ISER

Facilitating Social Justice

INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS

"Here, When You Are Poor, You Die!"

Healthcare On Sigulu Islands

March, 2018

ISER
Facilitating Social Justice
INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS

"Here, When You Are Poor, You Die!"

Healthcare On Sigulu Islands

March, 2018

ISER is a registered Non - Governmental Organisation (NGO) in Uganda founded in 2012 to promote the effective understanding, monitoring, accountability, implementation and realization of economic and social rights.

For more information, please visit ourwebsite: https://www.iser-uganda.org

Recommended Citation:
Initiative for Social and Economic Rights (ISER) 2018, "Here, When you are poor,You die!" *Healthcare on Sigulu Islands,* Kampala, Uganda

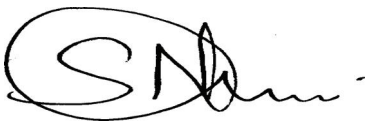
FOREWORD

It's the era of the Sustainable Development Goals (SDGs) and countries, Uganda inclusive, are quick to champion "leaving no one behind." As a country, we have aligned our health policy and National Health Sector Development Plan 2015/16-19/20 with SDG 3 calling for Universal Health Coverage. We are at the cusp of passing a bill to operationalize a national health insurance scheme. Official statistics reveal Uganda has achieved its targets for ensuring access to health facilities. According to the latest Annual Health Sector Performance report 2016/17, one of the sector achievements is meeting the target of 100% of the population living within a 5 km radius of a health facility, exceeding the 85% mark set in the Health Sector Development Plan.

This report, is the first in a series of reports questioning this progress, revealing that we are failing to ensure access to healthcare to those that need it the most, particularly in hard to reach areas like the islands and remote areas like Karamoja. This report, focuses on Sigulu islands, an amalgamation of islands in Namayingo district, and finds widespread disparities in access to health care.

As this report shows, failure to address these disparities disproportionately affects women and poor people living in remote areas. Women in Sigulu islands, who due to the lack of access to healthcare, have given birth in boats while trying to go to a health centre. Women who have had to trade their belongings including their mattresses to raise the necessary transport fare necessary to travel to health facility. People who have no choice but to visit a bat infested health facility, because it is the only one within close proximity. In the words of a community member, "Here, when you are poor, you die."

Achieving universal health coverage will require more than paying mere lip service to the ideal. It requires ensuring equitable access to health care and transformation of service delivery to realise increased accessibility. It requires frank discussions about the gaps that exist and targeting resources to ameliorate those gaps. Through this series of reports highlighting challenges and barriers to access to health care in hard to reach areas, ISER hopes to stimulate discourse and action on addressing these deep inequities.



Salima Namusobya
Executive Director

ACKNOWLEDGEMENTS

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, Joshua Kisawuzi were instrumental in designing and conducting this research as well as writing this report with the assistance of students in the Clinical Legal Education (CLE) program under the Public Interest Law Clinic (PILAC) at School of Law, Makerere University namely Ferdinand Tumuhaise, Geoffrey Obbota, Gloria Nagami, Winnie Begumisa, James Nuwagaba.

Matthew Wrocklage, a student at Yale University and former ISER intern, deserves huge thanks for his research and tireless editing of the report.

ISER also appreciates the efforts of Ms. Salima Namusobya, Ms. Angella Nabwowe, and Ms. Diana Ahumuza were instrumental in providing feedback and support along the way and the experts who generously took time out to speak with the team and assisted in the design and development of the research including Hon. Abott Ouma, Member of Parliament, Bukooli Island County, Namayingo District and Dr. Juma Nyende.

Finally, a special thanks to the leaders and community members who were kind enough to welcome us to their homes, provide us with the necessary context and speak with us about their experience, especially those that had to relive difficult moments where they lost loved ones due the lack of easy access to healthcare on the islands. Without their active participation in this research, we would not have understood the disparities in access to healthcare on the islands. This report is dedicated to them.

TABLE OF CONTENTS

LIST OF ACRONYMS

ACHPR	African Charter on Human and People's Rights
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
BMU	Beach Management Unit
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
CHEWS	Community Health Extension Workers
DHO	District Health Officer
FGD	Focus Group Discussion
HC	Health Centre
HCI	Health Centre Level One
HCII	Health Centre Level Two
HCIII	Health Centre Level Three
HCIV	Health Centre Level Four
HCT	Hematocrit Testing
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan
HSDP	Health Sector Development Plan
HUMC	Health Unit Management Committee
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICCM	Integrated Community Care Management

ISER	Initiative for Social and Economic Rights
LQAS	Lot Quality Assurance Sampling
NDP	National Development Plan
PWDs	Persons With Disabilities
NMR	Neonatal Mortality Rate
NSDS	National Service Delivery Survey
PFMA	Public Finance Management Act
PNFP	Private Not-For-Profit
STAR-E	Strengthening Tuberculosis (TB) and AIDS Response in Eastern Uganda
STAR-EC	Strengthening Tuberculosis (TB) and AIDS Response in East-Central Uganda
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
UDHR	Universal Declaration of Human Rights
UDHS	Uganda Demographic and Health Survey
UHC	Universal Health Coverage
VHT	Village Health Team

LIST OF TABLES

EXECUTIVE SUMMARY

The right to health has been formally recognized for over half a century, reaching back to the adoption of the International Covenant on Economic, Social and Cultural Rights (ICESCR) by the United Nations General Assembly in December 1966. Under Article 12, signatory states are compelled to "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,[1]" and to ensure the creation of "conditions which would assure to all medical service and medical attention in the event of sickness.[2]"

Current roadmaps for actualizing the right to health increasingly call on states to achieve Universal Health Coverage (UHC) for all individuals. Most notably, Goal 3 of the Sustainable Development Goals Agenda 2030 sets a clear target that all countries should have successfully achieved UHC, by ensuring "access to quality health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.[3]" This is in line with Uganda's National Health Policy and Health Sector Development Plan which "aim to accelerate movement towards UHC.[4]"

Despite such wide-reaching and long-standing obligations to ensure health services for all, the failure of the State to reach remote communities with health services has entrenched deep inequity in health care access in Uganda. Despite the Ministry of Health naming Universal Health Coverage as a cornerstone goal in the Health Sector Development Plan 2015/16-2019/20, disparities in access to quality healthcare remain wide-spread in Uganda.

In discussing access to health care for Uganda's remote communities, inadequate attention has been

[1] United Nations International Covenant on Economic, Social and Cultural Rights (ICESR), Article 12.1 adopted in December 16, 1966, http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx (last accessed August 18,2017)

[2] Ibid, Article 12.2 of the ICESCR.

[3] Sustainable Development Goal 3: "Ensure healthy lives and promote well-being for all at all ages," United Nations Sustainable Development Goals, United Nations, 2015 accessed at http://www.un.org/sustainabledevelopment/health/ (last accessed August 19, 2017)

[4] Ministry of Health, Health Sector Development Plan 2015/16-2019/20. 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."

paid to isolated island communities across Lake Victoria. While the current literature discusses accessibility concerns in upcountry and rural Uganda, far less focus has been given to the unique challenges facing Uganda's remote islands, communities for whom island geography, severe poverty, and poor healthcare infrastructure continues to hinder access.

To illuminate the status of access to health services for Uganda's island communities, the Initiative for Social and Economic Rights (ISER) conducted a fact-finding mission to the Sigulu Islands from March-April 2017 in Namayingo District.[5] Through key informant interviews and focus group discussions, ISER collected information from a range of stakeholders, including leaders who shared their personal experiences of accessing health services on the Islands; health care personnel, including members of local Village Health Teams (VHTs) operating across the Islands; health unit management committees and community members.

The findings were evaluated through the lens of Uganda's obligations to safeguard the right of individuals and communities to realize the highest attainable standard of health. This report marshals the criteria outlined in the United Nation's General Comment No. 14 to the ICESCR, which provides the gold standard to determine the degree to which any given community is able to actualize its right to health. These criteria include health service availability, accessibility, acceptability, and quality.

The fact-finding mission found severe deficiencies in the state of healthcare. The following primary areas of concern require serious attention from government authorities:

- Limited accessibility of health centers on the Sigulu Islands. Few health centres operate on the islands, while some parishes do not have any at all, falling short of the requirement to have a health facility within a 5 km radius as set out in the health policies.

- Status of health centres and range of services provided. The few facilities on the islands are HCIIs and HCIIIs, which offer limited services and cannot handle serious complications.

- Lack of access to emergency care. There is no functional ambulance on both the District and the islands which has resulted in rampant loss of life and exorbitant out of pocket costs as residents seek to hire boats to transport patients with severe conditions. This disproportionately affects vulnerable groups like women and people with disabilities. The fact-finding team repeatedly heard testimonies from individuals describing instances of attempting to overcome distance and other barriers to access emergency health care services, episodes not infrequently resulting in loss of life before reaching the health facility.

[5] The ISER team visited Matolo village in Manga Parish, Rabachi Parish, and Nampongwe Parish in Sigulu Sub-county Haama Parish and Lolwe Parish in Lolwe Sub-county.

- The quality of health services provided is poor. Some of the few health facilities available are dilapidated which limits their functionality and they often lack essential supplies and electricity.

- Human Resource is severely lacking. None of the health facilities on the island meets the minimum staffing requirements per health policies. Despite the need, there is no resident medical officer based on Sigulu islands. Chronic understaffing results in long waiting times and affects the quality of healthcare provided.

- Access to underlying determinants of the right to health such as clean and safe water and sanitation facilities remain a challenge. The island topography has made it difficult for residents to construct sanitation facilities like toilets. Some residents revealed that the water at the shores of the lake is contaminated from human excretion yet it is their main source, making the community vulnerable to sanitation related diseases including cholera and typhoid.

- Absence of avenues for the community to meaningfully participate in monitoring the right to health holding the leaders accountable for health related violations. Health Unit Management Committees (HUMCs) are often informally constituted and are ad hoc. On some islands, the HUMCs were self-appointed thus they lacked orientation on their role and responsibilities. The community is not consulted during the national budget processes.

Finally, this report considers lessons learned from other contexts of healthcare provision in remote and island settings, distilling out potential solutions from the literature for fulfilment of the right to health and improvement of health systems on the Sigulu Islands. The report concludes with suggestions of recommendations for improving services for communities residing on Sigulu islands, directly informed by the recommendations given by individuals interviewed and derived from best practices identified during the course of the research. Specifically the report makes the following recommendations:

RECOMMENDATIONS

Ministry of Health

- Construct more health facilities on the island.
- Upgrade HCIII-level facilities to HCIV facilities and HCII-level facilities to HCIII-level facilities.
- Provide overland and marine ambulance vehicles for all health centers.
- Build staff quarters.
- Increase the number of health workers at the health centers to meet standard staffing allocations.
- Increase access to family planning and community health education.
- Take measures to ensure provision of safe water.
- Take measures to address the lack of electricity.
- Increase the supply of essential drugs.
- Meet the urgent equipment needs of island health centers.
- Train health workers to provide disability friendly health service.
- Take into account the unique health challenges faced by island communities when formulating health policy and passing the health budget.
- Increase the general connectivity of the Sigulu Islands to the mainland.

Local Government

- Increase Local Supervision of Private and Public Facilities.
- Construct more pit latrines and provision of mobile pit latrines.
- Sensitize the community members on the exercise of their right to health and preventative measures.

Parliament

- Strengthen the legal and policy framework relating to health by including a right to health in the Constitution, enacting a law on health that would among other things provide for affirmative action in hard to reach areas such as islands.
- Ensure that budgetary allocations within the health sector will promote equity in access to healthcare.

Civil Society

- Use this report to advocate for implementation of recommendations.
- Engage in research and documentation to highlight challenges in access to healthcare for hard to reach areas.
- Conduct sensitization on a rights based approach to health.

1.0 INTRODUCTION

1.1 Background: The Context of Uganda's Island Communities and the Eastern-Central Region

The Sigulu Islands constitute just one of the numerous island communities dotted across Lake Victoria, some located a short distance from the coastline and others are found in archipelagoes further removed from the mainland. In addition to the Sigulu Islands of Namayingo District, Uganda is home to other Lake Victoria communities, including the Ssese Islands, the islands of Buvuma District, and Koome Island. Though each local context is unique, previous studies show that Uganda's island communities share a number of common characteristics – and challenges to access to healthcare.

With fish export being the third leading contributor to Uganda's GDP, fishing represents a vital component of the economy of Uganda's island communities.[6] The population of fishermen on these islands can be highly mobile, moving between different residences as fishing conditions vary throughout the season.[7] Researchers have often described the occupation and livelihood island fishermen as high-risk and characterized by uncertainty, producing high transience into and out of the fishermen workforce.[8] Such island economies include migratory fishermen, as well as support workers engaged in fish processing and households engaged in agriculture or other livelihoods.[9]

National monitoring has found that island communities face a number of common challenges to health. While the plight of individuals residing in Uganda's islands and fishing communities has received national media attention,

[6] Bwire. G, Munier. A, Ouedraogo. I, et al. (2017), "Epidemiology of cholera outbreaks and socio-economic characteristics of the communities in the fishing villages of Uganda: 2011-2015", PLoS Negl Trop Dis 11(3): e0005407 available at http://journals.plos.org/plosntds/article?id=10.1371/journal.pntd.0005407 [last accessed on March 2, 2018].
[7] Westaway. E, Seeley. J, and Allison. E, (2007) "Feckless and Reckless or Forbearing and Resourceful? Looking behind the Stereotypes of HIV and AIDS in "Fishing Communities" African Affairs 106, no. 425 (2007): 663-79 available at http://www.jstor.org/stable/4496487 [last accessed on March 2, 2018].
[8] Ibid
[9] Ibid.

particularly with regard to disease outbreaks[10] and the high HIV prevalence[11], the state of healthcare on the island remains ignored. Yet certain islands remain isolated from health centers. In rural areas of the islands, the distance to the nearest government health facility from residences visited was much higher than the recommended 5 km.[12] These distances, and resulting transportation difficulties, continue to hinder accessibility of health services and transportation to health facilities.

The 2015 National Service Delivery Survey identifies 9 districts in Uganda as "island" districts, namely: Buikwe, Buvuma, Kalangala, Masaka, Mayuge, Mukono, Namayingo, Rakai, and Wakiso.[13] In several key health indicators, these island districts lagged dramatically behind national averages. In Table 1, two common indicators of health system performance (successful provision of at least 4 antenatal visits, as well as administration of the anti-malarial Fansidar to pregnant women) from select island districts are compared against national averages.[14] Though some island districts performed at the level of national averages, others lagged far behind and all of them fell beneath Kampala's performance level. Of the 111 districts in Uganda surveyed by the Ministry of Health, two of the ten lowest-performing districts[15] were island districts, namely Wakiso and Buvuma, the latter being the lowest performing district. A basic finding of this survey, based on district infrastructure and capacity for delivering health services, is observation of a "consistent relationship between hard-to-reach districts and poor performance," prompting the report to call for "special attention…to these districts in order to tackle the unique challenges in the districts."[16]

[10] Basudde, E. (2012) "HIV eating up islands and fishing communities," New Vision, December 14, 2012 available at http://www.newvision.co.ug/new_vision/news/1311365/hiv-eating-islands-fishing-communities (last accessed on March 4, 2018). See also Simunyu F, "72 Dead in Suspected Meningitis Outbreak on Remote Island," Uganda Radio Network, April 27, 2010 available at https://ugandaradionetwork.com/story/72-dead-in-suspected-meningitis-outbreak-on-remote-island (last accessed March 4, 2018).

[11] Ibid

[12] Ministry of Health, Annual Health Sector Performance Report: Financial Year 2015/2016, 2016 at p.12.

[13] Ministry of Health, "2015 National Service Delivery Survey" available at http://www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/2015%20NSDS%20report.pdf (last accessed March 4, 2017).

[14] Uganda Bureau of Statistics, (2017), Uganda Demographic and Health Survey (UDHS) 2016, Kampala, Uganda at p. 41.

[15] Annual Health Sector Performance Report: Financial Year 2015/2016, Ministry of Health, 2016 at p.25.

[16] Ibid at p. 37.

Table 1. Health Indicators for Select Island Districts, 2015/2016[17]

Health Indicator (2015/16)	Indicator	Districts				National Average
		Kalangala	Buvuma	Wakiso	Namayingo	
	% Pregnant women who receive 4 antenatal care visits	28	8	16	33	32
	(Difference from nat. avg.)	-4	-24	-16	+1	
	% Pregnant women who receive 2nd dose of Fansidar for IPT	36	33	29	63	49
	(Difference from nat. avg.)	-13	-16	-20	+14	

The high prevalence of HIV/AIDS across Lake Victoria's fishing communities, as well as the difficulty in providing effective treatment in these communities, represents another common challenge faced by Uganda's islands. Research conducted across these fishing communities found HIV prevalence rates four times higher (26.7%) than the general population and a new HIV infection rate 8-10 times higher than in the general population.[18] Among nine districts studied in Eastern-Central Uganda in 2011, Namayingo District had the highest HIV prevalence rate (10.3%).[19] The transience of fishermen in these communities often creates challenges for HIV/AIDS treatment and prevention. Various studies have found individuals in fishing communities maintain wide sexual networks with multiple partners.[20]

Poor sanitation across many island communities contributes to heightened risk of outbreak of epidemic diseases. Recent estimates by the Ministry of Health report 28% of households in island communities have no toilet facilities.[21] Such sanitation challenges have made containment of diseases such as cholera difficult across Uganda's fishing communities. From 2011-15, fishing villages along Lake Victoria and other waterways contributed 55% of national cholera deaths despite being home to only 5-10% of the population.[22] Whereas the Sigulu Islands reported no cholera cases during the 2011-15 study period, the neighboring

[17] Uganda Demographic and Health Survey (UDHS) 2016, supra note 14 at p. 41.
[18] Kiwanuka et al., "High HIV-1 Prevalence, Risk Behaviours, and Willingness to Participate in HIV Vaccine Trials in Fishing Communities on Lake Victoria, Uganda," Journal of the International AIDS Society 16 (March 2013): 18621 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3720985/ [last accessed on March 5, 2018].
[19] Strengthening TB and HIV&AIDS Responses in East Central Uganda (STAR-EC), (2011), "Program Year 3 Annual Report: Achievements, Lessons Learned and Way Forward" available at http://pdf.usaid.gov/pdf_docs/PA00J9DS.pdf (last accessed on March 7, 2018).
[20] Grellier R et al., (2004), "The Impact of HIV/AIDS on Fishing Communities in Uganda: Appendices to Field Study Report," Marine Resources Assessment Group (MRAG), October 2004 available at http://www.uac.go.ug/Fisheries/impact.pdf [last accessed on March 7, 2018].
[21] Ministry of Health, Annual Health Sector Performance Report Financial Year 2015/2016, at p.25.
[22] Bwire. G, Munier. A, Ouedraogo. I, et al. (2017), "Epidemiology of cholera outbreaks and socio-economic characteristics of the communities in the fishing villages of Uganda: 2011-2015", PLoS Negl Trop Dis 11(3): e0005407 available at http://journals.plos.org/plosntds/article?id=10.1371/journal.pntd.0005407 [last accessed on March 2, 2018].

Mutumba Sub-County reported over 100 cases.[23]

These findings from Uganda's fishing communities provide important contextualization for understanding the challenges faced by the Sigulu Islands. The Sigulu Islands are situated in the Eastern-Central sub-region of Eastern Uganda. Recent health systems monitoring has shown that Eastern Uganda lags behind other regions in numerous performance indicators important for maintaining accessible healthcare for all. According to the 2014 Hospital and Health Centre IV Census Survey, Eastern Uganda had the lowest ambulance availability rate with ambulance services available at 65% of health facilities, as compared to 72% availability nationwide.[24] When hospitals and Health Centre IV (HCIV) facilities in Eastern Uganda were examined, only 55% offered an ambulance or emergency vehicle, compared to 71% nationwide.[25] These hospitals and HCIVs also had the lowest mean availability (39%) of essential medicines out of all four regions, with only 7% reporting having at least half the medicines listed, compared to 22% nationally and four times lower than Central region.[26] For non-communicable diseases, only 5% of hospitals and HCIVs in the region had half of recommended medicines, compared to 10% in rural areas nationwide and 38% in Uganda's urban areas.[27] In all, 57% of hospitals and HCIVs reported having low availability of medicines for patient use.[28] The Ministry of Health's Annual Health Sector Performance Report 2016/17 ranks Namayingo District 103 out of 116 in the recent District League Table which assesses performance based on a composite index informed by indicators including staffing levels, deliveries in health facilities, and latrine coverage in line with the Health Sector Development Plan.[29] Namayingo was among the districts that showed the most decline on health care, scoring below the national average of 66.2%.[30]

In the most recent Population Census 2014, Namayingo District, home of the Sigulu Islands, was found to have a population of 215,442, with 199,717 living in rural areas compared to 15,725 living in urban areas.[31] Average household size was 5.[32] Total population density for the district was 367 persons per sq. km.[33] With this regional, cultural, and demographic context, the fact-finding mission sought to capture in detail how these and other challenges of island healthcare uniquely manifest on the Sigulu Islands.

