

DISCUSSION PAPER #5
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SUSTAINABLE HEALTH

Community perspectives on the determinants
of the right to health in the
post-2015 Agenda



CEHURD
social justice in health





A community health worker attached to Makindu HC III with condoms for free distribution

**TOP COVER:
Patients wait for services at Nyabbani HC III in Kamwenge district**

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ABBREVIATIONS

CPI	Consumer Price Index
FGD	Focus Group Discussion
FY	Financial Year
GDP	Gross Domestic Product
GNP	Gross National Product
GOU	Government of Uganda
HC	Health Centre
HSSIP	Health Sector Strategic Investment Plan
HSSP	Health Sector Strategic Plan
KII	Key informant interview
LC	Local Council
MDGs	Millennium Development Goals
MOFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
MSS	Minimum Service Standard
NGO	Non-Government Organization
SSA	Sub Saharan Africa
SWAP	Sector Wide Approach
UHC	Universal Health Coverage
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
UNHS	Uganda National Household Survey
UNMHCP	Uganda National Minimum Health Care Package
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

This paper summarizes views from a sample of community stakeholders in three districts in Uganda on a selected set of determinants of the right to health. The views are considered in the light of the newly adopted UN Sustainable Development Goals (SDGs). The objectives were:

- 1) To capture community perspectives on how the right to health framework could support the achievement of the health SDG in Uganda.
- 2) To assess key determinants of the right to health: health financing; a basic package of services (Uganda National Minimum Health Care Package); and community participation and accountability.

This work assesses the right to health using a framework developed by a consortium of 15 institutions headed by the Institute of Tropical Medicine under the Goals for Health (Go4Health) project.¹ This work builds on the work of the Go4Health project. Hence, community views were collected on a set of themes:

- 1) A legal mandate for the right to health at the country level;
- 2) Health financing;
- 3) A national policy framework for achieving universal health coverage (UHC); and
- 4) Community participation in the post-2015 agenda.

The views were collected from Gulu, Buikwe and Kamwenge districts using a qualitative process. Data collection was conducted between May and June 2014 using focus group discussions (FGDs) and key informant interviews. The survey team also analyzed available evidence to answer questions in the quantitative realm of the survey.

Most respondents participating in this process were supportive of the idea of the right to health constituting an appropriate framework for post-2015 global health agenda. However, they noted that poor quality services, non-implementation of health laws and bylaws as well as limited provisions for

1 <http://www.go4health.eu/wp-content/uploads/Go4Health-interim-report-September-20131.pdf>

vulnerable groups were major barriers to realization of the right to health.

On health financing, the results reveal that the public sector contributed 15% to Uganda's total expenditure on health in FY 2009/10; far below the contribution of donors and NGOs (36%); and private sources (49%).² Households, through direct out-of-pocket payments, were the most dominant private source constituting 87% of all the private sources in 2009/10.

Between 2010/11–2012/13, per capita public financing was about one quarter of what was needed to provide the minimum health care package irrespective of the scenario considered.

Results from field data suggest that the majority of respondents feel that health does not receive a fair share of government expenditure and felt that additional resources for health could be shifted from defense, agriculture, the President's office, State House and Parliament to finance recruitment and remuneration of health workers, infrastructural development including staff accommodation, equipment and supplies. Community perceptions about the extent to which government should finance health care were more inclined towards free services.

Majority of respondents recommended addition services for the Uganda national minimum health care package (UNMHCP): injuries from accidents and violence.

Respondents noted that their participation was often dictated "from above" through forced service uptake and that their views rarely influenced decisions. Majority of respondents suggested that community participation could be effectively monitored by independent external agencies.

