

*Full Length Research Paper*

# Integrating Women's Reproductive Health rights in the decentralized health care delivery in Uganda

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Health experts say if unmet need for contraceptives were satisfied, maternal mortality would drop by 40 per cent, and unplanned pregnancies and induced abortions would decline by 84 per cent. The current emphasis on reproductive health (RH) in population programs began years ago when human rights and women's health advocates began to question the rationale of traditional policies that mainly focused on reducing population growth through the provision of family planning services (Dixon-Mueller, 1993 Sinding and Ross, 1994). Women's Reproductive health needs in Uganda are not adequately met causing persistently high maternal mortality rates estimated at 345 deaths per 100,000. Although there is growing support for integrated reproductive health services that include (F/P, HIV and AIDS, Immunization etc), efforts to improve women's health have continued to focus on reproductive health care with limited focus on reproductive health rights. Reproductive health rights examined included access to RHS, Information, Privacy and decision making. A non- experimental exploratory study design was used to examine how local governments are integrating women's reproductive health rights in the decentralised health care delivery. Methods of data collection included, key informant interviews, Exit polls, document reviews and observations with 84 respondents. Limited access to education or employment, high illiteracy rates and increasing poverty levels and generally women's health improvement is still a challenge to government. The overall goal of the study was to assess the extent to which reproductive health rights are being integrated into the decentralized health services delivery in two districts in Uganda.

**Keywords:** Reproductive health right, maternal mortality, unplanned pregnancies and induced abortions

## INTRODUCTION

Reproductive Rights embrace certain human rights recognized in national and international legal and human rights documents including:

1. The basic right of all couples and individuals to decide freely and responsibly the number and spacing of their children, and to have the information, education and means to do so.
2. The right to attain the highest standard of sexual and reproductive health
3. The right to make decisions concerning reproduction free of discrimination, coercion and violence (FWCW 1995, ICPD 1994, WCHR 1993 and CEDAW 1979).

Protecting and promoting sexual and reproductive rights should be, a fundamental basis for all relevant policies including decentralization. In order to ensure respect of human rights there should be mechanisms and actions

to guide implementation.

Women's reproductive rights and freedom are key determinants of their health and are highly influenced by their roles in society as mothers, care takers, wives etc.

Although government and other partners are committed to reducing maternal mortality as outlined in the National Health Policy, Maternal mortality (MM) rates in Uganda are still ranked among the highest in the region (UDHS, 2006). According to the Uganda Local government Act (1997) the establishment of health sub-districts and implementation of the essential health care package throughout the country, are the over-riding priority for the implementation of the policy. Women's reproductive health rights should be seen as part of the essential health care package in the reproductive health services delivery. There is serious concern that health sector reforms have had detrimental effects on

reproductive health for women in developing countries. Existing literature does not provide enough conclusions on either the positive or negative impact of decentralization on access to reproductive care or reproductive health outcomes. This clearly signals the need for research and evidence on whether women's reproductive rights are being addressed in the decentralized health care services delivery.

There is increasing interest in implementing reproductive health services through integrated programs. However, are integrated programs putting into consideration women's reproductive rights? Women's reproductive health rights have been neglected as integral to health care services delivery.

According to The Centre for Reproductive Rights (CRR), International Conference on Population and Development (ICPD) (1994), Convention for Elimination of all forms of Discrimination Against women (CEDAW) and Uganda's National Constitution (1995), reproductive health rights are human rights with which every woman is endowed. The ICPD (1994) programme of Action and the Beijing Platform for Action also recognized sexual and reproductive rights as human rights, thereby affirming them as an inalienable and integral. Women's reproductive health rights must be integrated into the development processes as a whole.

Two main rationales have been offered for integrated delivery of reproductive health services: integrated services may better meet clients' needs, and integrated services may improve the efficiency and effectiveness of services. The most fundamental rationale for integrated services is the likelihood that programs will be better able to help clients meet their reproductive needs (IPPF, 1981; Taylor et al., 1983b; Kunii, 1984; Rosen et al., 1989; Bruce, 1990; Simmons et al., 1990; Dixon-Mueller, 1994). Integration of various policy and program components may occur in varying degrees at the national, provincial, district, local, and other administrative levels. In this case, the need was to examine the extent to which reproductive health rights are being integrated into the decentralized health services delivery at local government levels.