---

[23] Ibid.
[24] Ministry of Health, "Hospital and Health Centre IV Census Survey 2014," January 2016 available at http://www.who.int/healthinfo/systems/SARA_H_UGA_Results_2014.pdf [last accessed on March 2, 2018] at pp. 29, 53 and 54.
[25] Ibid at p. 54.
[26] Ibid at pp. 165.
[27] Ibid at p.168.
[28] Ibid at p.166.
[29] Ministry of Health, Annual Health Sector Performance Report Financial Year 2016/17 at p.38, accessed at http://health.go.ug/content/annual-health-sector-performance-report-201617 [last accessed16 December 2017].
[30] Ibid. at pp.37-38.
[31] Uganda Bureau of Statistics, The National Population and Housing Census 2014 – Main Report, Kampala, 2016 at p.51.
[32] Ibid at p.54.
[33] Ibid.

1.2 Background: Health Systems in Uganda

In Uganda, the government-run health system involves multiple tiers of public health facilities intended to provide free health services to the communities. The system includes four designations of health centers: Health Centres I (HCIs), Health Centres II (HCIIs),[34] Health Centres III (HCIIIs), and Health Centres IV (HCIVs).[35] The higher the health centre in this hierarchy, the greater its capacity to provide specialty and referral services, beginning with HCIs comprised of the local Village Health Teams (VHTs). The VHTs do not provide medical services per se, but conduct health education among the community members. This hierarchy within health centres ends with the HCIV, where patients should be able to access emergency surgery, blood transfusions, laboratory services, and all services provided at lower-designation health centers.[36] Beyond the HCIV level are the General hospitals, Regional Referral Hospitals and National Referral Hospital that provide all HCIV-level services and specialty services including intensive care, radiology, pathology, psychiatry, high level surgery, dentistry among others.[37]

In Namayingo District, a total of 32 health facilities provide services, including twenty five (25) government facilities and seven (7) Private Not-For-Profit (PNFP) facilities.[38] The health centers available on Sigulu Islands are designated HCIIs and HCIIIs.[39] According to Ministry of Health Guidelines, HCIIs provide the first level of interaction between health workers and the communities.[40] A HCII only provides outpatient care and community outreach services,[41] employing an enrolled comprehensive nurse who provides linkages with the VHT.[42] A HCII facility, intended to serve up to 5,000 people, should be able to treat common diseases like malaria.[43] Designed to serve communities up to 20,000 in population, HCIIIs provide basic preventive, promotive, in patient, maternity, laboratory and outpatient curative services, as well as supervise the community and HCIIs under their jurisdiction.[44] In examining the performance of the health system on Sigulu Islands, these Ministry of Health Guidelines for health centers at each designation provided important evaluative criteria for the fact-finding mission.

---

[34] The Ministry has proposed phasing out HC IIs and instead upgrading them to HC IIIs to ensure 100% coverage of sub counties with HCIIIs to enable an upgrade of maternal health and delivery capacity. Ministry of Health, Annual Health Sector Performance Report, Financial Year 2015/2016, at p.105

[35] Ministry of Health, Guidelines for Designation, Establishment and Upgrading of Health Units, Health Infrastructure Working Group, 2011 at p. 6.

[36] Ibid.

[37] Ibid.

[38] Interview with the Assistant District Health Officer (DHO), Namayingo District on April 3, 2017.

[39] Ibid.

[40] Ministry of Health, "Guidelines to the Local Government Planning Process Health Sector Supplement, 2016" accessed at http://library.health.go.ug/download/file/fid/580957(last accessed December 1, 2017) at p. 38.

[41] Ministry of Health, Guidelines for Designation, Establishment and Upgrading of Health Units, supra n35 at p.6.

[42] Ministry of Health, "Guidelines to the Local Government Planning Process Health Sector Supplement, 2016" at p.57.

[43] Ministry of Health, Guidelines for Designation, Establishment and Upgrading of Health Units, supra 35 at p.6.

[44] Ibid.

2.0 REALIZING THE RIGHT TO HEALTH IN REMOTE DISTRICTS

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. At a domestic level, Uganda is bound by obligations under the country's legal and policy framework to ensure realization of the right to health. Similarly, Uganda is a signatory to a number of conventions and treaties at both the regional and international level, which guarantee the enjoyment of the highest attainable standard of health. In the sections that follow, national laws and policies and international instruments informing Uganda's obligations to promote health rights are discussed. The core principles deployed by the fact-finding mission to assess whether human rights obligations to the communities of the Sigulu Islands are currently being met are embodied therein.

2.1 Overview: The Guiding Framework of General Comment No. 14 under Article 12 of the International Covenant on Economic, Social and Cultural Rights

In August 2000, the Economic and Social Council of the United Nations issued a decisive statement, which was adopted by the UN, clarifying the obligations of states to protect citizens' health, as provided in Article 12.1 of the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR), which compels states to provide for "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[45] General Comment No. 14 outlines four essential elements to the right to health, providing the prevailing framework by which the fact-finding team evaluated the health system on the Sigulu Islands. The essential guiding elements are discussed below, with reference to numerous other international and national standards that uphold the criteria established in the General Comment.

[45] International Covenant on Economic, Social, and Cultural Rights (ICESCR) adopted by the United Nations General Assembly on December 16, 1966. Uganda ratified the ICESCR on January 21, 1987.

[46] UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4, available at: http://www.refworld.org/docid/4538838d0.html [last accessed March 7, 2018].

[47] Ibid, para 12.

For the right to health to be realized, the following elements must be present:[47]

Availability: Functioning healthcare facilities must be provided in sufficient quantity. All underlying determinants of health including safe drinking water, essential drugs, well-trained medical personnel and well-equipped hospitals and clinics, should be present.

Accessibility: Individuals must not be blocked from free use of health facilities, goods and services. Accessibility involves physical accessibility, economic accessibility, and information accessibility. Accessibility also implies non-discrimination in delivery of health services. General Comment No. 14 emphasizes the right of women to access sexual and reproductive health services[48] in line with Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).[49] Additionally, Article 14 of CEDAW specifically obligates States to ensure that rural women have "access to adequate health care facilities, including information, counseling and services in family planning."[50]

Acceptability: Healthcare facilities, goods and services must respect ethics and the culture of individuals, minorities, and other communities. Healthcare providers must uphold confidentiality and be sensitive to needs of the patient in all aspects.

Quality: Health facilities, goods and services must be scientifically sound and administered by trained medical personnel. Drugs and equipment should be unexpired and functional respectively, and adequate sanitation must be observed.

General Comment No.14 furthers an interpretation of the right to health as an inclusive right, extending beyond adequate health care to encapsulate the underlying determinants of health, including access to safe drinking water, adequate sanitation, food security and nutrition.[51] The right to health involves enjoyment of a healthy home and work environment, as well access to health-related education and information, including on sexual and reproductive health.[52] The General Comment requires that the public is engaged in all health-related

[47] Ibid, para 12.

[48] Under para 21, a major goal should be reducing women's health risks, particularly lowering rates of maternal mortality. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.

[49] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) adopted by UN General Assembly, on December 18, 1979 available at http://www.ohchr.org/Documents/ProfessionalInterest/cedaw.pdf [last accessed March 7, 2018]. Article 12 of the CEDAW reads: "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. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

[50] Ibid.

[51] General Comment No. 14, supra n46 at para 4.

[52] Ibid, para 11.

decision-making at the community, national and international levels.[53] These elements of the right to health provided further conceptual criteria for the fact-finding mission.

The General Comment enumerates many of the actions and services expected of governments in pursuit of realizing the right to health. Article 12.2 of the ICESCR obligates governments to create "conditions which would assure to all medical services and medical attention in the event of sickness." As the General Comment elaborates, creating such conditions requires governments to guarantee equal and timely access to basic preventive, curative, and rehabilitative health services; health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; access to essential drugs; and appropriate mental health care.[54]

Beyond these expected services, the General Comment discusses a number of immediate obligations governments have in relation to the right to health. The General Comment obliges governments to provide at minimum certain services including essential primary health care.[55] The government should enforce non-discrimination in the exercise of health rights ensuring health facilities, goods and services are accessible to all. The government is obliged to take concrete and targeted steps towards full realization of Article 12.[56]

The standards set by the ICESCR and explicated in the General Comment compel government service providers to take meaningful action to empower communities to overcome the barriers they face to access healthcare, including geographical barriers physical disability, economic constraints, and other challenges. The General Comment emphasizes the need for rural areas to access medical services and all underlying determinants of health, such as safe water and good sanitation. These provisions bear special relevance to the needs of isolated island communities and helped to guide the work of the fact-finding mission on the Sigulu Islands.

Beyond the ICESCR and the General Comment, a broad body of international conventions and precedents give shape to Uganda's obligations to provide for the realization of health rights on the Sigulu Islands and nationwide. Internationally, the right to health was first articulated in the 1946 Constitution of the World Health Organization (WHO), whose preamble defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."

---

[53] Ibid.

[54] Ibid, para 17 states that "a further important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels."

[55] Ibid, para 43. "Accordingly, in the Committee's view, these core obligations include at least the following obligations: (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water; (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs; (e) To ensure equitable distribution of all health facilities, goods and services; (f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population… [and] shall give particular attention to all vulnerable or marginalized groups."

[56] Ibid, para 30. "Such steps must be deliberate, concrete and targeted towards the full realization of the right to health."

Since that articulation in 1946, a number of international instruments have been ratified affirming the right to health and tasking governments with three types of obligations: the responsibility to respect, protect and fulfill the right to health of its citizens.[57] These include the aforementioned ICESCR,[58] the Universal Declaration of Human Rights (UDHR),[59] the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),[60] the Convention on the Rights of the Child (CRC),[61] and the Convention on the Rights of Persons with Disabilities.[62] The CRPD creates special responsibilities for the State on Sigulu Islands to accommodate Persons with Disabilities to access services at the island health facilities.

In the regional context, Uganda is signatory to a number of regional instruments under which it committed to realize health rights for all in its jurisdiction. Among these regional instruments are the following: The 1981 African (Banjul) Charter on Human and Peoples' Rights (ACHPR);[63] the 1990 African Charter on the Rights and Welfare of the Child (ACRWC);[64] and the 2003 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol).[65] The Maputo Protocol clarifies the duty of 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.[66] The 2010 Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights (Nairobi Principles and Guidelines) mandate that health policies of State parties should eliminate discrimination against any groups of persons particularly marginalized areas.[67]

At a national level, although the Constitution of the Republic of Uganda, does not explicitly protect the right to health in the Bill of Rights, the National Objectives and Directive Principles of State Policy (NODPSP) have been interpreted as effectively guaranteeing the protection, respect, and fulfillment of the right to health. Article 21 on equality and non-discrimination and Articles 32, 33, 34, 35 also guarantee protection of vulnerable groups including women, children, older persons, and persons with disabilities from discrimination in the enjoyment of their right to health.[68]

---

[57] General Comment No. 14, para 33.

[58] Article 12 of the ICESR.

[59] Article 25 of the UDHR.

[60] Article 12 of the CEDAW.

[61] Article 24 of the CRC.

[62] Article 25 of the CRPD.

[63] Article 16(1) of the ACHPR.

[64] Article 14 of the ACRWC.

[65] Article 14 of the Maputo Protocol.

[66] Article 14 of the Maputo Protocol.

[67] Nairobi Principles and Guidelines, para 67 (f).

[68] Among these provisions are Articles 8A, 20, 45, 247, and Objectives XIV and XX of the National Objectives and Direct Principles of State Policy (NODPSP). See Center for Health, Human Rights and Development V Mulago National Referral Hospital Civil Suit No.212 of 2013, as per Justice Lydia Mugambe.

protection of vulnerable groups including women, children, older persons, and persons with disabilities from discrimination in the enjoyment of their right to health. Beyond the Constitution, other legislation has deepened Uganda's obligations to realize the health rights of both the general population and vulnerable groups, such as the Persons with Disabilities Act, 2006 and the Children (Amendment) Act, 2016.[69]

Furthermore, the government of Uganda has adopted a policy framework committing to implementation of its obligations to realize the right to health and creation of legal standards to which the country has chosen to hold itself accountable – ensuring availability, accessibility, acceptability, and quality of health care. The Patients' Charter of 2009, for instance, aims to promote the rights of patients and empower them to demand high-quality healthcare, deepening the state's obligation to promote access to healthcare and ensure acceptability specifically via community participation in health systems. [70] The Charter emphasises the right of all persons in Uganda to impartial access to treatment at any given time in the government health care system.[71]

Uganda's latest strategic plans and development policies further enunciate government obligations to promote the right to health, including the Second National Development Plan (NDP II) and the Health Sector Development Plan (HSDP) for 2015/16-2019/2020 which seek to prioritize universal health coverage in Uganda[72] and the 2010 National Health Policy, under which the State commits to provide a minimum healthcare package for all.[73]

In summary, the legislation, plans, and policies outlined above embody a substantive recognition by the Ugandan government of its obligations to protect and fulfill the right to health of inhabitants of the Sigulu islands. The fact-finding mission attempted to evaluate the extent to which these obligations are being met, particularly for vulnerable groups.

[69] Section 7 and 8 of the Persons with Disabilities Act, 2006 and Section 4 (1) g of the Children (Amendment) Act, 2016.

[70] Article 5 of the Patients' Charter, 2009.

[71] Article 1 of the Patients' Charter, 2009.

[72] NDP II, para 570 and HSDP p. xv.

[73] In particular, see Policy 6.1, 6.2, and 6.3 of the National Health Policy, 2010. The minimum health care comprises "the most cost-effective priority healthcare interventions and services addressing the high disease burden that are acceptable and affordable within the total resource envelope of the sector." It consists 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."

3.0 STUDY METHODOLOGY

3.1 Objectives of the Fact-Finding Mission

Overall Objective

The main aim of the fact-finding mission was to investigate the state of healthcare on the Sigulu Islands by critically examining whether the necessary elements for realisation of the right to health namely; availability, accessibility, acceptability, and quality of healthcare outlined in General Comment 14 to the ICESCR exist on the islands. In accordance with this health rights framework, the fact-finding evaluated health service delivery on the islands.

Specific Objectives

a) To assess the availability of healthcare through government-run health centres on the islands;

b) To investigate the scope and range of health services offered by the health centres;

c) To investigate accessibility of health services and facilities on the islands, including the emergency referral system;

d) To evaluate the state of physical infrastructure of the available health centres;

e) To assess availability of safe water and hygienic sanitation facilities at the health centres;

f) To assess the sufficiency of health personnel staffing levels and the conditions under which these health workers perform their duties;

g) To establish the availability of essential drugs and medicines and the effectiveness of drug management at the health centres;

h) To investigate the quality of healthcare provided on the island;

i) To examine the existing mechanisms for community participation in health decision making, including the Health Unit Management Committees (HUMCs) and Village Health Teams (VHTs);

j) To assess whether the communities on the island participate in national budgetary processes; and

k) To determine whether vulnerable groups like Persons with Disabilities (PWDs) are able to access disability sensitive health services on the island.

3.2 Scope of the study

The fact-finding mission was carried out on the Sigulu islands situated in Namayingo District. These were chosen for study because of their unique geographical positioning, as well as an apparent need for further observational study after discussion with key stakeholders and a literature review on healthcare for island communities. The islands, located in Lake Victoria and near the Kenyan Boarder, are considered a hard-to-reach area, providing a prime case study for investigating service delivery in Uganda's remote island contexts.

Sigulu islands are located in Bukooli Constituency, Namayingo District. Sigulu and Lolwe Sub-Counties were the case studies. Sigulu Sub-county comprises five parishes namely Rabachi, Bumalenge, Nampongwe, Mukani and Manga, collectively containing thirty (30) villages. Sigulu Sub-County is served by a Health Centre III (HC III) and has an approximate population of 18,759 people[74] which is distributed among its different parishes as seen in Table 2. The team visited the parishes of Manga (particularly Matolo village hereinafter referred to as 'Sigulu main island'),[75] Nampongwe and Rabachi. In Lolwe Sub-county, the team visited two parishes: Haama, which has a population of 4820 people,[77] and Lolwe.

Table 2. Parish Populations in Sigulu Sub-County[78]

Parish	Population
Bumalenge	3999
Nampongwe	3504
Mukani	3178
Rabachi	4379
Manga	3729

[74] Interview with In Charge of HC III in Sigulu Sub-county on March 27, 2017.

[75] Sigulu HCIII is located on the Sigulu main island, Matolo village, Manga Parish, Sigulu Sub-County.

[76] The team visited four villages in Nampongwe namely: Kasosoli, Namugongo, Radanga and Bugoma.

[77] Interview with In-charge of Haama HCII on March 31, 2017.

[78] Interview with In-charge of Sigulu HCIII, supra.

3.3 Criteria for Evaluation

In broad strokes, the fact-finding team analyzed testimonies, field observations, and other data collected through the lens of the four elements necessary for realization of the right to health, as outlined in General Comment No. 14 to the ICESCR. Observations were interpreted via the following criteria for healthcare services:

a) Availability
b) Accessibility
c) Acceptability
d) Quality

Findings were organized into several broad thematic categories for further interpretation and analysis.

3.4 Methodology

The researchers deployed numerous methods including key informant interviews, focus group discussions, observation and data collection through literature reviews and analyzing the government's data.

3.4.1 Focus Group Discussions

Eleven (11) Focus Group Discussions (FGDs) were held with community members on the islands, enabling users of health services to share information regarding service delivery.[79] These were chosen for their unique capacity of effectively generating qualitative data from numerous participants. The FGDs were split according to gender to encourage participation of women in the discussions.

In particular, these FGDs were carried out at Sigulu HC III, Haama Parish, Rabachi Parish, and Nampongwe Parish. The use of focus group discussions proved useful in revealing communal values and public opinion of healthcare delivery, and services having impact at the community-level. Responses of the participants were recorded and are reflected in this report.

3.4.2 Structured questionnaire interviewing

Data was collected from health care personnel, district officials, HUMC members, and community members using structured questionnaire-based interviewing. This method was chosen to generate responses on select issues that could easily be compared between respondents.

[79] The team held eleven (11) FGDs in total – three (3) at the Sigulu main island, two (2) at Haama parish, two (2) at Rabachi parish, two (2) at Namugongo village, Nampongwe parish, and two (2) at Bugoma village, Nampongwe parish.

3.4.3 Key Informant Interviews

Focused interviews were conducted to gather insights from key informants, including district leaders, sub-county leaders, health care personnel, and community members. Key informants were selected based on their direct involvement in the planning, management, formulation and approval of policies related to delivery of health services at various levels on the islands and in the surrounding district.

Key informants interviewed included officials from the District Health Office (DHO), Health Inspector, Local Council chairpersons, In-charges of health centres, health workers, parish coordinators, VHTs, and members of HUMCs.

Informant selection also sought to represent the experiences of individuals with regard to accessing healthcare on the islands. These included: community members who faced barriers to access to healthcare such as women on the islands who had to travel long distances to access maternal services; and general encounters of the community members in accessing health care on the remote islands.

3.4.4 Observation

The researchers recorded eyewitness details throughout visitations to health centres on the islands. Fact-finding team members took note of important details regarding the state of physical infrastructure and the facilities available at selected health centres, including the buildings, water and sanitation facilities, drug storage facilities, availability of latrines, electrification and lighting, among others. The researchers documented these eyewitness observations of the health system on the islands.

3.4.5 Research Literature Review

A review of the literature was conducted to further contextualize observations and provide grounds for analysis of the team's findings. Resources consulted during the review included, among others, the following: archives of Ministry of Health communications and policy documents accessible to the public; reports and census data from other government ministries; academic literature on healthcare in remote and island settings; and reports from NGOs and CSOs working in island contexts within the public domain. Keywords used in databases and search engines included the following: "island health in Uganda," "Sigulu Islands," "healthcare in remote communities", among others. Results from the literature review are included in this report to enrich and further contextualize the direct observations gathered by the fact-finding mission.

4.0 FINDINGS: THE RIGHT TO HEALTH ON THE ISLAND

This section of the report discusses the availability, accessibility, acceptability, and quality of healthcare on the Sigulu Islands in light of the legislation, policies and plans by which Uganda is bound.

4.1 Status And Function Of Health Centres On The Sigulu Islands

4.1.1 Accessibility

Current government data shows that 100% of the population in Uganda is living within a 5 km radius of a health facility.[80] This means that at least every Parish should have a HCII.[81] Service coverage on the Sigulu Islands falls far short of this target increasing disparity in access to health services.

Nampongwe Parish for instance, which comprises the six villages of Radanga, Mayakado, Bugoma, Busero, Namugongo and Kasosoli, lacks a health facility, forcing residents to travel long distances to other parishes to access health services.[82] Relatedly, across the five parishes in Sigulu Islands Sub-County, there are only two HCII facilities[83] and one HCIII which serves as a referral facility to residents of Manga, Mukani, Nampongwe, Rabachi and Bumalenge Parishes.[84] There is only one HCIV which handles operations and other complex medical procedures and it is located on the mainland in Buyinja, Namayingo District. There is no district referral hospital.

