Maternal Health & Rights In Uganda

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Maternal Health & Rights in Uganda

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Completed 2019
Master of Public Health 2019
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Abstract
This report will contribute to the global narrative about maternal health and rights by examining the current state in Uganda in regional (Sub-Saharan Africa) and global context. The report will focus on indicators of maternal health and rights in Uganda and the complex social, political, legal, and sociocultural factors that influence maternal health in a developing nation. This report will contribute to understanding of the current issues impacting maternal health, and will culminate with recommendations for appropriate policies and advised programmatic response to improve maternal health in Uganda, with implications for the Sub-Saharan African region and the world.

Acknowledgments
This report was inspired by the incredible women of the Kabughabugha Young Mother’s group in Kasese Uganda, who I had the privilege to work with during the summer of 2018. I would like to sincerely thank each and every member of the Young Mothers Group for welcoming me so graciously into their community and their lives. I am forever touched by their kindness, infectious energy, dedication, and passion in pursuit of their health and rights. This is for you.

Kabughabugha Young Mother’s Group – July 2018

I also am so grateful to my family and friends, especially Faiz and Dieren, for encouragement and love in the completion of this thesis project and pursuit of my Master’s in Public Health. Special thanks to my talented sister Olivia for the beautiful cover design, and to my wonderful parents for their support in whatever I do, wherever I go. I am so appreciative to my readers Mary Alice Lee, MSN, PhD and Ali Miller, J.D. for their guidance, insight, and valuable feedback.
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Importance & Impact of Maternal Health

Maternal health is defined as the health and wellbeing of mothers in the duration of their pregnancies, during labor and delivery, within the immediate postpartum period, and up to a year following the end of a pregnancy (1). Indicators of maternal health include assessment of factors including: maternal deaths, maternal morbidity, indicators of skilled attendants at births, access to family planning services, access to ante- and postnatal care services as well as many others (2).

One of the primary indicators of maternal health is maternal death, also known as maternal mortality. Maternal mortality is defined by the World Health Organization as deaths caused by or associated with pregnancy, while a person is pregnant or within 42 days of the end of a pregnancy (3). A maternal mortality ratio represents the number of maternal deaths per 100,000 live births, and is typically assessed on a regional or national scale (3).

Another primary indicator of maternal health is maternal morbidity, which includes any health complication, mental or physical, that is related to pregnancy, labor, or delivery, and results in short or long-term effects that can negatively impact the health of mothers (4). It is estimated that for every maternal death that occurs worldwide, approximately 30 maternal morbidities arise, which have the potential to affect the health of a mother for the rest of her life (5).

The consequences of poor maternal health, maternal mortality, and maternal morbidity can be severe, and have significant implications on the overall health and lives of the mothers affected as well as their families, communities, and society at large with physical, psychological, social, and economic effects.

The worst maternal outcome that can occur is death. However, even if that outcome is avoided, complications or maternal morbidity can have a significant impact on a mother’s life. Both short and long-term physical, reproductive, and psychological health of the mother can be affected in a number of ways, as well as cognitive and social abilities (6). Such effects range in severity, and can include incontinence, obstetric fistula, hemorrhoids, chronic pain, hypertension, depression, and many more conditions that could potentially affect the rest of a woman’s life (4).

In addition to the mother herself, maternal mortality or morbidity can significantly affect her infant and any other children the mother might have by increasing risk of poor outcomes in child health and development. The most severe consequence to children is death, particularly infant mortality, which increases with maternal mortality (4) along with poor nutrition (8). Additionally, the dynamic of the family is likely to shift as a result of the loss or disability of a mother, and particularly in developing nations, a child might be forced into labor for economic family support (8). This might force children to drop out of school, limiting their education and potentially restricting future opportunities. Not to be understated are the significant psychological effects and lifelong impact of losing a parent, or having a parent living with a
chronic complication from pregnancy, which could significantly impact the development of a child (8).

In a similar manner, maternal mortality and morbidity can also significantly impact family and household dynamic. The loss or disability of a mother in a household could increase risk of poverty and economic insecurity in a number of ways, including the possible financial burden of medical expenses in addition to potential loss of income (8). The burden of financial strain can deepen the psychological effects associated with the grief of the loss or disability of a family member (8). The effects poor maternal health can be felt on a familial level for generations.

On a community level, maternal mortality and morbidity can create more single-parent homes, more orphans, and reduce economic productivity (8). Poor maternal health can also have significant personal and psychological impacts on medical care providers (9).

![Figure 1. Ripple Effects of Maternal Mortality (9)](image)

In a similar way that poor maternal health can impact society on multiple levels, society itself has a significant impact on maternal health. Gender based discrimination persists to some degree in every nation worldwide, and gender inequality can manifest as a result of laws, policies, social norms, and practices, which can lead to the denial of full rights of women (10). Discrimination and violation of human rights places women at greater risk for denial of personal autonomy concerning health and limited access to health care, which can ultimately result in poorer health outcomes for women and mothers (10).

A major way that women’s health can be effected by the denial their full rights is voluntary motherhood: a women’s ability to choose whether or not to have children, and to determine the number and spacing of children if they choose (11). For the choice of voluntary motherhood to be realized, legal and social barriers need to be eliminated that prevent many women from achieving personal autonomy concerning heath, and prevent access to reproductive health care, particularly family planning and contraceptive services.
Poor maternal health, maternal mortality, and morbidity can have broader societal impact, including economic effects. Research from the Partnership for Maternal, Newborn & Child Health at the World Health Organization shows that many countries exhibit a relationship between maternal mortality and economic growth, with national GDP improving with maternal health (12). This can be particularly impactful in developing nations, and in families and communities that are economically disadvantaged or vulnerable.

In addition to the effects of poor maternal health that are felt a number of levels, many indicators of maternal health, including maternal mortality, are widely recognized as important indicators of development, a nation’s overall health, and reflect the successes and shortcomings of the country’s health care system.

It is important to note that the full extent to which maternal health and maternal mortality and morbidity affect the world on a large scale is yet unknown due to challenges in comprehensive data collection and assessment. However, despite gaps in data, the impact is clear: the health of women when they become mothers has the potential to impact us all.

