

# Civil Society Organisations Perspectives and Priorities



Health Sector Performance  
FY 2009-2010



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# Executive Summary: Priorities and Perspectives

The objective of this report is to illustrate priorities and document perspectives from civil society organizations (CSOs) on the performance of the health sector and outline key recommendations. As advocates, organizations, health workers, health consumers and concerned citizens who constitute civil society, we are using this opportunity to put forth key concerns about the health sector's performance in the past year and the health system overall. We believe that if the recommendations put forth are duly addressed with reinvigorated leadership from the Ministry of Health, we might be able to witness a transformation of the health sector from one that is largely failing to meet the health needs of Ugandans into one that achieves its goals, as outlined in the Health Sector Strategic and Investment Plan III (HSSIP).

## Key Messages

The overwhelming priority areas are, not surprisingly, in the integrated health systems including health workforce development, increasing production and equitable deployment of health workers, increasing financial resources, strengthening the role of civil society in monitoring and accountability, and ensuring reliable access to medicines and health supplies. What emerges from the various recommendations, though, is the need for the Ministry of Health to demonstrate its leadership, stewardship, and political will to push forward the recommendations not only elucidated in this report, but also repeated year after year in their own documents (this year's AHSPR included).

In addition to the foundational health system investments, specific critical areas of intervention are highlighted. These include mental health and non-communicable diseases (including cancer and sickle cell disease), malaria, HIV/AIDS, health promotion, and human rights. The several recommendations made throughout the report are listed in Annex A.

## Conclusions

Civil society has become an extremely integral element of the health system in Uganda. Therefore, its recommendations should be considered with the urgency of internal Ministry of Health policies.

Upon reflection and review of various civil society organizations' programs, Ministry of Health documents, as well as various media reports, we recommend critical interventions in the following areas:

- HEALTH FINANCING: The GoU must allocate at least 15% of the national budget to the health sector and increase the per capita expenditure by at least US \$ 1 every year. Without increasing financial resources, efforts to expand and improve health services will fail to make real change.
- HUMAN RESOURCES FOR HEALTH: Recruiting, training, and retaining sufficient numbers of health workers must be at the cornerstone of the MoH priorities. Recommendations from WHO are included here and especially focus on retention in rural and hard-to-reach areas.
- ESSENTIAL MEDICINES AND HEALTH SUPPLIES: The continuous availability of medicines, health commodities, and equipment for patients and health workers alike is a critical factor in the prevention and treatment of disease in this country. The funds, infrastructure and capacity to manage drugs and supplies in health centres and hospitals throughout the country must be conceptualized as a central component to all other MoH efforts.
- DELIVERY OF THE UGANDA MINIMUM HEALTH CARE PACKAGE (UMHCP): The UMHCP is guaranteed to all Ugandans, yet certain elements of this package are prioritized while others are neglected. Those largely funded by donors also require sufficient and progressively increasing investment from domestic resources. Certain interventions can improve effective and efficient use of health funds. Herein we offer recommendations for improving critical areas of the UMHCP.

# Introduction

It is the duty of the Government of Uganda (GoU) to meet the health needs and basic rights of each and every Ugandan, currently estimated at 31.6 million (World Bank). The GoU has already signed many national and international agreements enshrining human rights and the right to health.

Uganda is striving to achieve the Millennium Development Goals by 2015. In order to achieve its development aims, Uganda must ensure health for its people. The MDGs are ambitious goals and include several health-related targets, especially regarding child health, maternal health, and major infectious diseases including HIV/AIDS, malaria, and tuberculosis.

Civil Society has contributed in myriad ways to providing health services and advocating for improvements in health service provision. But the Government of Uganda, represented by the Ministry of Health, is the principle duty bearer and it must step-up efforts to strengthen the Ugandan health system and facilitate the enjoyment of the right to health for Ugandans.

This booklet is intended to raise the banner on top priority issues, as well as specific recommendations from civil society organizations (CSOs). CSOs (see list on page 7) have come together to reflect upon the performance of the health sector in the past year.

## Who is behind this report?

This report is the product of a participatory process in which over 50 civil society organizations based in Kampala were invited to submit and to invite their partners to submit. The following list of civil society organizations (in alphabetical order) encompasses those that have participated in planning, submitted contributions, or validated the report.

Action Group for Health, Human Rights, and HIV/AIDS (AGHA)  
 African Medical and Research Foundation (AMREF) Uganda  
 Basic Needs Uganda  
 Coalition for Health Promotion and Social Development (HEPS)  
 Community Health and Information Network (CHAIN)  
 Epilepsy Support Association Uganda  
 Health Rights Action Group  
 Human Rights Awareness and Promotion Forum (HRAPF)  
 International Community of Women Living with HIV/AIDS East Africa  
 International Federation of Health and Human Rights Organizations  
 Joyce Fertility Center  
 Malaria and Childhood Illness NGO Secretariat (MACIS)  
 Marie Stopes Uganda  
 Mental Health Uganda  
 MIRUDA, Kibaale  
 National Care Centre (NACARE)  
 National Community of Women Living with AIDS (NACWOLA)  
 Platform for Labour Action  
 Sickle Cell Association Uganda  
 The AIDS Support Organisation (TASO)  
 Traditional and Modern Practitioners Together Against AIDS (THETA)  
 Uganda Community Based Association for Child Welfare (UCOBAC)  
 Uganda Health and Science Press Association (UHSPA-Uganda)  
 Uganda Medical Association (UMA)  
 Uganda Network on Toxic Free Malaria Control (UNETMAC)  
 Uganda Nurses and Midwives Union  
 Uganda Village Project (UVP)  
 Uganda Women's Cancer Support Organisation (UWOCASO)  
 Women's Awareness Against Cervical Cancer (WAACC)  
 Women's Organisation Network for Human Rights Advocacy

# Show Stewardship: Strengthen the Health System

The next five sections address critical areas for improving health in Uganda. They are: 1) Increasing the health budget, 2) Improving procurement and delivery of medicines and essential health supplies, 3) Training, recruiting, and retaining more health workers by increasing professionalism, 4) Passing effecting legislation and strengthening implementation, and 5) Mainstreaming Human Rights.

These building blocks of the health sector are accounted for in Ministry policies and strategic plans. So why are we repeating them here? We are calling on the Ministry of Health to demonstrate leadership and stewardship in pushing forward the recommendations of the AHSPR and the strategies outlined in the various policy documents. While the Sector Wide Approach (SWAp) was a powerful opportunity to integrate overlapping efforts in development of infrastructure for health, it meant everyone was involved and there was no responsibility held by MoH for success or failure of programs. The collective approach is meant for civil society to be a complement, not a supplement for Ministry of Health minimum responsibilities and duties. Even in donor-funded initiatives lack indications of leadership from MoH.

Additionally, there is no implementation research about successful research. What programs should we scale up? What interventions are working? The Ministry of Health should be surveying all activities in the health sector and leading us forward into the future.



## 4.1 Health Financing: Increase the Health Budget

### **Introduction:**

Health financing remains very low compared to the needs of the ever increasing population. The potential to implement the recommendations articulated in this year's Annual Health Sector Performance Report relies fundamentally on the availability of sufficient financial resources. If the GoU does not finance the health sector with 15% of the annual national budget during the next budget cycle, the Ministry of Health will not be able to implement the Health Sector Strategic Plan III (HSSIP) or to provide the Uganda National Minimum Health Care Package (UMHCP) to the country's growing population.

### **Background:**

The goal of health financing for the HSSP II was to raise sufficient financial resources to fund the plan whilst ensuring equity and efficiency in resource mobilisation, allocation and utilisation during the plan period. The medium term objectives were: to mobilise additional resources to fund the HSSP II; to ensure effectiveness, efficiency and equity in resource allocation and utilisation and to ensure transparency and accountability in resource utilisation.

Uganda's health sector has made important gains in the past several years, but chronic underfunding, poor accountability for health funds, corruption, and a lack of transparency are major impediments to improving healthcare. The Government of Uganda has not allocated funds in accordance with international commitments, including the Abuja Declaration to commit 15% of the national budget to health. At the same time, donors funding of parallel or off-budget projects undermines long-term strengthening of the health system.

Additionally very poor monitoring mechanisms are in place throughout the country. The MoH oversight of the financial information for general and regional hospitals is very weak, apparently relying on submission of reports for the purpose of drafting the AHSPR. (Only 54 of 113 general hospitals and only 8 of 13 regional referral hospitals returned reports with complete financial data).<sup>1</sup> MoH has not prioritised analysis of efficiency and use of funds, and must be more active in pursuing and publishing this information in order for the health sector to offer basic services.

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<sup>1</sup> Draft Zero, Ministry of Health Annual Health Sector Performance Report (AHSPR) FY 2009/2010, p 134, 137

## Progress during HSSP II:

### ***Mobilizing Additional Resources***

The health sector budget as a proportion of the Government of Uganda budget during the final year of the HSSP II is 10.2%, which is far from the HSSP II target of 13.2% and even farther below the Abuja target of 15%. In 2001, African Heads of State made a commitment to allocate 15% of their annual domestic budgets to health during the special summit on AIDS, TB and Malaria held in Abuja. The Abuja commitment was to exclude donor support.<sup>2</sup> Whereas budget allocations should be gradually increasing to reach this target, they have decreased in the past two years (see table 1).

### ***Government of Uganda Contribution***

The Government of Uganda budget allocation to the health sector (excluding donor support) has been consistently increasing from Uganda shillings 242 billion in 2006/07 to 375.38 billion in FY 2008/2009 and 433.17 billion in 2009/2010. However Donor support to the health sector currently comprises 41% of the total budget which raises questions about country ownership and sustainability of health financing. The Government has proposed a health insurance scheme to raise additional resources.

**Table 1. Percentage of GoU budget allocation to health**

<b>FY</b>	<b>2006/07</b>	<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>	<b>Abuja Target</b>	<b>HSSP II Target</b>
<b>%</b>	9.3%	9.0%	10.7%	10.2%	15%	13.2%

### ***Donor Project Support***

In the absence of sufficient commitment and funds from the GOU, Donor or Development Partner (DP) funding contributes substantially to the health sector budget in Uganda. Some DPs channel funding through general budget support and/or project funding. Budget support contributes to the financing of the Health Sector Strategic Plan (HSSP) and in effect the National Development Plan (NDP).

Health sector donor project funding decreased in 2006/2007 and increased between 2007/2008 and 2009/2010. Donor support to the health sector on budget

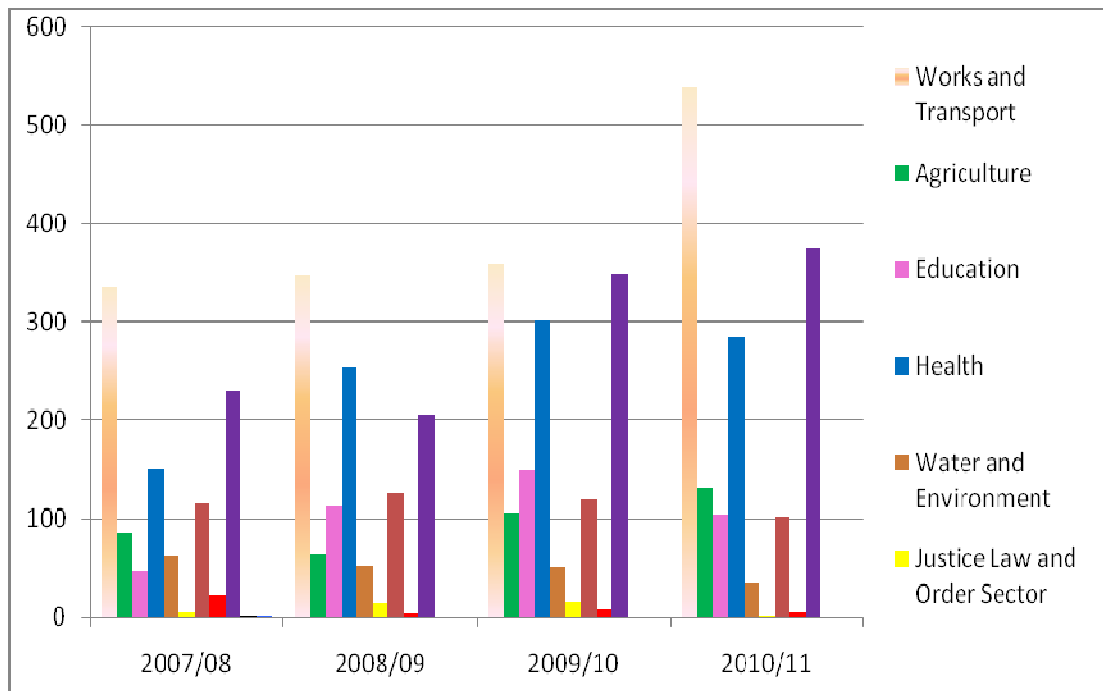
<sup>2</sup> UN. African summit on HIV/AIDS, tuberculosis and other related infectious diseases: Abuja declaration on HIV/AIDS, tuberculosis, and other infectious diseases. New York: United Nations, 2001. [http://www.un.org/ga/aids/pdf/abuja\\_declaration.pdf](http://www.un.org/ga/aids/pdf/abuja_declaration.pdf)

constitutes 41.07% of the health sector budget for FY 2009/10, which is a slight increase from 40.27% in 2008/2009.

**Table 2. Donor Project support to the health sector /GoU Contribution in billion UGX between FY 2006/07-2009/2010**

FY	Total allocation to health	GoU contribution	Donor Project funding	% of donor Contribution
2005/06	497.00	228.62	268.38	54
2006/07	381.86	242.63	139.23	36
2007/08	418.48	277.36	141.12	34
2008/09	628.46	375.38	253.08	40.27
2009/10	734.67	433.17	301.5	41.07

As shown in Figure 1, donor project support to the health sector has generally increased over the years. However, donor project allocation to the health sector (at 21%) has been and remains remarkably below that of other sectors such as the Energy (24%) and Works and Transport Sector (34%). Donors should give more and government also needs to increase its investments.



**Figure 1. Sectoral comparison of donor project funding (US \$ millions)**

Source: Public Investment Plan

## Challenges:

### ***High levels of off-budget funding***

There has been an overall increase in off-budget funding to the health sector between 2008/09 and 2009/2010. In FY 2008/2009, total off-budget health sector contributions from development partners was US \$440.25 million, compared to US \$463.55 million in FY 2009/2010. The biggest off-budget contributors are USAID and PEPFAR who largely fund HIV/AIDS-related projects. In 2008/2009, PEPFAR alone contributed \$255 million, which is about 58% of overall off-budget funds. Danida, GTZ, Irish Aid, Italian Cooperation and DFID also increased off-budget funding between FY 2008/2009 and 2009/2010. (Danida and DFID subsequently pulled back from the health sector.) Furthermore, there are many challenges to accessing accurate information on off-budget funds. Off budget funding can impede alignment with MoH sector priorities and monitoring.<sup>3</sup> The data in the table on the following page was obtained from MFPED.

