TRANSITIONING TO SUSTAINABLE DEVELOPMENT GOAL 3: AN INTERSECTIONAL APPROACH

TRANSITIONING TO SUSTAINABLE DEVELOPMENT GOAL 3: AN INTERSECTIONAL APPROACH EXAMINING MATERNAL HEALTH POLICY IN UGANDA

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LAY ABSTRACT

Under the lens of intersectional theory, this study aspired to determine what lessons can be learned from Uganda's attempt to achieve Millennium Development Goal (MDG) 5, related to maternal health, from 2000-2015, and also how these lessons will inform its transition to Sustainable Development Goal (SDG) 3 between 2016-2030. The barriers and challenges surrounding Uganda's maternal health outcomes were also investigated, and four themes were found. This study demonstrates how various aspects of women's social identities intersect and form the basis for much of the oppression they encounter surrounding their maternal health, with implications for policy-makers, health care workers, and women. Attainment of SDG 3 seems unlikely for Uganda, and also not in its best interests. Rather than attempting to meet globally developed targets to improve its maternal outcomes, Uganda should engage in multisector collaboration to enable realistic and sustainable progress in its quest to counteract its maternal mortality crisis.

ABSTRACT

Background: Uganda is one the leading countries around the world which account for 60% of the total number of maternal deaths globally. Following the unsuccessful trajectory of MDG 5, no comprehensive research was conducted to determine why targets were not achieved, and maternal health priorities were reorganized under SDG 3. However, the efficacy of this approach remains uncertain.

Methods: A meta-narrative review (MNR) provided insight into maternal health trajectories within Uganda prior to and during MDG 5, and informed the development of questions for key informant interviews. Interviews were conducted with 7 key informants to explore the development and implementation of maternal health policy in relation to MDG 5 and SDG 3. Thematic coding analysis was conducted using NVivo 12, in accordance with the criteria of constructivist grounded theory, to identify recurring themes.

Findings: Four major themes were identified: i) the current narrative surrounding maternal health is deterring investment in SDG 3, ii) Uganda's fragmented health care system impedes access to maternal health care, iii) empowerment issues among women, and iv) increased collaboration efforts are needed from Uganda's government to improve maternal health outcomes.

Implications & Contributions: Uganda has failed to advance women's rights, as the government focusses on infrastructure development to drive economic development. However, Uganda will not progress if women continue to be oppressed and die as a result of its multifaceted maternal mortality crisis.

Implications for maternal health policy: MDG 5 and SDG 3 were imposed on Uganda and do not necessarily reflect its best interests or its collective needs related to improving its maternal health outcomes. Striving to achieve SDG 3 would likely further oppress women and disadvantage the country overall. Thus, Uganda's government must increase multisector collaboration to develop realistic and sustainable goals towards improving maternal health outcomes to better counteract its maternal mortality crisis.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF ABBREVIATIONS

CAQDAS	Computer Assisted Qualitative Data Analysis
CGT	Constructivist Grounded Theory
GBV	Gender-Based Violence
IMF	International Monetary Fund
MDG 5	Millennium Development Goal 5
MMR	Maternal Mortality Ratio
MNR	Meta-Narrative Review
NGO	Non-Governmental Organization
ODA	Official Development Assistance
OECD	Organization for Economic Co-operation and Development
SDG 3	Sustainable Development Goal 3
SDH	Social Determinants of Health
UN	United Nations
WHO	World Health Organization

DECLARATION OF ACADEMIC ACHIEVEMENT

The following is a declaration that the content of the research in this document has been completed by Amanda Latchman, recognizing the valuable support of her thesis supervisor Dr. Christy Gombay and supervisory committee Dr. Deborah DiLiberto and Dr. Olive Wahoush

CHAPTER 01: INTRODUCTION

Drawing on intersectional theory, this qualitative study investigates what lessons can be learned from Uganda's efforts to achieve Millennium Development Goal (MDG) 5, related to maternal health, from 2000-2015. This study also seeks to determine how these lessons might inform Uganda's transition to Sustainable Development Goal (SDG) 3 from 2016-2030. Findings from this study may inform progress towards SDG 3 by identifying whether Uganda is repeating the same approaches and strategies employed during MDG 5.

As Uganda transitions into the era of the SDGs, findings from this study may provide insight into whether any positive lessons from the course of MDG 5 are being brought forward. This study will also identify adjustments made within Uganda since MDG 5, in particular efforts to address barriers and challenges. It is anticipated that study findings may support the attainment of SDG 3 within Uganda, bridging the gap between lessons learned during MDG 5 with the current trajectory of SDG 3 in the region, with implications for Ugandan women, health care professionals, and policy-makers alike.

An estimated 830 women die daily due to complications related to childbirth and pregnancy, with most preventable deaths occurring in low-resource settings (WHO, 2019a). The World Health Organization (2019a) defines maternal mortality as:

> The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Maternal mortality is a health indicator which quantitatively illustrates gaps between the rich and poor, urban and rural areas, and between countries as well as within them (WHO, 2019a). When a woman dies in pregnancy or during childbirth, this is universally considered to be both an individual tragedy and a human rights violation with far-reaching repercussions for the long-term global burden of disease (Miller & Belizan, 2015).

Women in developing countries are 33 times more likely to die due to a maternal-related cause compared to women in developed countries (WHO, 2019a). The high prevalence of maternal death across developing countries is indeed a terrible injustice to women and leads to several intergenerational and multi-sectoral disruptions. Furthermore, the high prevalence of maternal death within developing countries results in inequities and layers of marginalization among vulnerable and poor women, often amidst widespread health system dysfunction (Miller & Belizan, 2015). In particular, a high maternal mortality ratio (MMR) has negative consequences for infant and child mortality, economic opportunities, and cycles of poverty among deceased women's families and communities (Miller & Belizan, 2015).

In response to the maternal mortality crisis occurring across several developing countries, the United Nations General Assembly launched the Millennium Development Goals (MDGs), which included Improving Maternal Health as part of its eight MDGs in September 2000. Goal 5 established two specific targets (i.e. 5a and 5b) for national signatories to the MDGs in an attempt to improve maternal health (MDG Monitor, 2016). Target 5a of MDG 5 sought to reduce the MMR by 75% and focused on indicators 5.1

(i.e. maternal mortality ratio) and 5.2 (i.e. proportion of births attended by skilled health personnel; Waage et al., 2010).

Over and above reducing maternal mortality, target 5b of MDG 5 sought to achieve universal access to reproductive health and attain the indicators related to 5.3 - contraceptive prevalence rate, 5.4 - adolescent birth rate, 5.5. - antenatal care coverage and 5.6 - unmet need for family planning (Waage et al., 2016). Reproductive health coverage includes having access to family planning counselling, education and services for prenatal care, safe delivery and post-natal care, the prevention of unsafe abortion and management of the consequences of abortion, and the prevention and treatment of reproductive tract infections, sexually transmitted diseases, and other reproductive health conditions (United Nations, 2017).

Despite experiencing a slight delay with signing the Millennium Declaration, Uganda officially became a signatory in September 2001 (The Republic of Uganda, 2015). While neither one of the global MDG 5 targets were achieved by 2015 (MDG Monitor, 2016), the MMR did decrease by 43% around the world (WHO, 2019a). However, most countries throughout sub-Saharan Africa, including Uganda, experienced sluggish progress in reducing their individual MMRs (Tesfaye et al., 2018). Although Uganda achieved a notable reduction in its MMR from 620 per 100 000 live births in 2000 (WHO, n.d.), to 343 per 100 000 live births by 2015 (UNICEF, 2019), it still remains among the top 10 countries around the world which account for 60% of the total number of maternal deaths globally (Dunn et al., 2017).

Following the unsuccessful global trajectory of MDG 5, no comprehensive research was conducted to determine why the targets were not achieved, especially in sub-Saharan Africa where progress was especially limited. Instead, the United Nations (UN) reorganized previous maternal health priorities under SDG 3 as part of the SDGs launched in 2016. However, there are mixed opinions about how well the MDGs reflect Africa's collective needs, and so the potential efficacy of the UN's reorganization of maternal health priorities is uncertain. It appears that while implementation of MDG 5 was a good idea for Uganda, it did not reflect its national development priorities (Durokifa et al., 2018).

During the development and execution of the MDGs, Jeffrey Sachs asserted that "the voices of the poor should have been heard rather than the thoughts of what others want Africa to become" (as cited in Ndaguba et al., 2016, p. 619). Given the extensive period of time that Africa has faced oppression, exploitation, colonialism, slavery, political and social violence, and marginalization, it appears that poor judgment was made regarding the timing and gestation of implementation for MDG 5 across the continent. Furthermore, throughout the development and trajectory of MDG 5 in Uganda, there has been limited consideration of the intersectional discrimination which women from its various marginalized ethnic groups encounter, nor have there been many targeted policies to support these women (United Nations, 2010).

The literature identifies direct causes of maternal mortality among Ugandan women (e.g. abortion, bleeding, infection, hypertension and obstructed labour), and also predisposing factors (e.g. short birth intervals, inadequate maternal nutrition, young age at

first birth, and a shortage of trained assistance during delivery; Tashobya & Ogwal, 2004). Yet, it appears that there are other contributing factors which also drive Uganda's maternal mortality crisis, most of which have gone largely unrecognized. It is hardly surprising that results suggest that the targets for MDG 5 were unrealistic and ambiguous for attainment in Uganda as they did not account for the country's deep-rooted institutional, structural, and governance issues (Ndaguba et al., 2016). Furthermore, it appears that several challenges within Uganda limited progress towards achieving MDG 5, which is concerning as these challenges persist as the country transitions into SDG 3.

When considering the maternal mortality crisis in Uganda, it is imperative to recognize that Ugandan women, like other women, are not a homogenous group of individuals who face the same maternal health challenges (Davies et al., 2019). Ugandan women are dissected by race, stratified by religion, occupy diverse positions depending on geographic location, and have varying access to maternal health care depending on their income and socioeconomic status. Consequently, this study uses intersectional theory as a theoretical perspective to better understand the lived realities of Ugandan women.

Intersectional theory argues that people who are both female and of colour continue to be marginalized by "discourses that are shaped to respond to one [identity] or the other, instead of both" (Crenshaw, 1991). It is useful to use this theory within the context of this study because "the core of intersectionality…is coming to appreciate that all women do not share the same levels of discrimination just because they are women" (Coleman, 2019, p. 1). It is important to investigate the oppressions that Ugandan women

encounter because as Crenshaw (1991, p. 1242) maintains, “ignoring differences within groups contributes to tension among groups.” Hence, failing to recognize this complexity can be equated to failing to understand the lived realities of women in Uganda (Coleman, 2019) because dissimilar experiences of oppression and privilege influence women’s health, wellbeing, and illness differently (Magar, 2015).

The following chapters of this thesis outline this study’s attempt to answer the research questions. In chapter two, background information surrounding Uganda’s history, intersectional theory, and the social determinants of health is presented. Thereafter, chapter three outlines a meta-narrative review (MNR) that was conducted to develop a more nuanced understanding of the major social determinants of maternal mortality within Uganda to thereby identify gaps within the greater literature.

Chapter four outlines the methods used to conduct this study’s individual key informant interviews and to analyze subsequent findings as per Charmaz’s (2000) constructivist grounded theory (CGT) approach and computer assisted qualitative data analysis (CAQDAS) using NVivo 2012. Chapter five then presents major findings from the key informant interviews organized into four recurring themes, whereby chapter six outlines this study’s discussion section. Finally, chapter seven presents study conclusions with suggested recommendations to further support maternal health within Uganda and ultimately its attainment of SDG 3.

CHAPTER 02: BACKGROUND

In an attempt to solve development challenges and bring forth a higher standard of life for citizens of developing countries, particularly in sub-Saharan Africa, the UN developed the MDGs (Durokifa et al., 2018). Throughout their 15-year span, the eight MDGs aspired to nurture a close relationship between the developed global North and the underdeveloped global South (Durokifa et al., 2018), and eventually became one of the major foreign aid efforts for developing countries (Easterly, 2008). In particular, the MDGs focused on achieving several goals, targets, and indicators in an attempt to reduce poverty in its various forms (e.g. maternal deaths, lack of shelter, and disease), while simultaneously promoting gender equality, foreign aid, environmental sustainability, and education for all (Durokifa et al., 2018).

The Organization for Economic Co-operation and Development (OECD) worked alongside the UN to support attainment of the MDGs throughout the world by financing the goals with official development assistance (ODA) from its donors, forming a global partnership for development, and supporting strategic areas that contributed to advancement of the goals (OECD, 2012). Additionally, the OECD also played a pivotal role in helping to monitor progress related to the MDGs by tracking donors' aid commitments and examining how innovative financing can amass development resources and involve new participants (OECD, 2012). Throughout the MDGs, ODA from donors increasingly rose amidst an evolving international landscape.

In an attempt to realize the MDGs by 2015, the OECD encouraged accelerated development policy implementation in strategic MDG-related sectors, and urged

development actors to make greater investments in prioritized areas (OECD, 2012). From 2000-2013, Japan, the United States, and the World Bank were the largest donors to the MDGs and collectively contributed 41% of the total ODA financing (AidData, n.d.). Gender equality and women's empowerment was one of the MDG-related sectors emphasized by the OECD, and investing in women and girls was promoted as yielding the greatest returns amongst all of the development investments including decreased MMRs (OECD, 2012). Moreover, ensuring equality between men and women was thought to multiply progress towards attainment of all the MDGs (OECD, 2012).

OECD donors focused spending on activities related to health in Africa, including maternal health. Africa received 48% of global spending on activities related to health, and Uganda in particular received $4.788billion USD in health financing (AidData, n.d.). However, the implementation and adoption of the MDGs across Africa drew much criticism, especially from Africans regarding the progress of their continent (Durokifa et al., 2018). Instead of encouraging development in African countries, many believed that the MDGs did not reflect the inclusive voice of developing nations.

Critics maintained that the MDGs were really a form of neo-colonialism, which is concerning as Western-led reform in Africa has often conflicted with the continent's own development strategies (Durokifa et al., 2018), and has largely ignored the oppression of women. Moreover, many argued that developmental issues cannot be reduced to eight unified goals as different countries have dissimilar areas of concern (Durokifa et al., 2018).

At the midway point of the MDG era in 2007, officials unanimously agreed that most regions in sub-Saharan Africa would not likely meet any of the MDGs due to resurgent malaria rates, the AIDS crisis, environmental degradation, and poor housing conditions (Easterly, 2008). However, little was done to better support sub-Saharan Africa to achieve the MDG targets including those related to MDG 5. Similarly, there is limited help being offered to assist sub-Saharan Africa with achieving the SDG 3 targets related to maternal health. While the current SDGs call for "ODA and beyond" to meet the various indicators of the 2030 agenda, there have been challenges with monitoring their progress (OECD, 2018).

MDG 5 was recognized for laying the foundation to decrease maternal deaths in certain developing countries (Kyei-Nimakoh et al., 2016) however, it was largely unsuccessful and powerless in addressing health concerns of women in Uganda (Ndaguba et al., 2016). Throughout sub-Saharan Africa reproductive health coverage levels have remained stagnant for the past 20 years, with a minor increase demonstrated in the number of women receiving recommended maternal care from 47% to 49% in 2015 (Tesfaye et al., 2018). Since the development and implementation of the SDG agenda, spending on SDG 3 has increased in some countries and there has been mixed progress towards meeting specific targets (Sundewall & Forsberg, 2020).

The Government of Uganda has implemented various policies, some of which focused on improving maternal health care, as a means of accelerating the movement towards universal health coverage with essential health services. For example, one of the primary goals of Uganda's second national health policy is to increase access to quality

hospital services at all levels within the private and public sector (Kyaddondo et al., 2017). Similarly, Uganda's quality improvement framework and strategic plans are trying to ensure that by 2020, all citizens accessing health care services attain the best possible health outcomes, and that both acceptability of services and patient satisfaction improve (Kyaddondo et al., 2017).

Despite Uganda's attempts to implement policies to advance maternal health and counteract its maternal mortality crisis, these policies have not been very effective thus far as Ugandan women continue to experience significant obstacles towards securing their right to reproductive health. Furthermore, there have been limited efforts to improve patient satisfaction in maternal care in Uganda, as the focus has mainly been on meeting technical and clinical standards (Kyaddondo et al., 2017). It appears that Uganda's greatest challenge in providing patient-centered quality maternal care is not due to the absence of a supportive policy environment, but rather in obtaining information on how to bridge the policy-to-practice gap (Kyaddondo et al., 2017).

