“FOR US, WE ARE LIKE FORGOTTEN PEOPLE!”

ASSESSMENT OF HEALTH SERVICES IN AMUDAT DISTRICT

JULY 2018
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Table of Contents

FOREWORD ................................................................................................................................. v

ACKNOWLEDGEMENTS ......................................................................................................... vii

LIST OF TABLES ....................................................................................................................... x

LIST OF FIGURES .................................................................................................................... x

EXECUTIVE SUMMARY ....................................................................................................... xi

CHAPTER ONE ......................................................................................................................... 2
1.0 INTRODUCTION ............................................................................................................. 4
  1.1 Contextual Background of Amudat District, Karamoja Sub-region................................. 4
  1.2 The District Public Health Sector Performance............................................................ 6
  1.3 Background: Health Systems in Uganda..................................................................... 9

CHAPTER TWO ....................................................................................................................... 12
2.0 THE LEGAL AND POLICY FRAMEWORK ...................................................................... 14
  2.1 International Obligations............................................................................................. 14
  2.2 Domestic Laws and Policies Enshrining the Right to Health......................................... 19

CHAPTER THREE .................................................................................................................. 22
3.0 STUDY METHODOLOGY .............................................................................................. 24
  3.1 Objective of the study................................................................................................... 24
  3.2 Scope of the study........................................................................................................ 24
  3.3 Criteria of Evaluation.................................................................................................. 25
  3.4 Methodology............................................................................................................... 26
    3.4.1 Focus Group Discussion.................................................................................... 26
    3.4.2 Structured questionnaire interviewing......................................................... 27
    3.4.3 Key informant interviews............................................................................. 27
    3.4.4 Observation..................................................................................................... 28
    3.4.5 Literature Review....................................................................................... 28
CHAPTER FOUR..........................................................................................................................30
4.0 FINDINGS: THE RIGHT TO HEALTH IN AMUDAT.........................................................32
4.1 Availability..........................................................................................................................32
  4.1.1 Limited availability of Health facilities.................................................................32
  4.1.2 Limited Human Resource For Health.................................................................34
4.2 Accessibility.......................................................................................................................38
  4.2.1 Limited Physical Accessibility.............................................................................38
  4.2.2 Limited Economic Accessibility........................................................................42
  4.2.3 Limited Access to Emergency Healthcare services..........................................43
4.3 Quality.................................................................................................................................45
  4.3.1 Lack of Medical Equipment...............................................................................45
  4.3.2 Perennial Stock Outs of Drugs and Supplies......................................................46
  4.3.4 Facilities lack access to clean and safe water.....................................................48
  4.3.6 Lack of electricity.................................................................................................48
4.4 Acceptability......................................................................................................................49
  4.4.1 Unresponsive Sexual and Reproductive Health Services.................................49
  4.4.2 Culture and Normadic Nature of the Community Requires Specific
     Interventions.............................................................................................................51
4.5 Unregulated Private Actors.............................................................................................51
4.6 Non Discrimination..........................................................................................................53
  4.6.1 Persons with Disabilities....................................................................................53
  4.6.2 Older Persons......................................................................................................54
  4.6.3 Women..................................................................................................................55
4.7 Unresponsive Financing for Health.................................................................................55
4.8 Limited Community Participation..................................................................................59
4.9 Access to Underlying Determinants of the Right to Health........................................60
  4.9.1 Limited Access to Clean and Safe Water............................................................60
  4.9.2 Lack of sanitation and hygiene facilities............................................................63

CHAPTER FIVE..........................................................................................................................65
5.0 CONCLUSION....................................................................................................................66
5.1 Recommendations............................................................................................................66
  A. Recommendations to the Central Government.......................................................66
  B. Recommendations to local government and local leaders.....................................73
  C. Recommendations to Parliament............................................................................74
  D. Recommendations to Civil Society.........................................................................76
  E. Recommendations to Community.............................................................................76

REFERENCES.........................................................................................................................78
FOREWORD

Are you from Kampala? You have been to this Bushy Place. As you can see, this is not like Kampala. For us we are like forgotten people. I think you have seen with your naked eyes. We lack everything. This so called HIV, we don’t know where it comes from yet many people die of it. The real thing is you have seen. I want you to say what you have seen. You have seen that there are few health facilities here. You saw the distance as you drove here. We walk that distance trying to get to health facilities. There is no hospital. Our mothers, our children are delivering in bushes. If you are sick here, you just die. Now you tell those people there what you have seen. Take this message for us-- to those in Kampala!

- Resident, Amudat District.

In 2015, Uganda embraced the 2030 Agenda, committing to the Sustainable Development Goals (SDGs), and the mantra Leaving No One Behind. The country has subsequently aligned its policy frameworks including the National Health Policy and National Health Sector Development Plan II 2015/16-19/20 to Sustainable Development Goal (SDG) 3 calling for Universal Health Coverage among other targets. It has embarked on designing a National Health Insurance Scheme in a bid to ensure equitable access to healthcare. The Annual Health Sector Performance Report 2016/17 revealed 100% of the population lives within 5km of a health facility, exceeding the 85% target set by the Health Sector Development Plan.

This report, is part of a series of reports, which assess Uganda’s progress in ensuring no one is left behind as the country strives to achieve SGD 3 and the right to health. Focusing on Amudat, a district in Karamoja, in the north eastern region of Uganda, this report finds that despite the legal and policy instruments put in place to avail the right to health, these policies have failed to translate substantive change on the ground.
As this report shows, for people in Amudat, obtaining healthcare remains elusive. Consistently ranked the worst performing district in health, the systematic failure to adequately invest in health for marginalized areas disproportionately affects vulnerable groups. Women who have no alternative but to foot for two days to the nearest health facility at the risk of getting raped at night. Women who give birth along the way, often burying the child they have lost because they could not get to a facility in time to get the necessary care. People held hostage in health facilities because they lack the money to pay for the treatment they urgently need.

Assessing whether we are on course to achieve universal health coverage requires us to track how the poorest and most marginalized are faring and to undertake proactive actions to ensure that those at risk of being left behind are included from the start. Beyond rhetoric, combatting the structural causes of marginalization will require investing resources and placing marginalized groups’ progress at the top of the list. This report makes targeted recommendations to policy makers and other stakeholders on how to ameliorate these gaps and achieve equity in health.

Salima Namusobya
Executive Director
ACKNOWLEDGEMENTS

The development of this report would not have been possible without the help of an incredible number of people.

The right to health program at the Initiative for Social and Economic Rights (ISER) including Allana Kembabazi, Nona Tamale, Ahmed Zakaria, Adane Matebi, Nabasirye Margret and Nassozi Rehema Ssozi with the support of AIDI conducted the research. Salima Namusobya, Angella Nabwowe were instrumental in providing feedback and support along the way.

Finally, a wide range of stakeholders were interviewed for this report. Special thanks to the leaders and community members who shared their personal experiences, insights, data—providing the necessary context to assess the state of the healthcare in the district.
## ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>CAUUM</td>
<td>Doctors with Africa</td>
</tr>
<tr>
<td>CESC</td>
<td>Committee on Economic, Social and Cultural Rights</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All forms of Discrimination against Women</td>
</tr>
<tr>
<td>CIDI</td>
<td>Community Integrated Development Initiative</td>
</tr>
<tr>
<td>CRC</td>
<td>Convention on the Rights of a Child</td>
</tr>
<tr>
<td>CRPD</td>
<td>Convention on the Rights of Persons with Disabilities</td>
</tr>
<tr>
<td>DHO</td>
<td>District Health Officer</td>
</tr>
<tr>
<td>DLT</td>
<td>District League Table</td>
</tr>
<tr>
<td>EMHS</td>
<td>Essential Drugs and Health Supplies</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>GH</td>
<td>General Hospital</td>
</tr>
<tr>
<td>HC</td>
<td>Health Centre</td>
</tr>
<tr>
<td>HC II</td>
<td>Health Centre Level Two</td>
</tr>
<tr>
<td>HC III</td>
<td>Health Centre Level Three</td>
</tr>
<tr>
<td>HC IV</td>
<td>Health Centre Level Four</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HSDP</td>
<td>Health Sector Development Plan</td>
</tr>
<tr>
<td>HUMC</td>
<td>Health Unit Management Committee</td>
</tr>
<tr>
<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
</tr>
<tr>
<td>JMS</td>
<td>Joint Medical Stores</td>
</tr>
<tr>
<td>LC</td>
<td>Local Council</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Rate</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NDP</td>
<td>National Development Plan</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organization</td>
</tr>
<tr>
<td>NMS</td>
<td>National Medical Stores</td>
</tr>
<tr>
<td>OPD</td>
<td>Outpatient Department</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PNFP</td>
<td>Private Not for Profit</td>
</tr>
<tr>
<td>PPP</td>
<td>Public Private Partnership</td>
</tr>
<tr>
<td>PWDs</td>
<td>Persons with Disabilities</td>
</tr>
</tbody>
</table>
SDGs  Sustainable Development Goals
TBA    Traditional Birth Attendants
UDHR  Universal Declaration of Human Rights
UNEPI United Nations Expanded Program for Immunization
UNICEF United Nations Children’s Fund
VHT   Village Health Team
WFP   World Food Program
WHO   World Health Organization
LIST OF TABLES

Table 1: DLT score results of Amudat district in comparison to the national average.

Table 2: Comparison of DLT Performance of Amudat with other Districts in Karamoja Sub-Region.

Table 3: A table showing sub counties, villages and health centres visited.

Table 4: A table showing level of staffing for health in Amudat District.

LIST OF FIGURES

Figure 1: Distribution of population by Sub County; Amudat District, 2014.

Figure 2: Focus Group Discussion with women on healthcare in Nagulet village, Amudat.

Figure 3: Parents waiting in a queue for immunization services at Amudat Hospital.

Figure 4: Percentage Distribution of Households 5 Km and Over to the nearest Public Health Facility; Amudat District

Figure 5: The carrier of the motor cycle ambulance in Achorichor HCII in Looro Sub County.

Figure 6: Residents fetching water.

Figure 7: Percentage Distribution of Households without access to Safe Water; Amudat District.
EXECUTIVE SUMMARY

The adoption of the International Covenant on Economic, Social and Cultural Rights (ICESCR) by the United Nations General Assembly in December 1966 was the first formal international recognition of the right to health; with Article 12 compelling signatory states to “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” and to ensure “conditions which would assure to all medical service and medical attention in the event of sickness.” In the current context, target 3.8 of Goal 3 of the Sustainable Development Goals (SDG) in Agenda 2030 clearly articulates that all countries should provide Universal Health Care (UHC), by ensuring “access to quality health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.” Uganda’s National Health Policy II and Health Sector Development Plan 2015/16 – 2019/20 is in sync with SDG 3, by focusing on accelerating the movement towards UHC.

These policy frameworks require the government to provide health services for all. To investigate access to health for Uganda’s hard to reach areas, the Initiative for Social and Economic Rights (ISER) conducted a fact-finding mission in Amudat in November 2017. Amudat district, situated in Karamoja region is consistently ranked as the worst performing district in

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2 Ibid at Article 12.2.
4 Ministry of Health (2015), Health Sector Development Plan 2015/16-2019/20, available at http://health.go.ug/content/health-sector-development-plan-201516-201920 (last accessed July 5, 2018). The Executive Summary and para 3.1.1 states: “The goal of this Plan is to accelerate movement towards Universal Health Coverage (UHC) with essential health and related services needed for promotion of a healthy and productive life. UHC makes it possible to ensure that all people receive essential and good quality health services they need without suffering financial hardship.”
the District League Table score; a measure of performance for healthcare delivery of districts in Uganda. Through key informant interviews and focus group discussions, ISER collected information from a range of stakeholders, including local leaders; health care personnel, including members of local Village Health Teams (VHTs) operating across Amudat; health unit management committees; and community members.

