GENDER POLICY BRIEF

FOR UGANDA'S HEALTH SECTOR

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Gender Policy Brief for Uganda's Health Sector

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1.0
GENDER AND HEALTH POLICY BRIEF FOR UGANDA

1.1 Introduction

The goal of Uganda's Health Sector is to reduce morbidity and mortality from the major causes of ill health as a contribution to poverty reduction and socio-economic development. In the words of Nobel peace laureate AmartyaSen, health, like education is among the basic capabilities that give value to human life (Sen1999). Uganda has been one of the pioneering countries in undertaking health sector reforms within the framework of decentralization. In line with these reforms, Primary Health Care (PHC) and the Minimum Health Care Package (MHCP) were introduced and have significantly contributed to improving the health of the population, thus facilitating improvement in a number of health outcome indicators.

In addition, the second National Health Policy (NHP II) that covers a ten year period 2010/11-2019/20 was developed whose operationalization will be through the Health Sector Strategic Plan (HSSP III) running 2010-2015. Inspite of these reforms however, health indicators in

Uganda remain among the worst in the continent. Malaria, Malnutrition, Respiratory tract infections, HIV/AIDS, and Tuberculosis remain the leading causes of morbidity and mortality. Non communicable diseases are an emerging problem and these include hypertension, cardiovascular diseases, diabetes, chronic respiratory diseases, mental illness, cancer conditions, injuries as well as oral disease. The increase in non-communicable diseases is due to multiple factors such as adoption of unhealthy lifestyles, an increasingly ageing population and metabolic side effects resulting from life-long anti-retroviral treatment. The high burden of disease continues to undermine social and economic gains.

Health, a basic human right, vital for sustainable development, eludes the majority of women. Although women in most societies including Uganda, live longer than men, (for biological reasons), women suffer greater burdens of illness and disability than their male counterparts. About half a million women die every year in Uganda from the complications of pregnancy and child birth (John Mushomi, 2007). As a result of visible and invisible discrimination, subordination and under valuation experienced throughout their life cycle, women are more vulnerable to poverty, poor nutrition, preventable diseases, uncontrolled fertility, premature death, violence, disability, alienation and loneliness. The quality of women's lives is further impaired by insufficient education, poor housing and sanitation, long hours of work in physically demanding and often dangerous and inaccessible health care services and lack of family and community support.

Aware that gender issues play a critical role in determining an individual's health and vulnerability to disease and infection, the ability to cope with the disease, and to access health care, it is imperative that they are properly identified analyzed and integrated in all health programmes such as Antenatal Care (ANC), Prevention of Mother To Child Transmission (PMTCT), Reproductive Health (RH,) Family Planning (FP) and nutrition among other programmes.

2.0
PERFORMANCE OF HEALTH FINANCING

2.1 Contribution to health care financing

In Uganda, households constitute a major financing source of the National Health Expenditure at 49.7 % and this is followed by Development Partners at 34.9 %, Central Government at 14.9 % and international NGOs at 0.4 % (HSSP III, 2010). Households spend about 9 % of their expenditure on health. Although no user fees are paid in lower level government health units and general wings of publicly owned hospitals, the private sector charges user fees. When medicines are not available in the public sector, patients buy them from the private sector. Private health insurance, largely subsidized by employers on behalf of employees, is for a few people, thus health expenditure remains high for most households. It is also known that while public health services are largely free many patients pay under-the counter fees in public institutions. Nearly 5 % of the households in Uganda are experiencing catastrophic payments at health units while 2.3 % are impoverished because of medical bills. The establishment of the National Health Insurance Scheme, which is at an advanced stage, is expected to cater for the majority of Ugandans.

2.2 Health budget as a percentage of the total government budget

Health expenditure from public sources in absolute terms has increased in the past 10 years (UGX 242.62 billion in 2006/07 to UGX375.38 in 2008/09) However, as a percentage of the total Government spending, it has actually decreased. In recent years, governments allocation to health as a percentageof the total government budget has been on average 9.6%. It thus remains below the Abuja Declaration target of 15%. There is inadequate funding to provide the UNMHCP in all facilities as envisaged: the per capita cost was estimated at USD 41.2 in 2008/09 and will be rising to USD 47.9 in 2011/12 (or UGX 2.75 billion) yet the health budget according to the MTEF was estimated at USD 12.5 per capita in 2008/09, demonstrating a shortfall of almost USD 29. This trend has important implications for service delivery.