Bridging the policy-to-practice gap would prove useful in the post-MDG strategy planning period, as lessons from the trajectory of MDG 5 may inform and impact the feasibility of achieving SDG 3 in Uganda by 2030 (Kyaddondo et al., 2017). During 2000-2015, Uganda experienced various challenges pertaining to weak multi-sectoral implementation planning, data and reporting inadequacies, coordination gaps, limited financial resources, and weak public private partnership (Republic of Uganda, 2016). Uganda also continued to uphold several failing neoliberal policies, as part of structural

adjustment programs from the World Bank and the IMF during this time, which exacerbated many of these challenges.

Uganda's progress towards achieving the MDG 5 targets was hindered due to widespread underdevelopment, deterioration of its health sector, high mortality rates among its vulnerable populations, human rights abuses, rural poverty, and gender inequalities (Ndaguba et al., 2016). Since these challenges continue to persist within Uganda, the United Nation's consensus to achieve SDG 3 in the region may be overly ambitious and remain wishful thinking unless appropriate measures are implemented accordingly (Ndaguba et al., 2016).

Despite Uganda not being able to achieve the targets of MDG 5, there are certain positive elements to be brought forward as it transitions into SDG 3. In actuality, the unsuccessful trajectory of MDG 5 in Uganda should not be interpreted simply as the targets it missed, but as an opportunity to develop insights into the underlying constraints surrounding maternal health across the country. Thus, it appears that as the Government of Uganda works to decrease its MMR through attaining SDG 3, it should give equal consideration to both the journey and the destination of this objective (The Republic of Uganda, 2013). Furthermore, at both an implementation and a policy level there may be lessons learned from 2000-2015 which could inform the ways in which Uganda's government, international and local stakeholders approach SDG 3.

During the course of MDG 5, the Ugandan government revitalized its approach at the implementation level early on by enlisting additional public health workers to facilitate the delivery of maternal health interventions (The Republic of Uganda, 2013).

The government also set measures to increase focused antenatal care (e.g. prevention of mother to child transmission of HIV), and to increase comprehensive and basic emergency obstetric care services during this time (Atuhaire & Keruka, 2016). While the level of skilled assistance at delivery increased considerably during MDG 5, there is still great room for improvement within Uganda as the MMR remains high in the Post-2015 era, with a significant proportion of deaths occurring more than 24 hours after birth (The Republic of Uganda, 2013).

As Uganda transitions into SDG 3, the Ugandan government must work at a policy level towards achieving improvements in the efficiency of service delivery, stimulating the expansion of economic opportunities, investing in rural transportation infrastructure to improve access to emergency obstetric care, and developing a broader development strategy to accelerate progress towards SDG 3 (The Republic of Uganda, 2015). Overall, the challenges surrounding maternal health in Uganda require its government to experiment, learn, and adapt as it develops innovative, responsive, and effective services (The Republic of Uganda, 2015).

There are several implications that can be drawn from the delayed start of the MDGs across Africa, including Uganda. MDG 5 was delayed in Uganda between 2000-2005 as Africa had little to no support from world leaders to help attain the MDGs (Ndaguba et al., 2016). The UN and industrial countries did not extend financial assistance to meet MDG-related targets until 2005 at the G-8 Summit (Ndaguba et al., 2016). At this time, leaders renewed their commitment to fight extreme poverty in Africa,

and offered debt relief as well as humanitarian and economic assistance (Ndaguba et al., 2016).

During 2007-2008, the world's economic collapses led to shortages of government expenditure globally. The widespread job losses across the world, including within Uganda, negatively impacted private-sector investment in the country, which was a major target of the MDGs (Ndaguba et al., 2016). Consequently, it may be of benefit for Uganda's government, international, and local stakeholders to be cognizant of the lessons which emerged during 2000-2015, to prevent recurrence of such delays and impediments, as Uganda transitions into SDG 3.

The history of post-independence Uganda is one strewn with inter-ethnic conflict (Kurian, 1992). The complex relations between the various ethnic groups has led to uneasy alliances between the Baganda, who live around Kampala, and the Banyankole and Banyoro, who formed the backbone of the National Resistance Movement which led to the demise of President Milton Obote's regime in 1986. While collectively marginalized ethnic groups comprise a significant proportion of Uganda's population, they remain largely unrecognized as the country battles various inter-ethnic challenges (OHCHR, 2011; Ssentongo, 2014).

The distribution of marginalized ethnic groups within Uganda's population is an issue of contention among inhabitants. While the Baganda represent 16.2% of Uganda's population, there are other groups that constitute 8% or more (Kurian, 1992). In fact, since colonization the power dynamics within Uganda have been unstable and continue to shift (Kurian, 1992). It appears that different groups are marginalized from access to

power more broadly and health services more specifically, although the latter remains an empirical question for further consideration.

In the 1960s, Uganda's health care system was one of the best in East Africa however, the political upheaval which ensued between 1970-1985 weakened the system extensively (Mukasa, 2012). Since then, Uganda's health care system has been struggling with the emergence of several new districts and a resulting widespread fragmentation of services (Mukasa, 2012). Uganda currently has a decentralized hierarchy within its health care system, with the public sector, private sector, and donors having key roles. The public sector is comprised of its central government and district health services under local government authorities, whereas the private sector consists of private health practitioners, traditional and complementary medicine practitioners, and private not-for-profit organizations (Mukasa, 2012).

During the current SDG era, Uganda's health care system continues to be a private system that has not changed significantly since the MDG period. There are eight levels within Uganda's health care delivery system hierarchy: a) national referral hospitals, b) regional referral hospitals, c) district health services, d) referral facility, e) health sub-district level, f) health center III, g) health center II, and h) health center I (Mukasa, 2012). While Uganda's health care system is set up to run based on referrals, the lack of defined gatekeeper roles often results in regional referral hospitals being overcrowded and the emergence of various issues including poor patient care, health care worker bribery, and shortages of essential medications (Mukasa, 2012).

In Uganda, maternal health care is predominantly available only to wealthy women from urban areas, namely its capital city Kampala. However, an estimated 41% of Ugandans live in poverty, and nearly 80% of people live in rural areas (World Bank Group, 2020). Almost half of Uganda's population is below 15 years of age, and represents one of the world's youngest populations (Opportunity International, 2020). In a primarily rural country like Uganda, there tends to be a correlation between low-income and a lack of access to maternal health services, with poor rural women being at a greater risk for mortality. Furthermore, Uganda also has the largest refugee population in Africa, with over one million people currently seeking asylum (Opportunity International, 2020).

Mbonye et al. (2007) found that there are issues surrounding the quality of care that women receive once they enter Uganda's health units, with women from its eastern region having a higher risk of death compared to those from its western and central regions. Pregnant women seeking care in eastern Uganda are also more likely to present with severe complications due to protracted armed conflict within the region, which has led to poor infrastructure and challenges in accessing care (Mbonye et al., 2007). In northern Uganda, there is a legacy of internal violent conflicts and suffering. The insurgency of the Lord's Resistance Army from 1987-2006 led to one of the worst humanitarian disasters in the world, and resulted in approximately 1.5 million internally displaced persons and extensive massacres (ICG, 2004).

During the insurgency, extensive deficiencies surrounding the government's ability to protect the population were emphasized (ICG, 2004). The insurgency perpetuated the North-South conflict that has featured heavily in Ugandan society and its

political system since its independence (ICG, 2004). Furthermore, the violence demeaned President Yoweri Museveni's National Resistance Movement and the stability it otherwise brought Uganda (ICG, 2004). Despite the conflict within Northern Uganda, women there were less likely to die in health units due to the close proximity of internally displaced camps to level III health centers (Mbonye et al., 2007). Uganda still faces political instability, as President Museveni's rising authoritarianism and the country's weak institutions further add to existing challenges (ICG, 2020). The political upheaval in Uganda adversely affects provision and access to quality health care services and therefore attainment of SDG 3. There is also much discontentment among marginalized ethnic groups due to Uganda's repression of political opposition and its dependence on security responses to political issues (ICG, 2020).

Women from marginalized ethnic groups in Uganda are largely unable to provide their input surrounding the various policies and programs which have been implemented to support maternal health and ultimately, the attainment of SDG 3. However, under article 36 of the Ugandan Constitution, it states that "minorities have a right to participate in decision-making processes and their views and interests shall be taken into account in the making of national plans and programs" (OHCHR, 2011). Sadly, the pluralistic nature of Ugandan society has led to various groups discriminating against each other and resulted in many marginalized ethnic groups experiencing inadequate health care, insufficient education provision, sporadic development, and regional violence (OHCHR, 2011). Furthermore, this discrimination has greatly obstructed these groups' efforts to sustain and develop their own culture and identity (OHCHR, 2011).

Since women from marginalized ethnic groups comprise a major proportion of Uganda's population, it appears that the county needs to make additional efforts to address their plight to improve maternal health outcomes. While the Ugandan government declared a strong political commitment to supporting maternal health to achieve MDG 5 early on, there continued to be a widespread lack of prioritization of the health sector at the national level from 2000-2015, which resulted in a gross lack of resources (Wallace & Kapiriri, 2019). Between 2012-2014, Uganda's expenditure on its health sector was 7-8% of its gross domestic product (Munabi-Babigumira et al., 2019). Yet, this expenditure was well below the 15% agreed upon by the African Union Countries in the Abuja Declaration of 2001, and approximately only 14 % of this expenditure was for reproductive health conditions (Munabi-Babigumira et al., 2019). The literature suggests that improving the quality of maternal care, to decrease the MMR, requires the government of Uganda to truly recognize the importance of supporting maternal health and employ a more pertinent approach than what has previously been employed.

It is of fundamental importance that the Government of Uganda understands all women's previous experiences, their cultural values, and their perceptions surrounding their role in Uganda's health care system to devise a shared vision of quality (Kyaddondo et al., 2017). Considering the limited amount of research and knowledge pertaining to the complex political, legal, cultural, and socioeconomic problems facing mothers from marginalized ethnic groups in Uganda, and that its institutions are poorly equipped and financed to address these problems, it appears that further efforts are needed to support SDG 3 within the region (OHCHR, 2011).

The current state of maternal health and limited access to accompanying social services is quite concerning for women from marginalized ethnic groups in Uganda (OHCHR, 2011). Marginalized ethnic groups are often not accounted for in Uganda's public health system, with maternal health outcomes being bleaker among minority women compared to national averages (OHCHR, 2011). The literature indicates that women and girls from marginalized ethnic groups around the world tend to experience significantly worse maternal health outcomes compared to majority populations (UNFPA, 2018).

Due to a scarcity of reliable health data pertaining to women and girls from marginalized ethnic groups, there is limited awareness surrounding their poor maternal health outcomes; such ambiguity impedes the development of effective solutions (UNFPA, 2018). Women and girls undergo double discrimination as they are often excluded from health care decision-making, and their gender-specific interests are never prioritized within applicable national policies and programs (OHCHR, 2011). Furthermore, the lower levels of education and literacy among these women and girls further aggravate these disparities (OHCHR, 2011).

Members of marginalized ethnic groups often turn to their traditional knowledge of medicinal herbs to support their maternal health, an approach that does not provide adequate protection against sexually acquired diseases, or improve maternal health outcomes (OHCHR, 2011). Consequently, it appears that the Ugandan government needs to increase its efforts to protect and prioritize women's rights among its marginalized ethnic groups, followed by ample community sensitization (OHCHR, 2011).

Marginalized ethnic groups were not given due consideration in any of the MDG country reports under each of the eight goals (United Nations, 2010). The literature clearly indicates that Uganda needs to increase its efforts to protect the reproductive health rights of its marginalized ethnic groups, raise social awareness, and ensure access to free, viable, and culturally sensitive maternal and reproductive health services (OHCHR, 2011). However, it seems that these efforts are contingent on first identifying and understanding the true experiences of women from marginalized ethnic groups within Uganda as they suffer intersectional discrimination while trying to find support for their maternal health (UNFPA, 2018).

Kabeer (2015, p. 2) maintains that the slow progress of MDG 5, which was dubbed the "hardest to reach" of the MDGs, indicates important lessons about the systemic nature of certain forms of inequality. In fact, approximately 99% of maternal mortality is concentrated in low-income countries, among their most impoverished populations, with women at the intersection of class, race, gender, geographical, and ethnic inequality (Kabeer, 2015). In an attempt to better understand the extent of discrimination that women, especially those from marginalized ethnic groups, experience within Uganda, applying intersectional theory could serve to identify some helpful insights from its MDG 5 trajectory as the country transitions into SDG 3.

The origins of intersectional theory date back to the 1970s, with historic roots within and beyond the United States of America (Hankivsky, 2014). Intersectional theory became popular through the work of American critical legal race scholar Kimberle Williams Crenshaw, who coined the term *intersectionality* in 1989 (Hankivsky et al.,

2010). An intersectionality perspective posits that inequities never arise due to single, distinct factors, but rather due to the intersections of different power relations, experiences, and social locations (Hankivsky, 2014). Intersectionality enables one to see where power emerges and collides, and where it interlocks and intersects (Crenshaw, n.d.), making it an innovative framework and research paradigm for challenging inequities and promoting social justice (Hankivsky, 2014).

Intersectionality argues that people's lives are multi-dimensional, and complex, with their lived realities being influenced by social dynamics and different factors operating simultaneously (Hankivsky, 2014). Moreover, intersectionality maintains that no one category of social identity is necessarily of greater importance than any other (Hankivsky et al., 2010). Thus, it appears that intersectionality can provide some novel insights into how the intersection of various social determinants of health may produce differing maternal health outcomes for Ugandan women (Caiola et al., 2014).

The intersection of social determinants of health for Ugandan women may operate to produce different maternal health outcomes. In particular, the social determinants of health (SDH) "are the conditions in which people are born, grow, live, work and age" (WHO, 2020). These circumstances arise due to the allocation of power, money, and resources at local, national, and global levels, and are largely responsible for various unjust and preventable differences in health status within and between countries (WHO, 2020).

Currently, the conventionally accepted SDH by WHO (2020) are: employment conditions, social exclusion, public health programs and social determinants, women and

gender equity, early child development, globalization, health systems, measurement and evidence, and urbanization. At the present time, it is difficult to identify the role of gender within the SDH, which is concerning as gender is an important determinant of health that intersects with other drivers of inequities, marginalization, social exclusion, and discrimination (Manadhar et al., 2018).

Gender is dynamic and layered with a vast array of multiple, intersecting social determinants that can influence health (Magar, 2015). Since gender often reflects how power is distributed within relationships between people, it can have far-reaching effects on health and wellbeing (Manadhar et al., 2018). While WHO (2020) does not recognize gender as one of the major SDH, it does acknowledge it as an important determinant of health in relation to gender inequality and gender norms. Gender inequality results in health risks for girls and women around the world (WHO, 2020). Addressing gender norms and roles provides great insight into how the social construction of identity and unbalanced power relations between women and men affects risks, health-seeking behaviour, and health outcomes among different populations (WHO, 2020).

The three major social determinants of maternal mortality within Uganda are gender, economic factors, and education and literacy (Batist, 2019). Maternal mortality within Uganda is also influenced by limited health care and resources, discriminatory social practices, limited recognition for female autonomy in reproductive health decisions, and the disempowerment of women and girls (Dunn et al., 2017). Batist (2019) contends that there is an imminent need to address the major social determinants of maternal mortality within Uganda. However, the issue of contention is that the social

determinants of maternal mortality within Uganda do not directly relate to the current SDH as outlined by the World Health Organization (WHO).

The wider literature suggests that the entire SDG framework needs to be reconsidered through a gender lens (Manadhar et al., 2018), to better determine the interconnection between gender, women, and global health (Davies et al., 2019). Women have been rendered as being "conspicuously invisible" as maternal health policy and programs continue to be oblivious to their needs and their unequal position within society (Davies et al., 2019). While there are various forms of gender analysis, Batist (2019) contends that addressing each of the major social determinants of maternal mortality requires the use of intersectional theory to effectively contextualize how societal positions intersect to influence maternal mortality across the region (Batist, 2019). Based on preliminary scans of the literature to date, there have been no/limited attempts so far to assess the progress of MDG 5 in Uganda using intersectional theory.

Intersectionality is a transformational paradigm which has the potential to change the status quo for Ugandan women as it examines the relationship between different social categories and intersecting systems of privilege and oppression (Lopez, & Gadsden, 2016). Moreover, intersectionality also does not condone blaming victims of oppression since it does not attribute their problems solely to their genetics, or social and cultural behaviours (Lopez & Gadsen, 2016). Indeed, using intersectionality is a means by which to excavate how Ugandan women's social positions and multiple identities are embedded within longstanding systems of inequality within the country (Lopez & Gadsen, 2016). Given the increasing pressure to develop better ways to account for

differences and respond to the various factors that influence different components of women's health, intersectionality is now gaining recognition as a valuable means by which to reevaluate existing health practices and policies (Hankivsky, 2012).