The findings were evaluated based on a human rights approach; by employing the criteria stipulated in the United Nation’s General Comment No. 14 to the ICESCR: availability, accessibility, acceptability, quality and in light of the State’s obligation to respect, protect and fulfill the right to health.

ISER found the State has consistently failed to meet its obligation of providing hard to reach areas with health services. Insufficient attention has been given to hard to reach areas such as Amudat District and Karamoja region as a whole; despite unique challenges including severe poverty, poor road networks, poor healthcare infrastructure and the nomadic nature of the community. ISER found the following significant gaps:

- **Limited accessibility of health services in Amudat.** There are few health centers in Amudat with some areas lacking health centres completely, falling short of the policy requirement to have a health facility within a 5 km radius. There were several testimonies of people having to walk for over 24 hours in order to access health care.

- **Limited availability of health services.** Despite the government’s policy requirement to have a public hospital per district and a HCIV health center for populations over 100,000; Amudat has neither. All other government facilities in the district are HCIIs and HCIIIs, offer limited services and cannot handle serious complications. Amudat relies on a private facility through a Private Not For Profit Public Private
Partnership (PNFP) to serve as the defacto HCIV. However, residents reported that the services, when not available at government facilities, were often unaffordable and they spent high out of pocket expenditure on health, significantly limiting their access to health services.

- **Lack of access to emergency care.** At the time of the factfinding, ambulances in Amudat were not operational, resulting in rampant loss of life and exorbitant out of pocket costs when transporting patients during medical emergencies.

- **Poor quality health services.** The existing facilities visited lacked essential drugs, equipment, staff, access to clean water and adequate electricity.

- **Severe Understaffing.** All areas pertaining to healthcare in Amudat are significantly understaffed from the district administration to the operational staff in health centers, resulting in long waiting times and poor quality of healthcare services.

- **Access to underlying determinants of the right to health remain a challenge.** There is limited access to clean and safe water. Most boreholes in Amudat are nonfunctional, forcing residents to share water sources with their livestock, or resort to drinking stagnant water. Pit latrine coverage also remains low, with only 21% latrine coverage.

- **Limited avenues for the community to participate.** There are few avenues for the community to participate in realizing their right to health. The existing avenues are ineffective. The Health Unit Management Committees (HUMCs) that should be the bridge between the community and healthcare providers are not trained on their role
and are not always active. Furthermore, the community is not adequately consulted during the budgetary process.

- **Unregulated private actors.** The absence of public health facilities in some parishes i.e at minimum HCIIIs, long distances travelled to access the available health centers, and persistent drug stock outs have forced residents of Amudat to resort to private clinics and drug stores. Many of these facilities are unlicensed and charge exorbitantly for healthcare services, increasing out of pocket expenditure on health and further impairing access to healthcare, particularly for the poor. Residents reported being held hostage at the Private Not For Profit Public Private Partnership hospital when they failed to pay hospital charges. While there is existing regulation for private actors, it is piecemeal and not enforced.

The challenges highlighted above stem from inadequate health financing. The national health budget remains underfunded, oscillating between 5-8%, far short of the 15% Abuja declaration target Uganda committed to. Despite being the worst performing district, Amudat is among the districts that receives the lowest financing for health. Amudat was allocated UGX. 951,421,000 in 2018/19 and 654,877,000UGX in FY 2017/18 to serve a population of 105,769.  

This report concludes with targeted recommendations to different key stakeholders derived from consultations with the community and best practices. Adopting the recommendations below will ameliorate the gaps highlighted above in realizing the right to health.

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A. Recommendations to the central government

5.1.1 Address the shortage of health centers:
   i. Construct more health facilities in Amudat.
   ii. Construct HCIII level facilities. Upgrade existing HCIII-level facilities to HCIV-level facilities and HCII-level facilities to HCIII-level facilities and implement mobile clinics.

5.1.2 Increase access to Emergency care.

5.1.3 Build more staff quarters.

5.1.4 Increase the number of health workers at the health centers to meet standard staffing allocations.

5.1.5 Increase access to family planning and community health education taking into account gender and cultural barriers.

5.1.6 Ensure the provision of safe and clean water.

5.1.7 Take measures to address the lack of electricity.

5.1.8 Increase the supply of essential drugs.

5.1.9 Meet the urgent equipment needs of health centers.

5.1.10 Provide disability friendly health services.

5.1.11 Acknowledge the unique health challenges faced by hard to reach communities in health policy, planning and financing.

5.1.12 Build the Capacity of HUMCs.

5.1.13 Fast track the National Health Insurance Scheme.

5.1.14 Emphasize Preventative Care.

5.1.15 Conduct a comprehensive study on access to health care in hard to reach pastoralist communities.

5.1.16 Invest in access to education.

B. Recommendations to local government and local leaders

5.1.17 Regulate private facilities.

5.1.18 Sensitize community members on the right to health and preventative measures.

C. Recommendations to Parliament

5.1.19 Strengthen the legal and policy framework relating to health.

5.1.20 Ensure that budgetary allocations within the health sector enable equity in access to healthcare.

5.1.21 Follow up on implementation of some of the policies and guidelines put in place to strengthen the health system.

D. Recommendations to Civil Society

5.1.22 Use this report as a tool of advocacy for implementation of recommendations.

5.1.23 Engage in research and documentation to highlight challenges in access to healthcare for hard to reach areas.

5.1.24 Partner with local governments to conduct sensitization on a rights based approach to health.

E. Recommendations to the Community

5.1.25 Construct more pit latrines and practice preventative care.
ASSESSMENT OF HEALTH SERVICES IN AMUDAT DISTRICT

CHAPTER ONE
INTRODUCTION
CHAPTER 1

INTRODUCTION
1.0 INTRODUCTION

1.1 Contextual Background of Amudat District, Karamoja Sub-region

Amudat District is located in the North Eastern region of Uganda, bordered by Moroto in the north, Nakapiripirit in the west, Bukwo and Kween in the south, and Kenya in the east. With a total area of 1,615 Sq. Km and density 73.42 Km, Amudat was carved out of Nakapiripirit district and established as a district by an Act of Parliament on 1st July 2010.

The district is comprised of 1 county, Pokot; 3 sub-counties: Loroo, Karita and Amudat; 9 parishes: Abiliyep, Loroo, Achorichor, Karita, Losidok, Lokales, Amudat, Katabok and Loburin. According to the most recent National Population Census of 2014, Amudat has 108 villages. However, the number of villages could be higher, as high as 222 given that a number of villages have not been captured by the census data. The Amudat District headquarters are situated in Amudat Town Council.

According to the National Population and Housing Census (2014), the total population of Amudat was estimated to be 105,769 and growing at a fast rate. The population growth in Amudat is 5.4%, higher than the national level of 3.2%. Population distribution among gender is almost proportional (54,246 male and 51,523 female).

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7 Interview with Francis Kiyonga, Chairperson LCV, Amudat District, 23 November 2017.


9 Ibid.
The population is predominantly young with those aged 0-17 accounting for 63.5% of the population in the district. The majority of the population resides in the rural areas (93,983).  

Figure 1: Distribution of population by Sub County; Amudat District, 2014

Source: National Population and Housing Census 2014 area specific profile Amudat District 2014

10 Ibid.
With respect to the social economic status of people living in Amudat District, the main activities in the district are subsistent agriculture, particularly growing maize and sorghum and livestock rearing.\(^\text{11}\) Dry spells and the lack of adequate water supply for livestock has led residents to live a semi nomadic lifestyle which involves moving to neighboring districts in search of water and pasture for their animals.\(^\text{12}\) Poverty levels are high both in Amudat and in Karamoja region, which is the least developed region in the country. At 60.8, Karamoja is the region with the highest incidence of poverty.\(^\text{13}\) Karamoja has the highest percentage of children experiencing multiple child poverty (68 percent).\(^\text{14}\)

### 1.2 The District Public Health Sector Performance

Since its creation in 2010, Amudat District has consistently been the worst performing district in healthcare in Uganda.\(^\text{15}\) According to the Ministry of Health District League Table (DLT), which is the aggregate result of

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key health indicators\textsuperscript{16} Amudat scored last in healthcare service delivery in the FY 2016/17.

Amudat scored 46.8\% in sharp contrast to the national average (66.2\%) and the best performing district, Adjumani (80.9\%).\textsuperscript{17}

Amudat is significantly underperforming on key health indicators, lagging behind the national average. In Table 1, below common indicators of health system performance from Amudat are compared against national averages. In FY 2016/17, Amudat had the lowest Antenatal care (ANC) coverage for the fourth visit at 19.5\% in comparison to 37\% national wide, both of which are below the below the Health Sector Development Plan (HSDP) target of 40\%.\textsuperscript{18} Only 39.8\% of deliveries in Amudat are successful, below the 58.2\% national average. Amudat has 26.8\% fresh still births per 1,000 deliveries, more than double the national average, which stands at 10.2\%.\textsuperscript{19} 79.3\% HIV+ pregnant women initiated on ARVs in comparison to the national average, 90.1\%.\textsuperscript{20} There are significant shortcomings with regard to health personnel, only 38.5\% approved posts are filled with qualified personnel in comparison to the national average, 71.7\%.\textsuperscript{21}

\textsuperscript{16} The composite index employed is computed by weighting the agreed upon indicators, ranking districts from best to worst performer. The scores are aggregated to form 100\% out of the individual indicators. The indicators assessed include fresh still births per 1,000 deliveries; maternal deaths audited; TB treatment success rates; patients diagnosed with malaria that are lab confirmed; approved posts filled with qualified personnel; monthly reports sent on time; Packed Cell Volume (PCV3), the absolute neutrophil count (ANC4)+, Immune thrombocytopenic purpura (IPT2), deliveries; HIV+ pregnant woman initiated on ART; latrine coverage; completeness of monthly reports, and timelines of quarterly OBT reporting per percent.

\textsuperscript{17} Ministry of Health (2017), Annual Health Sector Performance Report, FY 2016-17, http://health.go.ug/content/annual-health-sector-performance-report-201617 (last accessed July 5, 2018)

\textsuperscript{18} Ibid.

\textsuperscript{19} Ibid.

\textsuperscript{20} Ibid.

\textsuperscript{21} Ibid.
### Table 1: DLT score results of Amudat District in comparison to the national average

<table>
<thead>
<tr>
<th>%score 2016-2015</th>
<th>Amudat</th>
<th>%Score National</th>
<th>Financial Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>75.5- 92.9</td>
<td>19.5</td>
<td>PCV3 (%)</td>
<td>ANC4+ (%)</td>
</tr>
<tr>
<td>39.6</td>
<td>54.4</td>
<td>IPT2 (%)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>39.8</td>
<td>58.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>79.3</td>
<td>90.1</td>
<td>HIV+ pregnant women initiated on ART (%)</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>76.7</td>
<td>Latrine Coverage (%)</td>
<td></td>
</tr>
<tr>
<td>26.8</td>
<td>10.2</td>
<td>Fresh Still Births per 1,000 Deliveries</td>
<td></td>
</tr>
<tr>
<td>0.0</td>
<td>23.9</td>
<td>Maternal Deaths Audited (%)</td>
<td></td>
</tr>
<tr>
<td>49.2</td>
<td>80.4</td>
<td>TB Treatment Success Rate (%)</td>
<td></td>
</tr>
<tr>
<td>91.6</td>
<td>68.9</td>
<td>Patients diagnosed with Malaria that are lab</td>
<td></td>
</tr>
<tr>
<td>38.5</td>
<td>71.7</td>
<td>Approved posts filled with qualified personnel</td>
<td></td>
</tr>
<tr>
<td>91.7</td>
<td>88</td>
<td>Monthly reports sent on time (%)</td>
<td></td>
</tr>
<tr>
<td>100</td>
<td>94.3</td>
<td>Completeness monthly reports (%)</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>9.1</td>
<td>Timeliness of Quarterly OBT reporting (%)</td>
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<tr>
<td>46.8</td>
<td>66.2</td>
<td>% score (total score/90)*100)</td>
<td></td>
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</tbody>
</table>

*Source: Ministry of Health 2016/17 Annual Performance report.*

Karamoja sub-region is lagging behind in health service delivery. In FY 2016/17, out of 116 districts, five of the ten worst performing districts were from Karamoja: Nakapiripirit, Napak, Moroto, Kaabong, Amudat. Other districts from other regions included Budaka, Kakumiro, Buliisa,
Bulambuli, Buvuma. In FY 2015/16, Kotido, Moroto, Napak, Amudat from Karamoja region featured among the worst performing districts, alongside Wakiso, Sembabule, Bulambuli, Koboko, Sironko, and Buvuma.