The strain on some HCIIs is currently heavy; for instance Bumalenge HCII in Bumalenge Parish, operates for only eight (8) hours a day, despite also serving Nampongwe Parish, creating a double caseload for the facility. This shortage of health facilities on the islands strains the capacity of the existing ones.
The sparse service coverage on the islands results in residents being forced to travel extremely long distances by foot or by boat to access health care, on the islands or mainland. Nationally, the average time spent traveling to a government health center was reported to be 54 minutes, and average waiting time at the center was estimated to be 67 minutes.[85]

---

[80] Ministry of Health, Annual Health Sector Performance Report: Financial Year 2016/2017 at p.123.
[81] Ministry of Health, Guidelines to the Local Government Planning Process Health Sector Supplement, 2016 available at http://library.health.go.ug/download/file/fid/580957 [last accessed August 20, 2017] at p. 59.
[82] Interview with LC1 Chairman, Namugongo Village, Nampongwe Parish on April 2, 2017 and the In Charge of HC III in Sigulu Sub-county on March 30, 2017. According to information received from the District Health Office on April 3, 2017, Buduma and Biisa Parishes located on the islands also lack HCIIs.
[83] Interview with In-Charge of HC III in Sigulu Sub-county on March 27, 2017.
[84] According to an interview with the In-charge Sigulu HC III, the population of the Parishes in Sigulu Sub-county is as follows: Mukani - 3,178; Nampongwe – 3,564; Rabachi – 4,379; and Manga – 3,729.
[85] Uganda Bureau of Statistics (UBOS), Uganda National Household Survey, 2012-13 available at http://www.ubos.org/onlinefiles/uploads/ubos/UNHS_12_13/2012_13%20UNHS%20Final%20Report.pdf [last accessed on March 9, 2018].

These estimates considered the following categories of transportation: foot, vehicle, bicycle, and motorcycle. In contrast, the travel and waiting times reported by inhabitants of the Sigulu Islands, by boat or by foot, often far exceeded this average waiting and travel period in search of health services, thus highlighting the challenge of inadequate health centres on the Sigulu Islands, an obstacle to realizing the right to access healthcare.[86] This poor health service coverage perpetrates another barrier to access health services due to the high transportation costs incurred in travelling between islands to health facilities. Since parishes such as Nampongwe do not have health facilities—there is only one HCIII serving a population on various islands that are isolated from one another— travel by boat is often the only option. This entails incurring costs of hiring a boat, a motor for the boat and a driver, which are not stand-by thus are not readily available, as well as purchasing fuel.[87]

VHTs from Sigulu Sub-County noted that using a boda boda (motorcycle) from Rabachi to Sigulu HCIII costs Ten Thousand Uganda Shillings (UGX. 10,000/=). [88]

In case of emergencies, due to lack of an emergency boat ambulances, families often must hire a boat and a driver and also purchase fuel, hiking the travel costs. For instance, it was reported that travelling to Buyinja HCIV on the mainland from Sigulu Islands during an emergency could cost as high as One Hundred Thirty Thousand Uganda Shillings (UGX. 130,000/=).[89]

AMIN SUSAN

Haama Parish, Lolwe Sub-county

"I live on the island permanently although I was born in Kisumu Kenya. In December 2015, I went to the HCII when I was feeling labour pain at around 7:00 a.m. The In-charge was with me until 4:00 pm when she could not handle the situation any longer. My family and other community members began to search for a boat which they got at around 9:00pm. Luckily, we did not pay for the boat but we had to buy fuel worth UGX 60,000.

I left the lake shore at around 10:00p.m headed for Gotagula in Kenya because it was the nearest option. I reached two hours later. The doctor who examined me said it was a serious complication which he could not handle so I was transported to Bondo in an ambulance where I was further referred to Kisumu. I was scanned at Kisumu and informed that I had lost my child. I was operated upon and discharged a few days later.

I am very unhappy about the situation because had the nurse here in Haama had enough equipment for delivery or had there been an available ambulance, my child would have been alive today."

[86] See Section 4.2.1 below.
[87] Ibid.
[88] Focus Group Discussion held with Village Health Teams (VHTs), supra
[89] bid. These costs are split into: Fuel of 20 litres which costs approximately UGX. 80,000/=; hiring a boat driver at UGX. 40,000/=; Boda Boda cost of UGX. 10,000/= from the landing site at Busiro to Buyinja HCIV. These costs are doubled to UGX. 320,000/= to cater for the journey to Buyinja HCIV on the main land and back to Sigulu main island.

Such costs present a huge barrier to health care and increase dramatically for individuals who live further away from the mainland for example residents of Haama Parish. The In-charge of Haama HCII revealed that for referrals to Sigulu HCIII, the associated costs include hiring a boat and driver at Three Hundred Thousand Uganda shillings (UGX. 300,000/=).[90] According to a Volunteer interviewed at Lolwe HCII, travelling to Buyinja HCIV on referral would require approximately forty (40) litres of fuel at Five Thousand Uganda Shillings (UGX. 5,000/=) and Three Hundred Thousand Uganda Shillings (UGX. 300,000/=) to hire a boat and pay the driver. Many island residents revealed that this is a time-intensive process yet this is the same experience faced even in cases of emergencies.[91]

The shortage of health facilities and low capacity of the existing facilities to handle the high number of patients on the islands poses a great challenge to access to health care for the residents of Sigulu Islands. This state of affairs reflects similar challenges across Eastern Uganda. Eastern Uganda reported only 12.8 maternity beds, 1.2 medical beds, and 0.6 surgical beds per 100,000 people, compared with 28.9 maternity beds, 3.1 medical beds, and 1.8 surgical beds nationally per 100,000 people.[92] Eastern Uganda reported the lowest densities out of all regions nationwide. Facing such shortages, patients in this region are forced to seek care through informal providers and pharmacies, rather than at full-service health centers. Over half of persons surveyed in 2016/17 who fell sick in Busoga region, which comprises Namayingo district, sought care first at a pharmacy (40.2%) instead of government health centers (23.5%) or government hospitals (5.7%), far outpacing the dependence on such secondary health providers in other regions.[93]

4.1.2 Infrastructure of the health facilities

The quality of the health facilities examined on the islands falls far below the quality standards currently set by the Ministry of Health. A health centre should have sufficiently functional medical buildings and equipment to deliver the designated level of services.[94] This includes providing on-site accommodation for at least 50% of required staff.[95] The health centers in Sigulu generally did not meet these targets.

[90] Interview conducted with In-Charge at Haama HCII, supra.
[91] Ibid.
[92] Uganda Bureau of Statistics (UBOS), Uganda National Household Survey, 2012-13, supra.
[93] Uganda Bureau of Statistics (UBOS), Uganda National Household Survey, 2016/17 at p. 64.
[94] Ministry of Health, Guidelines for Designation, Establishment and Upgrading of Health Units, 2011 at p. 7-8.
[95] Ibid.

An independent assessment conducted in 2013 by STAR-E found significant gaps in infrastructure in eight of the health facilities surveyed in Namayingo District.[96] None of the facilities surveyed met the minimum requirements for infrastructure, electricity; refrigeration; sterilization of equipment; a safe water source; communication capabilities; working ambulance; and working latrine.[97]

In the present report, the health facilities were found to have insufficient space to provide effective health services. At Haama HCII, the only public health facility in the entire parish, the structure comprises only two rooms: one room used as a consultation room, examination room and drug store, and another used as a treatment room with only two beds.

Other health centers visited on the islands were in severe disrepair especially Rabachi HCII which is in a dilapidated state. A portion of the wall has collapsed, and the ceiling of the facility harbors bats, whose waste has caused the ceiling to rot. It has only two rooms: one room is used as both an examination room and a delivery room, while the other room is used as a drug store. The drugs are not stored hygienically, despite attempts by the health workers to secure them from bat wastes. The only available bed for treating patients in the facility has a torn mattress. The facility has a nauseating smell, as a result of the bat infestation, deterring both patients and health workers from the health centre. The health workers have resorted to treating patients under a tree opposite the health facility. This state of affairs has subsisted for close to two years but no steps have been taken to rectify the situation, despite the district officials being aware of the problem.[98]

Rabachi Health Centre II.

[96] Strengthening TB & AIDS Response – Eastern Region (STAR-E), "Namayingo District: Health Facilities Assessment," September 2013 available at http://www.starelqas.ug/wp-content/uploads/Namayingo-Distric-HFA-report-.pdf (last accessed August 26, 2017).

[97] Ibid, p. 8.

[98] Interview with a Volunteer Nursing Assistant, Rabachi HCII on April 1, 2017.

Portion of the ceiling of the Health Centre which has been infested by bats.

Maintaining adequate staff on-site, too, is made more difficult by the existing infrastructure. All the HCIIs visited on the islands do not have staff quarters thus most staff reside far from the health centre, hindering their capacity to urgently respond to emergencies.[99] Of the thirty two (32) health facilities in Namayingo District, only seven (7) have housing units for health workers. [100] Similarly according to a Clinician at Buyinja HCIV, the only HCIV in the district and main referral facility from the islands, which is based on the mainland, disclosed that the staff quarters at the HCIV are insufficient so only one health worker stays in them while the rest reside away from the facility.[101]

4.1.3 Staffing

The health facilities on the Sigulu islands are understaffed. Engagement with health centre in-charges, local officials, and island residents repeatedly surfaced concerns that the number of health workers at the islands is inadequate in comparison to the population served.[102] The latest Annual Health Sector Performance Report found only 52.6% of approved posts in Namayingo District are filled with qualified health personnel.[103]Official data from the Ministry of Health found that

[99] The team visited Haama HCII, Lolwe HCII and Rabachi HCII on March 31 - April 1, 2017.
[100] According to information received from the office of the District Health Officer (DHO) on April 30, 2017.
[101] Interview with a Clinician at Buyinja HCIV on the mainland, Namayingo District on April 3, 2017.
[102] This was discovered through interviews with at the District Health Office, In-charges of Sigulu HCIII and Haama HCII, a clinician at Buyinja HCIV and interaction with the community from March 30 – April 3, 2017.
[103] Ministry of Health, Annual Health Sector Performance Report, Financial Year 2016/17 available at http://health.go.ug/content/annual-health-sector-performance-report-201617 (last accessed on March 9, 2018) at page 128

only 58.3% of approved health personnel positions in Namayingo District were filled at the time of survey.[104] The survey found stark staffing deficiencies in many of the health facilities.[105]At Rabachi HCII, only 11.1% of approved positions had been filled, representing a medical workforce of only a single nurse supported by a single midwife while at Bumalenge HCII, only 22.2% of approved positions were filled, far below the district-wide HCII staffing rate of 82.5%.[106]

Whereas the survey states that Sigulu HCIII had filled 94.7% of approved positions (with most vacancies being nursing staff), Sigulu HC III was found to be understaffed, despite high patient load. The In-charge at Sigulu HCIII, revealed that the facility is far below the staff ceiling with only thirteen (13) of the required nineteen (19) qualified staff.[107]The facility lacks a nursing officer in the section of midwifery. It also has only two (2) enrolled nurses instead of three (3) yet at the time of visit, one (1) of the nurses was away on study leave, leaving the HCIII with a single on-call nurse.[108]

Despite the need on the islands, there is no resident medical officer. Although the district officials posted a medical officer to Sigulu HC III, the said officer found it difficult to reside on the island and rarely pays visits there, serving instead, primarily on the mainland at Buyinja HCIV.[109]

The HCIIs on the islands are particularly understaffed. According to the Ministry of Health, each HCII is supposed to have five (5) technical staff namely one (1) enrolled nurse, one (1) enrolled midwife one (1) health assistant and two (2) nursing assistants assisted by four (4) support staff.[110] However, the situation on the islands falls short of these targets. For example, Haama Health Centre II had only two (2) health workers, a clinical officer and an enrolled nurse, yet it serves over four thousand (4,000) people.[111]

Rabachi HCII, despite neighboring Nampongwe Parish (which has no health centre), has only one health worker— an enrolled nurse— who is assisted by a volunteer. Even the midwife who had

[104] National District Health Staff Records, "District Summary: Staff Audit, Namayingo, Eastern, Uganda," available at http://hris.health.go.ug/districts_manage/index.php/audit_district_summary?district=district%7C230 (last accessed on March 9, 2018).
[105] Ibid.
[106] Ibid.
[107] Interview with Charles Mpata, in-charge of HCIII on March 30, 2017. Ministry of Health, "Guidelines to the Local Government Planning Process Health Sector Supplement, 2016" available at http://library.health.go.ug/download/file/fid/580957 (last accessed March 6, 2018) at p. 56 - 57. According to these Guidelines, a HCIII should have one (1) Senior Clinical Officer; one (1) Clinical Officer; one (1) Nursing Officer; one (1) enrolled nurse; two (2) enrolled midwives; three (3) enrolled nurses, one (1) health assistant, one (1) information assistant; three (3) nursing assistants; one (1) laboratory assistant; two (2) watch men and two (2) porters.
[108] Ibid.
[109] According to the interview with an official from the District Health Office on April 3, 2017.
[110] Ministry of Health, "Guidelines to the Local Government Planning Process Health Sector Supplement, 2016", supra. The support staff required include: two (2) watchmen and two (2) porters.
[111] Interview with In-charge of Haama HCII on March 31, 2017.

been stationed at Rabachi left in December 2016 and no replacement had been arranged.[112]This chronic understaffing hampers delivery of health services and dramatically increases patient wait times.[113]As a result, patients are often forced to seek care from informal healthcare providers.[114] Those health workers who are available can themselves become overloaded, limiting their efficiency.[115]

4.1.4 Supplies/Resourcing

4.1.4.1 Drug Supplies

A problem of drug shortage affects all of the health centers in the Sigulu islands, from Sigulu HCIII to Rabachi HCII and Hama HCII. The few supplies of medicines and essential drugs delivered on the Islands tend to be outpaced by demand. Nationwide, the distribution of medicines is managed centrally through the National Medical Stores (NMS), however only 27% of Uganda's hospitals and 40% of the health centres reported receiving the needed quantities of essential drugs demanded through the NMS.[116] No facility surveyed in Namayingo District had all relevant Integrated Management of Childhood Illness (IMCI) drugs in stock for managing child illness.[117]The same report found that none of the facilities surveyed had all essential drugs needed in maternity wards and for treatment of malaria in stock on the day of the visit.[118]At Sigulu HC III, the In-Charge, noted that the usual supply of the malaria drug, Coartem, is eighty-one (81) packets of 24 by 30 in a cycle of two (2) months, which is quickly used up by the community before the next supply.[119]

A similar situation was noted by a resident of Singila about Singila HC II in Lolwe Sub-County. The 23-year-old mother of four (4) who stays near the HCII, stated, "I see boxes of medicine being delivered. But I don't know where they go."[120]

At Rabachi HCII, there is no treatment offered for sexually transmitted diseases other than ART services. Participants in a male FGD in Rabachi revealed that whereas Rabachi HCII offers ART services, it does not offer drugs for other sexually transmitted diseases (STDs) such as syphilis.[121]

---

[112] Interview with Volunteer Nursing Assistant at Rabachi HCII on April 1, 2017 and a male Focus Group Discussion held at Rabachi on April, 1, 2017.

[113] Interview with In-charge of HCIII on March 30, 2017. He revealed that inadequate staffing hampers the operation of the health centres.

[114] According to participants in female FGDs conducted on Haama, Rabachi and Nampongwe islands from March 31 – April 2, 2017, Shortage of key staff such as midwives has forced people to rely on traditional birth attendants who pose a risk in handling pregnant mothers as they are not trained on how to conduct safe deliveries.

[115] The team was told by the local community at Rabachi parish that at times, the health worker there spends a whole week without attending to the people.

[116] Windisch R., Waiswa P., Neuhann F., Scheibe F. and Savigny D., "Scaling up antiretroviral therapy in Uganda: using supply chain management to appraise health systems strengthening," Globalization and Health 7:25, 2011 available at https://globalizationandhealth.biomedcentral.com/articles/10.1186/1744-8603-7-25 (last accessed March 6, 2018)

[117] Ibid.

[118] Ibid., p. 14.

[119] Interview with In-charge, Sigulu HC III supra.

[120] Interview with resident of Singila on April 1, 2017.

[121] Male FGD conducted at Rabachi on April 1, 2017.

They noted that the latter is particularly prevalent in Rabachi, however, treatment is generally acquired from traditional herbalists.

NABWIRE CATHERINE

Matolo Village, Sigulu Parish

"The challenges faced by women are many, including being given expired drugs. I didn't want to give birth anymore so I went to Sigulu HCIII for a family planning injection.

I, however, conceived in the same month that I had received the family planning injection. Signs of pregnancy began emerging months after I got the injection. When I checked, I found that I was 4-months pregnant, meaning an expired drug had been administered to me.

What's interesting to me is that when I was experiencing signs of pregnancy following the injection, I kept complaining that the drug may not have worked but was always disputed and thought to be confused about symptoms."

Ordinarily, HCIIs do not administer injectable forms of treatment, but given the overwhelming demand for such injections and the fact that the few HCIIIs on the Sigulu islands are often far away and inaccessible for the marjority, the HCIIs have been forced to offer such services.[122] At Haama, the HCII is only equipped with oral drugs but it does not have injectables yet it is the only health facility in the parish and serves a great number of people on the island.[123] Given the island setting, the nearest referral facility is located at Lolwe, on another island, which entails travel by boat for hours.[124] Patients who need injectable treatment at the HCII, therefore, often must cover the cost of this medication and syringes, since the facility does not have injectable drugs in stock.[125] As noted, drug shortages impact the Eastern Region at levels more severe than other regions. Hospitals and HCIVs in Eastern Uganda had the lowest mean availability (39%) of essential medicines out of all four regions, with only 7% of Eastern Uganda's hospitals and HCIVs reporting having at least half the medicines listed, compared to 22% nationally.[126] As also noted, 57% of hospitals and HCIVs in the region reported having low availability of medicines for patient use.[127]

4.1.4.2 Inadequate Medical Equipment

The health centres observed suffered deficiencies in a range of different kinds of equipment, including microscopes, patient beds, and refrigerators, among other clinic resources. It was observed at the Sigulu HCIII that seven (7) of the fifteen (15) beds in the ward lacked mattresses, and patients are required to carry their own mattresses. Similarly, Buyinja HCIV

[122] Ministry of Health, "Guidelines for Designation, Establishment and Upgrading of Health Units," The Health Infrastructure Working Group, 2011 and Ministry of Health, "Guidelines to the Local Government Planning Process Health Sector Supplement, 2016" available at http://library.health.go.ug/download/file/fid/580957 (last accessed March 6, 2018].

[123] According to the In-Charge of Haama HCII, the island population is 4,820 persons.

[124] Ibid. Interview conducted on March 30, 2017.

[125] Ibid.

[126] Ministry of Health, Hospital Census Report, January 2016 available at http://www.who.int/healthinfo/systems/SARA_H_UGA_Results_2014.pdf [last accessed on March 2, 2018] at p. 165.

[127] Ibid.

on the mainland which is the referral facility for cases from Sigulu HCIII, a Clinician reported that there are only five (5) beds in the male ward and six (6) in the female ward so in the event of outbreaks such as cholera, the patients who are admitted sleep on the floor.[128]

Additionally, in the district-wide survey by STAR-E; of eight (8) selected facilities on Sigulu islands, only one (1) health facility had at least one (1) standard sterilization method.[129]

4.1.5 Lack of electricity on the islands

All the health facilities on the Sigulu islands visited did not have electricity, a constraint that has affected the functionality of the units including the operation of the laboratory. Sigulu HCIII In-charge noted that though the health facility uses solar energy, it is not functional presently due to battery failure.[130] He also noted that the microscopes at the facility cannot be operated because of the lack of electrification.[131] Without the diagnostic tests enabled by microscopy, the HCIII's medicine is often quickly depleted due to indiscriminate prescription, since it becomes difficult to accurately diagnoses illnesses and discern which patient is sick and in need of medication from those who simply want medication in order to keep it for a rainy day.[132]

Similarly activities in the maternity ward are greatly affected by the lack of electricity. Health workers on the islands interviewed disclosed that midwives are forced to use the torches on their mobile phones to conduct deliveries at night.[133]Relatedly, due to lack of electricity, the HCII facilities on the islands do not have refrigerators where they can store injectables like immunisation drugs and tetanus injections for pregnant women thus some women opt to travel to Kenya for these services.[134]Whereas the district officials are aware of the problem, there have been no efforts to rectify the same due to funding and budget constraints.[135] With recent amendments to the Essential Healthcare Packages (EHPs) at lower-level health facilities, which require HCIIIs to perform laboratory tests like CD4 counts, dysfunctional laboratories including the one at Sigulu HCIII represent a widening deficiency between island health centers' capacity and ministry targets.[136]

[128] Interview with a Clinician at Buyinja HCIV on the mainland, Namayingo District on April 3, 2017.
[129] Strengthening TB & AIDS Response – Eastern Region (STAR-E) (2013), "Namayingo District: Health Facilities Assessment" at p. 15. Accessed at http://www.starelqas.ug/wp-content/uploads/Namayingo-Distric-HFA-report-.pdf (last accessed 26 August 2017).
[130] Interview with In-Charge Sigulu HCIII, supra. The solar system of the HCIII was installed in 2007 and to date, there has been no maintenance. The batteries have served for over ten (10) years and need to be replaced.
[131] Interview with In-Charge Sigulu HCIII, supra.
[132] Ibid. The In-Charge revealed that since drugs are scarce, community members go to the HCIII when they hear that drugs have been delivered to collect some to save in the event that a family member falls sick at a time when the drugs are in stock at the health facility.
[133] Interview with In-Charge Sigulu HCIII and In-charge Haama HCII, supra.
[134] Interview with In-charge Haama HCII, supra.
[135] Interview with In-Charge Sigulu HCIII, supra.
[136] Ministry of Health, "Guidelines to the Local Government Planning Process Health Sector Supplement, 2016" available at http://library.health.go.ug/download/file/fid/580957 (last accessed March 6, 2018).