### ***High Expenditure on disease-specific interventions***

The majority of health development partners fund HIV/AIDS as part of their projects. Uganda's ART programme is 95 percent donor-funded, with the two main contributors being PEPFAR and the Global Fund (MoH, ACP). In FY 2008/09, 72.1% (US \$ 317.39) of off-budget funding was for HIV/AIDS with PEPFAR and USAID being the largest contributors. In FY 2009/2010, 76.12% (US \$ 352.86 million) of off-budget funds went to HIV/AIDS.

The large proportion of off-budget donor funding signifies a lack of confidence in the Ministry of Health to properly spend the funds on the HSSP. This can be improved by increasing transparency to ease accountability and cooperation by national GoU, district health teams, other implementers, development partners, and civil society.

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<sup>3</sup> Health Sector Strategic Plan II 2005/06-200/10 Mid Term Review Report (October 2008) pxxiv

**Table 3. Health Sector DP Expenditure for 2008/09-2009/10**

	Name of Development Partner	Project support to health sector for FY 2008/09 in Million USD		Project support to health sector for FY 2009/10 in Million USD	
		On budget	Off budget	On budget	Off budget
1	DANIDA	12.50	5.85	9.92	7.61
2	Sweden	1.95	2.16	1.35	2.10
3	Germany	2.72	2.43	1.19	3.75
4	World Food Programme	9.30	-	-	-
5	African Development Bank	20.16	-	15.75	-
6	Ireland	0.54	2.60	0.54	3.2
7	JAPAN	4.03	-	-	-
8	Belgium	-		1.76	-
9	Italy	-	2.30	2.16	4.46
10	European Union	-	2.81		1.54
11	UNICEF	1.10		0.88	-
12	UNFPA	1.10		0.88	-
13	WHO	8.50	-	6.72	-
14	World Bank (IDA)	-		4.80	-
15	DFID	0.45	5.05	0.36	6.03
16	USAID	-	152.9	-	147.99
17	Austria	-	0.1		-
18	PEPFAR		255.0		285
19	Norway		0.58	-	
20	GAVI	22.00		18.00	
21	GFATM	89.98		71.99	
22	Netherlands	1.77			
	<b>GRAND TOTAL</b>	<b>176.12</b>	<b>440.25</b>	<b>136.30</b>	<b>463.55</b>

### ***Problems with absorption of funds***

While inadequate health financing is a problem, there are still problems with absorption of funds.<sup>4</sup> While there are drug stock-outs, the National Medical Store at the end of FY 2008/2009 had some utilised funds which had to be returned to the treasury. According to the Ministry of Finance, Planning and Economic Development (MFPED), “...the biggest chunk of unutilized money was for roads, under the works ministry and drugs under the National Medical Stores.” The

<sup>4</sup> NEW VISION: Ministries fail to spend sh700b Monday, 24th May, 2010

MFPEP attributed the problem to poor planning by ministries and inadequate specifications of output.

### ***Lack of commitment to Accountability***

Over USD 367 million funds from Global Fund to fight Tuberculosis, HIV/AIDS and Malaria (GFTAM) were misallocated in 2005. This fraud, which was a subject of Judicial Inquiry, saw over 300 people being implicated. Five years down the road, although over 300 people were implicated, only 4 have been prosecuted.<sup>5</sup>

Moreover, only low cadre culprits have been prosecuted. No significant effort was made to prosecute those implicated and recover this money until 2009 when pressure from the Office of the Inspector General (OIG) of Global Fund led to some action. The total value of funds repaid is approximately USD 1.3 million. This is still a small amount compared to the sums misallocated.

### ***Difficulty in obtaining information about donor support***

Information about donor contribution to the health system is difficult to obtain from some DPs and largely unavailable at the MoH. Estimates of donor project funding are supposed to be provided to the Health Sector Budget Working Group at the time of preparation of the health sector budget. However, this does not always happen. Some donors, such as USAID, prefer to channel information directly to the MFPEP. This, in effect, may limit comprehensive planning for sector priorities.

Setting priorities and collecting funds for the health system in Uganda is a consultative process, including the participation of donors within the SWAp framework. However, limited reporting on the part of some Health Development Partners (HDPs) impedes efforts to promote mutual accountability. The difficulty associated with getting aid information from HDPs is an enormous challenge. This information would be useful in informing the level of projected funding to the health system as well as monitoring their commitment to mutually agreed development priorities.

The Table on the following page (from the Ministerial Policy Statement of 2009/2010) illustrates the scarcity of information about expenditure releases for

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<sup>5</sup> Charges have been laid in two cases-meaning investigations have been finalised in eight cases, fifteen cases are in advanced stages of investigations; twenty two cases are under investigation and the remaining cases have been assigned to investigation teams. See The Global Fund, Progress Report of the Office of the Inspector General, October 2009-February 2010.

DP contribution to the sector available at the MoH. In 2008/2009, the donor expenditure data was unavailable at the MoH.

**Table 4. Overview of Health System Expenditures (Ushs Billion)**

<b>Excluding Arrears, Taxes</b>	<b>2007/2008 Outturn</b>	<b>2008/2009 Approved Releases Budget</b>	<b>MTEF Budget Projections 2009/10</b>	<b>2010/11</b>	<b>2011/12</b>
<b>Wage</b>	2.834	3.484	3.443	3.616	4.158
<b>Recurrent</b>		3.321			
<b>Non Wage</b>	42.361	97.269	92.385	91.385	109.662
		89.148			
<b>Gou</b>	19.502	12.880	12.563	39.963	100.662
<b>Development</b>		7.397			
<b>Donor*</b>	N/A*	250.475	262.627	231.447	14.910
		N/A*			
<b>Gou Total</b>	64.696	113.633	108.392	134.964	214.799
		99.865			
<b>Total Gou+Donor(MTEF)</b>	N/A	364.108	371.019	366.411	229.709
		N/A			
<b>Arrears (ii) Arrears and Taxes Taxes**</b>	0.320	2.778	0.000	N/A	N/A
		2.761			
	2.400	7.362	0.000	N/A	N/A
		3.686			
<b>Total Budget</b>	<b>N/A</b>	<b>374.248</b>	<b>371.019</b>	<b>N/A</b>	<b>N/A</b>
		<b>N/A</b>			

\*Donor expenditure data unavailable

\*\*Non Vat taxes on capital expenditure

### Recommendations:

The Health Development Partners must:

- Improve commitment to agreed priorities by providing funding to the agreed levels and inputs so as to make external funding sufficient and more predictable. This will help facilitate a coordinated sector development and avoid wastages that arise from discontinuous funding.

- Promote transparency by availing accurate and adequate reports on the levels of their funding and the areas of focus. This not only also empowers peer monitoring and mutual accountability but also informs the alignment of their funding to sector priorities.
- Report (always and timely) on level and targeting of off-budget funding. This promotes coordinated sector investment and funding, promotes equity across regions, gender and priorities, avoids duplication of funding and most importantly facilitates proper macroeconomic management.
- Honor their commitments in full.

The Government of Uganda and Ministry of Health must:

- Work with development partners to fund the HSSIP (HSSP III) in accordance with the Paris Declaration on Aid Effectiveness of 2005 and the International Health Partnerships, with an emphasis on strengthening the health sector without compromising progress in disease-specific interventions around HIV/AIDS, TB, and malaria.<sup>6</sup>
- Set funding targets that are transparent enough so that external resources do not displace domestic funding to the sector.
- Honor—in full—the commitments made in funding agreements.
- Monitor and track all funding to the health system so as to develop a sustainable funding modality mix. By tracking all off-budget funding, the government should design sustainable levels of project support and General budget support to achieve health sector priorities and civil society to deliver community based needs in a stable and sustainable macroeconomic environment
- Fight corruption in the health sector
- MoH should advocate for increased domestic health financing through innovative mechanisms in order to fund the HSSIP (HSSP III).
- GoU should employ new strategies to increase revenue for health priorities, particularly those expenditures requiring long-term or life-long investments. Some promising proposals for the GoU include:
  - Airline tax, cigarette tax, soda tax, alcohol tax, financial transactions tax

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<sup>6</sup> Ooms G, Van Damme W, Baker BK, Zeitz P and Schrecker T (2008) The 'diagonal approach to Global Fund financing: **a cure for the broader malaise of health systems?** Globalization and Health 2008, 4:6 doi:10.1186/1744-8603-4-6



## 4.2 Stop Stock-outs: Ensure Access to Essential Medicine, Health Supplies, and Equipment

### **Introduction:**

Most interventions under the Uganda National Minimum Health Care Package depend on access to essential medicines and health supplies. The National Medicines Policy aims at ensuring at all times availability and accessibility of adequate quantities of affordable, efficacious, safe and good quality essential medicines and health supplies to all. Implementation of NMP is challenging as it is currently afflicted with many financial and logistical obstacles. Numerous studies and reports have elucidated the availability of drugs or the incidence of stock-outs at health facilities. The number of health units reporting stock-outs has increased since last year for certain HSSP II indicator drugs (Coartem Green, Sulfadozine Pyrimethamine tab, and Depo Provera). Therefore, progress is not uniform, nor is it linear. Government should come out and meet its commitment to provide appropriate healthcare to its citizens.

### **Background on availability of essential medicines:**

There has been a slight increase in availability of medicines since Vote 116 was enacted last August. Overall availability of medicines, however, remains far below the desired 100%. Compared to the previous quarter (July-Sept 2009) there was an increase of 9 percent (to 59%) in the public sector; an increase of 6 percent (to 73%) in private sector and an increase of 3 percent (to 78%) in mission sector.<sup>7</sup>

### ***Rural areas***

Availability of medicines remained lower in rural health facilities compared to their urban counterparts. The persistent marked difference in availability of medicines between the urban and rural facilities in the public, private and mission sectors (presently at 16%, 22% and 8% respectively) invariably affects rural communities. It also indicates that distribution and stocking of medicines is a logistical problem that must be addressed with logistical and management solutions, with the necessary funding to take into consideration extra transport costs and lack of infrastructure in rural areas.

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<sup>7</sup> MoH/WHO/HEPS Medicine Price Monitor, April-June 2010

## Anti-malarials

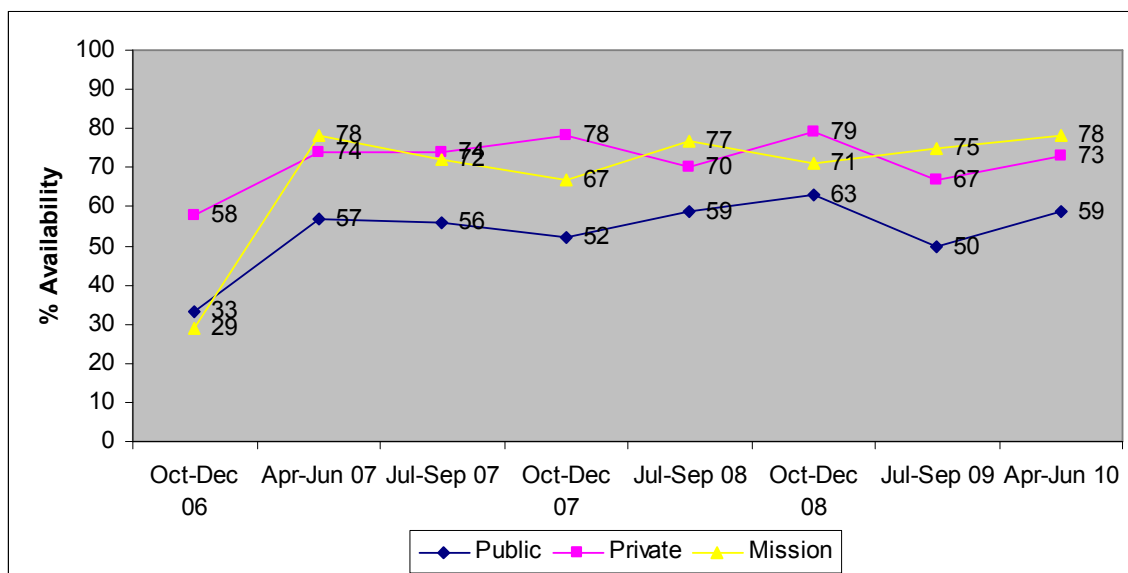
Lack of availability of medicine for malaria impedes efforts in the fight against the country's number one killer. Availability of first-line antimalarial Artemether/Lumefantrine (A/L) in public facilities declined from 93% in the quarter July-September 2009 to 68% in April –June 2010. In the Mission sector, availability dropped from 73% to 56% and this is directly related to the fact that Joint Medical Stores did not receive the 20% of public A/L for meant for Private Not For Profit (PNFP) facilities in FY 2009/10. The availability of Fansidar tablets, used for prophylaxis of malaria especially in pregnant women, in public facilities also decreased from 70% to 57%. Anti-malarials in the private sector became more expensive as stock-outs in the public sector increased.

## Drugs for non-communicable diseases

Management and treatment of non-communicable diseases remains a challenge, in large part because of the inaccessibility of many drugs. Although availability of antidiabetic Glibenclamide rose by 17 percent to 68%, medicines for hypertension (Nifedipine), other simple medicines for the management of diabetes (e.g Metformin) and ulcers (e.g Cimetidine and Omeprazole) remain very poorly stocked due to poor pharmaceutical management and lack of resources.

## Paediatric formulations

Paediatric formulations were also poorly stocked in public sector. Amoxicillin Suspension 250mg/5ml is 25% (July-September 2009); Cotrimoxazole suspension 8/40 mg/ml reduced by 13 percent to 18%; Metronidazole suspension increased by 2 percent to 18%. However, ORS availability rose from 75% to 82% suggesting better management of diarrhoea in children.



## Trends on Availability of 25 Tracer Medicines

Source:  
MoH/WHO,  
HAI (HEPS)  
Medicine price  
Monitor Vol.9,  
Apr-June 2010

### ***Equipment and supplies for hospitals and health centres***

Monitoring and supervision visits to health centres of all levels throughout all regions of the country revealed that machinery and equipment is severely lacking. Some of this equipment is essential for instance, in order to offer basic treatment of HIV/AIDS (CD4 Machines), for record keeping (forms), and for caesarian deliveries (pulse oxymeters). Additionally hospitals often lack access to clean water and have poor sanitation for patients.

### **Progress in the HSSP II period:**

- The National Pharmaceutical Sector Strategic Plan, which effects the National Medicines Policy, was developed.
- In the FY 2009/2010, the Ministry of Finance increased the autonomy of the National Medical Stores (NMS) and increased the NMS allocation of total funding for medicines from 30% to 70%. NMS has since increased customer care and publishing of delivery schedules.
- Donors are responding to the need for capacity building, as evident in the launch of USAID-funded Safeguarding Uganda's Right to Essential Medicines (SURE). SURE will be operationalised in 45 districts to build capacity of health cadres in pharmaceutical management.
- Despite being phased out in the early 2000s in favour of a more needs-based "Pull" system, the "KIT" system (which involves packaging predetermined quantities of selected medicines and "pushing" them) has been re-established as a mechanism for preventing medicine stock-outs at HC II and HC III. This is in part due to the failure to build procurement and drug management capacity at health facilities as had been recommended in the MoH "Push-Pull" study of 2002.

### **Challenges:**

#### ***Financing Essential Medicines and Health Supplies***

The health system is still predominantly donor-dependent. The lack of GOU commitment to improving health services and reliable access to affordable and quality medicines and health supplies is not a good indication of sustainability, especially given the dwindling and fuzzy donor support in the midst of the global economic turmoil.

