



ISER

Facilitating Social Justice

INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS

Are We Failing to Progressively Realise the Right to Health in Uganda?

An Analysis of Health Sector Budget Trends

November 2018





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List of Acronyms

| | |
|--------|--|
| ACHPR | African Charter on Human and People’s Rights |
| ACRWC | African Charter on the Rights and Welfare of the Child |
| AIDS | Acquired Immune Deficiency Syndrome |
| ART | Antiretroviral Therapy |
| CEDAW | Convention on the Elimination of All forms of Discrimination Against Women |
| CRC | Convention on the Rights of the Child |
| CRPD | Convention on the Rights of Persons with Disabilities |
| DHO | District Health Officer |
| DLT | District League Table |
| EMS | Emergency Medical Services |
| EMHS | Essential Medicines and Health Supplies |
| EmOC | Emergency Obstetric Care |
| EOC | Equal Opportunities Commission |
| ESRs | Economic and Social Rights |
| FGD | Focus Group Discussion |
| FY | Financial Year |
| GAVI | Global Alliance for Vaccines and Immunizations |
| GDP | Gross Domestic Product |
| HC II | Health Centre Level Two |
| HC III | Health Centre Level Three |
| HC IV | Health Centre Level Four |
| HIV | Human Immunodeficiency Virus |
| HDPs | Health Development Partners |
| HSSP | Health Sector Strategic Plan |
| HSDP | Health Sector Development Plan |
| ICESCR | International Covenant on Economic, Social and Cultural Rights |
| ISER | Initiative for Social and Economic Rights |
| LG | Local Government |
| MOH | Ministry of Health |
| NDP | National Development Plan |
| NGO | Non- Governmental Organization |
| NHP | National Health Policy |
| NMS | National Medical Stores |
| NODPSP | National Objectives and Directive Principles of State Policy |
| PHC | Primary Health Care |
| SDGs | Sustainable Development Goals |

| | |
|--------|--|
| TB | Tuberculosis |
| UDHS | Uganda Demographic and Health Survey |
| UGX | Uganda Shillings |
| UHC | Universal Health Coverage |
| UNAD | Uganda National Association of the Deaf |
| UNAS | Uganda National Ambulance Service |
| UN | United Nations |
| UNEPI | Uganda National Expanded Programme on Immunisation |
| UNMHCP | Uganda National Minimum Health Care Package |
| WHO | World Health Organisation |

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Introduction

Introduction

The Initiative for Social and Economic Rights (ISER) is a Non- Governmental Organization (NGO) which was established to promote the effective understanding, monitoring, implementation, accountability and full realization of social and economic rights including the right to health especially for poor persons and the most vulnerable groups including Persons with Disabilities (PWDs), children, women and older persons.

In advocating for the fulfillment of Economic and Social Rights (ESRs), ISER monitors budgetary allocations to ascertain whether the State is meeting its obligation to commit adequate available resources in order to progressively realise ESRs and to ensure non-discrimination.

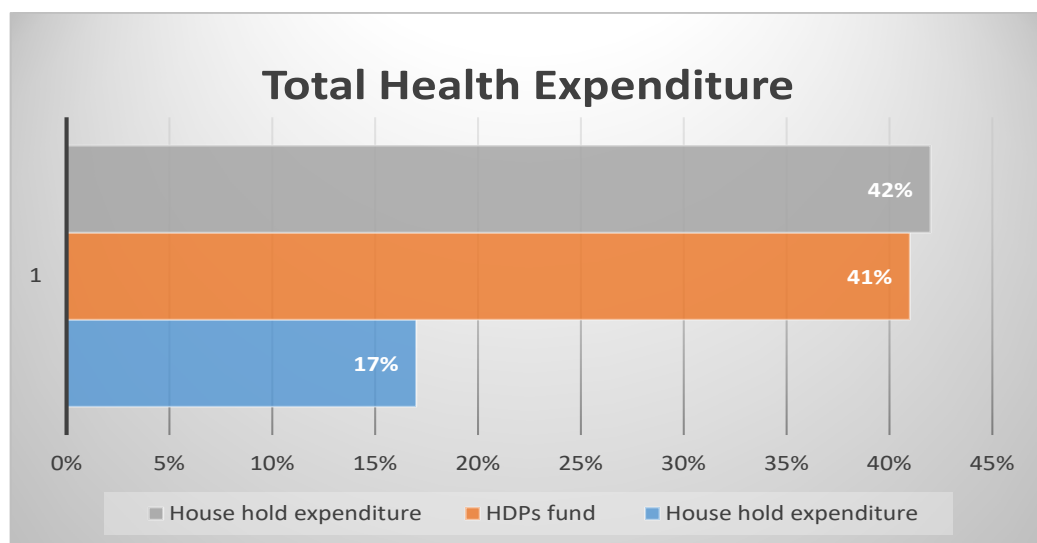
The departure point of this budget analysis is a discussion on the right to health and health financing in Uganda. This brief assesses the fiscal commitment of the Government of Uganda to the health sector right from FY 2015/16, the commencement year of the Second National Development Plan (NDP II) 2015/16 to the current FY 2018/2019. The analysis is also anchored on the commitments and targets set under the National Health Sector Development Plan. The Brief was also done bearing in mind the level of financing that will be required to implement the proposed National Health Insurance Scheme.

This brief goes on to analyze the adequacy of budgetary allocations to specific crucial areas of the health sector over the past few years including budgeting for Essential Medicines and Medical Supplies (EMHS), ambulance services and the special needs of hard to reach areas.

Some of the key findings from the analysis include:

- The budgetary allocation for EMHS over the years does not correspond with the needs of the growing population. There has been minimal increment in the budget allocation for drugs over the years and the average percentage of health facilities which had over 95% availability of a basket of essential commodities stands at 56.2%.

- EMHS is predominantly funded by external funders. This places the country in a precarious and vulnerable situation given the unpredictability and uncertainty of external funding, and the challenges it creates in governance for health. Donors also do not always follow the country priorities in health.
- Currently, Government health financing stands at **17%** while HDPs fund **41%** and the households contribute **42%** of the total health expenditure.¹ The out of pocket expenditure is approximately **40%**, over and above the World Health Organisation (WHO) maximum recommended household spending on health of **15%**.²



- According to the latest National Health Accounts, Uganda’s per capita expenditure for health from all sources is **\$51.4**, below the recommended minimum **\$84** per capita for low-income countries³ and below the Health Sector Development Plan target of **\$92.7**.⁴ Government per capita expenditure on health in FY 2018/19, is approximately **US\$ 16**, far below the World Health Organisation (WHO) Commission of Macro Economics and Health (CMH) recommended per capita government expenditure on health of **US \$ 34**⁵ and the HSDP target of a minimum

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

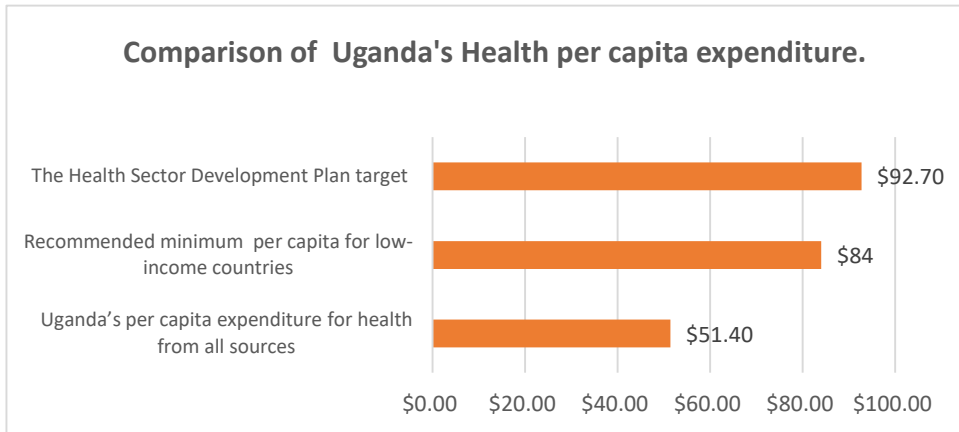
2 Ibid.

3 Ministry of Health (2017) National Health Accounts at p.24; Ministry of Health (2016) Health Financing Strategy 2015/16-2024/25 at p.14, <https://health.go.ug/sites/default/files/Health%20Financing%20Strategy%202016.pdf> (last accessed 1 August 2018).

4 Ministry of Health (2015), Health Sector Development Plan 2015/16-2019/20 at p. 81, <https://health.go.ug/content/health-sector-development-plan-201516-201920> (last accessed 1 August 2018).

5 Ministry of Health, Health Sector Development Plan 2015/16-2019/20 at p. 45.

per capita expenditure on health of **US\$ 17%** in FY 2018/19.⁶ Current health expenditure as a percentage of GDP is **2.21%** for 2017/18, far below the World Health Organization recommended **5%** minimum of GDP.⁷



- Uganda National Ambulance Service (UNAS) has, since its establishment, received inadequate funding, which has crippled its operation and national roll out of ambulance services, falling short of the NDP II and Health Sector Development Plan (HSDP) targets set to expire in FY 2019/20.
- Continued low funding of hard to reach areas directly affects their performance in the health sector. Amudat and Buvuma, two hard to reach districts which have recorded the lowest performance in the health sector for the past five years, have correspondingly received the lowest total budget allocation compared to other districts in Uganda.
- Although Ministry of Health has set objectives to ensure inclusion of vulnerable and marginalized groups, the sector budgets fall short of highlighting specific measures to be taken to facilitate equitable access to healthcare.
- Consistent under funding of the health sector has resulted in a decline in the quality of public health system hence forcing people to resort to a rapidly growing private sector that is not well regulated. This makes it impossible to maintain health as a public good.

6 Ibid. at p. 81.

7 Approved Budget Estimates from FY 2015/2016 – 2017/18, Report of the Budget Committee on the Annual Estimates for FY 2018/19 and National Development Plan II.

Recommendations

The health sector budgetary allocation should align with the set targets in the NDP II, HSDP and Agenda 2030 in order to achieve universal health coverage.

The health sector budget should be progressively increased and should avoid retrogression.

The budgetary allocation for essential medicines and health supplies (EMHS) should be increased to meet the existing funding gap. Failure to do so has resulted in drug stock outs, which hinder access for all to drugs.

The Government ought to employ strategies aimed at increasing the financial resources for EMHS in a sustainable manner to minimize dependence on uncertain and unpredictable external funding.

The Uganda National Ambulance Services (UNAS) requires adequate funding to expand its operations thus fulfilling its mandate to ensure access to ambulance services nationwide as a means of improving the referral system and emergency care in Uganda.

The funding for poorly performing districts should be increased to match the commitment of the State to improve service delivery.

Primary Health Care (PHC) funds for health facilities in hard to reach areas such as Sigulu islands should be increased taking into consideration the unique challenges faced and the higher need for outreaches to reach people who are unable to access health facilities.

In order to reach the most vulnerable and marginalized groups, the Government should collect and rely on disaggregated data to inform service delivery. Without clear interventions on how equitable access to healthcare for vulnerable groups will be improved, stating objectives in that regard in order to adhere to the legal requirement of gender and equity budgeting, will not be of much consequence.

Recruitment of health workers should trickle down to the lower level facilities in rural and hard to reach areas. This is especially important because these facilities are usually the point of first reference for majority of the Ugandan population which lives in rural areas.

I. Right to Health

Right to Health

The right to health is recognised in Uganda’s national, regional and international legal and policy framework. The Constitution of the Republic of Uganda, 1995, under the National Objectives and Directive Principles of State Policy (NODPSP) and Article 8A, requires the State ensure that all Ugandans enjoy access to health services through the provision of basic medical services to the population.⁸

Uganda has committed to protect, respect and fulfill the right to health of everyone through ratification of several international and regional instruments including the International Covenant on Economic, Social and Cultural Rights (ICESCR).⁹ Specific reference is made to the ICESCR General Comment No. 14 on the Right to the highest attainable standard of health which provides a comprehensive guiding

Essential elements of the right to health namely; Availability, Accessibility, Quality and Acceptability of healthcare

framework on what the right to health entails and the corresponding duties of the State.¹⁰ It explains the essential elements of the right to health namely availability, accessibility, quality and acceptability of healthcare.¹¹ Availability refers to the existence and functioning of public health facilities and underlying determinants of health including essential drugs, health infrastructure and trained

⁸ Constitution of the Republic of Uganda, NODPSP Objectives XIV and XX.