The key recommendations are:

- a) Implementation of the global health goal under the SDG framework should focus on enhancing the right to health
- b) There is urgent to integrate the right to health into Uganda's laws
- c) Budgetary allocations and funding for health should be substantially increased in order to achieve UHC
- d) The SDG reporting framework needs to require country update reports to include community participation in the implementation of SDGs

2 National Health Accounts (NHA) survey (MOH 2013)

1. BACKGROUND

1.1 Introduction

The International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Article 12). The Millennium Development Goals (MDGs) have since the Millennium Declaration of 2000 constituted the framework for achieving this right. The MDGs have, among other things, elevated health onto the political agenda; inspired and motivated governments, civil society and health workers; leveraged much-needed funding; and stimulated many innovative ideas to improve the equitable delivery of effective health care. They mobilized government and business leaders to donate tens of billions of dollars to life-saving tools, such as antiretroviral drugs and modern mosquito nets.¹

In same breathe however, judged in their own terms – the reduction of certain elements of disease burden – the MDGs have only been a qualified success. In the 75 “countdown” countries (selected as they have 98% of all maternal deaths and deaths among children younger than 5 years of age) progress has been mixed, with only 44 achieving the goal of reducing mortality among children under five (MDG 4) and 62 achieving the goal for maternal mortality (MDG 5).²

As the Sustainable Development Goals (SDGs) succeed the MDGs as the global development framework, attention shifts to the next 15 years and what the new agenda might mean for the right to health. One of the newly adopted 17 SDGs focuses on health (SDG 3), aiming to “Ensure healthy lives and promote well-being for all at all ages”. Up to 13 targets have been set to achieve this Goal, presenting a new opportunity to advance the right to health for the next 15 years, even though the right to health is neither

1 McArthur J (2013). Own the Goals: What the Millennium Development Goals Have Accomplished.

<http://www.brookings.edu/research/articles/2013/02/21-millennium-dev-goals-mcarthur>

2 Zulfiqar A. Bhutta, Z.A. & Black, R.E. (2013). Global Maternal, Newborn, and Child Health: So Near and Yet So Far. *The New England Journal of Medicine*. http://www3.med.unipmn.it/papers/2013/NEJM/2013-12-05_nejm/nejmra1111853.pdf

explicitly stated in the SDG text nor within any of the targets.³

This new global development agenda, including the health goal, have been informed by a widely consultative process, and the preamble pledges that no one will be left behind in the 2030 Agenda for Sustainable Development.⁴ Yet the debate continues on what SDG 3 and the entire development agenda might mean for the right to highest standard of health (right to health).

In this paper, Center for Health, Human Rights and Development (CEHURD) considers community views from different parts of Uganda on a set of determinants of the right to health that might be key in implementing the health SDG (SDG 3) and in making progress on the realization of the right to health.

1.2 Objectives

This paper highlights views from community stakeholders on the salient development issues as highlighted in the debate on the SDGs and how international human rights law and the right to health in particular could achieve better health in the post-2015 development agenda in Uganda and globally.

Hence, this paper considers community views on the following determinants of health:

- 1) A legal mandate for the right to health in Uganda
- 2) Options for financing health care
- 3) The adequacy of the Uganda National Minimum Health Care Package (UNMHCP) in the realization of universal health coverage (UHC) as envisaged under SDG Target 3.8.⁵
- 4) Community view on participation mechanisms in the post-2015 agenda implementation

3 Williams C & Blaiklock A (2015). SDG Series: What Might the SDGs Mean for Health and Human Rights? An Introduction to the Series. *Health and Human Rights Journal*: September 1, 2015. <http://www.hhrjournal.org/?p=6709>

4 Transforming Our World: The 2030 Agenda for Sustainable Development. <https://sustainabledevelopment.un.org/content/documents/7891Transforming%20Our%20World.pdf>

5 Target 3.8: “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”

2. METHODOLOGY

This work uses a framework developed by the Go4Health project that implemented a consultative process sponsored by the European Commission to inform the formulation of the SDGs.⁶ The framework proposes an overarching health goal of “realizing the right to health for everyone”, which together with a “healthy environment” would achieve universal health coverage (UHC). The project suggested a set of indicators, including a legal mandate for the right to health, enhance health expenditure and community participation. These proposals have somehow been captured in the final health SDG and/or the accompanying health indicators.