- GoU funds less than 35% of essential medicines that go through the public system and the remaining bulk is left to donors.

- More than 50% of medicine needs are met out of pocket from the private sector, primarily through out of pocket payments by patients.
- 90% of all adult Antiretroviral Therapy (ART) is funded through PEPFAR and all paediatric ART through the Clinton Health Access Initiative.

DANIDA has officially left the health sector and an amount UGX 6.8 billion contribution to the Essential Medicine Account was not remitted in the financial year 2009/10. Using the US\$ 5.8 per capita envisaged in the Minimum Health care package this would have treated close to 600,000 people. However, because the PNFP did not receive GoU support in 2009/10, DANIDA disbursed UGX 3 billion directly to JMS.

### ***Low Drug Management Capacity***

Delays in procurement, poor quantification by and late orders from facilities and poor records keeping are among the management issues that contribute to shortage and wastage of medicines in the public sector (Ministry of Health, 2010). The performance of NMS as the sole procurement and supply agency is very crucial to ensuring availability of medicines in the entire public health system. In cases of stock outs at NMS, districts and health facilities have no other alternative to avail medicines since even the said PHC 30% in Vote 116 has not gone to them. This monopoly may also create cases of insolence and reduced bargains for competitive prices.

### ***Shortcomings of KIT System***

The new KIT system for lower health centres has received enormous criticism from health workers. There has been widespread discontent due to the disempowerment created by reintroduction of this ancient system; there have also been claims of insufficient and non-needs based medicines given to some centres with no consideration of population served. Although MoH has claimed the system will be revised regularly based on a continuous evaluation, this is not the optimal way to build capacity at these levels.

### ***Vote 116***

By the time of drafting this report, there is still no formal framework between MOFPED, MOH, MOLG and NMS to operationalise VOTE 116. This would describe the roles and responsibilities of the various partners for control and performance monitoring of NMS and also reinforce coordination role of MoH, which has been found wanting by various studies.

### ***Infrastructure and basic supplies at Health Facilities***

Health facility infrastructure is still a large obstacle for efforts to assure access to medicines<sup>8</sup>. Access to communication facilities was found to be extremely poor; of 41 surveyed facilities, less than 10% had a functional communication system (any of: phone, email, fax, radio call) to send requisitions, make notifications regarding deliveries and report stock outs of medicines to the district.

Absence of records at health centres is rampant, pointing to poor accountability and monitoring, which may result in unavailability of medicines. Of the surveyed 41 health facilities, 16 did not have any documentary evidence of the dates and value of requisitions made to NMS and date and value of deliveries made by NMS and only partial figures were obtained from 60% of surveyed facilities.

The capacity of health centres to transport medicines from the district headquarters and clients in emergency situations is limited. Only four of 41 health centres, for instance, had ambulances that were functional. Only one of 41 health centres had a functional vehicle (not an ambulance) for transport purposes and about half of facilities depended on two-wheeler cycles.

Transport for patients is a major barrier to treatment. This has been documented in many clinical services, including especially maternal health services. Hospitals lack ambulances for referrals, etc. There have been initiatives to use bicycles as ambulances and vouchers for transport<sup>9</sup>. These programs should be evaluated and expanded if they improve outcomes. Studies on maternal health indicate that attendance at delivery by skilled health personnel and facility based care could help to reduce maternal mortality. Ensuring access to quality maternal health care services throughout pregnancy and childbirth is therefore essential, although it is often limited for the poor.

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<sup>8</sup> HEPS Uganda, Tracking Uganda's Health Sector in Financing and Delivery of Essential Medicines, June 2010

<sup>9</sup> Ekirapa-Kiracho E, Nalwadda G, Rahman H, Peters D, Bishai D, Pariyo G, Bua J, Mutebi A, Okui O (2010) "Implementing a Demand-side Financing Scheme for Maternal Health Services: Experiences from Uganda" Abstract, 6<sup>th</sup> Makerere University College of Health Sciences (MU-CHUS) Annual Scientific Conference, p. 20



*Photo: Cutting costs or cutting corners? We must evaluate and report on interventions like bicycle ambulances and vouchers for reproductive health services<sup>10</sup>.*

Ambulances are the fast first aid tool and should be adequately equipped. Most ambulances are no different from special hires. No surgical team is attached to these, no oxygen, no anesthetic facilities, no IV infusion. The paramedical services available in emergency situations, including resuscitations, should be able to be done on the way to the hospital. Bleeding should be stopped or controlled as we head to the referral hospital.

### ***Training***

Equipping hospitals must be accompanied by ongoing capacity building so that personnel know how to operate and maintain the equipment. Currently many nurses and clinical assistants do not know how to use the modern diagnostic monitoring equipment. Plus, equipment should be serviced and maintained.

### ***Medical Record Keeping***

Tradition of record keeping is generally lacking and yet it is one of the causes of medical errors. There is need for Total Quality Management (TQM). Even when machines are in good condition and working well, the record system can lead to error. Inaccurate records cause medical errors. Forms for tracking medications given and other treatments rendered should be appropriately stocked and training about record keeping should be facilitated.

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<sup>10</sup> Ssengooba F (2010) State of the Health Care System in Uganda: Major Issues for Political Considerations. Presentation, 26 August

## Recommendations

Government of Uganda must:

- Invest in strengthening the health system especially at service delivery point with more infrastructure, staffing, equipment, utilities, logistics, supplies and consumables for health centres.

Ministry of Health must:

- Increase efforts to build capacity of lower public health facilities to reduce stock –outs. This can be done through increased pharmaceutical and overall management capacities.
- Devise a mechanism to control prices of medicines especially in the private sector.
- Prioritise stocking of paediatric formulations to improve management of diseases in infants and children.
- NMS and MoH must enforce good record keeping in order to enable tracking of medicines availability.

The coordination, supervision and monitoring role of MoH cannot be over emphasized if the health system is to be revived.

## SPOTLIGHT ON KAGADI HOSPITAL, KIBAALE DISTRICT

- 100 bed capacity; Typical daily load: 150-200 patients, with many on floor, especially in paediatrics ward
- HRH: Only 46% approved staff positions are filled. The cadre mix is inappropriate: 30 % are nursing assistants, there is no pharmacist. Recruitment and retention of doctors, laboratory personnel and drug dispensers has been difficult.
  - Only 3 appointed doctors; 1 is the acting Medical superintendent who is often out for other official duties
  - Only 4 out of 5 clinical officers (COs) are active; 15 COs should be on staff.
- TRANSPORT: Only 1 out of 4 vehicles is functioning (no functional ambulance; referrals and outreach prohibitively difficult)
- STAFF ACCOMMODATIONS: No electricity/no light, poor security especially during the night, no strong walls to secure the hospital grounds/compound
- HIV/AIDS: Prevalence is 6.2%
  - Kagadi Hospital HIV Clinic is only operational 2 days/week and 8 clinical days/month
  - Clinic operates once monthly in Kyaterekera Health Centre near Lake Albert; but more are needed in other hard to reach areas of the district.
- HEALTH PROMOTION: Sanitation, safe water, counseling, and VHTs are carried out by NGOs and CSOs who dedicate extensive human and financial resources as well as political will. Organizations include MIRUDA, Pace, HAG, IDI, TASO, EMESCO, URDT but currently only IDI is active. Baylor supported child health but has left the region.
- GENDER: More women seek health services than men.
- CANCER: People living with HIV/AIDS and cancer are linked to Cancer Institute at Mulago, which covers transport for clients and all other necessities to clients freely
- MEDICINES AND EQUIPMENT:
  - Some times stock-outs occur, including in the HIV section, which calls for adjusting the visiting days of clients due to delayed response from NDA
  - Health Development Partners (Baylor, IDI) are generous but cannot consistently provide services
  - CD4 machine—new machine this year; before this one, there was no CD4 machine and people had to go to regional referral hospitals of Fort Portal and Hoima



## 4.3 Train, Recruit and Retain Health Workers

### Introduction:

Africa has approximately 25% of the burden of the world's diseases but only 1.3% of the world's health work force.<sup>11</sup> This crisis has been called 'the legacy of chronic under-investment in human resources'.<sup>12</sup> Uganda is one of the countries still facing human resources for health crisis.

### Background:

In Uganda, there is only one doctor for every 22,000 patients. 70% of Medical Officers, 80% of Pharmacists and 40% on Nurses/Midwives are based in urban areas with 12% of the Population. Reasons for low retention and recruitment into the field of health work include but are not limited to low wages, poor health infrastructure, heavy workload, and high stress. The dearth of trained doctors will continue to impede efforts to improve maternal mortality, child death, and the treatment of complicated diseases, including Tuberculosis, which is the leading cause of death for PHAs. Targets for HSSP II (staffing levels to reach 90% by the end of 2009) were not reached; instead, only 56% of posts are filled.<sup>13</sup>

### Progress in HSSP II Period:

- Average staffing levels have gone up from 38% in 2006/2007 to 56% in 2009/2010.
- The Human Resources for Retention Strategy was completed in 2009.
- Salaries of HCW in hard to reach districts increased by 30% in 2010/2011 budget.

### Challenges:

#### ***Leadership at Ministry of Health***

During the course of the financial year, there were many acting positions at the Ministry of Health. The Director C & C was acting as Permanent Secretary and Director General of Health Services for over 4 months. The position of Director Planning and Development was also being handled by the Commissioner, Planning

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<sup>11</sup> Evans T. Addressing Africa's health workforce crisis: an avenue for action. Proceedings Abuja High Level Forum 2004. Abuja, 2004.

<sup>12</sup> Chen L, Evans T, Anand S, et al. Human resources for health: overcoming the crisis. Lancet 2004;364: 1984–1990.

<sup>13</sup> MOH AHSPR draft

and Development. This kind of work overload creates inefficiencies in the sector as few people have to handle many tasks.

### ***Poor Coordination of Human Resources for Health Issues***

Human Resources for Health is poorly coordinated leading fragmented interventions. There are various coordination entities including the Human Resources for Health Technical Working Group (HRH TWG), Inter-Ministerial Standing Coordination Committee on pre-service training (IMSCC) and Health Workforce Advisory Board (HWAB). Except for the Faith Based Organisations (FBOs), there is no other Civil Society, private sector, academia, professional associations, and workers union representation on the HRH TWG. Particularly the MoH has failed to provide timely information to national health professional associations and to have them participate in policy working groups, including Working Groups on Public Private Partnership and Human Resource, where their expert opinions should be taken into account. Yet the medical associations are the main bodies representing health workers' interests (welfare, CPD, training).

Furthermore, there is little commitment from MoH to strengthen health professional associations which have important roles of mobilizing health professionals, promoting CPD and ethical and professionalism. There is also inadequate support for the regulatory professionals councils contributing to weak regulation.

### ***Internal Brain-drain***

Another area of concern is the failure to retain specialists in clinical practice leading to internal drain to public health. Trained doctors and nurses should be providing leadership in the public health sector. Unfortunately, it is not only the poor pay to blame for their departure from practice, but also the development partners who entice these health professionals from clinical practice and into desk jobs.

## **Financial Incentives**

Health workers in Uganda are the worst paid in the East African region. The Job Evaluation Report of the Ministry of Public Service 2000 recommended that health workers should be paid Duty Facilitation Allowances (DFA). After protracted negotiations between the health workers and the Ministry of Public Service (MOPS), a consolidated amount was agreed upon. This consolidated amount does not performance related and therefore does not affect motivation because all health workers get the same amount. Because of the DFAs, the lowest paid doctor in Kenya earns an equivalent of 700 USD while the counterpart in Uganda gets 350 USD. Doctors in Kenya have additional allowances (on-call, responsibility, risk, etc) which motivate and retain health workers. Moreover funds for health workers are allocated from domestic finances and not from donors! Yet the Health Sector there also gets less than 10% of the national budget

Furthermore, the purported salary increment in FY 2010/2011 of 30% for health workers in rural areas did not follow the procedure provided under the law. According to the Public Service (Negotiating, Consultative and Disputes Settlement Machinery) Act, the public service unions shall negotiate on issues of common interest on matters particular to them. However, health workers' unions were not involved in negotiating this salary increase. Government should have followed the negotiation machinery for the increase in salary to be more effective and should be across the board to prevent the migration of the most needed cadres to other countries.



### ***Many policy documents and no implementation***

There have been many HRH planning and policy initiatives but we have not made very substantial progress yet in implementation. There should be one Health workforce plan that supersedes this piecemeal approach and integrates best practices.

- National Health Personnel study 1991
- Manpower requirements and training priorities 1993
- Development of HRH plan 1996
- Studies in HRH with it Kampala Scenarios 2000
- 10 year health manpower plan
- HRH Policy 2006
- HRH Strategic Plan 2005-2020
- HRH Strategic Plan Supplement (FY 2008/09)
- Human Resources for Health Retention Strategy 2009
- National Development Plan
- National Health Policy II
- Health Sector Strategic Investment Plan
- Kampala Declaration and Agenda for Action 2008

### ***Job Satisfaction, In-service training, and Professionalism***

The reality and threat of trained health workers leaving the country for destinations with higher pay and with a better health system are real and growing.<sup>14</sup> High occupational stress due to high workload and relatively low job satisfaction among nurses in Kampala<sup>15</sup>, in Bwizibwera<sup>16</sup>, and in other parts of the country contribute to low performance and poor patient outcomes.

Increased professionalism, training and professional support for health workers can improve care and job satisfaction. A recent study showed that increasing access to health information through handheld computers (PDAs) had a positive

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<sup>14</sup> Luboga S, Hagopian A, Ndiku J, Bancroft E, McQuide P (2010) Satisfaction, motivation, and intent to stay among Ugandan physicians: a survey from 18 national hospitals. *Int J Health Plann Mgmt*

<sup>15</sup> Nabirye RC, Brown KC, Kohler CL, Maples EH, Park NJ, Pryor ER (2010) "Occupational Stress, Job Satisfaction, And Job Performance Among Hospital Nurses in Kampala, Uganda" Abstract, 6<sup>th</sup> Makerere University College of Health Sciences (MU-CHUS) Annual Scientific Conference, p. 76

<sup>16</sup> Petition by Mbarara District Nurses and Midwives on Work-place Safety, Promotions, Renumeration and Poor Working Conditions, circulated 12 March 2010, available at UNHCO

impact on clinical decision making of health workers.<sup>17</sup> Scaling up lifelong-learning efforts among health care workers also has a large potential to both improve patient care and job satisfaction.<sup>18</sup> Areas for increased training are many and include training for geriatric care<sup>19</sup> and human rights.<sup>20</sup>

There is a strong association between the failure to attract/retain senior level doctors and nurses in regional hospitals and the weak technical and administrative support supervision and monitoring systems of the MOH. The weak approach to monitoring and support has recently necessitated an ineffective and problematic monitoring unit under the State House. A proper support system should be put into place.