⁹ 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. Other International and Regional Instruments which recognize the right to health and have been ratified by Uganda include the Convention on Elimination of all forms of Discrimination against Women (CEDAW), Convention on the Rights of the Child (CRC), Convention on the Rights of Persons with Disabilities (CRPD), African Charter on Human and Peoples’ Rights (ACHPR), African Charter on the Rights and Welfare of the Child (ACRWC) and Optional Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Maputo Protocol).

¹⁰ ICESCR General Comment 14 on the Right to the Highest Attainable Standard of Health adopted by the UN Economic and Social Council, 2000.

¹¹ Ibid. at paragraph 12.

healthcare personnel while accessibility speaks to physical access by everyone to the existing health facilities, goods and services without discrimination in an equitable manner.¹²

Closely related, Uganda has pledged to achieve the 2030 Agenda for Sustainable Development, including Sustainable Development Goal (SDG) 3: Ensure healthy lives and promote well-being for all at all ages. For purposes of this brief, focus will be on Target 8 - “Achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.”

These commitments have been domesticated in Uganda’s policy framework. Under the Second National Development Plan (NDP II) and Health Sector Development Plan (HSDP) 2015/16-2019/20 it is stated that the primary goal of the Health Sector is the attainment of a good standard of health for all through provision of essential health services and achievement of Universal Health Coverage.¹³ This commitment by the Ministry of Health is reiterated in its Strategy for Improving Health Service Delivery, 2016 – 2021¹⁴ and the Patients’ Charter of 2009, which reaffirms the right of all persons in Uganda to impartial access to treatment at any given time in the government health care system.¹⁵

12 Ibid.

13 National Planning Authority (2015) Second National Development Plan (NDPII) 2015/16-2019/20, at pp. xxii and 5 available at <http://npa.ug/wp-content/uploads/NDPII-Final.pdf> and Ministry of Health, Health Sector Development Plan 2015/16-2019/20 at p. 48.

14 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-healthservice-delivery-2016-2021> [last accessed on April 3, 2018].

15 Article 1 of the Patients’ Charter, 2009.

II. Priorities for the Health Sector in the NDP II

Priorities for the Health Sector in the NDP II

According to NDP II, the health sector priorities for the FY 2015/16 – 2019/20 include mass malaria management, universal access to family planning services, development of health infrastructure, reducing maternal, neonatal and child morbidity and mortality, scaling up HIV prevention and treatment; and establishment of a National Health Insurance scheme.¹⁶

The Health Sector Development Plan (HSDP) priorities are defined around the NDP II include strengthening the national health system including governance; disease prevention; mitigation and control; health education, promotion and control; curative services; rehabilitation; palliative care services; and health infrastructure development.¹⁷ With regard to health sector investment, the focus of Ministry of Health is on critical health sector areas such as financing for health, human resources for health, access, availability of medicines and health supplies, health infrastructure, improving quality of care and responsiveness and health information.¹⁸

These priorities have featured in the health sector budgets from FY 2015/16 to date and this brief looks at financing of these priorities over the years. The key commitments of the Health Sector in the FY 2018/19 include upgrading health service delivery through interventions such as improving the referral system, improving primary health care and prioritizing the budget for Essential Medicines and Health Supplies (EMHS) among others.¹⁹

16 NDP II (supra) at p. xxvi.

17 Ministry of Health, Health Sector Development Plan (HSDP) 2015/16-2019/20 at p. 25.

18 Annual Health Sector Performance Report: Financial Year 2016/2017, *Ministry of Health*, 2017 at pp. ix and 15.

19 Ministry of Finance, Planning and Urban Development (2017), National Budget Framework Paper FY 2018/19 – 2022/2023 (Hereinafter referred to as NBFY FY 2018/19) at p. 20 -21 and Ministry of Health, Ministerial Policy Statement FY 2018/19 at p. xi.

These priorities require substantial financial commitment from the State thus this brief will assess, herein below, whether the budgetary allocation for the health sector is adequate to achieve the targets set in the NDP, HSDP and SDGs Agenda 2030.

III. Health Financing in Uganda

Health Financing in Uganda

The Government of Uganda has an obligation to allocate adequate public resources towards the realisation of the right to health²⁰ and meet the above NDP II objectives and targets. Health expenditure in Uganda is currently financed by the Government, Private firms, Households and Health Development Partners (HDPs).²¹ Currently, Government health financing stands at **17%** while HDPs fund **41%** and the households contribute **42%** of the total health expenditure.²² The out of pocket expenditure is approximately over **40%**, over and above the World Health Organisation (WHO) maximum recommended household spending on health of **15%**.²³

For the span of the NDP II thus far, the average budget of the health sector out of the total budget is **6.45%** as illustrated in the Table below. This percentage falls short of the pledge of the State in the 2001 Abuja Declaration to commit at least **15%** of its annual budget towards improvement of the health sector.²⁴

20 ICESCR General Comment 14, supra.

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

22 Ibid.

23 Ministry of Health (2016) Health Financing Strategy at p. vii.

24 Organization of African Unity (OAU) (2001), “*Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*” at para 26 available at http://www.un.org/ga/aids/pdf/abuja_declaration.pdf (last accessed on June 10, 2018).

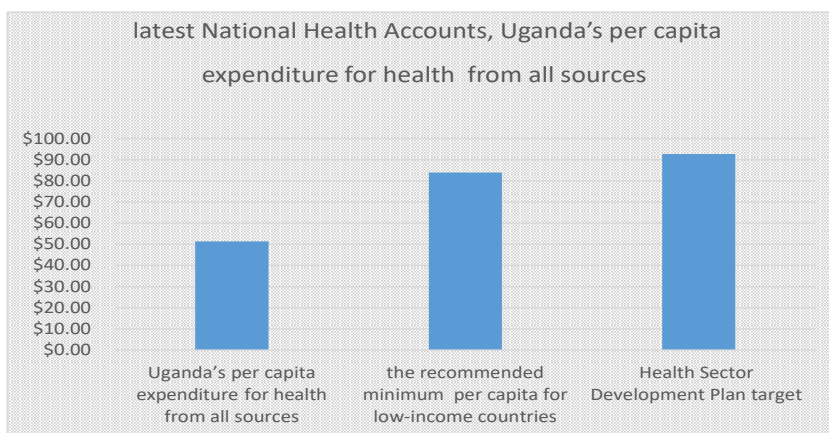
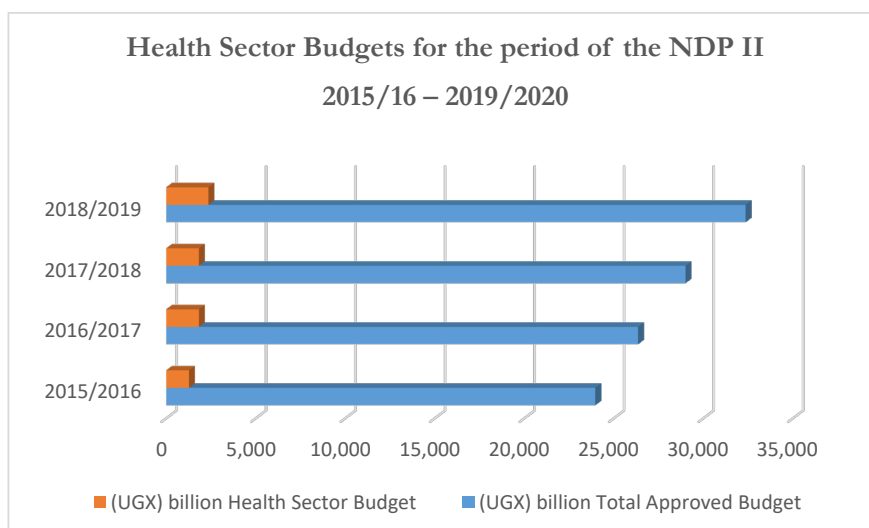
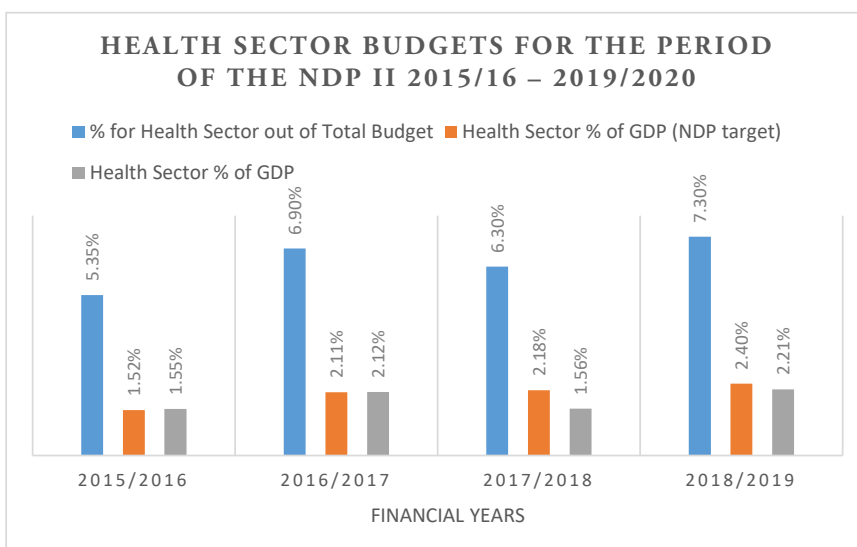


Table 1: Health Sector Budgets for the period of the NDP II 2015/16 – 2019/2020

| Financial Year (FY) | Total Approved Budget (UGX) billion | Health Sector Budget (UGX) billion | % for Health Sector out of Total Budget | Health Sector % of GDP (NDP target) | Health Sector % of GDP |
|---------------------|-------------------------------------|------------------------------------|---|-------------------------------------|------------------------|
| 2015/2016 | 23,972 | 1,270 | 5.3 | 1.52 | 1.55 |
| 2016/2017 | 26,361 | 1,827 | 6.9 | 2.11 | 2.12 |
| 2017/2018 | 29,008 | 1,824 | 6.3 | 2.18 | 1.56 |
| 2018/2019 | 32,367 | 2,358 | 7.3 | 2.40 | 2.21 |

Source: Approved Budget Estimates from FY 2015/2016 – 2017/18, Report of the Budget Committee on the Annual Estimates for FY 2018/19 and National Development Plan II





Although there is a noted increment in the financial investment in the health sector for FY 2018/19, as discussed above, it still stands below the NDP target, HSSIP 10% target and the Abuja Declaration 15% target.

Given the current Ugandan population of 37.7 million,²⁵ the health sector budget for FY 2018/19 equates to approximately US\$ 16 per capita on health, far below the World Health Organisation (WHO) Commission of Macro Economics and Health (CMH) recommended per capita government expenditure on health of US \$ 34²⁶ and the HSDP target of a minimum per capita expenditure on health of US\$ 17% in FY 2018/19.²⁷ The latest National Health Accounts, Uganda’s per capita expenditure for health from all sources is \$51.4, below the recommended minimum \$84 per capita for low-income countries ²⁸ and below the Health Sector Development Plan target of \$92.7.²⁹ Current health expenditure as a percentage of GDP is 2.21% for 2017/18, far below the World Health Organization recommended 5% minimum of GDP.

25 Uganda Bureau of Statistics (UBOS), *Uganda National Household Survey 2016/17* available at http://www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/UNHS_VI_2017_Version_I_%2027th_September_2017.pdf (last accessed on July 9, 2018).

26 Ministry of Health, Health Sector Development Plan 2015/16-2019/20 at p. 45, supra.

27 Ibid. at p. 81.

28 Ministry of Health (2017) National Health Accounts at p.24; Ministry of Health (2016) Health Financing Strategy 2015/16-2024/25 at p.14, <https://health.go.ug/sites/default/files/Health%20Financing%20Strategy%202016.pdf> (last accessed 1 August 2018).