2.3 Health expenditure and population growth

Uganda's population growth rate is high,at 3.2% and if not controlled will have an escalating effect on the total health envelope required. It implies that the sector should be prepared to provide quality healthcare to an extra 7 million people by 2015 and thus the need for considerable increase in the budgetary allocation to the sector. Demographic estimates indicate that 49% of Uganda's population constitutes of persons under the age of 15. Over the next 5 years of the HSSP III, Uganda will have to cover new specific age-related health needs. Whilst the Ugandan population will remain a young population with 18.5% of the

total population being under-five (down from 19.5% now), the population structure will start showing signs of aging, with the elderly (65+) slowly increasing from about 2.1% to 2.3% of the total population. Small as this percentage may seem, it does explain that there will be close to 1 million 'senior citizens' requiring medical attention. The very considerable increase in the number of females in reproductive years (from 7 million now to 8.3 million in 2014) will put considerable strain on all aspects of reproductive health services.

2.4 Health and Gender budgeting

"In terms of specific budgetary allocations to gender concerns, the health sector is on the right path although the pace seems to be slow". In the FY 2010/11, the sector emphasized the need to improve maternal health by rolling out the road map for reduction of maternal and neonatal mortality. This would entail scaling up of basic emergency obstetric and neonatal care to more HC IIIs which would make a contribution to addressing the health related gender issues for women of reproductive age and young children. In the same year, Government earmarked us$ 130 million over five years specifically to improve maternal and reproductive health outcomes and also to construct health infrastructure. Of this total amount, US $ 30 million was earmarked to cater for reproductive health. This is expected to progressively address the unmet national need for reproductive health supplies estimated at Ushs 7.5 billion.

In terms of the Primary Health Care non-wage recurrent budget, it is not sufficient to enable the health facilities to satisfactorily deliver services to the respective communities and yet this is where real gender constraints occur. The rising cost of health care delivery notwithstanding, a Health Centre (HC) III is on average allocated Ushs 450,000 per month to deliver a range of services such as maternal health including Emergency Obstetric Care (EMoC) and outreach to the community.

2.5 Health budgets and targets

Budgetary constraints have had an adverse impact on meeting of health care targets. For example, the proportion of pregnant women who receive Intermittent Preventive Treatment (IPT) increased to only 42% in 2007/08 against the HSSP II target of 80%. Only 42% of the households nationale have at least one ITN against a target of 70%. HIV prevalence in 2008/09 was estimated at 6.7% against a target of 3% in the HSSP II; HIV prevalence among women attending ANC was at 7.4% in 2007 against a target of 4.4%; and that only 50% of the HC IIIs were offering HCT services against a target of 100%. However, some targets for 2008/09 were achieved e.g. 68% of the HC IIIs were offering PMTCT services against a target of 50% and 90% of the HC IV were offering comprehensive HIV/AIDS care with ART against a target of 75% (HSSP III, 2010).

3.0
OVERVIEW OF UGANDA'S HEALTH OUTCOMES FROM A GENDER PERSPECTIVE

A brief analysis of the health indicators reveals that: Life expectancy increased to 45 years in 2003 from 52 years in 2000; the under-five mortality rate improved from 156 in 1995 to 137 deaths per 1000 live births in 2006; the infant mortality rate decreased from 81 to 76 per 1000 live births; HIV prevalence reduced from 27% to 7% between 2001/01 and 2008/09; underweight prevalence reduced from 23% to 16 % over the same period; stunted growth from 41% to 38.5%; the new born mortality rate was 33 % per 1000 live births in 2000 and decreased to 29 in 2006. 70% of overall child mortality is due to malaria, ARIs, diarrhoea, pneumonia and malnutrition. Maternal Mortality Rate (MMR) reduced from 527 to 435 per 100,000 live births between 1996 and 2006. Teenage pregnancy estimated at 25 per cent in 2006 is among the highest in sub- Saharan Africa and significantly contributes to overall maternal mortality rate.

3.1 Progress of maternal health indicators

Uganda, as a signatory of the Millennium Declaration, is committed to achieving the MDG targets. However, not much progress has been made with respect to MDG 5 which is to improve maternal health. As can be seen from Figure 1, MMR remains high and it is unlikely that the target for 2015 will be achieved unless deliberate or strategic investments are made to accelerate progress. There was very little decline in MMR between 1988 and 2006 when the last UDHS was conducted in Uganda. This implies that at current rates, 6,000 women die each year due to pregnancy and related factors (HSSP III, 2010). The percentage of pregnant women who deliver using skilled personnel and the contraceptive prevalence rate have remained low while the unmet need for family planning has remained high.