The escalating maternal mortality crisis within Uganda indicates that traditional, non-intersectional approaches have not been able to reveal the true extent of discrimination which Ugandan women endure (OHRC, n.d.). Intersectionality differs from other forms of gender analysis as it is not an additive approach; it does not estimate the collective impact of one's identity markers (e.g. gender, race, and class) as the sum of their independent effects (Hankivsky, 2012). Women continue to be structurally disadvantaged due to their staggering scarcity within decision-making positions, high-ranking research roles, and leadership, and their overrepresentation within informal care roles (Davies et al., 2019). Thus, intersectional analysis could prove useful to better support Ugandan women's maternal health as it fosters an equal focus on differences, rather than excluding some in favour of others (Hankivsky, 2012).

The first component of intersectional analysis necessitates moving away from the single ground perspective that has often been used to study maternal health in Uganda by assuming that women's experiences are based on multiple identities that can be attributed to more than one form of discrimination (OHRC, n.d.) The second aspect of this intersectional analysis demands consideration of applicable contextual factors (OHRC, n.d.), based on the realities of Ugandan women's experiences. It is imperative to recognize that intersectionality is not prescriptive, nor does it require a specific research design or unified method by which to perform research (Hankivsky, 2012). Alternatively,

the goal of intersectionality is to enable a conceptual shift in how social categories, their relationships, and interactions are understood, and then for this new understanding to be used to transform how processes and mechanisms of power are studied.

Intersectionality maintains that people are often disadvantaged by various sources of oppression through their identity markers, which include: gender, race, and class (YWCA Boston, 2020). Since intersectionality rejects the hierarchical ordering of oppressions (Hankivsky, 2012), these identity markers inform and mutually influence each other to form a multifaceted convergence of oppression (YWCA Boston, 2020). Understanding intersectionality is vital to counteracting the interwoven prejudices which Ugandan women encounter in their daily lives (YWCA Boston, 2020). Consequently, intersectional analysis will be used to reduce the risk of devaluing Ugandan women's identities and misinterpreting the various oppressions that may contribute to the current practices and culture surrounding maternal health within Uganda (Grinnell College, n.d.).

Intersectionality analysis is important when studying maternal health within Uganda as it recognizes the impact of place, time, and historical and localized specificity (Hankivsky et al., 2014). Given that intersectionality recognizes the importance of working with a wide variety of stakeholders to conduct research and to enable social change, it can also be used to study how power and power relations are upheld within a society (Hankivsky et al., 2014). Furthermore, intersectionality analysis seeks to identify what is generated and experienced at the intersection of two or more axes of oppression, and so it can be an effective tool to bring forth social justice and power shifts within a society (Hankivsky et al., 2014).

CHAPTER 03: META-NARRATIVE REVIEW

Introduction

The purpose of this chapter is to use the concept of intersectionality to denote how gender, economic factors, and education and literacy overlap to increase women's susceptibility to maternal mortality within Uganda (Crenshaw, 1991). Since intersectionality "conceptualizes social categories as interacting with and co-constituting one another to create unique social locations that vary according to time and place," (Hankivsky, 2014, p. 9), it will be used to draw attention to the state of civil society ahead of and during MDG 5 within Uganda.

In particular this meta-narrative review (MNR) will focus upon the context of women as Uganda's maternal mortality crisis remains one of its most multifaceted and longstanding issues. This chapter also seeks to identify current gaps within the literature surrounding both the unsuccessful trajectory of MDG 5 within Uganda and the subsequent feasibility of achieving SDG 3, in preparation for additional investigation.

Following a preliminary scan of the literature, it appears that academic scholars from various research traditions have conceptualized and studied maternal mortality across Uganda in different ways, producing both complementary and contrasting perspectives (Davey et al., 2013). Therefore, this MNR is needed because adopting a "one-size fits all approach" to analyze these findings will not effectively inform policies which aim to solve the persistent and growing social inequities that perpetuate the maternal mortality crisis across Uganda.

Greenhalgh et al., (2005, p. 417) indicate that a MNR has the ability to "make

sense of seemingly contradictory data by systematically exposing and exploring tensions between research paradigms as set out in their over-arching storylines." Therefore, it appears that a MNR is the most logical form of methodological analysis to effectively synthesize the diverse body of literature surrounding maternal health within Uganda. Intersectionality can also be applied while doing a MNR, in light of shifting paradigms surrounding maternal health within Uganda, to determine how gender relates to maternal mortality instead of reducing it to a technocratic entity. Furthermore, qualitative reviews, such as a MNR, lend themselves more easily to intersectional analysis (Hankivsky, 2012).

The MNR in this chapter seeks to identify key lessons and gaps within the literature surrounding the progress of MDG 5 within Uganda, and will focus on the MDG 5 to SDG 3 trajectory within the country. Findings from this MNR will form the basis for the subsequent individual interviews with policy-makers, legal experts, academics and health care professionals within the field. It is likely that this MNR will contribute to the existing understanding of the maternal mortality crisis across Uganda by considering the perspectives of a wide group of stakeholders found within peer-reviewed journal articles and grey literature. In particular, this MNR is expected to produce findings that will help to form a more holistic understanding of the maternal mortality crisis in Uganda than what has previously been recognized.

Findings from this MNR can also inform related policy-making decisions and support the attainability of SDG 3 within Uganda. It is anticipated that conducting this MNR under the lens of intersectionality will help to better identify the nuances of Ugandan women's lived realities, especially in terms of how different factors impact their

health and where they most need support to ensure positive maternal health outcomes (Hankivsky, 2014). Furthermore, by applying the lens of intersectionality to this MNR, new information may be generated surrounding the origins, root causes, and characteristics of the maternal mortality crisis within Uganda and identify important strategies that may be missing as it transitions into SDG 3 (Hankivsky, 2014).

During September-December 2019, the MNR was conducted by following the Realist and Meta-Narrative Evidence Synthesis (RAMESES) publication standards outlined by Wong et al., (2013). This study's overall research questions are:

(1) What lessons can be learned from Uganda's efforts to achieve MDG 5, related to maternal health, from 2000-2015?

(2) How might these lessons inform Uganda's transition to SDG 3 from 2016-2030?

In an attempt to better understand Uganda's efforts to counteract its maternal mortality crisis and better support maternal health, this MNR asks the following questions, based on the recommendations of Wong et al. (2013):

(1) Which epistemic traditions have considered this broad topic area?

(2) What are the main empirical findings?

(3) What insights can be drawn by combining and comparing findings from different epistemic traditions?

Methods

The MNR is considered the most appropriate approach to reviewing the literature since its pragmatic nature is well suited to this study's emphasis on examining the

multidimensional and intersecting trajectories of maternal health care within Uganda. In particular, this MNR will summarize differing perspectives surrounding maternal mortality within Uganda into an overarching narrative, and then pertinent interview questions will be identified to lead subsequent discussions with maternal health care professionals and policy-makers (Wong et al., 2013).

While conducting a MNR, Wong et al. (2013, p. 11) indicate that one should "present each meta-narrative as a coherent individual account which conveys the underpinning 'normal science' of the relevant research tradition (concepts, theories, preferred methods) and the key empirical findings in that tradition." However, this MNR will move beyond purely scientific research and consider the views of a broad group of stakeholders. As such, a few changes were made to the original review process outlined by Wong et al., (2013).

It seems more appropriate to present this MNR's findings according to topic area (i.e. gender, economic factors, and education and literacy) instead of individual accounts. Further detail will be provided on how each topic has evolved in relation to MDG 5 including initial conceptualizations within Ugandan society, consideration of various actors' perspectives, impacts on the SDG 3 trajectory, and how intersectionality has influenced related discourses.

Wong et al., (2013, p. 11) also emphasize that one must "present findings and inferences from the synthesis across the different meta-narratives as an over-arching narrative which retains the integrity of the separate research traditions but draws out what might be learned from the commonalities and differences between them." However, this

MNR will alternatively consider drawing commonalities and differences from the lens of intersectionality. In particular, this MNR will consider the extent to which concepts of the intersectionality framework feature across the various topic areas or not, and also what may have been gained by acknowledging the framework or what may have been lost by the lack thereof.

During the beginning stages of this MNR, the initial process of exploratory scoping of the literature was conducted informally to get a sense of the most pressing issues related to the role of intersectionality in relation to the maternal mortality crisis within Uganda. An early search of peer-reviewed and grey literature was conducted based on browsing, personal intuition, recommendations from scholars in the field, and informal networking, to roughly map the wide variety of approaches and perspectives employed by researchers who have studied maternal mortality within Uganda (Greenhalgh et al., 2005).

The iterative searching for this MNR was conducted by accessing relevant peer-reviewed journal articles from electronic databases and by using the snowballing technique (Greenhalgh et al., 2005). Peer-reviewed journal articles and grey literature, dated between 2000-2020, were obtained between September-December 2019 from the PubMed and Embase databases, using the following search terms: MDG 5, SDG 3, gender, maternal mortality, Uganda, economics, female education, and poverty. From an initial return of 169 articles, 13 articles were included in this MNR after title screening and reviewing their abstracts, as they appeared most relevant to the study's overall research questions. All articles were written in English and appeared in full-text. The search strategy for this MNR also included retrieving grey literature from the following

sources: the World Bank, the Uganda Bureau of Statistics, the United Nations, UNICEF, and the Bill and Melinda Gates Foundation using the same search terms that were used for finding the peer-reviewed journal articles. A total of 8 reports obtained from these sources were included in this MNR.

All literary works that were chosen for inclusion in this MNR were based on comprehensiveness, scholarship, and contribution to supporting maternal health within Uganda (Greenhalgh et al., 2005). The main principles of a MNR (i.e. pragmatism, pluralism, historicity, contestation, reflexivity, and peer-review) are reflected throughout this study's MNR process. Among the included peer-reviewed journal articles and grey literature within the MNR, data and information pertaining to underlying assumptions about maternal mortality, key actors, and events were extracted in an attempt to gauge the current priorities surrounding maternal health within Uganda. During the analysis and synthesis of this MNR, the historical development of the maternal mortality crisis in Uganda was traced by identifying various overview papers and articles and subsequently examining the conceptual models and perspectives proposed by academic scholars, health care professionals, and policy-makers (Wong et al., 2013).

Results

All of the peer-reviewed journal articles and grey literature reports originated from global health literature and were methodologically diverse.

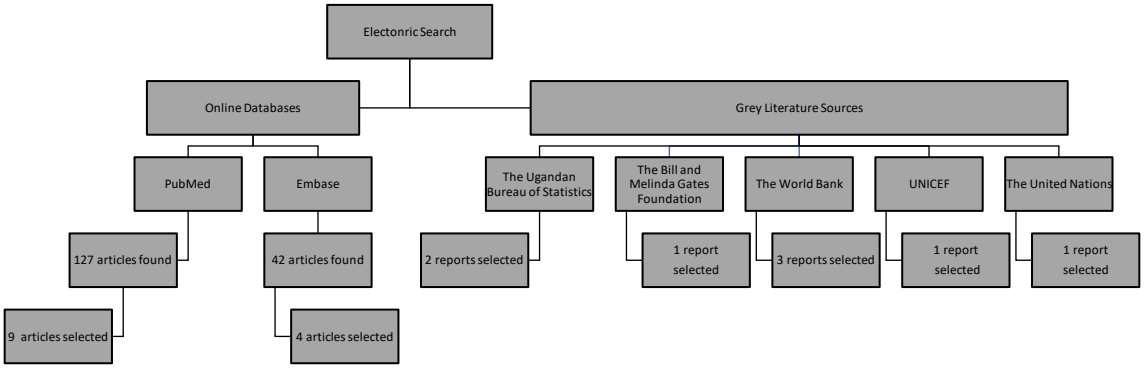

Figure 1: Document Flow Diagram for Online Databases used in MNR

Discussion

It should be noted that this MNR was not funded by any external sources, nor were there any conflicts of interest pertaining to the reviewer.

Gender

Gender is a critical social determinant of maternal mortality (Batist, 2019), with one of the most agonizing depictions of gender inequality being that of a young woman giving birth alone (Bill and Melinda Gates Foundation, 2019). Extensive gender inequalities make life harder for females, with further suffering inflicted upon those born in poor countries (Bill and Melinda Gates Foundation, 2019). In relation to MDG 5, gender was initially conceptualized as being essential to the achievement of better health

(WHO, 2019b). The conditions that heighten or diminish maternal mortality are also thought to have a gender dimension (WHO, 2003). While gender has the ability to help promote development at times, it can also seriously impede it at others (WHO, 2003). Consequently, addressing gender inequalities was of critical importance to MDG 5, especially since gender systems (i.e. the rules that govern the values and behaviours of women and men in any given society) have the potential to impact almost every aspect of life (WHO, 2003).

Several key actors held unique perspectives about gender prior to and throughout the duration of MDG 5 within Uganda. The United Nations (n.d., p. 1) has long maintained support for the rights of women, starting with its founding Charter in 1948, which reaffirms that "all human beings are born free and equal in dignity and rights." Furthermore, the United Nations maintained that gender equality is a global priority, a sentiment that has sparked much discussion and action among civil society, member states, and international organizations (UN, 2013).

Leading up to the MDGs, there were several discourses surrounding gender equality, male authority, and patriarchal norms which perpetuate inequalities within Uganda (Wyrod, 2008). Women's rights became integral to regional treaties, national legislation, grassroots activism, and international declarations across Africa, including Uganda (IFAD, n.d.; Wyrod, 2008). In response, the Ugandan government made a concerted effort to improve its image in the international aid community by projecting itself as being largely democratic and supportive of good governance (Nabacwa, 2010). The government also tried to appear receptive to the concerns which some civil-society

organizations had, such as NGOs about pervasive gender inequalities in Uganada. While relations between NGOs and the Ugandan government revolved around gender-focused NGO advocacy, this did not significantly improve the status of poor women within Uganda (Nabacwa, 2010).

The Ugandan government had previously created mechanisms to operationalize its international and constitutional obligations, such as through its National Gender Policy (1997) and its National Action Plan on Women (1999) however, there still remained a considerable amount of work to do before Uganda could implement gender equality within its legal framework prior to the launch of the MDGs in 2000 (Ellis et al., 2006). While various sections of Uganda's constitution prohibit sex discrimination, guarantee gender equality, and mandate affirmative action to support women who are marginalized due to their gender, key legislation in Uganda continues to be unconstitutional and discriminates on the basis of gender (Ellis et al., 2006).

In a cross-sectional study by Morgan et al., (2017), Ugandan women's lack of maternal health care access and utilization was attributed to gendered power relations which arise from the intersection of social norms, access to resources, division of labour, and decision-making. Gendered social norms often result in many men not providing resources and/or accompanying their partners to health care facilities due to societal pressures which dissuade them from being involved with their partners' maternal health (Morgan et al., 2017). The current division of labour across Uganda is highly problematic as women are frequently expected to fulfill household chores during and after pregnancy, whereas men are often unable to provide important maternal health care and supplies due

to poverty constraints (Morgan et al., 2017). Furthermore, unequal power within decision-making processes negatively affects women's maternal health as it restricts their autonomy, decreases their negotiation abilities, and increases fertility and unwanted pregnancies (Morgan et al., 2017).

While Morgan et al., (2017) acknowledge that they likely missed important gender-related factors and nuances, they suggest that gender needs to be integrated into the design, implementation, and evaluation of interventions in Uganda to successfully address the various gender inequities surrounding women's lack of maternal health care access and utilization. The authors ascertain that at the household and community level, interventions are needed to oppose norms that classify men as sole providers and women as caregivers to thereby ease pregnancy-related challenges (Morgan et al., 2017). At the health systems level, Morgan et al., (2017) suggest that moving Uganda's health system towards universal health care would help to guarantee that women have sufficient access to, and actually receive, suitable maternal health care.

Kyomuhendo (2003) conducted a cross-sectional descriptive study to determine why women in rural Uganda choose high-risk pregnancy treatment and delivery options, often resulting in severe morbidity and/or death. It was found that risk factors for maternal mortality in rural Uganda include: women following traditional birthing practices because they are familiar and accepted, societal beliefs that pregnancy is a test of endurance, and the perception that maternal death is a sad but normal occurrence. In Ugandan culture, pregnancy and childbirth are likened to the metaphor of "walking down a hazardous, thorn-strewn path," with the only outcomes being survival or death

(Kyomuhendo, 2003). This metaphor implicitly suggests that potential injuries and fatalities during childbirth are unavoidable risks, and depend on a woman's fate (Kyomuhendo, 2003). By the same sentiment, women who seek external help (e.g. by having a caesarean section or an episiotomy) are considered to be lazy, whereas those women who do not experience complications nor seek any assistance during pregnancy and childbirth are highly commended for their resilience (Kyomuhendo, 2003).

Ugandan women were found to have great levels of mistrust and cynicism about seeking maternal care in health care facilities due to previous experiences which entailed unethical treatment from staff, feelings of disrespect, and complaints of neglect and abuse (Kyomuhendo, 2003). Consequently, Kyomuhendo (2003) recommends greater community education to bridge the gap between Uganda's formal health care system and rural mothers, sensitizing health workers to treating rural mothers, and also increased involvement of men as leaders and partners in active community participation.

