

**UNDERSTANDING WOMEN'S EMPOWERMENT AND
MATERNAL MORTALITY IN THE UGANDAN CONTEXT:
EFFECTS OF MITIGATIVE INTERVENTION
STRATEGIES**

by

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ABSTRACT

In an international context of increasing attention to maternal health and unacceptable rates of maternal death, disease and disability in many regions of the world, more resources will become available to address the issue. This paper argues that in the case of high maternal mortality rates in Uganda, key stakeholders' framing of the issue has implications for the type and effectiveness of attempted interventions. While women's subordinate status in Ugandan society has been recognized by stake-holders as an important contributing factor in high maternal death rates, it is largely considered to be an intractable artefact of social and cultural beliefs and practices. Interventions informed by this framework can at best hope to mitigate the effects of a supposedly intractable, if unfortunate, reality. The root issue of women's lack of empowerment is therefore not often addressed within large scale maternal health interventions, contributing to a continued need for mitigation, and potentially increasing women's social disempowerment to reinforce the cycle of poor maternal health.

Keywords: women; Uganda; maternal health; maternal mortality; maternal morbidity; empowerment

For my mother, and for all mothers.

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ACRONYMS

| | |
|-----------|---|
| CBC | Canadian Broadcasting Corporation |
| EmOC | Emergency Obstetric Care |
| GDP | Gross Domestic Product |
| GoU | Government of Uganda |
| HIV/ AIDS | Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome |
| HSSP II | Health Sector Strategic Plan II (2005/60 2009/10) |
| HSSP III | Health Sector Strategic Plan III (2010/11- 2014/15) |
| MDG | Millenium Development Goal |
| MDG 5 | Millenium Development Goal 5: Improvement of Maternal Health |
| MGLSD | (Ugandan) Ministry of Gender, Labour and Social Development |
| MMR | Maternal Mortality Ratio |
| MNPEI | Maternal and Neonatal Program Efficiency Index |
| MPS | Making Pregnancy Safer |
| MoH | (Ugandan) Ministry of Health |
| NGO | Non- Governmental Organization |
| SAP | Structural Adjustment Policy |
| UN | United Nations |
| UNHCR | United Nations High Commission for Refugees |
| UNICEF | United Nations Children's Fund |

WHO

World Health Organization

CHAPTER ONE: INTRODUCTION

In recent years the desire for improvement of maternal health has increasingly been seen on the international health agenda. With increased awareness of the impact of the problem, it is no longer acceptable to allow great numbers of women to die in what must be recognized as a pandemic. Members of the international community have a potential role to play in maternal health globally, as providers of resources, training and capacity for health in developing nations where maternal mortality rates are the highest. Funding and other means of support determine development programming, and programming may work to counter dynamic processes affecting gender categories, roles and inequalities, or to reinforce them. It is a role that has been taken on with increasing urgency over the last decade or more. In September of 2000, the United Nations ratified the Millennium Declaration, which set out eight Millennium Development Goals (MDGs), ratified by 189 countries, and to be achieved by 2015 (WHO, 2008b: 1). Specifically for maternal health, MDG five has a target of reducing maternal death worldwide by 75 percent before 2015, as well as promoting universal access to reproductive health services. Progress on all MDGs has been slow, but those related to women's health have progressed particularly poorly. Globally, the maternal mortality ratio declined only by 5 percent between 1990 and 2005 (WHO, 2008b: 1).

However, Ronsmans et al. suggest that there is evidence to support the possibility of up to a 75 percent reduction in maternal death within 25 years (2006: 1191-1192). This is based on the rapidity of reduction across industrialized countries in the 19th century, as well as that of transitional countries such as Thailand, Malaysia and Sri Lanka, recently. This optimism is shared by at least some members of the international community. In 2010, Canadian Prime Minister Stephen Harper publicly announced his intention to focus on maternal health at the G8 summit in Huntsville, Ontario. Resulting from the G8 summit was a promise from the delegates to fight the “battle” against maternal mortality in the years to come (The Sunday Edition, CBC Radio, 2010). The push to renew interest in maternal health also resulted in the creation of programs like the World Health Organization (WHO)’s Making Pregnancy Safer (MPS). It is important to keep in mind, as Luttrell et al. observe, that global forces, no matter their intentions, may work to enhance or to further marginalize the lives of individuals (2009 : 23). Messages about health, based on particular ways of understanding, are created with the intention of encouraging investment, with an eye to investor priorities, values and beliefs. These understandings of health and illness will also shape attempts to solve health problems. Despite the potential for increased attention and funding it brings, renewed interest in improving maternal health is only promising if resources are directed at effective intervention strategies, based on a thorough understanding of the problem and its geographical and other contexts.

Maternal mortality (or maternal death) is the premature death of a woman from causes related directly to pregnancy, labour and delivery and post-partum complications up to 42 days after termination of a pregnancy (WHO, 2008c: 1-4; Ronsmans et al., 2006: 1190). Maternal morbidity is disease or injury resulting from conditions of pregnancy, labour and delivery and post-partum complications. Worldwide, the leading causes of maternal mortality and morbidity include haemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labour (WHO, 2008c: 1-4). The maternal mortality ratio is the most commonly used measure for maternal health, and is the estimated number of maternal deaths during a given time period for each 100,000 live births of the same period (Ronsmans et al., 2006 : 1190). Another common measure used to determine the extent of the maternal mortality problem of a country or region is the lifetime risk of maternal death. This indicator measures the probability that a woman will die of maternal causes during her reproductive years. The WHO acknowledges that the uncertainty margins for maternal mortality ratio measurements are very high in developing countries, making it difficult to determine them with reliable accuracy (2008c: 1). It is clear, however, that rates of maternal mortality and morbidity are very high across the developing world. Therefore, growing attention is being paid to the promotion of women's reproductive and maternal health. The link between women's (lack of) empowerment and (decreased) maternal health manifests as women's lack of control over decisions relating to pregnancy, labour and delivery and related health care needs, as well as institutionalized power imbalances which shape

women's opportunities and choices. This link has been widely noted by scholars, politicians, policy-makers and international medical and development organizations, as will be demonstrated further on.

Although maternal death may occur in any country, the discrepancy when comparing the maternal mortality burden of developed countries to that of the developing world is the largest of all public health indicators, greater than that for child mortality or neonatal mortality (Ronsmans et al., 2006: 1190). Regional high maternal mortality rates are a sign of global inequity. Ronsmans et al. highlight the lack of reliability in trend data for maternal mortality where the problem is at its worst, and express doubt that there has been any improvement in the sub-Saharan region (2006: 1192). This paper will seek to explore maternal mortality in the specific social, political and economic context of Uganda, and see how the subordination of women affects maternal health. Uganda is an important case to consider in examining maternal health deficiencies and interventions, because it continues to host one of the worst ratios of maternal mortality, with estimates around or above 504 per 100,000 live births (Okuonzi, 2004; Kiwuwa and Mufubenga, 2008). Bantebya Kyomuhendo states that even though estimates are relatively high, the real numbers are likely much higher, since the estimates are usually based on small-scale, hospital-based studies (2003: 16). The Maternal and Neonatal Program Effort Index (MNPEI) for Uganda cites that there are up to 13,000 deaths each year in the country from maternal causes, and that morbidity and long term disability from maternal causes is even more common (The Policy Project, 2005:1). The Government of Uganda (GoU) and its Ministry

of Health (MoH) admit to very little decline in their maternal mortality ratio in the years between 1988 and 2006 (GoU- MoH, 2010: 41). However, their estimates are much lower, with approximately 6,000 maternal deaths per year reported in the HSSP III. The MNPEI rates Uganda highly for its policy on maternal health, but cites a low level of commitment to such policy nationally (The Policy Project, 2005: 5). Low ratings were given Uganda for affordability, budget, professional training, and access to safe abortion. Health care access is particularly poor in rural areas, where up to 85 percent of the population lives. As reported in the MoH's HSSP III (2010: 11), maternal conditions make up 20 percent of the total disease burden for the entire country. For every maternal death in Uganda, there are up to 200 women suffering morbidity related to pregnancy, many of which lead to lifelong disabilities (Gorrette et al., 2005, Okong et al., 2006). Many researchers report that maternal mortality ratios in Uganda have stagnated over the last two or three decades, remaining above 500 per 100,000 live births (see Tuguminize, 2005; Gorette et al., 2005; Okuonzi, 2004). Considering these statistics, even allowing for a margin of error, it is clear that the maternal health situation in Uganda is having a negative impact on women's lives and livelihoods.

