

A photograph of a hospital room. In the foreground, there is a white and blue medical machine, possibly a ventilator or oxygen concentrator, with various tubes and gauges. To its right is a metal bed frame with a white sheet. The room has a dark floor and a light-colored wall. A large blue and white graphic element is overlaid on the right side of the image, featuring the text 'Be' in orange.[illegible]

## Acknowledgment

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## Beyond Statistics:

### Addressing Inequity and Discrimination in the Delivery of Health Services in Uganda

Health reports in Uganda are often characterized by aggregated statistical data showing progress on particular indicators such as maternal mortality, infant mortality, life expectancy, HIV/AIDS prevalence and so on. However, what the statistics fail to reveal are the individuals and groups of people excluded from the system, who are denied life saving services because of who they are or where they live. In applying a human rights perspective, it is imperative for policy makers to persistently peer behind the veil of lump-sum statistics and to test the universality and equitability of healthcare access and services.

This is the second issue of the Economic and Social Rights Advocacy (ESRA) Brief published by the Initiative for Social and Economic Rights (ISER). The ESRA Brief is dedicated to Economic and Social Rights (ESRs) advocacy in Uganda but draws on key lessons from the broader East African Community. The Brief is intended for policy makers, civil society actors, development partners and the donor community as it provides insight into the debates and steps currently being undertaken by Ugandan organizations individually and collaboratively to achieve the full realization of ESRs.

After setting out the general issues in the inaugural publication, published in October 2013 under the title ***Economic and Social Rights in Uganda: The Status Quo***; we have now embarked on thematic publications. In this issue, ***BEYOND STATISTICS: Addressing Inequity and Discrimination in the Delivery of Health Services in Uganda***, we provide a qualitative assessment of the degree to which the Uganda National Minimum Health Care Package (NMHCP) is available to the population and identify the health system constraints which impede its full implementation.

In this issue we put universal and equitable delivery of the NMHCP under the spotlight, paying specific attention to vulnerable and marginalized groups including women, the elderly, Persons with Disabilities (PWDs), and mental health patients. We pay attention to social standing and geographical inequities in the provision of health services by examining for example, the disparities between services offered both in rural and urban areas.

Our point of departure is to set the scene by outlining what a state's obligation is in respect of the right to health. This is ably done by ISER Executive Director, Salima Namusoby, who examines in detail the domestic and international legal instruments that give expression to this right.

The United Nations Office of the High Commissioner for Human Rights (UNOHCHR), Charles Kwemoi, shares the added value in using a human rights-based approach to prevent maternal morbidity and mortality.

Dr. Ruth Aceng, Director General of Health Services within the Ministry of Health, examines the capacity of the existing health service delivery structure to meet its mandate and provide universal and equitable access; she also looks into the strategies for universal health care coverage.

Dr Naamala Hanifah Sengendo, a Paediatrician and Public Health Specialist writes about why preventable and treatable diseases kill Uganda's mothers, newborns and children; and proposes some interventions.

Medicines Advisor and Deputy Director, Coalition for Health Promotion and Social Development (HEPS), Denis Kibira, discusses the status and trends of access to essential medicines. Dennis Odwee, Executive Director of the Action Group for Health and Human rights (AGHA), introduces the need for adequate financing to achieve equity in the provision of health care. Civil Society Budget Advocacy Group (CSBAG) provides detailed analysis of the 2014/2015 health sector budget proposals.

Patience Nsiimenta and Ivan Kintu provide us with analysis into the disadvantaged position of the elderly and mental health patients with respect to healthcare access and outcomes.

Finally, we feature a number of submissions from the field: We examine an ISER intervention in Kayunga District which sought to establish why pregnant women still seek out the services of Traditional Birth Attendants (TBAs), and assesses the implications of this. Saphina Nakulima's article looks into the role of Village Health Teams (VHTs) and the challenges they confront in Kayunga, which are important to understand in the light of VHTs being an important arm of the NMHCP.

We hope that this brief will help to inform policy makers and enhance civil society advocacy on the right to health.

***Addressing Inequity and Discrimination in the Delivery of Health Services in Uganda***



## State obligations in respect of the right to health

**By Namusobya Salima, Executive Director - ISER**

(Note: Article makes significant reference to the General Comments of the United Nations Committee on Economic, Social and Cultural Rights-UN CESCR)

The right to the highest attainable standard of physical and mental health (right to health) is recognized in various international, and regional human rights instruments to which Uganda is a signatory, including Article 12 (1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR)<sup>1</sup>, Article 5<sup>2</sup> (e)<sup>3</sup> (iv)<sup>4</sup> of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, Articles 11.1 (f)<sup>5</sup> and 12<sup>6</sup> 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<sup>7</sup> and Article 16 of the African Charter on Human and Peoples' Rights of 1981<sup>8</sup>.

Although there is no substantive right to health under Uganda's Bill of Rights, the Constitution provides for several rights that are determinants of health. Article 33 (3) provides that '[t]he State shall protect women and their rights, taking into account their...maternal functions'; Article 34 (3) states that '[n]o child shall be deprived by any person of medical treatment...by reason of religious or other beliefs' and Article 39 provides for the right to a clean and healthy environment. Direct provisions on health are found under the National Objectives and Directive Principles of State Policy (NODPSP) in the Preamble to the Constitution, which by virtue of the introduction of article 8A are now considered to be part of the Constitution. Objective XIV (b) inter alia enjoins the State to ensure that all Ugandans enjoy access to health services, while objective XX provides that the State shall take all practical measures to ensure the

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. States Parties undertake to...guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of...

3. (e) Economic, social and cultural rights, in particular

4. (iv) The right to public health [and] medical care....

5. Article 11.1: States Parties shall take all appropriate measures to eliminate discrimination against women...in order to ensure, on a basis of equality of men and women, the same rights, in particular [...] (f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

6. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

7. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. 2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (a) To diminish infant and child mortality; (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) To combat disease and malnutrition, including within the framework of primary health care... (d) To ensure appropriate pre-natal and post-natal health care for mothers; (e) To ensure that all segments of society...are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition... (f) To develop preventive health care, guidance for parents and family planning education and services. 3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children. 4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

8. 1. Every individual shall have the right to enjoy the best attainable state of physical and mental health. 2. State parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.



*Local leaders from Buikwe District meet the State Minister for Primary Health Health Care Hon. Sarah Opendi about poor health service delivery*

provision of basic medical services to the population. Objectives XXI and XXII provide for clean and safe water, and food security and nutrition respectively, both of which are determinants of health. The nature of the right to health requires active State intervention, and the State is not only legally responsible for violating or infringing the rights of individuals with its activities, but also for those violations that occur because it has not acted in the expected manner.

### **Obligations to respect, protect and fulfill**

The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The State should not deny or limit equal access for all persons, including prisoners, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; and should abstain from enforcing discriminatory practices as a State policy or imposing discriminatory practices relating to health status and needs.

The obligation to protect requires States to take measures that prevent third parties from interfering with the right to health. It includes among other things the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties. States should also ensure that third parties do not limit people's access to health-related information and services.

Finally, the obligation to fulfill requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health. The State should give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation; and it should adopt a national health policy with a detailed plan for realizing the right. This obligation requires states to take positive measures to enable



and assist individuals and communities to enjoy the right to health.

The ICESCR also imposes obligations on the State with respect to the fulfillment of Economic, Social and Cultural Rights (ESCRs) more generally, but also specifically in terms of the right to health. Whereas the ICESCR provides for progressive realization and acknowledges the constraints resulting from limited resources, it also imposes various obligations of immediate effect. Accordingly, the UN Committee on ESCRs has elaborated the nature of these obligations as discussed below:

### **Obligation to “take steps”**

Article 2 (1) of the ICESCR obliges States “to take steps” towards the full realization of the rights articulated in the Covenant. It has been noted by the UN Committee on ESCR that while the full realization of the relevant rights may be achieved progressively, steps towards that goal must be taken within a reasonably short time after ratification by a State, and should be deliberate, concrete and targeted as clearly as possible towards meeting the obligations relating to a particular right. In that regard, the State is obliged to take all appropriate measures, including policy and legislative, to give effect to the right to health. Measures that might be considered appropriate include, for example, the provision of judicial remedies, administrative, financial, educational and social measures among others.

### **Progressive realization and prohibition of regressive measures**

The concept of progressive realization constitutes recognition of the fact that full realization of all ESCRs is generally not achievable within a short period of time. However, the UN Committee on ESCR has noted that progressive realization of the right to health over a period of time should not be interpreted as depriving this obligation of all meaningful content. Accordingly, progressive realization means that States have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the right to health.

Implicit in the principle of progressive realization is a prohibition against the adoption of regressive measures that cause a reduction in existing levels of protection to the right to health. This could for example result from a reduction in budget allocations to the health sector. The UN Committee on ESCR has stated that there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible. If any deliberately retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the ICESCR in the context of the full use of the State party’s maximum available resources.

