects can vary widely across different consumers. Experiences and rumours that exaggerate the side effects have scared away many women from using contraceptives, to the extent that some are far more scared of the side effects than of the unsafe, illegal abortion of unwanted pregnancies.[14]

> *A 26-year old woman from Amach subcounty said she experienced a heavy flow of "clotted" blood after she used Injectaplan, so she stopped using it and then ended up becoming pregnant before she wished to.*
>
> *Another lady testified that she stopped taking her daily contraceptive pills because they used to make her feel dizzy and vomit and, as a result, she conceived while breastfeeding her baby of one year and two months. She said she contemplated abortion because she was scared of having another baby so soon.*
>
> *In Omoro subcounty, one woman reported that she had stopped taking her pills because they made her dizzy and weak, and yet she needed to work in her garden, where she had to stay under the hot sun for hours. Others complained of prolonged menstrual bleeding and shivering, and at least one had hopped through options in an attempt to find one without side effects.*
>
> *A woman participating in a focus group discussion in Aromo subcounty related a case of a neighbour who "stopped using contraceptives and then later conceived and gave birth to a deformed baby."*

A health worker at RHU in Lira Municipality said some women believe a contraceptive injection will make a woman bleed to death. The survey team was informed of a case from Alero subcounty, where a wife of a teacher who was counselled and given an injection of Depo-Provera. Two weeks after she received the injection, her husband came to RHU complaining that his wife was ill with fever and vomiting and refused to take her to hospital, insisting the family planning injection she had received was the cause. The woman later died, and people in the area can never use family planning again because they think it kills.

> *"It is very difficult to get people to use these products; they would rather keep conceiving and aborting. And when they abort, they do it crudely. They often come here with serious complications, like over-bleeding and with bits of the foetus still inside. We even had a case of a teenage girl who had pushed into herself a pair of scissors and*

[14] Interview with Ms Jessica Apio, Reproductive Health Uganda

was lucky not to have died before she reached here. We get these cases on a daily basis because we offer post-abortion care. After treating them, we usually advise them to use contraceptives, but three to four months later you will see the same woman here with the same problem. There is a young woman who has been here with post-abortion problems three times in one year!"[15]

3.2.2 Acceptability of ANC, delivery and neonatal care services

This subsection discusses the quality of the available services for ANC, delivery and neonatal care; the capacity of the facilities to satisfy demand; and attitudes and practices that affect access to them.

Table: Key service quality indicators in surveyed facilities in Lira district

Type of service		No. of clients received per day	Capacity of facilities	No. of staff
Family planning	Total No.	139	367	
	Average	12	31	
ANC	Total No.	555	603	
	Average	46	50	
Delivery and neonatal care	Total No.	51	64	
	Average	4	5	
Postnatal care	Total No.	59	100	
	Average	5	8	

Taken together, the surveyed facilities have excess capacity for family planning and postnatal care services, but are operating near-full capacity for ANC and deliveries. The uptake of family planning and postnatal care services is generally low. While the surveyed facilities reported a combined capacity to handle 367 family planning clients, the actual estimate of clients handled a day totals 139, reflecting a capacity utilisation of about only 38%.

Responses indicate about 63 health workers were available to provide maternal and reproductive health services at the surveyed facilities. Save for Lira Hospital, which accounts for almost half of the total number, most health centres have one staff on duty at a time (sometimes one midwife assisted by a nursing assistant) to attend to clients for ANC, deliveries and postnatal care. These health workers are overloaded, as they have to attend to between 50-80 clients of the various services on a single day. At the time of this survey, Lira Barracks HC III had suspended all maternal and reproductive health services because the only midwife at the health centre was on maternity leave.

At most health facilities health workers stay far away from the health centres due to lack of accommodation facilities at the health units,

[15] Jessica Apio, health worker, RHU Lira

increasing incidences of late-coming. Knowing that health workers are rarely available early morning and because of the need to first work in the garden, women tend to go for ANC in the afternoons, leading to longer queues and waiting time at peak hours.

Emphasis seems to be on ANC at most health centres, because it is the most demanded service. The number of women seeking ANC is four times higher than the number seeking family planning services. The quality of customer care however, is wanting and it is affecting willingness to access the service.