Tusiime et al., (2017) conducted a mixed methods cross-sectional study to measure the prevalence of sexual coercion and its impact on unwanted pregnancy among young (i.e. ages 15-24 years old) pregnant women in urban Uganda. In Uganda, approximately 67% of young people are faced with at least one instance of sexual coercion in their lifetime, with an estimated 36% of young females experiencing this form of sexual abuse (Tusiime et al., 2017). Young women are at a greater risk of sexual coercion compared to young men due to societal gender expectations, with women being expected to refrain from displaying sexual resistance (Tusiime et al., 2017). Women often feel forced to comply with unwanted sexual advances as men are widely perceived as

being the decision makers in sexual relations and as having uncontrollable sexual desires (Tusiime et al., 2017). Consequently, young women are at an increased likelihood of experiencing negative outcomes pertaining to sexual coercion including unwanted pregnancy, abortion, HIV/AIDS, and sexually transmitted diseases, exposing them to a higher risk of morbidity and mortality (Tusiime et al., 2017).

Tusiime et al., (2017) found that unwanted pregnancy was higher among those women who were sexually coerced and those who had nonconsensual sexual debuts. As such, the researchers suggest various strategies to counteract sexual coercion and unwanted pregnancies including: health education, youth friendly services, community services for youth, youth mobile services, and stricter punishments for perpetrators under Ugandan law (Tusiime et al., 2017).

The Uganda Bureau of Statistics (2019a) reports that ongoing social beliefs, perceptions, systems, and attitudes about women and men, as well as societal roles, instigate gender-based violence (GBV) in Uganda, reported as being mainly towards women and girls. The prevalence of GBV throughout Uganda is disconcerting as it "violates one's rights and slows down progress in achieving sustainable inclusive human development" (Uganda Bureau of Statistics, 2019a, p. 5). Major causes of GBV include alcoholism, drug abuse, poverty, cultural practices (e.g. bride price and early marriages), peer pressure, dwelling type, and limited counselling (Uganda Bureau of Statistics, 2019a). The repercussions of GBV are highly distressing, with survivors often developing mental health issues, poor reproductive health, life-long emotional distress, an increased risk of contracting HIV/AIDS, and sometimes even death (Uganda Bureau of Statistics,

2019a). The report indicates that while the risk of GBV increases with age, it decreases with the attainment of education and wealth (Uganda Bureau of Statistics, 2019a). Furthermore, despite awareness campaigns by both state and non-state actors, greater enforcement of GBV policy, improvements in alternative livelihood options, and female empowerment, additional action is needed to counteract both physical and sexual GBV within Uganda (Uganda Bureau of Statistics, 2019a).

It appears that the trajectory towards SDG 3, and arguably towards better supporting maternal health in Uganda, has been impacted by landmark achievements that have reinforced the importance of women's rights. The United Nations organized the first World Conference on Women in 1975 and adopted the Convention on Elimination of all forms of Discrimination against Women in 1979. Subsequently, in 1985 the United Nations (n.d.) held the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, which was described as the beginning of global feminism. Moreover, in 1995 the United nations (n.d.) held the Fourth World Conference on Women, whereby the Beijing Platform for Action likened women's rights to human rights.

Upon review of the literature, it appears that concepts of intersectionality can be applied to better understand the gender-related inequities which Ugandan women and girls encounter pertaining to their maternal health. The United Nations (2013) emphasizes that marginalized girls and women experience compounding inequalities, and there are several gaps in achievement for marginalized groups of females who experience multiple gender-based inequalities (UN, 2013). Societal beliefs surrounding what it means to be a

woman in Ugandan society affects the decision-making capacity of women and limits their access to health services. Furthermore, it appears that the normalization of mistreatment of women during pregnancy and childbirth have caused women to have low expectations of care (Betron, et al., 2018).

Intersectionality recognizes how a social stratifier like gender interacts amidst interconnected power structures, to better inform current understandings of the origins of maternal health inequities in Uganda and also aid in strategy development (Larson et al., 2016). In particular, intersectionality promotes an understanding of the dynamic nature of privileges and disadvantages that permeate the health system for women in Uganda, as reflected by its high MMR (Larson et al., 2016). Intersectionality also draws attention to the strong male dominance within the leadership of Uganda's health governing bodies and institutions, and how this disparity reinforces gender discrimination towards women due to a lack of policy responsiveness and widespread gender biases (Betron et al., 2018).

Concepts of intersectionality have also influenced gender discourses, in relation to maternal health, in the post-2015 era across Uganda. Some researchers have argued that gender inequality and poorly-resourced health systems go together, in that maternal health services in many developing countries do not receive sufficient monetary investments because they only serve women and women continue to be poorly prioritized (Betron et al., 2018). Under the lens of intersectionality, the mechanisms by which women's social identities drive this mistreatment during childbirth can be better understood, as well as the gender-related barriers they face in obtaining proper maternal health care (Betron et al., 2018). Furthermore, it is recommended that health systems must implement measures to

compensate for the various social and historical disadvantages that prevent women and men from operating on a level playing field (Betron et al., 2018). Culturally-defined expectations on what it means to be a woman also need to be challenged within Ugandan society to better support maternal health outcomes (Betron et al., 2018).

One of the key limitations surrounding the unsuccessful trajectory of MDG 5 was that it focused heavily on targets, amidst a widespread lack of focus on developing policies and conditions to support women (UN, 2013). MDG 5 also did not address the various discriminatory structures that underpin and spread gender inequality at all levels including laws, stereotypes, social norms, and practices (UN, 2013). While Ugandan women and girls did not play a pivotal role in the course of MDG 5, the literature reflects the importance of increasing their involvement to support the attainment of SDG 3 (UN, 2013).Women's and girls' participation in decision-making is imperative as it fulfills their human rights, structures public policies, influences spending priorities surrounding service provision, ensures gender-responsive management of resources, and guarantees their sexual and reproductive rights (UN, 2013).

Based on findings within the literature, it appears that conceptualizations of gender have evolved in the transition towards SDG 3. The United Nations (n.d.) is now focusing on its global development work to support the SDGs, recognizing the critical role of women. Unlike the MDGs, many targets of the SDGs now recognize women's equality and empowerment as both the objective, and as part of the solution (UN, n.d.). Progress towards SDG 3 for Ugandan girls and women is contingent upon tackling the structural drivers of gender inequality (UN, 2013). Thus, the United Nations (2013)

suggests comprehensive gender mainstreaming is needed to heighten progress towards SDG 3 through systematic efforts to harness the synergies between gender inequality and all of the SDGs (UN, 2013). The subsequent sections of this chapter will present further discussion of other structural drivers of maternal mortality within Uganda, namely economic factors and education and literacy.

Economic factors

During the 1970s and 1980s, Uganda experienced extensive economic and political upheaval, with the Ugandan Civil War occurring from 1980 to 1986. Throughout these difficult times, there was general system failure within the health sector. In 1986, the National Resistance Movement became the ruling government party and worked to restore social order and reestablish public services within Uganda (Tashobya et al., 2006). However, the health sector has been chronically underfunded by the government, and has historically used its limited resources inefficiently. In response, many bilateral and multilateral donors began to offer post-conflict support, including emergency rehabilitation of the health infrastructure (Tashobya et al., 2006).

While these efforts initially resulted in some system improvements, the majority of these gains started to stagnate or reverse by the mid-1990s. Despite a considerable amount of funding support, the health sector was unable to deliver the anticipated levels of improvements in outputs and outcomes (Tashobya et al., 2006). Thereafter, the Ugandan government introduced a National Health Policy and a Health Sector Strategic Plan in the 1990s, with key stakeholders including: central and local government officials, representatives from multilateral and bilateral agencies, private providers of health

services, and NGOs. While these various initiatives led to some positive outcomes, maternal health services within Uganda were still not considered to meet the expectations and needs of its population (Tashobya et al., 2006).

Maternal and perinatal health conditions comprise over 20% of the total burden of disease in Uganda (World Bank, 2012). In 2011, Uganda's Demographic and Health Survey showed improvements in maternal health indicators, with 95% of women experiencing antenatal care from a skilled provider at least once, 57% of women delivering their babies under the supervision of a skilled provider in a health facility, and 33% of mothers undergoing a postnatal check-up within two days postpartum (World Bank, 2012). However, Uganda's senior health officials recognized that it was still quite behind in meeting the targets of MDG 5 ahead of 2015 (World Bank, 2012). Furthermore, Uganda only had a ratio of 1.8 health workers per 1000 people, which was below the World Health Organization's standard of a minimum of 2.5 health workers per 1,000 people (World Bank, 2012).

Inadequate government funding also adversely impacts Uganda's health care sector. The health care sector is supposed to receive 15% of Uganda's national budget however, it only receives 7%; this further impedes government efforts to deliver comprehensive care (World Bank, 2012). In response, the World Bank's International Development Association provided a US$150 million credit, which encompasses a component pertaining to maternal health, to improve health systems and support delivery of the National Minimum Health Care package to citizens (World Bank, 2012).

Okuonzi (2004) asserts that key actors including the World Bank, the International Monetary Fund, and latter-day free-market converts (e.g. welfare-state donor countries and Uganda's Ministry of Finance) widely praise Uganda's economic progress. However, Uganda's persistently high MMR defies and questions the true basis of any economic progress the country claims to have made (Okuonzi, 2004). While key actors are hesitant to explain why Uganda has such a poor social welfare situation, Okuonzi (2004) argues that this paradox can be attributed to the economic policy within Uganda and how economic growth has progressed largely at the expense of the country's social welfare system.

Uganda's economic policy is based on export-oriented private-sector investment, which is expected to enhance economic growth and increase household incomes (Okuozi, 2004). As the focus on economic growth intensifies within Uganda, public expenditure for social services and social welfare programs decreases in order to create the necessary macroeconomic environment for prime private-sector investment. Consequently, any social-welfare targets that cannot be achieved under these restricted social spending limits must be abandoned (Okuoni, 2004). It appears that Uganda did not prioritize allocating the necessary finances to meet MDG 5, and as it transitions into SDG 3, its continued fixation on economic growth will likely compromise its ability to meet SDG 3 until it reaches an arbitrary optimum of economic growth (Okuoni, 2004)

In an observational study using qualitative research methods by Weeks et al., (2005) the socioeconomic determinants of maternal mortality in Uganda were explored, and it was found that women experience widespread social and institutional

powerlessness. For some women, this powerlessness results in medical problems such as consequences of rape, forced illegal abortions, or refusal of their partners to use contraception (Weeks et al., 2005). In addition, powerlessness limits access to care for other women through not being able to afford health care, or the transportation to reach it (Weeks et al., 2005). Powerlessness is also depicted through other features of daily living for women including a scarcity of food within hospitals, verbal abuse by health care professionals, or an inability to obtain medical information surrounding their current condition (Weeks et al., 2005).

As a means of making private health care affordable in Uganda, microfinance institutions have begun creating systems that provide low cost insurance to shift the balance of power within hospital settings (Weeks et al., 2005). However, Weeks et al., (2005) recognize that in order to effectively counteract the MMR in Uganda, it is imperative that efforts be made to understand the perspectives of those with the greatest risk of death. The Safe Motherhood Technical Consultation previously highlighted this sentiment in 1997 yet, the voices of those most at risk – the poor -are still seldom heard (Weeks et al., 2005). The authors also stress that future health promotion programs should focus on empowering women to decrease maternal mortality as the current degradation of women is contributing to this crisis by making contraception challenging, HIV likely, care-seeking complex, and health care intermittent (Weeks et al., 2005).

Uganda's current president, Yoweri Museveni, has been a longstanding advocate for a bigger national population despite indications that the country's alarming growth rate is fueling widespread poverty (Wakabi, 2006). In particular, health officials warn that

Uganda's sustained high population growth is a great burden on the provision of health care, and this is concerning as better quality reproductive health services are desperately needed to decrease the MMR (Wakabi, 2006). Moreover, despite being praised as an economic success story, Uganda has one the lowest human development indicators across Africa (Wakabi, 2006).

In a systematic review of the socioeconomic differences in morbidity and access to health care in Africa, Kiwanuka et al., (2008) acknowledge implementation of the Uganda National Minimum Health Care Package in 2000, meant to act as a strategy to improve health care access to the poor, and marginalized and/or disadvantaged people. While some of the interventions within this program were able to improve utilization of certain health services, there was limited progress regarding reproductive health services due to resource limitations and other constraints (Kiwanuka et al., 2008). Furthermore, the reprioritization and rationing of this program across populations made it only accessible from within higher-level health centres and hospitals within Uganda (Kiwanuka et al., 2008). Consequently, the maternal mortality rate has stagnated and/or worsened for the poor, with it being markedly higher among Ugandan females associated with a low socioeconomic status (Kiwanuka et al., 2008).

After reviewing the literature, it appears that intersectionality influences the discourse surrounding economic factors within Uganda in relation to its maternal mortality crisis. For instance, maternal mortality severely impacts the family and household dynamic in Uganda, with the effects of poor maternal health often prevailing for many generations (Rice, 2019). The loss of a mother within a household could

increase the risk poverty and economic insecurity of her family, with the burden of financial strain worsening the psychological effects related to the loss of a family member (Rice, 2019). On a community level, heightened maternal mortality can lead to more single-parent homes, orphans, and decreased economic productivity.

While access to maternal care has been positively associated with women's agency over income, the unfortunate reality is that a significant proportion of Ugandan women do not have economic autonomy (Rice, 2019). The wage gap within Uganda is an indication that Ugandan women need equal pay for equal work, as well as the decision-making power to invest in their maternal health (Rice, 2019). As Uganda transitions into SDG 3, it should consider the value of how intersectionality can be used to better support women's societal position to thereby advance their maternal health.

Education and literacy

Differences exist in the utilization of maternal health services in relation to the educational level of women (Atuhaire & Keruka, 2016). In particular, women who do not have a formal education are increasingly likely to confine their attendance to the health facility level, whereas educated women are more likely to use hospitals (Atuhaire & Keruka, 2016). It is important to recognize that maternal health outcomes are not that closely related to access to hospitals. It is more about access to competent providers on a routine for prenatal care, which is often best in health clinics. Later first birth and birth spacing are also important factors with maternal health outcomes. Authaire and Keruka (2016) recommend that the Government of Uganda, as well as other stakeholders, should increase their efforts to enhance girls' and women's education to encourage favourable

maternal health outcomes in the future. Interventions should be directed at keeping girls in school for longer by increasing scholarship programs to support those from poor families and also implementing government legislation against early marriages (Atuhaire & Keruka, 2016).

The 2019 Goalkeepers report indicates that throughout sub-Saharan Africa, girls tend to have two fewer years of education than boys on average, and even when girls are well educated they are less likely to be employed in the formal work force (Bill and Melinda Gates Foundation, 2019). Limited access to education and jobs disempowers women, decreases their children's life chances, and hinders economic growth (Bill and Melinda Gates Foundation, 2019).

While Uganda's national literacy rate is currently 74%, there is a disparity between male and female literacy levels (Uganda Bureau of Statistics, 2019b). The female literacy rate in Uganda is 70%, whereas the male literacy rate is 78% (Uganda Bureau of Statistics, 2019b). Interestingly, net enrollment levels for primary- and secondary-level education are both higher for girls compared to boys. In particular, the net enrollment for primary school is 80% for girls and 78% for boys, with heightened enrollment in urban areas (i.e. 85%) compared to rural ones (i.e. 80%; Uganda Bureau of Statistics, 2019b). Similarly, the net enrollment for secondary school is 29% for girls and 27% for boys, again with increased enrollment in urban areas (i.e. 44%) compared to rural ones (i.e. 23%; Uganda Bureau of Statistics, 2019b).

The literature indicates that educated girls and women tend to be healthier because their investment in their future acts as a strong incentive to protect their health; education

also helps them to access and process health-related information (de Walque, 2011). In a World Bank report by de Walque (2011), it was found that each additional year of education decreases young Ugandan girls' chances of contracting HIV by 6.7%. The mechanisms behind this result were attributed to changes in behaviour and sexual practices such as increased condom usage and visits to voluntary testing and counselling centres (de Walque, 2011).

Uganda has one of the highest fertility rates in Eastern Africa, at 6.2 births per woman in 2011, with one-quarter of all pregnancies occurring among adolescents (Burke et al., 2018). The country's growing youth bulge reflects its abysmal contraceptive prevalence rate, young ages at the time of first marriage, and cultural preferences for large families (Burke et al., 2011). However, girls who marry early, have children, and/or drop out of school are disempowered and deprived of their basic human rights (World Bank, 2017). According to the World Bank (2017), ending child marriage, preventing early childbearing, and improving educational attainment for girls are all imperative for Uganda's development. However, the impact that ending child marriage would have on the national MMR in Uganda is not fully understood. It does not follow that ending child marriage, and thus reducing early childbearing, would directly decrease the national MMR because women could opt to have children later on when MMRs are higher (World Bank, 2017).