### **Elimination of discrimination is not subject to progressive realization**

Non-discrimination is an immediate and cross-cutting obligation in the ICESCR. Article 2(2) of the ICESCR requires States parties to guarantee non-discrimination in the exercise of each of the ESCRs. Discrimination constitutes any distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of Covenant rights.<sup>9</sup> Discrimination also includes incitement to discriminate and harassment.

Notably, merely addressing formal discrimination will not ensure substantive equality. Rather, eliminating discrimination in practice requires paying sufficient attention to groups of individuals who suffer historic or persistent prejudice instead of merely comparing the formal treatment of individuals

<sup>9</sup> For a similar definition see art. 1, ICERD; art. 1, CEDAW; and art. 2 of the Convention on the Rights of Persons with Disabilities (CRPD). The Human Rights Committee comes to a similar interpretation in its general comment No. 18, paragraphs 6 and 7. The Committee has adopted a similar position in previous general comments.

in similar situations. States must therefore immediately adopt the necessary measures to prevent, diminish and eliminate the conditions and attitudes which cause or perpetuate substantive or de facto discrimination. In essence, the State is obliged to create conditions that ensure equitable access to health services; it has, further, an obligation to provide necessary health insurance and healthcare facilities to those who do not have sufficient means to acquire the same privately. It should be noted that inappropriate health resource allocation can lead to discrimination that may not be intentional or overt. For example, investments should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged group, rather than primary and preventive health care benefiting a larger part of the population.

***“In essence, the State is obliged to create conditions that ensure equitable access to health services; it has, further, an obligation to provide necessary health insurance and healthcare facilities to those who do not have sufficient means to acquire the same privately.”***

### **Obligation to achieve the minimum core obligations**

Every State party to the ICESCR has the obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights articulated in the Covenant. In order for a State party to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources, it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations. Accordingly, essential primary health care has been found by the UN Committee on ESCR to constitute a minimum core for the right to health, such that failure of the State to provide it constitutes a violation of the right to health. With respect to Uganda, therefore, the government has a responsibility to ensure that at the very least essential primary health care is available to all who need it, whether they reside in rural or urban areas.

### **Obligation “to take steps, individually and through international assistance and cooperation, especially economic and technical ...”**

When considering the issue of ‘maximum available resources’ with regard to the realization of ESCRs, a State must consider opportunities for international assistance. International cooperation for development is an obligation of all States and the UN Committee on ESCR has noted that it is particularly incumbent upon those States which are in a position to do so, to assist others in this regard. The Committee has also emphasized the importance of the Declaration on the Right to Development adopted by the General Assembly in its resolution 41/128 of 4 December 1986 and the need for States parties to take full account of all of the principles recognized therein.

### **Conclusion**

As a signatory to the ICESCR, the African Charter and other instruments providing for the right to health, Uganda must take steps to ensure the fulfillment of the various obligations as enumerated above. Failure to do so constitutes a violation of the State’s obligations under international, regional and domestic law. In order to move towards fulfillment of its obligations, government should prioritize the following: putting in place effective laws to protect the right to health, by for example, providing for an explicit right to health under the Constitution to enable access to effective remedies in cases of violations; ensure effective implementation of existing policies, by for example, redefining the National Minimum Health Care Package and comprehensively funding a core package of services across all social groups and geographical areas; increase the funding allocated to the health sector, and fast track the [formulation? or implementation?] of a national health insurance scheme.



## Implementing a human rights based approach to preventable maternal morbidity and mortality: the added value

By Charles Kwemai – UN Office of the High Commissioner for Human Rights (UN - OHCHR)

The World Health Organization (WHO) defines Maternal Mortality as: “the death of a woman while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes”.<sup>1</sup> In turn, maternal morbidity is defined as “condition outside of normal pregnancy, labor, and child birth that negatively affects a woman’s health during those times”.<sup>2</sup>

Maternal, new born, child mortality and morbidity continue to exert a terrible toll on women, especially impoverished women in many countries worldwide. WHO, the United Nations Children’s Fund (UNICEF), and the World Bank estimate that between 1990 and 2010, some 287,000 women died of maternal causes and between 10 and 15 million more suffer debilitating complications annually, yet 88 to 98% of these maternal deaths are preventable<sup>3</sup>.

In Uganda, the Maternal Mortality Rate (MMR) of 438/100,000 births, which is far from the 131/100,000 Millennium Development Goals (MDGs) target, paints a really gloomy picture despite reported progress in other health care indicators. The 2013 MDG report highlights the status of maternal mortality health targets as either stagnant or slow<sup>4</sup>. Clearly, the 2015 target may not be achieved. This is a serious concern that has drawn the attention of many including the United Nations (UN). This article argues that there is a value in using a Human Rights Based Approach (HRBA) to policies and programmes to prevent maternal mortality and morbidity, which entails addressing discrimination and empowering women and girls.

In its resolution 18/2, the UN Human Rights Council, in recognition of the challenge of maternal mortality requested the Office of the UN High Commissioner for Human Rights (OHCHR) to prepare a series of reports on preventable maternal mortality as a matter of human rights. In line with this and in cooperation with other UN agencies (especially UNFPA, WHO and UNICEF) and other experts, a technical guidance on the application of HRBA to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity was prepared. The High Commissioner presented the report to the Human Rights Council at its 21<sup>st</sup> session detailing proposals and guidance areas which I refer to in the subsequent sections of this article.

At the national level, the Government of Uganda, launched in November 2013, a major national drive to end maternal and child deaths across the country with a “sharpened Plan” that aims to prevent an additional 40% of under five deaths and 26% of maternal deaths by 2017. It is important to note that the sharpened Plan recognizes HRBA in maternal and new born health (MNH) and lays out five key strategic shifts; focusing geographically on areas with the highest number of child and maternal deaths; increasing access of social services to deprived and vulnerable populations; emphasizing high impact

1 WHO, *International statistical Classification of Diseases and Related Problems, Tenth Revision, Vol.2, Instruction Manual*, 2nd ed. (Geneva, 2004), p.141.

2 S.A Orshan, *Maternity, Newborn and Women’s Health Nursing: Comprehensive Care across the Life Span* (Philadelphia, Lippincott Williams and Wilkins, 2008), p.15.

3 *Trends in Maternal Mortality: 1990-2013*, WHO, UNICEF, UNFPA, World Bank, UN Population Division

4 According to the MDG Report 2013, Target 5 of Goal 5 on improving maternal health which aims to reduce by three quarters, between 1990 to 2015 the maternal mortality ratio and 5b on achieving by 2015 universal access to reproductive health are reported to be stagnant and slow respectively. MDG Report 2013, page 5.



*Preventable maternal deaths, members from civil society attending a Supreme Court session in Kampala about Constitutional Petition 16 challenging maternal deaths.*

intervention that target direct causes of death; addressing broader education, economic and environmental contexts and strengthening mutual accountability.

Clearly, these strategies resonate with the UN Human Rights Council's call to tackle MNH from a HRBA. However, it is important to flag that this plan should not become another of Uganda's "white elephants" but every effort should be made to ensure that it does in fact translate into tangible results thereby positively impacting the lives of vulnerable women and girls. Implementation of the plan should thus be closely scrutinized, tracked and monitored by all stakeholders. The technical guidance on application of HRBA provides another angle of solution that could be a game changer in the efforts to tackle maternal mortality and morbidity and which could marshal all actors to play their respective roles to meet their obligations.

### **Human Rights Based Approach (HRBA): Tackling discrimination and related rights issues to reduce preventable maternal mortality and morbidity**

There is an increasing understanding at the international and regional level that reducing maternal mortality and morbidity is not solely an issue of development, but a matter of human rights because of its implications for a range of human rights, namely the right to life, dignity, education, freedom of information, the right to be freed from discrimination and to enjoy the highest standard of mental and physical health. These rights are enshrined in various international and regional instruments, including the International Covenant on Civil and Political rights (ICCPR), The Covenant on Economic, Social and

Cultural rights (ICESCRs), and the Convention on Elimination of All forms of Discrimination against Women (CEDAW).

The CEDAW Committee, charged with overseeing States parties' implementation of their obligations under the Convention, became the first UN human rights body in 2011, to issue a decision on maternal mortality. *Alyne da Silva Pimentel v. Brazil* established that States have a human rights obligation to guarantee women of all racial and economic backgrounds timely and non-discriminatory access to appropriate maternal health services<sup>5</sup>. The decision affirmed the primary obligation of the State to respect, protect and fulfill the rights of women with regard to discrimination and access to services and thus highlighting the rights issues in maternal mortality.

Maternal Mortality is a result of what has been referred to as the “three delays” namely; **(a)** *Delay in seeking appropriate medical help for obstetric emergency care due to cost, poor education, gender inequality or lack of access to information* **(b)** *Delay in reaching an appropriate facility due to distance and transport* **(c)** *Delay in receiving adequate care when a facility is reached or because electricity, water or medical supplies are lacking*<sup>6</sup>.