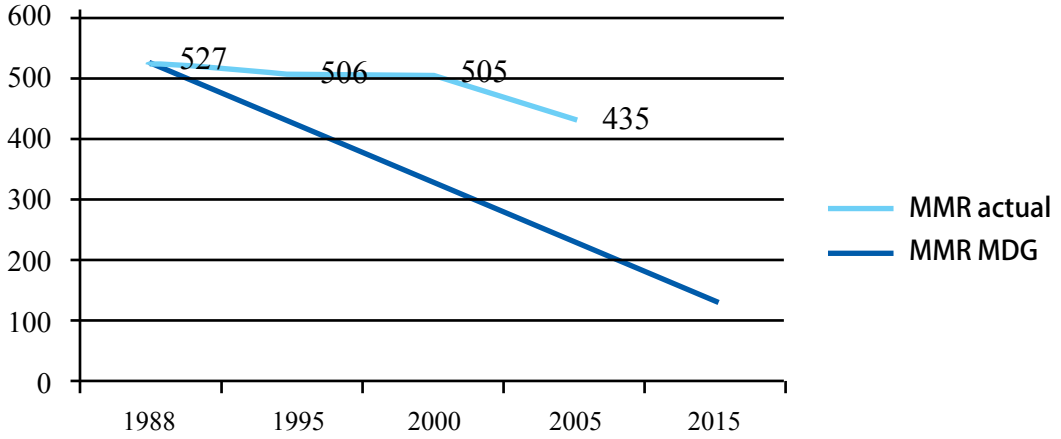
Maternal and child health conditions carry the highest total burden of disease with perinatal and maternal conditions accounting for 20.4% of the total disease burden in Uganda. Although, some progress has been made in the improvement of the health of mothers and children in Uganda over the implementation of the HSSP II, including rolling out of sexual and reproductive health (SRH) core interventions, the proportion of pregnant women delivering in public and private health facilities was still low at 32% by the end of HSSP II(against a target of 50%). The proportion of facilities providing appropriate Emergency Obstetric Care (EmoC) is still low and so is access to post natal care within the first week of delivery which stands at 26%. About 15% of all pregnancies develop life threatening complications and

require EmOC. The national met need for EmOC is only 40% leaving a big unmet need of 60%. Statistics also indicate that only 11.7% of women deliver in fully functional comprehensive EmOC facilities. (HSSP III, 2010).

The MMR for Uganda is still high at 435 deaths per 100,000 live births and the leading direct causes of these deaths are haemorrhage (26%), sepsis (22%), obstructed labour (13%), unsafe abortion (8%) and hypertensive disorders in pregnancy (6%).

Most of the HC IVs are not providing comprehensive Sexual and Reproductive Health (SRH) services yet there are a number of reproductive health challenges at that level. The current uncontrolled high fertility of women with an average of 7 children per woman predisposes women to high risk pregnancies and subsequently increases chances of morbidity and mortality. Early sexual involvement of girls has sometimes led to unplanned and unwanted pregnancy with evidence of high incidence of unsafe abortions and its related complications in the age group. HIV prevalence among pregnant women attending ANC is estimated at 20-30%.

Figure 1: Maternal Mortality Rates in Uganda (1988-2006)



Source: HSSP III, 2010-2015

3.2 Access to quality health care

Access is defined as the ease with which health care is obtained (Agency for Policy and Research 1995 cited in lawthers et al. 2003) or the freedom to use health care (Thiede 2005). The consistently inequitable nature of Uganda's health system limits access to quality health care especially among vulnerable groups like women and children that need the services most.

The health system is frequently ineffective in reaching the disadvantaged and marginalised groups in the society and most especially the poor households. Experience suggests that the poor people most of whom are women are excluded from accessing health care unless services are geographically accessible or of decent quality, fairly financed and responsive to their needs (Narayan et al. 2000).