In a qualitative study by Bbale and Guloba (2011), it was found that maternal education, especially at the postsecondary level, is the strongest predictor associated with Ugandan women using childbirth care. While the education of women's partners at all

levels is also important, Bbale and Guloba (2011) observed that maternal education has a noticeably stronger association. As a result, Bbale and Guloba (2011) suggest that future efforts to improve professional maternal care utilization across Uganda need to be directed towards facilitating and encouraging girls' education beyond the secondary level to achieve optimal maternal health outcomes. Bbale and Guloba (2011) recognize that the Ugandan Government's Universal Secondary Education Program, whereby free secondary education is offered in government institutions, is a good start and has scope for future growth.

Intersectionality has influenced discourses surrounding the relationship between female education and maternal mortality in Uganda. It is clear that the better educated a woman is, the more likely she is to receive maternal health services in Uganda (UNICEF, n.d.). Women with higher education tend to have improved personal illness control (Adriano & Monden, 2019) and are 93% more likely to have a skilled attendant present at birth compared to 38% of women with no formal education (UNICEF, n.d.). Throughout the trajectory of MDG 5, there were no efforts made to support women's and girls' education. Given the intersection between education, gender, and health, it would be beneficial for efforts to be made to support their education as Uganda transitions into SDG 3.

CHAPTER 04: METHODS

A qualitative approach was chosen to study maternal health policy within Uganda, in relation to MDG 5 and SDG 3, and to answer the following research questions: a) what lessons can be learned from Uganda's efforts to achieve MDG 5, related to maternal health, from 2000-2015 and b) how will these lessons inform Uganda's transition to SDG 3 from 2016-2030. In an attempt to interpret the complexities surrounding maternal health within Uganda, qualitative research was used to explore stakeholders' views of maternal health policy (Denzin & Lincoln, 2005). In particular, key informants' behaviours, attitudes, and experiences were explored (Green, 2005), with ample consideration shown towards differing contexts (Robson & McCartan, 2016).

While qualitative research is multiparadigmatic in focus, this study fell within the constructivist-interpretive paradigm (Denzin & Lincoln, 2005), which asserts that an objective reality does not exist (Mills et al., 2006). The constructivist-interpretive paradigm maintains that realities are social constructions of the mind, and there are as many such constructions as there are individuals, although several constructions may overlap (Mills et al., 2006). This study adopted a relativist ontology by recognizing that there are multiple realities among Ugandan women (Denzin & Lincoln, 2005). Furthermore, this study featured a subjectivist epistemology whereby the principal investigator and the key informants co-created understandings of Ugandan women's lived experiences using a naturalistic set of methodological procedures (Denzin & Lincoln, 2005). Findings were presented in accordance with the criteria of constructivist grounded theory (CGT), as discussed later in this chapter.

While CGT can be traced the previous work of Strauss (1987) and Strauss and Corbin (1990, 1994, 1998), Kathy Charmaz was the first researcher to describe her work solely as CGT (Mills et al., 2006). Charmaz (2000) maintains that a constructivist approach to grounded theory is achievable and desirable. Furthermore, Charmaz (2000) emphasizes that, "data do not provide a window on reality. Rather, the 'discovered' reality arises from the interactive process and its temporal, cultural, and structural contexts" (pp. 523-524). In comparison to traditional grounded theory, CGT uses the same tools however, it does not share its positivist and objectivist assumptions. Thus, CGT was used as this study's research methodology because it holds great explanatory power and it denies notions of the emergence of objectivity (Mills et al., 2006). CGT also aligns well with this study's ontology and epistemology by repositioning the principal investigator as "the author of a reconstruction of experience and meaning" (Mills et al., 2006, p. 26).

In comparison to CGT, traditional grounded theory requires researchers to embark on their investigations with as few predetermined thoughts as possible, including those depicted in the wider literature, to better focus on the emerging data (Mills et al., 2006). However, it was not possible to do that in this study as the principal investigator needed to conduct a MNR to identify current gaps in the literature to determine the areas of focus for the key informant interviews. A CGT approach was thus favoured as it encourages researchers to delve beneath the surface when seeking meaning in data, and to look for and question tacit meanings about respondents' beliefs, values, and ideologies (Mills et al., 2006).

Upon initial review of this study, the Hamilton Integrated Research Ethics Board (HiREB) deemed it exempt from HiREB review as it is a quality improvement/program evaluation activity. As such, this study did not require ethics review and a waiver was granted by HiREB in October 2019, as per the TCPS (2018) Article 2.5 (see Appendix A).

Sampling and Recruitment

Individual interviews were conducted as they are the most common method by which to collect data in grounded theory studies (Robson & McCartan, 2016). Theoretical sampling, a form of purposive sampling, was utilized in accordance with the criteria for sampling in grounded theory studies (Robson & McCartan, 2016). The principal investigator conducted an initial sampling of key informants between January-March 2020, with the intention of using insights from their experiences, attitudes, opinions, and beliefs to develop a theory to answer the study's research questions (Robson & McCartan, 2016).

Following analysis of information from these key informants, the principal investigator then extended the sample between April-May 2020 to better formulate the emerging theory accordingly (Robson & McCartan, 2016). In total, 7 key informants were interviewed to gather information surrounding maternal health policy within Uganda; information that would later assist the principal investigator in generating conceptual categories and eventually recurring themes (Robson & McCartan, 2016). There were no inclusion or exclusion criteria applied during the selection of key

informants. However, key informants were chosen based on their association with maternal health policy within Uganda.

Potential key informants of interest were shortlisted by the principal investigator based on having applicable publications, and also recommendations from other maternal health professionals through word-of-mouth. Those key informants who could speak about the development and implementation of maternal health policy in relation to MDG 5 and SDG 3 were of particular interest (Denzin & Lincoln, 2005). The principal investigator contacted potential key informants using a generic email template (see Appendix B), and included her contact information and a copy of the study's semi-structured interview question guide.

Those potential key informants who indicated interest were confirmed for participation in the study and scheduled for a 1-hour online interview with the principal investigator. Interviews were conducted through Google Hangouts, Zoom, and Skype, depending on individual preference. Certain confirmed key informants were unable to participate in their scheduled online interviews due to technical difficulties, scheduling conflicts, and/or other personal constraints. In these situations, the affected key informants completed their replies individually in Word Documents and then emailed them to the principal investigator.

Data Collection and Analysis

Following the recommendations of Robson and McCartan (2016), the principal investigator used the following order to conduct the individual interviews: introduction, warm-up questions, main body questions, cool-off questions, and closure. As such, at the

beginning of each online interview, the principal investigator verbally sought each key informant's permission to audio record the entire interview for subsequent analysis to identify recurring themes among responses. The principal investigator then tried to ease into each interview by briefly introducing herself as a MSc student and making casual conversation (Knight, 2013). Subsequently, the principal investigator reiterated the study's purpose, provided a brief summary of the goals of MDG 5 and SDG 3 to refresh the key informants' memories, and asked them if they had any questions prior to commencement of the actual interview questions. Thereafter, the principal investigator followed the study's semi-structured interview question guide (see Appendix C) to conduct each interview.

Given its fairly impersonal nature, a semi-structured questionnaire was utilized to avoid applying unnecessary pressure on the key informants and also ensure that they retain a level of anonymity (Ahmad, 2012). Furthermore, a semi-structured questionnaire was employed so that the key informants could share their insights without restriction, while concurrently allowing the principal investigator to ask follow-up questions in relation to thought-provoking insights that emerged (Ahmad, 2012). Qualitative research necessitates that researchers be open, receptive, reflexive, and deeply committed as they carry out their investigations (Robson & McCartan, 2016). Thus, throughout the individual interviews the principal investigator did not attempt to obtain objective responses from the key informants, in an effort to accept both the existence and the importance of their values, insights, and perspectives (Robson & McCartan, 2016).

The interview question guide consisted of nine open-ended questions as described below in table 1. In particular, the first two questions served to allow the key informants to describe how their work relates to the topic of study, whereas the closing question was meant to ensure that the principal investigator did not miss any aspects of their experiences and viewpoints (e.g. positive, neutral, and negative) surrounding maternal health policy within Uganda (Knight, 2013). The interviews were all conducted completely in English, and lasted between 22 to 56 minutes in duration.

Table 1: Semi-structured interview question guide

1) Can you please tell me a little bit about your work in relation to maternal health care?

2) Can you please tell me about how you see your work connecting with SDG 3?

3) Do you feel that there are any particular challenges women face across Uganda which should be addressed in order to support their maternal health?

4) How does access to maternal health care services vary across Uganda for women? Do the differences in roles of women in the north and west influence their access compared to those women in central Uganda?

5) It's interesting to see how the UN has changed its conceptualization of gender between MDG 5 and SDG 3. Do you notice any related changes in your work related to maternal health? Do you feel that there needs to be more of a shift in gender conceptualizations for Uganda to attain SDG 3?

6) How do you feel about Uganda's current progress towards achieving SDG 3 by 2030?

7) Can you share anything that you learned during the time between MDG 5 and SDG 3 that you feel Uganda needs to bring forward and/or think about to better support women's maternal health?

8) As Uganda transitions into SDG 3, how can it better develop and implement policies to support women's access to maternal health care services? Are there any measures which you feel should be taken to support the attainment of SDG 3 in the region by 2030?

9) Is there anything that I have not asked you, but that you feel is important to consider regarding this area of research? In other words, is there anything that I am missing?

All of the interviews were recorded using Apple's Voice Memos application and simultaneously transcribed using the voice typing tool in Google Docs. Upon completion of each interview, the principal investigator made memos to summarize the data obtained (Robson & McCartan, 2016). The memos roughly outlined what occurred during each interview, including emerging views, main ideas, and intuitions (Robson & McCartan, 2016). Following the completion of each interview, the primary investigator listened to the recording and edited the transcribed draft from Google Docs accordingly. After each interview transcript was ready, data was then coded and analyzed for recurring themes over three stages: initial coding, focused coding, and axial coding as part of the CGT approach (Charmaz, 2006).

In tandem with CGT, thematic coding analysis was used inductively as the codes and themes emerged solely from the principal investigator's interaction with the interview data (Robson & McCartan, 2016). Themes were found in an attempt to "examine the ways in which events, realities, meanings, and experiences are the effects of a range of discourses operating within society" (Robson & McCartan, 2016, p. 467). Thereafter, the principal investigator conducted computer assisted qualitative data analysis (CAQDAS) using NVivo 2012 in May 2020 (Robson & McCartan, 2016). CAQDAS can be used to aid in grounded theory analysis, whereas NVivo can facilitate several aspects of the iterative process associated with grounded theory (Hutchinson, et al., 2010). Furthermore,

NVivo can to help streamline the various coding and sorting tasks associated with thematic analysis, including development of consistent coding schemes (Robson & McCartan, 2016).

During the initial coding stage, the principal investigator closely read each interview transcript and considered what the data was a study of, what the data suggested, and whose point of view was being expressed, and then named each segment of data (Charmaz, 2006). Thereafter, during the focused coding stage, the principal investigator identified the most frequently appearing initial codes and used them to develop the most salient categories among the data in NVivo 12 (Charmaz, 2006). The principal investigator also compared the key informants' experiences, actions and interpretations (Charmaz, 2006). Subsequently, during the axial coding stage, the principal investigator proceeded to link the categories which were created during the initial coding stage with subcategories, to identify the emerging theory (Charmaz, 2006).

CHAPTER 05: FINDINGS

Table 2: Demographic Summary of Key Informants

Gender	• Female (n=4) • Male (n=3)
Ethnicity	• Canadian (n=1) • Australian (n=1) • Ugandan (n=5)
Employment Status	• Currently working (n=6) • Retired (n=1)
Occupation	• Physician (n=2) • Maternal health researcher (n=1) • Professor (n=2) • Human rights lawyer (n=1) • Policy-maker (n=1)
Participated through	• Individual interview (n=4) • Writing answers in a Word Document (n=3)

The following section outlines findings from this study's individual interviews with key informants, and subsequent qualitative data analysis. All quotations taken from the interviews include an interview identifier, ranging from Key Informant 01-07. As per the CGT-specific criteria, findings were written using a literary style as opposed to a

scientific one, to be evocative of the key informants' experiences (Mills et al., 2006). According to CGT, the principal investigator was part of this study's research and so aspects of her personal values have inevitably influenced the reported findings which follow (Mills et al., 2006). A total of four themes were found. The first theme describes how the current narrative surrounding maternal health is deterring external investment in SDG 3 in Uganda, whereas the second theme outlines how the country's fragmented health care system impedes access to maternal health care. Subsequently, the third theme provides insight into empowerment issues that Ugandan women struggle with as they seek to support their maternal health. Finally, the fourth theme summarizes the need for increased collaboration efforts from Uganda's government to improve maternal health outcomes.

Theme 1: Current narrative surrounding maternal health is deterring investment in SDG 3

A major theme that emerged during the individual interviews was that the unsuccessful trajectory of MDG 5 has contributed to further deterioration in the narrative surrounding maternal health in Uganda, and this is discouraging OECD donor states from investing in SDG 3:

> There's a sense that maternal deaths are inevitable. You know, 'they're just what happens in poor countries.' They're not things that you can directly intervene in, and if you choose to make it a priority, you can't turn it around (Key Informant 05).

The bleak narrative surrounding maternal health and limited funding for SDG 3 in Uganda can partly be attributed to OECD countries being discouraged, "because they have seen the failure of MDG 5" (Key Informant 06), and so they do not expect that

"such a monumental shift...towards building health systems" (Key Informant 02) is likely to be achieved in Uganda by 2030. Interestingly, the rather pessimistic standpoint that maternal deaths are seemingly inevitable in Uganda is in stark contrast to how OECD donor states earlier felt at the launch of the MDGs. In fact, there was great anticipation that achieving MDG 5 in the region would have counteracted its maternal mortality crisis and finally eradicate Uganda's longstanding position as one of the world's leading countries for the highest number of maternal deaths. The MDGs were launched with great enthusiasm and OECD donor states prioritized maternal health with the impression that, "there could be this goodwill of providing our funding to this goal... and we can now move onto the next one" (Key Informant 05).

Unfortunately, the general sense of goodwill amongst donor states focusing on maternal health in Uganda soon faded. While MDG 5 was somewhat successful in other countries, its weak progression in Uganda has made OECD donor states question the feasibility of reversing the country's maternal mortality crisis. However, such skepticism is concerning as Uganda greatly depends on external support to achieve SDG 3, and its attempts to achieve related targets are occurring within, "the context of building a financial system to increase its GDP per capita" (Key Informant 02). The key informants generally felt that attaining SDG 3 in Uganda might be unattainable at this point with the current conditions:

> We are setting the threshold, and the bar is very high. And the sense of failure and then the momentum that you lose. You know a lot of these things they're technical, but they also are emotive and normative as well (Key Informant 05).

The notion that the maternal mortality crisis in Uganda cannot be resolved has greatly impeded external funding from donor states for SDG 3. While the key informants stressed that external funding alone cannot resolve Uganda's maternal mortality crisis as there is much more to "building a whole health care system for 40 million people" (Key Informant 02), this decrease is quite concerning as such investments remain a major component of solving this dilemma. In fact, "the biggest concern then is the funding. And that has really come to the fore with the SDGs in a way that the MDGs did not, because they were lacking that specificity" (Key Informant 05).

Key Informant 03 expressed that presently in Uganda, "a huge percentage of funds is from development partners" to support its attainment of SDG 3. While all of the key informants recognized the impact of the current narrative surrounding maternal health in Uganda towards impeding external funding for SDG 3, some felt that it should not be deterring OECD donor states and instead that a change in perspective should emerge. In particular, certain key informants felt that despite the current overarching narrative pertaining to maternal health, that OECD donor states should continue to prioritize it in Uganda and invest in SDG 3 accordingly:

> I think that people should not just think that this is what it is. They have to change their minds and look at improving how we can reduce these mortality rates, whether in Africa or in anywhere else, because everyone is a human being and everyone has a right to life (Key Informant 06).

However, it appears that many OECD states are currently prioritizing other indicators over those related to maternal health in Uganda to maximize the effectiveness and impact of their investments, as well as to increase their position on the global platform:

> You're seeing that OECD donor states are then tending to select indicators or select issues and investing more bilaterally in those things. People want to attach themselves to things that they think are going to have these great narratives, and I worry that this obsession with the indicators might kind of affect that. And I think that we're seeing that with the funding (Key Informant 05).