### ***Staffing levels***

During 2009/2010, the health system has registered some improvements, but overall the slow progress is undermining the performance of the health sector. Averages show there was an increase in staffing levels, but they obscure a decline in staffing levels in HC IVs between 2009 and 2010. While some of the lowest staffed districts registered 10% gains in positions filled (i.e. Sironko and Isingiro), several of the lowest staffed districts witnessed a decline in staffing levels between 2009 and 2010 (Kaberamaido, Mubende, Mityana, Butaleja, Kamuli, Hoima, Ibanda, Sembabule, Maracha-Terego).

### ***Task Shifting***

Task shifting is currently a proposed temporary mechanism for expanding the health workforce to include lay people trained to perform specific tasks. As task shifting has already been implemented by some projects and health facilities, the MoH must release guidelines, in consultation with civil society, associations of health care providers, and public health experts.

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<sup>17</sup> Mworozzi EA, Rujumba J, Maganda A, Kakaire F, Kibaya P, Sewankambo N (2010) "The Impact of Health Information on Clinical Decision Making and Patient Care: Use of Mobile Devices in Rural Uganda" Abstract, 6<sup>th</sup> Makerere University College of Health Sciences (MU-CHUS) Annual Scientific Conference, p. 18

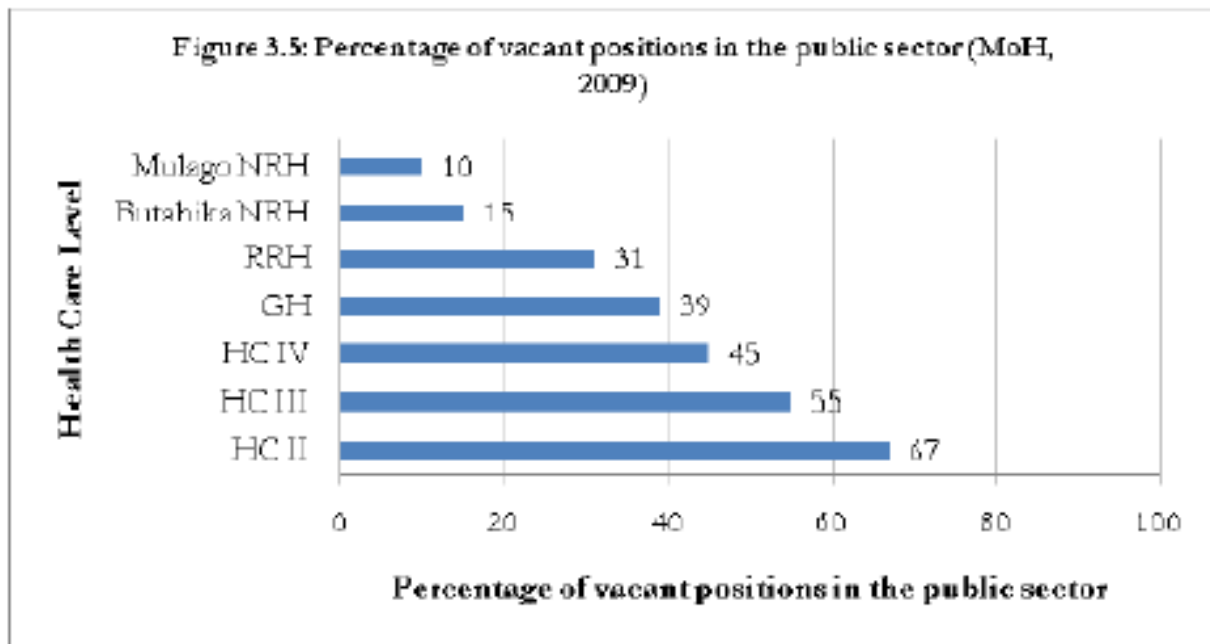
<sup>18</sup> Etyang C, Muliira JK, Kizza IB, Mbalinda SN (2010) "Orientation of Nurses in Uganda's National Hospital towards Life Long Learning" Abstract, 6<sup>th</sup> Makerere University College of Health Sciences (MU-CHUS) Annual Scientific Conference, p. 94

<sup>19</sup> Ajwang M, Muliira JK, Nankinga Z (2010) "Geriatric Knowledge and Attitude of Rural Healthcare Providers in Apac District, Uganda" Abstract, 6<sup>th</sup> Makerere University College of Health Sciences (MU-CHUS) Annual Scientific Conference, p. 44

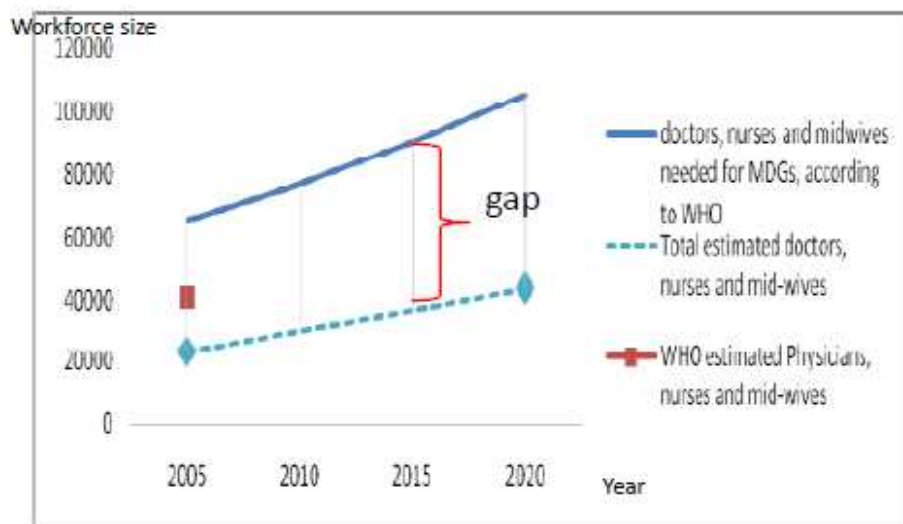
<sup>20</sup> Parikh SM (2010) "Innovation and Implementation of Health and Human Rights Education in the United States: Success, Challenges, and Opportunities for International Collaboration" 6<sup>th</sup> Makerere University College of Health Sciences (MU-CHUS) Annual Scientific Conference, p. 93

### **Maldistribution**

Staffing levels are still higher in urban areas than rural areas where health facilities are closest to the population. As the figures below<sup>21</sup> show, the percentage of vacant positions in the public sector in lower health centres is dangerously high and planning for the future is not adequate to fill Uganda's health needs. Furthermore, these figures do not illustrate the very low number of senior doctors and nurses.



### **Health Workforce plans not matched with health care needs**



<sup>21</sup> Ssengooba F (2010) State of the Health Care System in Uganda: Major Issues for Political Considerations. Presentation, 26 August

## Recommendations

### *Ministry of Health*

- Ensure that all MoH positions are held by a dedicated staff person committed to lead, not by place-holders. Vacant positions should be filled in a timely manner.
- Involve the national professionals associations in policy working groups particularly the human resources for health TWG
- Commit to strengthening the health professional associations and councils
- Prevent an internal brain drain of specialists into desk jobs in public health
- Improve framework and implementation of monitoring and support supervision, with intensified focus on efforts to retain senior staff in rural areas

### *Staffing levels*

- Ministry of Health must implement the Hard-to-Reach strategy and step up efforts to reach staffing levels over 100%

### *Job Satisfaction, In-service training, and Professionalism*

- Increase regularity and quality of in-service training for all cadres of health professionals to learn new medical knowledge and best practices
- Increase pay for all health workers to be commensurate with their level of education
- Nurture professionalism in healthcare with increased support to mentoring, especially in specialties
- Foster teamwork among health workers in different cadres, especially doctors, midwives, and nurses working within a given health facility

### *Hard-to-reach districts*<sup>22</sup>

Recruitment and retention of health workers is among the most pressing challenges currently facing the country, especially outside of urban areas. The following recommendations are both short-term and long-term.

Implement the policies especially the Retention Strategy focusing on:

1. Financial incentives

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<sup>22</sup> Adapted from WHO ([http://whqlibdoc.who.int/publications/2010/9789241564014\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241564014_eng.pdf)) and Physicians for Human Rights (<http://phrblog.org/blog/2010/08/27/who-issues-new-guidelines-on-rural-and-remote-worker-retention/>)

- Use the procedure provided for by the Law to revise/increase salaries. Government must involve the unions and institutions concerned before making decisions such as salary increases for health workers;
  - Combine fiscally sustainable financial incentives, such as hardship allowances, grants for housing, free transport, etc, sufficient to outweigh the opportunity costs associated with working in rural areas, as perceived by health workers
2. Implement regulatory requirements that increase service time in rural areas
- Create compulsory service requirements in rural and remote areas
  - Offer educational subsidies with enforceable agreements of return service work in rural areas
  - Focus on increasing the scope of medical practice in remote regions to increase job satisfaction
3. Address personal and professional needs of health workers
- Improve living conditions for health workers and their families in remote areas
  - Provide career development programs to help rural workers progress in their careers
  - Create senior posts in rural areas so that advancing workers are not forced to leave their communities.
4. Reform health professional education policy
- target admission policies to enroll students with rural backgrounds
  - expose students to greater rural field work
  - Build schools and residency programs outside of major urban areas



## 4.3 Promote Pro-health Legislation, Policy, and Effective Implementation

### **Background:**

There are numerous policies and strategic plans in place governing critical areas of the integrated health sector support systems, including medicines and human resources. Despite the existence of these documents, policy implementation has been largely ineffective and that Uganda is experiencing ‘implementation paralysis’.<sup>23</sup> In general, policies exist more in name than in practice. There are often numerous documents explaining guidelines and protocols. These are rarely disseminated appropriately with the proper trainings at district level. There must be efforts to streamline various documents, ideally into one comprehensive National Health Policy that can be widely disseminated, instead of a piece-meal approach to building the health sector and delivering health services.

Additionally, there are legislation and policy initiatives around disease-specific health issues, including mental health and HIV/AIDS. Some of these may have a negative impact on public health. However, the MoH has not taken initiative to get involved in these policy processes. The following legislation is under review at various stages in the legislative process. We call upon the Ministry of Health to lead policy development towards good for public health and for the human rights of all Ugandans.

### ***Mental Health Bill***

For the last 10 years, Uganda has been developing a policy on mental health. The draft is yet to be approved by cabinet. This response has been sluggish. The MOH has also worked on drafting a new mental health bill. However lack of stakeholder participation in the drafting process may cause the bill to be turned down by cabinet. MoH must finalize the Mental Health Policy and ensure adequate consultation with mental health service providers, patient support groups, and advocacy organizations before presenting the Mental Health Bill to Parliament.

### ***HIV/AIDS Bill***

Many aspects of the HIV/AIDS Bill impede effective HIV response and violate the human rights of PHAs. MoH should advocate for inclusion of clauses that promote

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<sup>23</sup> Uganda: A sleeping giant of too many leaders, laws, policies, and no implementation, 09 November 2010, Haggai Matsiko, The Independent

voluntary testing and for exclusion of clauses that criminalize people based on their HIV status.

### ***Public Procurement and Disposal Act (PPDA) Amendment Bill 2010***

This Bill was tabled before Parliament by the Ministry of Finance Planning and Economic Development in August 2010. The Bill proposes to amend the PPDA Act to allow certain institutions to apply for accreditation which allows them to make emergency procurements. This proposal would be useful for the National Medical Stores in cases where there is need to urgently procure medicines. MoH should participate in the process of designing this amendment in order to facilitate emergency procurement and to eliminate lengthy processes for obtaining medicines.

### ***Counterfeit Goods Bill***

There have been positive developments in regards to incorporations of civil society recommendations into this bill. Concerns about the original bill included the broad definition of counterfeiting, conflicts with existing legislation, overly broad criminal provisions, and enormous unchecked powers given to the Commissioner of Customs. MoH should sustain the improvements to the bill so that the legislation does not affect Uganda's ability to manufacture or import generic drugs.

### ***Universities and Other Tertiary Institutions Act***

Concerns have been raised that the Universities and other Tertiary Institutions Act has not been properly implemented. As a result, Public Nursing Institutions are run like secondary schools and the quality of graduates has deteriorated. The Act is not sufficiently implemented and the anticipated achievements have been minimal so far.<sup>24</sup>

### ***Anti-Homosexuality Bill, 2009***

The proposed Anti-Homosexuality Bill, 2009 ("The Bill").The Bill criminalizes homosexuality and anybody who knows about it, but does not report it to authorities—including health workers, who have a duty to patient confidentiality. Under Part III - Related Offences and Penalties of the Bill, any person and/or association, business or non-governmental organisation that "aids and abets homosexuality", promotes homosexuality practices, and fails to disclose the

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<sup>24</sup> Kalanzi MM, Bogere M, Kabumba I (2010) Challenges Encountered by Public Nursing Institutions in the Implementation of the Universities and Other Tertiary Institutions Act, 2001. Abstract, 6<sup>th</sup> MUCHS Annual Scientific Conference, p. 95

offence of homosexuality commits an offence punishable by law, including a fine, legal action, conviction and imprisonment.

For health workers, this means that if they treat an individual who is gay or who is suspected of homosexuality, they have committed an offense and could be imprisoned--a shocking violation of medical neutrality and the right to health. This will deter many medical professionals from properly and efficiently providing their services to the Ugandan people, and will have a direct and negative impact on the health of all Ugandans. Health care practitioners, who work under an oath of confidentiality created by the State, will no longer be able to guarantee a confidential and safe environment for their patients. This may result in any number of negative outcomes for patients and providers. Patients may be reluctant to fully disclose the types or causes of their ailments to the health worker, for fear that they will be identified as homosexual—which will in turn deprive health workers of information they need to have to make a proper diagnosis and prescribe appropriate prevention and treatment options. Out of the fear of punishment, health workers may withhold care from a patient, which further stigmatizes and alienates an already marginalized group from the health care system. Some health workers may choose to follow this discriminatory law instead of their own professional ethics, and report homosexual patients to the authorities—thus destroying patient-doctor confidentiality and driving a stake between health workers and patients, the impact of which will be felt throughout the country.

**Recommendations:**

1. The MoH should strengthen the policy analysis unit which should be proactive in promoting the human rights enshrined in the various national and international covenants. The MoH should ensure that proposed legislation or policy violates the rights of people by discriminating based on gender, ethnicity, socioeconomic status, religion, political affiliation, sexual orientation, health status, or any other demographic factor.
2. Government and the Ministry of Health must commit to effective implementation of policies and reporting on progress of specific programs.

## 4.5 Mainstream a Human Rights-based Approach into the Health Sector

### Background:

While there was no mention of human rights in the HSSP II, CSOs welcome the addition of the rights-based approach in HSSP III (see section 5.4.1 on 'The right to highest attainable level of health'<sup>25</sup>). This shift away from a needs-based approach that only meets the temporary health needs of Ugandans, towards a structural shift whereby MoH recognizes its obligation to provide care as a human right, is welcome. We also welcome the launch of the Patient's Charter, which if widely disseminated, promoted, and implemented will empower Ugandans to become better health consumers and interact on more equal footing with healthcare providers. People need to know their rights.