A study carried out by John Mushomi, using UDHS Survey data and UNHS publications to investigate the main determinants of health care seeking; revealed that there are significant differences in health care seeking behaviour according to age, gender, residence, standard of living and level of education. The probability to access any type of health care was found to be greater for men than for women. The study further revealed that men increasingly use private health care while women have an overall higher demand for government hospitals than men. This partly reflects the importance of standard of living and income quintile levels and work status on women's decision to seek health care. Given the interesting gender differences and cultural barriers especially regarding the status of women in Uganda, associated with health care seeking behaviour, this automatically deserves further attention. Lack of control over resources is a major inhibiting factor in seeking health care.

Due to economic inequalities, especially in developing countries Uganda inclusive, women have difficulty in acquiring the basic necessities for a healthy life. There is considerable evidence to show that gender-related constraints affect women's access to health services

and that this affects the poorest women in particular. The most serious obstacles to women's health and their rights are cultural, religious and social biases against women. These lead to barriers in accessing quality health information, education and services and the inadequate allocation of government and donor resources (ARROWS for change, 1997).

Gender therefore plays an important role in seeking health care. In most cases married women may not make decisions on their own regarding how resources in the home can be spent. The UDHS shows that about 55% of the women mainly decide by themselves how their earnings are to be spent, 32% report that they make the decision jointly with their husband/partner while 13% report that the decision is mainly made by their husband/partner. There are variations in the proportion of women who make independent decisions about their earnings ranging from 24% in Eastern region to 79% in Kampala. This shows that women in urban areas are more likely to make independent decisions compared to those in rural areas. Decision making is an important determinant of health care seeking behaviour and in contexts where decisions are made by men this may delay seeking appropriate health care.

3.3 HIV/AIDS Prevalence and care

HIV/AIDS remains a major health concern. Uganda has made great progress in HIV/AIDS service delivery and prevention since the advent of the epidemic in 1982. By 2008, HIV testing and counselling services were provided in more than 50% of health facilities. More than 830,000 pregnant women were tested and received their HIV status results in 2008. PMTCT

and ART services were provided in 66% and 83% of the health facilities respectively that are supposed to provide such services, according to the ACP annual report 2008/09. By the end of September 2009, there were 200,213 receiving ARVs, 8.5% of them being children. There is need to replicate these successful HIV services with others especially TB, RH and MCH.

However, albeit the above achievements, recent evidence suggests that the epidemic has shifted from the single younger-aged individuals to older individuals aged 30-35, who are married or in long-term relationships. Multiple concurrent partnerships, extra-marital relationships, discordance and nondisclosure are among the key factors driving the spread of HIV in Uganda. There is limited programming for the Most at Risk Populations (MARPs) and yet conspicuous evidence highlights high prevalence rates among these populations (CRANE Study 2009).

The MOT study conducted in 2008 showed that 130,000 new infections occurred in 2007. Eighteen per cent (18%) of the new infections occurred through mother to child transmission (MTCT) while the majority of people newly infected were through heterosexual relations. Forty three per cent (43%) of those new infections occurred among people in long term relationships, calling therefore for an increased focus on HIV prevention among couples and other high risk groups such as Commercial Sex Workers (CSW). Some targets as set in the HSSP II have not been achieved: e.g. HIV prevalence in 2008/09 was estimated at 6.7% against a target of 3% in the HSSP II; HIV prevalence among women attending ANC was at 7.4% in 2007 against a target of 4.4%; and only 50% of the HC IIIs were offering HIV Counselling and

Testing (HCT) services against a target of 100%. Some targets for 2008/09 were achieved e.g. 68% of the HC IIIs were offering PMTCT services against a target of 50% and 90% of the HC IVs were offering comprehensive HIV/AIDS care with ART against a target of 75%.

3.4 Nutrition Status

Nutrition also constitutes one of the priority areas or components of the UNMHCP. Food and food supplements are the primary medicines used in promotive nutrition, prevention of malnutrition and therapeutic diets used in treatment of the malnourished. However, anthropometric and other equipment for managing and monitoring nutrition programmes are found in very few health facilities. In the past 5 years, nutrition interventions have led to a reduction in underweight and stunting from 23% to 16% and 41% to 39%, respectively and a sustained proportion of households consuming iodized salt above 95%. However, the majority of other nutrition indicators remain unacceptably poor.

4.0
KEY GENDER ISSUES IN UGANDA'S HEALTH SECTOR

As already alluded to in the previous sections, Gender issues in the health sector manifest in several ways among which are discussed below;

4.1 High Maternal Mortality Rate (MMR)

Despite reforms by government, especially in primary health care, maternal health indicators are still worrying. Although there has been a decline in the maternal mortality ratio from 505/100,000 live births in 2001 to 435/100,000 in 2006 (UDHS, 2006), it is unlikely that Uganda will meet the MDG target of 131/100,000 live births by 2015 as indicated in figure 1. Access to quality maternal and reproductive health services for girls and women is still very low in the country.