Table 2: Comparison of DLT Performance of Amudat with other Districts in Karamoja Sub-Region

<table>
<thead>
<tr>
<th>District</th>
<th>% DLT score</th>
<th>Rank out of 116</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abim</td>
<td>67.6%</td>
<td>63</td>
</tr>
<tr>
<td>Kotido</td>
<td>65.2%</td>
<td>84</td>
</tr>
<tr>
<td>Nakapiripirit</td>
<td>60.8%</td>
<td>108</td>
</tr>
<tr>
<td>Napak</td>
<td>60.5%</td>
<td>109</td>
</tr>
<tr>
<td>Moroto</td>
<td>56.0%</td>
<td>112</td>
</tr>
<tr>
<td>Kaabong</td>
<td>54.6%</td>
<td>114</td>
</tr>
<tr>
<td>Amudat</td>
<td>46.8%</td>
<td>116</td>
</tr>
</tbody>
</table>

Source: Annual Health Sector Performance Report 2016/17

1.3 Background: Health Systems in Uganda

In Uganda, the public health system has tiered public health facilities that should provide free health services to the community. These include health centres designated as: Health Centres I (HCIs), Health Centres II (HCIIIs), Health Centres III (HCIIIIs), and Health Centres IV (HCIVs). The higher the level of health centre within this hierarchy, the more comprehensive the services provided.

HCIs constitute of local Village Health Teams (VHTs), who do not directly provide medical services but conduct health education and sensitization.

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22 Ibid. at p.40
23 Ibid.
24 The Ministry has proposed phasing out HC IIIs and instead upgrading them to HC IIIIs to ensure 100% coverage of sub counties with HCIIIIs to enable an upgrade of maternal health and delivery capacity. Ministry of Health (2015), Annual Health Sector Performance Report, Financial Year 2015/2016, at p.105.
among community members. The government has planned to gradually replace them with Community Health Extension Workers.\textsuperscript{26}

Health Centres II serve a population of up to 5,000 people and are the first point of call between the formal medical system and the community. They employ an enrolled comprehensive nurse and should be able to provide outpatient care and community outreach services.\textsuperscript{27} A Health Centre III, intended to serve communities of up to 20,000 in population, should provide basic preventive, promotive, in patient, maternity, laboratory and outpatient curative services, and serve as a referral for HCIIIs in a sub county.\textsuperscript{28} A Health Centre IV, which serves communities of up to 100,000 people, provides specialized services including emergency surgery, blood transfusions, laboratory services, as well as all services provided at lower-designation health centers.\textsuperscript{29} Hospitals, including Community hospitals (serving up to 250,000 people) General hospitals (serving up to 500,000 people), Regional Referral Hospitals and the National Referral Hospital should provide all services at the Health Centre IV level and specialty services including intensive care, radiology, pathology, psychiatry, high level surgery, dentistry, mental health.\textsuperscript{30}

In assessing the performance of health systems in Amudat, these Ministry of Health Guidelines for health centers at each designation provided important evaluative criteria for the team conducting the fact-finding.

\begin{itemize}
\item \textsuperscript{28} Ibid.
\item \textsuperscript{29} Ibid.
\item \textsuperscript{30} Ibid at page 6.
\end{itemize}
“Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. . . . Violations of the right to health . . . occur through the omission or failure of States to take necessary measures arising from legal obligations.”

Committee on Economic, Social and Cultural Rights, General Comment No.14: The Right to the Highest Attainable Standard of Health (Art. 12), Adopted 11 August 2000
CHAPTER 2

LEGAL AND POLICY FRAMEWORK
2.0 THE LEGAL AND POLICY FRAMEWORK

Uganda is bound by a broad legal and policy framework, which recognizes and guarantees the right to health at domestic, regional and international level. This section sets out these laws and policies, which form the yardstick upon which, the findings on the state of healthcare in Amudat District will be assessed.

2.1 International Obligations

The right to health is enshrined in a number of international instruments including article 12 of the International Covenant on Economic, Social and Cultural Rights; article 25.1 of the Universal Declaration of Human Rights; article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965; articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979; article 24 of the Convention on the Rights of the Child of 1989; the Convention on the Rights of Persons with Disabilities. At the regional level, it has been articulated in the African Charter on Human and Peoples Rights, 1981; African Charter on the Rights and Welfare of the Child (ACRWC), 1990; the Protocol to the African Charter on


Article 12 of the ICESCR, which first substantively articulated the right to health, defines the right to health as “the highest attainable standard of physical and mental health conducive to living a life in dignity.”39 The Committee on Economic, Social and Cultural Rights (CESCR) in General Comment 14, provided substantive guidance on the what the right to health entails, defining four interrelated and essential elements of the right to health, which must be present for the full enjoyment of the right.40 These include:

**Availability:** There must be sufficient and functioning health facilities in place in sufficient quantity. There must be trained medical personnel receiving domestically competitive salaries41 and essential drugs and supplies. Underlying determinants of the right to health like safe and portable drinking water and sanitation must also be scrutinized when assessing availability.42

**Accessibility:** Everyone should have access to high-quality and comprehensive health care without discrimination, especially the most

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40 CESCR, General Comment No. 14 at para 12.
41 Ibid. at para 12 (a).
42 Ibid. at para 12 (a).
vulnerable and marginalized persons or groups. Accessibility encompasses four dimensions: non-discrimination, physical accessibility, economic accessibility; information accessibility. In line with non-discrimination, health facilities should be accessible for all persons, particularly vulnerable and marginalized persons including persons with disabilities (PWDs), older persons and without discrimination on any grounds. Physical accessibility requires that health services and information are within safe physical proximity, particularly for rural areas. Economic accessibility requires that health facilities, goods and services, regardless of whether they are public or private, are affordable to all. Information accessibility refers to the right of everyone to seek, receive and impart information and ideas concerning their health without impairing the right to privacy and confidentiality of personal health data.

**Acceptability:** All health facilities, goods and services must be respectful of medical ethics, the culture of the persons being served especially for minorities, and sensitive to gender and life-cycle requirements.

**Quality:** Health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires having skilled medical personnel, provision of scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

**Participation:** The participation of the populace in health policy formulation, implementation both at the community and national levels has been recognized as integral to realizing the right to health in a number of instruments.43

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Non Discrimination: Recognising the barriers faced by certain marginalized groups in realizing rights, non discrimination has emerged as a core element of the right to health in a number of instruments. General Comment 14 prohibits discrimination in access to health care and underlying determinants of health on the basis of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status that would nullify or impair the enjoyment of the right to health.\textsuperscript{44} The Maputo Protocol obligates the State to ensure that the right to health of women in Africa is respected, fulfilled and protected, particularly the dimensions of sexual and reproductive health. It requires States to put in place health policies that eliminate discrimination against any groups of persons particularly marginalized areas.\textsuperscript{45}

Obligations of the State

The right to health, like all other rights, imposes three obligations on the government: to respect, to protect and to fulfil the right. The obligation to \textit{respect} requires the State to refrain from interfering with the right.

The obligation to \textit{protect} requires the State to prevent third parties from interfering with the right including legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties. This includes ensuring that “privatization of the health sector” does not threaten the availability, accessibility, acceptability and quality of health facilities, goods and services. The State is obligated to “control the marketing of medical equipment and medicines by third parties; and

\textsuperscript{44} CESCR, General Comment 14 at para 18.
\textsuperscript{45} Article 14 of the Maputo Protocol.
to ensure that medical practitioners and other health professionals meet appropriate standards of education.”

The obligation to *fulfil* requires the State to take administrative, budgetary, judicial and promotional measures to realise the right to health.

While recognising that the right will be progressively achieved, States also have immediate obligations. These include meeting minimum essential levels of the right including: ensuring access to health facilities, goods and services for vulnerable or marginalized groups on a non-discriminatory basis, equitably distributing goods, services and health facilities, providing essential drugs as defined under the WHO Action Programme on Essential Drugs; ensuring access to basic housing, sanitation and safe and portable water, minimum essential food that is nutritious. Other obligations include ensuring provision of reproductive, maternal and child care; immunization against infectious diseases, controlling epidemics, providing health information.

States have to use the maximum of available resources to realise the right to health and failure to do so violates the right. Violations of the right can also occur through acts of omissions including “the failure to take appropriate steps towards the full realization of everyone’s right to the enjoyment of the highest attainable standard of physical and mental health.”

### 2.2 Domestic Laws and Policies Enshrining the Right to Health.

Whereas the Constitution of Uganda, 1995 does not expressly guarantee

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46 CESCR, General Comment No. 14 at para 34.
47 Ibid. at para 12 (a).
48 Ibid. at paras 43-44.
49 Ibid. at paras 47.
50 Ibid. at paras 49.
the right to health in the Bill of Rights, it is embedded in the National Objectives and Directive Principles of State Policy (NODPSP) which read together with article 8A, 45 and 287 of the Constitution, require the State to ensure that all Ugandans enjoy the right to health.51 Articles 21, 32, 33, 34, 35 espouse equality and non-discrimination and guarantee the protection of vulnerable groups including women, children, older persons, and persons with disabilities from discrimination in the enjoyment of their rights including health.

Beyond the Constitution, piecemeal legislation has emerged further fleshing out this right. The Public Health Act, 1935 guides on aspects related to public health. The Persons with Disabilities Act, 2006 enshrines the right of persons with disabilities to enjoy the right to health on a non discriminatory basis while the Children (Amendment) Act, 2016 affirms the right to health of children in Uganda.52

To operationalize the right to health, Uganda has formulated policies setting out the blueprint to achieve the right to health. The National Health Policy (2010) obligates the government to provide a minimum healthcare package for all53 and requires the government to ensure everyone resides within 5km radius of a health facility.54

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51 Uganda Const. 1995: Objectives XIV, XX of the National objectives and Directive principles of state policy; Article 8A.
53 Ministry of Health (2010), National Health Policy, available at http://library.health.go.ug/publications/leadership-and-governance-governance/policy-documents/ministry-health-national-health (last accessed July 5, 2018). [In particular, see Policy 6.1, 6.2, and 6.3 of which states the minimum health care comprises “the most cost-effective priority healthcare interventions and services addressing the high disease burden “consisting of the following: “Health promotion, environmental health, disease prevention and community health initiatives, including epidemic and disaster preparedness and response; Maternal and Child Health; Prevention, management and control of communicable diseases; and prevention, management and control of non-communicable diseases.”]
II and the Health Sector Development Plan 2015/16-2019/2020\(^5\) seek to accelerate the achievement of universal health coverage in Uganda. The Patients Charter (2009) articulates the rights of patients including rights to participation and information regarding their healthcare.\(^6\) Recognizing that the public and private sector both play a role in delivering health services, the National Policy on Public Private Partnerships in Health (2012) outlines functional integration between the public and private sector in delivering health services and sets out a regulatory framework for private actors that partner with the government in form of Public Private Partnerships.\(^7\)

The State obligations derived from the legislation, plans and policies discussed above provide a comprehensive interpretation of the right to health and are used as a yardstick when assessing findings on the state of healthcare in Amudat district in Karamoja region, discussed in Chapter 4.