Due to the vital importance of maternal health, preventing maternal mortality and maternal morbidity should be a top global priority. A global maternal mortality ratio of up to 220 maternal deaths per 100,000 live births still persists, with much higher rates in some regions (13). Furthermore, annually more than half of all women who give birth will experience pregnancy complications of some degree, millions of whom will live with severe and lasting effects (5).

Nearly all maternal deaths worldwide, up to 99%, occur in developing nations, more than half in Sub-Saharan Africa alone (14). In addition to international disparities in maternal health, intra-national disparities also exist by income, education level, and geographic location (14). Furthermore, the vast majority of maternal mortality and morbidity worldwide is largely preventable. Each day, around 830 women worldwide die from preventable maternal deaths (14), more than 80% of which could be avoided through access to basic health care services, according to UNICEF (15).

The striking disparities and preventable nature of poor maternal health, maternal mortality, and maternal morbidity in developing nations in particular shows that maternal health is much more than just public health concern. Maternal health is a matter of human rights and social justice that has ramifications with the potential to be felt throughout the entire world, particularly in developing nations.

This report will contribute to the global narrative about maternal health and rights by examining the current state in Uganda in regional (Sub-Saharan Africa) and global context. The report will focus on indicators of maternal health and rights in Uganda and the complex social, political, legal, and sociocultural factors that influence maternal health in a developing nation. This report will contribute to understanding of the current issues impacting maternal health, and will culminate with recommendations for appropriate policies and advised programmatic
response to improve maternal health in Uganda, with implications for the Sub-Saharan African region and the world.

Maternal Health in Historical & Global Context

In light of its demonstrated impact on mothers, families, communities, and society at large, improving maternal health should be a global priority. The preventative nature of maternal morbidities and mortalities suggests great potential for opportunities for intervention and improving maternal health. Recent global efforts have prioritized the reduction of maternal mortality and morbidities, and great progress has been made in improving maternal health around the world.


In 2000, maternal health was prioritized as component the United Nations Millennium Development Goals (MDGs) to be achieved by 2015. The MDGs consisted of 8 goals aiming to improve global development in various ways (Figure 2).

![Figure 2. Millennium Development Goals (18)](image)

Millennium Development Goal #5 “Improve Maternal Health” was specifically dedicated to the cause that had been building momentum throughout the previous decade (18). Goal 5 consisted
of two components: Target 5A was to reduce the maternal mortality rate by 75% between 1990 and 2015, and Target 5B was to achieve universal access to reproductive health care in the same timeframe (18).

Though progress was made, the international success of these objectives was moderate and largely fell short of the goals. A report *Trends in Maternal Mortality: 1990 to 2015*, written in collaboration between WHO, UNICEF, UNFPA, the World Bank, and the United Nations Population Division, demonstrated that maternal mortality decreased by about 44% in the 25 year span, resulting in the most recent global estimate of approximately 220 maternal deaths per 100,000 live births (13). Though the maternal mortality ratio was nearly halved, the progress fell short of the Millennium Development Goal Target 5A by a margin of 30% (18). Unfortunately, progress with Target 5B was even less successful, with only moderate increases in the prevalence of skilled attendants at births worldwide by approximately 10%, and contraceptive use by women in committed relationships also increasing by nearly 10% (19)(18). At the completion of the Millennium Development Goals only around half of women worldwide received recommended prenatal care (18).

Following the Millennium Development Goals, the United Nations developed the next set of objectives: the 2030 Agenda for Sustainable Development. This list consists of 17 detailed and intersectional goals addressing various aspects of global development (Figure 3), each with comprehensive targets and indicators.

Figure 3. Sustainable Development Goals (20)
Encompassed within Goal 3 “Good Health & Well-Being”, is the objective to reduce global maternal mortality to fewer than 70 deaths per 100,000 live births by 2030 (21). Another target within this goal that is important to maternal health is to achieve universal sexual and reproductive health care access worldwide within the same timeframe (21). In addition to specific maternal health objectives, Sustainable Development Goal 3 consists of a multifaceted approach focused on health systems strengthening and capacity building as essential components of achieving health objectives. Likewise, the majority of the Sustainable Development Goals overall are intersectional in nature, and were created such that the progress of one often supports the success of other goals.

One shortcoming of the Millennium Development Goals was the narrow focus of many of the objectives, and lack of emphasis on mutually beneficial development aims. The MDGs have been criticized for lack of inclusion of sexual and reproductive rights, and neglecting women as decision makers in sexual and reproductive health (22). The World Health Organization in particular has critiqued the Millennium Development Goals, and particularly Goal #5 for falling short, particularly for lack of a holistic approach to development and specifically improving maternal health outcomes (23). In 2015, the WHO released a report entitled Strategies Toward Ending Preventable Maternal Mortality, which reinforced the importance of a collaborative commitment to development objectives to achieve maternal health aims (23).

“Ending Preventable Maternal Mortality targets and strategies are grounded in a human rights approach to maternal and newborn health, and focus on eliminating significant inequities that lead to disparities in access, quality as well as outcomes of care within and between countries. Attention to maternal mortality must be accompanied by improvements along the continuum of care, including commitments to sexual and reproductive health, family planning, and newborn and child survival.” (23)

As previously mentioned, the majority of maternal deaths that occur today are largely preventable (24). Furthermore, striking disparities in maternal health exist by geographic region, income level, and several other demographic factors. Developing nations account for 99% of maternal deaths that occur worldwide (24), and as recently as 2015 the WHO determined that 66% of maternal deaths worldwide occur within sub-Saharan Africa (13). Additionally maternal mortality rates are disproportionately high among women in low-income and rural settings across the globe (24).

The preventable nature of poor maternal health outcomes, in addition to the striking disparities, indicates significant human rights concerns. These concerns were formally acknowledged by the United Nations Human Rights Council beginning in 2009, with the adoption of Resolution 11/8: Preventable maternal mortality and morbidity and human right. The resolution identifies a number of human rights related to maternal health, including: “rights to life, to be equal in dignity, to education, to be free to seek, receive and impart information, to enjoy the benefits of scientific progress, to freedom from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health” (UNHRC Resolution
The recognition of the importance of maternal health from a human rights perspective was crucial to worldwide acknowledgment and prioritization of maternal health in the midst of the MDGs.