It is interesting to consider Uganda's poor maternal health record, particularly in the context of its economic achievements. Okuonzi (2004: 1632) and Gorette et al. (2005: 776) juxtapose these persistently high ratios with the contemporaneous economic progress. The country has been held up as an example of economic growth, that other countries in the region may strive for. However, over the same period that the country experienced this growth,

maternal mortality rates were stagnating (Okuonzi, 2004). In its 2010 HSSP III, the MoH remarks upon the inconsistency of another decade of strong economic growth (at an average annual increase of 7% in gross national product) without a commensurate improvement in public health (2010: 32). Over this same period, and again in contrast with maternal health indicators, Uganda had huge success in another public health area, that of HIV/AIDS. Gorette et al. further stress the inconsistency between stagnant maternal mortality ratios and dramatic HIV reduction over the same time period in the country (2005: 776). Due to factors such as drug costs, compliance requirements and medical training and capacity requirements, HIV is a notoriously persistent and devastating phenomenon. In comparison, the problems causing maternal death are relatively easy to prevent and manage medically. Such a stark contrast raises questions about priorities, values and understandings of health and illness that go beyond resources and capacity. Okuonzi suggests that economic success in Uganda has been achieved at the expense of social welfare (2004: 1632) Through a widely targeted campaign of education and prevention, the country managed to reduce HIV infection rates dramatically, another reason Uganda has been held up as a model for other nations suffering from high and increasing HIV/AIDS rates in the region. This accomplishment demonstrates that within the limited resources available for health in Uganda, effectively designed and targeted interventions can effect significant improvement.

Research Questions and Hypothesis

This paper attempts to understand how the lack of empowerment of Ugandan women has been understood by key international and domestic stakeholders as it relates to maternal health, maternal morbidity and maternal mortality. Further, it will explore the way this understanding has or has not shaped proposed and implemented policies and interventions intended to promote maternal health and examine whether or not and why such policies and interventions have been effective in reducing maternal mortality and morbidity in Uganda. The paper puts forward the argument that important actors in Ugandan health (in particular the World Health Organization and the Ugandan Ministry of Health) recognize the negative effects of women's disempowerment on maternal health as consequent to an intractable social tradition of women's subordination. Further, and as an inevitable result of such an understanding of the situation, interventions considered reasonable by the same parties to Ugandan maternal health will (and do) seek to mitigate the negative effects of the root problem. Steps to address rather than just mitigate women's disempowerment are avoided. Finally, the paper argues that mitigation strategies alone beget the need for further mitigation. Indirectly this occurs because the approach fails to remove the root causes creating the need for mitigation in the first place. Sometimes it occurs directly, by permitting or creating complacency about women's disempowerment, or otherwise reinforcing it within society. It is not the intention of this paper to suggest which interventions should be used, or to create a new framework within which the problem of maternal mortality should be approached.

Rather, the intention is simply to survey the Ugandan case, as well as to draw attention to how understanding shapes action and results.

Data and Research Methodology

The following chapter will establish a correlation between empowerment and health, and demonstrate that Ugandan women are disempowered, and lack the autonomy to make important decisions regarding their own maternal health. It will show that opportunities for women are restricted by socio-cultural and institutional structures, resulting in increased maternal mortality and morbidity. This will be accomplished by a literature review of scholarship related to empowerment and disempowerment and their effects on health, and particularly women's health, globally and locally in Uganda. Primary source evidence will be accompanied by a review of the Ugandan statistics on some widely accepted proxies for measuring disempowerment, including level of education, economic independence or lack thereof, and presence or absence of intimate partner abuse. The third chapter will establish that certain key actors within the Ugandan and International Communities recognize women's lack of empowerment, and the effects of disempowerment on health, but conceive of it as an intractable reality embedded within a (static) Ugandan culture. A discourse analysis of policy documents, program overviews and positions of interested organizations and other parties, and researcher recommendations, among other documents, will provide evidence of this recognition and conception. These and other documents from the same organizations will be shown as well to present statements that suggest a belief in the intractable, culturally embedded nature of women's

disempowerment, at times explicitly, or implicitly through the promotion of mitigative interventions.

Chapter Four will show that this framework, or way of understanding women's disempowerment, shapes which maternal health interventions are considered possible, and which impossible, and has resulted in a largely mitigative approach to maternal health promotion in Uganda. This point will be supported by a review of interventions undertaken and supported (through staffing, funding, or recommendations) by specified international and domestic stake-holders in Uganda. These interventions will be shown to have been mitigative, or aimed at reducing the negative effects of women's disempowerment on their maternal health. Further, the review will show that such mitigative approaches have not been successful in reducing the large maternal death and illness toll on Ugandan women. Chapter Five will discuss and analyze the results of the research. Other possible explanations for Uganda's high maternal mortality ratio will also be explored at this point. Chapter Six will conclude with a summary of the points made, a review of the paper's limitations and some remaining questions for future consideration and research.

CHAPTER TWO: EMPOWERMENT AND HEALTH

Defining and Using Empowerment

Many definitions of empowerment exist and lead to different approaches, and a variety of groups being targeted by government bodies and development organizations (Luttrell et al., 2009: 2). Wallerstein provides the following definition of empowerment: “a process by which people, organizations and communities gain mastery over their affairs” (2006: 17). Luttrell et al. broadly define empowerment as “a progression that helps people gain control over their own lives and increases the capacity of people to act on issues that they themselves define as important” (2009: 8). However it is defined, empowerment is intimately related to power and power relations or dynamics, and relationships between people and groups of people. Control of resources and control over ideology affect opportunities for education, employment and other living conditions (Wallerstein, 2006: 18). Luttrell et al. (2009: 9) point out that there are two important entry points for empowerment campaigns: at the agency level of enhancing individual capacity for choice and action, and at the structural level of addressing rules and other social and institutional forces that limit opportunities and shape choices and actions.

When used effectively, empowerment is intervention and action oriented, involving the transformation of power relations between individuals and between people and institutions or government.

Most development parties target women and other marginalized groups with empowerment campaigns, addressing different dimensions of empowerment. The most relevant dimensions of empowerment for this work are the social and cultural ones, by which individuals and groups are empowered to gain control over their lives, and to redefine cultural norms and practices, respectively (Luttrell et al., 2009: 1). For the purposes of this work, empowerment will be defined as the process of individuals gaining control over important issues in their lives, in this case for women over their maternal health. The term “disempowerment” will be used here to mean an individual’s or group’s lack of power or control over important issues in their lives, be this lack due to power relations within the family or community or be it due to cultural or institutional barriers to such control. Defining empowerment in the way described above is useful in the analysis of maternal health, as control over health seeking decisions, as well as control within the formal health care and other social institutions, has been identified by many Ugandan women as lacking, and related to maternal health outcomes. These and other experiences of Ugandan women regarding their maternal health have been highlighted in several interview series, which will be discussed below.

Effects of Empowerment on (Maternal) Health

The link between empowerment and health has been widely noted in the fields of health, international health, and gender studies, among other disciplines. Ensor and Cooper (2004: 77) highlight the need to empower the weakest members of society, pointing out that the fact that women have inferior access to

resources and are prevented from making their own choices has consequences for health. Weeks et al. (2005: 1307) insist on the central role of empowerment in any health promotion strategy to reduce maternal mortality in Uganda. Among other organizations that espouse empowerment strategies for health (World Bank, Pan American Health Organization, UNICEF, Health Canada and several international NGOs), the World Health Organization states that community action and empowerment are prerequisites for health (Wallerstein, 2006: 7, 17). Family life, the context within which individual health is produced, is structured by gender (Moss, 2002: 657). Therefore, when unequal power relations within the family lead to disempowerment (almost, if not, exclusively of women), the health of the disempowered individual and group may suffer. Ensor and Cooper (2004: 73) note that men in Uganda often make the decisions about health seeking for women, particularly when women are uneducated and contribute little to household income. Further damage may be caused to the powerless due to the psychosocial stress of their disempowerment and despair, making them more vulnerable to poor health (Wallerstein, 2006: 7). Wallerstein (2006) pronounces empowerment to be a viable strategy for public health, evidenced by multi-level research designs. She notes that internationally, empowerment strategies have led to improved service distribution, reduced institutional barriers, enhanced political participation and the creation of healthy policies (Wallerstein, 2006: 14). In some cases such interventions have even led to improved maternal and child health outcomes, through community developed improvements in emergency

transport, increased decisions to delay pregnancy, and increased awareness of obstetric danger signs (Wallerstein, 2006: 13).