\(^{5}\) Ministry of Health (2015), Health Sector Development Plan 2015/16-2019/20, available at http://health.go.ug/content/health-sector-development-plan-201516-201920 (last accessed July 1, 2018). The Executive Summary and para 3.1.1 states: “The goal of this Plan is to accelerate movement towards Universal Health Coverage (UHC) with essential health and related services needed for promotion of a healthy and productive life. UHC makes it possible to ensure that all people receive essential and good quality health services they need without suffering financial hardship.”


ASSESSMENT OF HEALTH SERVICES IN AMUDAT DISTRICT

CHAPTER THREE

METHODOLOGY
CHAPTER 3

METHODOLOGY
3.0 STUDY METHODOLOGY

3.1 Objective of the study
This study was conducted to assess the state of health care in Amudat District in line with a human rights based approach, particularly examining the availability, accessibility, acceptability and the quality of the health care provided alongside the State’s obligation to respect, protect and fulfil the right to health.

Specific objectives

- To assess the availability of healthcare provided by both public and private health facilities including Private Not for Profit (PFNP) facilities.
- To assess the quality of the health care services provided.
- To assess the access to health for vulnerable groups
- To investigate access to emergency health care services.
- To assess the underlying determinants of health in Amudat.
- To investigate the extent of community participation in their health including in local government level budgetary processes and Health Unit Management Committees (HUMCs).

3.2 Scope of the study
Initial research conducted by ISER\textsuperscript{58} in 2016 revealed that Amudat District is one of the hard to reach areas in Uganda in terms of geographical remoteness and access to social services like education and health. An assessment of Amudat’s performance in health care found that the district

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\textsuperscript{58} Eriks Development Partners, Initiative for Social and Economic Rights, Aidi, Prestudy of Education and Health in Karamoja focusing on Amudat, Napak (October 2016) [on file].
persistently ranks lowest in the sector, indicating the need for in depth research.

In 2017, the team conducted field research in Amudat sub county; Karita subcounty and Looro sub county visiting villages and health facilities.

**Table 3:** A table showing sub counties, villages and health centres visited

<table>
<thead>
<tr>
<th>Amudat Sub County</th>
<th>Looro Sub County</th>
<th>Karita Sub County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amudat Town Council</td>
<td>Abiliyep village</td>
<td>Karita HC III</td>
</tr>
<tr>
<td>Nabokotom village</td>
<td>Akorkeya village</td>
<td>Lokorokocha village</td>
</tr>
<tr>
<td>Matany village</td>
<td>Achorichor village</td>
<td></td>
</tr>
<tr>
<td>Kapetawe village</td>
<td>Naguliet village</td>
<td></td>
</tr>
<tr>
<td>Alakas HC II</td>
<td>Kakalas</td>
<td></td>
</tr>
<tr>
<td>Amudat Hospital</td>
<td>Achorichor HC II</td>
<td></td>
</tr>
</tbody>
</table>

### 3.3 Criteria of Evaluation

This study was conducted based on the State’s obligation to respect, protect and fulfil the right to health and the corresponding obligations of the State laid down in the ICESCR General Comment No.14 on the Right to the Highest Attainable Standard of Health, under the following specific elements namely:

i. Availability

ii. Accessibility

iii. Acceptability

iv. Quality
Other elements like participation, non-discrimination were assessed. The findings were sub-categorised into key components and underlying determinants of the right for further analysis.

3.4 Methodology

The field research commenced on November 19, 2017 and ended on November 25, 2017. The researchers deployed numerous methods including Key Informant Interviews, Focus Group Discussions (FGDs) and field observations.

3.4.1 Focus Group Discussion

Focus Group Discussions (FGDs) were held with community members in Amudat as a platform for sharing their experiences with respect to health service delivery. The participants were randomly selected based on location to participate. The FGDs conducted were gender sensitive with separate male and female FGDs held in order to allow free expression of women on the different issues regarding healthcare. Eleven FGDs were carried out and the discussions provided insight on the public perception of health care delivery in Amudat as reflected in chapter 4 of this report.
3.4.2 Structured questionnaire interviewing

Structured questionnaire-based interviews were used to collect information from health care personnel, district officials, Health Unit Management Committees (HUMC) members, Village Health Team members (VHT), and community members. The responses generated from these structured questionnaires on numerous selected issues on health and service delivery eased the comparison of different responses.

3.4.3 Key informant interviews

Focused interviews were conducted to gather insights from key informants, including district leaders, sub-county leaders, Health Centre staff, and community members. Key informants were selected based on their direct involvement in the planning, management, formulation and approval of policies and their role in the delivery of health services at various levels.
in Amudat District. Informant selection also sought to represent the experiences of individuals with regard to accessing healthcare in Amudat and diverse key informants from the community were selected.

### 3.4.4 Observation

Eyewitness details were recorded during visits to health centers in Amudat, highlighting the state of physical infrastructure, the facilities available at selected health centres, the general outlook of the health facility, water and sanitation facilities, drug storage facilities, availability of latrines, electrification and lighting, among others. The researchers documented eyewitness observations regarding the numerous health services rendered.

### 3.4.5 Literature Review

Existing government data and literature on the district and on healthcare was reviewed to further contextualize observations and provide grounds for analysis of the team’s findings. Resources consulted during the review included, among others, the following: Publicly searchable archives of Ministry of Health communications and policy documents; publicly available reports and census data from other government ministries; the academic literature on Amudat District; and publicly available reports. Keywords used in databases and search engines included the following: “the state of health in Amudat,” “Amudat district statistics,” “healthcare in remote communities,” “normadic communities” “health care in Karamoja” etc.
“If there was an ambulance, it would have saved my child. Amudat hospital is really far and there are no facilities near me. I walked. It took me four days. I walked and when it was nighttime, I asked for a place to sleep at any home I found along the way. I still lost my child. Talk on our behalf. Tell these people.”

Elizabeth
CHAPTER 4

FINDINGS: THE RIGHT TO HEALTH IN AMUDAT
4.0 FINDINGS: THE RIGHT TO HEALTH IN AMUDAT

This section of the report discusses the availability, accessibility, acceptability, and quality of healthcare in Amudat District in accordance with the legislation, policies and plans Uganda committed to as discussed in Chapter 2.

4.1 Availability

4.1.1 Limited availability of health facilities

According to the National District Health Staff Records, there are eight (8) public health facilities in Amudat District, and they are predominantly lower level facilities. There are two HCIIIs in the district, five HC IIs, and Amudat hospital, which serves as a public private partnerships. The health centres include: Alakas HC II; Lokales HC II; Cheptapoyo HC II; Achorichor HC II; Amudat Town Council HC II; Loroo HC III; Karita HC III.

Some parishes such as Abiliyep and Katabok do not have any health centers, in contravention of the requirement to have a health facility within a 5km radius as discussed in chapter 2 of this report. While the National Health Policy recommends the

“When I fall sick, my husband goes and tries to find drugs. If he fails; he gets me a bodaboda to take me to the hospital. But in the rainy season it’s very hard because the bodaboda cannot cross. So we carry the people because the road is too muddy. We carry them up to where the road is fair so the bodaboda can pick them from there.

We also pray to God when someone is very sick, especially when the bodaboda cannot cross. Like today my child was very sick, he was vomiting he could not even walk we had to carry him. We went at night to the government hospital and it was closed. So we moved on to a private clinic in Kalita. He was put on drip. I had to sell a goat to get the money.” Grace


60 Interview with Patrick Sagaki, acting District Health Officer, Amudat Hospital, 23rd November 2017
establishment of a Health Center IV where there is a population of 100,000; Amudat does not have a Health Centre IV nor does it have a district hospital despite having a population of over 105,000.61 Residents rely on Amudat hospital, which is a Private Not for Profit (PFNP) facility, owned by the Moroto Anglican Diocese that has a public private partnership (PPP) with the government to serve as a de facto health Centre IV. The number of health facilities in Amudat is not in tandem with the district’s growing population needs. Amudat’s population growth at 5.4% is higher than the national average of 3.2%.62 The inadequate number of health facilities has detrimentally impacted the capacity of the population to access healthcare as discussed in section 4.2 below.

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4.1.2 Limited Human Resource For Health

Health workers are the most important component of any health system; they design and manage the system, as well as deliver preventive and curative services. In well-designed and facilitated health systems, their salaries, wages and allowances account for more than 60% of the total health budget.\(^63\) The Ministry of Health has noted that sufficient, competent, equitably distributed, motivated and facilitated health workers have to be available at all levels of the health system in order to achieve quality healthcare for all people in Uganda.\(^64\)

Health facilities in Amudat face significant shortages of human resource. As shown in table 4, understaffing in the health sector is a significant challenge in Amudat, with the district lacking substantive

“I am the only midwife. I came here in November 2016. I do not sleep at night because patients are always coming. We never take leave. We are supposed to have 19 staff at this Health Centre but we are only 6. This is a problem that cuts across the district. There are eight health facilities only – yet they are understaffed. There is no way Amudat can compete with other districts in health service delivery. We neither have a laboratory nor a laboratory assistant here. We only do tests which involve use of strips such as malaria, HIV and Hepatitis. We cannot carry out tests for typhoid, brucella and other diseases. In the entire district of Amudat, there are only three laboratory personnel—two are currently on leave and only one technician is at Amudat Hospital. There are staff quarters but they are insufficient yet we are few in number. Health workers here receive hardship allowance but in my case, I have never received my salary or hardship allowance since I came here in November 2016. Sometimes, I am forced to call my family to assist me financially. This situation kills my morale and at times I do not feel like even working. I work overtime, both day and night and have not been paid for a year now.”

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\(^64\) Ibid.
officers in key positions such as District Health Officer, Assistant District Health Officer Maternal and Child Health, Principal Health Inspector, Biostatistician and Cold Chain Technician among others. Amudat Hospital, only has 24 positions filled out of the requisite 193 required; implying that the hospital lacks 87.5% of essential staff recommended by the guidelines for designation.\textsuperscript{65}

State of human resource in Amudat Health facilities

![Staffing levels are lowest for](image)

Staffing levels are lowest for Dispensers (41%), Anaesthetic officers (28.9%) and Health Assistants (26.7%).\textsuperscript{66} The main referral hospital in the district, Amudat Hospital has only two (2) doctors, with one permanently assigned to specialised treatment of Kalaazar. Each HCII should have nine staff: five (5) technical staff including one (1) enrolled nurse, one (1) enrolled midwife one (1) health assistant and two (2) nursing assistants.


assisted by four (4) support staff. As shown in table 4, none of the HClIIs have the requisite staff, with a number having only one or two of the required nine. For example Achorichor HC II only has an enrolled nurse.67

Table 4: A table showing level of staffing for health in Amudat District

<table>
<thead>
<tr>
<th>Department</th>
<th>Approved</th>
<th>Filled</th>
<th>Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHO’s office</td>
<td>11</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Amudat hospital</td>
<td>49</td>
<td>22</td>
<td>27</td>
</tr>
<tr>
<td>Loroo H/C III</td>
<td>19</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Karita H/C III</td>
<td>19</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Alakas H/C II</td>
<td>9</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Achorichor H/C II</td>
<td>9</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Amudat TC H/C II</td>
<td>9</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Cheptapoyo H/C II</td>
<td>9</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Lokales H/C II</td>
<td>9</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: Report of the auditor general on the financial statement of Amudat District Local government 2017; National District Health Staff Records, Human Resources for Health Information System.

As a whole, the health sector in Uganda is significantly understaffed despite a slight overall improvement in FY 2016/17 to 73% (45,029/61,796) from 71% (42,530/60,384) in FY 2015/16 slightly outperforming the Health Sector Development Plan (HSDP) target of 70%.68 The number of health workers per 1,000 populations in Uganda is still far below the WHO threshold of 2.3 doctors, nurses and midwives per 1,000 populations. In 2016/17 FY the ratio of doctors, nurses and midwives to the population

68 In 2016/17, 116 districts and 18 Central institutions were supported to develop costed recruitment plans. Following this mechanism 2,222 positions were advertised and 2,129 health workers were recruited but the understaffing remains a major challenge.
was 1: 28,202; 1: 2,121 and 1: 6,838 respectively. These staff shortages are also occasioned by delays in recruitment and inadequate remuneration packages for health staff.