Maternal Health & Rights in Sub-Saharan Africa

One region of the world in which maternal health and rights are of significant concern is sub-Saharan Africa (Figure 4). As previously mentioned, 66% of all maternal deaths worldwide occur in the sub-Saharan region of the African continent. (13)

Despite recent improvements, the World Health Organization has called sub-Saharan Africa “the most dangerous place for a woman to have a baby” (26), with consistently the highest mortality rate of any region in the world, currently at 546 maternal deaths per 100,000 live births (13) (Figure 5).

Figure 4. Sub Saharan Africa (25)

Figure 5. Regional trends in maternal mortality over time (27)
The risk of dying a maternal death throughout the lifetime of a woman in sub-Saharan Africa is 1 in 36, much higher than the worldwide average 1 in 180, and strikingly different from the lifetime risk in high-income nations of 1 in 3,300 (Figure 6) (13).

Several studies focused in sub-Saharan Africa have revealed striking correlations between maternal health and multiple development and health care systems factors. Education has been found to play a significant role in maternal health in sub-Saharan Africa, with an inverse correlation between adult literacy and maternal mortality rate (28). Higher education has been shown to reduce maternal mortality and morbidity in sub-Saharan Africa (29); in fact, if all women throughout sub-Saharan Africa completed a primary level of education, the maternal mortality rate is estimated decrease by 70 percent (30).

Several financial factors also significantly affect maternal health. Per-capita government spending on health has been inversely correlated with maternal mortality rate. The same was shown to be true with gross national income per capita. Furthermore, out-of-pocket expenditures on health in sub-Saharan Africa presented a statistically significant direct correlation to the maternal mortality rate (28).

In addition to the social and development components, there is an increasing understanding of maternal mortality and morbidity in Africa as a matter of human rights. The African Commission on Human and People’s Rights Resolution on Maternal Mortality in Africa:

“I. DECLARES that preventable maternal mortality in Africa is a violation of women’s right to life, dignity and equality enshrined in the African Charter on Human and Peoples’ Rights and the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa

Figure 6. Lifetime risk of maternal death by region and income group (2015) (13)
2. CALLS UPON African Governments to individually and collectively address the issue of maternal mortality in accordance with the recommendations attached to this resolution.” ACHPR/Res.135 (XXXIV)08 (31)

The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, mentioned above, contains Article 14 Health and Reproductive Rights:

“1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:
   a) the right to control their fertility;
   b) the right to decide whether to have children, the number of children and the spacing of children;
   c) the right to choose any method of contraception;
   d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;
   e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
   g) the right to have family planning education.

2. States Parties shall take all appropriate measures to:
   a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
   b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
   c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.” (32)

Despite human rights statements in support of maternal health in Africa, many of the outlined objectives fall short. Lack of accessibility and poor quality of health care plays a significant role in maternal health in sub-Saharan Africa. Within the region, nations where women are less likely to have access to skilled birth attendants (due to barriers including distance, cost, and inadequate services) are at higher risk for maternal mortality and morbidities (33). Additionally, if contraceptive needs of sub-Saharan Africa were met, it is estimated that 48,000 pregnancy-related deaths would be averted (34).

One striking analysis revealed an association between gender inequities (as measured by a Gender Inequality Index) and maternal mortality ratios across sub-Saharan African nations (35).
A Gender Inequality Index is a representation of the inequalities that exist on the basis of gender in a nation (36). A Gender Inequality Index is determined for each nation through a combination of several aspects of development, including reproductive health (measured using maternal mortality rate and adolescent birth rate), women’s empowerment (as determined by proportion of women in government and women’s secondary education) and women’s economic status (measured by women’s labor force participation) (36). An association between a poor Gender Inequality Index and maternal mortality ratio suggests that nations with less gender inequality may have worse maternal health outcomes than those that are more equal (35).

The current state of maternal health in sub-Saharan Africa indicates the interrelated nature of maternal health, development, and human rights. However, despite the vital importance of sub-Saharan African women’s lives, and their importance to their families, communities, and society, progress in improving maternal health has been slow. Throughout the 25 year period of the Millennial Development Goals from 1990-2015, antenatal care coverage increased by less than 10%, and presence of a skilled attendant at birth increased by a margin of only 15% in sub-Saharan Africa (37).

“Women are not dying because of illnesses we cannot treat. Women are dying because society has yet to decide that their lives are worth saving”

Mahmoud F. Fathalla, Renowned African Obstetrician (38)

The denial of human rights that many women in sub-Saharan Africa experience continues to perpetuate poor maternal health outcomes in the region, which are the worst in the world.

Maternal Health & Rights in Uganda

Country Context

Uganda is an equatorial nation in East sub-Saharan Africa (Figure 7) with a population of approximately 45 million people (39).

![Map of Uganda](image)
The earliest people that occupied the region in known history formed several independent kingdoms with unique ethnic identities and cultures. These kingdoms were involved in an internal African slave trade until the 19th century brought the arrival of British and French missionaries and trading companies (41). What is now known as Uganda became a British protectorate, but was never fully colonized. The British brought thousands of people from Asia (primarily India, Bangladesh, and Pakistan) for labor, and the profits from cash cropping and absence of British settlers allowed the region and people to prosper (42)(43). However, when the transfer of power to local leaders in a ministerial system occurred throughout the 20th century, there was division among the kingdoms (43).

The Republic of Uganda became independent and joined the Commonwealth in 1962, under the leadership of President Edward Mutesa, the ruler of the Buganda, Uganda’s largest kingdom. Just four years later, the Prime Minister Milton Obote overthrew President Mutesa and abolished the traditional kingdoms (43). Obote’s administration was short-lived as he too was overthrown in 1971 by a military coup led by prominent General Idi Amin. Amin ordered the forced migration of Asian Ugandans from the nation; this population, at the time about 60,000 people, was a large and essential component of Ugandan society and the national economy (42). The forced migration of Asian Ugandans, along with systemic corruption, led to economic devastation in Uganda. Amin’s dictatorial regime was also known for violence and torture of any who opposed him, resulting in approximately 300,000 deaths in his eight years of power (41).