Available data reveals that, 16 women die every day from pregnancy related illness and that while 95% of women visited antenatal clinics, only 47% had the recommended four or more

visits (UDHS 2006) and only 42% of births are assisted by a skilled provider. Additionally, 63% of women in rural areas give birth at home compared to 20% of women in urban areas (NDP, 2010). Poor health outcomes for women and girls are magnified in the post-conflict areas of the North where incidences of early marriages stand at 43.1%.

The main factors responsible for maternal deaths relate to the three delays - delay to seek care, delay to reach facilities and intra-institutional delay to provide timely and appropriate care. The two first delays have a gender dimension in that many pregnant women may have to consult or request for financial support and other support from their husbands to seek health care. Slow progress in addressing maternal health problems in Uganda is also due to lack of human resources, medicines and supplies and appropriate buildings and equipment including transport and communication equipment for referral.

4.2 High Fertility Rate

The Ugandan population has been growing rapidly over the last two and a half decades. Population grew from an estimated 16 million in 1991 to 24.2 million in 2002 to 30.7 million in 2009. At a growth rate of 3.2% per annum (1991-2002), the population increased to 31.8 million in 2010 and is projected to reach 38 million in 2015. At this rate, a total of about 1.2 million people are added per year to Uganda's population. (NDP, 2010)

This rapid population growth is largely attributed to a high fertility rate. In fact, Uganda is ranked among the countries with the highest fertility levels in the world, currently at 6.7 children per woman. This has resulted in a young population as nearly half of the population in Uganda is under the age of 15, and the population will continue rising even if fertility declined.

The population trend described above presents several challenges to future growth and structural transformation unless serious measures are taken to convert it into a population dividend. The causes of high fertility include low levels of education, poor access to family planning services with unmet demand estimated at 41%, a low contraceptive prevalence rate of 24% and early childbearing with 25% of adolescents being pregnant before the age of 19. Despite high levels of awareness, available data indicates that only 18% of married women in Uganda use a modern contraceptive method. This is partly because of cultural and religious factors which facilitate preferences for large families as a source of social security at old age. On the other hand, it is due to low access to reproductive health services. These poor results are compounded by unfavourable practices in health seeking behaviour and limited male involvement.

4.3 High levels of HIV infection among women and married couples

Almost as many women as men are now dying from AIDS. However, there are important differences between women and men in the underlying mechanisms of infection. These stem from biology, sexual behaviour and socially constructed gender differences between women and men in roles and responsibilities, access to resources and decision-making power. A number of studies have examined the role of gender inequalities on women's risk and vulnerability to HIV/AIDS. A 1998 study in Kisumu, Kenya, showed that the prevalence of infection among young women was 23%, while among young men of the same age it was 3.5%. This is probably due partly to biological factors but perhaps more importantly to the fact that social norms dictate marriage at an early age for women in many places, and that the sexual partners of younger women are often significantly older than the women themselves. These findings are also true for the Ugandan scenario due to similarities in the cultural dynamics.

Early initiation of sexual activity among girls is directly related to the practice of early marriage for girls in many developing countries. Furthermore, the sexual partners of young women are often much older than the women themselves: research from 16 countries in Sub-Saharan Africa indicates that husbands of 15-19 year-old girls are on average ten years older than their wives. Early marriage may expose girls to an increased risk of HIV and STI infection, especially if their partners are older and have had more sexual exposure.

For many women, being vulnerable to HIV can simply mean being married. Social norms that accept extramarital and pre-marital sexual relationships in men, combined with women's inability to negotiate safe sex practices with their partners, make HIV infection a risk even in women who have only had one partner in their entire lives. For such women, "remaining faithful" is no protection. Information from countries such as Thailand and South Africa indicates that poverty, lack of education and limited income-earning opportunities often force women into commercial sex work, exposing them to a high risk of HIV infection and other STIs.

Women are more affected and infected by HIV/AIDS than men in Uganda like in many countries world-wide. The HIV prevalence rate amongst women in Uganda is 7.5% compared to 5% among men. According to the UDHS of 2006, 21% of married women say they cannot refuse sex, while 46% of them say they cannot ask their husbands to use a condom. Young women and girls are also vulnerable to infection, especially those affected by conflict and violence.