Service integration might involve the linkage of several provider functions at the service delivery point and would require modification of worker roles, allocation of time and referral requirements. One of the objectives of the study was to establish the reproductive health services offered at every level of service provision in the decentralized health care system.

The neglect of sexual and reproductive health and rights lies at the root of many of the problems that international community has identified in need of urgent action, including violence, sexual abuse and rape of women and children, HIV and AIDS, maternal mortality, teenage pregnancy, abandoned children, harmful practices such as female genital mutilation, population growth, feminization of poverty and violation of fundamental human rights and human dignity (Maria Jose -

Alcal, 1995).

A human rights approach is a powerful tool in the fight to save women from death and disability; it holds governments accountable, places women's health and well-being at the center of efforts to reduce maternal deaths, and empowers women to defend their right to maternal health. (Center for reproductive rights, 2009 in ([www.reproductiverights.org/](http://www.reproductiverights.org/))). The historic 1978 Alma-Ata International Conference on Primary Health Care offered a framework for understanding health in terms of equity and its related socioeconomic and other related issues. The PHC model equates health with freedom, endorsing a definition of health that is not merely the absence of disease (WHO, 1988) and the overarching framework included promotion, protection, prevention, care and support, and rehabilitation. District health systems, as formulated by WHO in 1983, supported PHC with "coherent health services closer to the people" (Korte, 2004: 22).

Decentralization of health services has become a key element of health sector reforms in developing countries including Uganda. Many countries have adopted decentralization as one of the major means of implementing reforms for better efficiency, quality, and equity. The issues of equity in health care and the impact of poverty, have major concerns in sub-Saharan Africa (WHO, 2006; Commission for Africa, 2005). Achievement of equity through access to reproductive health services, choice of family planning, liberty to choose the number of children and access to information are critical for the realization of women's reproductive health rights.

The transfer of responsibility for service delivery to the Health Sub-District has necessitated redefining the roles and responsibilities of the District Director of Health Services' Office. The District Health Teams (DHTs) retain the functions of planning, budgeting, coordination, resource mobilization, and monitoring of overall district performance. It has been realized that poor logistics, inadequate staffing, weak management capacity and poor working conditions are some of the factors dictating the pace and general effectiveness of this policy change (Annual Health Sector Performance Report, 2003/04). This has an implication to reproductive health rights promotion.

Health sector reforms have been implemented in an effort to improve health services management and supervision. These reforms are intended to decentralize health systems, reduce bureaucracy, and increase cost-effectiveness and efficiency in part by reorganizing services, streamlining management, and allocating resources to better meet local needs.

Major health reforms that have been instituted include: Decentralization of governance to districts; health sub district approaches; civil service reforms; user fees; Sector-Wide Approaches (SWAPs); Unification of health and family planning services, and health care financing.

Decentralization is intended to reduce inequalities in

the provision of health care and for more people to be able to access health services. In that vein, under Uganda's decentralized structure, the responsibility for the provision of health services, including maternal and child care for the 90% of the population that lives in rural and urban areas rests on the district.

This study on women's reproductive health rights included entitlement to access family planning, antenatal and postnatal care, access to information, freedom to choose number of children to produce and decision making on reproductive health care. Focus was on establishing the reproductive health services offered at different levels, examining the accessibility to reproductive health services, documenting women's perceptions in accessing reproductive health services under the decentralized health care system and highlighting challenges in addressing women's reproductive health rights under the decentralized health services delivery.

A non- experimental exploratory study design was used to examine how local governments are integrating women's reproductive health rights in the decentralized health care delivery system. For comparison purposes, the study was done in two districts in Eastern Uganda that represented a rural- based and urban- based district (Mayuge and Jinja). Using purposive sampling, both qualitative and quantitative study techniques were employed on a total population of 80 respondents, who included medical officers, administrators, community leaders and women in the community, at the different levels of health care delivery. Several methods were used that included Exit polls, Interviews, Observation and document reviews. Qualitative data was transcribed and put into themes identifying the similarities and differences between the two districts. After analysis, the data was interpreted and organized according to the study objectives/themes showing the correlation between the different methods used.

## FINDINGS

In the decentralized health care policy, reproductive health rights have not yet been fully integrated into client perspectives. However, the women's knowledge of reproductive health rights was based only on information received from health care service providers.