Amin’s rule ended in 1979, when he was overthrown by the Front for National Salvation, a resistance movement founded by Yoweri Museveni (44). Museveni then ran for office, but was defeated by Amin’s predecessor Milton Obote, who was elected President of Uganda for a second time in 1980, in elections that are widely believed to have been rigged in his favor (43). Obote’s second administration resulted in furthering the economic devastation and violence in Uganda, taking an estimated 100,000 additional lives (41). In response, Museveni created the National Resistance Movement, leading the National Resistance Army in an ultimately successful guerrilla war against Obote’s regime (44).

Museveni declared himself president of Uganda in 1986, and served for 10 years before being formally elected president in 1996 (44). Since his declaration of power, Museveni has been elected in 5 consecutive presidential elections following a five-year term: in 2001, 2006, 2011, and 2016, resulting in an administration spanning more than 30 years. An amendment to Uganda’s constitution in 2005 removed presidential term limits, allowing Museveni to be reelected and remain in office (45). More recent presidential elections in Uganda have been accused of corruption and rigging to ensure Museveni’s success (44). In April 2019, the Supreme Court of Uganda in a 4:3 majority upheld a constitutional amendment to remove a 75 year age limit for presidential candidates, securing Museveni’s eligibility to run in the upcoming 2021 elections for a sixth term (46).
Throughout Museveni’s time as president, Uganda has seen increased stability, development, and economic growth. Museveni encouraged the return of the Ugandan Asian population that had been displaced by Amin, reinstated traditional kingdoms, implemented efforts to reduce HIV in Uganda, and attracted foreign aid to the nation, facilitating the receipt of some of the most aid in Africa during the 1990s (43).

Museveni’s presidency brought some semblance of peace to the majority of Uganda, with the major exception of military opposition by the Lord’s Resistance Army (LRA) led by Joseph Kony. In the 1990s and early 2000s, the LRA kidnapped thousands of children forced to join the violent militant resistance efforts against Museveni’s administration, creating a humanitarian crisis in northern Uganda (47). Peace efforts made in the mid to late 2000s, followed by a joint military operation with Democratic Republic of Congo and South Sudan failed to resolve the conflict (47). Kony remains elusive, and the LRA largely disseminated into neighboring nations Democratic Republic of Congo, South Sudan, and the Central African Republic, where acts of terror continue (47).

Corruption has long been an issue in Uganda’s history, and Museveni’s administration has been no exception. Museveni’s evasion of any limitations on his presidency, and intolerance of opposition, have been cause for concern for domestic and foreign critics (44). Museveni’s more recent reelections have faced allegations of rigged voting, and for many this continues to be of concern for the upcoming elections in 2021 (44). Uganda’s complex political history has resulted in the diverse and dynamic nation it is today. President Museveni allowed the Ugandan kingdoms and leaders to be restored, more in symbolic tradition than ruling power (48).

Although English is the official language, Luganda is also common and more than 30 different dialects are commonly spoken throughout the nation, with the majority of the population being multilingual (49).

Today, the population of Uganda just shy of 45,000,000 people (50). Uganda has one of the fastest growing populations in the world, with an annual population growth rate of 3% (51). Projections estimate that the population of Uganda could reach 100 million by the year 2050 (51). Uganda also has one of the world’s largest youth populations (Figure 8), with nearly 50% of the population between ages 0 and 14 (41).

![Figure 8. Population pyramid of Uganda (2016) (41)](image)
Throughout the Museveni administration, Uganda has experienced increased national stability, economic growth, and poverty reduction (51). More recently, the Gross Domestic Product (GDP) peaked in 2014 at $27.292 billion USD before experiencing a slight decline that has been attributed to instability in neighboring South Sudan and the Democratic Republic of the Congo, as well as weather patterns negatively affecting agricultural practices (51) (50). Currently, the GDP is increasing again, almost up to $26 billion USD (50), but modern Uganda remains highly reliant on international aid and support to fund social services including education and health (41).

Progress made in Ugandan development has been significant, but remains fragile. Despite achieving the Millennium Development Goal of reducing poverty by 50% (52) more than a third of the population still lives below extreme poverty of $1.90 per person daily (53). Two out of every three Ugandans who have escaped poverty fall back into a state of poverty (53).

Additionally, despite progress, the people of Uganda continue to be denied a number of human rights, including violations of freedom of expression and assembly, a lack of accountability for torture, and denial of freedoms of sexual orientation and gender identity (54). These violations occur despite the ratification of several international and regional human rights treaties and a principles on the “protection and promotion of fundamental and other human rights and freedoms” in the Constitution of the Republic of Uganda in 1995 (55) (56). The Uganda Human Rights Commission was established within the Constitution to protect and promote human rights, but violations continue to be made that negatively effect the wellbeing of many Ugandan people (57).

**Health System**

The complex history of Uganda has affected the development of the nation’s health care system, resulting in a slowly modernizing, but ultimately fragile and under-resourced system. Uganda’s national health system is led by the Ministry of Health, whose mission is:

“To provide the highest possible level of health services to all people in Uganda through delivery of promotive, preventive, curative, palliative and rehabilitative health services at all levels” (58)

The Ugandan health care system is a combination of both private and public components that are decentralized at the national and district level. The public sector is comprised of all government-funded services that operate on a referral system, including hospitals (national and regional), health centers (tiered by service provision capacity level) and health services departments (58). A referral system is one in which a patient may be referred by a care provider to a different facility that is better equipped with resources (including equipment, drugs, and skills) to care for them (59). A referral system is intended to connect the different tiers of health facilities within a nation’s health system and promote access to the best possible care (59).
The private sector provides approximately half of health care in Uganda, and includes all practitioners that work for private non-profit organizations and for-profit private health practitioners. (58). Additionally, the private sector of the Ugandan health system includes traditional complementary medicine practitioners, who practice health care rooted in cultural traditions outside of the nation’s mainstream health care system (60).