4.1.6 Sanitation and hygiene

Communities on the islands contend with a number of challenges concerning sanitation and hygiene. Among these are the following:

4.1.6.1 Inadequate access to clean and safe water

Before its creation in 2010, Namayingo District was originally under Bugiri District. In a 2009 survey of Bugiri County, it was found that only 17% of Sigulu Sub-County had access to safe water.[137]Indeed, all health centers visited during this research did not have clean and safe water. The patients are given their tablets to be taken from home since there is no safe drinking water. In Lolwe, the borehole on the island is far away from the HCII and if the patient is sick, it is their relative who is supposed to fetch the water from the lake to the HCII to be used by the health worker during treatment.[138] At Sigulu HCIII, clean water is only gotten at the facility when it rains yet a number of health centres do have tanks to harvest rain water.[139]During the dry season, access to clean and safe water is an even greater challenge.[140] At Maninga landing site at Sigulu main-island, residents bathe, wash clothes, and excrete in the lake, which is the same water that the communities use for cooking and drinking. This has resulted in an increased prevalence of waterborne diseases.

4.1.6.2 Low availability of latrines

The situation is exacerbated by the low availability of latrines. Due to island topography, the community faces challenges constructing pit latrines on the islands, with many areas being either too rocky or too sandy for digging latrines such as Nampongwe and Lolwe Parishes respectively.[141]Generally in the community, there are few pit latrines. District-wide, only 48% of households in Namayingo were estimated to have pit latrines.[142] As a result of the challenges with constructing latrines discussed above, the community in Sigulu islands mostly uses the pit latrine at the health facilities, and often misuses them, a potential threat to patients at the health facilities because they may be exposed to disease.[143]

---

[137] Uganda Bureau of Statistics (UBOS), Bugiri Higher Local Government Statistical Abstract: Bugiri, June 2009 available at http://www.ubos.org/onlinefiles/uploads/ubos/2009_HLG_%20Abstract_printed/Bugiri%20HLG%20Abstract-Final.pdf [accessed on February 28, 2018] at p. 27.

[138] At Lolwe sub-county on April 1, 2017, a group of community members interviewed noted that that there is no tap water at the HCII.

[139] Interview with the In-Charge at Sigulu HCIII, supra.

[140] Ibid. The In-Charge further noted that last year, there were attempts to bring piped water to the health center but the facility is yet to receive the Two Hundred Thousand (UGX. 200,000) required to install piped water. However, the district through development partners, sponsors the use of water guard at the facility.

[141] Interview conducted with the Vice Chairperson LCIII, Sigulu Sub-County on March 29, 2017 and a Volunteer at Lolwe HCII on April 1, 2017. The Volunteer explained that very few community members have toilet facilities because of the nature of the soils in Lolwe which is mainly sandy.

[142] Uganda Bureau of Statistics (UBOS), 2016 Statistical Abstract accessed at http://www.ubos.org/onlinefiles/uploads/ubos/statistical_abstracts/2016%20Statistical%20Abstract.pdf (last accessed February 18, 2017).

143Ibid.

Elsewhere across the islands, the public latrines that do exist are few. Community members are required to pay to use these latrines. For example, at Radanga Village in Nampongwe, a community member noted that although pit latrines are available on the island, they are under lock and key.[144] Individuals are charged Uganda Shillings One Hundred (UGX. 100/=) for each use which monies are used to pay the cleaners.[145] However, some community members who cannot afford this cost simply find other places of convenience, mostly bushes and the lake.[146]

The lack of latrines results in contamination of the main water source, Lake Victoria, when community members—unable to access the pit latrines— opt to use the lake instead, which is the main water source for the islands communities, contributing to outbreak of diseases such as cholera, dysentery and typhoid.[147]

It is noteworthy that some health facilities on the islands, like Haama HCII, do not have the capacity to treat these sanitation related diseases thus patients have to travel to Lolwe HCIII or Sigulu HCIII by boat to seek medical treatment.[148]

4.1.6.3 Waterborne and endemic diseases

The sanitation challenges faced by the residents on the islands are exacerbated by the island geography. Proximity to Lake Victoria accelerates the transmission of diseases, made even worse by the congestion of areas such as Maninga landing site at Sigulu main island. Health workers and community members interviewed on this island recalled cholera outbreaks, the most recent outbreak occurring in 2016.[149] Group discussions helped illuminate a wide range of other infections endemic to the island climate. In a FGD at Nampongwe, a community member noted that waterborne diseases are prevalent in the area, including cholera, bilharzia, and diarrhoea.[150]

Other widespread conditions with prevalence exacerbated by the climate and isolation of the islands were reported, including malaria and dysentery.

[144] Interview conducted on April 2, 2017.
[145] Ibid.
[146] Ibid.
[147] Interviews conducted with In-charge of Sigulu HCIII, In-Charge at Haama HCII and Volunteer at Lolwe HCII, supra. Ibid.
[148] Ibid.
[149] Interview conducted with In-Charge of Sigulu HCIII, supra and focus group discussions held at Sigulu main-island on March 30, 2017.
[150] Male Focus Group Discussion (FGD) held at Sigulu main-island on March 30, 2017.

4.2 Accessibility And Range of Services Provided

4.2.1 Accessibility Of Services

4.2.1.1 Distance to health facilities

The shortage of full-service health centres across the islands, coupled with the remote geography, creates serious challenges to access to health services. Patients are often forced to walk extreme distances seeking medical treatment or travel long distances by boat off the island, making the process of seeking health care incredibly difficult.

For islands such as Nampongwe which have no health facility, residents are forced to seek treatment from health centres on nearby islands such as Rabachi HCII, Bumalenge HCII and Sigulu HCIII Main yet the only means of transport is a boat which comes at a hefty cost as discussed in section 4.1.1

4.2.1.2 Transportation challenges

Many community members reported having to traverse the long distances to island health centers on foot. From Mukani and Manga parishes, for instance, a trip to the nearest health centre, Sigulu HCIII, takes approximately one (1) to two (2) hours on foot.[151] In Nampongwe, the Parish Cordinator of VHTs highlighted the challenge of long distances for locals stating that the roads are impenetrable, making access to the nearest health centre at Rabachi difficult.[152]From Nampongwe on foot, it takes approximately one (1) hour to Rabachi HCII, two (2) hours to Bumalenge HCII and three (3) hours to reach Sigulu HCIII.[153] It takes approximately five

AKECH PETRONILA
Nampongwe Parish

"In May last year (2016), when my son was four months old, he passed away. The baby was healthy at delivery but he became sick after a while. There is no health centre on this village. I wanted to take him to Port Victoria in Kenya, but I had no money for transport in the passenger boat which was about UGX.6,000. I was only able to get transport after two days. In the meantime, I visited drug shops on the island and bought medicine, but there was no improvement. When I finally got transport, he passed away in the boat on the way to the hospital. I stayed in the boat and when it passed by Busiro, Namayingo, I left the body at the health centre and my husband picked it later that day. To this date I do not know what disease he had since I was not able to reach the hospital in time.

"We really need a hospital here. The hospital was far - that is why my child died. We left at 6:00am for the hospital and my child passed away in the boat at around 10:00am, yet the estimated time to reach Port Victoria was 1:00pm. If we had a fueled emergency boat, my child would be alive since I would not have waited so long to take him to the hospital."

[151] Focus Group Discussion held with some Village Health Teams (VHTs) of Sigulu Sub-County at Sigulu HCIII on March 30, 2017.
[152] Interview with Parish Coordinator for VHTs in Nampongwe Parish, conducted on April 2, 2017.
[153] Focus Group Discussion held with Village Health Teams (VHTs), supra.

(5) hours to reach Sigulu HCIII, the nearest referral facility, using a rowing boat without an engine.[154] In Bugoma village, Nampongwe, female participants in a FGD explained that the journey to Busiro HCIV is one (1) hour when using an engine boat and three (3) hours for a rowing boat.[155]

As extensively discussed in section 4.1.1, the challenge of transportation levies exorbitant costs on community members seeking health services. In a FGD at Haama, participants revealed that they sometimes opt to seek medical treatment in Kenya because the distance is shorter.[156]However, they are not spared from incurring high costs of transportation. They still have to hire a boat for travel (using Kenyan currency) at approximately Ten Thousand Kenya Shillings (Kshs 10,000/=); pay a boat driver close to Three Thousand Kenya Shillings (Kshs 3000/=); and purchase between thirty to forty (30-40) litres of fuel at a cost of Five Thousand Uganda Shillings (UGX 5000/=) each.[157]It is noteworthy that at some health facilities in Kenya, Ugandans are required to pay for services.[158]Several residents of the island have lost their lives or family members due to the problem of long distance coupled with high costs of transportation to health facilities.[159]

Many patients on the island described cost barriers to accessing healthcare services on the island, and these cost barriers are prevalent both in public and private medical facilities. While some community members revealed that they pay a minimal amount at the public health facilities, the prevalent drug stock outs in public health facilities have resulted in them paying high costs at private clinics and drug shops for basic services and essential drugs.[160] This was found particularly true for the provision of family planning and STI treatment services. A resident of Namugongo village, Nampongwe parish stated that he was charged Fifty Thousand Uganda Shillings (UGX. 50,000/=) per dose for gonorrhea and syphilis at a private health facility.[161]

In Busoga Sub-Region (which includes Namayingo District), 35% of patients reported having to pay for services received from government health facilities, the highest regional count of all sub-regions.[162]While 20% of patients nationwide reported having to make such payment, 29% of patients in Uganda's island districts reported paying for treatment at government health services.[163] These statistics show poor enforcement of state-mandated costing guidelines at government health centers in island communities, creating another cost barrier for island communities to overcome.

[154] Interview with Parish Coordinator for VHTs in Nampongwe Parish, supra.
[155] Female Focus Group Discussion held at Bugoma Village, Nampongwe Parish on April 3, 2017.
[156] Female Focus Group Discussion held at Haama Parish on March 30, 2017.
[157] Ibid.
[158] In a Focus Group Discussion with some VHTs at Sigulu HCIII on March 29, 2017, some VHTs revealed that Ugandans are charged higher fees for health services in some Kenyan health facilities. For instance, they pay Three Hundred Fifty Kenyan Shillings (Kshs. 350/=) for consultation and upon admission, they are charged Five Hundred Kenya Shillings (Kshs. 500/=) per night,
[159] Ibid.
[160] Female Focus Group Discussion held at Haama and Rabachi Parishes on March 30 and 31, 2017.
[161] Male Focus Group Discussion held at Namugongo village, Nampongwe Parish on April 2, 2017.
[162] Ministry of Public Service, 2015 National Service Delivery Survey, p. 93 available at http://www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/2015%20NSDS%20report.pdf (last accessed March 7, 2018).
[163] Ibid.

4.2.2 Scope Of Services Offered

4.2.2.1 General services

An independent assessment found significant shortcoming in the service range of a number of health facilities in Namayingo District.[164]Out of the eight (8) facilities surveyed, Sigulu HCIII was one of only two (2) facilities found which lacks a minimum standard for service availability (five (5) working days per week) for all four (4) of the following indicators: child immunization, growth monitoring, antenatal care, or family planning.[165]All the surveyed facilities offered outpatient services at the minimum standard for availability and also met the stipulated standards (1 day a week) for provision of the following services: TB management, ART for HIV, and HCT.[166]

As noted above, there are two levels of health centres on the islands: HCIIs and HCIIIs.Between the health centres on the islands, a range of health services are offered. However, the isolation of the health facilities means that any given health centre may be required to offer medical services generally performed only by higher-designation centers. For example, due to the dearth of accessible HCIIIs, HCIIs may perform procedures generally reserved for higher-designation and higher-capacity HCIIIs such as deliveries. The In-charge at Haama HCII explained that she conducts deliveries, a procedure generally not delegated to HCIIs under the Ministry of Health Policy, because there is only one health facility on the island.[167] With some lower-designation health centres able to assume some functions of the higher-designation centers, many community members reported frustration over not finding desired higher-level health services at all

OKUNGA GODFREY
Haama Parish, Lolwe Sub-County

"At the time of her unfortunate demise, [my wife] was 27 years old, and we had produced four children. This pregnancy was to give us a fifth child. Before the fateful day, my wife had not undergone any complications. In fact, her earlier births had passed smoothly.

It all began with her getting labour pains upon which I rushed her to the Haama HC II. It was 6:00pm in the evening and as such it was getting dark. She had been bleeding profusely while the medical personnel looked on and in the process, she pushed a dead baby. While all this was happening, the health worker did not advise me at any point on what I was to do next. I decided to look for fuel and a boat so that I could take my wife to hospital. My wife had, however, bled so profusely that before we could set off, she passed on.

It took me some hours to get fuel and a boat, but I still believe that with the bleeding, having been too much and unattended to, it was already too late for my dear wife. And because of her, when I got another wife, I decided to always take her to the mainland whenever she gets pregnant. It is costly since I have to rent her a house and supply her

[164] Strengthening TB & AIDS Response – Eastern Region (STAR-E), "Namayingo District: Health Facilities Assessment," September 2013 available at http://www.starelqas.ug/wp-content/uploads/Namayingo-Distric-HFA-report-.pdf (last accessed August 26, 2017).
[165] Ibid, p. 8.
[166] Ibid.
[167] Ministry of Health, Guidelines to the Local Government Planning Process: Health Sector Supplement, 2016 available at http://library.health.go.ug/download/file/fid/580957 (last accessed March 6, 2018).

HCIIs.[168] Multiple complaints also arose over all HCIIs not administering drugs in the form of injectables.[169] Rabachi and Nampongwe islands are the most affected islands in Sigulu sub-county because they are situated far from Sigulu HCIII, the only nearby facility where higher-level services can be reliably obtained.

Due to the limited services offered at HCIIs, most diseases go undiagnosed. For example, residents of Bugoma village, Nampogwe parish, revealed that they usually ignore symptoms of diseases because they have do not have health facilities on the island and the nearby Rabachi HCII does not provide diagnoses for some illnesses and conditions such as typhoid, dental problems among others.[170] While such diagnoses may be offered at the Sigulu HCIII and Buyinja HCIV on the mainland, it is costly to travel all the way.[171]

Whereas Sigulu HCIII offers more comprehensive services than the HCIIs on the other islands, the health facility has serious gaps in the range of services offered. The HCIII does not offer laboratory services on a full time basis due to intermittent electricity nor dental services, among others, even though these services are critically needed on the islands.[172] To access such health care requires making the long and costly journey to Buyinja HCIV on the mainland.

4.2.2.2 Maternal and Child Health

Nationwide, the maternal mortality ratio in Uganda is 336 deaths per 100,000 live births.[173] Whereas women living on the Sigulu Islands can access maternal health services, the range and quality of services provided is low. Due to the limited maternity services, there are very many women who have either lost their lives and/or the lives of their children. Originally, only HCIIIs were supposed to offer maternity health services to the community, but the presence of only one HCIII on the entire island was insufficient to meet the service demand, forcing some HCIIs, such as the Haama HCII, to provide maternity services to the women.

As of 2016, HCIIs are required to not only provide antenatal care services but also conduct emergency deliveries.[174] Being tasked to provide such emergency deliveries to mothers, health workers at HCIIs are expected to be on standby in order to provide immediate response when needed. Unfortunately, all the HCIIs on the islands close by 5:00pm and do not open on weekends.[175] This presents a huge challenge for pregnant mothers who go into labour at night and cannot easily access maternity services. At Haama HCII,

[168] Female Focus Group Discussions held at Haama and Rabachi Parishes on March 30 and 31, 2017.
[169] Ibid .
[170] Female Focus Group Discussions held at Bugoma village, Nampongwe Island on April 2, 2017.
[171] Ibid. The Participants in the FGD revealed that travelling from Bugoma village, Nampongwe Parish to Buyinja HCIV takes close to an hour with an engine boat and three (3) hours with a rowing boat. The cost of hiring an engine boat is approximately Seventy Thousand Uganda Shillings (UGX. 70,000/=). See Section 4.2.1 on Accessibility.
[172] Interview with In-Charge of the Sigulu HCIII, supra.
[173] Uganda Bureau of Statistics, (2017), Uganda Demographic and Health Survey 2016, Kampala, Uganda at p.57.
[174] Ministry of Health, "Guidelines to the Local Government Planning Process Health Sector Supplement, 2016" at p. 5 available at http://library.health.go.ug/download/file/fid/580957 (last accessed March 6, 2018).
[175] According to interviews conducted with health workers at the HCIIs at Haama and Rabachi, the health facilities open at 8:00am and close at 5:00pm in the evening. The health facilities do not open on weekends. However, since the health workers reside on the islands, they are called from their homes when there is an emergency.

the In Charge noted that while there was no midwife at the facility, she is an enrolled nurse with the capacity to deliver babies.[176] Infrastructural challenges, such as no electrification at the HCII, further complicate maternal care, requiring mothers who come to the facility at night to deliver by torch light.[177]

Poor service coverage and medical worker absenteeism detrimentally affects the health outcomes and health seeking behavior of expectant mothers on the islands. Due to these difficulties in accessing maternal health services, pregnant women resort to seeking maternal and/or antenatal services from Traditional Birth Attendants (TBAs).[178] Majority of the TBAs on the island are not trained in conducting safe deliveries and preventing Mother to Child HIV/AIDS transmission. Some TBAs admitted that they do not have the required equipment and tools to conduct a safe delivery.[179] The VHTs reported increasing preference among women for birth assistance by TBAs over health centres, prompting the government to discourage TBA-assisted delivery.[180] If the TBA cannot handle a given case, the VHTs urge TBAs to refer the case to the health centre.[181] Across the whole of Namayingo District in 2014/15, only 29% of deliveries were conducted in government and PNFP health facilities, implying widespread use of such informal health providers during childbirth.[182]

All the women participating in the Focus Group Discussions in Kasosoli and Bugoma in Nampongwe reported having given birth at home while being attended by their mothers-in-law at least once.[183] A mother of eight among them had delivered all her children from home. The women noted that the children delivered from home often miss out on immunization administered at health facilities at birth, while the mothers do not access vital antenatal or post-delivery care, which they would have otherwise received if they delivered at health facilities.[184]

Underlying problems such as drug shortages and lack of equipment particularly impact maternal healthcare. This is prevalent in the region as a whole. In Eastern Uganda, no hospital or HCIV reported having all recommended priority life-saving medicines for mothers, and only 22% of these health facilities reported

[176] Interview conducted with Haama HCII In-Charge, supra. Hama HCII is not supposed to conduct deliveries but the In-Charge improvises since the Health Center III at Sigulu is far away and the transport costs are high for the expecting mother to travel to the facility.

[177] Ibid. The In-Charge noted that it is very hard for her to conduct a delivery in such conditions in the dark. She also noted that the facility does not have mama kits to give to the expecting mothers. These mother are therefore expected to carry their own supplies when they go to deliver at the health facility.

[178] During the FGD with the VHTs at Sigulu HCIII, they noted that at the Bumalenge HCII, the medical staff does not work over the weekends. If a woman needs to give birth, she has to look for a Traditional Birth Attendant (TBA) or go to the HCIII which is always open but the only hindrance is the transportation to the Health Center. The VHTs further noted that the TBAs who help mothers in child delivery are not well trained in child delivery and at times do not have maternity kits. They also noted that so far, around three people have died while delivering with the help of the TBAs and that there are various dangers of delivering with the help of the TBA for example mother to child transmission of HIV/AIDS.

[179] Interview conducted with a Traditional Birth Attendant (TBA) in Kasosoli Village, Nampongwe Parish, Sigulu Sub-County on April 2, 2017.

[180] Focus Group Discussion with VHTs at Sigulu HCIII on March 30, 2017.

[181] Interview conducted with the VHTs in a FGD at Sigulu HCIII, supra.

[182] Uganda Bureau of Statistics (UBOS), 2016 Statistical Abstract, supra

[183] Focus Group Discussion [Female] at the border of Namungogo and Kasosoli villages in Nampowe Parish held on 2nd April, 2017.

[184] Ibid.

having half of the medicines.[185]

4.2.2.3 Sexual and Reproductive Health

There is limited access to family planning services on the islands. A 2013 survey of health facilities in Namayingo District found that only one (1) of eight (8) health facilities maintained adequate stocks of family planning methods, including oral contraceptives, injectable contraceptives, implants, IUDs, and condoms.[186] At the time of this research four (4) years later, the problem was still persisted.

At Rabachi HCII, a health worker noted that condoms are brought to the islands, but supplies are not enough.[187] They receive five (5) boxes every quarter.[188] The condoms are distributed free of charge when they go for outreaches. During a FGD at Rabachi, when asked about condom use, community members noted that they access condoms through the VHT when they want.[189] The group also noted that injectable methods of family planning are periodically given.