> *A woman in Amach sub-county, 23, testified that the first time she went for ANC at a HC IV she received very poor reception from the service providers where they were very rude, vulgar (accusing her of) not having a maternity dress and a lesso (wrapper) and since then, she has not gone back to that health centre for ANC.*

The capacity to handle deliveries is too small. Most health centres have labour wards that can only accommodate 2-3 expectant mothers at ago. Cases of some expectant mothers delivering on the floor as well as new mothers sleeping on the floor with their new born babies were reported during the FGDs. By handling 51 deliveries daily out of a possible maximum of 64, the system is already operating at 80% capacity yet supervised deliveries in the district are estimated at only 26%. Trained midwives were found in 93% maternity wards, implying that some deliveries are handled by unqualified staff.

Testimonies of women participating in focus group discussions indicated that some midwives and nurses tend to harass women in labour, do not provide full assistance, and assault them for "failure to push the baby".

> *A woman in Omoro subcounty said, "Midwives wait until the baby's head comes out before they come in to help."*
>
> *A testimony from a 28-year old mother of four from Adyaka village, Amach subcounty, who had attended ANC at a HC III, alleged that a midwife at a HC IV told her to "go and deliver where (she) attended ANC", when she showed up after her labour pains started late in the night.*
>
> *Another woman in Amach subcounty said health workers at a HC IV declined to attend to her when she went there for delivery without her husband. She was assisted to deliver by an elderly woman, presumed to be a traditional birth attendant (TBA), near the health centre.*

Many women prefer to deliver with the assistance of TBAs or relatives because they find methods used at health centres more difficult; or health workers just not available.

> *A 25-year woman in Orum subcounty, "I prefer the TBA because I am used to kneeling during child-birth, in hospital they force you to lie on your back, which makes pushing the baby very difficult."*
>
> *In Orum subcounty, one woman said she went to deliver at the health centre but found no midwife, and decided to return home where she was assisted by her mother in law to deliver safely.*

Women claimed the herbs traditional birth attendants (TBAs) give them after delivery are effective in facilitating post-delivery recovery. They said health centres discharge them immediately after delivery, and do not give them any treatment.

There is a strong belief that the herbs TBAs give mothers make the delivery process easier and healing faster. Some women indicated that they were scared of delivering at health centres on their first delivery because they feared to be embarrassed before health workers. Further, older women who become pregnant are equally stigmatised at health centres.

Ironically, women of reproductive age were by and large unanimous in focus group discussions on the ability of health centres (compared to TBAs) to deal with complicated deliveries; offer PMTCT services; and effectively help C-section cases.

Other sentiments indicated that women did not perceive a high level of risk in delivery. For instance, a 28-year old in Omoro subcounty said she had managed to deliver on her own six children without the help of a health worker or TBA. Indeed, some women cannot make decisions without the consent of their husbands, even in life-threatening situations.

> *I was embarrassed to see a wife of a school head-teacher die after getting obstructed labour for a whole day without medical attention because her husband was at school and not available to take her to hospital.*[16]

However, it was reported that LCs had banned TBAs in Aromo Sub County to avoid transmission of HIV to clients; and to avoid delayed referrals during complications.

[16] Interview with Lira DHO Dr Peter Kusolo

Other findings on quality indicators for delivery services are summarised in the table below.

Table: Quality of maternity wards at surveyed facilities

Description	Percentage
Room is neat and orderly	78.57
Room has ceiling for Temperature control	100.00
Room has adequate beds and mattresses	57.14
There are windows with curtains	78.57
There is privacy i.e. cabins / Curtains	42.86
There is a water storage	71.43
Light provided for the night	71.43
There is disposal system	92.86
Fridge for cold chain available	85.71
Resuscitation unit available	42.86
Functional Theatre at HC IV (C-section)	21.43
Functional lab with STI kits and HB estimation kits	71.43
Security at Unit	71.43
Ambulance available	28.57
Presence of trained midwife	92.86

The table shows that 79% of facilities had maternity wards that were neat and orderly. A similar proportion of facilities had windows with curtains, and all facilities visited had ceilings that could keep temperatures under control.