Examined carefully from a human rights perspective, these three delays manifest numerous rights issues at play, which require that states human rights responsibilities are engaged. But the scale of maternal mortality and morbidity reflects a situation of inequality and discrimination suffered by women throughout their lifetimes, perpetuated by formal laws, policies, and harmful social norms and practices<sup>7</sup> which must be addressed. An approach that applies human rights principles of equality and non discrimination and that invokes States human rights obligations will provide stakeholders, including States, with vital tools in their ongoing efforts to address the root causes of the problem and to remind duty bearers of their obligations to respond as appropriately required. It will mean understanding the vulnerabilities associated with the three delays and the factors that perpetuate these circumstances, which lead ultimately to maternal deaths.

A HRBA identifies right holders and their entitlements, and the corresponding duty bearers and their obligations. It promotes capacity strengthening of both right holders to make their claims and the duty bearers to meet their obligations. To reduce maternal mortality, a HRBA is premised upon empowering women to claim their rights

***“To reduce maternal mortality, a HRBA is premised upon empowering women to claim their rights and not merely avoiding maternal death or morbidity.”***

and not merely avoiding maternal death or morbidity. Tackling maternal mortality will therefore require mechanisms to empower women to recognize maternal health as an entitlement including comprehensive understanding of sexual and reproductive health in the constitution and/or legislations together with accountability mechanisms for the vindication of health rights. Development plans and policies should, therefore, have inbuilt mechanisms for massive awareness and empowerment of women and girls.

In a HRBA, measures are required to address the social determinants of women's health that affect the enjoyment of their civil, political, economic, social and cultural rights. Patterns of maternal mortality and morbidity often reflect the power differential between men and women. A HRBA calls

<sup>5</sup> <http://www.who.int/bulletin/volumes/90/2/11-101410/en/>

<sup>6</sup> Peter Waiswa, Karin Kallander Stefan Peterson Goran Tomson and George W. Pariyo (2010) “Using the three delays model to understand why newborn babies die in eastern Uganda”, *Tropical Medicine & International Health* volume 15 no 8 pp 964–972 august 2010 at 965

<sup>7</sup> Navi Pillay, UN High Commissioner for Human Rights, [http://www.ohchr.org/Documents/Issues/MDG/Info\\_note\\_maternal\\_mortality.pdf](http://www.ohchr.org/Documents/Issues/MDG/Info_note_maternal_mortality.pdf)



for attention and efforts to tackle these differentials, beyond just a quick fix of the maternal mortality problem. It entails dealing with income inequalities and poverty, discrimination and marginalization that disadvantage women and ultimately impact on their maternal health status. In concrete terms, it means any intervention and strategies aimed at reducing preventable maternal mortality meaningfully, including Uganda's "Sharpened plan" must have inbuilt or deliberate mechanisms to address power differentials, income inequalities and discrimination based on gender beyond the administrative or medical measures.

Lastly, the implementation of HRBA to policies and programmes to reduce preventable maternal mortality and morbidity provides an opportunity for coordination, which is also a viable strategy for actualizing HRBA. Any advances in reducing maternal mortality will stem from collective commitment, and efforts of all stakeholders. However, as HRBA also demands, the root causes and specific responsibilities to address the various issues including the 'Three Delays', must be clearly identified with the involvement of the affected groups. Strengthening accountability and empowering women and girls, with deliberate measures to reduce discrimination must be the focus of any meaningful onslaught against maternal mortality and morbidity in Uganda. OHCHR will continue to contribute towards these efforts especially through technical support to the implementation of a human rights approach.



**Capacity of the existing health service delivery structure to provide for universal and equitable access: Q and A with Dr. Jane Ruth Aceng, Director General of Health services – Ministry of Health**

*“People are frustrated with the services in public health facilities and do not think that there is value in contributing to the scheme. So the Bill is facing a number of challenges.”*

**1. What effort is the Ministry of Health undertaking to achieve universal health care coverage?**

The Ministry is developing the National Health Insurance Scheme Bill, now called the Social Health Insurance Scheme. This scheme is talking to all groups of people including the working class, non working class and business class. The current system does not address equity for free services for all and favours only the rich and working class. So with the new scheme, everyone will have access to both public and private health services. In this new scheme, everyone will be able to contribute to the scheme.

**2. What are the constraints with the Bill so far?**

The problem lies with low level of awareness about the Bill. People are frustrated with the services in public health facilities and do not think that there is value in contributing to the scheme. So the Bill is facing a number of challenges.

**3. Are there any constraints in implementing the universal coverage?**

There are no constraints yet because the scheme is still under development. However, perceived general poor service delivery in health facilities may prove to be a constraint.

**4. Looking at the public health care system now, are services available at health facilities where they ought to be?**

Provision of Health services is categorized according to the level of facility. The sector has facilities at the level of National Referral Hospital, Regional Referral Hospital, General Hospitals, Health Center IVs, IIIs, IIs and the Village Health Teams (VHTs). At each level, different services are provided. As a sector, each facility has been provided with adequate services in terms of equipment, staffing and medical supplies.

**5. What is the basis/criteria for resource allocation?**

Resource allocation is on a ceiling basis. It is determined by the level of facility, the catchment area, burden of disease, prevalence of diseases, and the number of people getting services at the given facility.

## **6. Are services provided uniformly?**

All health services are provided uniformly. For example, antenatal care services are provided to whoever is in need of them, whether one is disabled or not, whether one has HIV or not. Uniformity does not preclude us from catering to the specific needs of certain groups where appropriate, hence we are procuring labour suite beds for disabled mothers.

## **7. What are the challenges in disaggregating data on health care service delivery and all performance indicators?**

A number of factors including but not limited to; inadequate human resources; equipment constraints for example, some districts have been offered computers to perform this function but cannot maintain the computers due to a number of factors and therefore the districts in question fail to provide data. Health workers do not prioritize data collection. Concentrating exclusively on treatment makes it difficult to get an accurate sense of what is happening on the ground.

## **8. What are the general challenges facing the sector?**

- Inadequate funding of the health sector to fully carry out its mandate
- Inadequate human resources, as a result of the inability to attract and retain health workers in certain areas, undermining the ability of the sector to deliver quality health services
- Epidemics distorting budgets and plans resulting in the re-allocation of funds
- Weak linkages between sectoral stakeholders who contribute to the health outcomes of the population.



## Why preventable and treatable diseases kill Uganda's mothers, newborns and children

By Dr Naamala Hanifah Sengendo<sup>1</sup>

**(Note: This article makes significant reference to the PLoS medicine series on maternal, neonatal, and child health in Africa)**

The right to health is provided for under Article 25 (1) of the Universal Declaration of Human Rights, which states that *“Everyone has a right to a standard of living adequate for the health and well-being of himself and of his family including...medical care...”*. Art 25 (2) provides that *“Motherhood and childhood are entitled to special care and assistance...”* In the light of this, it is incumbent upon states to provide healthcare that is premised on principles of universality, equality, and quality and, which is delivered in a transparent and accountable manner. Despite the Universal Declaration's recognition that women and children are entitled to special care and assistance, all too often women and children suffer from negative disparities in terms of accessibility and quality of health care.

The World Health Organization (WHO) reports that in Sub Saharan Africa nearly 4.7 million mothers, newborns (babies below one month of age) and children die each year due to complications in pregnancy and child birth. This is further exacerbated by the 1,208,000 babies who die before they reach one month, and the 3,193,000 children who die before their 5<sup>th</sup> birthday. In Uganda, the number of women dying as a result of pregnancy- and child birth-related complications is about 310 deaths per 1,000 live births or 43,000 women per year. These deaths are attributable largely to direct causes such as excessive bleeding, hypertension and infections including HIV/AIDS. The number of newborn fatalities Uganda records annually is equally stark: 120 babies, less than a month old, die each day due to delivery-related complications, such as premature births, infections, pneumonia and the like. There is a correlation between the causes of death of expectant women/mothers and their babies with about 50% of mothers and their newborns dying within 24 hours of delivery on account of these avoidable or preventable causes. The overwhelming causes of death in children under five years include pneumonia, malaria, poor nutrition and HIV/AIDS.

All these causes of death among women and children are either treatable or preventable. The above direct causes are further complimented and compromised by social determinants of death and ill health like, poverty, inequitable access and poor quality of health services; all of which undermine the prospects of maternal and infant survival.

According to Ugandan policy, public health services should be provided at no cost. However, Uganda's healthcare performance is still ranked as one of the worst in the world because of gaps in coverage, equity and inequality.