Theme 2: Uganda's fragmented health care system impedes access to maternal health care

The literature documents that women in Uganda struggle to obtain proper maternal health care, and these challenges were echoed by the key informants who described that women are often overwhelmed by the "issues around a fragmentation of services, and how services relate to one another" (Key Informant 04). Furthermore, in Uganda's health care system there are many areas which are "impacted by gender and power differentials" (Key Informant 02) and women often "don't have the time or the money to navigate complicated health systems" (Key Informant 04). Women who are unable to navigate Uganda's health care system to obtain effective maternal health care amidst its fragmented services often face dire consequences. As Key Informant 06 recollected:

> My sister almost died in the hospital because she was due to deliver… she could not push but at that time there was no doctor at the hospital. And imagine that it was at night. And so, we had to struggle to get her transported to another regional hospital in the night. One regional hospital has one gynecologist, so it's really very difficult to have healthy women and also to reduce the maternal mortality rate. If there are only a few doctors in the hospital, maybe one, and he's not available, a woman who fails to deliver has to die. You have no options because if you're to deliver and need to be transported to another hospital you cannot survive.

As Uganda attempts to transition into SDG 3, the fragmentation of services within its health care system becomes more pronounced as, "with SDG 3 it's an even broader mandate,

much broader than maternal health, which would mean that a struggling health system is forced to look even wider than its previous limit" (Key Informant 04). It appears that Uganda's health care system was not able to deliver the services needed to attain SDG 3 targets related to maternal health. While access to maternal health care appears to be greatest in Uganda's capital city, the majority of Ugandans do not live in Kampala. In particular, "regional differences in access are due to poverty at a household level and infrastructure development. The North and East are poorer compared to the central region" (Key Informant 01). Key Informant 04 agreed with these sentiments, and reflected:

> Whenever we visited health facilities, like up north or north-eastern or western parts of the country, their facilities, the number, the infrastructure within the facilities definitely would vary between the western or the southern parts of the country. But that said, there will be variation between urban and rural. There will be variation definitely by geography, by physical infrastructure, and by human resources too because human resources tend to be distributed through areas that have better infrastructure.

Outside of Kampala, efforts are being directed towards improving Western Uganda's infrastructure and health care services over other areas of the country. Key Informant 06 revealed:

> In Uganda with the current situation...we have had a long-serving president who is coming from the West. In Central Uganda we have our capital, and most of the developments are in the capital, and people can easily access the health care services. But we also have clinics that are operated by people who are not qualified, so women still die. And in the West, the hilliness of the area can affect the women. But of course, the president is trying to develop the west with everything, like the transport system. So, I believe that there is a difference, but the North and the East are the most neglected areas and that's where most of the women are mostly dying. Because people there mostly don't support the current president, so they don't really care much about people in general from those areas. The focus right now is mainly in the west because that's where the president comes from and those people are supporting him to keep him in power. And then of course the Central, because of the capital, where there are so many investments with people trying to invest here and there.

The key informants also indicated that women encounter several issues when interacting with health care workers amidst a widespread fragmentation of services within the health care system. Regarding the agency of health care workers, Key Informant 05 described:

> So, there's a massive focus on the health care attendants now and that's seen as this measure and Uganda does relatively well in that space. But I think we need to probe a bit deeper and understand what power and agency do these health care workers and birth care attendants actually have in these situations? How much can be expected of them?

Continuing along a similar trajectory, another key respondent indicated, "health workers are strained and overworked with minimal pay. They end up not committing 100% of their time" (Key Informant 07). In further agreement, Key Informant 06 conveyed:

> We have the issue of the harassment that the women get from the frustrated health workers who actually are not paid well. They are paid low salaries and actually can go for 4-5 months without pay. So, the health workers are already frustrated and then they are bringing their frustration to these women who are pregnant, who are innocent, and are not the ones that are supposed to pay them. So, it becomes a challenge whereby women get frustrated.

Theme 3: Empowerment issues among women

The circumstances in Ugandan society "often makes it more challenging for women to be independent" (Key Informant 02) and so, "there is a need to socially and economically empower women...to give them more power and decision making at the household level (Key Informant 07). The key informants discussed various issues which impede women's empowerment in Uganda. Key Informant 03 expressed, "the patriarchal nature of the society, and the fact is that men do decide for women as much as they wish, including making decisions on their bodies. Hence, women cannot decide when and how to have babies." Echoing these sentiments, Key Informant 05 shared:

> In terms of Uganda...there are still a lot of very traditional gender stereotypes around women's roles and men's roles, and that plays a very important role in influencing what women can ask for and claim in the area of maternal but also sexual and reproductive care.

Women's limited autonomy over their reproductive health often has serious consequences. As Key Informant 02 indicated, "we often see in the field examples of spousal abuse in the transmission of sexually transmitted infections." Furthermore, it appears that there is great stigma surrounding HIV testing for women. As Key Informant 06 disclosed:

> Where I come from in my region, in my tribe, men are not accepting to go with their wives or partners to the hospital. Because it's one of the requirements now, due to HIV, they want partners to come so they can test them together and also advise them about how they can go about their pregnancies and the challenges that come with it. But men do not want to go to the appointments with their women, and so they're left to do it alone. And in case they are found to be HIV-positive, they're actually stigmatized by the men and the men start blaming them that they are the ones that are bringing the HIV and they don't support them. So, they find that it becomes a challenge for them.

It appears that Ugandan women struggle to meet various cultural demands, which can further obstruct their empowerment and deteriorate their maternal health. In fact, "local customs and cultures play into the different health care services which patients are willing to access...traditional medicine plays a role" (Key Informant 02). Similarly, Key Informant 05 emphasized:

> The language around family planning and the focus on contraceptive needs for married women instantly excludes a number of women who do not or may not meet the traditional threshold for what is a respectable married woman, who may not necessarily want to access family planning but want to access contraceptives for a number of different reasons. There's a lot of social, cultural, and religious demands and expectations around what women's role is and should be. And it's very hard to agitate for those rights, those health care needs, when there are so many additional burdens on top of these women and there's a lot of judgment and stereotypes attached to women.

Ugandan society is governed by certain laws and restrictions that adversely affect women's reproductive health. As Key Informant 03 indicated, "the laws are very restrictive of women's access to reproductive services, for example the penal code act, and this has a huge contribution to maternal health challenges in the country." Furthermore, it appears that amidst the ongoing tensions within Uganda, that women's rights have been sacrificed so as to maintain some level of peace, as Key Informant 05 maintained:

> You may get an end of conflict, you may get an end of fighting, but there are still massive inequalities. And sometimes the political arrangements that have been achieved to create that peace have required the exclusion and the removal of particular voices and particular experiences of particular groups to sort of settle the fighting. You find that certain groups' rights, particularly women's rights, are the thing that gets traded away. It is very much seen as 'if you fight for these things you're going to weaken our chances of peace.'

Despite abortion being illegal and generally condemned in Uganda, many women seek the procedure and often face severe repercussions as a result. The key respondents had contrasting views on abortion. Key Informant 06 expressed, "in Uganda, abortion is illegal. So, most women use local herbs for abortions. Then also they end up with unskilled and unprofessional doctors to do them, and some of them end up dying." Similarly, Key Informant 05 shared:

> The other part that is really important about the maternal death rate, is access to abortion. It's a factor, it's there. Guttmacher has shown pretty definitely that between a third and a half in some countries of maternal rates are because of failed abortions or women trying to deliberately miscarry. So again, if we can't have this conversation about access to abortion, then we are not going to fix the maternal mortality problem.

However, Key Informant 06 countered:

> We have different values as Africans, whereby we believe more in Christianity, whereby abortion is a sin. It's a very big debate and I don't think that it can break through so easily in Africa for abortion to be legalized. I don't think so, that's my view. Our traditional beliefs...we believe that children are inheritance and also that children bring in wealth, like girls. So, if you abort, you are a disgrace to society. Abortion is not encouraged generally, even before we got this Christianity in Uganda.

Unintended pregnancies often "lead to induced abortions which contribute a big proportion of maternal death" (Key Informant 07). However, it appears that women who die due to abortion-related complications are not accounted for in Uganda's MMR. Key Informant 03 shared that, "26% of Uganda's maternal deaths are caused by unsafe abortions, a key issue that the country pays relatively less attention to." However, it is likely that even more women die to due unsafe abortions as such data is not formally collected in Uganda. As Key Informant 06 revealed:

> You don't hear that someone died because of abortion, I have never heard it. It's really not recognized because no one reports it. Now if someone goes to a local unqualified doctor, they even fear to report it because 'why did you go there in the first place?' It's a shame because it's not something that's accepted in the society, so people do not speak out.

Theme 4: Increased collaboration efforts are needed from Uganda's government to improve maternal health outcomes

Uganda's government has not historically prioritized improving its maternal health outcomes despite being faced with a severe crisis. Due to widespread corruption within the government, the limited funding which Uganda's president has allocated for maternal health is often misused as, "even the money that he's allocated, the little money, it ends up in a few hands where it's embezzled or they do fraudulent transactions" (Key

Informant 06). Several OECD donor countries were deterred by the Ugandan government's lack of transparency surrounding how external funding was used to support the attainment of MDG 5 and subsequently, have since decreased their contributions as the country transitions into SDG 3. Consequently, there appears to be an imminent need to "keep a number of different stakeholders involved" (Key Informant 02) with Uganda's progress towards SDG 3. However, whether donor countries decide to increase funding or not appears to be partially contingent upon:

> If there's any funding that is channeled to maternal health, it needs to be about how we are going to hold the government accountable and ensure that those who are taking care of this implementation are accountable for these funds that should be used for improving the health of women (Key Informant 06).

Throughout Uganda's various districts, maternal health is generally poorly understood and women's needs are disregarded due to a lack of representation within the government. The key informants shared that the Ugandan government has long depended on the input of predominantly male district managers when making budget allocation decisions for maternal health supplies and medications. Furthermore, Uganda's budget heavily favours addressing men's health needs over those of women, and in the majority of lower-level maternal health facilities, "one of the biggest challenges is that stock runs out for basic supplies and medicines for maternity care" (Key Informant 04).

The Government of Uganda's blatant negligence towards improving maternal health outcomes has left many women to incur extra costs that most simply cannot afford, which is especially unfortunate as "regional level imbalances, poverty, and education play a critical role in maternal health care" (Key Informant 03). At district-level health facilities, maternal health supplies quickly deplete and it is assumed that the "women will

provide their own supplies from out-of-pocket expenses" (Key Informant 04). The key informants unanimously agreed that Uganda's maternal health crisis is multifaceted, and improving related outcomes requires the undivided attention and cooperation of all ministries within the government. As such, it appears that the Ugandan government needs to increase:

> Intersectoral collaboration between health, local government, finance and the Ministry of Gender itself. At a country level, parliament and women's advocacy groups are very important stakeholders in improving maternal health. There is also a need to work closely with the Bureau of Statistics and universities to collect credible data to evaluate interventions and disseminate the findings to stakeholders (Key Informant 01).

Essentially, Uganda can no longer "rally behind global politics and policies to run" (Key Informant 03). Besides increasing collaboration among its various ministries, the key informants also believed that the Ugandan government should improve collaboration with its development partners to better represent women's voices and improve maternal health outcomes:

> At the international level, it requires collaboration of many key stakeholders. Close collaboration of international agencies is necessary like UNFPA, UNICEF, USAID, SIDA, and the World Bank to harmonize their approach to maternal health (Key Informant 01).

Increased intersectoral collaboration could also help the Ugandan government to streamline communication between itself, the country's legal framework, and lower-level health facilities to improve the national supply of maternal health resources:

> If we say we are going to provide a service at a certain level of the health system then we need to allocate the resources that are needed. And that resource decision is made usually at the national level. It's a balance between the macro-level factors like legislation, regulation, governance (i.e. management and supervision), and how those then relate to the lower-level facilities (Key Informant 04).

During the MDG 5 trajectory, the Ugandan government was not entirely forthcoming with the global community surrounding how external funding was used to improve maternal health outcomes (e.g. program development, delivery, implementation of services, etc.). As such, there is an urgent need for maternal health outcomes to be more closely monitored in Uganda as it attempts to transition into SDG 3. Intersectoral collaboration could facilitate greater transparency surrounding how the Ugandan government uses external funding by enabling it to:

> Set up some kind of mapping and review process around maternal health care and try to keep track of who is funding what and where is it being located. So being able to trace the money right down to delivery, and then being able to trace the degree of expenditure on programs versus service (Key Informant 05).

Despite collectively agreeing that heightened intersectoral collaboration is critical for Uganda to improve its maternal health outcomes, the key informants differed over whether this should be part of national efforts to support attainment of SDG 3, or serve as a basis for more specific countrywide maternal health goal development. Proponents of using intersectoral collaboration to improve maternal health outcomes as part of Uganda's attempt to transition into SDG 3 argued that, "SDG 3 is also about multisector collaboration" (Key Informant 04). These key informants felt that Uganda has thus far performed well during its SDG 3 trajectory, and that increased intersectoral collaboration could further strengthen its efforts, "Uganda is progressing towards SDG 3. Priority interventions with high impact, reaching the most vulnerable populations, need to be scaled up in a sustainable way" (Key Informant 01). Furthermore, these key informants proposed that enhanced intersectoral collaboration would enable a stronger, collective

focus of the various ministries that could increase Uganda's likelihood of achieving SDG 3:

> Looking at how the Ministry of Health, or the health actors relate with gender (e.g. the Ministry of Gender) or how they relate to the Ministry of Education or even between ministries and how they seek to collaborate and work across sectors to be able to achieve the SDGs (Key Informant 04).

Other key informants were skeptical of Uganda using heightened intersectoral collaboration to pursue SDG 3 due to its weak performance thus far and its unsuccessful attempt to achieve MDG 5. Since SDG 3 is much more comprehensive than MDG 5 some key informants expressed that this will likely make it even more challenging to attain as, "Uganda did not achieve MDG 5 and chances are high that SDG 3 indicators will also not be achieved" (Key Informant 03).

Despite Uganda's current attempt to transition towards SDG 3, it continues to struggle to address various challenges that fuel its maternal mortality crisis including gender inequities, extensive poverty, and limited health care resources. While Uganda's MMR has decreased somewhat since MDG 5, it is still among the highest in the world. Thus, it appears that the time has arrived for every woman in Uganda "to be helped to have a baby or safely terminate the pregnancy" (Key Informant 07). Consequently, some key informants felt that instead of focusing on attaining SDG 3, Uganda's government could make better progress towards improving maternal health outcomes by collaborating to, "set priorities it can achieve. Global agendas perhaps could be guiding principles" (Key Informant 03). The key informants expressed that the Ugandan government should examine its maternal mortality crisis holistically and take on a more proactive role to

directly counteract this dire situation, especially since both MDG 5 and SDG 3 do not account for the specific country-level challenges that Uganda currently faces.

Uganda's government could promote collaboration between various ministries and other stakeholders to develop more realistic and manageable goals to improve its maternal health outcomes compared to the SDG 3 targets, which are likely too ambitious for it to achieve within the next decade. Increased intersectoral collaboration could also enable the government to devise a budget that is actually reflective of women's needs to better support their maternal health because currently, "prioritization in the budgeting processes may not reflect the actual needs, women's needs, in terms labour supplies for maternity care" (Key Informant 04).

Uganda is working with constrained health resources, and counteracting its maternal mortality crisis will likely not be a straightforward endeavour because "while the country has made a little progress on reducing its MMR, a lot still needs to be done" (Key Informant 03). Consequently, it might be more sensible for Uganda to develop and implement policies related to attaining more manageable goals, as opposed to SDG 3, which it develops through intersectoral collaboration. However, while working to reverse its maternal mortality crisis, Uganda must recognize that the policy learning process is important because while it may:

> Develop new policy documents that will frame or will bring to the fore the SDG issues, what will be most important is how we go on to implement this. And that has to go with the budgets, that has to go with the infrastructure, and resources in the country to achieve the intended goals of those policies. So, the policy may be developed, but the implementation part should not be forgotten. And that goes with learning, that goes with evaluation and monitoring to ensure that we are learning as we are going, or using the previous learning experiences to inform the

> new policy. So that policy learning process needs to happen as we implement them, it shouldn't actually be forgotten (Key Informant 04).

While heightening collaboration on various fronts to better support maternal health outcomes, it is also important for the Ugandan government to ensure that any related progress made is sustainable:

> There's a need then to really focus on how to make sure that this is sustainable and to recognize that governments have a role in this definitely and how then to support governments in achieving that. And to really actually focus a lot more (Key Informant 05).

The key informants argued that the Ugandan government should now focus on better supporting maternal health outcomes locally to sustain progress in the future. Collaboration should focus on effective policy development, implementation, and monitoring/evaluation. While there was a fair amount of policy development to support maternal health during MDG 5, there was also an extensive lack of consideration for subsequent implementation. While many policies are well-intentioned, they often do not come to fruition as there are limited financial resources to implement them with and even fewer resources to monitor and evaluate them.