Disempowerment can lead to poor health outcomes both directly and indirectly. Directly, health may be affected because of lack of decision-making capacity, poor illness management skills or ineffective health behaviours (Wallerstein, 2006: 11). Indirectly, it may lead to weakened support networks and caregivers, low levels of satisfaction with health provider relationships and poor service access. Moss (2002: 651) explains that health can be determined by many non-medical factors, including limited psychological and social resources, perceived hostility and discrimination and frustration. Therefore, empowerment strategies may improve health by reducing reliance on (discriminating) health professionals, ensuring cultural sensitivity of interventions, increasing capacity and sustainability, and engaging community stakeholders (Wallerstein, 2006: 8). Ensor and Cooper (2004: 72) explain that while distance is an obvious barrier to demand for medical and other services, it is sometimes not acknowledged that this barrier is greater for women than men, even when they have similar incomes. If empowerment and power relations are considered when creating health interventions, the possibility of using empowerment strategies opens, and the disempowered woman is no longer a constant reality, the effects of which will forever need to be mitigated. (More on the idea of mitigative strategies will follow in the next chapter.) Presumably, the empowerment strategies (aimed at reducing or eliminating women's disempowerment in their reproductive health) that arise within such a frame will be more effective at reducing maternal

mortality and morbidity. Both Wallerstein (2006: 2) and Luttrell et al. (2009: 14), however, emphasize that empowerment is a complex strategy that is being applied to already complex environments, and it must therefore be carefully adapted to the local cultural and historical contexts, in order to identify locally relevant barriers and facilitators. The Ugandan Ministry of Gender, Labour and Social Development (MGLSD) explains how gender shapes health care experiences for Ugandans thus: “Gender distinctions include the different attributes, statuses, roles, relationships, responsibilities, and potentialities as well as their access to and control over resources and benefits. With regards to health care, gender determines people’s occupations, work patterns, and potential health benefits and risks associated with either as well as the means to seek health care if and when it is required” (2007: x.) Accordingly, the importance of gendered analysis in health care is to explain disparities in vulnerability to illness and injury arising from gender inequality, and to assess appropriateness of interventions to address these disparities.

Empowerment and Maternal Health in Uganda

Looking at both qualitative and quantitative data for women in Uganda, it is evident that many experience both poor health and the consequences of a lack of empowerment. Several researchers interested in the causes of maternal mortality (see Weeks et al., 2005, Okong et al., 2004, Penn-Kekana, 2007; results discussed below) have conducted interviews with Ugandan women who nearly suffered maternal mortality incidents, regarding their experiences of maternal health and illness. Considering such qualitative evidence is of great

value, since it sheds light on the problems and circumstances leading up to such a death. Pregnant women and mothers, particularly those who have come close to death from maternal causes, are in a unique position to help researchers understand the reality of maternal mortality for individual women and groups of women. If the purpose of research and intervention is ultimately to improve the health and lives of women vulnerable to maternal death, neither is complete without an understanding of and engagement with the experiences of the most vulnerable.

In a series of interviews women who had experienced near- miss maternal morbidity largely expressed the opinion that their health complications were the result of their lack of empowerment. Women's own statements and opinions recorded in the interviews reflected feelings of disempowerment, and often an understanding of how this reality had affected their health (see Weeks et al., 2005). Weeks et al. conducted a series of interviews with Ugandan women who had experienced near miss maternal morbidity, in order to understand what makes women vulnerable to maternal mortality. Throughout the interviews, the predominant theme expressed by women was that of powerlessness, both in the hospital and in their lives outside of the official health care system. Lack of power causes medical problems and (unwanted) pregnancies, through rape, partner refusal of contraceptive use or forced illegal abortions.

Bantebya Kyomuhendo (2003: 17) recognizes that, in Uganda, the maternal mortality ratio is influenced by different statuses and roles between the sexes. Thus, it must be considered and understood that women do not

deliberately choose high risk options in their pregnancies and births, instead, their social environments limit the available choices. Specifically, the centrality of continuing the family lineage to many Ugandan cultural groups subordinates women to the family and community, in the role of child production. In this context, pregnancy and childbirth are one of few areas where women may gain respect and improve their status in the eyes of the community (Bantebya Kyomuhendo, 2003: 18). A woman's ability to become pregnant and deliver babies is key to her status transition, as evidenced by negative associations attached to barren women who are seen as evil, bad luck or sinful and suffer consequently from a low social status (Bantebya Kyomuhendo, 2003: 19). Women are expected to deliver inside the community, and those who require professional help, or caesarian sections are seen as lazy or weak. Death in pregnancy or childbirth is largely seen as a failure on the part of the woman to fulfill her childbearing duties, no matter the external factors at play (Bantebya Kyomuhendo, 2003: 18, 19).

The MNPEI (The Policy Project, 2005: 2) underlines the importance of addressing women's disempowerment in attempts to improve maternal health: a woman's low status, her lack of access to and control of resources, her limited educational opportunities and lack of decision making power all contribute to a poor maternal health outcome. This occurs because women's lack of power in Uganda manifests as high fertility rates (7), low contraceptive prevalence (23 percent), young age for girls at the time of their first sexual experience (16 on average), and high rates of adolescent pregnancy (43 percent) (Bantebya

Kyomuhendo 2003: 16). These manifestations, among others, increase a woman's risk of maternal mortality. Women are not in a position to access contraception, or to make decisions regarding contraception use, resulting in high rates of teen pregnancy and unwanted pregnancies. Younger and more frequent pregnancies expose women to higher risk of maternal mortality, resulting in an extremely high lifetime risk of maternal death in Uganda (1 in 25). Where desire to limit family size is becoming more common, and abortion remains illegal, frequent incidence of illegal and unsafe abortions contributes greatly to high maternal mortality (Gorrette et al., 2005: 776).

Women interviewed experienced institutional and social powerlessness, resulting in delays accessing financial and practical help, inability to access care or receive referrals rapidly enough, and medical mistakes or even inhumane care and abuse from health care workers (Weeks et al., 2005: 1302). Weeks et al. report that women felt their disempowerment contributed to their near deaths at many stages (2005: 1303). Women felt also that their lack of power prevented access to care when it was needed, because of inability to afford transportation or the care itself, as well as distress caused when accessing care, such as due to lack of food, caretaker refusal to provide information and abuse at the hands of health care practitioners. Results found in interviews by other researchers were similar. In interviews they conducted with women following near miss maternal morbidity, Okong et al. found that at least one quarter of all women had had to wait for permission from a spouse to attend the hospital. A further one in six had been refused money by their spouse for transport to the hospital, and one in five

had been delayed by interfering relatives who advised against attending the hospital (2004: 800). These findings do not include statistics for women who were ultimately unable to attend the hospital for reasons of disempowerment, not for women who attended but did not survive. Inclusion of these statistics, were it possible, would undoubtedly paint an even bleaker picture. As it was, the researchers found conclusively that women's lack of empowerment and relegation to the appropriate gender role in Ugandan male-dominated society led to potentially fatal delays in health care seeking (Okong et al., 2004: 803). In an ethnography carried out in a Ugandan maternity ward, Penn-Kekana et al. uncovered the importance of value systems and beliefs at various levels in a woman's maternity experience (2007). Women and their communities are not "empty vessels" awaiting education and the lifting of barriers to their health, Penn-Kekana et al. insist (2007: 30). They are active participants in the processes leading to health and other outcomes. Neither are health care providers devoid of their own cultural and professional value systems. In their study, Penn-Kekana et al. found that 28 of 30 women on the ward had planned to deliver there, and belonged to social circles that believed it was right to deliver in health facilities (2007: 33).

A number of other researchers have noted the lack of power and its effect on Ugandan mothers, including Moss (2002: 654), who points out that male partners or in-laws often have control over women's access to their children, to money, and to health care. Further, Moss suggests, women may experience differential diagnosis or treatment (2002: 655). The Ugandan MoH acknowledges

that health care providers in the country often do not feel accountable to their client communities (2010: 21). Unsurprisingly, clients are also dissatisfied with much available health care service, because of long waiting times, lack of information provision, and especially poor behaviour of health care providers (GoU- MoH, 2010: 6). For these and other reasons, the MoH estimates that 60 percent of the population seek care from alternative providers first, such as traditional birth attendants (GoU- MoH, 2010: 8). Such providers have no functional relationship with the formal health care system, resulting in late referrals and poor management of obstetric and other conditions, and contributing to high morbidity and mortality rates. Many Ugandans expressed a preference for community initiatives to their Ministry of Health, because services are free and allow community members to participate in the management of their health services (GoU- MoH, 2010: 6).

Okong et al. (2004: 797) found in their audit of “near miss” maternal morbidity that in at least half of cases women had delayed seeking care because they were averse to health care conditions, or because relatives were unhelpful. Lack of funds to access care is an oft-cited barrier to maternity care access in Uganda. Hjelm and Nombozi (2008: 439) point out that women have had to take on greater income generating responsibilities in current economic circumstances, while still maintaining responsibility for the household. However, their economic contribution is rarely valued, and they are still largely left out of control over cash and assets, even those they bring into the household through their efforts (Hjelm and Nombozi 2008: 438). High fertility rates in Uganda are due in large part to

women's low status. As discussed earlier, the value of women in many Ugandan cultural groups is as a mother (MGLSD, 2007: 8). Women have many children to avoid being seen as a failure in their social role. Very high teen pregnancy rates are also indicative of women's disempowerment, as young women and girls experience pressure from adult men to fulfill their seen gender role, and are married at a young age for the dowry they earn their families (MGLSD, 2007: 9). This phenomenon explains in part women's higher vulnerability to HIV/AIDS, as women are two to four times more likely to be infected, and the infection ratio among teens is one boy to five girls (MGLSD, 2007: 9, 10). Early marriage also serves to reinforce women's disempowerment, as education for young married girls is terminated early.