Inadequate health financing is one of the major problems leading to out-of-pocket/cash expenditure on health remaining high and mainly affecting the poorest quartile. The Ugandan Government's allocation to health stands at just 8.4% of the total State budget, which is far off the recommended 15% African States committed themselves to under the Abuja Declaration. Consequently, there is a funding gap insofar as public facilities are concerned, which has resulted in increased numbers of people being required to pay cash/out of pocket for health services. Equitable care implies the provision of care to all families who need it as opposed to solely those who can afford it or who

<sup>1</sup> Paediatrician/Public Health Specialist, Chief of Party Maternal, Newborn, Child health Programming, Save The Children International, President Association of Uganda Women Doctors

belong to some other privileged social group.

However, the quality of health care should not become compromised even as it is expanded to meet greater needs. Quality health service provision requires the availability of suitably qualified health workers, essential equipment and drugs. Uganda's healthcare expenditure is about \$25 per capita with out-of pocket expenditure accounting for the largest share of health care expenditure despite "free" services accessible in public facilities. Large discrepancies exist in both the accessibility and quality of the health services available to affluent and more impoverished parts of the country, between public and private provinces and districts and among rural, urban and peri-urban populations.

***"Quality health service provision requires the availability of suitably qualified health workers, essential equipment and drugs."***

Low levels of education amongst the female population, gender discrimination, and a lack of empowerment prevents women from seeking care and from having the autonomy to make timely decisions, to seek medical assistance when danger signs present during pregnancy, or to take children to health facilities as soon as they show signs of illness. Equally frustrating is when women do seek medical intervention, they often have to walk long distances only to receive poor customer service, a lack of basic drugs, staff shortages and so on. Such critical delays and disparities in accessibility and quality of health care lead to unnecessary deaths of too many women and children.

Another contributing factor to these high maternal and infant mortality statistics is the high number of women living below the poverty line, particularly as research tells us that maternal mortality rates are higher in the poorest households than they are among more affluent households.<sup>2</sup> Poverty undermines health through increased risk of illness and poor nutrition, inadequate housing and sanitation and reduced propensity to both seek and access health care services.

What is encouraging, however, is that there are scientifically proven health interventions available to reduce the direct causes of maternal and infant mortality – on the health front and these include immunization, medicines, malaria interventions, and equipment for emergency care. It is unfortunate; therefore, that Uganda is currently underutilizing this existing scientific knowledge as this would significantly reduce current maternal and infant mortality rates in the country. Simple measures, such as Kangaroo Mother Care, whereby mothers provide body warmth to their newborn or premature babies by enveloping them, could be scaled up in facilities where there is a shortage of electronic incubators. Similarly, managing excessive bleeding after birth requires the administration of drugs within minutes



Contributing to neonatal deaths, the only suction machine for new born babies with breathing problems is non-functional at Lugasa Health Centre III in Kayunga District.

2 See 'Trends in Maternal Mortality: 1990-2013', WHO, UNICEF, UNFPA, World Bank, UN Population Division; 'Uganda, 16 September 2013: Mix of old and new helps cut child deaths in Uganda', UNICEF, accessed 8 May 2014 [http://www.unicef.org/esaro/5440\\_uganda\\_child-mortality.html](http://www.unicef.org/esaro/5440_uganda_child-mortality.html)

of delivery; however, this simple yet life-saving protocol is generally not followed.<sup>3</sup>

Unless focus on women, newborns and children is highlighted by prioritizing equity, access and quality of care, Uganda is unlikely to meet its Millennium Development Goals (MDG) for maternal and child health targets as only a year remains in which to achieve them.

### **Call for action**

Government, Civil Society organizations, and funders should prioritize equity, coverage and quality and to address any gaps pertaining to these by:

- Focusing on maternal, newborn and child health to increase access to comprehensive reproductive health services, voluntary family planning, and utilization of the Uganda National minimum health Care Package for mothers and children.
- Pledging new financial commitments to reduce financial barriers for the implementation of national maternal, newborn and child health plans.
- Fill the health worker gap: increase access to skilled healthcare professionals, including midwives, skilled birth attendants and nurses.

Promote inter-sectoral actions such as improving girl child education, improving living conditions and improving water and sanitation can dramatically improve health outcomes.

<sup>3</sup> For more on this, see the website of 'Saving mothers giving life' accessed 8 May 2014 [http://www.savingmothersgivinglife.org/about/maternal\\_mortality.aspx](http://www.savingmothersgivinglife.org/about/maternal_mortality.aspx)



## The status and trends of universal access to Essential Medicines and Health Supplies (EMHS) in Uganda

By Denis Kibira – Deputy Director, Coalition for Health Promotion and Social Development (HEPS)

The World Health Organization (WHO) defines essential medicines as ‘those that satisfy the priority health care needs of the population’.<sup>1</sup> ‘Essential medicines are intended to be available within the context of functioning health systems at all times, in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price the individual, community or government can afford’.<sup>2</sup> The United Nations Development Group in their indicators for monitoring the Millennium Development Goals (2003) defined access as having medicines continuously available and affordable at public or private health facilities or medicine outlets that are within one hour’s walk or five kilometers from an individual’s home.

The Uganda Pharmaceutical Sector Strategic Plan operationalizes the National Drug Policy which aims at ensuring the availability and accessibility at all times of adequate quantities of affordable, efficacious, safe and good quality essential medicines and health supplies to all Ugandans who need them. The public sector is very important for the delivery of medicines, especially to the poor who may not be able to afford private sector services. The procurement and delivery of public sector medicines is a mandate of the National Medical Stores (NMS). Since 2009, there has been tremendous improvement in the financing and supply of essential medicines and health supplies (EMHS) in Uganda; despite this, however, universal access still remains a challenge.

The 2013 mid-term review of the Health Sector Strategic Investment Plan (HSSIP) shows that medicine availability has improved steadily from 21% in 2009/10 to 53% in 2012/13 according to data from

ZONE	DISTRICTS	CYCLE	ORDER DEADLINE	DELIVERY ENDS
ZONE 1	Abim, Amolatar, Amudat, Amuria, Budaka, Bududa, Bugiri, Buikwe, Bukedea, Bukwo, Bulambuli, Busia, Butaleja, Buvuma, Buyende, Iganga, Jinja, Kaabong, Kaberamaido, Kaliro, Kamuli, Kapchorwa, Katakwi, Kayunga, Kibuku, Kotido, Kumi, Kween, Luuka, Manafwa, Mayuge, Mbale, Moroto, Mukono, Nakapiripirit, Namayingo, Namutumba, Napak, Ngara, Pallisa, Serere, Sironko, Soroti, Tororo	CYCLE 1	04-Jun-13	15-Jun-13
		CYCLE 2	06-Aug-13	12-Sep-13
		CYCLE 3	03-Oct-13	08-Nov-13
		CYCLE 4	28-Nov-13	22-Jan-14
		CYCLE 5	12-Feb-14	19-Mar-14
ZONE 2	Buhweju, Bukomansimbi, Bushenyi, Butambala, Gomba, Ibanda, Isingiro, Kabale, Kalungu, Kanungu, Kiruhura, Kisoro, Lwengo, Lyantonde, Masaka, Mbarara, Mitooma, Mpigi, Ntungamo, Rakai, Rubirizi, Rukungiri, Sembabule, Sheema	CYCLE 1	20-Jun-13	01-Aug-13
		CYCLE 2	26-Aug-13	26-Sep-13
		CYCLE 3	22-Oct-13	22-Nov-13
		CYCLE 4	03-Jan-14	05-Feb-14
		CYCLE 5	28-Feb-14	02-Apr-14
ZONE 3	Bulisa, Bundibugyo, Hoima, Kabarole, Kamwenge, Kasese, Kibaale, Kiboga, Kiryandongo, Kyankwanda, Kyegegwa, Kyenjojo, Masindi, Mityana, Mubende, Ntoroko	CYCLE 1	15-Jun-13	17-Aug-13
		CYCLE 2	09-Sep-13	08-Oct-13
		CYCLE 3	05-Nov-13	04-Dec-13
		CYCLE 4	17-Jan-14	17-Feb-14
		CYCLE 5	14-Mar-14	14-Apr-14

1 'Essential Medicines', *World Health Organization*, accessed 7 May 2015 [http://www.who.int/medicines/services/essmedicines\\_def/en/](http://www.who.int/medicines/services/essmedicines_def/en/)

2 Ibid

facilities had better availability of medicines than the rural based ones.

Furthermore from the HEPS Uganda survey, 89% of the public and mission facilities reviewed had Artemether/Lumefantrine, which is used to treat uncomplicated malaria. In contrast, only 75% of the private facilities were in possession of this drug on the day of the survey. However, public facilities had a very low availability of paediatric formulations. The availability of medicines for the management of childhood infections was very low with amoxicillin suspension at 11%, cotrimoxazole syrup at 16% and metronidazole syrup at 45%.

As noted in previous surveys, the management of non-communicable diseases remains a big challenge in the public sector. Medicines for the most common non-communicable diseases (diabetes and hypertension) were available in less than 70% of the facilities surveyed across public, mission as well as private sectors.