CHAPTER 06: DISCUSSION

This study examined maternal health policy within Uganda to identify lessons from the country's attempt to achieve MDG 5, and how these lessons may inform its current transition to SDG 3. Additionally, this study generated a deeper understanding of the impact of maternal health policy and programs on Ugandan women's maternal health care experiences and outcomes. In particular, this study offers an intersectional perspective to current discussions within the wider global health community surrounding the ongoing maternal mortality crisis within Uganda as it identifies how various social determinants of health operate to influence women within the region. In the subsequent section, the findings of this study's four major themes are explored in relation to the wider literature and the lens of intersectionality within the Ugandan context.

Theme 1: Current narrative surrounding maternal health is deterring investment in SDG 3

Uganda's longstanding maternal mortality crisis has greatly affected the lived realities of women within the region, fueling a bleak overarching narrative. Despite maternal death being the most severe maternal outcome, it is increasingly being viewed as inevitable within low-income countries like Uganda. The unsuccessful trajectory of MDG 5 within Uganda has intensified this narrative among OECD donor states as the country attempts to transition into SDG 3. Investments in the SDG pool-fund are not progressing with as much momentum as during the MDG era, and many OECD donor states are bilaterally investing in other issues over maternal health. Considering that most maternal deaths are preventable (UNICEF, 2019), the limited efforts made by OECD donor states

to prioritize maternal health in support of Uganda attaining SDG 3 targets is rather concerning. The OECD's limited funding for maternal health appears to contradict its stance towards supporting the overall attainment of the SDGs as the goals are all interrelated.

Following the MDG era, the OECD recognized that globally sustainable and systemic change cannot be obtained through single-sector goals and approaches (OECD, 2018). Subsequently, the current 2030 SDG agenda breaks down silos, and stresses the interconnectedness and complexity of the various dimensions needed to achieve development (OECD, 2018). The 2030 SDG agenda also challenges the traditional sector-based approach of looking at health as a separate area (OECD, 2018). While it is clear that global development will be hindered if maternal health is not uniformly supported across the world, it is highly unfortunate how the narrative surrounding maternal health within Uganda acts as a deterrent for external funding.

As the OECD works to support overall attainment of the SDGs, it must be cognizant of the fact they were imposed on Uganda, similarly to their predecessor the MDGs. While there are alternative ideas about why this decision was external rather than internal, it does not appear that Uganda was ever treated fairly during this process. The MDGs were the first common framework for fostering global development and were credited for promoting advancement where it was lacking however, no single organization or individual was responsible for actually achieving them (McArthur, 2013).

Subsequently, several private, public, and nonprofit actors worked in developing countries to further the MDGs (McArthur, 2013). However, within the context of Uganda,

the MDG targets were overly ambitious and unfair, which greatly minimized its overall progress (McArthur, 2013). Uganda actually signed the Millennium Declaration in 2001, a year later than most countries (The Republic of Uganda, 2015), and experienced extensive delays from 2000-2005 with receiving external financial assistance from the UN and industrial countries to meet various MDG targets including those related to maternal health (Ndaguba et al., 2016). Moreover, a series of poor and arbitrary choices made during the development of the MDGs made it less likely for various regions in Africa, including Uganda, to achieve related targets (Easterly, 2008).

The implementation of the MDGs across Africa was arguably a form of neo-colonialism that tried to strengthen the West's economic power and its mainstream development discourse across the continent (Durokifa et al., 2018). Throughout its duration, the MDG campaign emphasized sub-Saharan Africa's slow progress and poor performance towards achieving various targets including those for MDG 5 as compared to other regions (Easterly, 2008). The overall design and success measurements of the MDGs led to sub-Saharan Africa's performance being portrayed worse off than is justified compared to other developing regions, resulting in the emergence of blanket statements about Africa's apparent failure (Easterly, 2008). However, many of the fundamental issues that hindered sub-Saharan Africa's progress towards meeting MDG targets, including MDG 5, were not actually Africa-bound (Durokifa et al., 2018).

The presumption that a high number of maternal deaths is ultimately inevitable within Uganda is an example of a blanket statement that emerged following the unsuccessful trajectory of MDG 5 within the region. However, the assumed inevitability

of a high rate of maternal deaths across Uganda is unwarranted because the official agencies monitoring the MDGs were largely unable to present any reliable data on maternal mortality trends across the region (Easterly, 2008). It almost seems that MDG 5 was biased against Uganda from its inception, as the country was classified as failing to meet related targets because its success was measured against deprivation and poverty instead of credible maternal mortality data (Easterly, 2008). Consequently, Uganda's limited success towards MDG 5 was depicted as an overall failure.

The blanket statement that Uganda failed to achieve MDG 5 is not fair to the country nor to sub-Saharan Africa as a whole as it produces a more negative image than is justified (Easterly, 2008). The damaging image of 'Uganda as a failure' amplifies the stereotypical role of the West as being its liberator, which is highly demoralizing to those Ugandan leaders and activists who worked with limited resources and funding to best support MDG 5 attainment (Easterly, 2008). Furthermore, the idea that 'sub-Saharan Africa always fails' is incredibly problematic as it will likely deter future global foreign investment in maternal health (Easterly, 2008), as demonstrated by the current limited OECD funding for SDG 3 within Uganda.

Historical evidence suggests that reducing the MMR within Uganda will be difficult considering the extensive period of time that it has been undergoing a maternal mortality crisis. Uganda also lacked the infrastructure and leadership needed to maximize donor funding compared to other countries who had greater success with MDG 5. Thus, the unsuccessful trajectory of MDG 5 in Uganda should not impede external funding for SDG 3, but alternatively serve as a foundation from which to build upon and better

support maternal health within the region. Compared to MDG 5, SDG 3 is much more specific, and OECD donor states must acknowledge the resources that Uganda needs to achieve such an ambitious objective.

In order for Uganda to achieve SDG 3 targets and resolve its maternal mortality crisis, substantive discussion must occur between the country, OECD donor states, and related institutions surrounding what external investments will be made to support maternal health within the region. Funding for MDG 5 did not reflect Uganda's inclusive voice and specific needs, and this oversight must not reoccur as the country shifts into SDG 3. During 2000-2013, Uganda was the sixth highest recipient in Africa of health financing (AidData, n.d.). External aid has since decreased for SDG 3, which is concerning because one of the major strategies to support the attainment of SDG 3 is domestic resource mobilization (Sunderwall & Forsberg, 2020). Through increasing domestic resource mobilization, low-income countries like Uganda can assemble the necessary resources needed to achieve SDG 3 indicators (Sundewall & Forsberg, 2020).

As Uganda transitions from MDG 5 to SDG 3, several important lessons have emerged. MDG 5 was made at the global level, and later applied to the regional and country level, which made it harder for sub-Saharan Africa to meet targets as compared to other regions in the world (Easterly, 2008). Therefore, as Uganda transitions into SDG 3, this lapse in judgment must not be repeated. OECD donor countries must increase their efforts to prioritize maternal health within Uganda, and understand how its various country-level issues (e.g. post-war conflict, discrimination against marginalized ethnic

groups, and political corruption) and extensive poverty intersect and fuel its maternal mortality crisis.

Another lesson that appeared following MDG 5 is that the world needs to recognize and give proper credit for African achievements, irrespective of whenever and wherever they occur (Easterly, 2008). OECD countries need to interpret Uganda's progress towards MDG 5 for what it is within the context of the country's various hardships that it has endured, well before the MDGs launched. Despite the bleak narrative surrounding maternal health in Uganda, it is unreasonable that OECD donor states withhold funding for SDG 3 because the country was in many ways largely disadvantaged compared to others ahead of and during the MDG era, and within the current SDG era.

Theme 2: Uganda's fragmented health care system impedes access to maternal health care

Uganda's health care system is highly fragmented, and this greatly impedes women's abilities to obtain adequate maternal care. Despite health being a diverse entity, the health care system's overwhelming orientation towards serving the needs of men over women is appalling. While the health care system plays a major role in both the current level of Uganda's MMR and also its potential reversal, the focus on men dismisses women's needs, especially surrounding maternal health, and so greatly contributes to Uganda's maternal mortality crisis. Despite the life-altering implications which emerge during pregnancy, delivery, and postpartum, women in Uganda experience further oppression during these times depending on how different elements of their personal

identities intersect (i.e. geographic location, culture, gender, and class) as they attempt to access maternal health care.

There are several unique ethnic and linguistic groups in Uganda, and this diversity has largely been used by the government to divide and rule the region (UPR, 2011). Women from various ethnic groups tend to disproportionally experience challenges with poor maternal health provision compared to other citizens (UPR, 2011), which is concerning as most Ugandan women are from a marginalized ethnic minority within northern or eastern regions of the country. From a cultural standpoint, maternal health care is not considered compulsory and often conflicts with various traditions among marginalized ethnic groups. These women are generally encouraged to utilize traditional remedies instead of health care.

In terms of maternal health care, women are hesitant to seek it as it is believed that surviving pregnancy and delivery is a measure of their internal strength and integrity as women. Consequently, many women who forego seeking maternal health care end up dying during pregnancy or following childbirth from primarily preventable causes. Those women who do persist and actively seek maternal health care often find this to be an incredibly daunting task, and typically do so alone with little support from their partners and families.

Uganda's health care system in general does not cater to the specific needs of women from marginalized ethnic groups. Women are not viewed as equal to men, and even within health care settings these inequalities persist. Consequently, many women further doubt the necessity of maternal health care when they encounter challenges

navigating the system, and eventually forego seeking it altogether out of frustration. Furthermore, the health care system is not oriented towards serving the specific needs of women from marginalized ethnic groups.

While most doctors are male, hold the utmost power in health care decision-making and are well compensated, they spend limited time with maternity patients which results in many dying alone. Conversely, most health care workers and birth attendants are female, hold very little power in health care decision-making, are severely underpaid, likely have limited training for their role, and spend the most time with maternity patients. The gross imbalance in power due to gender is concerning within the health care system, and it is severely impairing the overall state of maternal health within Uganda. The gender imbalance within Uganda's health care system is further deterring women from seeking maternal health care as they feel that the system does not view their health as important. Pregnancy and childbirth are thus generally seen in society as being personal issues which should be addressed at home instead of a hospital.

Currently, the health care system is not able to cater to most women's needs for various reasons. There is a gross lack of qualified medical practitioners who specialize in maternal health, with the brunt of care delivery falling upon other health care workers. Many women who seek maternal health care do not understand the underpinnings of the health care system's fragmentation, and complain of poor treatment by health care workers. Almost by default, these health care workers are assumed to have similar agency and authority as the scarce physicians however, they do not and frequently find themselves in detrimental situations with bleak maternal health outcomes. It is not

uncommon for women to have to be transferred between facilities during labour due to a lack of supplies and/or reporting physicians.

A large proportion of women, especially those from marginalized ethnic groups, cannot afford various maternal health services, and feel incredibly overwhelmed by the health care system. Women often question the system's ability to actually help them during such a complex and transformative period in their lives. Uganda's health care system is not currently catering to the needs of most women, and instead favoring the select wealthier ones; this makes it appear that women's financial position determines how well they will likely fare during and after childbirth.

Uganda's bleak MMR is not completely surprising given that most Ugandan women hail from marginalized ethnic groups and their needs are greatly neglected by the country's current president, which suggests that political interests have a greater impact on maternal health care access and delivery than women's actual needs. The Ugandan president's longstanding and blatant disregard for maternal health, especially within northern and eastern Uganda, also underscores deep-routed patriarchal norms.

As the president continues to endorse infrastructure development within western and central Uganda, in an attempt to secure additional private investment to build the country's economy, he is destroying any social attempts to bring forth goodwill for women. The president is unable to recognize that Uganda's economy cannot truly prosper if women continue to die at unprecedented numbers during pregnancy and childbirth. Since infrastructure developments are focused on central and Western Uganda, women

from marginalized ethnic groups seem to be most negatively impacted by the disorganized health care system.

Uganda's health care system is under incredible strain, and likely the quest to attain SDG 3 targets related to maternal health by 2030 will only further deteriorate it by exhausting limited resources and decreasing morale among health care workers. In fact, striving to achieve the targets of SDG 3 would undoubtedly cause additional fatigue for midwives and birth attendees as the health care system lacks the infrastructure to meet the country's maternal health needs, and so would likely worsen the national MMR. Thus, greater efforts need to be made by the Ugandan government to equalize maternal health care access throughout the country, irrespective of geographical location. The vast variation in maternal health care availability and access between urban and rural settings needs to be drastically reduced because the needs of most women in Uganda are not being met, and they are greatly suffering. Maternal health care is a multifaceted realm and encompasses various aspects of care which currently are scarcely distributed among the health care system.

Most women in Uganda are poor and their maternal health is being compromised as a result. It is morally wrong to attribute a price to human life as the current president is doing. If women continue to die in large volumes during pregnancy and childbirth, Uganda's future as a nation will be jeopardized. The president needs to adopt a more holistic perspective in trying to build the economy, one that accounts for women's health and needs. Doctors also need to be held accountable for the care they provide, and additional measures are needed to ensure that all hospitals have enough staff and

resources to effectively attend to women. The various systemic issues and forms of oppression cast against women within the health care system also need to be addressed to make it more accommodating and welcoming towards women.

By making the health care system more welcoming to women, it will enable women to have a better future for themselves and their children, although there still needs to be some substantive supports and care. Women should not be forced to go through pregnancy and childbirth alone, nor be subjected to the same atrocities of dying during childbirth as if they were to remain at home. At the current juncture, Uganda's economic progress as a nation will likely stagnate if the president does not focus on developing and improving health care access in north and east Uganda. When a woman dies during childbirth, it has far-reaching repercussions for her family, community, and the country as a whole. Thus, investing in making maternal health care accessible, affordable, and readily available will not just work to reduce Uganda's MMR but also support its future growth as a nation.

Theme 3: Empowerment issues among women

Women in Uganda tend to have limited autonomy over their reproductive health, resulting in many undergoing unwanted pregnancies as a result of the intersection of cultural constraints, sexist laws, gender stereotypes, and religious values amidst a predominantly patriarchal society. Uganda's history with conflict has created considerable inequalities for women, and it appears that their rights are being surrendered in favour of maintaining some semblance of peace. However, by silencing women's voices to quell fighting and political upheaval, their inner desires become suppressed and

ultimately this further oppresses them. As such, the government's attempts to maintain peace by stifling women's voices seems counterintuitive and actually further inflicts injustice and violence against them. Arguably, the government's disregard for women's voices also sends a dangerous message to society that women can be exploited sexually, and that they do not deserve to exercise their autonomy over their reproductive health decisions.

Currently, Uganda spends most of its GDP on its army and defense, and only 7-8% on health, of which maternal health comprises a tiny proportion (Munabi-Babigumira et al., 2019). The government's attribution of women's empowerment and support for their maternal health as threats to national peace levels seems farfetched. In actuality, national defense and maternal health care can coexist and work in tandem to more effectively relieve political upheaval within Uganda. Thus, in order for Uganda to truly achieve peace, women's rights need to be protected and upheld by enabling universal access to reproductive health services and counteracting the national maternal mortality crisis. Moreover, empowering women is vital in order to achieve impactful and sustainable development as Uganda works to decrease its MMR and develop targets to foster better maternal health outcomes across the country.

Culturally speaking, family planning is not encouraged within Uganda, and those who opt to use contraceptives or undergo abortions are deemed to be dishonorable women. The strong notions which prevail surrounding men's roles versus women's roles perpetuate gender stereotypes that imply women are incapable of making sound decisions, including those related to their reproductive health. Gender stereotypes enable

spousal abuse against women, which can lead to harmful repercussions including heightened risk of HIV transmission and accompanying stigma. While abortion is illegal in Uganda and strongly condemned among its devout Christian population, many women secretly undergo botched procedures and experience devastating side effects thereafter. Furthermore, as dire as Uganda's MMR is, the recorded rates do not reflect all of the women who die due to abortion as no reporting data is collected on its incidence within the population. Thus, in Uganda the maternal mortality crisis is likely more serious than what is currently perceived/realized.

Efforts to reverse this maternal mortality crisis in Uganda cannot achieve their maximum potential without accounting for the missing deaths related to abortion in the national MMR. In Uganda, strong religious values influence the law, and it is unlikely that abortion will be legalized anytime in the near future. Given the highly negative connotation that abortion carries within Uganda, survivors of the procedure also struggle with feelings of worthlessness, inferiority, and guilt. However, women should not be shamed for taking control over their reproductive health and instead be shown compassion and empathy. Many women in Uganda who undergo abortions face prolonged poverty, have an existing family to feed, and are unable to express their reproductive wishes to their partners. A considerable number of women also resort to abortion after experiencing sexual abuse and/or rape. Indeed, women are often left to deal with the consequences of unwanted pregnancies alone with limited education, resources, and support.