The objective of the current health system in Uganda is to provide a standard of services available to all Ugandans, called the Uganda National Minimum Health Care Package. This package was implemented in the year 2000, as part of the first national Health Sector Strategic Plan and aims to offer the following health services:

A. Health promotion, environmental health, disease prevention, and community health initiatives, including epidemic and disaster preparedness and response

B. Maternal and Child Health

C. Prevention, management, and control of communicable diseases

D. Prevention, management, and control of noncommunicable diseases (61)

To achieve this objective, the Republic of Uganda has increased spending on health care system over time. However, the increase has been modest, and the nation spends fewer than 7.5% of the national budget on health, amounting to an allocation of approximately $33 USD per capita each year (62). The Ugandan government public financing towards health care only accounts for approximately 23% of the National Health Expenditure. There is significant support from donor aid to Uganda, amounting to another 32% of the National Health Expenditure, and Ugandans in need of health care services pay the remaining 54% out-of-pocket for private health care (63).

It is clear that the Ugandan health system’s objective of free health care is not taking the financial burden off of Ugandans, many of whom are forced to pay significant out-of-pocket fees for private health care services. In 2011, a USAID assessment identified insufficient cost analysis of the Ugandan National Minimum Health Care Package in the Ugandan Ministry of health annual appraisals, resulting in inefficient allocation of resources (63). While the structural foundation of a health system exists, it is weak due to uncoordinated leadership, uncoordinated donor funding, and overall lack of resources (64).

Structural and systems shortcomings impact the accessibility and quality of health care available to Ugandans. Studies have demonstrated that health care facilities are not in locations that are accessible to many Ugandans, who may have to travel long distances to seek medical attention (65). When they are able to reach the facilities, those seeking health care may be met with a shortage of care providers or essential equipment or drugs (65). Even at public facilities where resources may be available, Ugandans are subject to long waits and an inefficient referral process between various levels of health centers and hospitals (65). Uganda is experiencing an extreme
shortage of skilled care providers, with only about 1 physician and 6.5 nurses and trained midwives for every 10,000 Ugandans (66). This shortage in care providers is despite the numerous in-country training institutions in Uganda, including more than 10 medical schools and over 50 nursing schools offering certificate or degree programs (67). The care provider crisis is believed to be primarily caused by emigration of skilled workers motivated by higher wages and better working conditions outside of Uganda (41) (68).

A number of systems shortcomings prevent equitable access to public health care for all Ugandans, and force many Ugandans in need to pay catastrophic costs for private health care. Many Ugandans continue to seek traditional medicinal remedies. Ultimately, while Uganda’s policies are representative of health as a national priority, infrastructure is weak and the reality of the implementation is lacking, resulting in a weak health system in Uganda.

Maternal Health & Barriers

Despite the shortcomings of Uganda’s current healthcare system, overall health status in some key areas in Uganda has been improving. Development has been demonstrated in areas such as successful scaling-up in administration of immunizations, significant declines in under-5 mortality, and possession of insecticide treated nets for vector-borne disease prevention (69). However, many health concerns remain, including prevention and treatment of HIV/AIDS, malaria, respiratory diseases, tuberculosis, diarrheal diseases, and most importantly for the purposes of this report: care regarding maternal health (70). Notably, although the total fertility rate in Uganda has steadily decreased over time, the current rate of around 6 children per woman remains high (71).

Consistent progress has been made in gradually reducing maternal deaths in Uganda, with an average reduction in maternal mortality ratio of 3% per year from the year 1990 to 2015 (Figure 9)(71). The most recent estimate is 343 maternal deaths per 100,000 live births, with an estimated lifetime risk of maternal death of 1 in 47 Ugandan women (71).

Figure 9. Maternal mortality ratio (per 100,000 live births) over time (72)
The maternal mortality ratio for Uganda has been consistently lower than that of the average regional ratio in sub-Saharan Africa, but has remained much higher than the global average (72). In addition to maternal mortality, maternal morbidity in Uganda has a significant impact. Global estimates suggest that for every maternal death worldwide, up to 30 other women experience serious morbidities that have the potential to significantly alter the rest of their lives (5). Estimates of maternal morbidity for developing nations are more severe, with approximately 100 women experiencing maternal morbidities for every maternal death (73). Ultimately, it is estimated that 20% of the total burden of disease in Uganda can be attributed to maternal health concerns (74).

High rates of maternal mortality and morbidities are caused by a number of direct and indirect causes. Over half of maternal all maternal deaths occur during labor and delivery, or within the 24 hour period following birth (75). The majority of maternal deaths in sub-Saharan Africa are attributed to direct causes, including hemorrhage, eclampsia and pre-eclampsia, obstructed labor, postpartum infections or sepsis, and complications from unsafe abortions (75). A smaller, but significant proportion of maternal deaths are due to indirect causes, primarily conditions whose ill-effects are exacerbated by pregnancy, such as chronic diseases, malaria, HIV/AIDS, and anemia (75). The high fertility rate, young age at first pregnancy, and short time periods between birth also contribute to the high maternal mortality rate in Uganda (41).

As previously mentioned, inadequacies exist within the health care system itself, many of which have an impact on maternal health. Inadequacies include the aforementioned excessive burden of out-of-pocket costs on Ugandans seeking healthcare, as well as the overall shortage of resources including drugs, and particularly lack of basic supplies for emergency obstetric care (76). The shortage of care providers can impact the prevention and treatment of maternal health conditions, with only 1 physician and 6.3 nurses or midwives for every 10,000 Ugandan people (66). On average, only about 58% of births in Uganda occur under the supervision of skilled attendants, and even fewer occur at health care facilities (77). An ongoing challenge for many Ugandans, and pregnant women in particular, is physical access to health care facilities, as many face barriers including distance, affordable transportation, as well as terrain and conditions due to seasonal weather patterns (78). Particularly in the event of an emergency, there is lack of formal coordination and transportation available for transfer from communities to health care facilities, and referrals to higher tier care facilities (79).