At Nampongwe, John Opio, the Parish VHT-coordinator, highlighted that while the VHTs distributes condoms, there is low demand for the contraceptives.[190] In Nampongwe particularly, the public attitude towards condom use was negative, with some men simply preferring intercourse without condoms.[191] Many women, in turn, reported that they forego the use of condoms because of the associated stigma - men often accuse their wives of being 'sex workers' if they suggest the use of or possess condoms.[192] Some women reported having unprotected sex with their husbands, even when they suspected that he might have multiple sexual partners or may be HIV-positive because their husbands do not accept to use condoms.[193]

The absence of health facilities often represented another barrier to accessing contraception. In Bugoma village, women interviewed said they access family planning only at private clinics because there is no public health facility on the island.[194] One woman participating in the FGD said, "If you don't have money, you don't get." Transportation costs presented another barrier. Many women at Bugoma village said whereas they want family planning, they often lack transport to go to Sigulu HCIII to access comprehensive family planning services.[195] Other respondents reported traveling either to Buyinja HCIV on the mainland or to

[185] Ministry of Health, Hospital Census Report, January 2016 at p. 175 available at http://www.who.int/healthinfo/systems/SARA_H_UGA_Results_2014.pdf [last accessed on March 2, 2018].
[186] Strengthening TB & AIDS Response – Eastern Region (STAR-E), "Namayingo District: Health Facilities Assessment," September 2013 available at http://www.starelqas.ug/wp-content/uploads/Namayingo-Distric-HFA-report-.pdf (last accessed August 26, 2017).
[187] Interview with a Volunteer Nursing Assistant at Rabachi HCII, supra.
[188] Ibid.
[189] Male Focus Group Discussion at Rabachi Parish on April 1, 2017.
[190] Interview conducted on April 2, 2017.
[191] Male Focus Group Discussion held at Kasosoli village, Nampongwe Parish on April 2, 2017.
[192] Female Focus Group Discussion held at Bugoma village, Nampongwe Parish on April 2, 2017. Several women laughed when asked whether they can buy condoms to use with their partners, saying that if their partners found them with condoms the woman is called "a Malaya" – a sex worker.
[193] Ibid.
[194] Ibid.
[195] Ibid.

Kenya for family planning, the both trips involving high transport costs.[196]

In a FGD held in Rabachi Parish with male participants, they revealed that community members are shy and afraid to seek treatment for sexually transmitted diseases or infections (STDs and/or STIs) such as gonorrhea or syphilis.[197] Whereas there are some private clinics in the Parish which offer treatment for STDs and STIs, this is done at a high cost thus only those who can afford are able to access these services.[198] However, majority of the community members opt for traditional herbal therapies for these infections because it is much cheaper.[199] The community members also disclosed that when they go for the said herbal therapies, they are not informed of the name or ingredients of the traditional medicine by the herbalists.[200]

Family planning services were reportedly more available at Buyinja HCIV, where the health facility has a room dedicated to family planning. A Clinical officer at the HCIV reported that the health facility offers all family planning methods.

The situation encountered on the Sigulu Islands reflects poor coverage of family planning services in the wider region. Only 30% of health facilities in Eastern Uganda reported offering all or at least half of a list of important family planning commodities, compared to 34% nationally.[201] Such data helps to further illustrate the challenges to availability and accessibility encountered by the fact-finding mission.

4.2.2.4 Immunization services

The Ministry of Health implements immunization services through the Uganda National Expanded Program on Immunization (UNEPI).[202] Under the Program's guiding principles, immunization shall be accessible to all eligible persons at the nearest health center.[203] These include: i) all children below one (1) year who should be vaccinated five (5) times before their first birthday; and ii) all women of childbearing age (15-45) years including pregnant women to protect them and the new born babies from getting tetanus.[204]

Access to immunization services is a challenge for residents of the Sigulu islands. Health workers at Haama and Rabachi Parishes revealed that since they have no refrigerators to store the vaccines, they have to travel to Lolwe HCIII and Sigulu HCIII respectively, on a weekly basis, to collect vaccines for immunization.[205]

---

[196] Ibid.
[197] Male FGD held on April 1, 2017.
[198] Ibid.
[199] Ibid.
[200] Ibid.
[201] Ministry of Health, Hospital Census Report, January 2016.
[202] Ministry of Health, "Uganda National Expanded Program on Immunization (UNEPI)" available at http://health.go.ug/programs/uganda-national-expanded-program-immunisation-unepi (last accessed March 5, 2018).
[203] Ministry of Health, "Immunisation Guidelines by UNEPI" available at https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=0ahUKEwjZ4NzCspzWAhXsJsAKHckkDb4QFggvMAE&url=http%3A%2F%2Fhealth.go.ug%2Fdownload%2Ffile%2Ffid%2F1118&usg=AFQjCNECGSK-Zj1_-pt1fgNa0iruNksT8A (last accessed March 5, 2018).
[204] Ibid. at p. 1.
[205] Interview conducted with the In-Charge at Haama HCII and Volunteer Nursing Assistant at Rabachi HCII, supra.

Due to inability to store the vaccines, immunization services are only offered on one day a week (the day the vaccines are picked from the HCIIIs).[206] Despite the fact that there are funds specifically allocated to immunisation at the HCIII on Sigulu main island and a boat assigned to the facility to ensure provision of these services, there are no monies allocated for fuel.[207] This further burdens the HCIII, which operates under a fixed budget.

A community member from Nampongwe Parish described the arduous process by which mothers seek immunization for their newborns.[208] The majority of the mothers walk to Sigulu HCIII to access immunisation services, given the fact that the nearby Rabachi HCII and Bumalenge HCII lack refrigerators to properly store the vaccinations.[209] During outreaches, medical personnel carry a refrigerator to the island for immunization purposes, after which it is returned to the mainland.[210] The community member also noted that majority of the mothers in Nampongwe wait for outreaches on the island to immunize their children and until such time, they rely on their natural immunity.[211]

In a female FGD held at Nampongwe, two participants, reaffirmed that most mothers on the island take their children for immunisation at Sigulu HCIII.[212] However, a mother of five (5) among the particpants, explained that her children have not completed the requisite doses of immunisation because she does not have the transport to take them all the way to Sigulu HCIII for all the doses.[213] The women noted that on some occasions, even when they travel all the way to Sigulu HCIII, they find that the vaccinations are out of stock at the facility so they return home or continue to Buyinja HCIV on the mainland if they can afford.[214]

It was also revealed by the Assistant District Health Officer of Namayingo District that the funds allotted for immunization programs on the islands are the same as on the mainland, even though the need is greater for island communities.[215] One of the reasons attributed for lack of immunisation services on the Sigulu islands is the centralized distribution of drugs through the National Medical Stores.[216] Vaccines are delivered to a health facility on the Namayingo mainland, from which point, decisions are made on distribution levels to

[206] In a male focus group discussion at Haama Island on March 31, 2017, the group noted a challenge in immunizing their children as there is no refrigerator at the Haama HCII to store the vaccines. At Rabachi HCII, the Volunteer Nursing assistant revealed that since the facility lacks a refrigerator, immunisation services are difficult to provide can only be done once a week. Some people travel to Sigulu Health Centre III by bicycle takes approximately two (2) hours or use a boat which is approximately one (1) hour for immunisation.
[207] According to the In-charge of Sigulu Health Centre III, in a financial year, the facility is allocated Four Million Uganda Shillings (UGX. 4,000,000/=) and 50% of these funds are earmarked for immunisation. He noted that UNEPI provided the facility with a small boat but there is no provision made for fuel and so the boat does not operate efficiently. He also pointed that there is Primary Health Care (PHC) grant for community outreach immunisation programs.
[208] Male Focus Group Discussion at Nampongwe on April 2, 2017.
[209] Ibid.
[210] Ibid.
[211] Ibid.
[212] Female Focus Group Discussion held at Namugongo village, Nampongwe Parish on April 2, 2017.
[213] Ibid.
[214] Ibid.
[215] Interview conducted with the Assistant District Health Officer (DHO) of Namayingo district on April 3, 2017.
[216] Ibid.

the island health centers.[217] Such distribution does not always meet on-the-ground need.

4.2.2.5 Access to Health Services for Persons with Disabilities (PWDs)

According to the National Population Census 2014, 15.8% of the population of Namayingo district reported having a disability.[218] The health services provided to PWDs on the Sigulu Islands are not disability sensitive insofar as they are provided without appropriate attention to any special needs of PWDs.

Some of the HCIIs and HCIIIs visited on the Sigulu Islands lack accessibility features for persons with physical disabilities, such as ramps and adjustable delivery beds.[219] At Sigulu HCIII, out of the fifteen (15) beds in the facility, there was no adjustable bed specially designed to aid deliveries for women with disabilities. Similarly, Rabachi HCII, there were no adjustable beds for women with disabilities and the buildings did not have ramps.

With respect to persons with hearing disabilities, the health workers at all the health facilities visited, save for one at Haama Parish, admitted that they are not trained in sign language, creating a serious communication barrier with Deaf patients.[220]

4.2.2.6 Lack of emergency and referral services

The referral system in Sigulu Island is very poor, leading to the death of many people attempting to access health services on the islands and on the mainland. There are no emergency ambulance services offered to the residents. The geographical location of the islands and the distances travelled to reach health facilities during emergencies and referrals makes the absence of an assigned boat to handle the same a hindrance to access to healthcare. At the various FGDs held on the islands, the issue of the lack of an emergency referral boat resounded especially for women giving birth.[221] Participants cited numerous examples of women who died on the island for lack of ambulance services due to complications during child delivery.[222] At Haama Island, the HCII In-charge pointed out that patients sometimes do not accept referrals due to difficulty in accessing the higher-level health facilities.[223]

---

[217] Interview with the In-Charge at Sigulu HCIII, supra.
[218] Uganda Bureau of Statistics (UBOS) 2016, "The National Population and Housing Census 2014 – Main Report," Kampala, Uganda at p. 81.
[219] This was observed at Sigulu HCIII where out of the 15 beds in the facility, there was no adjustable bed specially designed for people with disabilities. Similarly, at Haama HCII and Rabachi HCII, there were no adjustable beds for women with disabilities and the buildings did not have ramps.
[220] All health workers are not trained in sign language and therefore, they rely on gestures. Only the health centre In-charge of Haama HCII, told the team that due to the growing need to deal with Deaf patients, she privately got training and can easily communicate with Deaf patients.
[221] This issue was raised by the FGDs with VHTs and community members at Sigulu main island, Haama Parish, Rabachi Parish and Nampongwe Parish.
[222] Ibid.
[223] Interview conducted with the In-charge of Haama HCII, In-Charge, supra.

The community members on all the islands disclosed that in cases of emergency, the family members of the patient have to mobilise monies to hire a boat, purchase fuel and pay a boat driver.[224] These costs vary depending on the island where the patient is from and where they are heading.

This problem is worse in Nampongwe Parish where there are no public health facilities on the island. Majority of the mothers engaged with disclosed that they delivered from home because they have to travel to other islands and at times, they do not have the means.[225] "There is no ambulance – our boats are the ambulance," said the Parish coordinator of VHTs at Nampongwe.

Overland ambulances are also lacking for referrals on the Namayingo mainland. Buyinja HCIV, located on the mainland in Namayingo district, is the main referral health facility for emergency cases on the islands. The ambulance of the facility was dysfunctional, creating great difficulty for transporting referral cases from the islands when they reach the landing site on the main land, especially in cases of pregnant women and children.[226] This is also the case for referrals from the HCIV to higher level facilities for further management.[227] Patients are forced to obtain alternative means of transport such as motorcycles from the landing site to the HCIV, which is not only dangerous but also an added physical and financial strain, particularly for pregnant women, compelling many patients to opt out of going to the HCIV.[228] The absence of a working ambulance thus structurally disrupts the working flow of the emergency department of the health system in Namayingo District.

The only ambulance in Namayingo district is non-operational, parked at the Health Centre IV on the mainland in Buyinja.

[224] FGDs conducted with VHTs and Community Members, supra. See Section 4.2.1 supra.
[225] FGD with women from Bugoma Village, Nampongwe Parish, supra.
[226] Interview with the Clinical officer at Buyinja Health Centre IV, supra.
[227] Ibid.
[228] Ibid.

Canoe boats hired by island residents when there are medical emergencies.

4.2.2.7 Isolation from Ugandan Referral Facilities

The challenges of traveling long distances, high costs of transport and lack of emergency ambulances result in community members on Sigulu islands being disconnected from possible referral facilities on the mainland at Namayingo district, so much so that they opt to travel to Kenya as the most feasible means of accessing health care.[229] At Haama Island, the In-Charge of the HCIII described how most people with serious illnesses or complications prefer to go to Kenya for referrals, because it is nearer than travelling to Buyinja HCIV on the main land.[230]

The decision to go to Kenya for healthcare is a costly one. In going to Kenya, individuals interviewed reported having to pay to access the services and incur high transport costs.[231] According to the LCIII Vice-Chairperson of Sigulu Sub-County, the charges are usually doubled for Ugandan patients seeking health care in Kenya.[232]

When patients receive referrals from the HCII level, HCII In-charge noted, many patients from the parish often go to Margeta health centre in Kenya, which provides services comparable to those of a HCIII in Uganda.[233] The In-charge of Haama HCII pointed out that the services there are good, even though payment

[229] Community members from Sigulu main island and Rabachi, Nampongwe and Haama Parishes revealed that they opt to travel to Kenya for health services in some instances because the Buyinja HCIV is far and there are no means of transport from the landing site to the health facility save for motorcycles (boda bodas), which are costly. The estimated cost of a boda boda from Busiro land site to Buyinja HCIV is Ten Thousand Uganda Shillings (UGX. 10,000/=).

[230] Interview with the In- Charge of the Haama HCII, supra.

[231] Female FGD at Haama Parish held on March 31, 2017.

[232] Interview conducted on March 29, 2017.

[233] Interview with the In- Charge of the Haama HCII, supra.

is required from international patients. For example, while registration is free, laboratory services cost approximately Nine Thousand Uganda Shillings (UGX. 9000/=).[234] Whereas the health workers refer patients to Buyinja HCIV on the mainland, patients from Sigulu usually go to Port Victoria health facility in Kenya, while patients from Haama Parish often go to Port Margeta health facility. [235]

At Rabachi parish, one of the participants in a FGD explained that he incurs costs of Sixty Thousand Uganda Shillings (UGX. 60,000/=) to travel to and from Kenya for ART services.[236] Another participant stated that he goes to Kenya for eye check-ups occasionally.[237] Community members from Nampongwe Parish also noted that many pregnant women nearing their delivery date travel to Port Victoria, at an estimated transport cost of Fifty Thousand Uganda Shillings (UGX. 50,000/=).[238] Women in a FGD held in Radanga village, Nampongwe also described incurring similarly high expenses as well as unreliability of service, saying, "There is no way to go if the passenger boat leaves you."[239] Patients also have to pay for fuel on top of hiring a boat in the event there is an emergency at night of close to 20 litres at a cost of Four Thousand Five Hundred Shillings (UGX. 4500/=) per litre for a trip to Busia in Kenya.[240] The women also pointed out that they usually go to Kenya when sick because Buyinja HCIV is far away yet in most cases, it is an emergency. The Assistant District Health Officer starkly noted that many of the people on the islands go to Kenya for treatment, and those that cannot afford the money remain home and die.[241]

4.3 Administrative And Policy Challenges

4.3.1 Incapacitated Local Health Unit Management Committees (HUMCs)

The Guidelines on Health Unit Management Committees (HUMCs) issued by the Department of Quality Assurance in Ministry of Health generally stipulate that HUMCs have an obligation to monitor the general administration of the health centers on behalf of the Local Council and Ministry of Local Government.[242] As per the Guidelines, a HCII should have six (6) members namely: a Chairperson, a Secretary, three respectable public figures of high integrity and a Parish Chief[243] while a HCIII should have four members

[234] Female FGD at Haama Parish held on March 31, 2017.
[235] Interview with the In- Charge of the Haama HCII, supra.
[236] Male FGD held at Rabachi Parish on April 1, 2017.
[237] Ibid.
[238] Male FGD held at Rabachi Parish, supra.
[239] Female FGD held at Rabachi Parish, supra.
[240] Ibid.
[241] Interview with the Assistant District Health Officer, supra.
[242] Ministry of Health, Guidelines on Health Unit Management Committees (HUMCs) for Health Centre III available at http://www.health.go.ug/docs/Guidelines%20on%20Health%20Unit%20management%20committees%20for%20health%20Centre%20II%20(2003).pdf [last accessed March 5, 2018] and Ministry of Health, Guidelines on Health Unit Management Committees (HUMCs) for Health Centre II available at http://www.health.go.ug/docs/Guidelines%20on%20Health%20Unit%20management%20committees%20for%20Health%20Centre%20III%20%282003%29.pdf [last accessed March 5, 2018].
[243] According to the Guidelines for HUMCs for HCIIs, the Chairperson shall be a respectable person of high integrity, and not holding a political position nominated by Sub County or Division Council, a Secretary who shall be the In-Charge of the Health Unit, three respectable public figures of high integrity who are not holding a political position preferably from different Parishes shall be nominated by the Parish Council taking into consideration gender responsiveness and Parish Chief where the HCII is located.

namely: Chairperson, a Secretary, an educated representative from each parish and a teacher in the Zone where the HCIII is located.[244]

As explained by the In-charge of Sigulu HCIII, the HUMC of the facility comprises eight (8) members, including: a Chairperson; the Chairperson LCII; the head teacher of a nearby school; the Sub-County Chief; the health facility in-charge, a health assistant; and an opinion leader selected by the Sub-County leadership.[245]

The HUMCs at the facilities visited on the Sigulu Islands were not operating at their full potential and leadership capacity. At Hama HCII, the in-charge said the HUMC of the facility only comprised five (5) members.[246] Community members participating in a FGD at Haama disclosed that the HUMC had been recently formed in January 2017, but the members had not yet been trained on their roles and responsibilities.[247]

Some sub-counties have not formed HUMCs, while committees in other sub-counties had not yet been oriented on their roles and responsibilities.[248] We found that there had been no formal process to facilitate this. Some communities simply decided they were tired of the current HUMCs and elected new ones.[249] The District Health Office cited the lack of funds as an impediment to ensuring the formal appointment and orientation of HUMCs. As a result of the lack of constituted HUMCs and the lack of training for those that are, HUMCs are not fulfilling their mandate of promoting accountability by among other things raising the concerns of the community about the health facilities to the In-charge, monitoring the general administration of the health centre, supervising health centre budgets, monitoring the procurement, storage, and utilization of all the Health Centre's goods and services.[250] This resonates with findings of national surveying suggesting the limited function and implementation of HUMCs. Nationwide, only 37% of hospitals and HCIVs had procurement and finance committees, and only Eastern Ugandan hospitals and HCIVs reported only 67% of the key governance mechanisms inquired about in the Hospital Census Report.[251] It also resonates with ISER's research on social accountability mechanisms that found the lack of formal constitution and orientation for HUMCs.[252]

---

[244] According to the Guidelines for HUMCs for HCIIIs, the Chairperson shall be a prominent educated public figure of high integrity, and not holding a political position from the Sub-County and nominated by the Sub-County, a Secretary who shall be the In-Charge of the Health Unit, one educated representative of high integrity from each parish chosen by the Parish Council taking into consideration gender responsiveness and a Center teacher of the zone where the HCIII is located.

[245] Interview with the In-charge Sigulu HCIII, supra.

[246] Interview with In-charge of Haama HCII, supra.

[247] Male FGD held at Haama Parish on March 31, 2017.

[248] Interview with community members and interview with Assistant District Health Officer Namayingo district, supra.

[249] Ibid.

[250] For the mandate of HUMCs, see the Guidelines on Health Unit Management Committees (HUMCs) for Health Centre II and Guidelines on Health Unit Management Committees (HUMCs) for Health Centre III, para. 1, supra.

[251] Ministry of Health, Hospital Census Report, January 2016.

[252] Are they Effective? An Audit of Social Accountability Mechanisms in Local Government Processes, Initiative for Social and Economic Rights (July 14, 2017), available at https://www.iser-uganda.org/images/downloads/Are_They_Effective_An_Audit_of_Social_Accountability_Mechanisms_in_Local_Government_Processes_in_Uganda.pdf (last accessed March 6, 2018).

4.3.2 Unresponsive Budgeting and Supply Mechanisms

With respect to resource allocation, the government follows a standard formula in allotting funds to HCIIs and HCIIIs around the country. This in essence results generally into inequitable funding for health centers on the basis that they are same-level regardless of other considerations such as location. The government does not take into account the unique nature of challenges faced by persons living on the islands, such as population size, general healthcare shortages, remoteness of the islands, high island-specific cost barriers to accessing care, among others. Given the topography and unique challenges faced by the islands, it is not logical for a same-level health centre in the islands to receive the same government funding as a health centre in a better-resourced, less-remote township on the mainland.

Health facilities at the local district receive Primary Health Care (PHC) grants from the central government to fund their service delivery.[253] Current funding formulae involve various grant types, including Wage Conditional Grants, Non-Wage Conditional Grants, and Ad Hoc Transitional Development grants.[254] The different grant types afford modest preference to districts demonstrating higher need through indicators like infant mortality, poverty headcount, and the population count in hard-to-reach areas, such as mountainous and island regions.[255] However, the weight given according to poverty head count and the population in hard to stay areas is only 2% and 4%, respectively.[256] Based on witness testimonies and direct observation, it is the conclusion of the fact-finding team that the modestly higher weight given hard-to-reach and highest-need districts in funding allocation is not sufficient to address the needs of the Sigulu Islands or other underserved island communities.