However, nearly half of the wards (43%) did not have adequate beds and mattresses; more than half (57%) did not have privacy (cabins); 29% of facilities visited did not have water storage facilities; and 29% did not have a lighting system for the night. About 29% facilities did not have any security for mothers coming to deliver late in the night. Observations revealed that some maternity rooms are too small, some have only beds without mattresses, and some health centres are forced to handle deliveries in “emergency delivery rooms” when actually they do not have requisite facilities.

Only Lira Hospital has running water; the rest have a water source at least 300 metres away. Only Lira Hospital and Ogur HC IV have electricity to provide light in the night. Three other facilities providing maternity services have solar-powered lighting.

Preparedness for emergencies is low, as 57% and 79% of the facilities did not have a resuscitation unit and functional theatre, respectively, to assist handle complicated deliveries. There were no ambulance services in more than two-thirds (71%) of facilities, and surgeons are scarcer. Even basic laboratory tests, such as STI kits and HB estimation, are in short supply; the proportion of facilities with laboratories that were found

fully functional to provide them was 73%. Laboratory reagents, test kits, drugs and other reproductive health supplies are frequently out of stock.

The commonest complications among women delivering at the surveyed health centres are: obstructed labour and postpartum haemorrhage, followed by rapture of uterus, premature deliveries, miscarriages, and placenta previa. Health workers interviewed reported that referrals from TBAs often come when they are already in terrible condition. Some mothers do not have adequate support from their spouses, some men have reportedly abandoned their wives at health centres during prolonged labour or complications. This leaves such women in dire situations, particularly given that health centres do not provide food to inpatients. There are no follow-ups of mothers after delivery, including those who are HIV-positive and need postnatal PMTCT services.

Acceptability of services is also affected by strong negative attitudes and misconceptions within society. Most people in Lira are Catholics, and the fact that Catholic Church is against "unnatural" family planning methods, willingness to use family planning services is low. This has not been helped by widely believed rumours that contraceptives cause cancer, over-bleeding during delivery, miscarriages, and even death. Indeed, women who use contraceptives prefer to do it secretly for fear of being stigmatised by the community. At the household level, the idea of a small family is not yet well appreciated among men and most are not receptive to birth control. Polygamy is widespread and in general, men feel maternity issues are the concern of women and some are unwilling to accompany their wives for ANC for fear that they will be coerced into having an HIV test.

3.3 Affordability

This subsection discusses the legal and illegal, and formal and informal costs that women and households pay to access maternal and reproductive commodities and health services, and their ability to meet them.

3.3.1 Affordability of family planning commodities and services

Condoms were available at most health facilities surveyed for free. Other family planning commodities that were fairly available, including pills and Depo injections, were accessible only upon payment of a fee, even though they are supposed to be for free. Women in Ogur reported paying Ush 1,000 for pills; Night, a 30-year old mother of five, reported paying 3,000 for injectaplan; and elsewhere charges varied according to methods and whether it was the initial or subsequent application.

Most government and NGO facilities depend on Marie Stopes Uganda and RHU for delivery of more sophisticated family planning methods, such as IUD, implants and surgical contraception, all of which come at a fee. When accessed during outreach visits, simple methods are provided at a fee of 1000 by Marie Stopes. In private facilities, surgical contraception goes for up to Ushs 50,000. At RHU health facility in Lira town, the cost of implants is 20,000 while IUD costs Ushs 4000 and an injection of Depo is Ushs 1000.

3.3.2 Affordability of ANC services

During ANC, women reported receiving fansidar (an anti-malarial) and de-worming tablets for free. In Amoro sub-county, 28-year old Konga, a mother of five, reported having received a dose of fansidar to prevent malaria when she was pregnant and a free mama kit. She also received TT vaccination for free.

However, there were allegations that the non-availability of mama kits, which are also supposed to be for free, was artificial. A 29-year old mother of three alleged that at a certain HC IV, “Relatives of nurses are given free mama kits during ANC (to keep for delivery time) and are cared for very well. But when I also asked for one they told me it was not for free.”

ANC is supposed to be free of charge at government facilities, but women reported paying between Ushs 300-500 on each visit; Ushs 500 for a card; and Ushs 2,000 for each laboratory STI test.