For various reasons, women may choose to see a traditional healer first to address complications rather than reporting to a hospital, despite the additional cost (Weeks et al., 2005: 1305). Anecdotal evidence displays another reason why women may choose to see a traditional birth attendant rather than a formal health care worker. In an interview with CBC describing her experiences as a foreign obstetrician in Uganda, Dr. Jean Chamberlain reports that women feel safer with traditional birth attendants, and will in fact bypass a formal health care centre to seek one out, because they feel they are treated like people (The Sunday Edition, CBC Radio, 2010). In the Kampala University hospital, Dr. Chamberlain witnessed women turned away if they arrived without their own birthing equipment, women delivering babies on the floor, and women being slapped by their attending midwives if they do not deliver in a timely manner (The

Sunday Edition, CBC Radio, 2010). This kind of treatment was also reported in interviews conducted by Weeks et al. (2005: 1307), but women also expressed gratitude for treatment received, reflecting just how low their expectations for care were, and exposing another aspect of their disempowerment. Because of the beliefs and value systems held by all parties to maternal health, on the ground relationships between them are extremely important to the implementation of the *de jure* health care system (Penn-Kekana et al., 2007: 30). In order to bring the *de jure* system closer to the *de facto* system, Penn-Kekana et al. insist that programs and interventions must engage directly with the context. The Ugandan MGLSD explains that women have limited power to negotiate (safe) sex in the first place, both within and outside of marriage, leaving them more vulnerable to HIV and to other maternal complications (2007: 10). The ministry attributes this to illiteracy, limited access to information and services, and oppressive social practices such as polygamy. When the time comes to seek health care, women's access is not equal to men's, due to lack of resources, lack of decision making power and the time constraints associated with women's gender role (GoU- MGLSD, 2007: 15). Once health care assistance is sought, according to the MGLSD, women experience further discrimination due to the gender biases and norms of the Ugandan health care system (2007: 8). Within this formal system, women's informal care taking role is ignored, while professional care delivered largely under the supervision of male doctors is valued more highly.

Measuring Empowerment

A challenge to dealing with empowerment research and interventions is the innate difficulty of measurement. There are a number of proxies, however, that have been used to indicate women's lack of empowerment, such as low educational attainment, abuse by an intimate partner and lack of economic independence (Wallerstein, 2006: 18). These proxies will be explained, and the statistics for Uganda presented. The Ugandan MoH notes that education is a major determinant of health, contributing to health inequity between the sexes (2010: 33). According to the HSSP III, the literacy rate for girls aged 15 to 24 in Uganda is 58 percent, while for boys of the same age it is 70 percent (GoU-MoH, 2010: 33). Also according to the Health Sector Strategic Plan III (2010: 33), married women in most cases may not control their own resource expenditures, particularly those living in rural areas. The potential health consequences for women who have no fiscal control are obvious, and have been discussed above.

Intimate partner violence is an effective proxy for this paper as it is an expression on social inequality at the level of the individual, but produced and reproduced by cultural, social, economic and power relations. The MoH's HSSP III reports that gender violence is rampant throughout Uganda (2010: 80). Kaye et al. note that women experiencing domestic violence are also more likely to identify with other proxies of disempowerment, such as less decision making power in the home, and unplanned pregnancies (2006: 1576). It also serves to demonstrate a correlation between empowerment and maternal health outcomes, because gender violence is directly associated with maternal health

issues such as spontaneous abortion, low birthweight, premature rupture of membranes and preterm labour (Kaye et al., 2006: 1576). Intimate partner violence affects maternal health both directly, in the case of abdominal trauma, and indirectly, through the stress effects of victimization and isolation it causes. Karagami et al. reported intimate partner violence prevalence of at least 54 percent in the region of Uganda they studied, and the women interviewed expressed fear of performing health- promoting practices, such as HIV testing, or requesting partners use condoms, as they may lead to incidents of abuse (2006: 284).

Decision making is another evident proxy for women's empowerment. It is also highly correlated to maternal mortality ratios. Women who have little decision making freedom within the household are more likely to experience maternal mortality. "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" (GoU- MoH, 2010: 33). For example, women may be prevented from receiving life-saving treatments like caesarian sections if their husbands are not present or unwilling to sign for it (The Sunday Edition, CBC Radio, 2010). Control over economic earnings and household spending is indicative of empowerment. Money for treatment is often provided (or not) by a woman's husband (The Sunday Edition, CBC Radio, 2010). Examining these indicators for Uganda indicates low levels of empowerment among women (see below, Table 1: Women's Empowerment Proxies, Uganda). Table 1 shows that Ugandan women have lower rates of literacy than their male

counterparts, suffer extremely high rates of gender violence and barely half enjoy control over financial resources. This is correlated with Uganda’s very high maternal mortality rates. As would be expected, higher rates of maternal mortality are found among groups of women who experience lower levels of control over their own lives, as expressed by the identified proxies (see, for example, Gorrette at al., 2005; Kaye et al., 2006, Karagami et al., 2006).

| Table 1: Women’s Empowerment Proxies, Uganda | | |
|---|---------|--------|
| | women | (men) |
| Literacy | 57.70% | 76.80% |
| Incidence of gender violence | 43- 68% | |
| Economic independence | 55% | |
| statistics from: CIA factbook, www.cia.gov ; Uganda Bureau of Statistics, www.ubos.org | | |

As mentioned earlier, for over two decades, the World Health Organization has estimated ratios of over 500 deaths per hundred thousand live births in Uganda, as does the GoU itself. The WHO also notes that death registration coverage is less than 25 percent (2006: 1). This results in a very large margin of error for ratio estimates. In fact, the WHO itself has asserted the tendency to underestimate the maternal mortality ratio (Okuongzi 2004: 1633). Okong et al. (2004: 801- 2) report that there have been no regular maternal mortality and morbidity audits conducted at any of the health care sites they investigated in Uganda, and that, in fact, less than half of the records they found in conducting their audit were sufficient for their purposes.

The proxies discussed earlier, like high maternal mortality rates, represent manifestations of women's lack of empowerment. However, it is essential to look beyond the symptoms to the root causes, in order to have an idea of what is necessary to increase empowerment and thereby address the resulting symptoms. Root causes include structural, institutional and cultural arrangements that shape and define which options and life choices are available for Ugandan women to choose from. These include laws, institutions and systems, and socio-cultural traditions and customs.

Policy and Practice for Ugandan Women's Empowerment

At the political and policy level, Uganda has made great strides towards women's equality and rights. The Ugandan constitution outlaws traditional male dominance, and allows women affirmative action, which is intended to redress the imbalances created by history, culture and custom. Women have been given symbolic political appointments, offices and directorates of women's affairs, and guarantees of representation, with a female representative to parliament from each district, and one third representation in the local councils. However, Ottomoeller suggests that these concessions have not led to the Ugandan government prioritizing issues which are of concern to women, such as rural health improvement, small-scale loans, daycare facilities, or programs to ensure implementation of women's legal rights (1999 : 94-5). Affirmative action beneficiaries, despite their political positions, are usually not able to gain access to the informal male circles which dominate *de facto* Ugandan politics, and often feel beholden to the government for their positions. These positions tend to be

awarded in the first place based on wealth, status and education, making it unlikely that candidates will be able to relate to the poorer, more marginalized majority of Ugandan women (Ottomoeller, 1999: 97-100). Generally, progress at the political level has not made its way down to the daily lives of Ugandan people, and women in particular (Ottomoeller, 1999: 95) This is in large part because a great deal of the progressive Ugandan policies and laws that target marginalized groups such as women remain unimplemented due to a chronic lack of funding (Okuonzi, 2004). According to Penn- Kekana et al., proven effective interventions for maternal health are official policy in almost every region where they are needed, but rarely are actually provided to those vulnerable to maternal mortality (2007: 29). Such policies, despite their intention to improve equity and efficiency, are often distorted by interpretation in the implementation phase, even where resources and distribution are sufficient (Penn-Kekana et al., 2007: 33).

Despite the general tendency for progressive laws that favour gender equality at the policy level, Uganda persists in maintaining an anti-abortion law, by which doctors performing abortions may be sentenced to 14 years in prison, and women electing them may be held for seven years (Gorrette et al., 2005: 779). According to the Ministry of Health's 2003 report, unsafe abortion accounts for at least a third of maternal deaths, although statistics on abortion inductions are non-existent due to the procedure's legal status (Gorrette et al., 2005: 779). Clearly, maintaining a law preventing safe, legal abortions, rather than reducing

their occurrence, encourages the performance of illegal, potentially unsafe procedures, perpetuating the Ugandan maternal mortality problem.