In addition, pregnancy and childbearing raise specific issues for women. Pregnancy-related complications, such as haemorrhage, expose women to the risk of infection related to transfusion of blood or blood products. Since HIV can be transmitted through breast milk, breastfeeding presents a dilemma for many women. Those who decide to discontinue breastfeeding in favour of infant formula may reduce the risk of HIV transmission to their

child, yet may expose the infant to diseases resulting from an unclean water supply, as well as to malnutrition. The use of infant formula can alert others to the mother's HIV status and lead to stigma and discrimination.

In almost all cultures, masculinity is associated with virility. A UNAIDS report of 2002 based on research conducted in seven countries (Cambodia, Cameroon, Chile, Costa Rica, Papua New Guinea, the Philippines and Zimbabwe) found that notions of masculinity encourage young men to view sex as a form of conquest. Other research found that since ignorance is construed as a sign of weakness, men are often reluctant to seek out correct information on HIV/STI prevention.

4.4 High levels of Malnutrition among under-fives and women of reproductive age

Adequate nutrition is one of the key factors in human development and economic productivity. In Uganda, malnutrition is still rampant affecting millions of Ugandans in various ways, but is particularly devastating to women, babies and children. Malnutrition impairs educational achievement and economic productivity, costing families enormous amounts of money to treat related illness.

Data from the previous three Demographic Health Surveys, report high levels of child and maternal under nutrition that have persisted over the past 15 years. According to the 2006

UDHS, 38% of children under five in Uganda are stunted, 16% are underweight, and 6% are wasted. Fifty per cent (50%) of women and 73% of children less than 5 years are anaemic. One out of every five children (20%) and one out of every five women (20%) are vitamin A deficient. Countries with widespread iron deficiency as it is the case in Uganda are known to lose 2% of their GDP every year due to poor learning ability and low productivity due to iron deficiency. Infant and young child feeding practices are sub-optimal with only 60% of infants exclusively breastfeeding and 80% receiving complementary foods which is often not adequate in terms of quality and quantity. (UNAP, 2011).

To improve this situation, women of childbearing age must receive proper nutrition so that when they are pregnant, they are able to properly nourish their children from the time of conception until those children are weaned. These same women must receive related information and the health services to properly feed and care for their children so that they grow strong, smart, and healthy. Improving nutrition status requires putting into perspective the gender dimensions involved in food production, dietary intake and household income. In doing so it is important to analyse the factors surrounding the role of men in household nutrition and and consequently to promote male involvement in family health services, food security and nutrition programs. This is a critical gender issue given the fact that women in most cases do not control household resource, including farm products.

Inadequate dietary intake is partly caused by household food insecurity, mainly related to poor access to the range of foods needed for a diversified diet and consumption of foods that are relatively deficient in micronutrients. Seasonality in food production, variable food prices, and seasonal earning patterns exacerbate the instability and the poor quality of the diet consumed by the household through the year.

The second underlying cause is inadequate maternal and child care. Care-related constraints lead to both inadequate dietary intake and a high disease burden in young children and pregnant women. These constraints include the high daily workload that women as primary caregivers in the household must shoulder. Women do both farm and household chores and may engage in small business activities, while also being responsible for the continual care of the children and other dependents within the household. Frequent births limit the ability of a woman to properly care for her infant and other young children, while also regaining her own health.

Social dislocation in many households and communities in Uganda has led to changes in traditional gender roles and increased family breakups. These changes tend to adversely affect the quality of nutritional and health care women and young children receive. Different forms of malnutrition affect different groups of Ugandans. However, the "window of opportunity" is within the 1000 days from conception through the nine months of pregnancy up until two

years of a child's age. It is during this period that malnutrition develops in children. The greatest returns to effective action to prevent malnutrition are obtained during this period.

4.5 Gender and malaria infection

Gender norms and values that influence the division of labour, leisure patterns and sleeping arrangements may lead to different patterns of exposure to mosquitoes for men and women. There are also gender dimensions in accessing treatment and care for malaria. A thorough understanding of the gender dynamics of treatment seeking behaviour as well as of decision making, resource allocation and financial authority within households is key to ensuring effective malaria control. Therefore gender and malaria issues are increasingly being incorporated into malaria control strategies in order to reduce the prevalence of malaria. Although malaria affects everybody, women tend to bear most of the burden related to it. A large number of pregnant women living in malaria endemic areas suffer severe complications such as still birth and miscarriages. The rate of malaria infection is higher in pregnant women because of their decreased immunity. Pregnant women with malaria have an increased risk of abortion, still births, premature delivery and low birth weight infants.