29 Ministry of Health, Health Sector Development Plan 2015/16-2019/20 at p. 81, supra.



37.7 million
Ugandan population

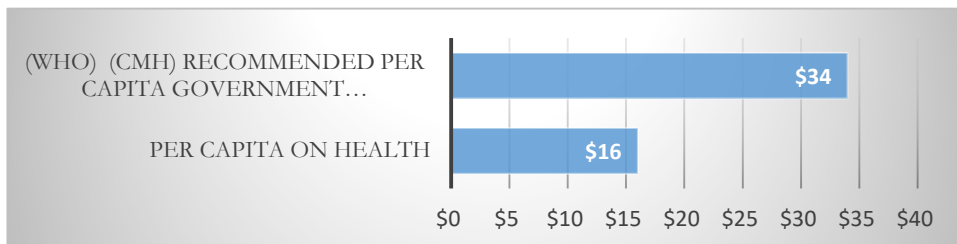


\$ 16 per capita
Health Sector budget
FY 2018/2019

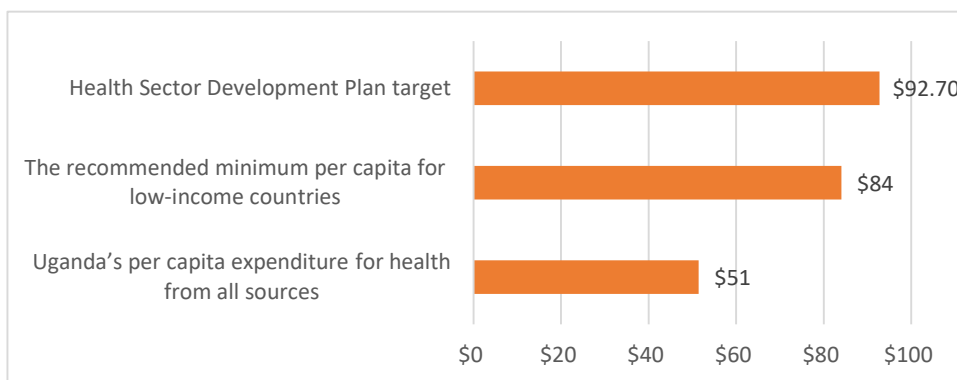


\$ 34
World Health
Organisation Recommendation

The health sector budget for FY 2018/19 equates to approximately



The latest National Health Accounts,



IV. Critical Areas of Concern in the Health Sector

Critical Areas of Concern in the Health Sector

1. Budgeting for Essential Medicines and Health Supplies (EMHS)

Availability of, and access to EMHS is a key component of the right to health and a core obligation on the State.³⁰ This is emphasized in the NDP II which reaffirms that “national policy on medical products and health technologies is zero tolerance to stock out of EMHS.”³¹ Under the HSDP, “the availability, accessibility, affordability and appropriate use of essential medicines of appropriate quality, safety and efficacy at all times” is of utmost priority,³² an objective and commitment reiterated in the National Health Policy (NHP) II,³³ Strategy for Improving Health Service Delivery 2016-2021: Presidential Directives for Health Sector Service improvements to attain Middle Income Status by 2020³⁴ and the Uganda National Drug Policy 2002.³⁵

National Medical Stores (NMS) is a body corporate mandated by law to procure, secure, safely and efficiently store, ensure proper administration of, distribute and supply of EMHS to public health facilities in Uganda.³⁶ In performing these tasks,

30 In the ICESCR General Comment 14 on the Right to the Highest Attainable Standard of Health (supra) para 43 (d), the Committee on Economic and Social Rights (CESR) states that “States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care... These Core obligations include: To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs”

31 NDP II, supra at p. 33.

32 Ministry of Health, Health Sector Development Plan (HSDP) 2015/16-2019/20 at p. xvi.

33 Ibid. at p. 24.

34 Ministry of Health, Strategy for Improving Health Service Delivery 2016-2021: Presidential Directives for Health Sector Service improvements to attain Middle Income Status by 2020, 2016 at p. 3.

35 Ministry of Health, Uganda National Drug Policy, 2002 available at <http://apps.who.int/medicinedocs/documents/s16463e/s16463e.pdf> (last accessed in June 8, 2018).

36 National Medical Stores Act Cap 207, Section 4.

NMS is required to take into consideration the national needs thus it is mandated to conduct an estimation of the current and future needs prior to procurement planning and budgeting.³⁷

1.1 Perennial Drug Stock outs

MOH acknowledges that there are persistent drug stock outs nationwide which generate public uproar, mainly attributed to budget shortfalls and incorrect forecasting for medicines for the public need.³⁸ In the FY 2016/17, the availability of drugs and supplies measured by a basket of 41 commodities fell from 87% in 2015/16 to 83%.³⁹ The essential medicines and health supplies (EMHS) kit system (push distribution system) employed by NMS to supply standardized packages of EMHS to lower health facilities has been criticized for being unresponsive to the needs of the population.⁴⁰ The contents of the kits are determined by NMS, District Health Officers (DHOs) and facility in-charges.⁴¹ It has been reported that health facilities are supplied with a shortage of drugs the population needs and others which they do not require, even in instances where they make advance requests to NMS.⁴²

It is noteworthy that even higher level facilities such as Health Centre IVs, General Hospitals, Regional Referral Hospitals and National Referral Hospitals, which develop their own procurement plan, have reported drug stock outs over the years. The MOH Hospital Census Report 2014 recorded severe shortage of medicines in these higher level facilities with only 22% having at least half of the 185 medicines considered vital for treatment of the common diseases and conditions in Uganda.⁴³

37 Ibid, Section 4.

38 Ministry of Health (2016), Strategy for Improving Health Service Delivery 2016-2021, supra at p. 3.

39 Ministry of Health (2017) Annual Health Sector Performance Report: Financial Year 2016/2017, at p.16.

40 Ministry of Health, National Pharmaceutical Sector Strategic Plan 2015-2020 at p. 4 available at <http://health.go.ug/sites/default/files/NPSSP%20III%20%284%29ready%20for%20print.pdf> (last accessed in June 8, 2018). Majority of the health facilities have reported either being under over supplied.

41 Ministry of Health (2018), National Quantification Report for Public Health Facilities in Uganda FY 2017/18 at p. 1 available at <http://www.nms.go.ug/jdownloads/National%20Quantification%20Reports/FY2017-2018%20National%20Quantification%20Report-Final-19-April-20171.pd>(last accessed on June 9, 2018).

42 Office of the Prime Minister, Government Annual Performance Report (GAPR) FY 2016/17, September 2017 at p. 61.

43 Ministry of Health (2014), Hospital and Health Centre IV Census Survey 2014 at p.165 available at <http://health.go.ug/content/uganda-hospital-and-health-centre-iv-census-survey> (last accessed on June 6, 2018).

The MOH Hospital Census Report 2014



1.2 Low Budget Allocations for EMHS over the past years.

The National Pharmaceutical Sector Strategic Plan III (2015-2020) reaffirms the importance of adequate financing for essential medicines for the people of Uganda, ensuring equitable provision for the poor and vulnerable.⁴⁴ Medicines are the most expensive out-of-pocket health expenditure item for Ugandans, creating a burden especially for the most marginalized and poor people.⁴⁵ One of the strategies MOH proposes to resolve this is increased public financing for essential medicines.⁴⁶ An analysis of the budget trends reveals the government is not on course to achieve this.

Currently, EMHS is funded under two budget lines namely Vote 14: Ministry of Health, Pharmaceutical and other Supplies programme and Vote 116: National Medical Stores. The funding in the former is mainly targeted towards provision of drugs for HIV/AIDS, TB, Malaria and immunization.⁴⁷ In FY 2018/19, NMS has committed to execute its mandate taking into account age, sex, location, unique and special needs

44 Ministry of Health (2015), National Pharmaceutical Sector Strategic Plan 2015-2020 (supra) at p. 30. available at <http://health.go.ug/sites/default/files/NPSSP%20III%20%284%29ready%20for%20print.pdf> (last accessed in June 8, 2018).

45 Ministry of Health (2015), National Medicines Policy, at p. 27 available at <http://health.go.ug/sites/default/files/National%20Medicines%20Policy%202015%20%286%29.pdf> (last accessed in June 8, 2018).

46 Ibid.

47 Ministry of Health, *Ministerial Policy Statement FY 2018/19* at p. 8.

of the different regions and marginalized groups including older persons and persons with disabilities (PWDs).⁴⁸ This, NMS intends to achieve through enhancing efforts to prepare and review procurement plans with health facilities to ensure that the “distinct needs for regions, for the youth, women, men and elderly” are taken care of, paying special attention to marginalized groups such as Persons with Disabilities and people living with HIV/AIDs through the test and treat policy.⁴⁹

Further, to counter stock outs and supply side deficiencies, MOH commits that it will “develop regional storage capacity for medicines to improve the availability of stock within the regions and reduce regional disparities.”⁵⁰

Table 2: Budgetary Allocations for National Medical Stores (NMS) and Availability of Essential Medical and Health Supplies (EMHS) at Health Facilities

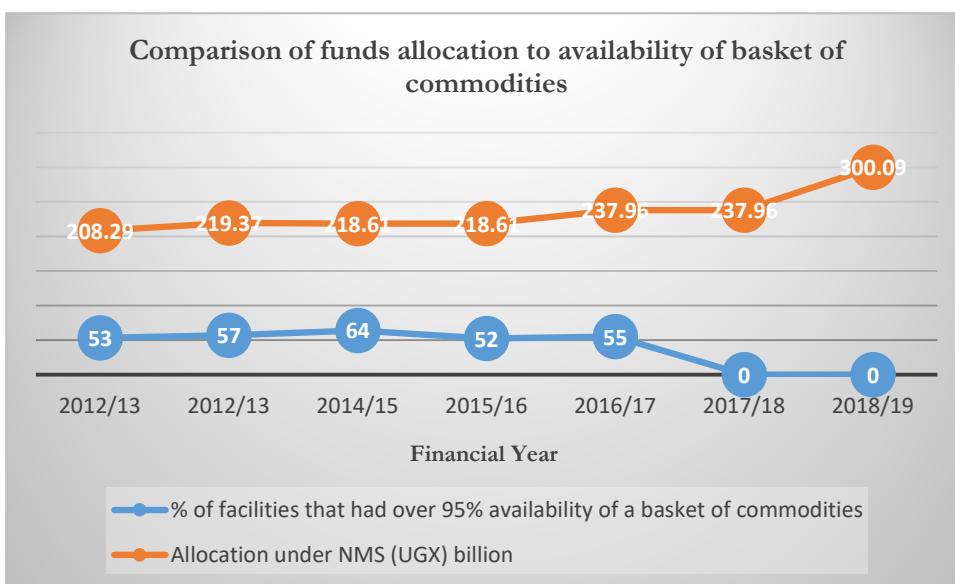
| Financial Year (FY) | Allocation under NMS: Vote 116 (UGX) billion | Growth (UGX) billion | Growth Rate/Trend (%) | % of facilities that had over 95% availability of a basket of commodities |
|---------------------|--|----------------------|-----------------------|---|
| 2012/13 | 208.29 | - | - | 53 |
| 2013/14 | 219.37 | 11.08 | 5.3 | 57 |
| 2014/15 | 218.61 | -0.76 | -0.3 | 64 |
| 2015/16 | 218.61 | 0 | 0 | 52 |
| 2016/17 | 237.96 | 19.35 | 8.9 | 55 |
| 2017/18 | 237.96 | 0 | 0 | - |
| 2018/19 | 300.09 | 62.13 | 26.1 | - |

Source: Approved Budget Estimates from FY 2-014/2015 – 2018/19 and Annual Health Sector Performance Report FY 2016/17

48 Ibid. at p. 37.

49 Ibid.

50 Ibid. at p.19.



From the above table, the allocation for EMHS over the years does not correspond with the needs of the growing population. The trend shows that there has been minimal increment in the budget allocation for drugs over the years and the average percentage of health facilities, which had over 95% availability of a basket of essential commodities, is only 56.2%.