Health workers in Uganda as a whole are not motivated resulting in a nationwide strike over the government’s failure to meet their demands for salary and allowance increases, as well as for a review of the supply of medicines and other equipment in health centres. Unfavorable working conditions have led professionals in the health sector to leave government facilities and join private health facilities.

With this level of inadequate staffing, the quality of health service delivery is significantly affected. The staff, overwhelmed by the number of patients and the volume of work they have to do, are limited in their efficiency. People in Amudat reported long waiting times—waiting at least three hours to see a health worker and rude health workers, caused in part by an overloaded workforce. During interviews with medical personnel at Amudat Hospital, they revealed that due to understaffing in the facility, particularly the absence of an anaesthetic officer; some nursing officers have been trained to assist the doctors in the theatre. The ability to follow

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74 Interview with Patrick Sagaki, acting District Health Officer Amudat Hospital, 23rd November 2017.
up on issues, like filling out drug stock cards, was significantly affected due to the deficiency in human resource.\textsuperscript{75}

Figure 3: Parents waiting in a queue for immunization services at Amudat Hospital

4.2 Accessibility

4.2.1 Limited Physical Accessibility

Due to geographic remoteness and service inaccessibility, Amudat District is significantly underperforming in access to basic health care. According to the Uganda Bureau of Statistics most recent housing and population census, only 29.2\% of the district’s residents live within 5 kilometers of a health facility both public and private while only 23.9\% reside immediately near facilities.

\begin{quote}
\textit{“The challenge of this place is the distance and lack of hospitals. When a child falls sick, the hospital is far. Even for mere malaria, you have to look for a bodaboda that will cost you just to get to the Health Centre. If you cannot get bodaboda you have to foot until the Health Centre. There are people who rape people along the way, especially at night. You start pondering about what to do when a child gets sick, when they have a fever. It disturbs you psychologically. You wonder whether to risk walking at night or wait until morning. You keep pouring water on the child to bring the fever down, praying for God to help you and for the child to survive the night. When you get to Amudat hospital, because it is so far and it is hard to get there given our roads, by then the condition is likely critical.”} Selina
\end{quote}

\textsuperscript{75} Ibid.
within 5k of a public facility. Sub counties like Looro have only 8.3% of households residing within 5km of a public health facility. This contravene the 2016/17 Annual Health Sector Performance Report, which found that 100% of the population lives within a 5 km radius to a health facility.

**Figure 4: Percentage Distribution of Households 5 Km and Over to the nearest Public Health Facility; Amudat District**

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77 Ibid.

As discussed in section 4.1.1 above, some areas completely lack health facilities, and the community faces significant challenges accessing the few that are available. Furthermore, the main referral hospital, Amudat hospital, remains out of reach for most residents.

The long distances from health facilities significantly bar access to health services by residents of Amudat. Community members are deterred from seeking treatment in time, resulting in the rampant loss of lives from preventable diseases. Focus group discussants reported having to walk for 1-4 days to get to the referral health facility. A number of women reported giving birth on the way to health facilities, often resulting in the loss of life. Some resort to Kenya—for example hospitals like Motony—given that those hospitals offer specialized medical care.


“The nearest Health Centre here is Karita HCII which is so far. If there is money, we use a boda. On most occasions, I walk because I have no choice. There is no money. Sometimes, if there is no money for a boda but the sick person is very weak, the community members help to carry the patient.

I have ten children. I delivered some at home, some at the Health Centre and others on the way. In 2007, I was at home when I got my labour pains. The Health Centre was so far so people advised me to deliver at home but I insisted. I began walking to the Health Centre with a Traditional Birth Attendant. I was really struggling because I had no energy. I could not hold the child anymore so I delivered on the road side. I was not even near the Health Centre when it happened. The child was fine so we just came back home.”

Jennifer

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81 Male FGD at Kapetawe village, Katabok Parish, Amudat Sub County, 21 November 2017; Women FGD at Kapetawe village, Katabok Parish, Amudat Sub County, 21 November 2017
services, which would otherwise only be available at Amudat hospital and depending on the subcounty, are in some instances relatively closer.82

The limited accessibility of health services in Amudat District is further compounded by the poor road network and lack of public transport. Residents in the district are forced to resort to boda bodas, a form of motorcycle transport that is very expensive as discussed in section 4.2.2 below. Boda bodas in the district are limited and difficult to find when they are required to transport community members to health facilities because the riders do not have permanent bases of operation. This mode of transportation is risky especially for pregnant women due to the long distances covered and the state of roads in Amudat; posing harm to both the mother and unborn child as well as other members of the community.

The aforementioned circumstances pose barriers to access to basic healthcare in Amudat. As a result, a number of people opt to stay

“We have a problem with the long distances to health facilities. We really need a hospital in the parish. We usually go to Looro HC III. On some occasions we go to Matony or Kenya because Loroo HCIII is so far from here. Most times, we have to carry our children when they are sick and weak to the hospital. Sometimes we do not even reach because they die on the way. People here die in large numbers on the way to Looro HCIII. For emergencies, we rush and buy Panadol for first aid from drug shops. We also use herbal drugs. After we give a sick person Panadol, we kill a cow and cook some soup from the beef. We mix herbs in the soup and give to the patient. If they vomit, then the disease goes away. If the sickness persists, we look for an energetic person to carry the sick person on the back to the hospital or we look for a boda boda. We only do this when a person is very sick because boda bodas are very expensive. We pay UGX. 70,000=. We usually sell a cow to get the money. We get a loan on credit then we sell a cow later to pay the loan.”

home or seek out traditional healers or herbs, often resulting unnecessary loss of life.

4.2.2 Limited Economic Accessibility

The limited physical accessibility of health services in Amudat makes accessing healthcare economically inaccessible. Given the lack of public facilities, residents have to go to private facilities like Amudat hospital where they have to incur high out of pocket expenses to receive healthcare. Residents reported paying 20,000UGX for admission, 60,000UGX for malaria, C-section 100,000-130,000UGX, 83 up to 340,000 UGX for Brucella treatment. 84 The high out of pocket expenses are compounded by the lack of public transport. The only form of public transport available are bodabodas (motorcycles for hire), whose costs range from UGX 30,000 85–UGX 70,000. 86 This is unaffordable for the majority of residents given the high levels of poverty and vulnerability in Amudat. Only 27% of the households depend on earned income and 65% of the population are subsistence farmers. 87 One in every nine households have only one meal per day (for adults). 88

Community members revealed that when emergencies occur, they have to resort to selling their livestock in order to pay for their transportation to health facilities. Those that don’t have livestock are left with no way of

84 Male FGD, Motany Village, Katabok Parish, Amudat Sub-county, 21 November 2017.
85 Male FGD, Motany Village, Katabok Parish, 21 November 2017; Male FGD Akorkeya village Abiliyep Parish conducted on 20/11/2017 (discussing amount to Amudat hospital from Akorkeya village).
86 Interview with the LCV Amudat Sub County, 22 November 2017; Female FGD, Lokorokocha Village, Karita Parish, Amudat Sub-county, 23 November 2017; female FGD, Nagulet Village, Looro Parish, Looro sub county, 20 November 2017 (discussing amount for two people—the sick person and attendant to Looro HC II; Interview with Patrick Sagaki, acting DHO Amudat Hospital conducted 23rd November 2017 (describing amount from Karitas to Amudat Hospital)
88 Ibid.
accessing healthcare resulting in avoidable deaths.

As a whole, economic accessibility for healthcare is a major concern for Ugandans. In Uganda, 37% of health expenditure contributed by household is majorly out of pocket spending, far above the World Health Organization (WHO) recommended maximum of 20%.\(^89\) This disproportionately affects the poor, who are often unable to afford healthcare.

### 4.2.3 Limited Access to Emergency Healthcare services

Amudat lacks functional ambulances. The fact finding team observed two non operational ambulances parked at Amudat hospital. The battery of one of the ambulances was flat, and the district administration could not afford to replace the worn out tyres or service these ambulances regularly. The District Health Office indicated that they rely on a project double cabin car meant for research and outreaches to serve as an ambulance some of the time but patients have to pay for fuel, which can make them inaccessible to poor patients. Motor cycle ambulances have been piloted in Amudat, however, they easily break down due to the nature of the roads. Achorichor Health Centre II has a motor cycle ambulance that was only used once to carry a patient from the health facility to Amudat hospital; on the return journey, the ambulance broke down and it has not been repaired since.\(^90\) Motor cycle ambulances are not ideal for the transportation of patients in emergency situations due to the bumpy roads in Amudat, which increase the risk


\(^{90}\) Interview with the In charge at Achorichor H/CII, 24 November 2017.
of road accidents, but also become impassable when it rains. They also cause extreme discomfort for the patient; in the event that a patient must be positioned in one place, this cannot be achieved with a motor cycle ambulance.91

Figure 5: The carrier of the motor cycle ambulance in Achorichor HCII in Looro Sub County

Non-profit organizations sometimes provide support to improve access to emergency care but the support provided is adhoc and not sustainable, ultimately dependent on the organization’s goodwill. For example Doctors with Africa (CAUUM), a non-profit organization, provided fuel and reimbursed the costs patients incurred using bodabodas to get to health facilities but capped the reimbursement at 10,000UGX. This support is inadequate and unsustainable because residents reported spending at least three times the maximum fee CAUUM will reimburse on transport to the

91 Ibid.
facilities. Moreover, since the costs incurred are reimbursed, patients who cannot afford to pay these costs upfront are unable to benefit. The district’s contract with CUAMM to provide this support expired, and its unclear whether this support will continue to be provided, reflecting the need for the State to invest in ambulances and emergency care.

The lack of ambulances is a problem in the northern region and nationally as a whole. In the northern region, 22% of hospitals and HC IVs lack a functional ambulance. While the government has committed to expand ambulances, they are mostly in urban areas and less than 7% of patients arrive at health facilities by ambulance in emergency cases, despite medical emergencies being the lead contributor of high causes of morbidity.

4.3 Quality

4.3.1 Lack of Medical Equipment

Even when health facilities are available, they lack critical equipment, constraining their ability to provide quality healthcare. The health facilities lacked key medical equipment such as sterilizers, scans and X-Ray machines, and adjustable delivery beds. Other facilities did not even have the basic vital medical equipment such as bowls, bath cushions, receivers and scissors. Staff at Amudat hospital stated that the facility has only one delivery bed and lacks adjustable beds and separators in the ward.

“We have a space constraint. In this ward, we have ANC patients, patients who have delivered, all waiting here. We are forced to discharge mothers a few hours after delivery because we do not have space. We only have 9 beds yet sometimes we admit up to 20 mothers. They are forced to share the beds – the small ones share the beds. We lay mattresses for the big ones on the floor under the beds.” Staff at Amudat hospital.

92 Male Focus Group Discussion, Motany Village, Katabok Parish, 21 November 2017.
93 Interview with Francis Kiyonga, LCV Amudat Sub County, 22 November 2017.
95 Ibid.
maternity ward, mothers shared beds, some mothers sleep on the floor or under the beds when the ward is full which exposes them to infection.96

4.3.2 Perennial Stock Outs of Drugs and Supplies

Amudat is facing drug stockouts at all levels of health care services.97 Numerous health facilities in Amudat reported stock outs of Oxytocin, a drug administered to expectant mothers to stop bleeding during the third stage of labor.98 When drugs run out, facilities borrow from each other. For example Amudat hospital has run out of drugs and has been forced to borrow from the lower level facilities such as Loroo H/C III, Karita H/C III and Alakas H/C II.99

Drug stock outs in Amudat are particularly concerning given the long distances patients already have to travel to the nearest facility. When major stock outs occurred in 2010, residents had to trek to

“National Medical Stores delivers drugs to us. We have a problem with the drugs they deliver e.g they bring a tin of Diaspam for treating convulsions every two months which can last for a year so at the end of the year we have 6 tins yet we do not get many patients who need these drugs. On the other hand, for essential drugs such as ORS, Coartem, Fancida SPA, oxytocin, Parafelle, Ceptrin we receive an inadequate supply. The supply we receive takes like 2 months only before it is out of stock. For ORS, they bring only 10, which is a prescription for only two people with Diarrhoea yet it is a common disease here. NMS does not give us enough Oxytocin because HCIs should not be conducting deliveries. However, in Amudat, the circumstances are different. HCIIs are so far from the community and the HCIIIs are very few. The DHO decided that we should all conduct deliveries. If we lack Oxytocin, we go to Loroo HCIII or to the District Health Stores. Some drugs end up there so in case a Health Centre lacks, we order through the DHO who authorizes a pickup.”