A 30-year old woman in Omoro sub-county, reported being charged Ushs 500 for a card on her first (ANC) visit to a HC III, and Ushs 300 on subsequent visits. Her claim was confirmed by the rest of the discussion participants.

A 37-year old woman said a health worker forced her to buy a mama kit when she went for ANC, claiming it was "advisable to buy early". She said she did not have enough money but felt she did not have an option.

3.3.3 Affordability of delivery and postnatal services

Findings confirmed that the proportion of women delivering at health centres in Lira was too low, compared to the total number of pregnancies and pregnant women attending ANC.

Delivery services remain above the means of the poorest women and households. Mama kits were not available at all health facilities visited; mothers are expected to bring them as they come to deliver. At some facilities, the mama kits were available for sale at up to Ushs 20,000. Mission facilities charge women for normal delivery between Ushs 5000-15,500; private facilities charge Ushs 40,000 and above; while public health facilities officially offer it free of charge but women pay all sorts of informal charges.

A 39-year old woman in Omoro sub county said, "The last time I went to deliver, they asked me to buy a quarter a litre of paraffin, gloves, detergent, cotton wool, and a plastic sheet…"

Complicated cases are more expensive across all categories of facilities. Private facilities charge delivery by c-section at Ushs 180,000 while at public facilities one has to negotiate with the doctor.

A 25-year old woman in Adyaka village, Amach subcounty, related that on her third pregnancy, it was discovered in a check-up at Lira Hospital that the baby was dead. Induction was done at a cost of Ushs 20,000 for one tablet, after paying Ushs 5,000 for scanning at a HC IV. "Currently I am pregnant but post-abortion care was not carried out, and I am worried that this might cause complications in my current pregnancy."

There are other expenses women and their households have to make to access services besides the direct cash payments. Women feel uncomfortable visiting health centres for ANC in tattered clothes. At a certain mission facility, couples are "forced" to come with new baby cloths for the newborn when they go there for delivery.

In addition, women live in culture which requires them to look after their families even when they are so heavy, which eats into the time they need to seek services. They fear to leave other young children unattended, must walk long distances, and fear embarrassment if they are too young or too old to have a baby.

The health workers who were interviewed were not satisfied with the level of demand and uptake of maternal and reproductive health services at public health facilities. Poor male involvement to support the women has resulted in fewer women delivering at health centres and low family planning up take. One health centre reported a decline of patients due to poverty and scarcity of food for upkeep of expectant mothers on the wards.

3.4 Geographical access

A person is considered to have geographical access to a health facility if they are within a radius of five kilometres, which is an estimated one-hour walking distance. Geographical access to health facilities is poor across the country, averaging about 37%. As expected, it is poorer in Lira district, where it is estimated that only one in every three people (about 33%) is within a one-hour's walking distance to a health facility[17]. The findings bring out several issues that compound the access problem for women of reproductive age in Lira.

3.4.1 Distances to health centres

Government policy is currently against building new health centres, but instead to improve the functionality of existing ones. As a result, the district has in the recent years established new maternity units at three health centres – Aromo, Apala and Okwang. There are plans to extend to another four centres. Under the Peace and Recovery Development Programme (PRDP), Ushs 1.8 billion has been allocated to boost health infrastructure in Lira over a three-year period. The district plans to use these funds to upgrade HC II's and to build new ones.[18]

In the meantime however, not all health facilities provide reproductive health services, and not all facilities that provide reproductive health services offer a comprehensive package. This means that the proportion of women of reproductive age who have access to a health facility that offers the reproductive health services they need is far lower than the picture the official figures paint. For instance, the reproductive health services offered at level-two health centres (HC IIs), which are the majority and are the closest for most people, are limited to ANC and one or two contraceptive options.

Women who are within a one-hour walking distance to a HC II have actually to walk longer to find a HC III to access normal delivery services; much longer to a HC IV to deliver in case of a complication; and even far longer – if they can – to the only hospital in the district to access higher referral services. The district depends heavily on non-government providers Marie Stopes and RHU for family planning services, and each of these has one clinic in the district, in Lira town. Rural women do not have ready access to these clinics. Marie Stopes and RHU have tried to make life easier for them through outreach services to health centres, but these are not structured and awareness about their schedules is low.