The 2013 mid-term review of the Health Sector Strategic Investment Plan (HSSIP) indicates that the budget allocation for medicines (including special programs like malaria, HIV/AIDS and Tuberculosis) has increased, almost doubling from Ushs 110 billion in 2010/11 to UGX 203 billion in 2012/13. Financing for other EMHS also shows significant increase in per capita expenditure from \$0.5 in 2010/11 to \$0.9 in 2012/13. The budget out turn has increased from 79% in 2010/11 to 96% 2011/12. Furthermore, the proportion of government funding for EMHS increased from Ushs 52 billion to Ushs 86 billion with NMS utilizing 95% of this budget with 38% spent mostly at district level.

Despite these increases, EMHS funding is still insufficient and equitable distribution is yet to be realized. However, the annual estimated need of Ushs 130 billion was not met by 55% in 2012/13 which points to significant shortfalls in the government's ability to achieve universal access.

### **Major issues of concern for limited resources**

Up to 70% of Uganda's disease burden is preventable, communicable diseases. This is deplorable especially given that the Minimum Health Care Package has a whole cluster dedicated to increasing health awareness and promoting community participation in health care delivery.

There are over 1.4 million people living with HIV/AIDS (PHAs), with 563,000 enrolled on antiretroviral therapy (ART), and 90% of ART funded by USAID. As per the National Budget Framework Paper (NBFP) 2014/15, a huge disease burden owing mainly to HIV/AIDS, malaria, tuberculosis, pneumonia and diarrhea particularly in children is funded by external donors. This continuous reliance on foreign donors is not sustainable and presents a major risk of paralyzing service delivery in the event of suspension of funding or winding up of projects. The enactment of the Anti Homosexuality Act 2009 has already driven some donors to announce that they will revoke their financial support to the country.

### **Key issues to consider/ way forward**

Going forward, there is need to ensure universal access to medicines. There is also need to scale up rights and responsibilities based household empowerment with an emphasis on prevention programs as well as the prioritization of the development of efficient monitoring systems for health care.

Advocacy should seek to increase funding mechanisms for medicines through for example the National Health Insurance Scheme (NHIS), taxation, and improved procurement and supply management (PSM) capacities especially at facility level. It is equally important to increase transparency and accountability in PSM through increased monitoring. A pricing mechanism should be implemented for medicines in the private sector to increase their affordability.

### ***Addressing Inequity and Discrimination in the Delivery of Health Services in Uganda***

## The need for adequate financing to achieve equity in health

**By Odwe Dennis, Executive Director, Action Group for Health, Human Rights and HIV/AIDS (AGHA)**

Health services in Uganda are provided by both government and the private sector. Health service delivery in Uganda takes place at seven levels of care to achieve the Uganda Minimum Health Care Package (MHCP) provided for in the Health Sector Strategic Investment Plan (HSSIP) III.

Uganda is a signatory to several treaties and conventions, including the Abuja Declaration, which mandates the state to assign at least 15% of its national budget to the health sector. The current budget allocates only 8.6% towards public health care costs; the projection for the next fiscal year is 8.4%. This regression is not only a dereliction by the State of its obligations under the Abuja Declaration, more worryingly it also serves to impede access to quality health care services and in so doing constitutes a violation of Ugandans' right to health.

A consequence of the State under-budgeting for health is that the financial burden shifts to consumers, which means access to health care becomes prohibitive or even closed off to those incapable of meeting the high costs of private health services – particularly worrying in respect of the vulnerable groups in society. Government has a responsibility to ensure not only broad access to health services to tax payers, but an additional responsibility to provide protection to poor and vulnerable members of society to ensure the wellbeing of all people in Uganda so that they are able to positively contribute to the country's economic growth and development.

State financing of health services in Uganda does not correspond with the needs of the population served. This hinders efficiency and effectiveness in health service delivery. The Government of Uganda has not provided alternative health financing options such as national health insurance schemes or community-based health cover, which could serve to provide some financial protection to impoverished rural and marginalized persons who cannot access the comprehensive health services more readily available in urban settings.

The Government of Uganda must strive to align its planning and financing of health services with the World Health Assembly's 2005 Resolution on "Accelerating the achievement of the internationally-agreed health-related goals including those contained in the Millennium Declaration"<sup>1</sup>

In addition, reforms in the health financing system relating to revenue collection, pooling and /or purchasing, will be of great value since this will enable the enhancement of the availability, quality, accessibility and affordability of health services for the benefit of the poorest of the poor.

Improvements to the management of health services should also be encouraged to ensure the invested resources produce the expected results. Attention needs to be directed at improving services at the primary health care level, since this more readily and effectively reaches the poor.

<sup>1</sup> Urging...African countries to fulfill their commitment made at the African Summit in Abuja in 2001 to allocate 15% of their national budgets to health. The resolution also identified specific issues for immediate action: the crisis in human resources for health and ensuring better health of the poorest people in countries...In a separate resolution, the Assembly stressed the importance of promoting the health of women, newborns and children, in meeting the development goals contained in the Millennium Declaration. The resolution urges Member States to commit resources and to accelerate national action towards universal access and coverage with maternal, newborn and child health interventions, through reproductive health care – see [http://www.who.int/mediacentre/news/releases/2005/pr\\_wha06/en/](http://www.who.int/mediacentre/news/releases/2005/pr_wha06/en/): accessed 29 April 2015

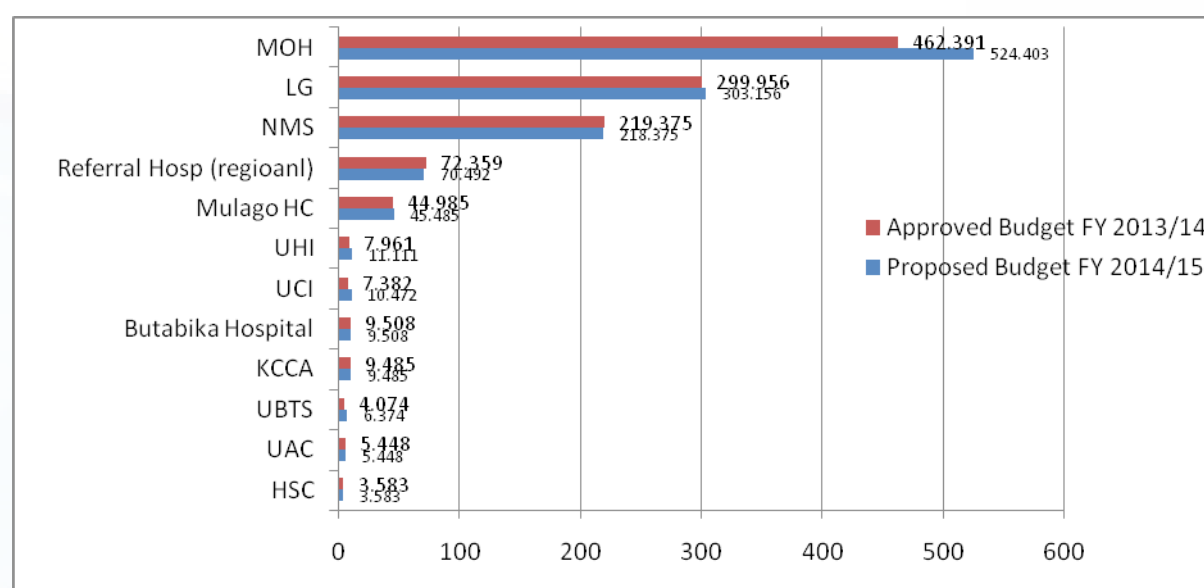


Approached in this way, health financing has the potential to reverse the challenges Uganda currently faces with respect to providing equitable, quality healthcare to all who need it.

## Can the health sector budget deliver universal and equitable health care to Ugandans? An analysis of the 2014/2015 budget projections

By the Civil Society Budget Advocacy Group (CSBAG)

According to the National Budget Framework Paper (NBPF) for 2014/2015 published by the Ministry of Finance Planning and Economic Development, the health budget projection is UGX 1,197.80bn which is 8.40% of the overall national budget. This indicates a decrease in health sector funding from 8.60 % in 2013/2014.



### FY 2014/15 Health sector allocations

Source: NBFP FY 2014/15

This continued decrease in health sector budget funding is inconsistent with the commitment made by the government to allocate 15% of the national budget to health as per the Abuja declaration<sup>1</sup>. This budget reduction is a retrogressive measure that will only cripple further health service delivery in the country.

Looking at the status quo, are we getting the priorities right? Is it exclusively a question of low funding or is it an issue of misuse and diversion of funds? These are critical questions that we should consider when looking at the budgetary allocations for 2014/15.