96 Interview with the maternity ward team, Amudat Hospital, 22 November 2017.
97 Interview with Patrick Sagaki, acting District Health Officer Amudat, Amudat Hospital, 23rd November 2017; Interview with Francis Kiyonga, LCV, Amudat Sub County, 22 November 2017
98 Interview with the staff at the maternity ward in Amudat Hospital on 22/11/2017.
99 Interview with Patrick Sagaki, acting District Health Officer Amudat, Amudat Hospital, 23rd November 2017
Residents reported that having to incur additional out of pocket costs to buy drugs that are stocked out in public facilities when they have already spent money getting to the facility, results in further delays as they seek the money, which results in the loss of lives.

Uganda is currently facing a shortage of essential drugs in government health facilities. Approximately 25% of the health facilities in the country still experienced a stock out of Essential Medicines and Health Supplies (EMHS). In FY 2016/17, the availability of a basket of 41 health commodities stood at an average of 83%, below the Health Sector Development Plan target of 100%. Only slightly more than half (55%), had over 95% availability of the basket of commodities. More than a quarter of facilities experience stockouts of essential medicines and supplies. This was attributed in part to inadequate management information systems to track drugs ordered, dispensed, prescribed, and balances, poor planning and budgeting resulting into a mismatch of supply and demand, and the fixed

“Sometimes when you go to the HC, they give you the drugs they have. If they do not have fluids and syrups, they ask you to buy from a private clinic. I was charged UGX. 20,000/= for 2 IV fluids recently. I did not have the money. I had to sell a goat. A small goat is around UGX. 50,000/= while a big one is Kshs. 2000 (UGX. 68,000). If you have nothing to sell to get money for treatment, you will die. Those who do not have animals cultivate crops and get some money when they sell maize.” Hellen

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102 Ministry of Finance Planning and Economic Development Budget Monitoring and Accountability Unit. Briefing paper [9/17] what are the key issues in the health sector?
104 Ibid.
105 Ibid.
or reduced budgets against increasing number of patients.106

4.3.4 Facilities lack access to clean and safe water

Health facilities in Amudat often lack access to clean and safe water. At Alakas HCII, the In-charge noted that the facility buys water for day-to-day activities at UGX 1,000/= per jerrycan, obtained from Primary Health Care (PHC) Funds, observing that this unsustainable. The facility lacks tanks in which it can harvest water when it rains, which would be a more sustainable solution.107 Despite Amudat hospital having access to piped water, the pipes were broken and rusty.

With health facilities lacking these basic amenities, the quality of healthcare services is significantly affected, with patients also facing an increased risk of exposure to infections from these health facilities.

4.3.6 Lack of electricity

The health facilities visited relied mostly on solar energy but most of the batteries were worn out and the light produced was not sufficient. As a result, this has hindered their service delivery especially in the maternity wards and affected the safe keeping of vaccines.108

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In this case the basket refers to the core of exclusively and universally publicly funded services that comprise the Centre, in accordance with the limits on eligibility and co-payments (Such as prescription drugs and home care).


108 Ibid.
4.4 Acceptability

4.4.1 Unresponsive Sexual and Reproductive Health Services

The provision of sexual and reproductive health services in Amudat, particularly family planning services, is not sensitive to the cultural barriers that impede access to these services for women. Health workers require women to bring their husbands to receive family planning services, in part because despite sensitization, family planning remains unpopular especially among the male population who assert that it is not in conformity with their culture. During male FGDs statements such as “condom use is for prostitutes,” “condoms are used by people who have HIV/AIDS,” “condoms are for men who go to the disco” and “our men are warriors they do not know how to use condoms.” The cultural practices and beliefs of the Pokots dictate that a woman can only stop bearing children when she reaches the age of menopause. Consequently, health workers in Amudat face resistance from husbands whose wives receive family planning services at health facilities, making it difficult for the health workers to provide these services in fear of violence from these husbands. Husbands have beaten their wives when they discovered they were on family planning.

“I really want family planning. I need one which will last for long so I want to inquire about and use injectables for family planning. I heard that they last for three years. I have no choice but to try on my own because my husband would not allow me to use family planning. I am a second wife. The first wife also has two children but succeeded at getting birth control. She went to Kenya and she was administered family planning. In Kenya, they do not insist that you should come with your husband unlike this Hospital. I tried going to Kenya last month but the doctor who administers family planning had gone to his village for burial and no one knows when he will return. It takes me about 4 hours to get to the Kenyan clinic and three hours to come to Amudat Hospital on foot.”

Women, on the other hand have expressed a need for it and come for it, even without the consent of their husbands. A number prefer Sayana press, a new type of contraceptive with a syringe that is injected in the upper arm with an implant is not easily traceable. Women revealed that the requirement by health workers to come along with their husbands for family planning creates a barrier to their access. Those that are able have hired men to pretend to be their husbands so as to get the family planning services. Young unmarried women are deterred from accessing these services because of this requirement. Some women go all the way to Kenya to obtain contraceptives because those health facilities there do not demand for the consent of their husbands. Given that Karamoja region has the lowest demand for family planning at 27%, with 19.7% of this need unmet, requiring consent of the husbands further impedes access to these essential services.

“We sometimes want to stop having children but our husbands do not allow us. They can even kill us if we stop having children. They do not accept. I have eight children and I want to stop delivering but my husband refused. We go to the health workers secretly to ask for family planning. We worry though because when our husbands see that we are not delivering for many years, they ask why we are not conceiving. We usually act like we do not know why and do not understand why we are not conceiving. The problem now is that the doctors are now asking us to bring our husbands before they give us the injections so we find it hard to do it secretly but want family planning.”

Women FGD. Looro Subscounty

110 Interview with Jabeth Cherotich, Enrolled Comprehensive Nurse, In-Charge of the Achorchor HC II, Alakas Parish, Alakas sub county, 24 November 2017.
111 Interview conducted at Amudat Hospital with a community member, Akorkeya Village, Abiliyep Parish waiting in line to receive family planning services, November 22nd, 2017.
4.4.2 Culture and Normadic Nature of the Community Requires Specific Interventions.

Culture and the normadic nature of the community pose specific challenges that should be taken into account and will require health interventions that are not one size fit all. Among the Pokot, especially those that had been circumcised, there was reluctance to give birth to the first baby in a hospital due to the fear that the health workers might not know how to handle a circumcised woman. Latrine coverage is low, in part due to the fact that the community which moves around a lot when searching for pasture and water for their animals find it futile to build latrines. There are also beliefs that when a girl squats on a latrine, she will not have children. Communities did not live near the roadside or in easily accessible areas for security reasons during the insurgency they faced in the past. As a result, many people live in areas that are not easily accessible, particularly when it rains, which poses additional barriers to access healthcare. Tailoring health interventions that take into account these unique characteristics is critical if the right to health is to be realized for communities in Amudat.

4.5 Unregulated Private Actors

Due to the failures of the public health system discussed above, particularly the absence of health facilities in some parishes, long distances travelled to access the available health centers, and persistent drug stock outs, residents are increasingly resorting to private providers of health services. These include drug shops and clinics. Some of these drug shops are unlicensed and unregulated.

“When you go to Amudat Hospital and you do not have money, they do not sympathise with you. They will not even conduct tests if you do not have the money. They just chase you away. Even if you say that your husband is coming tomorrow to pay, they still ask you to leave if you do not have money. They do not care.”

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113 Male FGD at Nagulet village, Looro Sub County, 20th November 2017.
114 Ibid.
115 Interview with Alia Sefine, Chief Administrative Officer Amudat, 2 August 2018.
operating illegally. This contravenes the National Drug Policy and Authority Act, which requires only “approved institutions” including gazetted hospitals, health Centre’s, dispensaries, Aid post, registered medical clinics and only authorized persons to dispense drugs in accordance with a prescription from a duly qualified medical practitioner.

Since there is no General Hospital, residents rely on the only hospital in the district, Private Not for Profit, Amudat Hospital which offers inpatient, emergency, and outpatient services, including HIV prevention, care and treatment.

**Table 5: Standard Unit of Output (SUO) Amudat Hospital**

<table>
<thead>
<tr>
<th></th>
<th>Admission</th>
<th>OPD</th>
<th>Deliveries</th>
<th>Total ANC</th>
<th>Postnatal Total</th>
<th>Family Planning</th>
<th>Immunization</th>
<th>SUO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amudat</strong></td>
<td>2,927</td>
<td>4,973</td>
<td>520</td>
<td>1,775</td>
<td>3,598</td>
<td>628</td>
<td>2,988</td>
<td>55,440</td>
</tr>
</tbody>
</table>


Residents reported having to make high payments in order to access any health care services, rendering these services inaccessible to most residents due to the high poverty levels in the district. In Naguliet, Loroo sub county, an area that has 3 private clinics; residents reported spending on average a approximately UGX 50,000 to treat a child for malaria and 100,000UGX for

“I gave birth in January 2016. The child died in the process. I wanted to go home and bury my child. The doctors at Amudat hospital said I could not unless I paid the hospital the money. The child was dead. Why would they not let me bury him? I told them my husband and his relatives were near and could be contacted. The staff at the hospital refused. They should look at our situation as mothers and understand when someone doesn’t have the money but urgently needs healthcare.”

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116 Interview with Nurse at a drug shop, Kapetawe village, Katabok parish, 21 November 2017.
118 Ibid
an adult. At Amudat Hospital, while it does depend on the prescription, community members reported paying 30,000UGX - 60,000UGX for malaria, 20,000UGX for normal deliveries while a C-section can cost 100,000UGX - 130,000UGX with costs depending on complications going up to UGX 200,000. Residents reported being held hostage at Amudat Hospital when they failed to pay for medical treatment.

It is important to regulate the private sector as part of the State’s duty to protect the right to health, particularly given the burgeoning role of the private sector in the delivery of health care. 49% of health facilities in Uganda are private. A survey taken across three predominantly rural districts found 63% of individuals sought care at private providers with 11.8% at private not-for-profits (PNFPs), 40% at a private for-profit (PFP), and 10.6% a traditional practitioners. Although there is a Public Private Partnership Act (2015) and a National Policy on Public Private Partnerships in Health (2012), they are not comprehensive and there has been inadequate regulation to ensure they do not violate the right to health.

4.6 Non Discrimination

4.6.1 Persons with Disabilities

Health facilities in the district do not have favorable conditions for people with disabilities to access to health services despite persons with disabilities

119 Female FGD, Loroo Sub- County Loroo Parish, Nagulet village, 20 November 2017.
121 Interview with Resident, Akorkeya village Parish Abiliyep, 22 November 2017.
122 Interview with Patrick Sagaki, acting District Health Officer Amudat, Amudat Hospital, 23rd November 2017.
124 Male FGDs at Nagulet village, Looro Sub County, 20th November 2017.
constituting 6.8% of the total population.\textsuperscript{126} Although the facilities visited had ramps, they did not always have adjustable beds and bath cushions. Furthermore, these facilities did not cater for the special needs of persons with hearing and visual disabilities. For example there is no sign language interpretation at health facilities, despite having 2621 people in Amudat with hearing disabilities. Similarly there is no use of braille despite 2793 people in Amudat with visual disabilities.\textsuperscript{127}

Furthermore, the aforementioned absence of health facilities in some parishes results in people travelling long distances to access health services, posing an additional obstacle for PWDs, particularly those with limited mobility.