Although the increment of UGX. 62.13 billion for FY 2018/19 is welcome, it remains inadequate and incapable of addressing the continued nationwide drug stock outs. The report of the Budget and Health Committees of Parliament highlights that despite this increment, the budgetary “allocation to supply ARVs to accredited facilities, supply tuberculosis (TB) medicines to accredited facilities and supply EMHS to specialized units” reduced by UGX 7.96 billion, UGX 0.36 billion and UGX 1 billion respectively.⁵¹

The Committee recommended that the State should provide an additional UGX. 60 billion for the expected increase of patients requiring ART under the Test and Treat Policy,⁵² however, there was no re-allocation to that effect.⁵³

51 Parliament of Uganda, “Report of the Budget Committee on the Annual Budget Estimates FY 2018/19,” May 2018 at para 163 at p.52 and Parliament of Uganda, “Report of the Sectoral Committee on Health on the Sector Ministerial Policy Statement and Budget Estimates for the FY 2018/19,” May 2018 at p. 28 -29.

52 Ibid.

53 Parliament of Uganda, “Report of the Budget Committee on the Annual Budget Estimates FY 2018/19, supra.

The inadequacy of funding to meet the need has been highlighted in previous years. In the National Quantification Report for Public Health Facilities in Uganda FY 2017/18, Ministry of Health noted that with the government allocations for NMS under Vote 116 for that year, it would only be able to meet 48% and 55% of the actual demand for essential drugs under credit line and non-credit line commodities respectively at health facilities.⁵⁴ In order to meet 100% of the public need (forecast), NMS would require UGX 101 billion for credit line commodities and UGX. 298 billion for non-credit line commodities.⁵⁵

This critique has also been raised by the Office of the Auditor General and the Ministry of Health given the increasing number of patients in health facilities and the depreciated shilling.⁵⁶ For instance despite the increase in FY 2016/17 by UGX. 19.35 billion, the Office of the Prime Minister noted that, in that same year, there were persistent EMHS stockouts countrywide and reported cases of people dying of treatable diseases due to failure to access drugs in public health facilities.⁵⁷

For the allocation under Vote 14, it has been a continuous critique that the Pharmaceutical and other Supplies programme is mainly externally funded as illustrated by the Table below.

54 Ministry of Health (2018), National Quantification Report for Public Health Facilities in Uganda FY 2017/18, *supra* at p. 14. The Report defines Credit line commodities as “items; funded by the Government of Uganda, have a budget ceiling, budgets are solely under the direct control of Health Facilities, and quantification is solely under direct control of Health Facilities” and Non-credit line commodities as “items; funded by the Government of Uganda and Development Partners, quantification, budgeting and reporting is under the control of Ministry of Health programs which include Uganda National Expanded Program on Immunisation (UNEPI), AIDS Control Program, National Malaria Control Program, TB / Leprosy Control Program, Reproductive Health Program and Neglected Tropical Diseases” at p. xviii.

55 *Ibid* at p. 14.

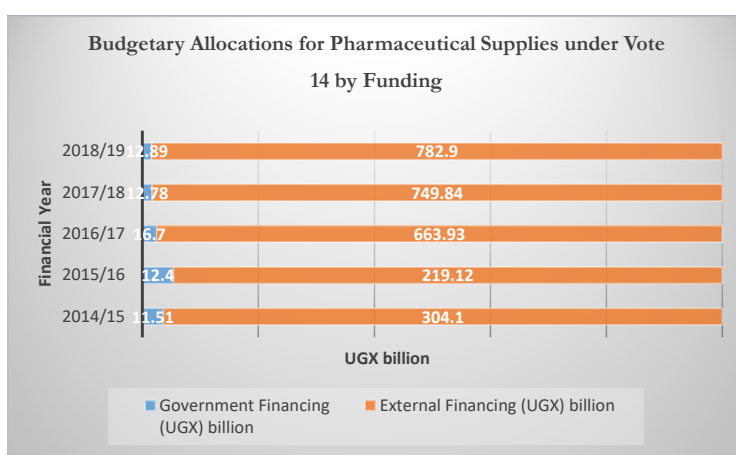
56 Office Of The Auditor General (OAG), Report of the Auditor General on the Financial Statements of National Medical Stores for the Financial Year ended 30th June, 2015 Uganda at p. 10 available at <http://www.oag.go.ug/wp-content/uploads/2016/03/NATIONAL-MEDICAL-STORES-REPORT-OF-THE-AUDITOR-GENERAL-2015.pdf> (last accessed on June 9, 2018).

57 Office of the Prime Minister (2017), Government Annual Performance Report (GAPR) FY 2016/17 (*supra*) at p. 61.

Table 3: Budgetary Allocations for Pharmaceutical Supplies under Vote 14 by Funding

| Financial Year (FY) | Allocation under Vote 014 (UGX) billion | Government Financing (UGX) billion | External Financing (UGX) billion | % of Government Financing | % of External Financing |
|---------------------|---|------------------------------------|----------------------------------|---------------------------|-------------------------|
| 2014/15 | 315.60 | 11.51 | 304.10 | 3.7 | 96.3 |
| 2015/16 | 234.14 | 12.40 | 219.12 | 5.3 | 94.7 |
| 2016/17 | 680.64 | 16.70 | 663.93 | 2.4 | 97.6 |
| 2017/18 | 762.63 | 12.78 | 749.84 | 1.7 | 98.3 |
| 2018/19 | 795.79 | 12.89 | 782.90 | 1.6 | 98.4 |

Source: Approved Budget Estimates from FY 2014/2015 – 2018/19



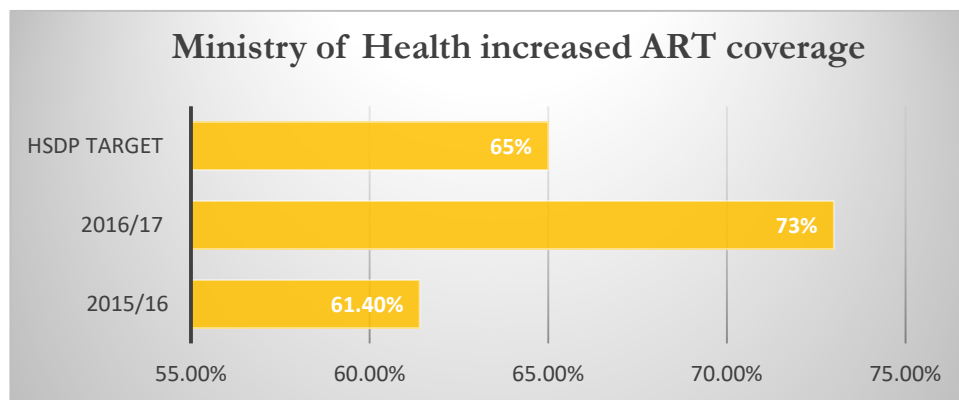
As illustrated by the Table above, EMHS budget is largely externally funded. Government reliance on donor support for EMHS, which should only be complementary, puts the country in a position of vulnerability in the event donors pull out or other funding uncertainties.⁵⁸ According to Ministry of Health, the greater portion of the government budgetary allocation for drugs and supplies goes to HIV, TB and malaria drugs and commodities and similarly, donor financing for medicines is predominantly targeted towards the same diseases and reproductive health, with only around US\$1 of the US\$2.3 for medicines spent on general medicines.⁵⁹ This leaves other EMHS with minimal funding, a gap the government has a duty to fill.

58 Ministry of Health (2015), Annual Pharmaceutical Sector Performance Report 2014-2015, June 2016 at pp. vi and 14 available at <http://health.go.ug/content/annual-pharmaceutical-sector-performance-report> (last accessed on June 9, 2018).

59 Ibid.

With regard to Antiretroviral Treatment (ART) for persons living with HIV/AIDS, there were various reports of stock outs of Antiretroviral (ARV) drugs in FY 2017/18 attributed to the Test and Treat Policy the government is currently implementing.⁶⁰ However, the Ministry of Health refuted these claims stating that Uganda has adequate stock of ARVs for all patients on treatment.⁶¹

Ministry of Health boasts of increased ART coverage to 73% in 2016/17 from 61.4% in 2015/16, above the HSDP target of 65%.⁶²



Yet in its Ministerial Policy Statement FY 2018/19, the Ministry notes, among its challenges, a funding gap of UGX. 116 billion for ARVs despite funding from the Global Fund and Government of Uganda, after adoption of the Test and Treat Policy.⁶³ The allocation for supply of ARVs by NMS has fallen by UGX. 7.96 billion, from UGX. 94.89 billion in FY 2017/18 to UGX. 86.93 billion in FY 2018/19.⁶⁴

60 Nakabugo, Z., “ARV stock-outs kill more Ugandans,” April 11, 2018, the Observer available at <http://observer.ug/news/headlines/57433-arv-stock-outs-kill-more-ugandans.html> (last accessed on June 10, 2018).

61 Ministry of Health, Press Release on Stock Situation for Antiretroviral Drugs in Uganda, Kampala, December 4, 2017 available at <https://reliefweb.int/sites/reliefweb.int/files/resources/Press%20Release%20-%20ARVs.pdf> (last accessed on June 10, 2018).

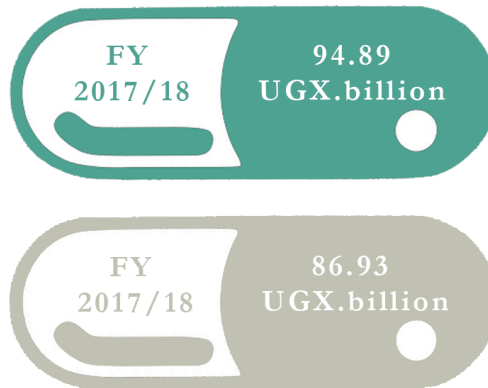
62 Ministry of Health (2018), Ministerial Policy Statement FY 2018/19 at p. xii.

63 Ibid. at xvi.

64 Parliament of Uganda, “Report of the Sectoral Committee on Health on the Sector Ministerial Policy Statement and Budget Estimates for the FY 2018/19,” supra at p. 28.

To realise its NDP II and HSDP objective of achieving universal health coverage and access to adequate essential medicines for everyone in Uganda especially the poor and most vulnerable, substantial financial commitment is required from government for EMHS as a more sustainable approach as opposed to unpredictable donor support.⁶⁵

The allocation for supply of ARVs by NMS



65 Ministry of Health (2015), National Medicines Policy, supra at p. 27.

2. Budgeting for Ambulance Services

2.1 Establishment of Uganda National Ambulance Services (UNAS)

According to the Ministry of Health, one of the leading causes of morbidity and mortality in Uganda is medical emergencies yet the existing ambulatory services do not meet the need countrywide with only less than 7% of patients arriving at health facilities

by ambulance in emergency cases.⁶⁶ Rural and hard to reach areas are disproportionately affected by the insufficient emergency services than urban areas. For instance on the Sigulu islands, the main means of transport across the different islands is boats thus making referrals unique from other mainland areas insofar as the residents have to travel longer distances to reach referral facilities and incur exorbitant costs, as high as UGX. 500,000/= in some instances, to hire a boat, purchase fuel and procure the services of a boat driver.⁶⁷

One of the achievements of the Ministry of Health in the FY 2017/18 was the development of an Emergency Medical Services (EMS) Policy which is undergoing consultations.⁶⁸ However, the Ministry acknowledges that several referral facilities do not have ambulances including Regional Referral Hospitals such as Hoima Referral Hospital, Soroti Referral Hospital and Naguru Referral Hospital, a major barrier to access to the Mulago National Referral Hospital.⁶⁹ According to the Uganda Hospital and Health Centre IV Census Survey 2014, 28% of Public Hospitals and Health Centre IV facilities do not have functional ambulances⁷⁰ attributed to challenges such as lack of fuel and absence of funds for maintenance and servicing.⁷¹

Among the strategic interventions proposed under the NDP II objective to “contribute to the production of a healthy human capital through provision of equitable, safe and sustainable health services” is the strengthening of the referral system, operationalizing

66 Ministry of Health, *Uganda National Ambulance Service*, available at <http://health.go.ug/departments/uganda-national-ambulance-service> (last accessed on June 4, 2018).