From the table above, we note that the allocation for the National Medical Stores has reduced from UGX 219.375bn in 2013/14 to UGX 218.37bn in 2014/15. The regional referral hospitals total budget has also reduced from UGX 72.4bn to UGX 70.5bn in 2013/14 and 2014/15 respectively. The likely result, if patients are not served at the regional referral hospitals, will be an increased intake load on Mulago National Referral Hospital. This would appear to motivate for a more diffuse allocation of funds rather

<sup>1</sup> In April 2001, African Union countries meeting in Abuja, Nigeria, pledged to increase government funding for health to at least 15%



*An ambulance donated by Hon.B. Namboozie, the shortage of ambulances at public health facilities has driven some parliamentarians to personally provide for their constituencies.*

than concentrating resources at national level since most people use the public health care system at the local government level. Viewed in this light, the discrepancy between the UGX 524.403bn to be set aside for Ministry of Health headquarters and the UGX 303.156bn for that of local governments/PHC is problematic.

On a positive note, the government should be commended for increasing the budget allocations to the Uganda Cancer Institute from UGX 7.382bn to UGX 10.472bn, and to Uganda Heart Institute from UGX 7.961bn to UGX 11.111bn. This is a step in the right direction towards recognition of the growing problem of non-communicable diseases, for which many Ugandans seek treatment abroad due to limited services in-country. The budget allocation for the Uganda Blood Transfusion Service (UBTS) has also gone up from UGX 4.074bn to UGX 6.374bn. This is also commendable because many deaths, particularly maternal deaths, could have been averted if greater blood stocks were available at health facilities, a case in point being the Nakasero Blood Bank which recently ran out of blood.

### **Critical activities underfunded in 2014/15**

The health sector has identified several critical gaps in the NBFPP, which have been submitted for parliamentary scrutiny, yet continue to be under or unfunded. These include:

- a) The wage enhancement of health workers: no funds have been earmarked for this (with the exception of medical officers at Health Centre IIIs and IVs). UGX 129bn is required for the annual salary enhancement of all staff in the sector.
- b) Recruitment of health workers: no funds have been set aside for the recruitment of health workers at both local government and MoH headquarters to address the shortage of medical sector personnel so that it corresponds with the needs of an increased population. UGX 2.5bn

### ***Addressing Inequity and Discrimination in the Delivery of Health Services in Uganda***



is needed to recruit an additional 3,000 workers, is the shortfall identified in terms of the 2012/2013 recruitment drive.

- c) **Health service delivery in local government:** The non-wage recurrent budget needs to be revised to enhance health service delivery in facilities at this level. UGX 41.6bn is required to make the current structure operate in a more efficient and effective manner. Currently, some health facilities have a budget of UGX 120,000 per month to deliver all the required services (excluding medicines).
- d) **Rehabilitation of general hospitals:** Many of the general hospitals – some of which were constructed in the 1930s and 1960s – are in dire shape. A total UGX826.8bn is required to rehabilitated these facilities, current and ongoing projects notwithstanding. A phased intervention, commencing with UGX25bn in the first year, has been proposed.
- e) **Ambulance Service:** UGX 40bn is required to support the first year during which ambulance services are introduced and implemented for local governments and regions. This would greatly improve the management of emergencies and referrals in the country.

This underfunding is likely to cause inefficiencies in service delivery and points to poor government planning and prioritization of improved health service delivery.

## Recommendations

### ***Re-prioritisation of health sector budget:***

Since the budget process is still on-going up until the presentation of policy statements, we recommend that the Ministry of Health re-aligns its budget towards more pressing needs at lower health units as opposed to concentrating resources at the headquarters. More money should be allocated to regional hospitals, district health budgets, mental health, vaccination, and the recruitment of health workers.

***“Universal access and equity in resource distribution should be ensured especially to cater for hard to reach areas such as the Island districts which include, Namiyango, Kalangala, Buvuma and parts of Wakiso and Mukono.”***

Universal access and equity in resource distribution should be ensured especially to cater for hard to reach areas such as the Island districts which include, Namiyango, Kalangala, Buvuma and parts of Wakiso and Mukono.

### ***Diversion of funds:***

Concerted efforts must be made by government to ensure that the gross underfunding of the health sector is not repeated going forward. While funding challenges are a reality, we recommend that the Ministry of Health’s available resources be put to optimal use. The Auditor General’s report for 2010/11 notes that UGX 620,320,431 meant for medical and agricultural supplies (expenditure item 224002) was utilised on the payment of salaries for intern doctors and sensitization workshops. Such diversion of funds hampers implementation of planned activities.

***No releases:***

In the 2013/2014 approved budget, money was allocated to expand and rehabilitate Kawolo Hospital outpatient department, theatre and maternity, construct four units of staff houses and mortuary – yet no release of these funds was made. All stakeholders must engage in budget tracking to ensure that all the funds approved and disbursed are spent on the delivery of health outcomes.

***Enhance monitoring and supervision of health services***

The budget for sector monitoring by the ministry health should be increased to reflect government's intentions to improve sector monitoring. The monitoring and supervising vote function has not received any increment and currently stands at UGX 0.85bn in the 14/15 budget proposal.

**Note: ISER is a member of the Civil Society Budget Advocacy Group (CSBAG)**

## Mental health: Uganda's silent plight

**By Nsiimenta Patience, Community Psychologist**

The World Health Organization (WHO) defines mental health as a broad array of activities directly or indirectly related to the mental well-being component in the WHO's definition of health: "A state of complete physical, mental and social well-being, and not merely the absence of disease". It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.

A 2006 report on the assessment of Uganda's mental health system, which was conducted using the World Health Organization – Assessment Instrument for Mental Health Systems (WHO-AIMS), as well as a situational analysis report of the mental health system in Uganda in 2008, revealed that some success could be claimed for the previous decade with respect to mental health in Uganda. For instance, mental health constitutes a component of the National Minimum Health Care Package (NMHCP). Other reforms include the integration of mental health into Uganda's Primary Health Care (PHC); the establishment of mental health in-patient units within the regional referral hospitals; the incorporation of mental health training into the curricular of general health workers; and also the involvement of other players, such as Civil Society Organizations (CSOs) and other relevant sectors, in the struggle for the prioritization of mental health issues. These reforms were facilitated by formulation of a mental health policy – a noteworthy feat for Uganda as the WHO estimates that over 40% of developing countries do not have a mental health policy, and over 30% have no mental health programmes in place at all.

However, we should be mindful of the adage that says "good is not good where better is expected". Mental health is still a low ranking priority on Uganda's health agenda, and this has far reaching impacts on productivity, poverty and interactions with other health factors – all of which impact negatively on Uganda's ability to achieve its Millennium Development Goals (MDGs).

Uganda is one of the few countries globally that has health legislation dating back to the pre-1960s, which undermines the human rights of people with mental disorders. Consequently, people with mental disorders are stigmatized; they experience all manner of abuses and discrimination. In part this can be attributed to the existence of out-dated laws on mental health, which are not in line with contemporary approaches, but instead use derogatory language thereby perpetuating and permitting negative and discriminatory attitudes towards people with mental health issues to flourish; and which regards institutionalization of mental health patients as an appropriate therapy.

Due to the widespread stigma and misconceptions around mental health, some non-medical administrators at health facilities do not regard mental health as an area that deserves attention, viewing treatment for such persons as a waste of resources that could otherwise be channeled to "normal" persons – this, in spite of the fact that mental health services are grossly underfunded, comprising only about 1%<sup>1</sup> of health expenditures that is directed towards mental health. Consequently the sector relies heavily on donor funding which presents a big challenge because it is unreliable, not sustainable, and comes with conditions.

<sup>1</sup> Report of the World Health Organization-Assessment Instrument for Mental Health, Uganda (2005), at p9



According to the WHO-AIMS report of 2005, there is only one national hospital dedicated to mental health. There is significant inequality between urban and rural areas in terms of the resources allocated to mental health care. There is also inadequate staffing and inequitable geographical distribution of psychiatric care services in favour of urban areas with 62.4% of the psychiatric beds in the country situated in or close to Kampala, the capital city. In some rural areas, patients have to walk a distance of at least 10kms because Uganda's lower level health facilities do not offer mental health services.

The absence of specific mental health services tailored for children and adolescents is another challenge faced by the mental health system despite the country having one of the youngest populations in the world (in 2005, 49% of the population was younger than 15)<sup>2</sup>.

Another daunting challenge is the mental health referral system. Despite the fact that there is an upward referral system in place, it is not generally followed. Patients apparently seek assistance where they believe there is a greater prospect of receiving it. When patients are referred to regional hospitals, some opt for the National Referral Mental Hospital.

***“The inadequacy of the referral system, coupled with limited access to mental health services, discrimination and stigma have pushed some of the patients to seek recourse in traditional healers.”***

The inadequacy of the referral system, coupled with limited access to mental health services, discrimination and stigma have pushed some of the patients to seek recourse in traditional healers. In some cases, cultural influence links mental illness to supernatural causes and/or witchcraft.