\textbf{4.6.2 Older Persons}

The gaps in the health system identified above have a detrimental effect on older persons, who have been particularly affected by the lack of accessible health services. Older persons are more susceptible to chronic diseases and often require services like palliative care, which none of the facilities in Amudat offer.

\begin{quote}
\textquote{As older persons, we suffer because we have to walk long distances. If we leave our home at 6pm to go to Amudat Hospital for treatment, we reach at 7am. We have to keep stopping along the way to rest especially if we are really weak. PWDs also face the same challenge. The stairs at Amudat hospital are so high so we have to be carried sometimes.} Male FGD, Kapetawe Village.
\end{quote}

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\textsuperscript{127} Uganda Bureau of Statistics (2017), The National Population and Housing Census 2014: Area Specific Profile Series Amudat District, Kampala, Uganda at page 23.
\end{flushleft}
4.6.3 Women

Women are disproportionately affected by the barriers to access health services discussed in this report, particularly expectant mothers in Amudat. The fact finding team interacted with various women who revealed that given the long distances to seek health care, and the risk of rape as they trek long distances to facilities, many opt to deliver from home with the help of traditional birth attendants (TBAs). However, these TBAs are not trained and do not possess the necessary supplies and equipment; for instance, some of them revealed that they do not even have gloves,\textsuperscript{128} cannot administer blood transfusion when required and have no means of preventing mother to child transmission of HIV. This results in unnecessary loss of life, particularly complications in childbirth. Furthermore, women often have no voice in decision-making including in decisions pertaining to their health, which impedes their participation.\textsuperscript{129}

4.7 Unresponsive Financing for Health

The challenges highlighted above stem from inadequate financing for health.\textsuperscript{130} African countries typically fund health care from tax revenue, donor funds and out of pocket expenditure. Uganda’s health budget has hovered around 5-8\% the last five years,\textsuperscript{131} averaging 6.45\% of the national budget during the duration NDP II.\textsuperscript{132} Despite being the worst performing district in health, Amudat has received the lowest total budget allocation

\textsuperscript{128} Interview with a Traditional Birth Attendant, Abiliyep village Looro Sub County, 24 November 2017.
\textsuperscript{129} Interview with Alia Sephine, Chief Administrative Officer Amudat, 2 August 2018.
\textsuperscript{130} Interview with Patrick Sagaki, Acting District Health Officer, Amudat, 23 November 2017.
\textsuperscript{132} Initiative for Social and Economic Rights (2018), Are We Failing to Progressively Realise the Right to Health.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{AmudatBudget.png}
\caption{Amudat Budget for Health}
\end{figure}
Primary Health Care (PHC) grants fund community outreach and remuneration of operational staff such as porters and security guards who assist the VHTs and HUMCs in monitoring and overseeing the operation of the health Centers within Amudat. PHC guidelines stipulate that when calculating grant allocations, hard to reach areas should be given special consideration. The Ministry of Health classifies districts as “hard-to-reach” depending on their geographical location in order to ensure access to health services for populations living there.\textsuperscript{138} This classification encompasses mountainous areas, islands, rural and disadvantaged areas and areas with peculiar terrain which require higher budgetary allocations because costs are expected to be higher.\textsuperscript{139}

Despite meeting the requirements for a hard to reach area, the budgetary allocations to Amudat are insufficient. The LCV chairman and the acting DHO revealed that the Primary Health Care (PHC) development grants had been reduced by the government, significantly affecting their operations especially in carrying out community outreach. For example,

\begin{itemize}
  \item \textit{In 2014 when the facility had just began, other HC’s around supported us. In 2015, we got PHC funds until June 2016. From June 2016 - June 2017, we did not receive funds. We did not receive PHC funds for the entire FY 2016/17 but we got in July 2017. However, since we had bank charges pending, it reduced the amount we received substantially. We informed the DHI, CAO and health sub-district in charge who said we should wait. We also informed the sub-county and they promised to help us in the next financial year. PHC is very important because these are the funds we use to run the health facility. The cleaner and the watchman have not been paid. We try to motivate them by including them in community programs. We also give them tasks as VHTs in communities and facilitate them. When we do not have funds, I am forced to use my own money to run the facility.}
\end{itemize}

\begin{footnotesize}
\begin{enumerate}
  \item Ministry of Health (2017), Sector Grant and Budget Guidelines FY 2017/18 at pp. 21, 28 available at \url{http://health.go.ug/content/sector-grant-and-budget-guidelines-201718} (last accessed on July 5, 2018).
  \item Ibid.
\end{enumerate}
\end{footnotesize}
In 2016/17, Amudat was allocated 36,665,156 UGX under PHC development for transitional sanitation (Health), which funds community sensitization and advocacy work that reduces morbidity rates from sanitation related diseases but was not allocated any in 2017/18 limiting activities like community sanitation. The allocation to PHC non wage recurrent for H/C II-IVs was 43,487,056 UGX. In 2017/18 the PHC non wage recurrent for HC II-IVs was 55,415,019. While this might seem like a nominal increase, HC IIs received the same amount in 2017 as in 2016—5,129,529 UGX per year, approximately 427,461 per month. Yet as the Ministry of Health has recognized, existing PHC grants are insufficient to cover utility bills, maintenance, sundries, cleaning and outreaches given that UBOS indicates a 20.4% increase in the cost of utilities alone (rent, fuel, water and electricity). It is for this reason that in FY 2018/19, Ministry of Health increased the PHC allocation by UGX. 202 billion from UGX. 343 billion to UGX. 545 billion.

When determining funding for health, policy makers should put into consideration the numerous challenges faced by the different regions.

142 Ibid. at p.59.
143 Ibid at p.67.
144 Ministry of Health (2016), Primary Health Care Guidelines 2016/17 at p. 153
Amudat is a hard to reach area with no clearly demarcated road networks and no public transport system that require special consideration.

4.8 Limited Community Participation

Communities’ participation in the planning and implementation of health services has been increasingly recognized as crucial. Budget processes are supposed to be participatory. Residents unanimously complained about the lack of consultation during budget processes. In focus group discussions with the males at Abiliyep Village, they disclosed that they had never been consulted about the budget processes at district level.\textsuperscript{147} In Nagulet Village, community members also expressed their dissatisfaction with not being involved in the budgeting and planning process.\textsuperscript{148} Vulnerable groups are often not consulted at all.

HUMCs, which were established to encourage the participation of communities, do not effectively function. Most are non functional. While some received training,\textsuperscript{149} it was adhoc and they did not understand their role. The HUMC of Achorichor HC II indicated that they had received some training but it was rare and there was no follow up.\textsuperscript{150} HUMCs do not interact with the community. Most residents interviewed revealed they had not heard of HUMCs nor did they understand their role.

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\[147\text{ Male FGD held in Abiliyep Village, 20 November 2017.}\]
\[148\text{ Female FGD held in Nagulet Village, Looro Subcounty 20 November 2017.}\]
\[149\text{ Interview with Francis Kiyonga, LCV Amudat Sub County conducted 22/11/2017}\]
\[150\text{ Interview with Goffrey Loliwale, Chairperson, HUMC, Achorichor HCII, 24 November 2017.}\]
one HUMC that indicated it consulted with the community limits the interaction to one educated member of the community who gives feedback to the committee. One health centre, Achorichor HC II, indicated that it had a quality improvement team, which had a slot for one community representative to serve as a liaison between the Health Centre and the community.

The lack of effective participation in Budget consultations and existing mechanisms like HUMCs violates the communities’ right to participate, contravening the government’s laws and policies. It also detrimentally affects the quality of health services provided by curtailing the monitoring of these services. Moreover, effective participation of the affected populace could improve policymaking. Health interventions that are designed top down with limited community participation have not been as successful, yet the reverse is true. Community members we spoke to suggested health interventions that could take into account needs of normadic communities like mobile clinic, latrines, suggestions that would improve policy making if the community effectively participated in the formulation of policies, budgets and monitoring.

4.9 Access to Underlying Determinants of the Right to Health

4.9.1 Limited Access to Clean and Safe Water

In Amudat district, access to clean and safe water is a challenge. In some areas such as Loroo, there is no water source and residents are forced to use water from the dams where their livestock feed for home consumption. Although some villages have boreholes such as Abiliyep village, Kapetawe village and Lokorokocha village, the boreholes are not functional despite

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the community raising the issue repeatedly with District Local Government officials. Some community members reported that they have resorted to consuming stagnant water, which exposes them to water borne and sanitation related illnesses including typhoid.¹⁵³

Figure 6: Residents fetching water

¹⁵³ Male FGDs held in Nagulet village, Looro Sub County, 20th November 2017.
Figure 7: Percentage Distribution of Households without access to Safe Water; Amudat District

<table>
<thead>
<tr>
<th>HHs without safe Water (%)</th>
<th>24.8 - 32.7</th>
<th>32.8 - 40.7</th>
<th>40.8 - 48.6</th>
<th>48.7 - 56.6</th>
</tr>
</thead>
</table>

4.9.2. Lack of sanitation and hygiene facilities.

Pit latrine coverage in Amudat is still limited which has greatly affected the health and sanitation levels of the people in Amudat District. Open defecation is often the norm, with Amudat having a 90% open defecation rate. There is only 21% latrine coverage. Nationally, Karamoja sub region performs poorly in hygiene and sanitation with less than 40% latrine coverage in comparison to the national target of 77%. Karamoja has a 65% open defecation rate. Communities we spoke to revealed that since nomadic communities move a lot in search of pasture and water, constructing a latrine, which they will later leave seemed futile.

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CHAPTER 5
CONCLUSION AND RECOMMENDATIONS
5.0 CONCLUSION

This report sought to assess the state of health care in hard to reach areas, focusing on Amudat district, which has been among the worst performing districts in health in Uganda. It found accessing healthcare for residents in Amudat is often a harrowing ordeal resulting in unnecessary loss of lives. Residents face challenges realising the right to health as a result of the limited availability of health facilities, limited access to healthcare, particularly emergency care, limited regulation of private actors and the resultant exorbitant out of pocket costs for healthcare and limited participation by communities.

Given that the enjoyment of the right to health is inextricably linked to other rights, interventions to improve access to healthcare will require multi sectoral interventions from different stakeholders. The report makes the following recommendations addressed to key stakeholders in the health care system especially line ministries and the Local Government, Parliament, civil society and the community.

5.1 Recommendations

A. Recommendations to the Central Government

While a number of the recommendations below are the purview of the Ministry of Health, interventions are multi sectoral and other line ministries like education have a role to play.

5.1.1 Address the shortage of health centers

i. Construct more health facilities in Amudat

The Ministry of Health needs to construct health centers in areas that lack
health facilities, such as Katabok Parish and Abiliyep Sub-County. Despite the Ministry’s plans of phasing out HCII facilities, the challenges faced in accessing health care in Amudat discussed in this report underscore the importance of having health facilities in all parishes in Amudat, at the very least HC IIs, taking into account the physical barriers to access as well as the phased construction of HCIIIs.

ii. Construct HCIII level facilities, Upgrade existing HCIII-level facilities to HCIV-level facilities and HCII-level facilities to HCIII-level facilities and implement mobile clinics.

As highlighted in this report, the majority of health centres in the district are HC IIs and IIIs, and Amudat lacks a public hospital or HCIV. Although the government entered into a PFNP PPP arrangement with Amudat hospital to serve residents, the hospital is inaccessible to most residents of Amudat due to geographical and cost constraints. The government needs to upgrade its health facilities in Amudat, particularly HCIIIs to HCIII and the existing latter to HCIV requiring medical staff (including clinical officers), thereby improving the access, scope and specialization of services available.

Given the fact that many of the health facilities in Amudat are constrained in terms of health personnel, adequate equipment and staff quarters; these upgrades should be done following proper planning. Upgrading a health facility requires more than calling a structure a HC III— for it to effectively operate, both adequate equipment and skilled human resources should be available.