67 Initiative for Social and Economic Rights (ISER), “*Here, when you are poor, you die: Healthcare on Sigulu Islands*” March 2018 at Chapters 4.2.1 and 4.2.2.6 at pp. 21, 30 - 31 and 38 - 39 available at <https://www.iser-uganda.org/publications/reports/366-here,-when-you-are-poor,-you-die-healthcare-on-sigulu-islands> (last accessed on June 4, 2018).

68 Ministry of Health (2018), *Ministerial Policy Statement FY 2018/19* at p. xiii - xiv & 1.

69 Ibid at pp. 90 & 94, 127 and 170 respectively.

70 Ministry of Health, Hospital and Health Centre IV Census Survey 2014, 2016 (supra) at p. 29.

71 Isaac Mufumba (2017), “*Government Ambulance Service stalls for two years after launch*,” Daily Monitor, April 19, 2017 available at <http://www.monitor.co.ug/SpecialReports/Govt-ambulance-service--Museveni-launch/688342-3894764-80nuew/index.html> (last accessed on June 6, 2018).

the Uganda National Ambulance Services (UNAS)⁷² and increasing access to Emergency Obstetric Care (EmOC) for expectant mothers.⁷³ The NDP II emphasizes the need for due consideration for hard to reach areas such as islands and mountainous areas.⁷⁴ Establishment of a National Ambulance System and City Referral and Ambulance Projects are on the list of NDP II Public Investment Plan Projects which should be implemented within its FY2015/16 - 2019/20 timeframe.⁷⁵

The commitment of the State to provide emergency care to all Ugandans is reiterated in the Ministry of Health HSDP⁷⁶ and Strategy for Improving Health Service Delivery 2016-2021 Presidential Directives for Health Sector Service improvements to attain Middle Income Status by 2020.⁷⁷ The HSDP sets a baseline target of preparation of a draft National Ambulance Policy and Structural Framework whereas the midterm target is a functional Ambulance Service for Kampala Metropolitan Area with a National Rollout as the end target to be achieved by FY 2019/20.⁷⁸

UNAS was established by the Ministry of Health in 2014 to operate a formal Emergency Medical Service (EMS) system in Uganda.⁷⁹ Its mandate is to provide pre-hospital care and emergency services countrywide in a prompt manner.⁸⁰

The Ministry of Health committed to purchase 100 ambulances at a cost of \$157 million over five years from FY 2014/2015, a target which has not been met due to insufficient funding,⁸¹ and is unlikely to be met as shown in the section below.

72 Second National Development Plan (NDPII) 2015/16-2019/20, June 2015 at p. 190 available at <http://npa.ug/wp-content/uploads/NDPII-Final.pdf>

73 Ibid at p.190.

74 Ibid.

75 Ibid at p. 302 and 313.

76 Ministry of Health, Health Sector Development Plan (HSDP) 2015/16-2019/20 at p. xvi. The HSDP states that emphasis will be placed on strengthening the referral system and ambulance service in a bid to improve service delivery systems.

77 Ministry of Health, Strategy for Improving Health Service Delivery 2016-2021, Presidential Directives For Health Sector Service improvements to attain Middle Income Status by 2020 at p. 15.

78 HSDP at p.65.

79 Ministry of Health, *Uganda National Ambulance Service*, available at <http://health.go.ug/departments/uganda-national-ambulance-service> (last accessed on June 4, 2018) According to the Ministry of Health, an EMS system “comprises of a continuum of care comprising of lay first responder response at the community level; pre-hospital care and transportation through an ambulance service; and definitive care at health facility emergency units. This system requires several key building blocks that include; a dedicated human resource of trained ambulance crews, a Call and Dispatch system with a toll free number; ambulance vehicles that meet the standards to offer quality care; an efficient referral system and governance.”

80 Ibid.

81 Ibid.

2.2 The Budget for UNAS is too inadequate to meet the NDP and HSDP Targets

UNAS is a division under the Clinical Services Department of the Ministry of Health.⁸² In the FY 2014/15 when the UNAS was established, the Ministry of Health noted in the National Budget Framework Paper that it would require UGX 40 billion for its first year of operation,⁸³ however, there was no budgetary allocation for ambulance services that financial year.⁸⁴ Fortunately, from the commencement of the NDP II, in the health sector budgets of FY 2015/16, 2016/17 and 2017/2018, resources worth UGX. 500 million, UGX. 1.305 billion and UGX. 1.195 billion respectively, were directed towards provision of National Ambulance Services.⁸⁵

UNAS, budgetary allocation for ambulance services



82 Ministry of Health, *Clinical Services*, available at <http://health.go.ug/departments/clinical-services> (last accessed on June 4, 2018). From FY 2014/15 – 2017/18, its budget line under Vote 14: Ministry of Health was Output 080412 - National Ambulance Services provided, under Vote Function 0804 Clinical and Public Health Programme 09 Shared National Services.

83 Ministry of Finance, Planning and Economic Development (MoFPED), National Budget Framework Paper (NBFP) FY 2014/15 at p. available at http://budget.go.ug/budget/sites/default/files/National%20Budget%20docs/National%20Budget%20Framework%20Paper%2014_15.pdf (last accessed on June 4, 2018).

84 Republic of Uganda, “*Approved Estimates of Revenue and Expenditure (Recurrent And Development) FY 2014/15 Volume 1: Central Government Votes for the year ending on the 30th June 2015*” 2014 at pp. 323 and 332 available at <http://budget.go.ug/budget/sites/default/files/National%20Budget%20docs/Approved%20Estimates%20Book.pdf> (last accessed on June 5, 2018). The Clinical and Public Health Vote Function used to comprise six outputs namely Community Health, Clinical Services, National Disease Control, Nursing Services, Public Health Laboratory strengthening project and Uganda Sanitation Fund Project. However, The State has adopted Programme based budgeting thus with effect from FY 2018/19, this Vote Function has been split into two separate programmes namely Public Health Services and Clinical Health Services.

85 Republic of Uganda, “*Approved Estimates of Revenue and Expenditure (Recurrent And Development) FY 2015/16 Volume 1: Central Government Votes for the year ending on the 30th June 2016*” 2015 at p. 335, Republic of Uganda, “*Approved Estimates of Revenue and Expenditure (Recurrent And Development) FY 2016/17 Volume 1: Central Government Votes for the year ending on the 30th June 2017*” 2016 at p. 340, Republic of Uganda, “*Approved Estimates of Revenue and Expenditure (Recurrent And Development) FY 2017/18 Volume 1: Central Government Votes for the year ending on the 30th June 2018*” 2017 at p. 494.

Nonetheless, this funding was too miniscule to fully operationalize UNAS. In FY 2015/16, Ministry of Health noted that although UNAS had been established, it would require donor funding given the inadequate GOU allocation.⁸⁶

Table 4: Budgetary Allocations for Uganda National Ambulance Services since inception in FY 2014/15

| Financial Year (FY) | Budgetary allocation for National Ambulance Services (UGX) billion | Trend/Growth Rate (%) |
|---------------------|--|-----------------------|
| 2014/2015 | 0.000 | 0 |
| 2015/2016 | 0.500 | 50 |
| 2016/2017 | 1.305 | 161 |
| 2017/2018 | 1.195 | -8.4 |
| 2018/19 | 0.958 | -20 |

Source: Approved Budget Estimates from FY 2013/2014 – 2018/19

A critique of the above trend was ably raised by both the Health and Budget Committees of Parliament in their analysis of the Health Sector budget for FY 2018/19. Both Committees recommended an increment from UGX. 958 million to UGX. 67.07 billion, specifically targeted towards the full operationalization of the UNAS.⁸⁷ Unfortunately, there was no budget re-allocation in this regard thus this remains an unfunded priority in FY 2018/19.⁸⁸

The failure to adequately fund ambulance services falls short of the NDP II and HSDP which classify the operationalization of UNAS as a “core project” to be implemented by expiry of both Plans in FY 2019/20, with the end term target of national roll out of ambulance services.⁸⁹

86 Ministry of Finance, Planning and Economic Development, “Annual Budget Performance Report FY 2015/16,” September 2016 at p. 475 available at <http://library.health.go.ug/publications/health-system-financing-health-financing/budgets/annual-budget-performance-report-fy-0> (last accessed on June 5, 2018).

87 Parliament of Uganda, “Report of the Sectoral Committee on Health on the Sector Ministerial Policy Statement and Budget Estimates for the FY 2018/19,” supra at p. 39 and Parliament of Uganda, “Report of the Budget Committee on the Annual Budget Estimates FY 2018/19,” supra at pp. 49 – 50.

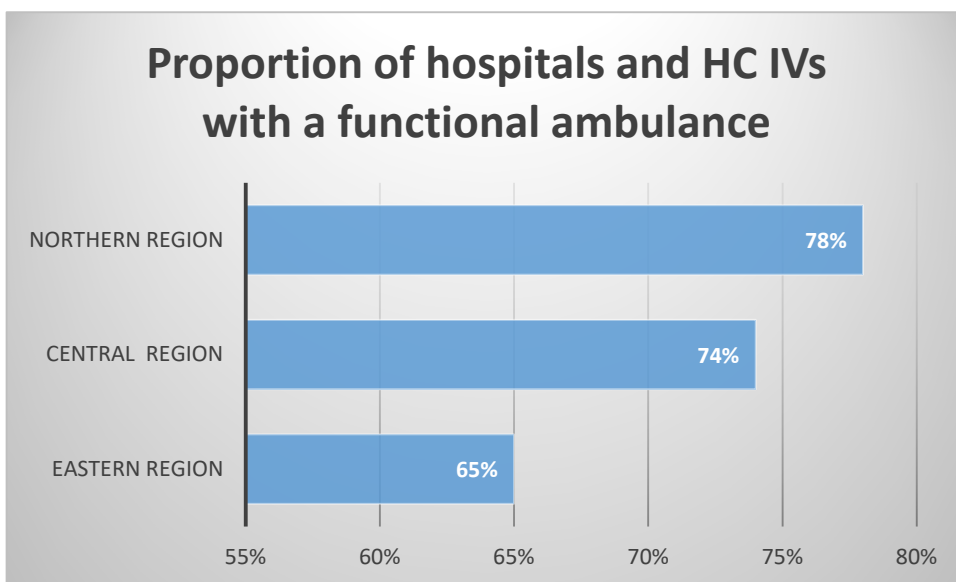
88 Parliament of Uganda, “Report of the Budget Committee on the Annual Budget Estimates FY 2018/19,” ibid and Republic of Uganda, “Draft Estimates of Revenue and Expenditure (Recurrent And Development) FY 2018/19 Volume II: Local Government Votes for the year ending on the 30th June 2019” at p. 50 available at http://budget.go.ug/budget/sites/default/files/National%20Budget%20docs/Draft%20Budget%20Estimates%20FY%202018-19%20_%20Volume%201.pdf (last accessed on June 5, 2018).

89 HSDP at p. xvi and 64.

Beyond operationalization, for FY 2018/19, the Ministry of Health has set a performance target of 50% calls and inter-facility referrals being received and responded to.⁹⁰

Also vital to note is the need for UNAS to give special consideration to rural and hard to reach areas especially in Eastern region to address the regional and geographical inequalities.⁹¹ The region reported the lowest proportion of hospitals and HC IVs with a functional ambulance at 65% compared to the Central and Northern region at 74% and 78% respectively.

These targets are far from being achieved due to underfunding of the UNAS, affecting access to ambulance services especially for the rural poor and most marginalized communities.