During focus group discussions, some women said they preferred traditional birth attendants (TBAs) because they are readily available in

[17] Interview with Lira DHO Dr Peter Kusolo
[18] Interview with Lira DHO Dr Peter Kusolo

the community, unlike the health centres that they have to walk long distances to reach. Women in Orum said long distances prevent them from going for check-ups during pregnancy. For women in Anyalima, the nearest referral points range from 1km to 18km.

3.4.2 Transport infrastructure

The transport system in Lira, as in the rest of the region, is poorer than in the rest of the country because of the ruin and neglect caused to the road network by two decades of civil conflict. During rainy seasons, many roads become impassable, cutting off entire villages and parishes from health facilities. And given that the region is sparsely peopled, the public transport is not well-developed. Bicycles are the commonest mode of transport, but women in families that cannot afford one have to walk to health centres. This becomes almost impossible when a woman is heavily pregnant and is unable to walk the long distances to health centres.

4. SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

This section summarises the key findings from this study, presents the conclusion, and offers some recommendations to improve demand, delivery, access and utilisation of maternal and reproductive health products, supplies and services.

4.1 Summary of findings

4.1.1 Availability

- The availability of maternal and reproductive health services varies widely from facility to facility both in terms of the service range and in comprehensiveness. All facilities surveyed, except one, had at least one of the services. ANC was the most available service; postnatal care is the least available service. The availability of services does not necessarily follow the recommended structure. At most facilities, the available services are not comprehensive.

- The supplies of essential maternal and reproductive health medicines and commodities for the district come most from donors; the district and Ministry of Health contribute only a small proportion. There was poor availability of gynaecological gloves (27.3%), mama kits (27.3%), insecticide treated nets (36.4%), and vaccines for children (63.6%).

- There is critical shortage of health workers to provide reproductive health services. On average, most health facilities surveyed had one staff on duty to attend to all categories of maternal and reproductive health clients. In one case, a health centre had suspended services because the only midwife had gone for maternity leave! The shortage of staff is has been exacerbated by the high level of absenteeism and late coming in government facilities.

4.1.2 Acceptability

- Inadequate staffing, absenteeism and late coming have led to long waiting hours, particularly for ANC, and undermined the quality of care. There is a shortage of skills among health workers in the administration of the various family planning methods, especially the long-term ones. There are strong misconceptions about family planning due to rumours that have exaggerated the side effects.

- Taken together, the surveyed facilities have excess capacity for family planning and postnatal care services due to low uptake, but are operating near-full capacity for ANC and deliveries. The capacity to handle deliveries is too small.

- Midwives and nurses harass women during labour and delivery. Women say this is the reason some prefer to deliver with the assistance of TBAs or relatives. There is also a strong belief that the herbs TBAs give mothers make the delivery process easier and healing faster. Other sentiments indicated that women did not perceive a high level of risk in delivery.

- The infrastructure is substandard at most health centres. Most facilities do not have running water and lighting. Preparedness for emergencies is low, as most facilities did not have a resuscitation unit and functional theatre to assist handle complicated deliveries. There were no ambulance services in the majority of facilities, and surgeons are scarcer. Even basic laboratory tests are in short supply due to lack of equipment, reagents, test kits, and drugs.

4.1.3 Affordability

- Condoms were available at most health facilities surveyed for free. Other family planning commodities that were fairly available, including pills and Depo injections, were accessible only upon payment of a fee, even though they are supposed to be for free. Women also pay illegal charges to access ANC and delivery. Delivery services remain above the means of the poorest women and households, who fork out up to Ushs 180,000 to deliver by caesarean section during complications.

4.1.4 Geographical access

- Women walk long distances to access maternal and reproductive health services and commodities. Women who are within a one-hour walking distance to a HC II have actually to walk longer to find a HC III to access normal delivery services; much longer to a HC IV to deliver in case of a complication; and even far longer – if they can – to the only hospital in the district to access higher referral services. This problem is compounded by the bad road, which are sometimes impassable during the rainy season.