Many of the barriers of costs, quality of care, and distance to facilities can cause delays to treatment that can affect maternal health outcomes. A number of factors known as the three delays can have significant impact on maternal health outcomes. The three delays include 1. Delays in care seeking, 2. Delayed arrival at health care facility, and 3. Delayed delivery of adequate care (80). Positive maternal health outcomes are more likely when timely and adequate treatment is provided in the event of obstetric complication, so any delay can increase risk of maternal mortality and morbidity (80).
There are several intersecting legal, economic, and cultural factors that act as barriers to maternal health in Uganda. When faced with the inaccessibility, lack of resources, and prohibitive cost that represents the health care system, many Ugandan women choose traditional medicinal methods for healthcare, including maternal care (81). Traditional practices in Uganda often include the use of medicinal herbs and the guidance of traditional birth attendants who may be untrained, but are often trusted and experienced members of a community. In some rural districts in Uganda, up to 80% of deliveries occur at home, utilizing traditional herbal remedies and untrained attendants (82).

Traditional medical practices in Uganda are often accompanied by traditional cultural perceptions about pregnancy and childbirth. Many Ugandan women, particularly those in rural areas, believe that pregnancy, labor, and delivery are representations of strength, status, and power in womanhood (81). Women who give birth unassisted by medical intervention are sometimes revered in their communities (81). Maternal death is also normalized as an unfortunate reality, but fairly common occurrence, where the deceased mother is considered somewhat of a martyr to her community (81). These traditional cultural perspectives can discourage utilization of available health care services, which could be potentially life saving if a mother is faced with any complications throughout pregnancy and delivery (81).

Despite the widespread use of traditional maternal health care methods, particularly in rural areas, up to 50% of births in Uganda now occur in health care facilities with a skilled attendant, and as many as 95% of Ugandan women receive antenatal care at least once before they give birth (77). However, fewer than half of Ugandan women receive the WHO recommended minimum of four antenatal care visits before giving birth (77) (83). While the majority of Ugandan women are receiving some antenatal care, it is significant that they are not meeting the recommended standards, as studies have shown that fewer antenatal care visits were associated with higher risk maternal death (84).

Lack of maternal health knowledge among Ugandan women is likely a contributing factor to insufficient antenatal care, as studies have shown that the importance of health care services during pregnancy may not be clear, particularly for women in rural communities (81). Studies suggest that, for many women in Uganda, the perception of health care and the decision whether or not to use it is based largely on common misconceptions in their community (85). A study of maternal health beliefs and practices showed that fewer than 20% of women who did receive the recommended minimum antenatal care could name three danger signs in pregnancy and delivery (86). It was unclear in the study whether the women receiving the recommended antenatal care were not receiving maternal health education, or if they were not retaining the information (86).

A disconnect from the Ugandan health system not only impacts antenatal care and delivery, but also has a significant influence on utilization of family planning. Only about a quarter of sexually active women in Uganda use some form of contraception (77) and unmet family planning needs were reported in over 40% of women, suggesting a gap between demand and access (87). Family planning choice and access is particularly important in Uganda, due to the
high rate of fertility. As has been previously referenced, Uganda’s population is one of the fastest growing and youngest populations in the world, with a fertility rate of about 6 children per woman (71). With the exception of some urban areas, women in Uganda are, on average, estimated to exceed their desired fertility by one or two children (41).

To cope with the high fertility rate on an individual level, many Ugandan women seek abortions. Abortion is illegal in Uganda, unless a physician determines that the life of a pregnant woman is at risk, meaning the majority of abortions that occur are not performed by a medical professional and are considered unsafe. Rates of unsafe abortion of Uganda have been increasing, and have been highlighted as an increasingly prominent cause of maternal mortality and morbidities in Uganda (88).

A number of social determinants of health have a direct impact on maternal health and outcomes in Uganda. Wealth has been shown to play a significant impact in effecting maternal health. Approximately 88% of the wealthiest Ugandans mothers give birth at health care facilities with skilled attendants, as opposed to 44% of mothers in the poorest households (71). Furthermore, many Ugandan women do not have economic autonomy. A small proportion of women work in the professional and technical Ugandan workforce, and those that do experience a 33% wage inequality for the same work (89). On average, Ugandan men make more than double the income of women each year (5). Ugandan women perform more than three times the amount of unpaid care work than men, mostly in home and child care (90). Access to maternal health care has been positively associated with women’s agency over income, suggesting that more women would receive maternal care if they had more access to and control over financial resources (91).

Where Ugandan women live can also significantly impact maternal health outcomes. In urban areas, 10% more women receive the recommended minimum antenatal care during pregnancy, and 36% more women give birth with a skilled attendant, compared to women living in rural areas (71). Skilled health care providers in Uganda tend to be concentrated in urban areas, which may present barriers to accessing health care for rural Ugandan women (92).

Education can also significantly affect maternal health outcomes. Due to free Universal Primary Education in Uganda, primary school enrollment rate for girls is at an impressive 95% (89). However, there are significant concerns with drop-out rates, low quality learning outcomes, and just over 20% of girls proceed to secondary school education (89). Increased education has been shown to empower women to have more agency and knowledge in their health decisions, resulting in increased access to maternal health care services, and better maternal health outcomes (Figure 10) (93).
In 2018, the First Lady and Minister of Education and Sport Janet Museveni implemented the first National Sexuality Education Framework within Uganda’s schools (94). The framework unifies the nationwide approach to sexual education, and was founded on the basis that “religious and cultural values will provide the compass of what is to be taught on matters of sexuality education” (94). The National Sexuality Education Framework is centered on abstinence-only education, an approach that fails to educate young Ugandans about safe sex practices in addition to shaping their perception of sexual and reproductive health in a way that could put them at risk for a number of factors associated with poor maternal health (94) (95).

The full extent of maternal mortality and morbidity in Uganda is difficult to measure, due to challenges in comprehensive data collection and assessment. In order for a death to be classified and recorded as a maternal death, essential information is needed that might not always be available, including pregnancy status and cause of death (96). Uganda’s vital registration system doesn’t currently possess the capacity to accurately record and represent all maternal deaths in the nation, as essential information may be under-reported, misclassified, or missing (64). It can be particularly difficult to measure maternal deaths that occur outside of the health care system.