At the level of the Ugandan community, where women live their lives, great importance tends to be placed on gender roles and norms, values which are based in cultural traditions, and which may perpetuate a history of gender discrimination (Ottomoeller, 1999: 96). Traditional social and cultural values in Ugandan communities promote a gendered power imbalance, within which women are subordinate to men (Karagami et al. 2006: 292). Wolff et al. also found that community narratives highlighted and reinforced the importance of gender norms, which grant men significant freedom of movement (including in their sexual relationships and behaviour), while relegating women to the home by marking those women who do not conform as subjects of sexual speculation or even violence (2006: 1282). Intimate partner abuse as a result of women's low status (or disempowerment), is widespread and widely tolerated, facilitating intergenerational transmission of the practice (Karagami et al., 2006). Women who have greater numbers of children are less likely to experience intimate partner violence, as are educated women (Karagami et al., 2006: 285, 292). These protective factors indicate mechanisms of internalization of subordination, but also of freedom from it. Women in Uganda appear to find safety in embracing their prescribed role as mother. This demonstrates why oppressive beliefs and values may be internalized and adopted by the oppressed, who then seem to limit their own opportunities. However, Ugandan women have found relative

safety also in rejecting the traditional domestic role through higher levels of education.

Wallerstein concludes that structural barriers to equality for women must not be ignored, and include unequal power dynamics set up by cultural prescription, bureaucracy that may be difficult to navigate, social stratification, top down implementation, racism and lack of representation (2006: 8). Even where equality and rights are institutionally recognized, power imbalances like those discussed above may prevent some individuals and groups from claiming them. In this way, Wallerstein suggests, ideologies and customs may act to create quiescence, whereby individuals restrict their own opportunities (2006: 18). All of these factors may combine to have a detrimental effect on women's health, as has been shown is the case in Uganda.

CHAPTER THREE: ON MITIGATION THINKING

Recognizing the Impacts of Disempowerment of Women's Health

Key actors interested in maternal health in Uganda include government bodies, international organizations, NGOs and international and domestic researchers. For this paper, the focus will be on the Ugandan government (GoU) and the World Health Organization (WHO), with supporting information drawn from international and domestic scholars. The Ugandan government, through its Ministries of Health (MoH) and Gender, Labour and Social Development (MGLSD), has an obvious interest in the improvement of maternal health, as the ministries are responsible for improving the health of Ugandans and the position of Ugandan women, respectively.

The World Health Organization, specifically its Making Pregnancy Safer unit, takes responsibility for maternal health promotion worldwide. The WHO identifies maternal health as a priority area (WHO 2008c: 2). The World Health Organization prioritizes 75 (developing) countries in which 97 percent of all maternal mortalities occur (WHO, 2008b: 3). The WHO works to improve maternal health based on the essential premise that most maternal deaths are avoidable when women have skilled care at their births (WHO, 2008c: 2). They work to improve maternal health conditions through the IMPAC, a set of guidelines for “effective, efficient, safe and culturally appropriate” maternity services and guide health authority actions to ensure sufficient numbers of well-

trained midwives and doctors (WHO 2008c: 3). Further, they are an organization that claims to support an empowerment approach. The government of Uganda (GoU), through the MoH acknowledges that maternal mortality has the highest total burden of disease in the country, and in response to this priority health situation has created a Road Map to accelerate Maternal and Neonatal Morbidity and Mortality (Ugandan MoH, 2010: 11). Because the WHO sets guidelines for international use, and because developing countries are largely influenced by which types of approach will receive funding and other support, the circumstances described here for the case of Uganda are likely to be similar to those of other developing countries. Therefore, it is the intention of this case study also to be able to shed light on other cases as well.

Within the policy and recommendations of both the WHO and GoU, the effects of women's empowerment on (maternal) health are recognized. The WHO recognizes the influence of disempowerment barriers to women in need of maternity care: "Gender inequality is one of the social determinants at the heart of inequity in health" (WHO 2008b: 2). The organization describes high maternal mortality ratios and incidence as a sign of gender inequity (WHO 2008c: 1). In their factbook on maternal mortality, the WHO identifies some demand barriers related to women's disempowerment that may affect pregnant women in need of care: the expenses of care and transport, the (culturally inappropriate) nature of care provision, cultural beliefs and the subordinate status of women (WHO 2008c: 2). The WHO even makes explicit that empowerment of women will positively affect the achievement of MDG 5 (WHO 2008b: 3). The Ugandan

government, and its MoH defines health according the WHO constitution, where not just access to quality health care services, but also all other determinants of health are considered fundamental human rights (GoU- MoH, 2010: 38). These rights are built into the 1995 Ugandan constitution. As the MGLSD explains, the gender- health link stems from understanding health in this broader context, rather than simply in the context of disease. However, in their analysis of the HSSP II, the MGLSD found that health had indeed been reduced to services, excluding the WHO- based definition of health, which would focus on people rather than just delivery structures (2007: 7). The Health Sector Strategic Plan created by the GoU and its MoH is a framework for national health, which is designed to work toward the government’s development goal of accelerating economic growth, and reducing poverty (GoU- MoH, 2010: 1). When a health framework is informed and directed by such a goal, it is likely that emphasis will be placed on providing services that work for development, at the expense of equally important but less cost effective strategies. The MGLSD suggests that this has occurred in Uganda, and that perhaps those programs promoting women’s empowerment were just such less cost effective strategies that have lost out. The Ugandan MoH reports in the Health Sector Strategic Plan III (HSSP III) that most women are not able to make decisions regarding allocation of household resources or about health care seeking, rather deferring to the decisions made by husbands and other male family members (GoU- MoH, 2010: 33). Further, the HSSP III acknowledges that this circumstance leads to delays in women seeking and receiving appropriate care. The MoH displays recognition

that factors related to women's empowerment, such as high fertility rates, early sexual involvement and high incidence of unsafe illegal abortion contribute to the country's high maternal death rates (2010: 11). Such recognition features in statements by both parties seeking to explain the roots of high maternal mortality.

Understanding Disempowerment and Responding to its Effects

Where disempowerment and its effects are noted, they are considered the circumstances of a culturally embedded (and therefore more or less intractable) reality. The above analysis shows examples of clear and explicit acknowledgment on the part of the GoU and the WHO, of women's lack of empowerment in Uganda, and the effects of this disempowerment on women's reproductive (and other) health. However, both the GoU and the WHO display a "mitigation thinking" framework, either explicitly- through statements that suggest the intractable, culturally embedded nature of women's disempowerment- or implicitly, through the suggestion of "mitigation strategy"- type responses. Women's disempowerment, while seen as contributing to incidence and prevalence of high maternal mortality rates in Uganda, is not considered in the list of reasons proffered by the MoH to explain slow progress in maternal death reduction. Lack of human resources, lack of medicines and supplies, and lack of appropriate buildings and transport and communication equipment are the reasons cited (MoH, 2010: 11). Presumably, if these are the barriers to progress that have been identified, these will be the focus of interventions intended to speed up and improve progress. The MGLSD recognizes that gender plays a role in how and if programs are funded (2007: 13). Within the HSSP, there is no

gender specificity in the costing or financing of the health sector- even those gender- based recommendations included in the HSSP do not have specified budget allocations (MGLSD, 2007: 3, 19). While the WHO claims an empowerment approach to health, its prescriptions for improvement of maternal health, as laid out in its Recommended Interventions for Improving Maternal and Newborn health, are entirely mitigative (as will be discussed further in the following chapter), not to mention that they are presented in a top-down format that is not often compatible with empowerment strategies.

Ensor and Cooper refer to demand-side barriers to health care, which are factors influencing demand at the individual, household or community level (2004: 69). Examples of demand-side barriers that are relevant to Ugandan maternal health include loss of work for patient or care-taker in order to seek health care, asymmetrical control of household resources, reluctance of women to seek care outside the home and community resistance to modern medical pregnancy care (Ensor and Cooper, 2004: 70). These barriers include those related to women's disempowerment, and are potentially as important as supply factors, or the physical availability of care, in deterrence from treatment (Ensor and Cooper, 2004: 69). While both the Ugandan MoH and MGLSD and the WHO recognize demand side barriers to maternal health as well as supply side barriers, interventions and recommendations focus mostly on the supply side. This apparent disconnect is the key to what is referred to here as "mitigation thinking." While demand-side barriers are recognized, they are seen as part and parcel of local cultures and life-ways, and somewhat beyond the scope of

maternal health interventions, if not completely intractable. Supply-side interventions are much easier to implement and measure, and are therefore more frequently attempted in order to mitigate the effects of these less tractable barriers.