Women struggle to express themselves and society seems to dismiss the importance of them being proactive about their reproductive health. Unfortunately, women's disempowerment also transcends into the political realm within Uganda as well, with widespread underrepresentation of their reproductive and other rights in most current policies and practices. When considering the empowerment issues which women encounter in Uganda surrounding their maternal health, the government must be cognizant of the fact that not all women experience these issues to the same extent. While the empowerment issues which women face have long been classified as solely their issue and not a collective problem, reversing Uganda's high MMR urgently demands united action.

Uganda is one of the world's leading countries for the highest number of maternal deaths. MDG 5 was not very effective at decreasing Uganda's MMR, and SDG 3 is also showing limited progress so far. Both of these goals require the Ugandan, predominantly male government to oversee, execute, and adapt as necessary to achieve them. Yet, neither one of these goals truly reflects the voices of women despite having targets related to improving maternal health.

It seems that if Uganda is going to truly reduce its MMR, in a realistic and sustainable way, it needs to work to empower women and support their autonomy. It is imperative that more conversations occur at the governmental level about educating women on their reproductive health and providing them with contraceptive options. Women and men also need to be educated accordingly in order to counteract prevailing

gender norms. Furthermore, the government must work to develop more holistic policies, laws, and practices that reflect women's needs and thereby improve gender equality.

Women must be encouraged to make individual decisions about their reproductive health. While it is important to respect religious beliefs among Ugandans, the religious doctrine around abortion clearly does not deter women from seeking it, and the government must recognize the need to legalize choice and better support women. The general consensus that abortion is a sin is causing many women to die after undergoing illegal procedures, in secret, and alone. Ultimately, choice in birth control, including option for abortion, could all work to decrease the level of unwanted pregnancies among women, better protect them from contracting sexually transmitted diseases and HIV, and reduce the country's MMR. Moreover, the government must consider the consequences for families when mothers die young, as children within the household are at higher risk of death, malnutrition, and stunting; all of which have long-term negative impacts on national economies.

Theme 4: Increased collaboration efforts are needed from Uganda's government to improve maternal health outcomes

Upon its inception, MDG 5 set unrealistic targets for Uganda to achieve amidst its ongoing national maternal mortality crisis, with weak infrastructure, poor governance, and political turmoil. Unsurprisingly, the state of maternal health outcomes within Uganda were further disadvantaged at the end of MDG 5 due to an extensive lack of ownership, evaluation and implementation issues, failure to retain goal-specific targets at different levels, and limited emphasis on sustainable development throughout the goal's

trajectory (Durokifa et al., 2018). The targets of MDG 5 and SDG 3 were both imposed on Uganda by OECD countries, with Uganda being essentially forced to comply. However, when Uganda did not perform as expected for MDG 5, the OECD countries decreased funding for SDG 3.

As Uganda transitions into SDG 3, the state still greatly depends on external economic assistance to improve its maternal health outcomes (Durokifa et al., 2018) while trying to solve many of the same country-level challenges that it previously encountered prior to and during MDG 5. While the MDGs were developed to improve the quality of life in the world's developing countries, they did not reflect their inclusive voice (Durokifa et al., 2018). The MDGs were especially unfair to African countries as the basis of their measurement made it nearly impossible for such countries to make progress (Durokifa et al., 2018). In particular, MDG 5 did not establish holistic policies that could have helped Uganda's government to address local underlying causes of maternal death (Durokifa et al., 2018).

The parallels between MDG 5 and SDG 3 are highly concerning within the context of Ugandan society, as it appears that the country is still being bound to the executive decisions of the UN and accompanying influence of Western economic power, which unfortunately does not appear to be in its best interests. Uganda's financial dependence on OECD donor countries to improve its maternal health outcomes has come at a high cost with its collective voice being misunderstood and inadequately represented.

SDG 3 emerged on a global platform with little consideration for the African context and employed a top-down approach, in a similar manner to MDG 5 (Durokifa et

al., 2018). Moreover, SDG 3 is highly specific and achieving its lofty targets in Uganda would require an extensive amount of resources which the country presently does not possess. Considering that Uganda was unable to achieve MDG 5, OECD funding for maternal health within the country has since decreased, and that it still greatly lacks the necessary resources to improve its maternal health outcomes, achieving SDG 3 within the next decade seems bleak at the present juncture. In fact, aspiring to meet SDG 3 would likely decrease momentum over time within Uganda and further fuel the sense of failure that the country has been struggling with following the unsuccessful trajectory of MDG 5.

The prospect of Uganda achieving SDG 3 targets related to maternal health may be an unrealistic expectation for the country considering the severity and duration of its maternal mortality crisis. Indeed, for Uganda to go from having one of the world's leading MMRs amidst a national crisis to achieving universal health coverage and a drastically reduced MMR within the next decade seems unlikely. Amidst widespread Western influence, Uganda has greatly relied on external directives and OECD funding to improve its maternal health outcomes nationally, but the directives and goal are largely not reflective of its context-specific challenges.

It appears that reversing Uganda's maternal mortality crisis goes beyond striving to attain externally determined targets. As Uganda strives to improve its maternal health outcomes, the government might use the emphasis on multisector collaboration in SDG 3 as a guiding principle to develop more realistic and manageable goals for the country. Goals that would make better use of the resources it has, and has received externally, instead of focusing on the difficult to attain targets outlined in SDG 3.

The Ugandan government should increase collaboration at the country-level between its various ministries and local stakeholders to bring forth improved maternal health outcomes which are also sustainable. Setting more realistic goals surrounding maternal health, that are attainable can work to build morale within the country, strengthen its position within the global community, and thereby decrease dependency on OECD donor funding. As such, it is pivotal that Uganda's government take on a more proactive role to understand and represent women's interests, in its attempt to decrease the country's staggering MMR.

Uganda's maternal mortality crisis is a multifaceted issue which demands a united effort and collective stance from its various government ministries. While the Ugandan government has highly prioritized disarmament and demobilization in the past, it must now recognize the importance of improving maternal health outcomes and strive to invest the political momentum, policy implementation, and resources necessary to reverse its maternal mortality crisis.

Indeed, the time has come for the Ugandan government to refocus and collaborate locally to develop more realistic maternal health goals that will yield gradual and sustainable progress in an otherwise dwindling situation. Given the ongoing limited representation of women in senior government positions, engaging with other resident stakeholders including local advocacy groups, women's rights groups, and civil societies could provide a more nuanced understanding of the lived realities women face when seeking support for their maternal health. Increased collaboration could also enable the Ugandan government to work against social issues which have adversely affected

maternal health outcomes (e.g. conflict, corruption, mismanagement of external and government funding, poor maternal mortality data, and weak policy implementation, monitoring, and evaluation).

Uganda needs to take better control over its maternal outcomes by collaborating with its ministries and other stakeholders to develop practical goals to improve maternal health outcomes. Fixing maternal health outcomes within Uganda is best left to Ugandans, the people who live and experience the intersection of various challenges in trying to support maternal health for Ugandan women. Furthermore, Ugandan women wish to improve their maternal health outcomes but their needs have thus far gone unnoticed by the government. The Ugandan government has not previously made a concerted attempt to use multisector collaboration to truly understand women's plight and how their maternal health suffers, nor how to resolve these issues accordingly.

While multisector collaboration seems very promising in supporting maternal health, it will likely not be easy to counteract deep-rooted attitudes and mindsets that tend to prevail within Ugandan society. Many women are perceived as weak if they seek maternal health care, and officials generally regard it as a frivolous expenditure. However, it is anticipated that increased multisector collaboration will enable the government to realize how poor maternal health disadvantages not just women but men as well, their children, and undoubtedly society as a whole. Uganda cannot progress as a collective if women continue to die during pregnancy, childbirth, or in the postpartum period in such unprecedented numbers. It is truly to the government's benefit to prioritize

maternal health, collaborate to determine how best to achieve that and fund it by using existing OECD funding and other resources, and work to address women's needs.

CHAPTER 07: CONCLUSION

From an intersectoral perspective, Ugandan women's lived realities are an amalgamation of several factors which they encounter daily, to varying extents, including extensive poverty, gender inequities, geographic location, cultural stigma, class differences, socioeconomic status and limited health care resources. Given the various oppressions which Ugandan women face, their nation's maternal mortality crisis is not entirely surprising, and indeed an unfortunate consequence of their needs historically not being recognized nor prioritized. The belief that maternal death is largely inevitable within Uganda is controversial, and works to further oppress women by insinuating that their lives are less valuable compared to their global counterparts. This dangerous and unethical rhetoric must cease, not just to support the attainment of improved maternal health outcomes within Uganda, but also to bring forth greater equality for women overall.

Attributing Uganda's unprecedented maternal mortality crisis to being an unescapable reality for women is highly alarming and works to further disadvantage women within the country by amplifying an already bleak narrative surrounding maternal health outcomes amidst an extensive fragmentation of health care services. The current narrative surrounding maternal health in Uganda needs to be reversed. Women from marginalized ethnic groups comprise a significant proportion of Uganda's population but their voices are largely unheard and their sentiments are disregarded. These women need to be involved in decision-making processes surrounding maternal health, to support improved maternal health outcomes and rectify the considerable power imbalance within

Ugandan society. Equitable engagement of women as key stakeholders in decision-making processes would also improve understanding, satisfaction, and compliance with priority setting for maternal health in Uganda (Wallace & Kapiriri, 2019).

It appears that Uganda is repeating most of the same approaches and strategies employed during MDG 5 as it transitions into SDG 3. In particular, the government is still largely focused on promoting economic growth, particularly within the country's central and western regions, at the expense of lowering its focus on social welfare programs, including those related to the SDGs. However, there is growing awareness that both MDG 5 and SDG 3 were imposed on Uganda, and that neither goal was developed with consideration of women's voices nor reflected Uganda's national development priorities. While it does not seem likely that Uganda will attain the targets of SDG 3 at the current stage within the 2030 agenda, reducing its MMR will ultimately require a holistic approach to counteract the daily oppressions which women experience.

Given the unsuccessful trajectory of MDG 5 in Uganda, focusing on achieving SDG 3 to improve maternal health outcomes is likely to result in a loss of momentum and dejection for the country as progress on this agenda appears even more difficult to attain. Alternatively, it seems that the time has arrived for Ugandans to have the opportunity to express themselves and develop targets based on their most imminent maternal health needs. Thus, the country should assume a more proactive role in reversing its maternal mortality crisis by engaging in multisector collaboration to develop more realistic and maintainable goals to improve maternal health outcomes. The OECD donor countries should continue to extend financial support and help Uganda throughout this process to

encourage development of goals that truly reflect the needs of women. The basis for MDG 5 and SDG 3 indicate that these countries do not understand the specific challenges that Ugandan women endure, nor the logistical and other issues that the government encounters. Thus, such widespread oblivion is positioning Uganda for further disappointment. Alternatively, slow and gradual progress towards reversing Uganda's MMR should be encouraged, and it would also help to strengthen the country's standing within the global community.

Uganda's maternal mortality crisis needs to be viewed as a collective issue, and not just the concern of affected women. Otherwise this problem will persist and more innocent women will die during pregnancy and/or childbirth. Peace can only be realized within Uganda if women's rights are upheld and they are able to exercise autonomy over their reproductive health irrespective of cultural expectations and male judgment. Furthermore, the Ugandan government must limit the power of religion over legislation and policies to support women's needs and reproductive rights.

Study Strengths, Limitations, and Recommendations

This study analyzed Ugandan women's lived realities from an intersectional perspective to better understand the basis for Uganda's maternal mortality crisis, lessons which emerged from its limited progress during MDG 5, and how these lessons are impacting its current performance to achieve SDG 3. An intersectional lens has not previously been applied in this regard. Applying an intersectional lens enabled this study to demonstrate how a history of oppression, colonization, and human rights abuses within Uganda combines with aspects of women's identities which weaken/worsen their

maternal health outcomes. Although this study only consulted seven key informants, and may not reflect the true extent of oppression which Ugandan women encounter, this work provides a glimpse into the situation surrounding Uganda's bleak MMR. Furthermore, while this study recommends that the Ugandan government engage in more multisector collaboration to develop realistic and sustainable goals towards improving maternal health outcomes, further analysis is needed to determine how this can best be accomplished in order to conserve the country's limited resources and also not further oppress women in the process.

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APPENDICES

Appendix A: HiREB Waiver

HiREB

Hamilton Integrated Research Ethics Board

Date: Oct-11-2019

Project Number: 8019

Project Title: Transitioning to Sustainable Development Goal 3: An intersectional approach examining maternal health policy in Uganda

Principal Investigator: Dr. Christy Gombay

Upon initial review of the above project, we have deemed this project exempt from HiREB review based on the following:

Your project involves program evaluation of a health program for Uganda, with the intent to review its potential effects and ramifications for the revised program now being implemented in that country. Being quality improvement/program evaluation activity, you do not require ethics review and a waiver is thus granted, as per the TCPS2 (2018) Article 2.5.

Your study is being returned and the file closed out with the HiREB. If you wish to discuss this further please contact the HiREB office.

Sincerely,

Dr. Kristina Trim, RSW, PhD
Chair, HiREB Student Research Committee

The Hamilton Integrated Research Ethics Board (HiREB) represents the institutions of Hamilton Health Sciences, St. Joseph's Healthcare Hamilton, Research St. Joseph's-Hamilton and the Faculty of Health Sciences at McMaster University and operates in compliance with and is constituted in accordance with the requirements of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans; The International Conference on Harmonization of Good Clinical Practices; Part C Division 5 of the Food and Drug Regulations of Health Canada, and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations; for studies conducted at St. Joseph's Healthcare Hamilton, HiREB complies with the Health Ethics Guide of the Catholic Alliance of Canada

Page 1 of 1

Appendix B: Recruitment Email Template for Key Informants

To: Key Informant's Email Address
From: Amanda Latchman <latchmaa@mcmaster.ca>
Subject: Request for Study Participation

Dear _____,

I am writing to you as a MSc Global Health student at McMaster University where I am currently completing my thesis pertaining to maternal health policy in Uganda. Drawing on intersectional theory, I am trying to discover what lessons can be learned from Uganda's efforts to achieve Millennium Development Goal (MDG) 5, related to maternal health, from 2000-2015. I am also trying to determine how these lessons will inform Uganda's transition to Sustainable Development Goal (SDG) 3 from 2016-2030.

Given your work within this area of research, I would appreciate the opportunity to speak with you in a one hour online interview during January 2020. As a key informant, I am interested in hearing your perspectives on both the trajectory of MDG 5 and the feasibility of SDG 3 in Uganda to gain further insight into this area of research. Please kindly review the attached letter of information/consent and let me know if you would like to participate in an interview with me. Please do not hesitate to let me know if you have any questions by contacting me through email or phone.

Thank you for your consideration.

Sincerely,

Amanda Latchman
(e) latchmaa@mcmaster.ca
(p) xxx-xxx-xxxx

Appendix C: Semi-structured Interview Guide for Key Informants

Study's Purpose:

This qualitative study investigates what lessons can be learned from Uganda's efforts to achieve Millennium Development Goal (MDG) 5, related to maternal health, from 2000-2015. This study also seeks to determine how these lessons will inform Uganda's transition to Sustainable Development Goal (SDG) 3 from 2016-2030.

Background on MDG 5 and SDG 3

MDG 5 tried to a) reduce the maternal mortality ratio (MMR) by 75% and b) provide universal access to reproductive health across all developing countries by 2015. These targets were largely not attained in most developing countries, and have now moved under the targets of SDG 3. By 2030, SDG 3 aims to improve overall wellbeing and has various targets, some of which are related to maternal health including a) a reduction in the global MMR, and
b) ensuring universal access to sexual and reproductive health services.

Interview Questions:

1) Can you please tell me a little bit about your work in relation to maternal health care?
2) Can you please tell me about how you see your work connecting with SDG 3?
3) Do you feel that there are any particular challenges women face across Uganda which should be addressed in order to support their maternal health?
4) How does access to maternal health care services vary across Uganda for women? Do the differences in roles of women in the north and west influence their access compared to those women in central Uganda?
5) It's interesting to see how the UN has changed its conceptualization of gender between MDG 5 and SDG 3. Do you notice any related changes in your work related to maternal health? Do you feel that there needs to be more of a shift in gender conceptualizations for Uganda to attain SDG 3?
6) How do you feel about Uganda's current progress towards achieving SDG 3 by 2030?
7) Can you share anything that you learned during the time between MDG 5 and SDG 3 that you feel Uganda needs to bring forward and/or think about to better support women's maternal health?
8) As Uganda transitions into SDG 3, how can it better develop and implement policies to support women's access to maternal health care services? Are there any measures which you feel should be taken to support the attainment of SDG 3 in the region by 2030?
9) Is there anything that I have not asked you, but you feel is important to consider regarding this area of research? In other words, is there anything that I am missing?