4.6 Gender based Violence (GBV)

The 2005/06 DHS brings on board health challenges related to Sexual and Gender Based Violence in all the regions of the country. This was a new area addressed in the HSSP II which will be consolidated in HSSP III. Gender based violence is rampant in Uganda as reported in the UDHS 2006. While programmes are being implemented to address GBV, challenges still exist such as lack of resources and equipment including transport and requisite skills among health workers to deal with such issues. In addition there is poor coordination and collaboration amongst different stakeholders in Uganda and this tends to weaken the National response to sexual and gender based violence. There is need to enhance awareness of all health workers and all other stakeholders about rolling out training of health workers on management of SGBV both in-service and pre-service; developing, translate and disseminate IEC materials on SGBV, empower and support male change agents for SGBV and Educating school pupils, students and communities about the health consequences of and response to SGBV.

5.0
ATTEMPTS TO ADDRESS GENDER ISSUES IN THE HEALTH SECTOR

A review of the Health Sector Strategic Plan 111 and the Health sector Policy indicates that over the last 10 years, the sector has increasingly paid attention to addressing gender concerns in the provision of health care. Efforts have particulary been made to improve the provision of reproductive health care, especially maternal health.

The Road Map to accelerate Reduction of Maternal and Neonatal Morbidity and Mortality and the National Child Survival Strategy were formulated in 2007 and 2009, respectively. The effective implementation of these strategies is expected to contribute significantly towards achievement of MDGs 4 and 5 by 2015

In the FY 2010/11, the health sector emphasised the rolling out of the road map for reduction of maternal and neonatal mortality to 40 districts. The budget speech revealed that Government had earmarked US $130 million over five years specifically to improve

maternal and reproductive health outcomes and also to construct health infrastructure. Of this total amount, US dollars 30 million was earmarked to cater for reproductive health. This is expected to go a long way in addressing the health related gender issues for women of reproductive age and young children.

In the same financial year, the sector prioritized allocation of resources to primary health care (29% of the budget), pharmaceuticals and medical supplies (32%) indicating that it was on track in terms of addressing real health issues which affect the majority of the population especially women and children in rural areas and the urban poor. Furthermore, the analysis revealed that the selection of projects and their geographical locations indicated a focus on rural, hard to reach and marginalised areas as well as areas hit by disasters.

Similarly, National commitment for integration of Gender in HIV/AIDS programs has been demonstrated in the National HIV Strategic Plan 2007-2012.

6.0
UGANDA'S HEALTH CARE CONSTRAINTS

High Poverty levels: Uganda is classified as a poor country, with about 24.5% of the population living below the poverty line and yet poverty is one of the major determinants of health status. High poverty levels are a major threat to improvement of health outcomes.

Low resource allocation: While Uganda's economy has been growing steadily at about 7% over the last few years, the budgetary allocation to the health sector has been stable at about 9.6 %, with heavy reliance on donor funding.

Low attention to disease prevention: The NDP notes that over 75% of the disease burden in Uganda can be prevented through health promotion and prevention. Nevertheless, preventive interventions such as immunization, promotion of sanitation and nutrition, though cost-effective, have not been given adequate attention by the health sector. Although there has been increase in funding for primary health care much of the funding goes into construction

of health facilities as a symbol of health service. There is less focus on strengthening the health promotion and disease preventive measures.

Limited male involvement: There is low male involvement in family health, nutrition and HIV precaution constraining health care promotion and health seeking behaviour.

Low integration of Gender issues: Despite the exisiting and enabling legal and policy environment, there is ineffective analysis and addressing of gender issues in some health programmes such as PMTCT, RH, FP, nutrition and general health service delivery. This is partly as a result of lack of gender technical expertise in the health sector.

No attention to socio-cultural factors: Analysis of health programs reveals that the health sector does not pay attention to socio-cultural factors that prevent women and men from seeking health care and the role of other sectors in addressing this constraint. Evidence suggests that availability of health facilities and human resources for health does not translate into women seeking health services.