In the experience of health workers and district officials interviewed, mechanisms for drug procurement are often similarly unresponsive to local need.[257] Medicines are procured from National Medical Stores (NMS), which sub-contracts another supplier to deliver to the islands.[258] Sometimes some drugs are delivered, yet others are missing. The missing drugs often are never delivered separately, thus they are counted as unspent monies, which keep accumulating over time.[259] At the end of the year, the total value of monies unspent by the health centre is considered part of the unspent funds of the district.[260] Since the district is barred from redeeming the value of these funds, the effective size of the local budget is reduced to align with unspent monies, further limiting supply of adequate drugs.[261]

[253] Ministry of Health, PHC Guidelines FY 2017-18, p.2 available at http://library.health.go.ug/download/file/fid/581153 (last accessed March 7, 2018).
[254] Ibid.
[255] Ibid.
[256] Ibid. at p. 20
[257] Interviews with In-charge at Sigulu HCIII, In-Charge at Haama HCII, a Volunteer Nursing Assistant at Rabachi HCII, Assistant District Health Officer, and Health Inspector Namayingo District from March 30 – April 2, 2017.
[258]Ibid.
[259] Interview with Assistant District Health Officer, supra.
[260] Ibid.
[261] Ibid.

On the ground, unresponsive resource allocation limits service delivery. This is evident at Sigulu HCIII, where the In-charge noted that the health centre receives a Primary Health Care (PHC) grant of Four Million Uganda Shillings (UGX. 4,000,000/=) per financial year, of which 50% is meant for immunisation and the rest for administration.[262] He added that the budget, given quarterly, is too small to fund administration or transportation costs around the islands especially for immunisation, inhibiting service delivery.[263] It is for this reason that the Sigulu HCIII has not been able to fund the maintenance of its electrification equipment and installation of piped water on its own.[264] Haama HCII, the only health facility in the parish serving a population of more than 4000 people, received a PHC Non-Wage allocation of only Two Million Uganda Shillings (UGX. 2,000,000/=) for financial year (FY) 2016/17.[265] This allocation has remained stagnant in FY 2017/18.[266]

With regard to the funding, the Parliamentary Committee on Health held that "the low operational budget for health facilities under local governments…has made service delivery almost a part time activity."[267]

Funding struggles impair other key areas of the health system on the islands as well. The Village Health Teams (VHTs), for example, act as local HCIs which are mandated to help link the community with lower level health facilities.[268] The VHTs are key in facilitating health promotion, community participation, service delivery and access to health services.[269] As such, VHTs are a crucial component of Uganda's health system, and especially for hard-to-reach areas like the Sigulu Islands.

However, the challenge the VHTs operating in Sigulu Islands is the lack of facilitation. This demotivates the VHTs and affects their effective participation in the provision of health services on the island. At Sigulu HCIII, the VHTs noted that though they are required to move around for long distances to serve the community, yet many a time, they do not receive facilitation. One of the VHTs at Hama HCII noted that they are not given any allowances, yet they do a lot of work in terms of sensitization of the community on prevention of diseases and assisting the health workers.[270] VHTs work hard throughout the day, she explained, only to return to a home without food and children demanding care.[271] Auma noted that the few occasions when they receive a small payment is when the district officials come to the island. Another VHT

[262] Interviews with In-charge at Sigulu HCIII, supra. This is corroborated by the PHC Guidelines FY 2016-17 at p. 162 which states that Sigulu HCIII received a PHC Non-Wage Grant allocation of Four Million Uganda Shillings (UGX. 4,000,000/=) for the FY 2016-17. See Ministry of Health, PHC Guidelines FY 2016-17, available at http://library.health.go.ug/publications/primary-health-care/primary-health-care-guidelines-financial-year-201617 [accessed on March 7, 2018].
[263] Ibid.
[264] Ibid.
[265] Ministry of Health, PHC Guidelines FY 2016-17, supra at p. 162.
[266] Ministry of Health, PHC Guidelines FY 2017-18, supra at p.117.
[267] Parliament of Uganda (2012), "Report of the Committee on Health on the Ministerial Policy Statement for the Health Sector Financial Year 2012/2013."
[268] Ministry of Health, PHC Guidelines FY 2017-18, p.16
[269] Ibid.
[270] Interview with a VHT at Haama Parish conducted on March 30, 2017.
[271] Ibid.

from Lolwe parish pointed out that the last time she had received facilitation for her work was in June 2016 from an NGO that supported their work.[272]

In a bid to strengthen engagement and participation of individuals and communities in health service delivery, the Ministry of Health is currently working towards the establishment of a Community Extension Workers (CHEWs) in the local government health care structure.[273] They shall operate at the Health Centre II level where they will "spend 40% of their time providing health services at the facility level and 60% of their time working in the communities to promote health through the model family approach."[274] Unlike VHTs who operate on a volunteer basis, CHEWs shall be employees of government and will be paid salaries for their services.[275]

Two (2) CHEWs will be selected and trained in every parish, totaling to fifteen thousand (15,000) CHEWs countrywide.[276] The training of the CHEWs will be trained for one (1) year starting in financial year 2017 /2018 in a phased manner until all the districts in the country are on board over a five (5) year period.[277] The existing VHTs who wish to become CHEWs and meet the criteria for selection will be absorbed into the program and trained as CHEWs but the VHTs program will continue to run concurrently with a clearly spelt out working relationship.[278]

With VHTs being a crucial part of the health outreaches on the islands, and the unclear time frame when the islands shall have CHEWs, lack of facilitation is yet another hindrance to the fulfillment of their potential and they should not be disregarded.

4.3.3 Lack of Intra-District Incentives for Island Health Workers

The Sigulu Islands are collectively regarded as a hard-to-reach area requiring special consideration in administering certain government policies. The Deputy District Health Officer (DHO), however, stated that government policies often do not adequately take into account the specific challenges of island healthcare, treating islands in a similar manner to areas on the mainland and other hard-to-reach areas.[279] Such treatment affects service delivery, staffing, and supply of drugs and other equipment. This is particularly striking in regards to resource allocation for the islands, outreaches on the islands, quantitative reporting

[272] Interview with a VHT at Lolwe HCII on April 1, 2017.
[273] Ministry of Health, Community Health: VHT / Community Health Extension Workers, available at http://health.go.ug/community-health-departments/vht-community-health-extension-workers [last accessed on March 9, 2018]. See Ministry of Health, Strategy for Improving Health Service Delivery, 2016 – 2021 at p. 13 available at http://library.health.go.ug/publications/service-delivery/strategy-improving-health-service-delivery-2016-2021 [last accessed on March 9, 2018]. CHEWs "shall engage easily and effectively with the communities and impart critical health educative messages and promotion programs."
[274] Ibid.
[275] Ibid.
[276] Ibid
[277] Ibid
[278] Ibid.
[279] Interview with Deputy DHO Namayingo District, supra.

systems which do not capture what is actually on ground on the islands, procurement of drugs and medical supplies for the islands among others.[280]

The government affords health workers in hard-to-reach areas an additional 30% hardship allowance on top of their salary. However, this allowance is also given to health workers on the mainland by virtue of living in Namayingo district, classified on the whole as a hard-to-reach area.[281] This arrangement means that there is minimal intra-District incentive for health workers to work on the islands where hardships and needs are greater thus many of them prefer to work on the mainland since the allowance is the same. This has greatly affected the number of health workers who work and reside on the island.[282]

4.3.4 Community Participation

The community members interviewed on the islands all unanimously expressed that they are neither consulted nor do they participate in the budget process. General Comment No. 14 explains that participation of the community in health related decision-making is an important aspect of realizing the right to health.[283] Article 38 of the Constitution enshrines the right to participate and the Patients Charter 2009 also recognises that community participation as one of its objectives to empower people in Uganda.[284] The Public Finance Management Act (PFMA 2015) stipulates the right of the community to participate in budget discussions on health.

In a meeting with the VHTs at Sigulu HCIII, the VHTs disclosed that they had never been consulted about the budget at district level.[285] In FGDs at Haama and Rabachi Parishes, the community members revealed that they have never been consulted on the budgetary processes.[286] Some women in a FGD held at Bugoma village, Nampongwe Parish expressed that they have never been called for meetings discussing the district budget, stating "We have not reached that standard."[287] In response, the LC1 chairperson of the village explained that the community members are called for meetings and the budget is read to them,[288] but the community members insisted that they did not even know that they are supposed to participate in the budgetary process. Whereas, a few were aware of their right to participate, they had never been consulted.[289]

280 Ibid.
281 Interview with the In-Charge Haama HCII, supra.
282 Ibid.
283 Committee on Economic Social & Cultural Rights, General Comment No.14, Para 11
284 Patients Charter 2009, Article 3
285 Meeting with VHTs at Sigulu HCIII, supra.
286 FGDs held at Haama and Rabachi, supra.
287 Female FGD held at Bugoma village, Nampongwe Parish, supra.
288 Interview with LCI Chairman, Bugoma Village, Nampongwe Parish.
289 Female FGD at Bugoma village, Nampongwe, supra.

5.0 DISCUSSION: A WAY FORWARD

5.1 A Human Rights-Based Analysis of Island Care

The challenges facing the Sigulu Islands documented by the fact-finding team represent significant barriers to the realization of the right to health for the residents on the island. Applying the four essential elements to the right to health introduced by General Comment No. 14 will provide a framework for a discussion of the key findings.

5.1.1 Availability

With regards to healthcare availability, the shortage of health facilities, poor service coverage, and staffing challenges characterizing the health system of the islands mean healthcare is often unavailable to those who need it. Drug shortages in the health facilities on the island represent one of the most severe shortcomings in availability. Sanitation challenges, too, such as the lack of latrines and access to clean and safe water, severely curtail the functionality of existing health facilities, thus limiting the effective availability of services.

The 2016 Hospital Census Report notes that in Uganda, the target "is to have at least a hospital or a level IV primary care facility per 100,000 people," a target the Ministry of Health claims was met in 2014.[290] While the report goes on to mark the success of the Ministry in meeting other similar targets for hospital-to-person ratios, these macro-scale indicators do not capture the reality of district-by-district inequity and withered health systems below the hospital or HCIV level. The conditions on the ground in Sigulu emphasize the need to qualify these reported successes in ensuring availability of healthcare by acknowledging the reality of local deficits in remote communities.

[290] Ministry of Health, "Hospital Census Report," January 2016, supra.

The element of availability specifically requires the provision of "trained medical and professional personnel receiving domestically competitive salaries."[291] Respondents encountered during the mission suggested that greater incentives may be necessary to make medical practice on the underserved Sigulu Islands more attractive for providers, highlighting one particular way in which service availability has yet to be realized. Strained VHTs represent another challenge to availability in the area of strong human resources for health rights realization.

5.1.2 Accessibility

With regards to healthcare accessibility, recurring reports of patients having to travel for hours to reach health services, if they are able to reach services at all, suggest a grievous failure to ensure accessibility for the Islands. The costs incurred by travel, as well as the cost of accessing private clinics in the absence of operational public health facilities on some islands, represent further barriers to economic accessibility. Geographic barriers and low capacity for consistent outreach programs among island health personnel mean that providing accessible public health information to all individuals on the islands is also a challenge. The physical barriers of distance, as well as the observed absence of disability friendly services, particularly challenge the accessibility of island health services to PWDs. This hinders the enjoyment and realization of their right to non-discrimination.

In considering the element of non-discrimination under the right to health, it is important to consider the dimension of intra- and inter-regional inequality in service delivery and realization of health rights. National health performance data is generally disaggregated to the levels of rural versus urban areas. Comparison of the findings from Sigulu, however, with national findings for rural settings can help clarify the relative level of healthcare accessibility on the Islands compared to other remote communities.

According to the Hospital Census Report published in 2016, only 13% of rural hospitals and HCIVs had at least half of the medicines on a list of 185 drugs deemed essential for treating common diseases in Uganda, compared to 41% of peer facilities in urban areas.[292] Only 13% of public hospitals and HCIVs, compared to 43% of private facilities, maintained stocks of half the medicines.[293] These findings portray serious national challenges in ensuring the security of important drug stocks for patients in rural settings, suggesting the experience of the Sigulu Islands is shared by other rural districts across Uganda.

[291] ICESCR General Comment 14, UN ESC, 2000.
[292] Ministry of Health, "Hospital Census Report", supra at p.165.
[293] Ibid. at p.165.

When statistics for the Eastern Region of Uganda, which includes the Sigulu Islands, are compared to national statistics, however, regional disparities in drug accessibility are suggested. Only 7% of hospitals and HCIVs in Eastern Uganda maintained supplies of half the medicines recommended for treating common diseases in Uganda, compared to 22% nationally.[294] Shortfalls were noticed specifically in the availability of drugs for infectious diseases. In eastern Uganda, 62% of hospitals and HCIVs had at least half of the medicines needed for non-TB and non-HIV infectious diseases, compared with 76% nationally.[295] In multiple performance indicators, Eastern Uganda showed itself to be relatively under-resourced and having made less progress in realizing health rights, as compared to other regions. This suggests the existence of regional accessibility challenges that exacerbate the local isolation of the Sigulu Islands.

Regional disparities in health system capacity are reflected in data on individuals' health-seeking behaviors, indexed by patient intake rates. In Eastern Uganda, the inpatient admission rate from 2013-2014 was 351 intakes per 100,000, compared to 618 per 100,000 nationally.[296] The Hospital Census Report states that inpatient admission rates depend on public willingness to seek treatment, the location and accessibility of services, and other referral patterns.[297] Similarly, Eastern Uganda's regional OPD attendance rates were lower than national indicators, as were Northern Uganda's, reflecting low availability of facilities in these regions.[298] Taken as a possible indicator of the population's ability to access services, the data taken for Eastern Uganda suggests system reforms are needed to promote higher patient admission rates and ensure those needing services can actually access those services.

Broadly speaking, the level of healthcare accessibility correlates with poverty level, creating discrimination against Uganda's poorest communities, on the islands and elsewhere. Health providers for the poorest quintile consulted six patients per day, double the caseload of providers for the richest quintile, resulting in increased waiting time and crowding at health centers for sick people in poorer areas.[299] In both the Eastern and Northern Regions, Uganda's poorest, measures of infrastructural availability and health facility equipment levels were the lowest nationally.[300] As already presented above, wider shortfalls in capacity were reported for Eastern Uganda than for other regions, further highlighting the burden of regional disparities upon the Sigulu Island's local health system. These shortfalls illustrate broader disparities in regional health systems' patient capacity and personnel levels.

[294] Ibid. at p. 165.
[295] Ibid. at p.172.
[296] Ibid. at p.50.
[297] Ibid. at p.48.
[298] Ibid. at p.47.
[299] World Bank IBRD-IDA, (2016), "Uganda Poverty Assessment Report: 2016," at p.xxvi available at http://pubdocs.worldbank.org/en/381951474255092375/pdf/Uganda-Poverty-Assessment-Report-2016.pdf. [accessed on March 7, 2018].
[300] Ibid.

5.1.3 Acceptability

In terms of healthcare acceptability, the fact-finding mission found the health system on the Sigulu islands needs to be more responsive and sensitive to individuals' gender and life-cycle requirements. Unreliable access to family planning services represents a particular breakdown in sensitivity to the expressed desires of female community members on the islands. The general accessibility challenges discussed in this report levy the greatest tolls on pregnant women, as well, constituting another breakdown in sensitivity to female residents of the islands. The difficulties incurred by pregnant women and the elderly (who similarly are disadvantaged by barriers of distance and travel) cannot be taken as acceptable given the unique needs of these patient demographics.

Community perceptions of healthcare acceptability depend on the public's expectations of government duty-bearers. As noted in the 2016 Uganda Poverty Assessment Report, if stakeholders in poorer areas have low expectations, the community's ability to effectively monitor the quality of healthcare is lessened.[301] Social accountability mechanisms, such as engagement with HUMCs and other bodies, become ineffective if community members do not understand the proper standards of service to which they are entitled, the standards against which communities measure healthcare's acceptability and must hold duty-bearers accountable. As such, a crucial component of realizing acceptable healthcare is to sensitize residents of the Sigulu Islands regarding their rights, the duty of the government to provide quality services, and the role of social accountability mechanisms.

5.1.4 Quality

In terms of healthcare quality, the lack of fully-serviced laboratories in the island health centres represents a serious challenge to the ability of the health system to provide scientifically appropriate medical testing and services. Reports of administration of expired drugs, as well as the sanitation problems encountered in certain health facilities, also represent shortcomings in the guarantee of healthcare quality on Sigulu islands.

In total, ISER's fact-finding encountered numerous accounts of patients suffering as a result of inability to access quality treatment – and thus inability to realize their individual rights to health. From the accounts given, it is no exaggeration that the most meaningful measure of the performance of the health system on the Sigulu Islands is that of lives lost.

[301] Ibid.

6.0 LEARNING FROM OTHER ISLAND CONTEXTS: CHALLENGES AND POTENTIAL SOLUTIONS

When assessing health challenges faced on the Sigulu Islands, other island areas generally and fishing communities across Uganda, too often discussion has attributed these challenges (particularly high HIV/AIDS prevalence) to the lifestyles of the individuals living in these communities or considered island geography too helplessly deterministic of these communities' potential for developing comprehensive healthcare systems.[302] However, this report has sought to highlight that behavioral or environmental challenges are no justification for the State not to commit fully to the initiation of innovations and interventions necessary to effectively provide for island communities' health rights.

The absence of government-run-and-monitored health facilities on some of Uganda's island communities has created a vacuum of services that has encouraged informal private providers, who often offer services falling short of governmental health standards, to fill the void. Across the island communities of Kalangala District, Kibira and Hasunira (2012) found that in addition to failing to cover each island with at least some form of health facility (as is the case in the Sigulu Islands), private medical providers and local drug shops were often "operated by unqualified people," in the words of the Kalangala DHO.[303] Despite the concerns over quality, the DHO reported that "we cannot crack down upon them because [the government] cannot provide the service." As such, effective regulation is often compromised. This situation emphasizes the dilemmas created when government duty-bearers fail to provide island communities with formal service providers. Failure to meet quality concerns would usually compel regulators to shut down sub-standard providers, but doing so would only further deepen provider shortages. Such are the compromises faced by island communities like Kalangala and Sigulu.

The government has an immediate responsibility to commit to expanding health centre coverage and improving the referral system. Until that happens, though, government duty-bearers in low-resource island contexts have a number of even shorter-term strategies available to them in order to meet existing service

[302] Diana Bwette, "The Islands of Kalangala District and Access to Antiretroviral Treatment: A Question of Human Rights and Global Health Justice," International Institute of Social Studies, December 2014 available at https://thesis.eur.nl/pub/17386/Diana-Bwette.pdf [accessed on March 8, 2018].
[303] Kibira, Denis and Richard Hasunira, "Access to medicines in hard to reach areas: A case study of Kalangala and Kibaale districts: A household and supply chain situation analysis," Coalition for Health Promotion and Social Development (HEPS-Uganda), 2015 at p. 20 available at https://heps.or.ug/system/files/attachments/access_to_medicines_in_hard_to_reach_areas_a_case_study_of_kalangala_and_kibaale_districts_oct_2012.pdf [accessed on March 9, 2018].

needs most efficiently. In Kalangala, Kibira and Hasuna found that 90% of respondent households were within 5 km of private medical outlets, 83% of which were drug shops.[304] Given the high coverage and utilization rates of drug shops in island communities, Kibira and Hasunira suggest government duty-bearers might seek ways to leverage this pre-existing private infrastructure to provide public medical services, such as by developing public private partnerships to strategically station nurses at certain drug shops or by licensing qualified shops to provide a fuller range of needed medicines.[305]

Drug shops, however, cannot fully answer the needs created by the shortage of government health centers – as noted, drug shops need special licenses to carry many standard medications stocked by formal health centers and simply cannot provide the care that health centers can. While Kibira and Hasunira present this strategy as a short-term tactic to alleviate the challenges created by the health center shortage in Kalangala, the fundamental problem remains that all Ugandans are entitled to the same access to no-cost, government-provided primary healthcare services. Government duty-bearers might leverage certain private partners to begin meeting obligations in the short-term, but the responsibility remains to expeditiously provide the permanent infrastructure needed to ensure all communities living on Sigulu islands can enjoy access to comprehensive health services at a government health facility.

The efforts of other organizations on the islands of Kalangala District have indeed documented similar challenges to those encountered by ISER on the Sigulu Islands – for example, surveyors from the Iceland International Development Agency (ICEIDA) reported similar travel and human resource constraints on the islands, under which women needing C-sections must endure three (3) hours' travel to the health facility and the surgical facilities are commonly unstaffed by the needed doctors.[306] However, the experiences of other islands also model potential interventions for implementation in Sigulu. For example, ICEIDA reported successfully enabling health centers to remain open effectively for 24 hours a day by facilitating the implementation of solar panels at health centers, an intervention that could be implemented on Sigulu to extend operating hours for health centers with large caseloads, high service demand, and no electrification.[307]

For resource-challenged settings like the Sigulu Islands, the importance of maximizing the available human resources in the health system is all the more amplified. For Pacific Islanders inhabiting the remote Torres Strait, where much inquiry has been done within the literature on remote island health, McDermott et al. found that deploying indigenous community members as health workers to help improve indigenous patients' chronic disease management could produce sustainable improvements in patient health, as

[304] Ibid. at p.25.

[305] Ibid. at p.

[306] Icelandic International Development Agency (ICEIDA), "Uganda: Over Half of the Inhabitants in some of the Fishing Villages infected by HIV/AIDS" 2010, available at http://www.iceida.is/english/about-iceida/news/nr/2454 (last accessed March 9, 2018).