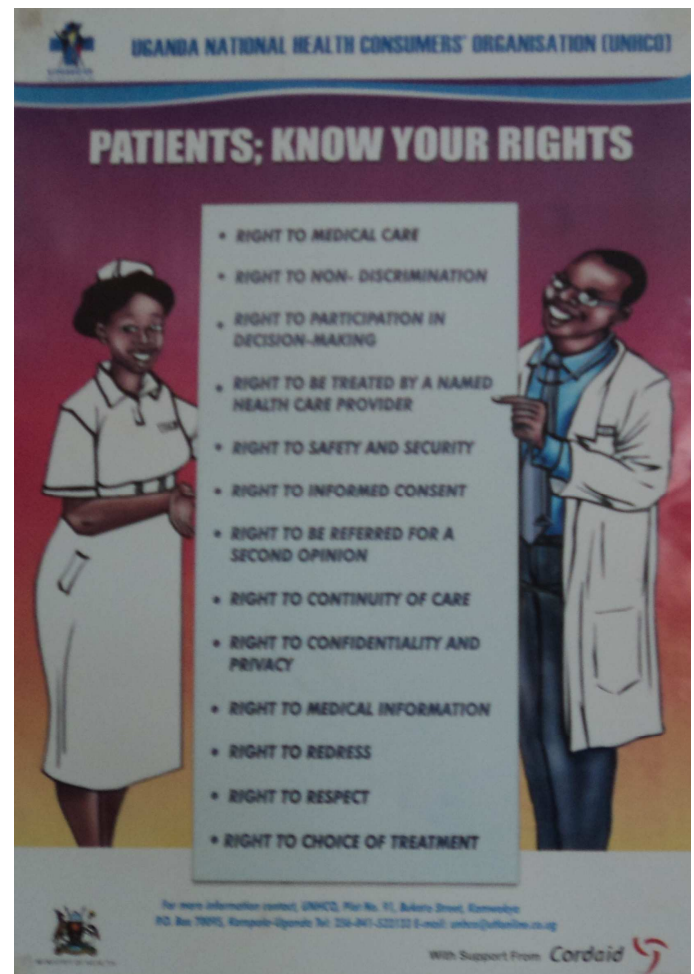
### Recommendations:

*Create an Action Plan to Disseminate the Patient's Charter*

Work with national medical associations, health professional associations, VHTs, health workers, district health teams, national NGOs, international NGOs, faith based organizations, community based organizations, and other stakeholders to translate and widely disseminate and display the Patient's Charter at all health facilities. It would be a great shame and injustice if the Patient's Charter were not widely promoted.

*Mainstream human rights in all MoH operations*

Continue to work to mainstream human rights-based approach into policy design, implementation, monitoring and evaluation of health goods and services.



<sup>25</sup> [www.health.go.ug/docs/HSSP\\_III\\_2010.pdf](http://www.health.go.ug/docs/HSSP_III_2010.pdf)

*Train health workers in human rights*

Facilitate the training of health workers (both pre-service and in-service) in human rights, the rights-based approach and the relationship between health and human rights. Health workers are in a special position to monitor and report on violations to the right to health.

*Recognize human rights violations*

Formally recognise the continued discrimination of marginalised groups as human rights violations. This includes instances wherein discrimination or fear of discrimination prevents people with disabilities (PWD), the elderly, and sexual minorities from accessing quality healthcare. By adopting the human right-based principle of non-discrimination in its practices, the Ministry will be able to progressively eliminate instances in which the rights of minorities and rights of the poor are violated.

## **5. Optimise and Ensure Delivery of Uganda Minimum Healthcare Package (UMHCP)**

The Uganda National Minimum Health Care Package is guaranteed by the state, free for the population. The purpose of developing and using the minimum package approach was to assist in resource allocation in the health sector especially in the face of a huge and growing health burden that has to be addressed. By defining this minimum package, Uganda has committed itself to make this package available and effective to all those in position to benefit from it.

The four clusters of the UNMHCP are:

1. Health Promotion, Disease Prevention, and Community Health Initiatives
2. Maternal and Child Health
3. Control of Communicable Diseases
4. Control of Non-Communicable Diseases

Although US \$28 is required to finance the UMHCP, government expenditure has been just over US \$10 per capita. This is far below what the government has set out to achieve and of course much lower than the US \$41 recommended by WHO. Although government has provided free healthcare and medicines at public facilities, still over US \$5 is spent out of pocket for medicines.<sup>26</sup> Health systems issues discussed previously underlie the ability to deliver this package. But there are specific issues that fall within certain areas of the UMHCP. Civil society and services providers have come together to reflect on the HSSP II period and provide specific recommendations to the Ministry of Health and Government of Uganda to maximize the delivery of UNMHCP, to save lives, and to decrease disability and morbidity among the population.

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<sup>26</sup> HEPS Uganda, Tracking Uganda's Health Sector in Financing and Delivery of Essential Medicines, June 2010

## **5.1 UMHCP: Strengthen Treatment and Care for Mental Health, Neurological Disorders, and Substance Abuse**

WHO's Mental Health Gap Action Programme (mhGAP) estimates that the global mental health disease burden has grown from 12.5% to 14% in the past 6 years. Uganda Ministry of Health reports that 85% of the estimated 3.6 million Ugandans with moderate to severe mental disorders are not able to access treatment.

HSSP II built on gains made in HSSP I, which succeeded in proving that addressing mental health issues was central to the development agenda in Uganda. In addition to this, HSSP II was written as the LRA insurgency ended, leaving a large population in Northern Uganda traumatized and in need of some kind of psychosocial intervention.

### **Assessing progress made on HSSP II targets:**

#### **i) All regional referral hospitals with functional mental health units**

By the end of 2009, all the regional referral hospitals had constructed and furnished mental health units. Those built in HSSP I were functional, staffed with psychiatric clinical officers, psychiatric nurses and, in some cases, social workers; however, only Mbarara, Gulu and Jinja have recruited Psychiatrists. In the absence of criteria to determine the standard of functionality, it is difficult to assess the extent to which these 5 units are functional.

The hospitals built in HSSP II have also been completed and all have been handed over to the regional hospitals.

The mental health unit in the Masaka Regional Referral hospital has been converted into the maternity unit until the new maternity ward is built. It appears people with mental disorders will always be treated as second class citizens.

### **Recommendations**

- Develop criteria for assessing functionality of a mental health unit.
- Restore the mental health unit in Masaka to provide its intended function.

## **ii) To increase community access to mental health services by 50%**

Current HMIS measures hospital attendance as opposed to actual numbers of people accessing mental health services. Therefore, in as much as the numbers reported in the HMIS by Butabika, Regional Referral Hospitals and districts may be large, it does not necessarily mean a drastic increase in the number of people accessing mental health services. From our experience as CSOs, the health sector still falls short of increasing access to mental health services.

In the districts where there is improved access, this is as a result of partnership with NGOs like Mental Health Uganda (MHU), Basic Needs (BNUU), TPO, Avis, Epilepsy Support Association-Uganda (ESAU) and THETA. Chances are high that the districts where there are no NGOs working in mental health are those with the lowest performance in mental health service provision.

## **Recommendations**

- MOH should partner with NGOs to test the scalability of their interventions
- In particular MOH should evaluate the effectiveness of Drug Banks and other community financing initiatives.

## **iii) To establish a community strategy for prevention of mental health problems**

This strategy is yet to be finalized as a component in the larger national strategy on mental, neurological and substance abuse disorders (MNSD).

## **Assessing progress against HSSP II core interventions**

### **i) Promote the integration of mental health services into primary health care**

- A number of general health workers have been trained in mental health management by MOH, TPO and BNUU. In addition to this, the essential medicines list has been amended to include basic medicines for mental health. The HMIS was also revised to include 6 common mental disorders and epilepsy. However, this has not translated to integration for the following reasons:
  - Mental health is not adequately integrated in the support supervision structure. DHOs and health drug inspectors are ill-equipped to support PHC staff to provide mental health services
  - NMS still refuses to send mental health medicines on the essential medicines list to health centres that they feel are manned by staff of a



lower cadre e.g. enrolled nurses and nursing assistants, with good reason.

- Outreach services in most districts are inconsistent due to logistical problems, lack of health worker facilitation and poor supply of medicines.
- In some districts like Mpigi, Masaka, Sembabule and Amuria, people with mental disorders have organized themselves and formed drug banks (they make monthly contributions for the purchase of medicines). This mechanism should be evaluated, improved, and supported by MoH in order to improve regular access to medicines for neurological and mental illness.
- A study by BasicNeeds on skills of health workers to provide mental health services found that those trained in Gulu had graduated without taking the module on mental health.
- The HRH strategy clearly states that each health sub district should recruit at least one psychiatric nurse. The HRH biannual reports do not report on the progress of this. However in the districts where TPO, BNUU and MHU are working, this has been achieved largely through the lobbying activities of these organizations.
- Experience from ESAU shows that the general public is willing to pay for consistent antiepileptic medicines as has been in Apac, Mbarara, Luweero and Jinja where ESAU partners with Faith-based PFNP health centres to provide services.

## Recommendations

- Invest heavily in training health workers (including DHOs and HSD Managers) to provide mental health services in the community. Special emphasis should be given to linkages between communicable diseases e.g., malaria and epilepsy, malaria and organic mental disorders, HIV and mental health.<sup>27</sup>
- Create working relationships between Regional Referral Hospitals and districts to implement mental health services until staff are recruited and properly inducted.

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<sup>27</sup> Nakimuli-Mpungu E, Nachege J, Bass JK, Mojtabai R (2010) Depression, Alcohol use, and adherence to Anti-retroviral therapy in Sub-Saharan Africa: A systematic review and Meta-Analysis. Abstract, 6<sup>th</sup> Makerere University College of Health Sciences (MU-CHUS) Annual Scientific Conference, p. 67 ; Munyaneza G, Nakimuli-Mpungu E (2010) 6<sup>th</sup> MU-CHUS Annual Scientific Conference, p. 69; Okello ES, Ngo VK, Ryan G, Musisi S, Akena D, Wagner G (2010) The influence of Antidepressants on Psychological Health among ART Clinets in Uganda: A Qualitative Study, p. 70

## **ii) Development and dissemination of appropriate messages for improving community mental health**

The only evidence of this is IEC materials and radio messages developed and disseminated by the Ministry of Health and CSOs. This is mostly in the form of posters around the themes of the World Mental Health Day celebrations. However, there are very few disorder-specific IEC materials for the public or general health workers.

No guidelines have been disseminated on how to provide community mental health services. The messages produced are normally in English, meaning only a few people understand them.

### **Recommendations**

- Create messages for health workers as well as the general public
- Develop treatment algorithms or other simplified materials to improve diagnosis of mental health problems at health centre level.
- Develop and disseminate materials in local languages
- Develop guidelines for DHOs and HSD managers on how to integrate mental health in PHC.

## **iii) To promote the rights of the mentally ill**

Lack of quality community mental health care (accessible, available, appropriate and quality) and stigma including that from health workers is the reason that the mentally ill are vulnerable to human rights abuse. Despite the fact that the constitution of Uganda, the Equal Opportunities Act and the PWD Act clearly state that no person should be discriminated against on the basis of their health status, the health system is the first to discriminate people with mental disorders.

For the last 10 years, Uganda has been developing a policy on mental health. The draft is yet to be approved by cabinet. This response has been sluggish. The MOH has also worked on drafting a new mental health bill. However lack of stakeholder participation in the drafting process may cause the bill to be turned down by cabinet.

### **Recommendations**

- Finalise the Mental Health policy
- Ensure adequate consultation before presenting the mental health bill to parliament.

#### **iv) Monitor and provide technical support supervision at all levels**

Monitoring and supervision at regional and district level is done by the Mental Health Section, Ministry of Health. Area teams also assess a component on mental health. At district and HSD level, support supervision is limited and lacking.

#### **Recommendations**

- The guidelines on support supervision should be revised and the mental health component strengthened
- DHOs and HSD Managers should submit support supervision reports to the ministry every six months.

#### **v) Provision of care for neurological disorders at primary care level**

Currently there are services for epilepsy at primary care largely through mental health care outreach clinics. CSOs also found that even where there was little NGO support, HCs manned by a clinical officer were more likely to provide services for people with epilepsy. People suffering from other neurological services have to travel to regional hospitals or Mulago. There is also a poor link between neurological services and other support services like physiotherapy, occupational therapy and speech therapy.

#### **Recommendations**

- Develop strategy for the prevention and management of neurological disorders. This strategy should include:
  - Awareness raising on the causes and prevention of neurological disorders
  - Training of health workers, including neurologists and neurosurgeons
  - Increasing the essential medicines to manage neurological disorders in the community
  - Strengthening intra-sectoral linkages with maternal health, occupational and physiotherapy and others.

#### **vi) Provide services for demand reduction for alcohol and drug abuse**

Substance abuse and addiction are on the increase both in rural and urban areas. One study of Kawempe district reveals a high percentage (88%) of youth consume

alcohol or other drugs.<sup>28</sup> Substance abuse in turn is linked to increases in domestic violence and SGBV. Additionally, links have been established between depression, alcohol abuse, and stigma resulting from HIV status.<sup>29</sup>

There is now a functional alcohol and drug rehabilitation unit at Butabika National Referral Hospital. Other services are provided by NGOs like Serenity Centre and NACARE. TPO had piloted a community approach but its results have not been adequately disseminated.

The Ministry is working on the Alcohol and Drug Abuse Control Master Plan.

### **Recommendations**

- Conduct research to establish outpatient care for rehabilitation of abusers of alcohol and drugs
- The master plan should strengthen collaboration with law enforcement, local councils, community support systems and the education sector.
- Develop capacity for regional hospitals and general hospitals to provide services for the reduction of alcohol and drug abuse.

### **vii) Address effects of trauma and violence in conflict situations**

There have been efforts to support this with TPO, WHO and Avis. In addition to this, the Peter Alderman Foundation operates trauma units in Gulu, Kitgum, Pader and Tororo Districts. The GoU, MoH, and researchers have conducted surveys on the mental health or psychological impact of the war<sup>30</sup>. While CSOs working in Northern Uganda report high levels of suicide, hysteria, depression, and other anxiety disorders with some researches reporting up to 50% prevalence for PTSD, the PRDP mostly focuses on rebuilding northern Uganda.

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<sup>28</sup> Kawuma AN, Kitutu FE, Kalyango JN, Kalidi R, Adome RO, Kutyabami P, Anyama NG (2010) Drug and substance abuse among the youth in Kawempe division. Abstract, 6<sup>th</sup> MU-CHS Annual Scientific Conference, p. 87

<sup>29</sup> Munyanez G, Nakimuli-Mpungu E (2010) Relationship of Depression and Alcohol Use disorders to Disclosure of HIV Status. Abstract, 6<sup>th</sup> MU-CHUS Annual Scientific Conference, p. 69

<sup>30</sup> Kinyanda E, Musisi S, Biryabarema C, Ezati I, Oboke H, et al. (2010) War related sexual violence and it's medical and psychological consequences as seen in Kitgum, Northern Uganda: A cross-sectional study. BMC Int Health Hum Rights. Nov 10;10(1):28.

**Recommendations**

- MOH should negotiate and include a community psycho-trauma service in northern Uganda and insist that all development programmes include this as a component.
- Provide special training for health workers in northern Uganda on management of PTSD in the community.