4.2 Conclusion

The findings of this survey indicate that there have been efforts by government and the Ministry of Health through the district health office, as well as by non-government players to improve access to essential maternal and reproductive health services and commodities by women of reproductive age in Lira district. This has, among other achievements, helped improve institutional deliveries from about 11% to the estimated 26% over the five-year period to 2006 when the latest survey was conducted.

These efforts and their outcomes however, are yet to achieve the required universal access to adequate, affordable, quality and readily accessible

maternal and reproductive health services, supplies and commodities. Many factors stand in the way of access: under-funding by government and the district, shortage of supplies and stock-outs, skill limitations among health workers, shortage of health workers, lack of facilities, limited awareness, negative attitudes among both women and men at the community level, serious side-effect profiles of available commodities, unaffordable charges, high levels of poverty, low morale and poor attitudes among health workers, bad roads and long distances to health centres, among others.

No doubt, government has failed women through commission and omission. It has obligations under various international and national instruments it must live up to ensure women realise their reproductive health rights. The findings of this study clearly demonstrate that government has taken those obligations casually, through under-funding infrastructure, logistics and supplies; failure to train, recruit, motivate and supervise enough health workers; and equip reproductive health service points. This is a violation of women's reproductive health rights. In addition, women's reproductive health rights are being abused through non-availability of services, medicines, supplies and other commodities, illegal charges, substandard services, harassment, and at times by outright denial of services.

All stakeholders have a role to play to change this situation. Government must urgently allocate more resources to reproductive health services for health centres, medicines and other medical supplies, and salaries. The Ministry of Health should amend the regulations and guidelines that govern health workers and strengthen supervision, motivation and disciplinary measures to minimise absenteeism and late coming. The district must enforce existing disciplinary measures to fight unethical conduct and absenteeism among health workers. Politicians at the district level must stop peddling influence in the recruitment of health workers, and interfering with personnel management matters for health workers. The civil society should come out with innovative programmes to sensitise the public on the responsibilities of women and men in reproductive health, and dispel fears and attitudes that affect access to reproductive health services and commodities, including male involvement.

4.3 Recommendations

- *Ministry of Finance, Planning and Economic Development*
  Government must urgently allocate more resources to reproductive health services for health centres, medicines and other medical supplies, ambulances, staff houses and salaries. Money should be allocated to improve the road network in northern Uganda.

- *Ministry of Health*
  The Ministry of Health should amend the regulations and guidelines that govern health workers and strengthen supervision, motivation and disciplinary measures to minimise absenteeism and late coming.

  Stock-outs must stop. The Ministry of Health should streamline the medicine supply system to ensure adequate supply of drugs and supplies, including gloves, test kits and laboratory reagents to all health units providing maternal and reproductive health services.

  Ministry of Health should invest in reproductive health commodities and stop depending almost entirely on NGOs and donors. The ministry should widen the range of contraceptives available in health centres to include both short-term and long-term options and to widen the range of choice.

- *Ministry of Health and Ministry of Education*
  The ministry of health should liaise with that of education to incorporate administration of current family planning methods and customer care skills in the training curriculum for nurses and midwives. The ministry also should organise refresher courses for existing health workers to give them skills in the surgical contraception methods as well as in inter-personal communication.

  Train more village health teams to mobilise and sensitise women on the need for seeking maternal and reproductive health services and commodities.

  The ministry of education should specifically promote girl-child education as a long-term strategy to empower them to make decisions about their health, including access to family planning and other reproductive health services.

- *Lira district/ district health office*
  The district must enforce existing disciplinary measures to fight unethical conduct and absenteeism among health workers.

Politicians at the district level must stop peddling influence in the recruitment of health workers, and interfering with personnel management matters for health workers.

The district health office should coordinate the supplies of reproductive commodities from donors, by sharing information on needs and commitments from the various donors.

Extension of outreach services to the communities to enable follow up of women by using community health workers who can follow up the mothers and give them the much needed information, and basic services

The district works department should ensure that feeder roads are well maintained and bridges/culverts installed in valleys to handle floods during rainy seasons

- *Civil society organisations and community-based organisations*
  The civil society should come out with innovative programmes to sensitise the public on the responsibilities of women and men in reproductive health, and dispel fears and attitudes that affect access to reproductive health services and commodities, including male involvement.