90 MOH, *Ministerial Policy Statement FY 2018/19* (supra) at p. 10.

91 Ministry of Health, *Uganda National Ambulance Service*, supra at p. 54.

3. Budgeting for Hard-to-Reach Areas

3.1 Linkage between Poor Performance and Hard-to-Reach Areas

The Ministry of Health classifies districts as “hard-to-reach” depending on their geographical location in order to ensure access to health services for populations living there.⁹² This classification encompasses mountainous areas, islands, rural and disadvantaged areas and areas with peculiar terrain which require higher budgetary allocations because costs are expected to be higher.⁹³ Some of the districts categorized by Ministry of Health as hard-to-reach include **Gulu, Lamwo, Ntoroko, Mukono, Agago, Namayingo, Kitgum, Mayuge, Bundibugyo, Nwoya, Abim, Amuru, Kisoro, Kaabong, Pader, Kotido, Moroto, Napak, Amudat, Buvuma, Nakapiripirit, , Kalangala among others.**⁹⁴

Upon analysis of the findings of the District League Table (DLT), which assesses and ranks the performance of all local governments on critical health indicators,⁹⁵ the list of lowest performing districts has been dominated by hard-to-reach districts for the past five financial years. The performance is assessed based on various aspects including institutional deliveries, outpatient visits, four antenatal care visits, timeliness and completeness of HMIS reporting, latrine coverage and performance in MOH programs such as HIV/AIDS, TB, human resources and Environmental Health Division.⁹⁶ The rationale of comparing districts is to determine the best and poor performing districts so as to put in place “corrective measures which may range from increasing the amount of resources (financial resources, human resources, infrastructure) to the LG or more frequent and regular support supervision” for the latter.⁹⁷

92 Ministry of Health, *Sector Grant and Budget Guidelines FY 2017/18*, 2017 at pp. 21 and 28 available at <http://health.go.ug/content/sector-grant-and-budget-guidelines-201718> (last accessed on June 7, 2018).

93 Ibid.

94 Annual Health Sector Performance Report: Financial Year 2015/2016, *Ministry of Health*, 2016 at pp. 36 -37.

95 Ibid.

96 Ibid.

97 Ibid.

Table 5: 10 Lowest Performing Districts in the DLT for the Past Five Financial Years

| | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 |
|---|--------------|-----------|----------------|-----------|----------------|
| Bottom 10 Districts in descending order (*Hard-to-reach Districts) | Bukomansimbi | *Kotido | Buyende | Wakiso | Budaka |
| | *Adjumani | Luuka | Kween | Sembabule | *Nakapiripirit |
| | Yumbe | Amuria | *Kaabong | Bulambuli | *Napak |
| | Amuria | *Moroto | Buhweju | *Kotido | Kakumiro |
| | *Moroto | Sembabule | *Moroto | Koboko | Buliisa |
| | Kween | Kween | *Nakapiripirit | *Moroto | *Moroto |
| | *Ntoroko | Moyo | *Kotido | *Napak | Bulambuli |
| | Moyo | *Ntoroko | *Buvuma | Sironko | *Kaabong |
| | *Kaabong | *Kaabong | Bulambuli | *Amudat | *Buvuma |
| | *Amudat | *Amudat | *Amudat | *Buvuma | *Amudat |

Source: Annual Health Sector Performance Reports for FY 2012/13 – 2016/17

From the above, over the years, it is observed that at least five (5) hard-to reach districts feature in the bottom districts each year with Amudat, Buvuma, Moroto, Kaabong and Kotido showing a continuous trend of poor performance. The majority of the poor performing districts are located in the Karamoja and Northern regions of Uganda as shown above.

In its Annual Health Sector Performance Report 2015/16, the Ministry of Health acknowledged the linkage between hard-to-reach districts and poor performance stating that these districts require special attention in order to address the unique challenges and barriers to healthcare,⁹⁸ which includes financial resources.

To illustrate the relationship between low funding of local governments in hard-to-reach districts and poor performance, a case in point is Amudat and Buvuma, the poorest performing local governments in health for the past five years.

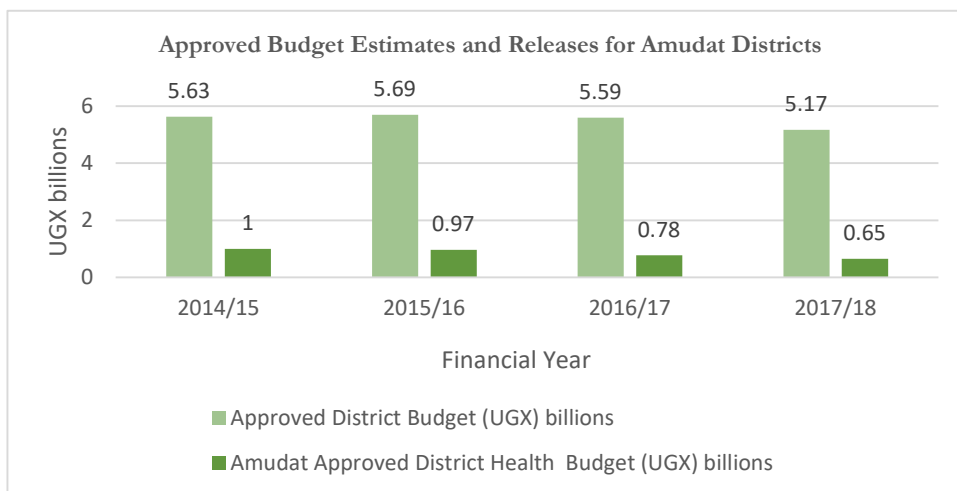
98 Ministry of Health, Annual Health Sector Performance Report: Financial Year 2015/2016, 2016 at pp. 37.

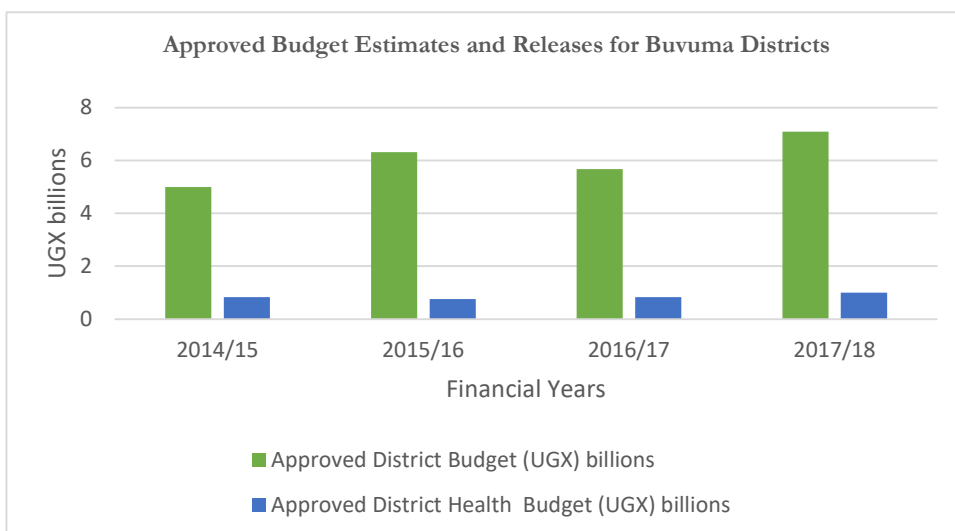
Table 6: Approved Budget Estimates and Releases for Amudat and Buvuma Districts from FY 2014/15-2017/18

| Financial Year (FY) | Amudat | | | Buvuma | | |
|---------------------|---|--|----------------------------------|---|--|----------------------------------|
| | Approved District Budget (UGX) billions | Approved District Health Budget (UGX) billions | DLT Ranking/ Number of Districts | Approved District Budget (UGX) billions | Approved District Health Budget (UGX) billions | DLT Ranking/ Number of Districts |
| 2014/15 | 5.63 | 1.00 | 112/112 | 5.00 | 0.83 | 110/112 |
| 2015/16 | 5.69 | 0.97 | 111/112 | 6.32 | 0.76 | 112/112 |
| 2016/17 | 5.59 | 0.78 | 116/116 | 5.68 | 0.83 | 115/116 |
| 2017/18 | 5.17 | 0.65 | - | 7.09 | 1.00 | - |

Source: Annual Approved Budget Estimates for Local Governments for FY 2014/15 – 2017/18

The Table illustrates that there is a relationship between low funding of hard to reach areas and their poor performance in the health sector. Despite the continued poor performance of these two districts, their budgetary allocations are not targeted towards alleviation of the problem.





Amudat and Buvuma, two hard to reach districts which have recorded the lowest performance in the health sector for the past five years, have also received the lowest total budget allocation compared to other districts in Uganda.⁹⁹ For the FY 2018/19, the health budget for Amudat and Buvuma Districts is as follows.¹⁰⁰ The total annual budget for Amudat is UGX. 4.59 billion and UGX. 6.81 billion for Buvuma.¹⁰¹ Only UGX. 1.37 billion was allocated to health in Amudat and UGX. 1.65 billion allocated to health in Buvuma respectively, a minuscule amount compared to UGX. 11.40 billion spent on Members on Parliament per month.¹⁰²

99 Ministry of Finance, Planning and Economic Development, “Annual Budget Performance Report FY 2015/16,” September 2016 at p.1053 available at <http://library.health.go.ug/publications/health-system-financing-health-financing/budgets/annual-budget-performance-report-fy-0> (last accessed on June 5, 2018), Ministry of Finance, Planning and Economic Development, “Annual Budget Performance Report FY 2014/15,” September 2015 at p. 960 available at <http://www.budget.go.ug/budget/national-budgets-documents> (last accessed on June 5, 2018) and Office of the Prime Minister, Government Annual Performance Report (GAPR) FY 2016/17, September 2017 at pp. 224 and 248.

100 Ministry of Finance, Planning and Economic Development, “Draft Budget Estimates of Revenue and Expenditure for FY 2018/19 Volume II: Local Government Votes” 2018 at p. available at (last accessed on June 5, 2018).

101 Parliament of Uganda, “Report of the Budget Committee on the Annual Budget Estimates FY 2018/19,” supra.

102 Parliament of Uganda Hansard for 4th August 2015 cited in Musa Mugoya, “Parliament to spend an Annual District budget on MPs in One Month,” Parliament Watch , 2016 available at <http://parliamentwatch.ug/parliament-to-spend-an-annual-district-budget-on-mps-in-one-month/#W0iNbdIzbiU> (last accessed on July 11, 2018).

| FY 2018/19 | Amudat District | Buvuma District |
|--------------------------------|--|----------------------------|
| Total Annual Budget | 4.59 billion | 6.81 billion |
| Allocated to Health | 1.37 billion | 1.65 billion |
| | compared to | |
| | UGX. 11.40 billion | |
| | spent on Members on Parliament per month. | |

Going by this trend of low financing, the performance of these districts in FY 2017/18 and FY 2018/19 is projected to remain stagnant at the bottom if the State does not commit itself financially. This includes taking affirmative action to correct the inequalities and disparities in access to health services caused by the unique challenges faced in these hard-to-reach districts.

Inadequate funding has a direct negative implication on health service delivery in these districts. In November 2017, the Initiative for Social and Economic Rights (ISER), having identified Amudat as one of the poorest performing districts in health, undertook a fact finding mission to understand the unique barriers to access in the district.¹⁰³ ISER found that access to health care was a challenge because the entire district has only eight (8) health facilities thus some Parishes such as Abiliyep and Katabok do not have health facilities, the staffing levels in all health facilities was below the required threshold, including lacking a District Health Officer.

The district lacked ambulance services and the few facilities faced persistent drug stock outs among others.¹⁰⁴ The District Health Office admitted that inadequate funding was at the center of these challenges.¹⁰⁵

103 The Fact Finding team was in Amudat from November 19 -25, 2017. Information was obtained through observation, focus group discussions with community members and key informant interviews with health workers, Local Government leadership, Village Health Teams (VHTs) and Health Unit Management Committees (HUMCs).

104 Interview with the Acting District Health Officer (DHO), Amudat District on November 23, 2017.

105 Initiative for Social and Economic Rights (ISER), “*For Us We Are Like Forgotten People: Assessment of Health Services in Amudat*” August 2018 available at <https://www.iser-uganda.org/publications/reports/378-%E2%80%9Cfor-us-we-are-like-forgotten-people-%E2%80%9D-assessment-of-health-services-in-amudat-district> (last accessed August 2018).