The majority (71%) said they were indeed satisfied with reproductive health services provided. Since the major reason for seeking reproductive health care was antenatal care, the services are provided at all levels (HC II, III, IV and Hospital). Only 29% said they were not satisfied mainly because they were unable to access the Family Planning methods of their choice. Satisfaction comes with the liberty to make choices and the availability of information and services. The fact that decentralization takes health services is closer to the communities; most women are able to access repro-

ductive health services.

Issues identified at the service delivery level included: poor infrastructure and referral systems; inadequate medical support, supplies and logistics; lack of updated reproductive health service delivery guidelines, low competence of personnel; lack of supervision; and evaluation of integrated programs. Some facilities like theatres had been built but, were not in use either due to lack of equipments or lack of personnel to operate the equipments. Such situations deprived women of their rights, to access some of the reproductive health care services from those levels. Rights to access permanent family planning methods (for men and women) and emergency obstetric care were only available in hospitals.

Although a wide range of reproductive health services are offered in all health units, most women reported receiving Antenatal care (38%), Immunization (33%), HIV Testing and Counseling (23%) and family Planning (8%). Most women visited health units for antenatal services where they were tested for HIV and got immunized however, not all health units offer these services for example HC IIs where very basic services are provided. The women at the lowest levels are in greater need and yet services are not availed to them like HIV and AIDS testing, family planning etc.

Lack of special rooms for confidentiality and privacy during counseling sessions, in all health units, undermines individual counseling and may create more stigma. In all the health units, group counseling is practiced. It is assumed that women have similar needs and experiences yet there could be personal problems that require individual private attention. Some health workers are not trained counselors which further make service delivery difficult. They may not understand the importance of confidentiality and integrity and so group counseling is done.

Antenatal care in both hospitals and health centers is provided on particular days of the week when a range of other reproductive services are provided. This does not give women a chance to choose when to visit the health unit. It also contributes to the long waiting hour before they are served. On average women wait for 3-5 hours to be attended to by the health worker. In an effort to integrate services, the health workers also end up getting overworked (50-100 women) which may contribute to inefficiency and poor attitudes.

Postnatal care which is very important is not provided partly because the HCs only have two delivery beds. If more than one woman delivers in a day, others would have to be discharged immediately. With inadequate staffing, the midwife cannot even make follow ups or do home visits of the new mothers. The mothers who get complications after delivery on seek help when the situation is bad, when it could have been handled early.

Inadequate staff training was cited repeatedly as an issue for integrated services. The need of training personnel in integrated services delivery was one of the

concerns. The need to train health workers in accountability and quality of care, including technical competence, sensitivity to the needs of clients, continuity of care, commitment to informed choice, and listening to clients are essential. To a large extent, health workers especially in the rural areas felt neglected by the system and felt helpless, because they were unable to access up-to-date information on reproductive health. Ministry of Health, who are supposed to play a supervisory role in the decentralized health care, were not visible at the lower levels of health care. The lack of support supervision combined with irregular supplies of drugs, contributed to low morale among health workers and reduced trust in the health care delivery, among other reasons.

Decentralized health care is not adequately promoting community participation, which is key to meeting women's reproductive health rights. When women are not aware of their reproductive rights, they cannot demand for them e.g in family planning, antenatal care, HIV and AIDS care etc. and cannot hold government accountable. Women do not realise that family planning for instance is their reproductive right; the majority reported practising it secretly without the knowledge of their spouses. Lack of knowledge about the rights to choose methods of family planning, limits women's accessibility to one particular method (injectable). However, due to irregular supplies at the HCs the women end up losing trust in the health system and FP in general.

The interrelationship of poverty with equity issues and the meaningful participation in health and health-care services seems obvious, but is not well explored.

A midwife from Buwenge hospital gave an account:

***“One time some woman came to deliver her baby, she came late in the evening and delivered at night. She did not have anything so, we helped her and she delivered her baby normally. After delivery we were forced to wrap the baby in her gomesi (cloth) and she stayed naked until her people came in the morning”***

Such a woman will unlikely access and utilize the maternity services again after such humiliation due to poverty.

Challenges in accessing and utilizing reproductive health services are similar between urban and rural but the rural are more disadvantaged, they have less access, economically disadvantaged, poor communication and less literate. Rural women are less involved in decisions concerning their reproductive health like family planning, number of children, choice of services etc. In Mayuge only 30% of the women are able to make decisions on the number of children they want and the 70% are not able to do that.