## 5.2 UMHCP: Stop Malaria

### Background:

Malaria accounts for an estimated 26% of the burden of disease in Uganda (BOD Uganda 1995). At the time of writing of the HSSP II, malaria was responsible for:

- One in every 3 persons attending OPD (33%)
- One in every 4 persons admitted in hospitals (25%)
- One in every 5 child deaths in hospital (20%)
- 70,000 –120,000 deaths annually or 320 deaths daily
- Severe anemia in children/pregnancy ↑abortions, ↑low birth weight  
↑MMR ↑IMR
- Severe economic losses (25% HH incomes, US\$ 658 p.a) lost school days, low economic productivity, long term mental disability

The National Malaria Control Program (NMCP) devised the following strategies/core interventions:

1. Effective Case management: Accessing effective treatment within 24 hours of symptoms
2. Intermittent Preventive Treatment in pregnancy
3. Vector Control: Insecticide treated nets & Indoor residual spraying
4. BCC/IEC

These were coupled with overall malaria epidemic preparedness and response. These core interventions are in line with the Abuja declaration.

### Progress during HSSP II:

#### ***Increasing the proportion of households having at least one insecticide – treated net from 15% to 70%***

Only 42% of the households have at least one ITN against a target of 70%. Overall high coverage rates are being achieved for the vulnerable groups like pregnant women and U5 under the Global Fund Round 1 Phase 1 distribution. Phase 2 will target universal coverage and it will be 1 net for 2. Net usage in the coverage areas, however, is still only 11%.

***Increasing the proportion of targeted structures for indoor residual spraying (IRS) in targeted areas from 0 to 85%***

IRS approved in 2006 has since been consolidated and expanded in malaria endemic areas and 85%-100% household coverage in targeted areas for IRS in both endemic and epidemic areas against a target of 80% in 2009/2010, which shows that the ***target has been reached***.

This is great news but have impact evaluation been done in these areas to assess the outcomes? What is the current OPD attendance, U5 mortality due to Malaria and pregnant mothers in these areas? Which insecticide is being used? DDT and resistance to pyrethroids have been contentious for quite some time.

***Increasing the proportion of children under five getting correct treatment within 24 hours of onset of symptoms from 25 to 85%***

The proportion of children with malaria who receive effective treatment within 24 hours after the onset of symptoms has increased from 25% at the end of HSSP I to 71% in 2007/08 falling short of the 80% target for 2009/10.

***Increasing the proportion of pregnant women who have completed IPT2 from 24 to 80%***

The proportion of pregnant women who receive IPT has increased to 42% in 2007/08 against the HSSP II target of 80%. Still, recent reports indicate that 20% of pregnant women had been or were infected when giving birth at Mulago Hospital<sup>31</sup>. Reports also indicate that attendance at antenatal clinics is not necessarily associated with universal coverage of insecticide-treated nets (only 32%) and intermittent preventive antimalarial treatment (only 41.5%).<sup>32</sup> Currently, mothers attend ANC at health facilities but are told to buy their own SP and take it, without DOT.

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<sup>31</sup> Namusoke F, Rasti N, Kironde F, Wahlgren M, Mirembe F (2010) Malaria Burden in Pregnancy at Mulago National Referral Hospital in Kampala, Uganda. Malaria Research and Treatment Volume 2010 (2010), doi:10.4061/2010/913857

<sup>32</sup> *ibid*

## **Recommendations**

### *Insecticide treated nets*

- Government must fund social mobilization and BCC campaigns alongside the net distribution to increase net usage as well promote replenishments by household heads if the current nets become old.
- The government needs to commit funds as well to this intervention since it is largely donor funded.
- The Civil Society Fund should expand their mandate beyond HIV/AIDS to other diseases, including malaria prevention and control.

### *Indoor Residual Spraying*

- Government should share best practices and report on results

### *Timely and Appropriate Treatment of Children*

- The diagnosis of Malaria in many facilities is still presumptive. Less funding is available for parasite based diagnosis. The government needs to look at streamlining the prices of RDTs to be affordable for the smaller health centres that don't have laboratory personnel and equipment.
- There are many health facilities with shortages of ACTs due to the current procurement and supply chain method that is largely centralized and removes the oversight role of the district health team since commodities are delivered at the end user (health facilities). The ACTs can't, therefore, be enough for the CMDs if the health facilities are failing to access them.
- The percentage of health facilities without stock outs of first line anti-malarial drugs only decreased from 35% to 26% in 2006/07 and 2008/09 respectively, despite channeling all the PHC funds to NMS leaving the districts with no emergency funds for procurement of drugs.
- Understaffing still remains a big challenge in many areas including the self accounting national referral hospital

### *Malaria in pregnancy*

- Ensure access to prophylactic drugs, i.e. sulfadoxine-pyrimethamine (SP), and to insecticide-treated nets for all women in antenatal care.
- Implement directly observed therapy for malaria prophylaxis in pregnancy.



## 5.3 UMHCP: Achieve Universal HIV/AIDS Treatment and Prevention

### Introduction

Since the early days of AIDS, Uganda has been known for its effective response which brought the national HIV prevalence down from 18% to 6.4%. But with approximately 1 million people living with HIV, including 100,000 new infections annually, and with 20,000 new paediatric cases (MTCT) in 2009, the current AIDS response leaves much to be desired.

### Background

#### *Treatment*

The ARV programme is over 90% US donor-funded, raising serious concerns about long-term sustainability. In response to pressure from various local and civil society groups, PEPFAR recently committed to scaling-up treatment for an additional 36,000 PHAs per year for two years. PEPFAR had planned to continue treating only those individuals already enrolled in its program and not to take on new recruits except in case of replacing those that had passed on. The GoU was asked to source additional funding for escalating domestic ARV program, but this has not been prioritized by the MoH. Likewise, Clinton Health Access Initiative (CHAI) is the country's sole supplier of paediatric ART. Like PEPFAR, CHAI had also planned to phase out at the end of 2010, but has committed to stay, obviating the problem of a US\$14 million funding gap at least for another year. How long will this last?



"We spend a lot of time in queues waiting for drugs and treatment, but only to be told the drugs are not there ..... come back after two weeks"

- an HIV positive woman in Bundibugyo during an assessment carried out by International Community of Women Living with HIV/AIDS (ICW) to establish the availability and accessibility of ARVs in health centres.



#### *Prevention:*

#### *PMTCT*

The low availability of PMTCT services (38%) is far off from the HSSP II target of 50% and a sharp decline from the reports from FY 2008/09 that 68% of HC IIIs were offering PMTCT.<sup>33</sup> This is alarming, as this intervention is highly cost-effective

<sup>33</sup> MOH Draft AHSPR FY 09/10, pg 82

as it can prevent the costs of a lifetime of ART. PMTCT programmes in West Nile are not running well because of lack of adequate knowledge of the assigned staff. Copies of PMTCT policies and protocols are lacking in many districts, including most of the health centres in West Nile, especially among the larger hospitals.

### *Condoms*

Many monitoring and support supervision visits to health centres throughout the country reveal that condoms are not available. This is true, for example, in West Nile, in Busoga, and even within Kampala. As a barrier method that is 100% effective when used consistently and correctly, condoms must be free and available. They are a very effective and inexpensive weapon in the fight against HIV.

### *Sero-discordant couples*

Uganda HIV/AIDS sero-survey of 2005 suggests that 65% of new HIV infections are among married people and discordant couples may comprise up to 50% of these. Support groups for serodiscordant couples have proven to be effective mechanisms for prevention. Reports of one such group (which includes couples' counseling, re-testing every 6 months, experience-sharing, talks of risk reduction, negotiating safer sex, condom use, reproductive choices, promotion of free male medical circumcision, and more) in Kayunga district show that there has been only one sero-conversion among the 140 discordant couples in the group. Psychosocial prevention support from peers is reducing HIV transmission among discordant couples. Ministry of Health should invest resources in providing support to discordant couples and should develop a standard package for prevention specific to discordant couples.<sup>34</sup>

### **TREATMENT IS PREVENTION**

Pioneering studies published in 2010 indicate that transmission rates decrease by 92% when people with HIV are on anti-retroviral therapy<sup>35</sup>. Therefore, universal access to prevention must include treatment for people living with HIV.

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<sup>34</sup> Mukwaya S, Magala F, Breda M (2010) Reduction of HIV Transmission among Discordant Couples: A Case-Study of the Kayunga District Discordant Couples Support Network Strategy. Abstract, 6<sup>th</sup> MU-CHUS Annual Scientific Conference, p. 35

<sup>35</sup> Donnell D, Baeten JM, Kiarie J, Thomas KK, Stevens W, Cohen CR, McIntyre J, Lingappa JR, et al (2010) Heterosexual HIV-1 Transmission After Initiation of Antiretroviral therapy: A prospective cohort analysis. The Lancet, early online publication 27 May 2010

## Challenges<sup>36</sup>

1. Inadequate PHC funds. HIV activities are planned for as separate activities from the main work plans.
2. Fragmented district planning and lack of a consolidated planning for all partners.
3. Lack of sustainability of funding beyond project funds.
4. Delayed absorption, release and accountability of funds through the district system leading to disruption of services like sample transportation.
5. Although there are CD4 machines in the region, transportation of samples is still a challenge.

## Recommendations

1. Pass HIV policies that will increase the gains of the AIDS response and will reduce stigma and discrimination among PHAs and the community as a whole.
2. Train and sensitise health workers to improve their attitude towards HIV+ clients.
3. Roll out PMTCT services as strategy for preventing babies from acquiring HIV infection.
4. Ensure timely and thorough updates to health workers on all new policies and clinical guidelines released by the MoH and other relevant governing bodies
5. Facilitate district coordination of implementing partners to avoid overlaps, duplication, and for efficient/effective use of resources of implementing partners and CSOs/CBOs
6. Strengthen referral systems between HIV care and non-HIV services
7. Enable districts to coordinate and develop a single, harmonized HIV plan for MoH and development partners
8. Strengthen support supervision of health facilities by DHT teams
9. Strengthen HIV/AIDS data management and reporting
10. Recruit health workers, especially laboratory technicians and pharmacy technicians
11. Strengthen ordering and reporting for commodities by the health facilities to facilitate logistics chain management
12. Supply buffer stocks to health facilities based on need
13. Fight stigma to increase the uptake of paediatric ART

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<sup>36</sup> From **REPORT ON THE INTEGRATED SUPPORT SUPERVISION OF HIV AND AIDS ACTIVITIES IN MBALE AND BUKEDI REGIONS**, October 2010

14. Move beyond HIV treatment: empower and support PHAs to be self reliant and not depend on handouts like food so as to improve their livelihood and family welfare

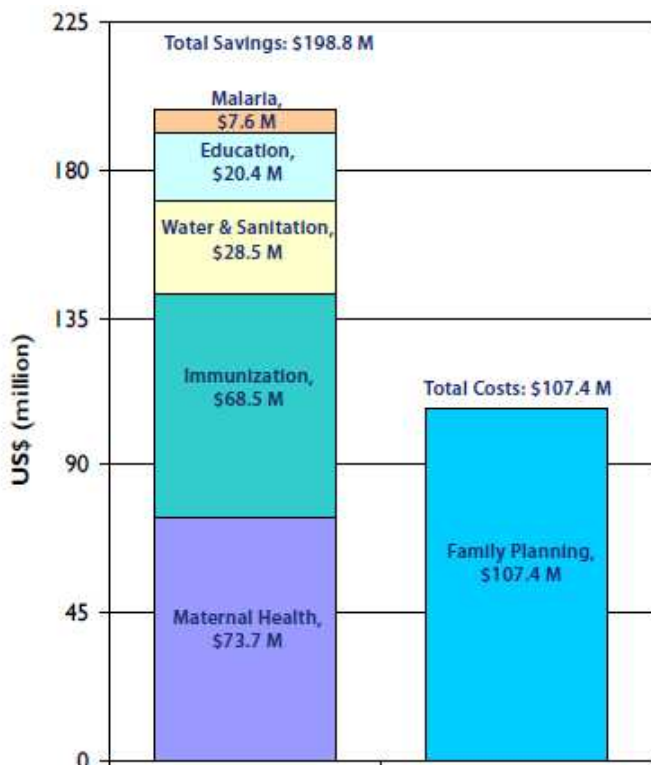
## 5.4 UMHCP: Reduce Maternal Death and Ensure Universal Access to Family Planning Services

“Family planning is to maternal health what immunisation is to child health.”

– Janet Museveni<sup>37</sup>

The maternal mortality ratio in Uganda is around 435 deaths per 100,000 live births.<sup>38</sup> This is exceptionally high, especially relative to the MDG target ratio of 131/100,000 for 2015. Progress towards the target is lagging, suggesting that core interventions against the top causes of maternal mortality (low coverage of emergency obstetric care, inadequate availability of appropriate staff and equipment, lack of transport, and insufficient access to family planning) have been under-prioritized.

Access to family planning is not only a right, but a very cost-effective intervention for the government. The figure to the left shows how family planning investments



yield significant cost-savings on other services, including education and immunization.

“Increasing access to and use of family planning is not one of the MDGs; however, as analysis has shown, it can make valuable contributions to achieving many of the goals. Increased contraceptive use can significantly reduce the costs of achieving selected MDGs and directly contribute to reductions in maternal and child mortality. ***The cost savings in meeting the five MDGs by satisfying unmet need outweigh the additional costs of family planning by a factor of almost 2 to 1.***”

<sup>39</sup> (Source: USAID- *Achieving the MDGs: The*

*contribution of Family Planning – Uganda 2009*)

<sup>37</sup> allAfrica.com We Can Achieve Safe Motherhood 12 March 2010, <http://allafrica.com/stories/201003120103.html> (FROM THE MONITOR..)

<sup>38</sup> 2006 Uganda Demographic and Health Survey

<sup>39</sup> [http://www.usaid.gov/our\\_work/global\\_health/pop/techareas/repositioning/mdg\\_pdf/uganda.pdf](http://www.usaid.gov/our_work/global_health/pop/techareas/repositioning/mdg_pdf/uganda.pdf) pg 2

### Civil Society Perspective on Progress:

1. Stock-outs of oral contraceptives and lack of availability of other family planning services are not acceptable<sup>40</sup>
2. Promotion of ANC visits must strive for higher coverage, especially in rural areas
3. Applaud efforts to gain investment from private sector (corporate social responsibility) and garner new revenue, including airline tax (Janet)
4. We welcome the integration of reproductive health services with HIV care, but urge stronger coordination of RH and HIV services. Data from a study at TASO Mulago and Tororo showed that the use of hormonal contraception (HC) among women on HAART was 37.9%, which is higher than the national average (18%) but far lower than desirable targets, given the urgent need to reduce unintended pregnancies. Increased resources for counseling and education are needed to help PHAs minimize the risk of vertical HIV transmission and pregnancy-related complications. The data reveals a need to strengthen the basic care package for people with HIV to include reproductive health services.<sup>41</sup>

### Recommendations:

1. Ensure universal access to family planning. Studies have shown innovative efforts, including community-based distribution of contraceptives, can increase coverage to FP services<sup>42</sup>
2. Improve proportion of deliveries facilitated by skilled attendants, especially by improving upon systems for transport and on availability of comprehensive EmOC at HC IVs and hospitals
3. Reconsider legislation on abortions in order to reduce maternal death due to septic abortions

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<sup>40</sup> <http://www.newvision.co.ug/D/9/34/713693> and <http://www.newvision.co.ug/D/9/34/713688> as posted on rhu.or.ug

<sup>41</sup> Mwase I, Kalyango JN, Kitutu FE (2010) Hormonal Contraception Utilization and Associated Factors among HIV+ Women on HAART at Two Ugandan Treatment and Care Centres. Abstract, 6<sup>th</sup> MU-CHUS Annual Scientific Conference, p. 34

<sup>42</sup> Akol A, Abbott A, Krueger K, Wamala P (2010) Scaling-up Community-based Distribution of Injectable Contraceptives in Uganda: Lessons Learned from Private and Public Sector Implementation. Abstract, 6<sup>th</sup> MU-CHUS Annual Scientific Conference, p. 55

## SPOTLIGHT ON OBSTETRIC FISTULA

“Because nothing or little is currently done for fistula patients, they tend to keep away from the hospitals and stay in the communities, where it is difficult to identify them,” says Dr. Apollo Karugaba.