Similarly, research conducted by ISER on the Sigulu Islands located in Namayingo District, another hard to reach area which was among the fifteen (15) lowest performing district in FY 2016/17,¹⁰⁶ found that the population faces barriers in access to healthcare attributed to low funding of the district. For instance, some of the islands do not have health facilities such as Nampongwe despite having a population of over four thousand (4,000) people.¹⁰⁷ The only means to access health services or referral care in most instances is by boat transport thus patients have to incur extremely high costs to hire a boat and purchase fuel.¹⁰⁸

The Office of the District Health Officer noted that the funding received is so low that even inspection and supervision of the island health facilities is done on an occasional basis, much less than expected and mandated.¹⁰⁹ The findings from the above research contradicts the Ministry of Health's data which notes that by the end of FY 2015/16 and FY 2016/17, 100% of the Ugandan population was living within 5km of a health facility.¹¹⁰

While the central government provides Primary Health Care (PHC) grants to health facilities to facilitate service delivery,¹¹¹ the amount received by the health facilities on the Sigulu islands is not enough to ably fund administrative costs and outreaches especially given the unique challenges the health facilities face due to their island location.¹¹² In both FY 2016/17 and FY 2017/18, Sigulu Health Centre III, the main referral facility on the islands, was allocated only UGX. 4 million¹¹³ while Hama HCII, the only health facility on an island close to three (3) hours away from the mainland with a population of over 4,000 people, received UGX. 2 million,¹¹⁴ sums that are inadequate amidst the unique challenges faced by the people living on islands due to the topography, which poses additional barriers to receiving healthcare.

106 Annual Health Sector Performance Report: Financial Year 2016/2017, *Ministry of Health*, 2017 at p.38.

107 Initiative for Social and Economic Rights (ISER), "*Here, when you are poor, you die: Healthcare on Sigulu Islands?*" March 2018 available at <https://www.iser-uganda.org/publications/reports/366-here-when-you-are-poor-you-die-healthcare-on-sigulu-islands> (last accessed on June 4, 2018).

108 Ibid.

109 Ibid.

110 Annual Health Sector Performance Report: Financial Year 2016/2017, *Ministry of Health*, 2017 at p. 15.

111 Ministry of Health, PHC Guidelines FY 2017-18 at p. 2 available at <http://health.go.ug/content/sector-grant-and-budget-guidelines-201718> (last accessed on June 6, 2018).

112 Initiative for Social and Economic Rights (ISER), "*Here, when you are poor, you die: Healthcare on Sigulu Islands?*", supra.

113 Ministry of Health, PHC Guidelines FY 2017-18 (supra) at p. 117 and Ministry of Health, PHC Guidelines FY 2016-17 at p. available at <http://health.go.ug/content/primary-health-care-grants-guidelines> at p. 162 (last accessed on June 6, 2018).

114 Ibid.

The Ministry of Health is commended for the increment in the budget allocation for Primary Health Care services (PHC) in FY 2018/19 by UGX. 202 billion from UGX. 343 billion to UGX. 545 billion.¹¹⁵ Ministry of Health rightly noted that this will:

“... enable the health facilities operate at a reasonable level, currently some facilities at HC II level receive less than UGX. 100,000 monthly to cater for utility bills, maintenance, sundries, cleaning and outreaches which is inadequate. Analysis of the UBOS price indices shows that prices of goods and services in general have increased by 44% between 2008/09 and 2012/13 while those of utilities alone (rent, fuel, water and electricity) increased by 20.4%.”¹¹⁶

The Ministry of Health should therefore ensure that this increment of PHC grants trickles down to the health facilities at the lowest level especially in hard to reach districts such as Amudat and Sigulu Islands on Namayingo District to ensure that they are able to operate smoothly. This is particularly important given the fact that due to the remoteness and topography of the area, distance between facilities and absence of high level health facilities in close range, many of these HC II facilities perform the functions of a HC III, providing critical services to the community.

115 Republic of Uganda, “*Draft Estimates of Revenue and Expenditure (Recurrent And Development) FY 2018/19 Volume II: Local Government Votes for the year ending on the 30th June 2019*” available at http://budget.go.ug/budget/sites/default/files/National%20Budget%20docs/Draft%20Budget%20Estimates%20FY%202018-19%20_%20Volume%201.pdf (last accessed on June 5, 2018).

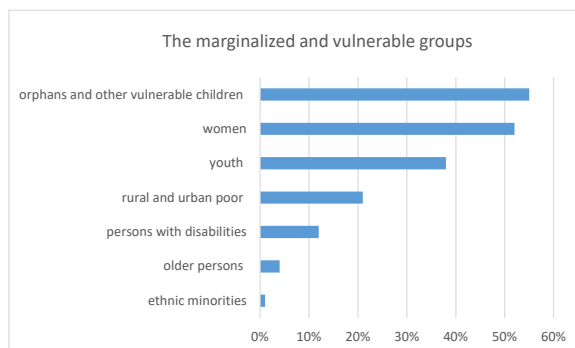
116 Ministry of Health, *Ministerial Policy Statement FY 2018/19* at p. xvi.

4. Vulnerable and Marginalized Groups are being left behind.

The Uganda National Household Survey 2017 indicates that out of the estimated 37.7 million people in Uganda, marginalized and vulnerable groups namely women (52%), youth (38%), orphans and other vulnerable children (55%), older persons (4%), ethnic minorities (1%), persons with disabilities (12%), the rural and urban poor (21.4%) and persons living with HIV/AIDS in Uganda constitute 80% of the total population.¹¹⁷

37.7

**million
estimated
people in
Uganda**



80%

**are vulnerable
to
HIV/AIDS**

In a bid to ensure that Government plans and budgets take into consideration the special needs of the above groups, the Parliament of Uganda enacted the Public Finance Management Act (PFMA), 2015 which introduced the requirement of gender and equity budgeting under the oversight of the Equal Opportunities Commission (EOC). All government institutions are required to prepare gender and equity responsive annual plans and budgets, highlighting specific measures which will be taken to ensure equalization of opportunities for all women, men, persons with disabilities and other marginalized groups in order to obtain a Certificate of Gender and Equity Compliance, a prerequisite to review and approval by Parliament.¹¹⁸

The requirement of gender and equity budgeting falls squarely within the goal of the health sector under the HSDP and NHP to ensure universal access to quality healthcare to all people in Uganda with emphasis on vulnerable populations.¹¹⁹

117 Uganda Bureau of Statistics (UBOS), *Uganda National Household Survey 2016/17* available at http://www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/UNHS_VI_2017_Version_I_%2027th_September_2017.pdf (last accessed on July 9, 2018) and Equal Opportunities Commission (EOC), *Statement by the Chairperson at the Gender and Equity Budgeting Stakeholders' Forum*, Kampala, May 14, 2018 available at <http://www.eoc.go.ug/media-updates/2018/05/statement-chairperson-gender-and-equity-budgeting-stakeholders%E2%80%99-forum-sheraton> (last accessed on July 9, 2018).

118 Sections 9 (6) (a) and (b), 13 (11) (e) (i) and (ii), and 13 (15) (g) (i) and (ii) of the Public Finance Management Act (PFMA), 2015.

119 Ministry of Health, Health Sector Development Plan (HSDP), *supra* at p. 24.

Since inception of the gender and equity budgeting requirement in FY 2015/16, the Ministry of Health is commended for incorporating key objectives aimed at inclusion of vulnerable and marginalized groups in its Policy Statements and Budgets. These include equitable access to quality healthcare for all, access to sexual and reproductive health services, access to adequate and affordable essential medicines and health supplies by children, women, elderly and persons with disabilities, fighting stigma against persons with mental illness including women, children and persons with disabilities (PWDs), providing community mental health services among others.¹²⁰

However, the actual budgets of the Ministry fall short and negate to highlight specific measures it will take to ensure access for all especially since vulnerable and marginalized groups are not a homogenous group. For instance, in the Ministry of Health Ministerial Statement FY 2018/19, a core NMS objective is to procure and avail medicines and medical supplies to children, mothers, age bearing women, youth, older persons and persons with disabilities.¹²¹ However, the corresponding planned intervention is to “procure, store and distribute essential medicines and health supplies worth shs 254 billion” to be measured by a performance indicator of “essential medicines and health supplies procured, stored and distributed to health facilities spread across the country.”¹²²

Similarly, Butabika Hospital is commended for planning to conduct outreaches in FY 2017/18 and 2018/19 aimed at reaching persons with mental illnesses at a community level.¹²³ However, in FY 2017/18, the facility managed to conduct 30 out of the planned 60 outreaches specifically in the areas of Nkokonjeru, Nansana, Kitetika, Kawempe Katalemwa and Kitebi.¹²⁴ This is a limited geographical scope, limited to Kampala, Buikwe and Wakiso, in terms of access to health services for all persons with psychosocial disabilities countrywide yet beyond outreaches and regional referral hospital mental health units, there is no mention of provision of community mental health services.¹²⁵ This critique was previously raised by the Initiative for Social and Economic Rights (ISER) before the Health Committee of Parliament.¹²⁶

120 Ministry of Health, Ministerial Policy Statement FY 2017/18 and Ministry of Health, Ministerial Policy Statement FY 2018/19.

121 Ministry of Health, Ministerial Policy Statement FY 2018/19 at p. 41.

122 Ibid.

123 Ministry of Health, Ministerial Policy Statement FY 2018/19 at pp.62 and 65.

124 Ibid.

125 Ibid.

126 Initiative for Social and Economic Rights (ISER), “Analysis of the Mental Health Bill, 2014: Submission to the Health Committee of the Parliament of Uganda on February 8, 2018,” Policy Advocacy Brief No. 7, February 2018 at pp. 6-7 available at http://iser-uganda.org/images/downloads/ISER_Analysis_of_the_Mental_Health_Bill_2014.pdf (last accessed on July 10, 2018).

Mental health services remain majorly concentrated in urban areas and at national and regional hospitals, posing a barrier to access to people from rural and hard to reach areas.¹²⁷

The Ministry of Health budgets, over the years, have not made specific provision for health services for older persons such as palliative care at a community level.¹²⁸ Similarly, the budgets have been silent on both the provision of sign language to patients with hearing disabilities at health facilities,¹²⁹ contrary to the Persons with Disabilities Act. Section 7 of this Act requires Government to ensure that sign language is introduced into the curriculum for medical personnel and sign language interpreters are incorporated in the Ugandan hospital organizational structure. This concern was raised in August 2017 when Initiative for Social and Economic Rights (ISER), Uganda National Association of the Deaf (UNAD), Wasswa Ronald and Namusisi Josephine petitioned the Constitutional Court in Petition No. 29 of 2017. The Petitioners challenged the absence of sign language interpreters and health workers trained in sign language at health facilities countrywide.

With respect to children, the Government is commended for the 100% increment in FY 2018/19 on reproductive health items to UGX. 16 million from UGX. 8 million in FY 2017/18.¹³⁰ Nonetheless more commitment is required from the State to fund child health programmes. In January 2018, the Ministry of Health announced its plans to roll out the rotavirus into the national routine immunization schedule with effect from FY 2018/2019 as an intervention under health promotion and disease prevention.¹³¹ These plans came into fruition in June 2018.¹³² The vaccine protects children under five years from the highly contagious rotavirus infection, one of the top five leading causes of preventable diarrheal diseases (40%),¹³³ with over 37% of children admitted at health facilities in Uganda with acute diarrhea having rotavirus infection.¹³⁴ Consequently, it's a major cause of infant mortality in Uganda, with an estimate of 10,637 children under 5 years dying annually due to rotavirus diarrhea.¹³⁵ The vaccine is administered free of

127 Ibid.

128 Ministry of Health, Ministerial Policy Statement FY 2017/18 and Ministry of Health, Ministerial Policy Statement FY 2018/19.

129 Ibid.

130 Parliament of Uganda, “*Report of the Sectoral Committee on Health on the Sector Ministerial Policy Statement and Budget Estimates for the FY 2018/19*,” supra at p. 28.

131 Ministry of Health, *Uganda to roll out Rota-virus Vaccine early 2018*, January 2018, available at <http://health.go.ug/content/uganda-roll-out-rota-virus-vaccine-early-2018> (last accessed on July 13, 2018).