Testing for HIV and AIDS during antenatal care is controversial because although it is good for the unborn baby, it violates the woman's right to privacy. Issues concerning disclosure are overlooked and that is why

women were of the view that the service should be mandatory to include men as partners in the counseling and testing for HIV.

Male involvement in reproductive health should ensure that men are included in services delivery e.g provision of family planning methods for men and women. Different health centers carry out their health education differently for instance some health centers carry out routine health education on sexual and reproductive health during antenatal. Others carry out health education on Family Planning separately so as to give it special attention. Information on Family Planning is focused on women even when they are accompanied by their spouses. Some health workers are still operating in the traditional way of understanding reproductive health where it was viewed as a women's issue. Lack of male involvement may not be because men do not want to be involved but rather that the system does not expect men to be participants. In Jinja hospital men access permanent methods of family planning (Vasectomy), the service is readily available and the numbers of men opting for it was said to be increasing. The major reason for this situation was that the men are realizing how expensive it is to take care of large families. It could also be that couples are able to discuss and mutually agree on the family size they want.

Health education is given during every antenatal visit but due to the large numbers of women, it may not be adequately given. Women are not given opportunity to ask questions during these sessions as it is given little time. This would be an opportunity to teach women about their reproductive health rights. In most of the health units posters were not adequately utilized, some of them were in the midwife's office but not for clients. It was only Jinja hospital with a list of reproductive health rights pinned on the wall in the examination room but, they are written in English and meant for the health worker not clients. Most rural women do not listen to radios, so health programmes on radio may not help them much.

Some health workers are willing to carry on outreach services but due to inadequate staffing and facilitation, the exercise is rarely done. One of the in-charges at HCII said:

***“We use a bicycle to go out, but we do not even get an allowance for lunch. We try our best but when it rains we cannot even attempt to go out”***

In Mayuge district which is rather remote, it was reported that despite the available accommodation for resident doctors, none has accepted to stay. This situation was common in all health center IVs, which puts women's lives more at risk, in cases of emergencies that could have been handled at that level. The health sub-districts have not been functional as part of the decentralized health care delivery. Without incentives, health workers are unlikely to work in some places/health units.

Most women also said they did not have the liberty to

decide on the number of children they wanted to have (59% and 70%) for Jinja and Mayuge districts respectively. This shows that most women do not have control over their sexuality and reproduction; the decisions are made by their partners. It also shows that rural women are less able to make decisions on the number of children they want. Women basically have the role of producing as many children as they can for their husbands, or else he marries another wife. One woman lamented:

*"When a man has married you, you must produce as many children for him as possible. Failure to achieve that means that he will get another woman who will produce for him."*

## CONCLUSION

Integrating reproductive health rights into the minimum health care package would ensure that health planners give priority and allocate adequate resources for women's reproductive health, in the decentralized health care delivery. Community participation in health services delivery would empower women to be in control of their reproductive health. Revival of the Primary health care strategy, where traditional birth attendants can make a contribution to women's reproductive health care would make decentralized health care delivery a reality. This would mean that government changes their strategies on how to involve TBAs to integrate women's reproductive health rights in the decentralized health care delivery. Since the TBAs are already playing a significant role in reproductive health care delivery, proper training and closer supervision would give support to health care workers who are overburdened with too much work. Health care budget allocations must include the interests of the poor women. The costs of health care that the poor must bear during health care are unsustainable. The real costs of maternal health care and family planning for communities are increasing in the era of decentralization, which shows that the budgeting process is not based on the interests of the poor women who cannot afford gloves, cotton wool Macintosh etc.

Mothers are aware that delay in seeking health care contributes to maternal mortality and morbidity. Women delayed to seek help because they depend on their partners to take major decisions like transport costs, where to go for antenatal or deliver from (health center, hospital or home Maternal Mortality rates cannot be reduced by the health system alone, active community participation is necessary. There is need to understand the health seeking behaviors of communities so as to design appropriate interventions.

Some Health centers in Mayuge district had trained community health workers whose main responsibility is to mobilize communities. If all health centers had such arrangements, outreaches would be strengthened to promote efficient reproductive health care delivery.

For reproductive health rights to be integrated into decentralized health care delivery there may be need for reinforcement with by-laws. Jinja Hospital has tried to involve men in reproductive health care through inviting them to accompany their partners for antenatal care as a condition for service delivery. This initiative has not been successful, but could have been enforced using by-laws for the whole district to achieve male involvement.

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