Obstetric *fistula* is an affliction of the very poor, and is directly related to a lack of EmOC. Though a simple surgical repair can mend most cases of obstetric fistula, most Ugandan women go untreated because of lack of availability of or access to this surgery. The most dramatic reduction in OF incidence would be achieved through increasing skilled attendants for deliveries. Other challenges to preventing and treating obstetric fistula include limited education about causes and potential treatment for OF, stigma, limited financial resources, transport, and a dearth of in-country professional capacity.

### **Perspective on Fistula Progress:**

National and International NGOs in partnership with Community Based Organizations are reaching out to traditional birth attendants and other healthcare workers in the Iganga district to educate about preventing the condition, eliminate stigma, and promote treatment-seeking behaviors. A small number of local NGOs and international medical missions partner with hospitals, including Kamuli Mission Hospital, to facilitate surgical repairs. Much more can be done to prevent and treat fistula.

### **Recommendations**

1. Increase awareness about the causes and treatment of obstetric fistula, especially in hard-to-reach villages where the prevalence of fistula is highest due to lack of access to proper obstetric services. MoH, international NGOs and DPs should partner with local organizations to reach rural areas and to share, translate, and disseminate IEC.
2. Develop comprehensive fistula repair guidelines that include household visits with patients and their families before and after surgery as well as transportation and support during the repair.
3. Train surgeons to perform fistula surgeries during graduate medical education programs or as continuing medical education certification. When expatriate surgeons visit to provide repairs, every effort should be made to ensure that they are paired with and assisted by Ugandan surgeons who can be trained during the repair camps with an explicit plan for training the Ugandan surgeons to be able to practice independently.
4. Equip at least one hospital per district to perform comprehensive fistula repair, with specific focus on the necessary surgical equipment.



## 5.5 UMHCP: Decrease preventable disease and death, including paediatric and non-communicable diseases

### Background:

This section is a collection of perspectives and priorities from civil society on certain topical issues, highlighting priorities in Village Health Teams (health promotion), cancer, sickle cell anemia, anti-stigma, and neglected tropical diseases.

### *Financing and Operationalising the Village Health Teams*

The village health team (VHT) strategy is the cornerstone of efforts to promote awareness about various preventative conditions as well as community participation in healthcare delivery and service utilisation. The strategy can only work if VHT are trained and functional in every village. Unfortunately, this is not the case and only around 30% of districts have trained VHTs throughout. The main obstacles to implementation are lack of funds and lack of health educators. Additionally, VHTs are increasingly being used to distribute health commodities, including insecticide treated nets and even injectable contraception. Therefore, availability of medicines and health supplies will increasingly become a problem. VHTs are a promising model for health promotion and community involvement in health programmes.

### **VHT** Village Health Team



As the backbone of health promotion in the minimum healthcare package, VHTs must be paid. The strategy cannot rely on unsustainable and unpredictable project-based donor funding and must be more heavily financed by the MoH. Otherwise, the current situation will persist, with insufficient VHTs to cover entire districts, and VHTs funded for

one type of health promotion instead of a basic package that includes all health promotion strategies. Research from Iganga district has shown that NGOs can successfully facilitate VHT formation. Benefits to the NGO include an invaluable



community-level partner, increased program literacy, and sustainability. Key components for success include utilisation of non-governmental and governmental partnerships, intensive community collaboration, and support of VHT development. Current challenges include sustainable phase-out of NGO support and provision of incentives to VHT members.<sup>43</sup>

### **Recommendations:**

1. Systematise prevention efforts of VHTs
  - a. Finance the VHTs, including training, stipends, capacity building for management of health commodities like bed nets, contraceptives, etc.
  - b. Devise a National Health Communication Strategy that encompasses a system for sharing, translating, and printing standardized EIC materials. This communications strategy should include music, dance, drama, radio shows, and media that meets the needs of people with disabilities (blind, deaf, and low literacy).
  - c. Amend policy to allow VHT administration of contraception and conduct more research on efficacy and safety of VHT administration of injectable contraception<sup>44</sup>
  - d. Explore opportunities for integration of prevention services, especially around child health and family planning services
2. Document, share, and scale-up best practices among districts

### ***Averting the Cancer Crisis***<sup>45</sup>

“Uganda was ahead in Africa with a world-class research institute, a respected cancer registry and high calibre cancer experts. It was the envy of many countries in the region including South Africa which didn’t, by then, have a dedicated cancer centre. This good start was not sustained hence the current extremely high cancer morbidity and mortality.”

***-- Dr Jackson Orem, director of Uganda Cancer Institute***

The prevalence of cancer in Uganda is around 60,000. Eighty five percent of cancer patients live in rural areas and lack access to specialised care. Only four per cent

<sup>43</sup> Colley A, Hayward A (2010) Implementation of the Village Health Team Strategy Through NGO Support. Abstract, 6<sup>th</sup> MU-CHUS Annual Scientific Conference, p. 75

<sup>44</sup> [http://www.fhi.org/en/Research/Projects/Progress/res\\_works\\_in\\_progress\\_2.htm](http://www.fhi.org/en/Research/Projects/Progress/res_works_in_progress_2.htm)

<sup>45</sup> Adapted from Orem, Jackson. Averting the Cancer Crisis <http://www.monitor.co.ug/OpEd/Commentary/-/689364/1001310/-/13wioycz/-/> 2 Sept 2010

cases of cancers diagnosed currently are attended to at the Uganda Cancer Institute, meaning 96 per cent die without care.

Lifestyle changes (tobacco and alcohol use) are partially responsible for an increase in cancer. Viral infections have also contributed greatly to cancers, especially Kaposi's sarcoma and cervical cancer.

The high cancer death rate in Uganda can be attributed to late diagnosis and care, which is a reflection of poor access to services. Also, medical training is skewed towards infection. Cancer thus comes as an afterthought, so referrals are often in late stages. This is worsened by the fact that cancer treatment in the country is expensive and lacks donor support. Although 60 percent of the current increase of cancer can be directly attributed to HIV infection, cancer is not reflected in the funding of HIV such as Global Fund and PEPFAR. Cancer, therefore, is an example of inequity in health care adversely affecting vulnerable groups such as women, children and HIV population.

#### **Progress in HSSP II:**

- Modest increase in funding for the Uganda Cancer Institute
- Increased visibility of Non Communicable Diseases in the new Health Policy II and Health Sector Strategic Plan III.

#### **Recommendations:**

1. Develop a comprehensive National Cancer Control Programme, with a framework for participation of various stakeholders, including civil society, medical fraternity, international community, academic institutions and research organisations.
2. Include vaccination against Hepatitis B and cervical cancer in routine programmes. Screening for cervical and breast cancer must be available and easily accessible at the lowest level of health care system.
3. Facilitate accessibility of treatment countrywide through a network of centres coordinated by a national centre of excellence with referral conduits for patient follow-up and surveillance.
4. Implement policy on tobacco control: Uganda is signatory to the World Health Assembly declarations on cancer and framework convention on tobacco.

### ***Expanding treatment for Sickle Cell Disease***

Sickle Cell Disease accounts for approximately 16.2% of all paediatric deaths in Uganda.<sup>46</sup> An estimated 30,000 babies are born annually with the disease and 80% die before celebrating their fifth birthday.<sup>47</sup> Because extensive and country-wide surveys have not been conducted, it is unclear whether the disease prevalence is increasing or decreasing. In any case, sickle cell disease was not properly addressed during the HSSP II period.

Government committed to raising awareness of sickle cell and non-communicable diseases to 80% at the community level as part of the non-communicable diseases cluster of the UMHCP. But, there is still very little awareness of sickle cell anemia throughout most districts.

Government also committed to 100% districts implementing social mobilization for prevention and control of NCD/conditions. Despite this, sickle cell disease has only one clinic in the whole country at Mulago National Referral Hospital. While 7000 patients are registered, the clinic has not tested for the disease for the last 4 years for lack of reagents. So if Mulago is not doing this how can districts do it?

In the HSSP II, government committed to integrate NCD prevention and management in the functions of 100% HC1Vs. Efforts to increase awareness and manage sickle cell anemia are virtually undetectable. Prevention and management of the disease is still a mystery which has given room to traditional healers confusing patients and families that they cure sickle cell disease. Some have lost their lives because there are no management protocols of the disease.

### **Recommendations:**

1. Expand treatment for Sickle Cell Anemia by maximizing awareness within the MoH, among health workers, and in the communities through VHTs.
2. Equip the Sickle cell clinic at Mulago and availing transport for patients who come from rural areas for treatment.

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<sup>46</sup> Okwi AL, Byarugaba W, Ndugwa CM, Parkes A, Ocaido M, Tumwine JK (2010) An up-date on the prevalence of sickle cell trait in Eastern and Western Uganda. BMC Blood Disord. 2010; 10: 5.

<sup>47</sup> Ndugwa CN. Observations of sickle cell anaemia in Uganda 1976. J Trop Pediatr Environ Child Health. 1978 Jun;24 (3):152–154.

## ***Neglected Tropical Diseases (NTDs)***

The 7<sup>th</sup> National Health Assembly of the 2008/09 Joint Review Mission resolved to address the neglected tropical diseases by committing to 'Pay attention to neglected tropical diseases and emerging diseases.'<sup>48</sup> The past year has not seen MoH ownership of NTD prevention and control efforts. These NTD programmes catalogued in this year's AHSPR are mainly provided as free donations through international initiatives and partnerships.<sup>49</sup>

### **Recommendations:**

1. GoU must allocate country resources to neglected tropical disease programs and should work to integrate NTD programs into the health systems infrastructure of districts, instead of relying solely on development partners.

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<sup>48</sup> Aide Memoire, 7<sup>th</sup> National Health Assembly and 15<sup>TH</sup> Health Sector Joint Review Mission 2009, pg 18

<sup>49</sup> draft AHSPR FY 2009/10, pg 116

# SPOTLIGHT ON STIGMA: Fight Discrimination and Protect the Health Needs of Vulnerable Groups

Stigma significantly impacts treatment and care as well as patient safety.

## ***Sexual Minorities***

Uganda Health and Science Press Association (UHSPA-Uganda), a network of groups and individuals working to mainstream minority rights in Uganda's public health policies and laws, is concerned about the omission/exclusion of sexual minorities from accessing vital health services in Health Sector Strategic Plan III.

Although UHSPA participated in the Civil Society Joint Assessment of the HSSPIII, we have founded fears that the policy has not catered for health needs of sexual minorities under MARPS. The omission of this vulnerable group poses a threat to Uganda's management of HIV/AIDS as the HSSPIII was our best hope as a country, for starting awareness, sensitisation and information to sexual minorities, particularly LGBTI especially on HIV/AIDS.

While it is true that there are observed consistence of HIV infection rates among married heterosexuals, the 2010 UNGASS Report for Uganda<sup>50</sup> clearly shows that there is no policy intervention in our public health infrastructure to address vital access to health for sexual minorities. As a current member of the United Nations Human Rights Council, Uganda cannot afford to perpetuate the vulnerability of some sections of its population by keeping them off the health access radar.

Under state obligations to developing national health policies, Uganda agreed and committed to state parties responsibility in accordance with article 12.1 of the ***International Covenant on Economic, Social and Cultural Rights*** (ICESCR) to observe "the right of every one to the enjoyment of the highest attainable standard of physical and mental health." Under the same state obligations, Uganda also agreed under Article 12.2 to "steps to be taken by state parties..... to achieve the full realization of this right," under which the HSSPIII is conceived.

Additionally, the Ministry of Health's own National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights recognizes sexual orientation and defines Sexuality as a "central aspect of being human throughout

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<sup>50</sup> [http://data.unaids.org/pub/Report/2010/uganda\\_2010\\_country\\_progress\\_report\\_en.pdf](http://data.unaids.org/pub/Report/2010/uganda_2010_country_progress_report_en.pdf)

life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. It is experienced through thoughts, fantasies and perception.”

The right to health which HSSPIII intends to omit for sexual minorities is closely related to and dependent upon the realisation of other human rights as contained in the International Bill of Rights. By virtue of Article 2.2 and Article 3 of the ICESCR, the covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement.

### ***People with Mental and Neurological Disorders***

Stigma towards people with mental and neurological illness impedes treatment-seeking behavior and can have other negative effects on outcomes. Of a study done at Mulago and Butabika hospitals, 41% of 250 epilepsy patients enrolled in a study to measure psychological distress and felt stigma among patients with epilepsy met criteria for psychological distress while 36% met the criteria for highly felt stigma. More males were positive for felt stigma, but women scored higher on the alienation sub-scale.<sup>51</sup>

### ***Refugee populations***

Major constraints to prevention and response to sexual and gender based violence (SGBV) among refugee populations in four refugee camps in Uganda included inadequate service providers (community educators, volunteers, SGBV community task forces, LCs, health facilities and legal systems), poverty, and scarcity of IEC materials. The available community structures and service agencies should be strengthened through training and scale-up of resources. The extreme conditions of refugee populations, including poverty, power imbalances, loss of identity, and trauma should be central in the design and implementation of SGBV interventions.<sup>52</sup>

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<sup>51</sup> Bajangwe KJ, Nakku J, Muhwezi WW (2010) The prevalence and factors associated with psychological distress and felt stigma among patients suffering from epilepsy in Mulago and Butabika National Referral Hospitals. Abstract, 6<sup>th</sup> MU-CHUS Annual Scientific Conference, p. 14

<sup>52</sup> Kwiringira J, Rujumba J (2010) Community Capacity to prevent and respond to sexual and gender based violence (SGBV) among Refugee Populations: Evidence from Four Refugee Camps in Uganda. Abstract, 6<sup>th</sup> MU-CHUS Annual Scientific Conference, p. 32

## Conclusion and Way Forward: A Call to Action

As we see it, the launch of HSSIP is a moment of great opportunity. We have a new strategic plan. The HSSIP lays out a strategy that is realistic to achieve—with proper financing, coordination, and leadership.

Let us try to do things differently. Let it not be business as usual. Let us change our behavior to achieve our goals. How long are we willing to wait before we see progress? We need change. The MDG deadline is 2015—five years from now—and it is in line with our new strategic plan period. Let us take advantage of the opportunity to do things differently, make a change, and be an example for other countries.