158 Ibid.
Given the long distances patients walk to access healthcare, it is important specialized services are brought closer to the population, particularly through mobile clinics in the short term for those that reside long distances from health facilities.

5.1.2 Increase access to Emergency care

The Ministry of Health should purchase more ambulances for health centers in the district and ensure budgetary allocations for their maintenance, including fixing all defunct ambulances. Due to the long distances travelled to health facilities, poor road network, and absence of health facilities, the district needs operational ambulances in order to curb the unnecessary deaths resulting from delays in transportation of patients in emergency situations.

5.1.3 Build more staff quarters

Some of the health staff in Amudat reported that they share existing staff quarters, while some pointed out that they reside far from the health facilities and have to walk to long distances to work, limiting their availability to between 9 am and 5pm. Consistent presence of health workers in health centers is crucial, especially in smaller centers serving a large population in a hard to reach area. To ensure the availability of staff especially during times of emergency, staff accommodation units should be provided for the health centre personnel at all health facilities.

5.1.4 Increase the number of health workers at the health centers to meet standard staffing allocations

As discussed in chapter four, the District lacks critical health positions like a District Health Office and all the health centers visited in Amudat are
understaffed—the number of health workers is far below the standard staff allocations set by the Ministry of Health. Health workers are overwhelmed and underpaid, affecting the quality of the diagnosis and treatment provided; resulting in inefficiency and poor service delivery. An increase in staffing will not only improve the quality of health care but will also lessen the long waiting time for the patients. The Ministry of Health also put in place a policy to incentivize staff to work in hard to reach areas, by providing a 30% additional hardship allowance,160 which would apply to Amudat as a hard to reach area and if effectively implemented could incentivize staff to work there.

5.1.5 Increase access to family planning and community health education taking into account gender and cultural barriers

Residents of Amudat have a negative perception of family planning presenting a need to rethink the strategies being used to sensitize the community. Members of the community highlighted that the current adverts they hear on radio are not impacting them, showing that the strategy is ineffective. In providing these services, health workers and the district health staff should be sensitive to culture and gender barriers that impede access, particularly rethink the practice of requiring the husbands consent or accompaniment. These practices deter women from accessing these services.

5.1.6 Ensure the provision of safe and clean water

Government should immediately invest in providing safe water to the health centres in Amudat and drill boreholes or explore other safe water sources like water treatment, springs in the various villages where

community members have to walk long distances to access clean and safe water. Providing safe and clean water will not only improve health outcomes but will reduce the mobility of the community since they will not have to move to search for water for their animals.

5.1.7 Take measures to address the lack of electricity

Despite the government’s efforts to supply health centers in Amudat with solar, most of the health units do not have the resources to maintain the solar batteries. The lack of consistent power makes the storage of essential supplies like vaccines difficult and limits the ability of health centers to cater to patients who come to deliver at night.

Providing electricity to all health centers through the use of functional solar systems is a sustainable solution that will improve the quality of health service provision and extend the operating hours of the health facilities to meet service demands especially in emergency cases. The government need to prioritize funds for the maintenance and purchase of the batteries used to power health centers.

5.1.8 Increase the supply of essential drugs

The number of essential drugs supplied should be increased especially for hard to reach areas like Amudat. Failure to receive drugs at the health facilities after trekking miles to get to a facility subjects the residents to the high cost of drugs at the private facilities and drug shops and deters residents from seeking care in health facilities making the resort to traditional healers or remedies.
5.1.9 Meet the urgent equipment needs of health centers

Adequate supplies of basic equipment such as gloves and scissors; adjustable medical beds, refrigerators, diagnostic equipment should be provided to ensure access and quality.

5.1.10 Provide disability friendly health services

Amudat’s health workers are not equipped to professionally attend to the needs of PWDs and treat them like general patients. Health workers should be trained in aspects such as sign language in order to improve PWD accessibility to healthcare. Equipment that would cater to the needs of PWDs like adjustable beds should be available at health facilities.

5.1.11 Acknowledge the unique health challenges faced by hard to reach communities in health policy, planning and financing

Revise health policies and their implementation, acknowledging unique challenges faced accessing healthcare in hard to reach areas. Barriers to access to healthcare such as limited health facilities, distance resulting in high transport costs and the need to facilitate VHTs given the critical role they play in hard to reach areas should be considered prior to budget allocations.

5.1.12 Build the Capacity of HUMCs

HUMCs should be oriented on their role in order to strengthen the monitoring of the different health facilities. With the right skills, they will be equipped to hold the different health service providers accountable inherently improving service delivery.
5.1.13 Fast track the National Health Insurance Scheme

Out of pocket expenditure as a percentage of current health expenditure is 41%.161 Given the high out of pocket costs incurred by residents seeking healthcare, introducing a National Health Insurance Scheme (NHIS) would result in greater availability and affordability of healthcare. Uganda has been considering a NHIS for a number of years. The NHIS aims to, among others, “facilitate the provision of efficient, equitable, accessible, affordable and quality healthcare to the beneficiaries of the scheme” and to “provide health services to the indigent.”162 There is a draft NHIS bill that would operationalize the scheme but it is yet to be tabled before Parliament.163 The current draft NHIS bill (2014) does not adequately cover the poor and informal sector, categories where most residents of Amudat would fall, proposing instead to prioritise coverage for the formal sector. Passing a NHIS that covered the poor would ameliorate the challenges faced accessing healthcare, particularly the high out of pocket costs.

5.1.14 Emphasize Preventative Care

There has been a nominal decrease in preventative care, whose spending is far below what is spent on curative care.164 The latest National Health Accounts reveal Uganda spent only 29.7% of current health expenditure in FY 2014/15 and 38.5% in FY 2015/16.165 Yet investing in preventative care, particularly given the existing hurdles to access healthcare in hard to reach areas, is crucial.

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161 Ministry of Health (2018), National Health Accounts.
162 Section 6 of the National Health Insurance Scheme Bill (2014) hereinafter referred to as NHIS Bill (2014).
163 NHIS Bill (2014).
164 In FY 2015/16, of the total 813,087 public current health expenditure, less than half—only 371,790 was spent on preventative care. Ministry of Health, National Health Accounts
165 Ministry of Health (2018), National Health Accounts at p. 21.
5.1.15 Conduct a comprehensive study on access to health care in hard to reach pastoralist communities

To ensure informed decision-making, the Ministry of Health should commission a study that identifies the challenges in access to healthcare for pastoralist communities and recommends specific targeted interventions that take into account the unique nature of these communities.

5.1.16 Invest in access to education

Literacy rates in Amudat remain low due to the limited access to education. 72% of people aged ten and above are illiterate. 74.6% of children aged 6-15 years are not in school. 54.8% of households live 5km or more from the nearest primary school. Yet investing in education is key to improving health outcomes in Amudat since practices like sanitation, going to deliver in a health facility are often done when the population is educated.

B. Recommendations to local government and local leaders

5.1.17 Regulate private facilities

As aforementioned, expired drugs being distributed by certain private clinics in Amudat and patients held hostage for failure to pay fees reveals the lackluster regulation of private health facilities in Amudat. State regulation of private actors is especially important since deficiencies that impede the public health system from fully functioning result in residents resorting to private health facilities.

166 Interview with Alia Sephine, Chief Administrative Officer Amudat conducted 2 August 2018.
168 Ibid. at p.21.
169 Ibid. at p. 25.
170 Interview with Alia Sephine, Chief Administrative Officer Amudat, 2 August 2018.
5.1.18 Sensitize community members on the right to health and preventative measures

Residents of Amudat lack knowledge of their right to health, including their entitlement to participate in budgetary consultations, access free reproductive health services etc. They also lack knowledge of preventative measures like having pit latrines. Community Health Extension Workers (CHEWs) and VHTs should be deployed to sensitize community members on preventative measures. Supporting VHTs and CHEWs to provide community sensitization and first line treatment is essential given the inadequate number of health facilities in Amudat and the fact that no Ugandan radio stations seem to be available in Amudat. The sensitization should be ongoing and to be successful should take into account the cultural values the community has.

C. Recommendations to Parliament

5.1.19 Strengthen the legal and policy framework relating to health

Uganda’s legal and policy framework relating to health is inadequate with piecemeal protection provided in the National Objectives and Directive Principles of State Policy (NODPSP) in the Constitution and in the outdated Public Health Act, which predominantly focuses on public health aspects like epidemics. Parliament should amend the Constitution to include a right to health in the Bill of Rights and enact legislation on the right to health, providing for affirmative action in hard to reach areas like Amudat.

In order to ensure the right to health, the poor and vulnerable particularly, need legal protection to safeguard their ability to challenge and seek remedy

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171 Kenyan radio stations are received. This poses challenges for health campaigns that would otherwise be disseminated on radio.
for policies and actions that undermine their entitlement to the right to health. 172 The International Development Law Organization’s (IDLO) and World Health Organisation have shown that to fight discrimination and ensure access to medical treatment, the right to health must be enshrined in national law, and implemented with a focus on those most at risk.173

5.1.20 Ensure that budgetary allocations within the health sector enable equity in access to healthcare

The Parliament, particularly the Health and Budget Committees, needs to review budget allocations for the health sector. Parliament should increase the overall health sector budget while paying special attention to hard to reach areas including Amudat given the additional barriers they face accessing healthcare.

5.1.21 Follow up on implementation of some of the policies and guidelines put in place to strengthen the health system

A number of policies and guidelines were put in place to strengthen the health system. For example, in 2011, Parliament had a sitting to address maternal health issues and passed seven resolutions including resolution 6 that required Government to submit reports to Parliament on maternal health including full maternal mortality audit reports for Parliament to deliberate and come up with a way forward. This has not been done yet doing so would enable Parliament to assess gaps and recommend specific interventions.

172  Ibid.
D. Recommendations to Civil Society

5.1.22 Use this report as a tool of advocacy for implementation of recommendations

The recommendations made in this report require civil society to jointly advocate to ensure that the gaps highlighted in realizing the right to health in hard to reach areas are addressed by policy makers and local government.

5.1.23 Engage in research and documentation to highlight challenges in access to healthcare for hard to reach areas

There is inadequate research and documentation pertaining to access to healthcare in hard to reach areas, despite the additional barriers residents of these areas face accessing healthcare. Civil society needs to document gaps in accessing quality health services to inform government policy.

5.1.24 Partner with local governments to conduct sensitization on a rights based approach to health

Civil society can use these findings to aid in the sensitization of the community and duty bearers on a rights based approach to health. This will promote ongoing monitoring of the right to health and community participation in the policy formulation and implementation of health, including in budget processes.

E. Recommendations to Community

5.1.25 Construct more pit latrines and practice preventative care

The pit latrine coverage in Amudat does not meet the needs of the population, significantly affecting the community’s hygiene and increasing the risks to health. Residents should build more pit latrines in order to improve hygiene and deter the outbreak of epidemic diseases in Amudat.
For nomads, digging temporary latrines would be useful. However, given the cultural beliefs that have impeded residents from constructing or using latrines even when constructed, the local government and leaders should work with the community, sensitizing them to ensure appreciation of latrines.
REFERENCES

International and regional Instruments


Laws

13. Uganda Const. 1995: Objectives XIV, XX of the National objectives and Directive principles of state policy; Article 8A.


16. Public Health Act, 1935

17. Public Private Partnership Act (2015)


Policies, Plans and Guidelines


29. Ministry of Finance, Planning and Economic Development (2018),


Articles and Reports


32. Initiative for Social and Economic Rights (2018), Are We Failing to Progressively Realise the Right to Health?


37. Ministry of Health (2017), Annual Health Sector Performance Report,


**Websites**

Newspaper Articles

55. Elias Biryabarema, Doctors in Uganda’s public hospitals strike over pay and medical supplies, REUTERS, 6 November 2017, available at
About the Initiative for Social and Economic Rights (ISER)

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