[307] Ibid.

opposed to interventions facilitated by outside health workers.[308] In remote island communities, reform in administration of health services must be driven by local knowledge-holders familiar with the challenges of delivering care within a particular cultural and geographic context. In Sigulu, this may involve extensive and genuine consultation with service providers and community members on the islands and positioning health workers within the working networks of the local fishing industry, for example, or strategically engaging fishermen in grassroots health initiatives such as VHTs.

For island communities, the importance of training and facilitation of VHTs by government duty-bearers is crucial, in addition to the state's immediate responsibility to expand and improve permanent health facilities on the islands. On Uganda's Koome Island, for example, availability of drugs to fight schistosomiasis (a disease with 50% prevalence on the island) was found to be insufficient to encourage high uptake of the available drugs – rather, consistent community health education by a supervised, trained, and motivated VHT was identified as one factor important to boosting the uptake of the drugs.[309] Findings such as these emphasize the importance of both 1) effectively utilizing local human resources in island contexts and 2) the need to both ensure the availability of health services (like medicines) and effectively communicate with locals in order to ensure the resources are taken up by the community. In Sigulu, expanded medical services must be accompanied by meaningful local consultations and participation in order to achieve improved health system performance.

In order for government duty-bearers to fully meet their obligations to protect the health rights of island communities, service providers at state health centres must not only offer a standardized minimum package of services. Rather, the services offered must reasonably reflect the actual needs of the community, health or otherwise. As one study involving the islands of Wakiso District found, utilization of needed HIV care by fisher folk was influenced by the degree of accommodation by clinics, such as by offering midnight clinics to fit the schedules created by patients' livelihoods, and the likelihood of facing structural barriers such as long waiting times.[310] Practically, this suggests 1) a responsibility for health centers to know and respond to the accessibility needs of their most needful patients, and 2) that even if the few health centers operating in an under-resourced island district offer a full package of services, the overcrowding potentially created by health facility shortage can limit uptake of services. In short, Bogart et al. found that while the content of care must be directed towards community's health needs, human rights-based care mandates that service delivery must also be mindful of the social and lifestyle needs of the patient demographic, with providers making a

[308] McDermott R, Tulip F, Schmidt B, and Sinha A (2003), "Sustaining better diabetes care in remote indigenous Australian communities," British Medical Journal (BML) 327 (7412): 428-30 available at https://doi.org/10.1136/bmj.327.7412.428 [last accessed on March 9, 2018].
[309] Tuhebwe D, Bagonza J, Kiracho EE, Yeka A, Elliott AM, Nuwaha F (2015), "Uptake of Mass Drug Administration Programme for Schistosomiasis Control in Koome Islands, Central Uganda," PLoS ONE 10(4): e0123673 available at https://doi.org/10.1371/journal.pone.0123673 [last accessed on March 9, 2018].
[310] Bogart L, Naigino R, Maistrellis E, Wagner G, Musoke W, Mukasa B, Jumamil R, and Wanyenze R, "Barriers to Linkage to HIV Care in Ugandan Fisherfolk Communities: A Qualitative Analysis," AIDS and Behavior 20(10):2464-2476, Mar. 2016 available at https://link.springer.com/article/10.1007%2Fs10461-016-1331-z [last accessed on March 9, 2018.)

good-faith effort to ensure services actually can be utilized.[311] Provision of services without consideration of the local context can result in care that fails the acceptability test outlined in General Comment No. 14. Such a finding should certainly inform how government duty-bearers approach service expansion in areas like the Sigulu Islands.

While deployment and empowerment of VHTs does not provide the permanent medical infrastructure so desperately needed in Sigulu, findings from contexts far different from Sigulu demonstrate how even short-term, health worker-based interventions can lead the way for more lasting and comprehensive service expansion in the future. In Indonesia, for example, extension of family planning into villages in the 1970s helped create the administrative framework to later reach those same communities with parasite control and nutrition interventions.[312] Other creative interventions in the short-term can be immediately implemented to help mitigate the catastrophic consequences of the Islands' human resources shortage until government duty-bearers can begin providing the requisite permanent infrastructure. In other contexts, telehealth technology has been implemented, allowing patients in remote areas to access medical information and consult with medical workers virtually, thus empowering patients even when human resource shortfalls render physical presence of a physician in the remote district difficult. Research in Uganda has found that careful planning will be needed to adapt such interventions within the national context.[313]

While the government of Uganda has an immediate obligation to work to provide permanent, comprehensive medical infrastructure in the long-term, the opportunities are many to begin alleviating communities' suffering in the short term, as well, through resourceful interventions to solve the human resource and infrastructural shortfalls on the Sigulu Islands. Finding and implementing the strategies to do so in island contexts, though, requires political will, creativity, and good faith on the part of government duty-bearers.

[311] Ibid.
[312] Hotchkiss J, "Health Care on Small Islands: A Review of the Literature", WHO Division of Strengthening of Health Services, 1994 available at http://apps.who.int/iris/bitstream/10665/59103/1/WHO_SHS_NHP_94.4.pdf [last accessed at March 9, 2018].
[313] Kiberu VM, Mars M, Scott RE. "Barriers and opportunities to implementation of sustainable e-Health programmes in Uganda: A literature review." Afr J Prm Health Care Fam Med. 2017;9 (1), a1277, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5458569/ (last accessed March 9, 2018).

7.0 RECOMMENDATIONS

A. Recommendations to the Ministry of Health

7.1 Address the shortage of health centers

i. Construct more health facilities on the island

There is immediate need to construct health centers in areas that lack health facilities, such as Nampongwe Parish. The Sigulu HCIII In-Charge proposed the building of HCIIs in each parish as an immediate measure to address the deficit. At the time of the visit, out of the five (5) parishes of Sigulu Sub-County, only two (2), Rabachi and Bumalenge, had HCII facilities.[314]

According to the Ministry of Health Guidelines to the Local Government, the criteria for establishing a new HCII shall be where a community of about five thousand (5,000) people is not in reach of a health unit within 5 km walking distance.[315] The Ministry further prescribes that where "access to available health units for recognisable community is constrained by geographical features such as … water… or otherwise. Appropriate level of facility to be determined - specific assessment on a case by case basis."[316] The factors which shall be considered in reaching this decision shall include the "population, distance to different levels and feasibility of attracting staff to work in the area."[317]

Whereas the Ministry has announced its phasing out of HCII facilities with effect from the FY 2016/17,[318] due to the uniqueness of the challenges faced in accessing health care on the islands discussed in this report, it is of utmost urgency that public health facilities, HCII facilities in the least, are established in all parishes on the islands taking into account the geographical barriers to access and the fact that construction of HCIIIs is going to be implemented in a phased manner.[319]

[314] The other three Parishes of Sigulu Sub-county: Mukani, Manga and Nampongwe do not have any public health facilities.
[315] Ministry of Health, "Guidelines to the Local Government Planning Process Health Sector Supplement, 2016" accessed at http://library.health.go.ug/download/file/fid/580957 (last accessed 15 August 2017) on p.13 at para 3.11.
[316] Ibid.
[317] Ibid.
[318] Ministry of Health, Strategy for Improving Health Service Delivery, 2016 – 2021 at p. 13 available at http://library.health.go.ug/publications/service-delivery/strategy-improving-health-service-delivery-2016-2021 [last accessed on March 9, 2018].
[319] Ibid.

ii. Construct HCIII level facilities, Upgrading existing HCIII-level facilities to HCIV-level facilities and HCII-level facilities to HCIII-level facilities

A sounding recommendation from the leadership, health workers and community members living on the island was that the HCIIIs on the island should be upgraded to HCIV facilities and HCIIs to HCIIIs so as improve service delivery to the people on the island.[320] Most community members in Rabachi, Nampongwe and Haama Parishes expressed their frustration with referrals to Buyinja HCIV on the mainland, Sigulu HCIII and Lolwe HCIII which are too distant to realistically access given the geographical barriers and use of water transport. An upgrade to a higher service level would require a wider permanent medical staff (including clinical officers) to maintain presence at the clinic, widening the scope and specialization of services available.[321]

Before any health center can be upgraded to a higher service-designation, however, certain criteria for baseline capacity must be met – for example, staffing at a health center should be at least 65% of the core technical staff and 50% of required staff housing should be built before consideration for any upgrade will be given.[322] Currently, shortfalls in infrastructure and staffing across many of the islands' lower-level health centers make the possibility of upgrading to a higher-designation health center improbable. Standards in infrastructure and staffing at extant health centers need to first be met in order to enable any upgrades necessary for ensuring wider access to comprehensive healthcare.

The Uganda Hospital and Health Centre IV Census Survey 2014 states that:[323]

> Most of the districts that did not have a hospital have been newly created and had populations way below the 500,000 target required to have a hospital. However caution should be exercised in using a target population for constructing a hospital in resource poor countries such as Uganda where physical access to hospitals, mainly due to the poor public transport infrastructure, remains limited. Some of the districts, such as the island districts for instance will require a hospital even though they have small populations. (Emphasis added).

With special consideration of Namayingo as an island district, the Ministry of Health should upgrade Buyinja HCIV to a hospital to cater to the health needs of the communities living on the islands. The limited range of services offered at the HCIV poses a challenge to residents of the island who, after travelling miles to reach the facility, are referred further where the condition is beyond scope and capacity, incurring more transport costs while placing the lives of the patients at risk due to unnecessary delays.

---

[320] Interview with Vice Chairperson LCIII, Sigulu Sub-County, In-Charge Sigulu HCIII and In-Charge Haama HCII and community members from both Sigulu and Lolwe sub-counties.

[321] Ministry of Health, (2016), "Guidelines to the Local Government Planning Process: Health Sector Supplement, 6" available at http://library.health.go.ug/download/file/fid/580957 (last accessed March 9, 2018).

[322] Ministry of Health, Guidelines for Designation, Establishment and Upgrading of Health Units, the Health Infrastructure Working Group, 2011, supra.

[323] Ministry of Health, "Hospital and Health Centre IV Census Survey 2014," January 2016, supra.

7.2 Provide overland and marine ambulance vehicles for all health centers

Reliable emergency services would help prevent many avoidable patient deaths on the islands described in testimonies to the fact-finding team. Both overland ambulances and marine ambulances are desperately needed to convey patients from the homes to health centers around the islands and to the mainland, if needed.

In Rabachi, for example, this concern was voiced particularly strongly. The Rabachi HCII serves more than six parishes, namely Bumayindi, Buyanga, Rabachi, Lubiru, Bulari and Buyege. It is therefore key that Rabachi HCII receives an ambulance to manage patients across the parishes on time to avoid deaths and complications. Similarly, it is of utmost urgency that each landing site of Nampongwe parish receives a marine ambulance to enable efficient emergency transportation of patients to health facilities on the neighboring islands since it has no health facilities. Efforts to put in place ambulance services should run simultaneously with the establishment of health centres on the Parish.

7.3 Build staff quarters

Reliable presence of staff members at remote area health centers is crucial, given the small staff size and the multiple provider roles that any one staff member is usually tasked to perform. To facilitate the staff and ensure providers' availability during times of emergency, staff accommodation units should be provided for the health centre personnel at all health facilities where they are currently unavailable.

The Hama HCII In-Charge specifically requested the construction of staff accommodation at the health facility. Because the facility does not have a midwife, the In-Charge conducts deliveries out of necessity, requiring her presence at the facility at all times.[324] She added that during night deliveries and labor pains, she is forced to sleep on the floor while she attends to the patient. Similarly, in Lolwe, a nurse is forced to sleep in the health centre at night so as to attend to any emergencies. The need for construction of these quarters is thus imminent.

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

At multiple health centres, the number of health workers is way below the standard staff allocations set by the Ministry of Health for their respective levels. At Hama and Rabachi HCII facilities, for example, there are only two (2) staff members out of the required nine (9). As such, the respective In-Charges are forced to take on other roles including acting as a mid-wife which is over burdening given the large population they serve. Such shortages are widespread, causing inefficiencies and poor service delivery. Given the challenges in maternal care, there should be particular emphasis on expanding the number of midwives available in the Islands' health centers. Addressing this particular shortage will help limit dependence on unqualified TBAs, thus helping improve maternal health on the islands.

[324] Interview with In-Charge Haama HCII, supra.

7.5 Increasing access to family planning and community health education

As noted above, the fact-finding mission encountered a number of cultural attitudes adverse to the utilization of family planning from the community members. Special efforts should be made to provide comprehensive family planning services for community members and address resistance to contraceptive use among the residents on the Sigulu islands, especially Nampongwe parish. Consideration should be given to the lifestyles of fishermen and other unique demographics on the Sigulu Islands.

7.6 Provision of safe water

Government should immediately invest in providing safe water to the island health centres and drilling boreholes in the various villages especially in Nampongwe parish where it was noted that some villages, such as Bugoma do not have boreholes so the community members have to walk long distances to access clean and safe water.

7.7 Take measures to address the lack of electricity

Respondents on all islands visited pointed out the lack of electricity at all health centres, which not only makes storage of essential supplies like vaccines impossible but also impedes the ability of health centres to cater to patients who come to deliver at night. Currently those that deliver at night are attended to with the assistance of phone torches. Only Sigulu HCIII had solar power, which was unreliable at best because the batteries of the system were faulty and in urgent need of replacement. When the team visited, there was no power because the battery was down thus the facility was unable to conduct laboratory tests, a service which falls in the scope of a HCIII. Electrifying all health centers through the use of functional solar systems would enable the health workers to diligently attend to patients during emergencies at night especially during deliveries and would go a long way in extending the operating hours of the health facilities to meet service demands.

7.8 Increasing the supply of essential drugs

Supplies delivered to the Sigulu islands should be increased for all essential drugs, not just basic anti-malarial and anti-bacterial drugs. Current shortages force patients to go to private clinics, where drug prices can be prohibitively more expensive. Regulators should consider liberalizing the restrictions on which drugs are able to be stocked at HCIIs in such hard-to-reach communities in order to widen accessibility of needed medication.

The Ministry of Health should take into consideration the geographical location of the islands and the vast population which the existing health facilities serve in making plans for drug supplies on the islands. Due to the various barriers to access, drug shortages greatly affect the health rights of the community members living on the islands.

7.9 Meeting the urgent equipment needs of island health centers

Most health centers lack basic medical equipment, which hinders the smooth operation of the facilities as discussed above. Equipment shortages force health centers to make unnecessary referrals to higher-designation health facilities, thus forcing upon patients the many difficulties of island travel discussed already. Specifically, duty-bearers should provide refrigerators in all necessary health centers to enable safe storage of vaccines and other medication. Adjustable delivery beds, which were also found lacking in most health centers, should be provided to ensure that PWDs are able to access quality health services on the islands. For the sake of service quality and patient comfort, basic equipment needs such as these should be met.

7.10 Training of health workers to provide disability friendly health services

Health centres on the islands lack health workers who are able to professionally attend to the needs of PWDs. Most respondents stated that PWDs were treated in the same manner as general patients. Implementing special services to accommodate PWDs will ensure that all patients can engage providers and access the treatment to which they are entitled which entails training health workers on how to provide disability friendly services such as training in sign language. Special efforts should also be made to ease the transportation and accessibility challenges PWDs on the islands face in accessing health care.

7.1.1 Acknowledging the unique health challenges faced by island communities in state health policy

The inadequacy of the funding allocated to hard-to-reach areas is a common outcry by health personnel at all levels on Sigulu islands, including the DHO. There is need for revision of health policies and their implementation in remote communities to ensure equitable funding. The Assistant DHO stated that most policies are too often made, and implemented, without an on-the-ground needs assessment.

In particular, the Ministry during budget allocations for the health needs of the Sigulu islands, should consider the unique barriers to access to healthcare including limited coverage of health services, limited health facilities, and high transport costs (such as boat hire and fuel expenses) involved with marine transport. Revision of inspection protocol is also necessary. Travel difficulties often discourage inspectors from visiting all health facilities in an island district, thus causing the most isolated islands' health centers to be disproportionately neglected during periods when needs assessments are being done.

The budget for the district should specifically provide for the purchase and maintenance of ambulances, both vehicles and boats, to ease transportation during referrals and emergencies, on the islands. This should be separate from the PHC grants, which are already inadequate. In FY 2016/17, Sigulu HC III received a PHC grant of Four Million Uganda Shillings (UGX. 4,000,000/=), of which Two Million Uganda Shillings (UGX, 2,000,000/=) was specifically set aside for immunization. This only left half the amount to address the needs of the health centre. Spread over the year, this equated to One Hundred Fifty Uganda Shillings (UGX.

150,000/=) per month which translates to Five Thousand Uganda Shillings (UGX. 5000/=) per day. This meagre amount is insufficient. As discussed earlier, a litre of fuel is approximately Five Thousand Uganda Shillings (UGX. 5000/=). Accordingly relying on PHC grants to cover fuel or ambulance maintenance costs would not be feasible. Nonetheless, it is imperative that funding for emergency services is set aside. This is crucial towards promoting access to healthcare and emergency services.

Further budget recommendations gathered from the islands included affording VHTs regular facilitation to aid them in carrying out their roles. The VHTs currently do not receive consistent facilitation, an issue the community members said creates a disincentive for the VHTs to effectively complete the tiring and difficult work of health outreach across the islands.

This recommendation is made in accordance with Uganda's commitment to uphold the 2001 Abuja Declaration which compels States to promote public health and anti-HIV/AIDS efforts in their respective countries by directing 15% of their annual budgets towards improvement of the health sector.[325] Health sector funding in Uganda for FY2017/18 is UGX. 1,810.25, 6.4% of the budget[326] which falls even further than the allocation in FY 2016/17 of UGX. 1,828.07bn, 8.9% of the budget, both far short of the Abuja Declaration targets.[327] It is noteworthy that government will only contribute half of this budget allocation to the health sector and the rest will be externally funded.[328]

7.12 Promoting policy to increase the general connectivity of the Sigulu Islands to the mainland

The human resource challenges faced by island health facilities are often attributed to providers' aversion to living in so isolated a community as the Sigulu Islands. As such, forward-looking development measures to increase the Islands' integration into regional networks of exchange will be crucial in facilitating the attraction of medical personnel to the islands, enabling more reliable inflow of medical supplies, and the movement of patients for referrals. Such increased exchange, facilitated by investment in transportation routes to and from the islands, may also encourage greater commercial activity in non-fishing sectors between the islands and the mainland, promoting long-term economic growth needed to support the strengthening of the islands' health system. In the Second National Development Plan (2015/16-2019/20), priorities are set to boost investment in "water transport infrastructure" to better facilitate trade, reduce transportation costs, and increase connectivity.[329]

[325] Organization of African Unity (OAU) (2001), "Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases" available at http://www.un.org/ga/aids/pdf/abuja_declaration.pdf [last accessed on March 9, 2018].
[326] Parliament of Uganda (2017), "Report of the Committee on Health on the Sector Ministerial Policy Statement and Budget Estimates for the Financial Year 2017/2018" and Civil Society Budget Advocacy Group (CSBAG) (2017), "CSO Position Paper on the Health Sector Ministerial Policy Statement FY 2017/2018" available at http://csbag.org/wp-content/uploads/2017/04/CSOs-Position-Paper-on-the-Health-Sector-Ministerial-Policy-Statement-FY-2017-18.pdf [last accessed on March 9, 2018].
[327] Initiative for Social and Economic Rights (ISER), "2016 Uganda UPR Factsheet: Right to Health", 2016.
[328] CSBAG (2017), supra.
[329] Second National Development Plan (NDPII) 2015/16-2019/20, National Planning Authority of Uganda, available at http://npa.ug/wp-content/uploads/NDPII-Final.pdf (last accessed March 9, 2018).

7.13 Build the Capacity of HUMCs

Supervision of healthcare personnel would be made easier if local HUMCs were more functional. The Assistant DHO stated that the Ministry of Health should standardize the HUMC training manual so that they become functional and are able to better perform their duty of supervision. Whereas the District has provided a few trainings and capacity building sessions for HUMCs, the Ministry of Health has not provided a standard manual to be used as a guide thus the instruction given lacks uniformity nor have trainings been funded, relying on NGOs who partner with government to train HUMCs.[330] However, NGO funding for these HUMC trainings is sporadic and not an option in a number of districts, resulting in a number of HUMCs like the ones in Namayingo missing out on orientation and training.

B. Recommendations to local government and local leaders

7.14 Construction of more pit latrines and provision of mobile pit latrines

The construction of more latrines was requested, since the number of existing ones is not commensurate to the population on the islands and majority were full. This recommendation was particularly pronounced by people living in areas where latrines are hard to dig due to geographical features such as the sandy terrain of Lolwe or the hilly terrain of Nampongwe Parishes. The community members stated that irrespective of their efforts to construct more latrines, they do not have the capacity to build long lasting and sustainable facilities. This is a short term measure which is of utmost importance in terms of promoting good sanitation and prevention of outbreak of epidemic diseases such as cholera on the islands.

7.15 Increase Local Supervision of Private and Public Facilities

Given reports of sale and distribution of expired drugs by certain private clinics (as well as state health facilities) on the islands, this recommendation surfaced for more meaningful regulation of private health facilities on the Sigulu Islands. Such supervision becomes more important when state-run health centers cannot reliably provide needed medicines, as was observed on the islands. In such instances, private facilities become patients' next option, which the State should guarantee to be a safe one.