In addition to measurement challenges, there is a debate on what is the most comprehensive definition of maternal mortality. Currently, the World Health Organization defines maternal death as a death occurring during pregnancy or the postpartum period, within 42 days following the end of pregnancy (3). While this definition is used in international comparisons of maternal mortality, it is thought that these parameters aren’t representative of the full scope of maternal mortality. In the United States, the Center for Disease Control and Prevention as well as the American College of Obstetricians and Gynecologists recommend that the definition of maternal death is inclusive of a timeframe up to a year following the end of pregnancy (97).

However, by any measure, the trend is clear: there are many factors preventing Ugandan women from achieving optimal levels of maternal health. Many of the causes of maternal mortality and morbidity in Uganda are preventable, or otherwise treatable, yet there still remain a significant
number of barriers to achieving optimal maternal health outcomes. The preventable nature of poor maternal health outcomes, in addition to the striking disparities, indicates significant human rights concerns. In order to improve maternal health in Uganda, the systems perpetuating a dynamic number of barriers need to be examined.

Women’s & Maternal Rights in Uganda

The Gender Inequality Index is a representation of gender inequalities for a nation, determined on national measures in reproductive health, women’s empowerment, and labor market participation (36). The index is a measure from 0 to 1, with higher values representing increased inequality. The Gender Inequality Index measure for Uganda is 0.523, compared to the global average of 0.441, placing the rank at 126th out of the 160 nations that have been assessed (98).

Gender equality and women’s rights are important in their own right, and are additionally essential components to promoting maternal health. A number of studies have demonstrated the negative impacts of gender inequities on maternal health (99) (100). Gender inequities can prevent women from having agency in their own reproductive health and decisions (41). Access to maternal care services for Ugandan women can be restricted by lack of control of resources and limited decision-making power in their families (99). Predominantly male control of resources and decision-making power gives significant influence over maternal care access and family planning in Uganda (101). Additionally, traditional gender roles and responsibilities can inhibit maternal health care, as women may prioritize responsibilities in home and childcare before their personal health (93).

Significant gender inequality and poor maternal health persist in Uganda despite the inclusion of protections for women’s rights and health in the nation’s foundational documents. Women’s equality and rights are explicitly protected in the Ugandan Constitution of 1995 under article 33, ensuring:

“Women shall be accorded full and equal dignity of the person with men.

The State shall provide the facilities and opportunities necessary to enhance the welfare of women to enable them to realise their full potential and advancement.

The State shall protect women and their rights, taking into account their unique status and natural maternal functions in society.

Women shall have the right to equal treatment with men and that right shall include equal opportunities in political, economic and social activities.

Without prejudice to article 32 of this Constitution, women shall have the right to affirmative action for the purpose of redressing the imbalances created by history, tradition or custom.
Laws, cultures, customs or traditions which are against the dignity, welfare or interest of women or which undermine their status are prohibited by this Constitution.” (102)

The right to health is not explicitly guaranteed in the Ugandan Constitution. However, the importance of the health of Ugandans is demonstrated in a number of provisions outlining national objectives, as well as many of Uganda’s policies (103). Such policies include the 2009 National Health Policy, the third iteration of the Health Sector Strategic Plan, and the Reproductive Health Policy (103).

Additionally, recent court cases in Uganda have set a standard for the right to maternal health in Uganda. In 2011, the Ugandan Centre for Health, Human Rights, and Development (CEHURD) filed Petition No. 16 of 2011 to the Constitutional Court of Uganda on behalf of the families of two women who died giving birth: Sylvia Nalubowa and Jennifer Anguko (104). The CEHURD argued that government failure to provide commodities essential to maternal health was a violation on women’s rights and right to life as guaranteed by the Ugandan constitution (104). The Constitutional Court originally dismissed the case on the grounds that the court did not have power over a case concerning executive allocation of health sector resources (104). An appeal to the Supreme Court of Uganda resulted in a unanimous ruling in 2015 that ordered the Constitutional Court to hear the case, which was significant in supporting maternal rights, however the case has yet to be heard years later.

Another case, Civil Suit No.111 of 2012 was based on a claim about the denial of fundamental rights to Nanteza Irene, a pregnant woman who died following eight hours in a hospital without receiving sufficient care for obstetric hemorrhage (105). In addition to condemning the negligent care, the High Court ruled that Nanteza Irene’s equal rights and dignity as a woman and a citizen of Uganda had been violated, according to Article 33 of the Ugandan Constitution, and her husband and surviving children were awarded damages for their loss (105). This case is significant in setting precedent that supports a right to maternal health in Uganda: many cases like Nanteza Irene’s go unacknowledged, and more importantly fail to be prevented.

Maternal health is specifically incorporated into the Ugandan health care system. The Uganda National Minimum Health Care Package lists Maternal and Child Health as one of the four major divisions of health care services in the nation (61). Additionally both health and women’s rights are stated as a core value of Ugandan society; however, the systems in place in Uganda do not always promote these values. This is particularly true for the intersection of in women’s and maternal health. Despite policy affirmations of the importance of women’s rights and maternal health in Uganda, the reality that Ugandan women experience is not representative of these claims. While improvements have been made, there’s still a long way to go before optimal maternal health and rights outcomes become the norm in Uganda.
Recommendations

This report has demonstrated the vital importance of maternal health, and has joined the identification of the many barriers that are inhibiting the achievement of optimal maternal health in Uganda to the question of rights protection and promotion. It is clear that significant changes are required to improve the health of mothers that has such tremendous familial, social, and economic impact in Uganda. As this report has shown, maternal health and the rights of women generally are not separate issues. The significant intertwining of women’s health and rights suggests that the approach to addressing maternal health and rights in Uganda needs to be dynamic and intersectional, enacting change in multiple levels of health systems, social, cultural, and policy change.

First and foremost, increasing understanding of the mechanisms that contribute to the persistence of poor maternal health is essential to making changes. For this to occur, it is crucial that to have an accurate representation of maternal mortality and morbidity. Every effort should be made to accurately report and record each maternal death that occurs in Uganda, in order to better understand the full extent of this widespread issue and its many intersectional causes.