132 Ministry of Health, *Uganda Rolls out Rotavirus Vaccine into the Routine Immunization Schedule*, June 2018 available at <http://health.go.ug/content/uganda-rolls-out-rotavirus-vaccine-routine-immunization-schedule> (last accessed on July 13, 2018).

133 Ibid.

134 Ibid.

135 Ibid.

charge to infants at six weeks and ten weeks of age at all health facilities nationwide, with support from development partners including Global Alliance for Vaccines and Immunizations (GAVI) through counterpart funding.¹³⁶

However, the Health Committee of Parliament noted with concern that the GAVI vaccines and HSDP Support for FY 2018/19 has a funding gap of UGX. 3 billion on the part of Government, specifically required for the rotavirus vaccine.¹³⁷ A funding shortfall leaves room for possible drug stock outs and other programme implementation challenges which will affect the most vulnerable children from hard to reach areas and impoverished and rural households who are especially prone to the infection. Some of the risk factors include “poor sanitation especially in fishing communities, inadequate safe water, flooding/rain and cross-border movement.”¹³⁸

According to the Uganda National Expanded Programme on Immunisation (UNEPI), the vaccine is available in private facilities at approximately USD 100, a cost too high for most parents in Uganda.¹³⁹ The State must therefore ensure that it commits adequate resources to the implementation of this programme to ensure that the most vulnerable children are not left behind in access to healthcare due to cost barriers.

5. Increased Investment in Human Resource for Health will improve Service Delivery

Adequate and appropriate human resource for health service delivery is one of the objectives of the Second National Health Policy (NHP).¹⁴⁰ The Policy recognises that the health sector is predominantly labour intensive thus the availability of adequate human resources for health is a critical factor in the achievement of its objectives.¹⁴¹

The HSDP sets a target of at least 80% approved posts in public facilities filled with qualified personnel at a national level by FY 2019/20.¹⁴² Although it is commendable that as of FY 2016/17, the proportion of the approved positions filled stands at 73%,¹⁴³ the staffing levels still fall short of the recommended World Health Organisation

136 Ibid.

137 Parliament of Uganda, “*Report of the Sectoral Committee on Health on the Sector Ministerial Policy Statement and Budget Estimates for the FY 2018/19*,” supra at p. 41.

138 Ministry of Health, *Uganda to roll out Rota-virus Vaccine early 2018*, January 2018, supra.

139

140 Ministry of Health, Second National Health Policy, 2010 at p. 21.

141 Ibid. at p.7.

142 HSDP, supra at p. 51.

143 Ministry of Health, Human Resources for Health Audit Report, January 2017 available at <http://library.health.go.ug/publications/health-workforce/human-resource-management/human-resource-health-audit-report-2017> (last accessed on July 8, 2018).

(WHO) threshold of 2.3 doctors, nurses and midwives per 1,000 population since the ratio of doctors, nurses and midwives to the population was 1: 28,202; 1: 2,121 and 1: 6,838 respectively.¹⁴⁴

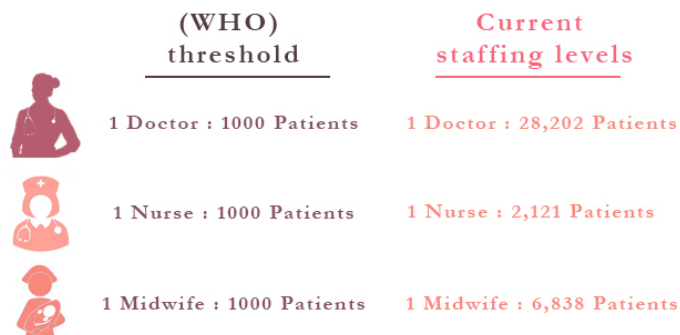


Table 7: Staffing levels of Health Facilities at the District Level in FY 2016/17

| No | Level | No. of Health Facilities | % Filled | % Unfilled |
|----|-------------------|--------------------------|----------|------------|
| 1 | General Hospitals | 45 | 68% | 32% |
| 2 | HC IV | 171 | 84% | 16% |
| 3 | HC III | 953 | 80% | 20% |
| 4 | HC II | 1,690 | 53% | 47% |

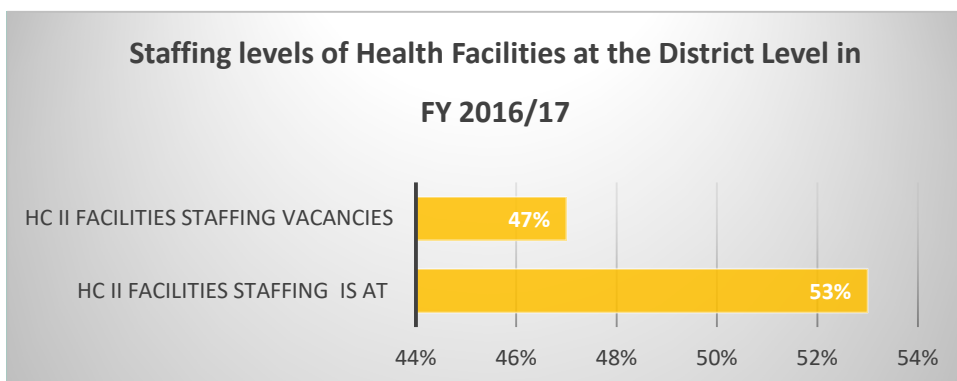
Source: Ministry of Health Human Resources for Health Audit Report 2017

From the above table, the staffing levels are lowest at the HC II facilities at only 53% with 47% vacancies. The effect of this is felt mostly in rural and hard to reach areas such as Sigulu islands for instance where some health facilities such as Rabachi HC II which serves patients from several islands has only one staff designated to the facility. Similarly, Hama HC II, the only facility on an island serving over four thousand (4000) people, conducts deliveries, a service outside the scope of a HC II, yet it has only two staff - a clinical officer and an enrolled nurse.¹⁴⁵ In Amudat district, Amudat hospital

144 Ministry of Health (2017), Annual Health Sector Performance Report: Financial Year 2016/2017, *Ministry of Health*, 2017 at p. x, <https://health.go.ug/content/annual-health-sector-performance-report-201617> (last available 1 August 2018).

145 Initiative for Social and Economic Rights (ISER), “Here, when you are poor, you die: Healthcare on Sigulu Islands” *supra* at p. 24.

lacks 87.5% of the essential staff recommended by the guidelines for designation and the district lacks key positions such as District Health Officer, Principle Health Inspector, Biostatistician and Cold Chain Technician.¹⁴⁶



The continued shortage of key health staff including doctors and midwives has a negative impact on the delivery of the Uganda National Minimum Health Care Package (UNMHCP) and service delivery in the sector on a whole.¹⁴⁷ The NDP II highlights the need to address the existing significant staffing disparities between rural and urban areas and across districts.¹⁴⁸ As a strategy to address the problem, the NHP “calls for strengthening human resources through attraction, proper motivation, remuneration, and development of human resources relevant to the needs of Uganda.”¹⁴⁹

For FY 2018/19, Ministry of Health spotlights addressing the health human resource challenges specifically attraction, motivation, retention, training and development as a sector priority.¹⁵⁰ The Ministry is applauded for increasing the health sector wage bill accordingly by UGX 189.08 billion to enhance salaries for health workers,¹⁵¹ following the nationwide strike by medical doctors in November 2017 protesting against poor remuneration.¹⁵² The Health Committee of Parliament on analysis of the recruitment plans for FY 2018/19 notes that majority of the positions aligned for filling are at lower level facilities. This move, which will improve service delivery especially in rural and hard to reach areas, going forward, will be crucial.

146 Initiative for Social Economic Rights (2018), “For Us We Are Like Forgotten People” Assessment of Health Services in Amudat District *supra* at p.35.

147 Ministry of Health, Second National Health Policy, *supra* at p. 21.

148 NDP II, *supra* at para 114 at p. 33.

149 Ministry of Health, Second National Health Policy, *supra* at p. 21.

150 Ministry of Health, Ministerial Policy Statement FY 2018/19, *supra* at p. x.

151 Parliament of Uganda, “*Report of the Budget Committee on the Annual Budget Estimates FY 2018/19*,” *supra* at p. 13.

152 Kamoga, J. (2017), “*Doctors Strike: Mothers to give birth in the open*” The Observer, November 8, 2017 available at <http://observer.ug/news/headlines/55844-doctors-strike-mothers-to-give-birth-in-the-open.html>

V. Conclusion and Recommendations

Conclusion

In the spirit of inclusion of all, the SDGs Agenda 2030, incorporated in the NDP II, is centered on “leaving no one behind” while the HSDP aims to accelerate the move towards Universal Health Coverage in Uganda to ensure that everyone in Uganda enjoys the highest attainable standard of health. However, these goals cannot be realized if the current trend of government health financing is not reviewed and improved accordingly. A proper functioning health system accessible to all will require significant financial commitment and investment from the State as the primary duty bearer.

Recommendations

- The health sector budgetary allocation should be increased to align with the targets set in the NDP II, HSDP and Agenda 2030. The allocation as it stands is insufficient to meet the needs of the population thus achievement of universal health coverage will remain a far reaching goal if the budget is not increased.
- The budgetary allocation for EMHS, which is still far below the public need, should be increased to meet the existing funding gap. The consistent challenge of drug stock outs requires serious and urgent intervention from the State, especially for people living in rural and hard to reach areas, to ensure access for all.
- The current dependence on donor funding to meet the needs for EMHS is precarious for the population especially since it is uncertain and unpredictable. The Government needs to employ strategies aimed at increasing the financial resources for EMHS in a sustainable manner because access to drugs is sensitive and central to the enjoyment of the right to health thus cannot be delegated predominantly to external financing.
- Improvement of the referral system includes facilitating access to ambulance services nationwide through the Uganda National Ambulance Services (UNAS), which

is currently unable to perform this mandate due to underfunding. It is a matter of utmost importance that UNAS is adequately funded to expand its operations which will save lives of patients seeking healthcare, especially for the rural and hard to reach areas with unique transport challenges including Sigulu islands.

- The funding for poorly performing districts needs to be increased to match the commitment of the State to improve service delivery. The budgetary allocation for Amudat and Buvuma districts for instance, which have over the years performed the worst in the health sector, has remained low which is alarming given that district comparison is to identify the poorly performing districts and through affirmative action, improve service delivery.
- Similarly, PHC funds for health facilities in hard to reach areas such as Sigulu islands should be increased taking into consideration the unique challenges faced and the higher need for outreaches to reach people who are unable to access health facilities.
- Beyond stating objectives to target the vulnerable and marginalized groups, there is need for MOH to collect and rely on disaggregated data to inform service delivery. There should be clear interventions that target vulnerable groups in terms of service delivery to ensure equitable access to quality healthcare in order to adhere to the legal requirement of gender and equity budgeting.
- Recruitment of health workers should trickle down to the lower level facilities in rural and hard to reach areas. This is especially important because these facilities are usually the point of first reference for majority of the Ugandan population, which lives in rural areas.
- Improve domestic revenue collection. Sustainable financing of the health sector requires domestic revenue collection. In Uganda, Shs. 1.2 trillion (\$370 million) was lost in tax exemptions yet the tax exemptions did not result in benefits to the population.¹⁵³ In 2009/10, African Development Bank estimated that Uganda's losses from tax incentives were "at least 2%" of GDP, nearly double Uganda's health budget at the time.¹⁵⁴ These are finances that could be channeled to health. A balanced and progressive fiscal regime will result in sustainable financing of the health system.

153 Tax Justice Network Africa, Action Aid (2016), Still Racing Towards the Bottom? Corporate Tax Incentives in East Africa, <https://www.globaltaxjustice.org/sites/default/files/Corporate-tax-incentives-in-east-africa-report.pdf> (last accessed 14 August 2018).

154 African Development Bank (2010), Domestic resource mobilization for poverty reduction in East Africa: Uganda case study, p.20, <https://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/Uganda%20case%20study%20final.pdf> (last accessed August 15,2018).

About the Initiative for Social and Economic Rights

ISER is a registered national Non - Governmental Organisation (NGO) in Uganda founded in February 2012 to ensure full recognition, accountability and realization of social and economic rights primarily in Uganda but also within the East African region.

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