CHAPTER FOUR: MITIGATIVE INTERVENTION STRATEGIES

Framing Mitigative Response

Severine Auteserre has developed an argument that actors within the international community address problems within specific, pre-set frameworks or sets of labels that have been developed to understand, and streamline responses to, situations of international interest (Auteserre, 2009). While in her case frames were examined as they pertained to international conflict and post-conflict responses in the Democratic Republic of the Congo, the concept of framing is transferable. Essentially, the particular understanding of an issue- in this case, women’s empowerment and its impact on maternal health- allows for the creation of some interventions while it explicitly or implicitly excludes others. The frame within which maternal health is seen internationally, and by international donors, shapes preferences in development programs for quantifiable, achievable indicators, often to the exclusion of more qualitative goals that take longer to measure and achieve (GoU- MGLSD, 2007: 37).

This paper argues that the empowerment-maternal health frame that is accepted and largely worked within by interested parties in the development community, including the WHO and the Ugandan government, is one of “mitigation thinking,” in which women’s inferior status is considered intractable, leading to the more or less exclusive possibility of “mitigation strategies” as a response. What has been referred to here as “mitigation thinking” is a way of

thinking about maternal health that stems from the dominant empowerment-maternal health frame suggested here, in which the fact of disempowered women is a constant and unchangeable variable, embedded in a culture that is presumed to be static, at least in this aspect. Within a framework of “mitigation thinking,” by definition, the only possible responses will be those which try to mitigate or lessen the negative effects of disempowerment, or what will be referred to as “mitigation strategies.” Particularly important is how the particular frame at work currently ignores the role of traditional birth attendants, resulting in a complete lack of relationship between these practitioners and the formal medical health system. As previously mentioned, most women in Uganda will see one of these practitioners first, before attending a health care facility, where practitioners may be seen as outsiders and not part of the local birth culture, whose practices and behaviours are potentially emotionally or physically injurious to women (Bantebya Kyomuhendo, 2003: 20, 22).

A review of interventions recommended and undertaken by the WHO and Ugandan government that partake of “mitigation thinking” demonstrates how such thinking leads to the recommendation and implementation of “mitigation strategies” for maternal health promotion. Such “mitigative” strategies are aimed at reducing the negative effects of women’s disempowerment on their maternal health. The WHO, through its department of Making Pregnancy Safer, works to improve maternal health through the Integrated Management of Pregnancy and Childbirth (IMPAC), promotion of skilled attendance at birth, midwifery training modules, training for midwifery trainers and promotion of evidence-based

programs and clinical practices (WHO 2008b: 3; WHO 2008c: 3). WHO recommendations as outlined in the IMPAC, etc. are a top-down dictation of mitigative interventions. While community participation is included, this participation is largely on WHO terms, in line with the top-down structure of the Making Pregnancy Safer program. This dictated participation evidenced by the insistence on increasing skilled birth attendants as a measure of improved maternal health, a measure that implicitly excludes traditional birth attendants, community members who are often seen as custodians of local birthing cultures and traditions, and are clearly preferred by many if not most Ugandan women. While these approaches are all important parts of improving maternal health, they represent mitigative strategies. Empowerment strategies to address the root cause are hinted at: “promotion of involving individuals, families and communities” (WHO 2008b: 3); advocating “for a social, political and economic environment conducive to action” (WHO 2008c: 3), however, it is not entirely clear how this involvement or environment is achieved, nor how it has been attempted on the ground in maternal health contexts.

Like the WHO, the GoU focuses on the promotion of skilled attendants at births, and the provision of emergency obstetric care- strategies intended to mitigate maternal mortality (GoU- MoH, 2010: 85). The key interventions outlined in Uganda’s Roadmap to Reduce Maternal Mortality are increasing access to Emergency Obstetric Care (EmOC), revitalization of family planning services, increasing antenatal care attendance, and increasing skilled attendance at deliveries (Mbonye et al., 2007: 286). Strategies for maternal health outlined in

the HSSP III include dissemination of evidence-based materials, awareness raising among community members, sensitization of communities around sexual and reproductive rights, promotion of skilled attendance at birth, provision of EmOC and addressing institutional barriers at the policy level (MoH, 2010: 86). Importantly, poor health-seeking behaviour is identified by the MoH as a potential threat to improved health for Ugandans (MoH, 2010: 38). This line of thinking is consistent with the mitigative framework discussed, and accompanies placing ultimate responsibility for health upon individuals. It also has the potential to re-victimize individuals for “failing” to maintain their health at standards set by and through methods preferred by the formal health care system, while the responsibility of government and other structures for poor health is all but removed. While the HSSP III includes mention of several empowerment interventions, such as community education and awareness raising around reproductive health, provision of community outreach services and programmes for men to promote supporting women in family planning, the Ministry suffers from a chronic lack of funding (MoH, 2010: 86, 23). To date, mitigative approaches have not sufficiently reduced the large maternal death and illness toll on Ugandan women, but have been in ever-increasing demand because of the continued effects of the unsolved root problem.

The WHO and the Ugandan MoH, as powerful players in Ugandan maternal health, hold similar beliefs to others in the field. Many researchers operate within the same frame. Kaye et al. performed a study of the effects of intimate partner violence on maternal health, finding that such abuse negatively

affects mother's health, and acknowledging that it is women's disempowerment which leaves them vulnerable to violence. However, despite this acknowledgment, their recommendations were to screen women for violence during pregnancy to assist prediction of complications (Kaye et al., 2004: 1582). This is clearly a mitigative strategy, based on a premise of the intractability of women's disempowerment. Coupled with the prior recognition of the root cause of women's disempowerment, it is indicative of a mitigative thinking frame, whereby the subordinate status of women is seen as an intractable reality.

Adjusting the Frame for a different Response

When maternal health care takes place outside the context of the dominant frame, it can be delivered in an alternative way. Within the same country, and even the same region, different maternal health care standards may exist. Looking at the example of refugee health care provides an effective example. There are approximately 200,000 refugees living in Uganda, in camps established and run by the UNHCR and NGOs, and treated by camp health facilities (Garimoi Orach and De Brouwere, 2006 : 611). A study found that because of camp health facilities, refugees have better access to health services than host populations in the same areas, obstetric intervention rates are higher among refugees and maternal mortality rates are at least 2.5 times lower than among Ugandan host populations (Garimoi Orach and De Brouwere, 2006 : 611). Perhaps because refugees are not subject to the same social expectations, and refugee health systems fall under the umbrella of refugee response, they are conceived of outside the dominant health (and maternal health) framework.

Similar examples of treating maternal and other health issues through a different framework follow in the discussion of the next chapter.

CHAPTER FIVE: DISCUSSION AND ANALYSIS

The Empowerment- Health Correlation Revisited

Maternal health indicators are highly correlated to women's social status (or relative lack of empowerment) in Uganda (Okong et al., 2006). Interventions have failed to address this factor adequately, and the disempowerment of women in Uganda has substantially contributed to high maternal morbidity and mortality rates. Disempowerment is by no means the only barrier to effective maternal health care delivery. Uganda also suffers from a severe shortage of human resources and a lack of appropriate health care infrastructure. Interventions for maternal health in Uganda, however, have seemed to focus largely on immediate causes of maternal ill health, and on improving capacity for mitigation, through improving infrastructure and increasing training for skilled staff, while ignoring more foundational causes. The reasons for this disconnect may lie in how the problem is conceptualized and understood by decision-makers in maternal health for Uganda. The disconnect may have the further effect of rendering interventions less effective than they could and should be.

Many interested international and national bodies and researchers recognize the detrimental effects of Ugandan women's low social status on their health, particularly in regards to reproductive and maternal health outcomes. However, women's subordinate status in Ugandan society is described by key stake-holders such as the WHO and MoH, both explicitly and implicitly, as

intimately linked to, and deeply embedded within, Ugandan culture and social practice. As such, effecting change in the area of women's empowerment is seen as very challenging, and usually beyond the scope of maternal health interventions. In creating and using this frame within which to view the problems of maternal health in Uganda, international and domestic actors are both reinforcing the acceptability of women's disempowerment, and limiting the actions and interventions which may be viewed as possible or legitimate. This has resulted in the implementation of strategies that intend to mitigate the effects of women's lack of empowerment on their maternal health, without attempting to address the disempowerment itself. Such instrumentalist strategies have been ineffective in reducing maternal mortality and morbidity as they fail to address the important root cause of women's status.

Cause- Effect Disconnect: Implications of a mitigative approach

Despite a general academic and political awareness of gender inequality in Uganda, the effects of this inequality on maternal health have not been adequately targeted by maternal health interventions. While much research in the area has recognized the health impacts of women's social circumstances and status, there has been little in the way of suggestions for interventions addressing this aspect of women's health. Most suggestions focus on the immediate causes of poor maternal health, and how to mitigate them. Ideas of mitigation, or "mitigation thinking" rather than of solution, stem from an understanding of women's low social status as, in fact, intractable and, therefore, insoluble. As a result, interventions for maternal health have not broached the

potential of social reform as integral to improvement and sustainability of maternal health. Understanding maternal mortality outside of the mitigation frame allows for the possibility that women's disempowerment is not a static reality. Once this possibility is unlocked, interventions aimed at social change for women's empowerment become conceivable and such strategies may be integrated into a maternal health program. It is important to note here that an empowerment framework does not deny the need for complimentary mitigation strategies, especially in the early stages, nor does it in any way preclude their use.