Research findings from other districts help demonstrate local demand for private health services in settings comparable to the Sigulu Islands. In a survey taken across three predominantly rural districts, 37% of individuals reported seeking care at a public health care facility, compared to 11.8% seeking care at Private Not-For-Profits (PNFPs), 40% seeking care at a private for-profit (PFP), and 10.6% seeking care from a traditional practitioner, for a total of 63% of individuals seeking care from private providers.[331] In light of such demand, it is essential that private health facilities are properly regulated to ensure they do not violate

[330] Interview with Assistant DHO, Namayingo, supra.
[331] Konde-Lule et al. (2010), "Private and public health care in rural areas of Uganda," BMC International Health and Human Rights 2010, 10:29.

the right to health of the island community members.

7.16 Sensitizing the community members on the exercise of their right to health and preventative measures

The fact-finding mission found that most of the islands' residents are uneducated on health matters, including their right to participate in budgetary consultations or to access reproductive health services, the various social accountability mechanisms with which individuals can engage to voice public requests for services. As noted above, low public expectations for healthcare quality can curtail the effectiveness of social accountability mechanisms such as HUMCs.

Sensitization on preventative measures like the building of latrines, sleeping under mosquito nets is also essential. In some instances, cultural attitudes (such as suspicion of family planning including condoms) inhibit exercise of health rights. Community Health Extension Workers (CHEWs) and VHTs should be deployed to inform community members of preventative measures. Investing in preventative care and supporting VHTs and CHEWs to provide community sensitization and first line treatment is essential given the lack of health facilities on the island and the fact that a number of diseases could be addressed by preventative care.

The community should be informed and engaged in budgetary planning so as to voice their service needs to government duty-bearers. Although the national budget process is supposed to be consultative and bottom down, very little if any consultation takes place in Namayingo District. Comprehensive, on-the-ground needs assessment is crucial to ensure budgets reflect the needs of the community as experienced and not as imagined.

C. Recommendations to Parliament

7.17 Strengthen the legal and policy framework relating to health

Parliament should include a right to health in the Bill of Rights of the Constitution and enact legislation on the right to health, which that would among other things provide for affirmative action in hard to reach areas such as islands. 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. It also lacks comprehensive legislation on health with existing legislation on specialized areas like HIV/AIDS, and an outdated Public Health Act which does not fully incorporate human rights.

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.[332] There is evidence that governments in countries with strong health laws are more likely to invest in the health sector, which in turn pays off in higher social and economic dividends. Even when governments' may lack the political will to discharge their obligations, law is a powerful tool, ensuring the poor and vulnerable are not deprived of the right to health by recognizing the right of individuals to challenge and seek remedy for policies and actions that undermine their entitlement to the right to health. [333]

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

The Parliament, particularly the Health and Budget Committees, should review the budget allocation for the health sector with a specific focus on hard to reach areas including Sigulu islands. In addition to increasing the overall health budget, which has hovered between 7-9% over the last five years and retrogressed to 6.4% in 2017/18, the budget allocation should factor in the unique barriers faced by persons living on the islands to accessing health care. The PHC funds allocated to the island health facilities should be increased to address the unique challenges of the people living on the islands. The current PHC Non-Wage allocation for HCII facilities on the islands is Two Million Uganda Shillings (UGX. 2,000,000/=) annually, which is meagre compared to the amount received by same level facilities in other locations such Ibanda district on the main land which receive Four Million Four Hundred Thirty Two Thousand and Six Hundred Forty Four Uganda Shillings (UGX. 4,432,644/=).[334] This is especially inequitable given the distinctive expenses incurred by HCII facilities on the islands including transportation costs to and fro Sigulu HCIII to collect vaccinations on a weekly basis, outreaches among others.[335] The Parliament, in exercising its oversight role, should ensure fair budgeting in order for hard to reach areas such Sigulu islands to realise their right to health equitably.

[332] International Development Law Organisation (IDLO) et al., "Advancing the Right to Health: The Vital Role of the Law" at p.63 available at http://www.idlo.int/publications/advancing-right-health-vital-role-law (last accessed December 18, 2017).
[333] Ibid.
[334] Ministry of Health, PHC Guidelines FY 2017-18, p. 117 and 103 available at http://library.health.go.ug/download/file/fid/581153 (last accessed March 7, 2018). Other HCII facilities in Ibanda district receive Three Million One Hundred Sixty Three Thousand Four Hundred Forty Seven Uganda Shillings (UGX. 3,163,447/=) annually.
[335] Interview with in change Health Centre II Hama, Islands

D. Recommendations to Civil Society

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

This report makes a number of recommendations and it will take the concerted effort of civil society to ensure the gaps highlighted in realizing the right to health in marginalized areas are addressed by policy makers and local government. Whereas there have been interventions by some NGOs in Sigulu islands, there is need for active advocacy and engagement on possible solutions to address the access to health challenges faced by persons living on the islands.

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

As mentioned at the onset of this report, there is inadequate research and documentation focusing on access to healthcare in hard to reach areas, yet people in marginalized areas face additional barriers to access healthcare. It is imperative that civil society documents these gaps in access to quality health services to inform government policy.

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

In line with recommendation 7.16, civil society can play an important role in sensitizing the community and duty bearers on a rights based approach to health. This will ensure ongoing monitoring of the right to health and community participation in the policy formulation and implementation of health, including in budget processes.

8.0 CONCLUSION

This report, in addition to the widening literature on the state of health accessibility in Uganda's most remote island communities, bears testament to the great difficulties faced by island inhabitants in accessing the medical care to which they are entitled alongside all Ugandans. This report urges government duty-bearers and public stakeholders alike to recognize the state's present failure to meet the health needs of isolated island communities as a real form of discrimination, non-inclusion predicated on the geography and poverty level of island communities.

For the residents of the Sigulu Islands, journeying to access even the most basic of healthcare services can become a harrowing ordeal marked by exorbitant travel costs, repeated referrals between under-resourced facilities, and the real danger of injury or death while attempting to reach the health facility. The cost of these shortages in services and these gaps in infrastructure is not merely statistical – it is the sum of children and mothers lost, the sum of many deaths that provision of simple transportation, medical equipment or other basic resources should have made avoidable.

While government duty-bearers must meet the healthcare shortage on the Sigulu Islands with the appropriate expansions of services and infrastructure, a broadening of philosophy is required on the part of government health authorities, as well, in order to heighten policymakers' sensitivity to the many different forms that discrimination can take with regards to healthcare accessibility. By investing in efforts to achieve healthcare equality for the communities of the Sigulu Islands, government duty-bearers will be furthering a precedent of inclusion that will enable the realization of health rights for marginalized communities of diverse varieties. Such is a crucial benchmark in Uganda's ongoing movement towards achieving universal health coverage, Vision 2040 and maturing as a nation able to realize the human rights and wellbeing of all its people.

REFERENCES

BOOKS, ARTICLES, REPORTS

1. Basudde, E. (2012) "HIV eating up islands and fishing communities," New Vision, December 14, 2012 available at http://www.newvision.co.ug/new_vision/news/1311365/hiv-eating-islands-fishing-communities (last accessed on March 4, 2018).

2. Bwette, D. (2014) "The Islands of Kalangala District and Access to Antiretroviral Treatment: A Question of Human Rights and Global Health Justice," International Institute of Social Studies, available at https://thesis.eur.nl/pub/17386/Diana-Bwette.pdf (last accessed on March 8, 2018).

3. Bogart L, Naigino R, Maistrellis E, Wagner G, Musoke W, Mukasa B, Jumamil R, and Wanyenze R, "Barriers to Linkage to HIV Care in Ugandan Fisherfolk Communities: A Qualitative Analysis," AIDS and Behavior 20(10):2464-2476, Mar. 2016 available at https://link.springer.com/article/10.1007%2Fs10461-016-1331-z (last accessed on March 9, 2018.)

4. Bwire. G, Munier. A, Ouedraogo. I, et al. (2017), "Epidemiology of cholera outbreaks and socio-economic characteristics of the communities in the fishing villages of Uganda: 2011-2015", PLoS Negl Trop Dis 11(3): e0005407 available at http://journals.plos.org/plosntds/article?id=10.1371/journal.pntd.0005407 (last accessed on March 2, 2018).

5. Civil Society Budget Advocacy Group (CSBAG) (2017), "CSO Position Paper on the Health Sector Ministerial Policy Statement FY 2017/2018" available at http://csbag.org/wp-content/uploads/2017/04/CSOs-Position-Paper-on-the-Health-Sector-Ministerial-Policy-Statement-FY-2017-18.pdf (last accessed on March 9, 2018).

6. Grellier R et al., (2004), "The Impact of HIV/AIDS on Fishing Communities in Uganda: Appendices to Field Study Report," Marine Resources Assessment Group (MRAG), October 2004 available at http://www.uac.go.ug/Fisheries/impact.pdf (last accessed on March 7, 2018).

7. Hotchkiss J, "Health Care on Small Islands: A Review of the Literature", WHO Division of Strengthening of Health Services, 1994 available at http://apps.who.int/iris/bitstream/10665/59103/1/WHO_SHS_NHP_94.4.pdf (last accessed at March 9, 2018).

8. Icelandic International Development Agency (ICEIDA), "Uganda: Over Half of the Inhabitants in some of the Fishing Villages infected by HIV/AIDS" 2010, available at http://www.iceida.is/english/about-iceida/news/nr/2454 (last accessed March 9, 2018).

9. Initiative for Social and Economic Rights (2017), "Are they Effective? An Audit of Social Accountability Mechanisms in Local Government Processes," available at https://www.iser-uganda.org/images/downloads/Are_They_Effective_An_Audit_of_Social_Accountability_Mechanisms_in_Local_Government_Processes_in_Uganda.pdf (last accessed March 6, 2018).

10. Initiative for Social and Economic Rights (ISER), "2016 Uganda UPR Factsheet: Right to Health", 2016.

11. International Development Law Organisation (IDLO) et al., "Advancing the Right to Health: The Vital Role of the Law" at p.63 available at http://www.idlo.int/publications/advancing-right-health-vital-role-law (last accessed December 18, 2017).

12. Kiberu VM, Mars M, Scott RE. "Barriers and opportunities to implementation of sustainable e-Health programmes in Uganda: A literature review." Afr J Prm Health Care Fam Med. 2017;9 (1), a1277, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5458569/ (last accessed March 9, 2018).

13. Kibira, D. and Hasunira, R. (2015) "Access to medicines in hard to reach areas: A case study of Kalangala and Kibaale districts: A household and supply chain situation analysis," Coalition for Health Promotion and Social Development (HEPS-Uganda), available at https://heps.or.ug/system/files/attachments/access_to_medicines_in_hard_to_reach_areas_a_case_study_of_kalangala_and_kibaale_districts_oct_2012.pdf (last accessed on March 9, 2018).

14. Kiwanuka et al., "High HIV-1 Prevalence, Risk Behaviours, and Willingness to Participate in HIV Vaccine Trials in Fishing Communities on Lake Victoria, Uganda," Journal of the International AIDS Society 16 (March 2013): 18621 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3720985/ (last accessed on March 5, 2018).

15. Konde-Lule et al. (2010), "Private and public health care in rural areas of Uganda," BMC International Health and Human Rights 2010, 10:29.

16. McDermott R, Tulip F, Schmidt B, and Sinha A (2003), "Sustaining better diabetes care in remote indigenous Australian communities," British Medical Journal (BML) 327 (7412): 428-30 available at https://doi.org/10.1136/bmj.327.7412.428 (last accessed on March 9, 2018).

17. Ministry of Health (2017), Annual Health Sector Performance Report Financial Year 2016/17 at p.38, accessed at http://health.go.ug/content/annual-health-sector-performance-report-201617 (last accessed16 December 2017).

18. Ministry of Health (2016), Annual Health Sector Performance Report: Financial Year 2015/2016,

19. Ministry of Health, "Hospital and Health Centre IV Census Survey 2014," January 2016 available at http://www.who.int/healthinfo/systems/SARA_H_UGA_Results_2014.pdf (last accessed on March 2, 2018).

20. Ministry of Health, Hospital Census Report, January 2016 available at http://www.who.int/healthinfo/systems/SARA_H_UGA_Results_2014.pdf (last accessed on March 2, 2018).

21. Ministry of Health, "2015 National Service Delivery Survey" available at http://www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/2015%20NSDS%20report.pdf (last accessed March 4, 2017).

22. Ministry of Health, "Uganda National Expanded Program on Immunization (UNEPI)" available at http://health.go.ug/programs/uganda-national-expanded-program-immunisation-unepi (last accessed March 5, 2018).

23. Ministry of Health, Community Health: VHT / Community Health Extension Workers, available at

http://health.go.ug/community-health-departments/vht-community-health-extension-workers (last accessed on March 9, 2018).

24. Ministry of Health (2016), "Hospital Census Report,"

25. Ministry of Health (2016), "Hospital and Health Centre IV Census Survey 2014,"

26. Ministry of Public Service, 2015 National Service Delivery Survey, p. 93 available at http://www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/2015%20NSDS%20report.pdf (last accessed March 7, 2018).

27. National District Health Staff Records, "District Summary: Staff Audit, Namayingo, Eastern, Uganda," available at http://hris.health.go.ug/districts_manage/index.php/audit_district_summary?district=district%7C230 (last accessed on March 9, 2018).

28. Organization of African Unity (OAU) (2001), "Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases" available at http://www.un.org/ga/aids/pdf/abuja_declaration.pdf (last accessed on March 9, 2018).

29. Parliament of Uganda (2017), "Report of the Committee on Health on the Sector Ministerial Policy Statement and Budget Estimates for the Financial Year 2017/2018"

30. Parliament of Uganda (2012), "Report of the Committee on Health on the Ministerial Policy Statement for the Health Sector Financial Year 2012/2013."

31. Simunyu F, "72 Dead in Suspected Meningitis Outbreak on Remote Island," Uganda Radio Network, April 27, 2010 available at https://ugandaradionetwork.com/story/72-dead-in-suspected-meningitis-outbreak-on-remote-island (last accessed March 4, 2018).

32. Strengthening TB and HIV&AIDS Responses in East Central Uganda (STAR-EC), (2011), "Program Year 3 Annual Report: Achievements, Lessons Learned and Way Forward" available at http://pdf.usaid.gov/pdf_docs/PA00J9DS.pdf (last accessed on March 7, 2018).

33. Tuhebwe D, Bagonza J, Kiracho EE, Yeka A, Elliott AM, Nuwaha F (2015), "Uptake of Mass Drug Administration Programme for Schistosomiasis Control in Koome Islands, Central Uganda," PLoS ONE 10(4): e0123673 available at https://doi.org/10.1371/journal.pone.0123673 (last accessed on March 9, 2018).

34. Uganda Bureau of Statistics, (2017), Uganda Demographic and Health Survey (UDHS) 2016, Kampala, Uganda

35. Uganda Bureau of Statistics (2017), Uganda National Household Survey, 2016/17

36. Uganda Bureau of Statistics (2016) The National Population and Housing Census 2014 – Main Report, Kampala

37. Uganda Bureau of Statistics (2016), Statistical Abstract accessed at http://www.ubos.org/onlinefiles/uploads/ubos/statistical_abstracts/2016%20Statistical%20Abstract.pdf (last accessed February 18, 2017).

38. Uganda Bureau of Statistics (2013), Uganda National Household Survey, 2012-13 available at http://www.ubos.org/onlinefiles/uploads/ubos/UNHS_12_13/2012_13%20UNHS%20Final%20Report.pdf (last accessed on March 9, 2018).

39. Uganda Bureau of Statistics (2009), Bugiri Higher Local Government Statistical Abstract: Bugiri, available at http://www.ubos.org/onlinefiles/uploads/ubos/2009_HLG_%20Abstract_printed/Bugiri%20HLG%20Abstract-Final.pdf (last accessed on February 28, 2018) at p. 27.

40. Windisch R., Waiswa P., Neuhann F., Scheibe F. and Savigny D., "Scaling up antiretroviral therapy in Uganda: using supply chain management to appraise health systems strengthening," Globalization and Health 7:25, 2011 available at https://globalizationandhealth.biomedcentral.com/articles/10.1186/1744-8603-7-25 (last accessed March 6, 2018)

41. Westaway. E, Seeley. J, and Allison. E, (2007) "Feckless and Reckless or Forbearing and Resourceful? Looking behind the Stereotypes of HIV and AIDS in "Fishing Communities" African Affairs 106, no. 425 (2007): 663-79 available at http://www.jstor.org/stable/4496487 (last accessed on March 2, 2018).

42. World Bank IBRD-IDA, (2016), "Uganda Poverty Assessment Report: 2016," at p.xxvi available at http://pubdocs.worldbank.org/en/381951474255092375/pdf/Uganda-Poverty-Assessment-Report-2016.pdf. (last accessed on March 7, 2018).

LAWS AND POLICIES AND GUIDELINES

NATIONAL

43. Constitution of the Republic of Uganda, 1995.

44. Persons with Disabilities Act, 2006

45. Children (Amendment) Act, 2016.

46. The Patients' Charter, 2009.

47. National Health Policy, 2010.

48. Ministry of Health, Strategy for Improving Health Service Delivery, 2016 – 2021, available at http://library.health.go.ug/publications/service-delivery/strategy-improving-health-service-delivery-2016-2021 accessed on March 9, 2018).

(last

49. Ministry of Health (2016), Health Sector Quality Improvement Framework and Strategic Plan 2015/16-19/20.

50. Ministry of Health, "Immunisation Guidelines by UNEPI" available at

https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=0ahUKEwjZ4NzCspzWAhXsJsAKHckkDb4QFggvMAE&url=http%3A%2F%2Fhealth.go.ug%2Fdownload%2Ffile%2Ffid%2F1118&usg=AFQjCNECGSK-Zj1_-pt1fgNa0iruNksT8A (last accessed March 5, 2018).

51. Ministry of Health, Guidelines on Health Unit Management Committees (HUMCs) for Health Centre III available at http://www.health.go.ug/docs/Guidelines%20on%20Health%20Unit%20management%20committees%20for%20health%20Centre%20II%20(2003).pdf (last accessed March 5, 2018)

52. Ministry of Health, Guidelines on Health Unit Management Committees (HUMCs) for Health Centre II available at http://www.health.go.ug/docs/Guidelines%20on%20Health%20Unit%20management%20committees%20for%20Health%20Centre%20III%20%282003%29.pdf (last accessed March 5, 2018).

53. Ministry of Health, Guidelines for Designation, Establishment and Upgrading of Health Units, Health Infrastructure Working Group, 2011.

54. Ministry of Health, "Guidelines to the Local Government Planning Process Health Sector Supplement, 2016" accessed at http://library.health.go.ug/download/file/fid/580957(last accessed December 1, 2017)

55. Ministry of Health (2015), Health Sector Development Plan 2015/16-2019/20

56. Ministry of Health (2017), PHC Guidelines FY 2017-18, p.2 available at http://library.health.go.ug/download/file/fid/581153 (last accessed March 7, 2018).

57. Ministry of Health (2016), Strategy for Improving Health Service Delivery, 2016 – 2021 at p. 13 available at http://library.health.go.ug/publications/service-delivery-/strategy-improving-health-service-delivery-2016-2021 (last accessed on March 9, 2018).

58. National Planning Authority of Uganda (2015), Second National Development Plan (NDP II) 2015/16-2019/20, available at http://npa.ug/wp-content/uploads/NDPII-Final.pdf (last accessed March 9, 2018).

INTERNATIONAL INSTRUMENTS

59. African Charter on Human and Peoples' Rights of 1981, OAU Doc CAB/ LEG/67/3 rev 5, 21 ILM 58 (entered into force 21 October 1986).

60. The African Charter on the Rights and Welfare of the Child of 1992 (Ratified August 17, 1994)

61. Covenant on the Rights of the Child.

62. Convention on the Rights of the Persons with Disabilities, G.A. Res.61/106, Annex 1, U.N. GAOR, 61st Sess., Supp. No.49, at 65, U.N.Doc. A/61/49 (2006).

63. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) adopted by UN General Assembly, on December 18, 1979 available at http://www.ohchr.org/Documents/ProfessionalInterest/cedaw.pdf [last accessed March 7, 2018].

64. Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples Rights, 2011 (hereinafter Nairobi Principles and Guidelines)

65. Sustainable Development Goal 3: "Ensure healthy lives and promote well-being for all at all ages," United Nations Sustainable Development Goals, United Nations, 2015 accessed at http://www.un.org/-sustainabledevelopment/health/ (last accessed August 19, 2017)

66. The Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa (2003) (Maputo Protocol) (ratified on July 22, 2010)

67. UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4, available at: http://www.refworld.org/docid/4538838d0.html [last accessed March 7, 2018].

68. United Nations International Covenant on Economic, Social and Cultural Rights (ICESR) adopted in December 16, 1966, http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx (last accessed August 18, 2017)

About the Initiative for Social and Economic Rights (ISER) - Uganda

ISER is a registered Non - Governmental Organisation (NGO) in Uganda founded in 2012 to promote the effective understanding, monitoring, accountability, implementation and realization of economic and social rights.

With Funding support from

KIOS Foundation

ISER
Facilitating Social Justice
INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS

Initiative for Social and Economic Rights (ISER)
Plot 60 Valley Drive, Ministers' Village, Ntinda
P.O Box 73646, Kampala - Uganda
Email: info@iser-uganda.org Tel: +256 414 581 041
Website: www.iser-uganda.org Cell: +256 772 473 929
Follow us: @ISERUganda
@ISERUganda