7.0
KEY POLICY RECOMMENDATIONS

1. It is important that in the current HSSP III, priority be given to sexual and reproductive health as it will help accelerate progress towards achieving MDG 5 and save the lives of women who die during pregnancy and child birth. Safe motherhood therefore must be given all the necessary resources and attention it deserves as a key element in the minimum health care package. At the same time addressing the unmet need for family planning will also address the challenge of high fertility rate thus reducing the rapid population growth and relieving pressure on health services in the medium and long-term.

2. Emphasis should be placed on the rolling out of the road map for reduction of maternal and neonatal mortality through scaling up of basic emergency obstetric and neonatal care to more HC IIIs and IIs. This will contribute to addressing health related gender issues for women of reproductive age and young children. Focus should be on training, supervision and mentoring of health workers; providing standard equipment and

ensuring availability of medicines and supplies; improving access and quality of family planning; focusing on commodity security; targeting male partners in family planning; conducting maternal audits and carrying out youth friendly services at the health facilities. Additionally funds allocated to the health sector should be released timely to ensure effective implementation.

3. Aware that Gender issues play a critical role in determining an individual's vulnerability to HIV/AIDS infection, the ability to cope once infected, and to access services for prevention, care, support, and treatment, it is imperative that gender issues are properly analysed and integrated in PMTCT, RH and FP policies, programs and implementation.

4. The health sector should put in place an appropriate collaborative mechanism with other key sectors to effectively address socio-cultural issues that affect health outcomes. Promoting male involvement in family health services, food security and nutrition programs; advocating for and seeking solutions for reducing workload for all women especially the pregnant and lactating mothers; as well as addressing negative food taboos and norms that affect nutrition of women, infants and young children are programmes that require a multi-sectoral approach so as to ensure that.

5. Tailor made trainings on gender responsive planning, programming, budgeting and implementation are necessary for the health workforce.

6. Effectively addressing the nutritional needs of infants and young children will arrest a lifetime of problems malnourished children face later in life and reduce the burdens they impose on the household, community, and nation. The nutritional condition of the women who bear these children is an equally important element as the health and nutritional well-being of the child is determined by the health and nutritional well-being of its mother. However, these two target groups cannot be served in isolation. Most causes of malnutrition are linked to practices or access to resources at household or community levels.

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FOWODE'S GENDER BUDGET PRORGAM

Forum for Women in Democracy (FOWODE) is a women's non-governmental organization in Uganda. Since 1999, FOWODE has been implementing a Gender Budget Programme whose goal is to advocate for gender balanced budgets that address the needs of women and men, girls and boys equitably.

The Programme implements its activities through the following strategies:

- Capacity development
- Advocacy
- Mass mobilization
- Research and publication

WHAT HAVE WE DONE?

- The advocacy efforts for Gender Responsive Budgeting in Uganda resulted in the government of Uganda through the Ministry of Finance, Planning and Economic Development in 2006 initiating the Budget Call Circular directive on gender, directing spending agencies to indicate how they plan to address gender inequalities in their sector work plans and budgets.
- Developing capacities of over 3000 government technocrats, politicians and Civil Society Organisations to independently analyse and interrogate budgets from a gender perspective.
- Conducting research to assess how women and men benefit from national development programmes.
- Annually engaging in the budgeting process to influence government allocation of resources with the aim of improving service delivery especially for the poor people.
- Collaborating with civil society organisations through the Civil Society Budget Advocacy Group (CSBAG) to produce alternative budgets that provide alternative policy recommendations to government.
- Providing technical assistance to government at national and local level. In the past FOWODE in partnership with Ministry of Finance Planning and Economic Development, produced a facilitators' manual on gender and equity budgeting for sector ministries and local governments. At the local level, FOWODE supported districts to develop Gender Policies and Gender Aware Budgets and Plans which provide a framework for the integration of gender in district plans and budgets
- Creating a critical mass of activists at the community level through the establishment of Village Budget Clubs at the grass root level to demand for improved and equitable service delivery.

This policy brief analyses the gender dynamics within the health sector in Uganda .it highlights key gender issues in the health sector ,attempts to address gender issues within the health sectors ,health care constraints and key policy recommendations that need to be addressed to enhance performance as a means of contributing positively to promoting women's health.

Our Vision

A just and fair society where women and men equally participate in and benefit from decision making processes.

Our Mission

To promote gender equality in all areas of decision making through advocacy, training and research and publication.

Forum for Women in Democracy

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