The constraints above stem from a failure to appreciate the prevalence of mental health issues; failure to understand the complexity of integrated, contemporary mental health interventions; poor media coverage; the persistence and significant influence of socio-cultural beliefs on causes and treatment; inadequate funding; competing development and health priorities; limited advocacy; and the stigma surrounding mental illness.

It is therefore evident that despite the affirmative action, the picture that emerges at implementation level is not so rosy, since there is a general perception that mental health care services are very expensive and do not produce fast, observable, and quantifiable outcomes.

A number of actions are needed to effectively address these bottlenecks to delivery of mental health care. As a point of departure, the Mental Treatment Act of 1964 needs to be radically overhauled so that it makes provision for: integration of mental health into the general public health policy and essential health care packages; health systems research to demonstrate the costs and effectiveness of basic mental health care packages in different regions; improved data collection of mental health prevalence and impact, including through the Health Management Information System (HMIS).

Other key reforms required are: increasing awareness, for example through public education and community service provision. This will increase the visibility of the positive effects of treatment by the general public, decision makers and media representatives and as such improve the discourse on mental health with the aim of confronting the stigma currently attached to mental illness. In addition, there is a need for coordinated action by development partners in their

2 Ibid, see p6

support of mental health in Uganda, and more concerted and targeted advocacy geared towards improving service delivery in this area.

These recommendations can only serve to strengthen Uganda's prospects of promoting a more progressive, human rights oriented approach to mental health care.

## Are health services universal and accessible to older persons?

**By Ivan Kintu, Human Rights Activist**

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. Equity-motivated interventions seek to allocate resources preferentially to those with the worst health status. This means understanding and influencing the re-distribution of social and economic resources for equity-oriented interventions, understanding and informing the power and ability that people (and social groups) have to make choices over health inputs and using these choices to enhance health care benefits. Going by this definition, health services in Uganda are still far from being universal and accessible to all social groups particularly in relation to older persons.

The Uganda National Household Survey (UNHS) Report of 2009/2010 published in 2011 estimated the population of older persons in Uganda at 1,300,000. The significant size of this population, which in many cases is either no longer or is a marginal contributor to the economy and therefore heavily reliant on the support of the family or state, has profound consequences at individual, community and national level.

The majority of older persons live in rural areas where poverty is rife, economic opportunities are limited, ill-health is common and health services are inadequate. The majority work in the agricultural sector, which is characterised by fluctuations in both produce and prices, leading to irregular/unreliable income and low returns on labour. The UNHS referred to above also states that 85% are employed in the agricultural sector. 'Older persons are generally too weak to perform productive work and are economically dependent on others, i.e. children, relatives and neighbors among others to survive. Some of them are faced with challenges of looking after grandchildren, especially orphans'<sup>1</sup>

Currently, the formal social security system under the Uganda National Pensions Scheme and the National Social Security Fund (NSSF) covers only a small percentage of the workforce in Uganda. Empirical evidence reveals that only 7.1% of older persons have access to pension, of which 60% are males. The few beneficiaries of pensions face multiple difficulties in processing their retirement benefits such as centralisation of the system, having to travel long distances from upcountry, and inordinate delays in disbursement of their payments.

Relating to health, older persons face specific challenges and vulnerabilities that make them fall through the cracks of the national health care system and would justify targeted interventions that do not exist at present.

Regarding access, older people's access to health care is limited by a number of factors, including: being unable to pay for transport to get to the health centre, or for the medication; being unaware of what they are entitled to; being physically unable to queue for a long time while waiting to be attended to by medical personnel. These factors are compounded by the fact that health care staff

***Relating to health, older persons face specific challenges and vulnerabilities that make them fall through the cracks of the national health care system and would justify targeted interventions that do not exist at present.***

<sup>1</sup> The Uganda National Household Survey (UNHS) Report of 2009/2010 published in 2011, page 137.



may not be trained in geriatric care, and may discriminate against older people.

A study of the Health Needs of Older Persons by the Ministry of Gender Labour and Social Development (MGLSD) in 2002 indicates that older persons are the worst hit by food insecurity and poor nutrition. They mainly feed on carbohydrates and take only one meal a day. Inadequate food intake and poor diet pre-disposes older persons to malnutrition, ill health, emaciation and chronic energy deficiency. Nutrition research and interventions tend to focus on the needs of under-fives, lactating mothers and other younger population groups. This focus has resulted in a failure to acknowledge the food and nutritional needs of older persons.

The common health problems of the older persons include hypertension, stroke, diabetes, heart diseases, trachoma and blindness that often lead to complications and permanent incapacitation. Poor health reduces the capacity of older persons to generate income, curtails their productivity and compels them to depend on other people. Older persons can hardly afford the costs of travelling to the health facilities at the sub-district or in urban centres where they could access the comprehensive National Minimum Health Care Package (NMHCP) provided by the health sector. Their health problems are compounded by the lack of money for seeking appropriate medical attention or buying drugs for non-communicable diseases.

Furthermore the HIV and AIDS pandemic poses a challenge to the Ugandan society and has had a devastating impact on older persons. They are sexually active, caretakers of HIV and AIDS patients and many are sexually assaulted. Most of them lose economic support when their children die and have to go through the stress of caring for orphans. Lack of family support or approval of older persons to marry leads them to secret sexual engagement, which exposes them to HIV and AIDS infection.

Most of the traditional healers and traditional birth attendants (TBAs) are older women and men. They are not targeted for support in terms of access to information on HIV and AIDS. As a result they are at a risk of contracting HIV and AIDS. Whereas Government has a strategic framework for coordination and implementation of HIV and AIDS interventions, most of them do not deliberately target older persons yet they are at risk of infection through unprotected sex, giving care to HIV and AIDS patients, as well as through the use of un-sterilized skin piercing instruments.

A study conducted by the Ministry of Gender, Labour and Social Development (2002) indicated that 42.8% of older persons use boreholes while the majority (59.2%) use water from other sources. The Uganda Reach the Aged Association Report (2005) indicates that older persons who cannot travel long distances use contaminated water, which puts their health at risk. These reports indicate that limited access to safe water, long distances to water sources and poor environmental sanitation are some of the root causes of ill health among older persons. Besides the low coverage of pit latrines, they are not user friendly as older persons usually have squatting problems. Physical accessibility to facilities is vital and has a major impact on the mobility and independence of older persons. Physical inaccessibility discourages older persons from accessing health facilities.

As people get older, their health care needs change. Older people often do not know the clinical effects of ageing, or lack the resources to meet their health care needs. Many older people experience chronic poverty, and this exacerbates the degenerative effects of ageing, such as hypertension, malnutrition, anemia, diabetes, osteoporosis, rheumatism, and hearing and eyesight problems.

Conclusively, we live in an ageing world, in which better public health has resulted in longevity. At the same time, population growth in many parts of the world is stagnating or declining with the result that

it is quite feasible that when the current youth bulge becomes an aging population, health care schemes and systems will struggle to address the significant demands placed on them by the ageing population.

However, this demographic change has led to an epidemiological transition. The predominance of infectious diseases is shifting to non communicable or chronic disease. Non-communicable diseases (NCDs) include a range of chronic conditions, including cancer, diabetes, cardiovascular disease, hypertension, as well as Alzheimer's and other dementias. They are commonly thought of as "diseases of affluence". But in reality, four-fifths of deaths from NCDs are in low- and middle-income countries and older people in developing countries are particularly at risk.

The National Development Plan reveals that Uganda does not have a policy on NCDs and our health system is not designed to handle such illnesses. For Uganda, a primary care strategy for NCDs, including identifying and managing modifiable risk factors, early diagnosis and effective care and follow-up should significantly improve the outcome. This strategy should be integrated in the existing care system, which will require strengthening for better results.

In the light of this, there is an overwhelming need for targeted interventions to address the health needs of older persons. Healthcare service providers need to take into consideration the specific needs and vulnerabilities of older persons by ensuring physical accessibility to health centres, access to information and treatment and ensure that the dignity of older persons is always upheld and respected.

## Experiences from the field under projects supported by the Open Society Institute for Eastern Africa (OSIEA) and the Finnish NGO for Human Rights (KIOS) – *Please watch out for the short videos*

### **Can the government do more to encourage women to seek maternal services at health facilities as opposed to TBAs?**

As part of the strategy to prevent and reduce maternal deaths in Uganda, the Ministry of Health and various stakeholders are engaged in numerous campaigns to persuade pregnant mothers to seek antenatal services from and also deliver at health facilities. The advantages of this are enormous and there is no doubt that the campaigns have yielded some positive results.

However, according to testimonies given at a community dialogue convened by the Initiative for Social and Economic Rights (ISER) in Kayonza Sub County Kayunga District on 19<sup>th</sup> February 2014, women within the Sub County often prefer to seek the services of Traditional Birth Attendants (TBAs). For many of them the nearest health facility that offers maternity services is 15 kms away from home. Due to high poverty levels, many said that they do not have the money needed to hire a motor vehicle or motorcycle to transport them to formal health facilities.