What has been here referred to as "mitigation thinking" has led largely to the implementation of "mitigation strategies" in women's reproductive health. This line of thinking has the potential to reinforce women's status by fostering a feeling of acceptance, and even acceptability, akin to cultural relativist thinking. It may act as a vicious cycle, as "mitigation strategies" that do not seek to resolve the root problem of social disempowerment will not put an end to the continued need for mitigation against the resulting maternal morbidity and mortality. Further, such "mitigation strategies" tend to have as their targets individual women, ignoring the fact that in Uganda, as in many societies, women often do not have the power to make autonomous decisions regarding their own health (Okong et al., 2006). Interventions targeted at women without an understanding of their experiences, both around pregnancy and delivery, and in their day to day lives, could have the counterproductive effect of reinforcing the status of women as well as detrimental beliefs and attitudes held in society. Targeting only women in education and

intervention campaigns may have the effect of essentially placing responsibility for maternal health (and ill-health) on the individual pregnant woman. This effectively relieves men, communities and government of their responsibilities, as well as ignoring many of the structural issues that contribute to poor maternal health outcomes among the most subordinated women. Disempowerment of women is likely reinforced by their perceived responsibility for failures in their own maternal health (Kiwuwa and Mufubenga, 2008). When empowerment of women is seen as impossible or beyond the (narrow) scope of the maternal health purview, some types of interventions become much less likely, such as community-wide targeting, which may spread the responsibility for maternal health more evenly, as well as involve those who do hold decision-making power (ie, men and their natal families). Community involvement and education has been expressed as the preferred approach to solving other gender- balance and health related problems in Uganda (see, for example, Wolff et al., 2006; Silver, 2001; GoU- MoH, 2010).

Other Frameworks for Maternal Health

Wolff et al. cite wide agreement in a studied Ugandan community that awareness raising would be most effective if targeted at entire communities, rather than just a target group, in the case of their study, drinkers (2006: 1282). Their insight on interventions to address the increased risk of HIV contraction with alcohol consumption, may easily be applied to other interventions that are related to risk behaviours. They question the use of behavioural interventions once such behaviours are understood as indicators, or symptoms of deeper

social issues. Instead, priorities for intervention should target the underlying ideas that shape, allow for and validate risk behaviours (Wolff et al., 2006: 1283). Applying this principal to maternal health interventions, understanding the foundational beliefs and barriers that prevent women from seeking maternity care is essential to understanding how behavioural interventions aimed exclusively at women may not be successful. This concept is exemplified well by a finding of the study by Bantebya Kyomuhendo (2003:23). Upon survey, health care providers were found to believe that poor maternal health was entirely due to women's ignorance and refusal to deliver in health care facilities. According to this understanding, the solution for the problem would be to educate women to decide on less "risky" behaviours. Women of the area, however, reported refusing to attend facilities because they were all treated poorly, and without the respect due their age and the status traditionally conferred upon women with pregnancy and birth inside the community. Understanding the situation from this point of view, targets for intervention should be in understanding the complex social traditions and associations attached to birth. As Wolff et al. put it: "...attempting behaviour change without understanding the context or more importantly without community consent and involvement is a well-documented path to failure" (2006: 1283). Further, The MGLSD reports that on the ground experience in Uganda has shown interventions directed at one group (be they women or men) will not be successful in creating change (2007: xi).

In order to remove hazards and barriers to women's maternal health, and to provide services that are culturally appropriate and desirable to women and

their families, the communities from which women come must be involved (Bantebya Kyomuendo, 2003: 25). Indeed, a number of examples demonstrate the success of targeting Ugandan communities for health promotion. As discussed above, the experience of the HIV/AIDS epidemic, and its incredibly successful decline in Uganda, demonstrates that behaviour change can be achieved through broad community involvement, rather than narrowly targeted risk factor prevention approaches (Wolff et al., 2006: 1283). Silver (2001: 52) reviews another community targeting intervention, the use of songs and storytelling as a health promotion tool to teach expectant mothers and their families in a rural community of Uganda the danger signs of maternal illnesses. This method was created by the community, and was well accepted, as it drew on an existing traditional practice. Silver points out that health information often does not make its way into the awareness of the majority of people, particularly those living rural lifestyles, but also that education is the most effective and practical health promotion strategy, one that is necessary despite the constraints of illiteracy and scarce resources (2001: 54). This innovative strategy employed the community itself to translate health information into understandable and culturally acceptable messages with locally composed themes, in an example of effective health communication (Silver, 2001: 53). Silver explains that the reasons this particular intervention has been able to contribute to changing attitudes and beliefs is that it offers participation and entertainment in a culturally relevant and credible way that is simple, repeatable and sustainable (2001: 56, 57). The strategy is empowering for mothers and communities, as it removes

health decisions from the exclusive domain of the experts or health care practitioners in a people-centred rather than issue-centred way (Silver, 2001: 57).

Researchers provide examples of ways to meet barriers from both the demand and supply sides, and there have been some successes from the African region. Distance to health care can be addressed on the demand side through a community travel fund, or on the supply side by the provision of vehicles (Ensor and Cooper, 2004: 74). The added benefit of the travel fund over vehicle provision is that the community will have worked together to establish and maintain the fund, actions that reinforce the importance of women and their health to the community. The problem of cultural appropriateness or desirability of health care may be addressed by education or provision of health care information on the demand side, or by adjusting services to suit the culture on the supply side. Specific to maternal health intervention, both demand and supply side barriers may be addressed at once, for example through provision of skilled attendants at home deliveries in the community (Ensor and Cooper, 2004: 73).

Across the sub-Saharan African region, community led empowerment strategies have had positive effects on maternal health. Community educators in Nigeria, Sierra Leone and Ghana have had substantial success in increasing health care facility admissions for normal and complicated births (Ensor and Cooper, 2004: 75). Community transport groups have seen results as well in Nigeria and Sierra Leone. In Zimbabwe and Ethiopia, maternity waiting homes have been successful in increasing admissions. In each of these interventions, local communities were consulted prior to investment and implementation, which

Ensor and Cooper credit for their success (2004: 75). They dismiss a direct targeting approach as inappropriate for maternal mortality interventions, and suggest rather community targeting (Ensor and Cooper, 2004: 77). They support the provision of information to individuals, households and communities in order to deal with informational gaps (Ensor and Cooper, 2004: 73). Wallerstein reports that empowerment approaches to HIV/AIDS reduction that focused on promotion of reproductive autonomy have proven more effective at increasing condom use than provision of condoms (2006: 12).

Alternative Explanations Discussed

There are a number of possible explanations for poor maternal health in Uganda that fit within the mitigative maternal health framework discussed above. For example, it has often been suggested that improvement in health indicators, including maternal mortality rates, will follow from economic growth, suggesting that health promotion strategies should be aligned to poverty reduction, as it is in Uganda. If poor health care and outcomes are the product of weak economies, then mitigation of these effects while growth is targeted is an appropriate response to high maternal mortality and other poor health indicators. This, in fact, has been the attitude of the Ugandan government, on the advice of the World Bank. However, this has not been the case in Uganda. Over the same period that growth has characterized the Ugandan economy, maternal mortality has risen. Wallerstein points out that improved market economies, like that of Uganda, have not been followed by improved health, and in fact may have resulted in increased health disparities because of the disinvestment in health infrastructure that

resulted from the adoption of SAP policies and heavy debt load (2006: 4, 7). The correlation between state-level economic strength and good health indications is, in fact, missing in many countries. Ronsmans et al. demonstrate that differences in maternal mortality ratios between countries and regions cannot be explained solely by variation in economic growth (2006: 1196). They use the examples of Vietnam and Sri Lanka, compared to Yemen and Cote d'Ivoire. The four countries share very similar gross national incomes, but the first two have maternal mortality ratios that are much lower than those of the latter two. Okuonzi notes the lack of correlation in countries such as Cuba, Costa Rica, Sri Lanka, and China, which have similar GDP levels to Uganda, but much lower maternal mortality rates (2004: 1636). See Table 2: GDP and Maternal Mortality in Uganda and other Developing Countries, which demonstrates the huge disproportionality of Uganda's share in global maternal death.