Civil society can make recommendations, but the Ministry of Health must lead by implementing the recommendations put forth in both our report and the Annual Health Sector Performance Report. Year after year, Ministry of Health is able to cite and describe all the problems of the health sector, but if nobody takes leadership to address the issues, we are not going to be able to improve health outcomes.

The new goal of the health sector is “Promoting people’s health to Enhance socio-economic development.” This new goal set by the MoH for themselves and for our society recognizes the centrality of health to development. We call on the Ministry of Health to demonstrate leadership, stewardship, and ownership of building the health sector. This involves gaining more support from the Government of Uganda, and especially making funding for health a priority in the National Budget, as well as working with development partners to take on leadership roles in programs they fund. There is serious concern that programs and policies that are launched are never implemented. Let this not be the case with the HSSIP.

Civil society plays a critical role of oversight and accountability. This report demonstrates that we as civil society are intensifying our watchdog role. We are not going to allow for compromises anymore. We are part of the sector, but we are increasingly going to hold duty bearers accountable. We urge you to play your part. Follow our recommendations, follow your recommendations, and together, we will see change happening.

# ANNEX A: LIST OF RECOMMENDATIONS

## 4.1 Health Financing: Increase the Health Budget

The Health Development Partners:

- Improve commitment to agreed priorities by providing funding to the agreed levels and inputs so as to make external funding sufficient and more predictable. This will help facilitate a coordinated sector development and avoid wastages that arise from discontinuous funding.
- Promote transparency by availing accurate and adequate reports on the levels of their funding and the areas of focus. This not only also empowers peer monitoring and mutual accountability but also informs the alignment of their funding to sector priorities.
- Report (always and timely) on level and targeting of off-budget funding. This promotes coordinated sector investment and funding, promotes equity across regions, gender and priorities, avoids duplication of funding and most importantly facilitates proper macroeconomic management.
- Honor their commitments in full.

The Government of Uganda and Ministry of Health:

- Work with development partners to fund the HSSIP (HSSP III) in accordance with the Paris Declaration on Aid Effectiveness of 2005 and the International Health Partnerships, with an emphasis on strengthening the health sector without compromising progress in disease-specific interventions around HIV/AIDS, TB, and malaria.
- Set funding targets that are transparent enough so that external resources do not displace domestic funding to the sector.
- Honor—in full—the commitments made in funding agreements.
- Monitor and track all funding to the health system so as to develop a sustainable funding modality mix. By tracking all off-budget funding, the government should design sustainable levels of project support and General budget support to achieve health sector priorities and civil society to deliver community based needs in a stable and sustainable macroeconomic environment
- Fight corruption in the health sector
- MoH should advocate for increased domestic health financing through innovative mechanisms in order to fund the HSSIP (HSSP III).
- GoU should employ new strategies to increase revenue for health priorities, particularly those expenditures requiring long-term or life-long investments. Some promising proposals for the GoU include:
  - Airline tax, cigarette tax, soda tax, alcohol tax, financial transactions tax



## 4.2 Stop Stock-outs: Ensure Access to Essential Medicine, Health Supplies, and Equipment

Government of Uganda:

- Invest in strengthening the health system especially at service delivery point with more infrastructure, staffing, equipment, utilities, logistics, supplies and consumables for health centres.

Ministry of Health:

- Increase efforts to build capacity of lower public health facilities to reduce stock – outs. This can be done through increased pharmaceutical and overall management capacities.
- Devise a mechanism to control prices of medicines especially in the private sector.
- Prioritise stocking of paediatric formulations to improve management of diseases in infants and children.
- NMS and MoH must enforce good record keeping in order to enable tracking of medicines availability.

## 4.3 Train, Recruit and Retain Health Workers

*Ministry of Health*

- Ensure that all MoH positions are held by a dedicated staff person committed to lead, not by place-holders. Vacant positions should be filled in a timely manner.
- Involve the national professionals associations in policy working groups particularly the human resources for health TWG
- Commit to strengthening the health professional associations and councils
- Prevent an internal brain drain of specialists into desk jobs in public health
- Improve framework and implementation of monitoring and support supervision, with intensified focus on efforts to retain senior staff in rural areas

*Staffing levels*

- Ministry of Health must implement the Hard-to-Reach strategy and step up efforts to reach staffing levels over 100%

*Job Satisfaction, In-service training, and Professionalism*

- Increase regularity and quality of in-service training for all cadres of health professionals to learn new medical knowledge and best practices
- Increase pay for all health workers to be commensurate with their level of education

- Nurture professionalism in healthcare with increased support to mentoring, especially in specialties
- Foster teamwork among health workers in different cadres, especially doctors, midwives, and nurses working within a given health facility

### *Hard-to-reach districts*

Implement the policies especially the Retention Strategy focusing on:

- Financial incentives
  - Use the procedure provided for by the Law to revise/increase salaries. Government must involve the unions and institutions concerned before making decisions such as salary increases for health workers;
  - Combine fiscally sustainable financial incentives, such as hardship allowances, grants for housing, free transport, etc, sufficient to outweigh the opportunity costs associated with working in rural areas, as perceived by health workers
- Implement regulatory requirements that increase service time in rural areas
  - Create compulsory service requirements in rural and remote areas
  - Offer educational subsidies with enforceable agreements of return service work in rural areas
  - Focus on increasing the scope of medical practice in remote regions to increase job satisfaction
- Address personal and professional needs of health workers
  - Improve living conditions for health workers and their families in remote areas
  - Provide career development programs to help rural workers progress in their careers
  - Create senior posts in rural areas so that advancing workers are not forced to leave their communities.
- Reform health professional education policy
  - target admission policies to enroll students with rural backgrounds
  - expose students to greater rural field work
  - Build schools and residency programs outside of major urban areas

### **4.3 Promote Pro-health Legislation, Policy, and Effective Implementation**

- The MoH should strengthen the policy analysis unit which should be proactive in promoting the human rights enshrined in the various national and international covenants. The MoH should ensure that proposed legislation or policy violates the rights of people by discriminating based on gender, ethnicity, socioeconomic

status, religion, political affiliation, sexual orientation, health status, or any other demographic factor.

- Government and the Ministry of Health must commit to effective implementation of policies and reporting on progress of specific programs.

#### **4.5 Mainstream a human rights-based approach into the health sector**

- Work with national medical associations, health professional associations, VHTs, health workers, district health teams, national NGOs, international NGOs, faith based organizations, community based organizations, and other stakeholders to translate and widely disseminate and display the Patient's Charter at all health facilities. It would be a great shame and injustice if the Patient's Charter were not widely promoted.
- Continue to work to mainstream human rights-based approach into policy design, implementation, monitoring and evaluation of health goods and services.
- Facilitate the training of health workers (both pre-service and in-service) in human rights, the rights-based approach and the relationship between health and human rights. Health workers are in a special position to monitor and report on violations to the right to health.
- Formally recognise the continued discrimination of marginalised groups as human rights violations. This includes instances wherein discrimination or fear of discrimination prevents people with disabilities (PWD), the elderly, and sexual minorities from accessing quality healthcare.
- By adopting the human right-based principle of non-discrimination in its practices, the Ministry will be able to progressively eliminate instances in which the rights of minorities and rights of the poor are violated.

#### **5.1 UMHCP: Strengthen Treatment and Care for Mental Health, Neurological Disorders, and Substance Abuse**

- Develop criteria for assessing functionality of a mental health unit.
- Restore the mental health unit in Masaka to provide its intended function.
- MOH should partner with NGOs to test the scalability of their interventions
- In particular MOH should evaluate the effectiveness of Drug Banks and other community financing initiatives.
- Invest heavily in training health workers (including DHOs and HSD Managers) to provide mental health services in the community. Special emphasis should be given to linkages between communicable diseases e.g., malaria and epilepsy, malaria and organic mental disorders, HIV and mental health.

- Create working relationships between Regional Referral Hospitals and districts to implement mental health services until staff are recruited and properly inducted.
- Create messages for health workers as well as the general public
- Develop treatment algorithms or other simplified materials to improve diagnosis of mental health problems at health centre level.
- Develop and disseminate materials in local languages
- Develop guidelines for DHOs and HSD managers on how to integrate mental health in PHC.
- Finalise the Mental Health policy
- Ensure adequate consultation before presenting the mental health bill to parliament.
- The guidelines on support supervision should be revised and the mental health component strengthened
- DHOs and HSD Managers should submit support supervision reports to the ministry every six months.
- Develop strategy for the prevention and management of neurological disorders. This strategy should include:
  - Awareness raising on the causes and prevention of neurological disorders
  - Training of health workers, including neurologists and neurosurgeons
  - Increasing the essential medicines to manage neurological disorders in the community
  - Strengthening intra-sectoral linkages with maternal health, occupational and physiotherapy and others.
- Conduct research to establish outpatient care for rehabilitation of abusers of alcohol and drugs
- The master plan should strengthen collaboration with law enforcement, local councils, community support systems and the education sector.
- Develop capacity for regional hospitals and general hospitals to provide services for the reduction of alcohol and drug abuse.
- MOH should negotiate and include a community psycho-trauma service in northern Uganda and insist that all development programmes include this as a component.
- Provide special training for health workers in northern Uganda on management of PTSD in the community.

## **5.2 UMHCP: Stop Malaria**

### *Insecticide treated nets*

- Government must fund social mobilization and BCC campaigns alongside the net distribution to increase net usage as well promote replenishments by household heads if the current nets become old.

- The government needs to commit funds as well to this intervention since it is largely donor funded.
- The Civil Society Fund should expand their mandate beyond HIV/AIDS to other diseases, including malaria prevention and control.

#### *Indoor Residual Spraying*

- Government should share best practices and report on results

#### *Timely and Appropriate Treatment of Children*

- The diagnosis of Malaria in many facilities is still presumptive. Less funding is available for parasite based diagnosis. The government needs to look at streamlining the prices of RDTs to be affordable for the smaller health centres that don't have laboratory personnel and equipment.
- There are many health facilities with shortages of ACTs due to the current procurement and supply chain method that is largely centralized and removes the oversight role of the district health team since commodities are delivered at the end user (health facilities). The ACTs can't, therefore, be enough for the CMDs if the health facilities are failing to access them.
- The percentage of health facilities without stock outs of first line anti-malarial drugs only decreased from 35% to 26% in 2006/07 and 2008/09 respectively, despite channeling all the PHC funds to NMS leaving the districts with no emergency funds for procurement of drugs.
- Understaffing still remains a big challenge in many areas including the self accounting national referral hospital

#### *Malaria in pregnancy*

- Ensure access to prophylactic drugs, i.e. sulfadoxine-pyrimethamine (SP), and to insecticide-treated nets for all women in antenatal care.
- Implement directly observed therapy for malaria prophylaxis in pregnancy.

### **5.3 UMHCP: Achieve Universal HIV/AIDS Treatment and Prevention**

- Pass HIV policies that will increase the gains of the AIDS response and will reduce stigma and discrimination among PHAs and the community as a whole.
- Train and sensitise health workers to improve their attitude towards HIV+ clients.
- Roll out PMTCT services as strategy for preventing babies from acquiring HIV infection.
- Ensure timely and thorough updates to health workers on all new policies and clinical guidelines released by the MoH and other relevant governing bodies

- Facilitate district coordination of implementing partners to avoid overlaps, duplication, and for efficient/effective use of resources of implementing partners and CSOs/CBOs
- Strengthen referral systems between HIV care and non-HIV services
- Enable districts to coordinate and develop a single, harmonized HIV plan for MoH and development partners
- Strengthen support supervision of health facilities by DHT teams
- Strengthen HIV/AIDS data management and reporting
- Recruit health workers, especially laboratory technicians and pharmacy technicians
- Strengthen ordering and reporting for commodities by the health facilities to facilitate logistics chain management
- Supply buffer stocks to health facilities based on need
- Fight stigma to increase the uptake of paediatric ART
- Move beyond HIV treatment: empower and support PHAs to be self reliant and not depend on handouts like food so as to improve their livelihood and family welfare

#### **5.4 UMHCP: Reduce Maternal Death and Ensure Universal Access to Family Planning Services**

- Ensure universal access to family planning. Studies have shown innovative efforts, including community-based distribution of contraceptives, can increase coverage to FP services
- Improve proportion of deliveries facilitated by skilled attendants, especially by improving upon systems for transport and on availability of comprehensive EmOC at HC IVs and hospitals
- Reconsider legislation on abortions in order to reduce maternal death due to septic abortions
- Increase awareness about the causes and treatment of obstetric fistula, especially in hard-to-reach villages where the prevalence of fistula is highest due to lack of access to proper obstetric services. MoH, international NGOs and DPs should partner with local organizations to reach rural areas and to share, translate, and disseminate IEC.
- Develop comprehensive fistula repair guidelines that include household visits with patients and their families before and after surgery as well as transportation and support during the repair.
- Train surgeons to perform fistula surgeries during graduate medical education programs or as continuing medical education certification. When expatriate surgeons visit to provide repairs, every effort should be made to ensure that they are paired with and assisted by Ugandan surgeons who can be trained during the

repair camps with an explicit plan for training the Ugandan surgeons to be able to practice independently.

- Equip at least one hospital per district to perform comprehensive fistula repair, with specific focus on the necessary surgical equipment.

## **5.5 UMHCP: Decrease preventable disease and death, including paediatric and non-communicable diseases**

1. Systematize prevention efforts of VHTs
  - a. Finance the VHTs, including training, transport, stipends, capacity building for management of health commodities including bed nets, condoms, contraceptives, etc.
  - b. Devise a National Health Communication Strategy that encompasses a system for sharing, translating, and printing standardized EIC materials. This communications strategy should include music, dance, drama, radio shows, and also the needs of people with disabilities (blind, deaf, and low literacy).
  - c. Amend policy to allow VHT administration of contraception and conduct more research on efficacy and safety of VHT administration of injectable contraception
  - d. Explore opportunities for integration of prevention services, especially around child health and family planning services
3. Document, share, and scale-up best practices among districts
4. Develop a comprehensive National Cancer Control Programme, with a framework for participation of various stakeholders, including civil society, medical fraternity, international community, academic institutions and research organisations.
5. Include vaccination against Hepatitis B and cervical cancer in routine programmes. Screening for cervical and breast cancer must be available and easily accessible at the lowest level of health care system.
6. Facilitate accessibility of treatment countrywide through a network of centres coordinated by a national centre of excellence with referral conduits for patient follow-up and surveillance.
7. Implement policy on tobacco control: Uganda is signatory to the World Health Assembly declarations on cancer and framework convention on tobacco.
8. Expand treatment for Sickle Cell Anemia by maximizing awareness within the MoH, among health workers, and in the communities through VHTs.
9. Equip the Sickle cell clinic at Mulago and availing transport for patients who come from rural areas for treatment
10. GoU must allocate country resources to neglected tropical disease programs and should work to integrate NTD programs into the health systems infrastructure of districts, instead of relying on development partners

## **Fight Discrimination and Protect the Health Needs of Vulnerable Groups**

1. Oppose stigmatizing legislation for sexual minorities and prioritize their health rights
2. Raise awareness about mental illness to decrease stigma toward people living with mental illness
3. Combat the sexual and gender based violence in post-conflict areas