Though they are more readily accessible and affordable, the services of TBAs is not without controversy. According to some women at the meeting, the TBAs do not respect the privacy of their patients. Other challenges cited by participants of the dialogue were that TBAs often do not adhere to the minimum standards of precaution and safety while delivering babies. Not wearing gloves and using unsterilized equipment were some of the shortcomings singled out by participants.

Are TBAs a necessary evil? Can the government do more to have more mothers deliver at health facilities as



*Some of the women who receive treatment at Lugasa HC111 in Kayunga District discuss health service delivery challenges at a community dialogue organised by ISER*



opposed to TBAs?

### **The need to strengthen VHTs!**

For a long time, the Government of Uganda has been promoting Village Health Teams (VHTs) as a model for the first level of health care. In essence, VHTs are taking primary health care to the people. Civil Society Organisations (CSOs) and development partners among other stakeholders believe that VHTs play a critical role in health education and promotion. It is therefore against this background that many CSOs are currently advocating for substantial budget allocation to cater for VHTs. But what is happening on the ground? ISER's community dialogue unearthed a number of challenges that threaten the effectiveness of the VHT effort. The challenges include unclear recruitment processes, poor training, inadequate and sometimes parallel funding by government and non-government actors, as well as failure to lead by example – in this regard, the participants indicated that some VHTs do not have basic sanitation facilities at their own homes.

The women however underscored the importance of VHTs and called upon government to strengthen the system by allocating greater resources to this program, to scale up the training of VHTs, streamline the process of recruitment and supervision to ensure a more professional VHT strategy.



*ISER Programs Manager Angella Nabwowe addressing the Kayunga District Council at the presentation of the budget estimates for FY 2014/15 on 29th April 2014*

## Bridging the health care gap in rural areas: the need to support Village Health Teams (VHTs)

**Saphina Nakulima, Senior Program Officer - ISER**

Evans, Hsu & Boerma<sup>1</sup>, define universal health coverage as the goal to ensure that all people obtain the health services they need without risking financial hardship from unaffordable out-of-pocket payments<sup>2</sup>. It involves coverage with good health services – from health promotion to prevention, treatment, rehabilitation and palliation – as well as coverage with a form of financial risk protection. A third feature is universality – coverage should be for everyone. Although many countries are far from attaining universal health coverage, all countries can take steps in this direction. Improving access is one such step.

As in many countries, health care provision in Uganda is delivered by both government and private providers. For government services, as per the Health Sector Strategic Plan III (HSSP 2010/11 – 2014/15) services are structured into National Referral Hospital (NRH), Regional Referral Hospitals (RRHs), general hospitals (district level), health centers IVs (county level), health centre IIIs (sub – county level) and health centre IIs (parish level). The health centre I has no physical structure but a team of people (the Village Health Teams - VHTs) who function as a link between health facilities and the community. VHTs were introduced by the government in 2001 to serve as the community's initial point of contact for health advice, screening and referral.

The National Health Policy (1999) and the Health Sector Strategic Plan I (2000/2005) articulate the role of community empowerment and mobilization for health, as an element of Uganda's National Minimum Health Care Package (UNMHCP) under the health promotion, disease prevention and community health initiatives cluster. The VHT strategy was identified as a means of achieving community empowerment, mobilization for health nationwide and a vehicle for operationalizing Primary Health Care (PHC).

According to the HSSP III, the responsibilities of the VHTs include the following:

- Identifying the community's health needs and taking appropriate measures
- Mobilizing community resources and monitoring expenditure aimed at securing health benefits
- Mobilizing communities for health interventions such as immunization, malaria control, sanitation and promoting health oriented behavior
- Maintaining a register of members of households and their health status, maintaining birth and death registers
- Serving as the first link between the community and formal health providers
- Community based management of common, childhood illnesses including malaria, diarrhea, and pneumonia; as well as periodic distribution of any health commodities availed by the state

About the successes of VHTs

<sup>1</sup> David B Evans, Justine Hsu & Ties Boerma: 'Universal health coverage and universal access', in *Bulletin of the World Health Organization* 2013, Vol. 91 at 546-547

<sup>2</sup> Ibid, at 546

Uganda's Demographic and Health Survey of 2011 found that 95% of women now receive antenatal care from a skilled provider at least once, and 57% deliver babies in a health facility under the supervision of a skilled provider. Furthermore, 33% of the mothers received a postnatal check-up within two days of birth.<sup>3</sup>

These positive indicators are, by large, attributable to the implementation of the VHT strategy. Notwithstanding this positive development, however, the strategy is not without challenges, the most significant of which is the lack of funding constraining the expansion/up scaling of the VHT programme<sup>4</sup>. This is a serious concern, considering that 'Uganda's health care services are still far from meeting half of the Millennium Development Goals (MDGs) targets to reduce child mortality and improve maternal health'<sup>5</sup>

According to the Ugandan Health Systems Assessment Report 2011, as of June 2010, the number of districts that had fully implemented the VHT strategy stood at 51 out of 93 districts with the other 39 districts at divergent levels of implementation. According to the Annual Health Sector performance report (AHSPR) 2012/2013, 84 districts have been covered at 100%, 6 districts (Kalangala, Kanungu, Kisoro, Mukono, Nakasongola and Ngora) are at 50% coverage, while 19 districts (for example Buikwe, Bulambuli, Busia, Buvuma, Buyende, Iganga, Kayunga, Kampala etc) are below 50%. There are some sub counties that have been left out yet the program should cover all villages in the country to ensure that at least all households, regardless of their geographical location, can access primary health care.

Secondly, there are different standards of motivation applied for VHTs even within the same districts, depending on who is facilitating their work. Those maintained by NGOs and other development partners are motivated to do their work while their counterparts rolled out under the government program receive very limited or no facilitation, and are therefore demotivated. Some VHT's are paid a weekly allowance, transportation, mobile communication while others are not. Such inconsistencies have undermined the efficiency of the VHT strategy and its ability to promote primary health care in certain districts.

Even in areas where the VHT programmes have been rolled out, some NGOs and other development partners as well as Ministry of Health programmes may support parallel VHTs and or community health workers. In AHSPR 2012/2013, it was noted that there are a number of partners supporting VHTs and providing tools using a programmatic rather than an integrated approach. This lack of coordination between the partners and the Ministry of Health and/ or District health offices negatively impacts the performance of VHTs and undermines the sustainability of VHT-driven initiatives because in many instances once the particular program for which the VHTs are trained concludes, VHTs may not, for example, be assigned to another project or redeployed, which seriously undermines the continuity of the VHT strategy.

The Ministry of Health also acknowledges in the AHSPR 2012/2013 that the training of VHTs is not in tandem with its establishment. Consequently, not all VHTs may have received training on their roles and responsibilities by the time programmes/projects are being implemented. The percentage of villages

3 'Uganda Makes Progress on Maternal Health, But Serious Challenges Remain', *World Bank*, accessed 1 May 2015 <http://www.worldbank.org/en/news/feature/2012/10/23/uganda-makes-progress-on-maternal-health-but-serious-challenges-remain>

4 HSSIP III cited lack of funding as a major constraint in the rolling out of VHTs in all districts in Uganda. VHTs are funded under the Ministry of Health budget primary health care vote.

5 Ibid

with trained VHTs decreased from 78% in 2011/2012 to 55% in 2012/2013 which is below the Health sector Strategic Investment Plan (HSSIP) target of 75%.

The Initiative for Social and Economic Rights (ISER) is implementing a project - “Innovations for Civic Engagement in Social and Economic Rights in Uganda” in Kayunga District and

during its outreach programs got information from the District Senior Health Educator to the effect that VHTs in the sub counties of Kayonza and Kangulumira are the only ones that received training out of the eight sub counties that form the district.

The Health Educator also identified the lack of tools and kits for use by VHTs as a serious challenge. He cited as an example the case of VHTs in Kayunga, a few of whom were given bicycles to facilitate their movement, noting however, that in the absence of medical supplies to disburse to community members, this mobility was not fully maximized.

Successful implementation of the VHT strategy in Uganda has a strong potential to solve the health personnel gaps prevailing in the rural areas. Having a wide coverage of VHTs with permanent incentives, proper management and coordination will strengthen the State’s ability to deliver primary health care in remote areas.

***“Successful implementation of the VHT strategy in Uganda has a strong potential to solve the health personnel gaps prevailing in the rural areas.”***





# ISER

Facilitating Social Justice

**About the Initiative for Social and Economic Rights - Uganda**  
*ISER is a registered national Non – Governmental Organization (NGO) in Uganda founded in February 2012 to ensure full recognition, accountability and realization of social and economic rights primarily in Uganda but also within the East African region.*

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