In addition to reporting, more robust and comprehensive research on the factors contributing to poor maternal health is an important step towards designing interventions to most effectively address the issue. Particular focus should be directed toward the understanding of significant disparities in maternal health that exist among Ugandan women by wealth, education, and in rural and urban life.

It is imperative that maternal health research is conducted and interventions are designed and implemented with community involvement. At every opportunity, Ugandan women and mothers should be at the root of the efforts to address poor maternal health in their communities. All efforts, in community and national policies, must be accountable to Ugandan women.

One internal change that has the most potential to improve maternal health in Uganda is through the strengthening of the health system. The preventable nature of many causes of maternal mortality indicate that health interventions may be highly successful in preventing maternal mortality and morbidities and promoting maternal health. As has been previously mentioned, maternal health is stated as a priority of the Ugandan Ministry of Health and is of primary focus in the health care system. However, the reality of the situation is that the health system in Uganda continues to fail women and mothers. At the most fundamental level, this would include further funding allocation by the Ugandan government towards the health sector. Increased spending is essential to fulfilling human rights obligations by strengthening health care.

Funds should also be allocated towards increasing physical accessibility to health care for Ugandan mothers through the creation of more health care facilities in rural areas, and potentially subsidizing transportation to secondary or tertiary facilities as needed for obstetric
care. Another critical aspect of the health care system that could benefit from increased funding is the health care work force. Skilled health workers should be incentivized to remain in Uganda and work at the public health facilities. As has been demonstrated in other low and middle-income nations, this can be accomplished through recruitment and retention of health care workers by offering incentives in the form of benefits, or through subsidies to their education that would require repayment in the form of years of service to the Ministry of Health (106). This would ensure that more care providers were available for Ugandan mothers to receive maternal care and have skilled attendants at births.

Removing some of these initial barriers will allow Ugandan women to receive the no-cost care that was intended by the health system, as they would not be forced to seek private care at catastrophic costs due to lack of resources. Every woman in Uganda should have access to quality family planning, labor & delivery, and post-natal care services.

If barriers to health care access were to be removed, overall health of women in Uganda could improve throughout the life course, which would in turn improve maternal health outcomes. Additionally, once women are more active in the Ugandan health care system, the opportunity for health education initiatives could arise. The opportunity could be taken to demystify some of the common misconceptions that lead women to relying on traditional methods, and empower women with health knowledge that can be crucial in making decisions about their health. Every woman in Uganda should be empowered with the knowledge and opportunity to make choices regarding her health.

Strengthening the health care system in Uganda in terms of access and quality has the potential for significant impact in improving maternal health, which would in turn have greater positive effects. Furthermore, the entire population of Uganda could stand to benefit from the strengthening of the health care system, which could increase development and productivity of the nation at large.

Strengthening the health care system in Uganda is necessary to improving maternal health in the nation, but it alone is not sufficient. Many opportunities for interventions to improve maternal health lie outside the health care system. As has been demonstrated in this report, many of the root causes of poor maternal health outcomes are social and culturally based. If underlying societal causes are not addressed in addition to interventions in the health sector, optimal maternal health outcomes cannot be achieved.

As has been previously indicated, gender inequality plays a significant role in the quality of maternal health. Women’s health and women’s rights are not isolated issues, and the promotion of gender equality in Uganda is central to improving maternal health. The empowerment of Ugandan women is critical to achieving gender equality in many spheres. Socially, women require agency over their own reproductive health and decisions. Women’s education should be supported and encouraged throughout Uganda as a human right. Additionally, maternal
education level has been shown to be an indicator of maternal health care service access and maternal health outcomes. Economically, women need equal pay for equal work, and need the financial and decision-making power to invest in their own health.

Shifting long-held cultural perspectives on gender equality can be a significant undertaking. Many of these social transformations will require accountable policy change to prevent gender discrimination and promote women’s rights. It is not enough for Ugandan politician and authorities to state the importance of maternal health. They must demonstrate the vital importance of maternal health by prioritizing the pursuit of maternal health promotion in their actions by passing legislation and allocating funds that support their views. Political will and true commitment that directly translates to accountable and effective change is essential.

It is important to enhance legal frameworks to address gender inequality. Continued education of women in Uganda should be encouraged by expanding universal education to secondary school. Additionally, comprehensive and scientific sexual and reproductive health education could be incorporated into education in effort to dispel myths and misconceptions. In the labor force, women must be entitled to equal pay for equal work, and maternity protections should be afforded to women in the work force.

More opportunities should be created for women, particularly in leadership roles across sectors, and especially in political spaces where they can enact the changes they wish to see in Uganda. It is essential that Ugandan women of all backgrounds are central to creating these policies, and that their voices are heard in the planning process. In every one of these efforts, special care and attention should be paid to diminishing the disparities in maternal health in Uganda that disproportionately affect the poorest women, women in rural areas, and other marginalized groups.

Finally, all of these policy changes will only be symbolic if mechanisms are not put in place for accountability. Accountability is essential to the success of each of these policies. Without it, the reality of the execution might not represent the values of the policy itself.

Conclusions
The benefits of improving maternal health and rights for Ugandan women alone are sufficient motivation to make recommended changes, but it is not only them who are affected. In this report, the vital importance of maternal health has been demonstrated; to the women directly affected, families and friends, their communities, and Ugandan society at large, including the economy. Uganda is an example of a nation where, despite significant progress, there is still a lot of work to be done in achieving maternal health and rights. There is so much that Uganda stands to gain by prioritizing and improving maternal health and rights. The same is true in the sub-
Saharan African region, and every location worldwide where optimal maternal health is not achieved.

Ultimately, poor maternal health outcomes aren’t isolated incidents; they are perpetuated by larger inequities in women’s health and rights. As such, they can’t be solved through medical or public health interventions alone. Maternal health must be prioritized in conjunction with coordinated global efforts to achieve gender equity and women’s empowerment. Only then can optimal maternal health be achieved, which is of critical importance worldwide.
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