Table 2: GDP and Maternal Mortality in Uganda and other Developing Countries (2005)

| Country | GDP / capita | MMR |
|---|--------------|-----|
| Uganda | 1300 | 550 |
| Cuba | 9700 | 45 |
| Costa Rica | 10900 | 30 |
| Sri Lanka | 4500 | 58 |
| China | 6600 | 45 |
| statistics from: CIA factbook, www.cia.gov WHO Maternal mortality in 2005 | | |

There is an argument for the private expense of health care as the cause of maternal ill-health. Essentially, by this argument, poor health is due to poverty. This explanation treats maternal health as an indicator of population health, and

one would expect to see a decline in health care access and health indicators across the population, if this were the case. However, in the case of Uganda, decline in maternal health has not been on par with any population-wide health decline. After the abolition of user fees in Uganda in March 2001, the numbers of people accessing health care rose significantly, resulting in reduced morbidity incidence (Okuonzi, 2004; Deininger and Mpuga 2005: 62-3). User fees in Uganda were a great barrier to poor people prior to their abolition in 2001. However, following their abolition, Okuonzi (2004: 1635) reports a surge in service use of over 100 percent. This abolition and increased usage has led to reduced morbidity in a pro-poor way (Deininger and Mpuga, 2005: 77) (see Table 3: Maternal Mortality Ratios vs other Health Indicators over Time, Uganda). Antenatal, postnatal and delivery visits to hospitals have also increased in some areas (Deininger and Mpuga, 2005: 77). However, antenatal care coverage in Uganda was already among the highest in Africa, and there has been no significant improvement in maternal mortality ratios since that time (Deininger and Mpuga, 2005: 65). Many women still choose not to access formal maternity care, even where it is available and affordable, for reasons previously discussed. The health sector of Uganda has set their goal in line with the national development aim of reducing poverty and accelerating economic growth (GoU-MoH, 2010: 1). As discussed above, this gender blind type of goal entails certain dangers for some groups. Organizations like the World Bank have focused their development efforts on poverty reduction, because of the drastic effects of SAPs (Moss, 2001: 652). Moss points out, however, that gender equity and

socioeconomic equality are independent of each other at the country level, according to UN data (2001: 650), suggesting that focusing on poverty reduction as a means to better health may not pay attention to gender differences, and poses the potential of leaving some members of the community with poorer health outcomes than others. "...We talk about gender-neutral concepts such as the poor, the vulnerable, the rich, the sick, children, etc. as if... gender relations amongst them do not matter" (GoU- MGLSD, 2007: xii). It is not the intention of this paper to suggest that poverty is not an incredibly important factor in health outcomes, particularly in developing countries. However, it must be acknowledged that poverty has gendered effects- poor women do not experience poverty in the same way as poor men. Women's poverty may be due largely to their gender.

An argument may be made that increased spending on maternal health alone will improve services and outcomes. However, several (successful) attempts have been made to increase funding for maternal health care in Uganda and worldwide. One example of this has been the cost-benefit argument that investment in women has the greatest return to the development dollar, otherwise known as the Women in Development approach. Poverty reduction approaches often promote investment in women for the high economic return it can bring. This is incompatible with the value of health as an inalienable right, because it depends upon economic outcomes for success. Luttrell et al. note that the Women in Development approach has often been criticized for ignoring or not questioning the underlying reasons for women's subordination in many societies

(2009: 3). Another recent example has been the union of women's health to children's health, often referred to as maternal-child health, a union that the GoU subscribes to. Both of these strategies have resulted in increased funding being channeled towards mothers. However, in treating investment in women as a means towards an end (a tool or strategy for the ultimate goal of national development, or of improved child welfare), rather than as individuals and groups whose intrinsic value and right to health is recognized, these strategies do not work towards the betterment of women's social situation. In fact, these approaches may again act to reinforce women's status in society, as subordinate providers of children and other domestic goods. Indeed, despite the implementation of these strategies, and the increased investment, there has been little progress in the reduction of maternal morbidity and mortality in Uganda, and elsewhere (see Table 3). Table 3 demonstrates that between 1990 and the present, Uganda has experienced economic and health gains, while maternal mortality rates have remained unchanged. Whichever framework and approach is taken in the fight against maternal mortality, the implications must be understood and appreciated, in order to anticipate and evaluate results. An approach that considers women's subordinate status in developing countries like Uganda will better explain and respond to health disparities between men and women.

| Table 3: Maternal Mortality Ratios and other Health Indicators over Time, Uganda | | | | | | | |
|---|--------------|-----|--------------|--|--------------|----------|------|
| | U5 mortality | MMR | Infant mort. | Fertility rate | Llife expect | HIV prev | GDP |
| 2005-2008 | 135 | 550 | 85 | 6.3 | 53 | 5.40% | 1300 |
| 1990 | 186 | 550 | 114 | 7.1 | 48 | 21% | 250 |
| | | | | | | | |
| | | | | statistics from: UNICEF, www.unicef.org ; CIA factbook, www.cia.gov ; WHO, www.who.int | | | |
| | | | | | | | |

CHAPTER SIX: CONCLUSIONS AND REMAINING QUESTIONS

Summary of the Ugandan Case Study

This paper has argued that Ugandan women lack empowerment, and suffer as a result from the consequences of such disempowerment, not the least of which is poor maternal health. Women's own feelings of powerlessness and their suffering from its consequences have been explored, as expressed in interviews about their maternal health. It has been shown also that Ugandan women have high indications of a lack of empowerment when measured by proxies, such as educational attainment, decision making, economic independence and presence of domestic gender violence. The link between maternal health (and health generally) and empowerment has been widely acknowledged, as demonstrated above. The link between Ugandan women's disempowerment and their high rates of maternal mortality and morbidity has been recognized and acknowledged by important players such as the Government of Uganda and the World Health Organization. However, priority interventions of both parties have been shown to be largely mitigative, due to an understanding of women's status as an unchanging and unchangeable facet of Ugandan culture. This paper has argued that by changing the framework of understanding women's disempowerment as it relates to maternal health, more dynamic and holistic interventions become plausible and even necessary.

While it may be said that any intervention aimed at improving maternal health is a positive thing, within the context of a resource-limited reality, it is incredibly important that funded interventions are effective. Ineffective interventions reduce resources available to other, more effective ones, and may even reinforce unhealthy attitudes and beliefs, as has been demonstrated. The way a problem is understood effects the way in which attempts are made to solve it, and the case of the maternal health crisis in Uganda is no exception. While working frames are chosen for a reason, in this case it would seem that a change of framework could allow for more far reaching results and improvements for women, as intervention possibilities are broadened. The dominant frame explored here is one supported by active international actors, who operate in many other countries around the world. This paper has explored the framework within the context of a country case study on Uganda, however, future research may explore if this frame has had a similar effect in other countries facing similar problems.

Limitations of the Case Study

Within the predefined constraints of this paper, including time, space and resources, it can only strive to be a survey of the situation, and not an exhaustive and definitive one at that. As suggested earlier, the paper has strived to acknowledge and explore the importance of ways of understanding the issue of maternal health to ways of addressing the problem. Further research is required to understand the exact mechanism of this process, as well as to understand the true and variable motives behind the choice of one frame over another. The

greatest limitation to understanding the effects of the proposed framework on Ugandan women, again due to the above mentioned constraints, has been the lack of opportunity for original ethnographic fieldwork, which would have added depth to the understanding provided within the context of other studies and interviews.

While the integration of a framework that includes women's empowerment to the field of maternal health is important and may result in improvements, it is certainly not a simple task nor does it require that mitigative strategies to maternal health be abolished. Luttrell et al. (2009: 16) and Wallerstein (2006: 4-5) caution that with empowerment strategies, it can be difficult to establish and measure outcomes, or to use empowerment as a framework for change or analysis, particularly without clearly defining the term. Empowerment has become very popular in the development community, and may be in danger of becoming a buzzword- some are concerned that use of the term has brought little real change to development practice and may even help actors who use it avoid tackling structural change (Luttrell et al., 2009: 4).

Further, changing to an empowerment frame would require changing attitudes and beliefs of international organizations and other groups and individuals, some of whom certainly have a vested interest in the current dominant frame. Of course, social (re-)engineering of the kind suggested here is a huge undertaking, requiring engagement by and coordination of many interested organizations, groups and individuals, and mobilization of a great deal of resources. An example of such engagement with widespread consequences of

attitude, belief and behaviour change may be found in Uganda itself, where the HIV/AIDS epidemic was controlled and infection rates were drastically reduced across the country. This was accomplished, as explained earlier, not through mitigative strategies alone, such as reducing the effects of the virus on individual lives, but also through promoted change in beliefs about the spread of disease, values and the stigmatization of infected individuals and, as a result, associated behaviours. This example demonstrates not only the possibility of frame change at the international, national and societal levels, but also the possibility of success.

The question of how to empower Ugandan women is a large one, with no easy answer. It has not been answered here, nor has the attempt been made. It is clear, however, that it is important, and that the process is likely to have good consequences for maternal and other health. It is also clear that strategies designed and imposed from the top to mitigate the maternal health crises in Uganda and other developing countries, without understanding and appreciation of the realities of women and their families, are unlikely to succeed. The paper comes to a close in the hope and belief that critical discussion of the sort presented here will contribute to improvements in maternal health, as individuals, governments, and organizations reflect on both the contexts surrounding the problem of maternal mortality, and their own understandings and motives in attempting to solve the problem.

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