2.1 Scope of the survey

The consultations were conducted on a set of determinants for the realization of the realization of the right to health under the post2015 agenda, on the basis of proposals that were being floated in the lead up to the SDGs:

- 1) A legal mandate for the right to health at the country level
- 2) Health financing
- 3) A national policy framework for achieving UHC
- 4) Community participation in the post-2015 agenda

2.1.1 A legal mandate for the right to health at country level

The legal mandate for the right to health may take a number of forms, depending on the country’s legal system. Thus, it may be incorporated in the constitution, as in South Africa, it may be established in national legislation, or it may exist because the country is one where the ratification of an international convention has effect in domestic law. The existence of a legal mandate is, a necessary, though not a sufficient requirement for the right to health and empirical evidence shows that countries with such a mandate are more likely to have achieved UHC.

2.1.2 Health financing

SDG Target 3.c sets to “substantially increase” health financing especially in least developed countries (LDCs). Achievement of UHC calls for

6 <http://www.go4health.eu/wp-content/uploads/Go4Health-interim-report-September-20131.pdf>

commitment of adequate resources to health systems. Some approaches, such as the Abuja Declaration, have focused on a specific share of government expenditure to be devoted to health. But there is also emerging evidence that the ability to deliver UHC is associated with a state's ability to raise direct taxation. We consider the option a fixed proportion of GNP being committed to health, even without suggesting a specific figure. Discussions considered figures in the range of 5-7%.

2.1.3 Reduction in the share of out of pocket payments for health care below a fixed percentage

SDG Target 3.8 highlights the need for financial risk protection. In this work, we consider the health system's ability to reduce the risk of catastrophic expenditure in the event of severe illness or injury, or spending that impoverishes people. These risks are directly related to the burden of out-of-pocket payments. The suggestion centers around reduction in the share of out-of-pocket payments for health care below a given percentage.

2.1.4 A national public health strategy and plan of action

General Comment 14 of the UN Committee on Economic, Social and Cultural Rights (paragraph 43(f)), addressing the right to health, states: "To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups".

The strategy should reflect a country's burden of disease, which includes evidence-based policies, and which ensures equity. This strategy should be regularly updated, publicly available, and subject to regular progress reports, both by governments and civil society, in the form of shadow reports. It should incorporate the principle of progressive realization, as set out in the ICESCR that underpins these proposals, and should address all

three dimensions of UHC: the percentage of the population covered; the range of conditions (and interventions) covered; and the extent to which the cost of provision is covered.

2.2 Participating communities

The community views discussed here were collected from three districts: Gulu district in the northern region; Buikwe district in the central region; and Kamwenge district in the west of the country.

Gulu district is located in the northern region of Uganda. It was at the heart of a two-decade, devastating armed civil conflict characterised by robbery, rape, gunshots, landmines, bombs, harassment, maiming, killings, abductions and displacements.⁷ The district, like the rest of the region, has been undergoing post-conflict reconstruction over the recent years following an improvement in the security situation, and most internally displaced persons have resettled. Social infrastructure, including health facilities, were destroyed during the insurgency, undermining its ability to achieve the MDGs.

Buikwe district lies in the central region of Uganda, sharing borders with the districts of Jinja in the East, Kayunga in the North, Mukono in South West and Buvuma Islands in the South. Buikwe district is one of the 28 districts of Uganda that were created under the Local Government Act of 1997. The district was initially one of the counties of Mukono district which was later declared as an independent district in July, 2009. Buikwe district has an estimated total area of 4,974sq.km and an estimated total population of 407,100 people. A substantial proportion of the population is made up of fishing communities, which are a key population as far as HIV is concerned.

Kamwenge is in the western region, 385km west of the capital Kampala. Kamwenge shares boundaries with Kasese in the west and Ibanda in the southeast, and Rubirizi (formerly part of Bushenyi district) in the south. It is bordered by Kabarole district in the northwest; Kyenjojo district in the north; and Kyegegwa district in the northeast. It has a total land area

⁷ Isis-WICCE, 2000; Panos Institute, (1995); UNICEF/World Vision (1997); Amnesty International (1999).

of approximately 2,439.4 sq.km. Kamwenge has an estimated population of 324,400 people (2011 projection), who are involved in cattle rearing as well as cultivation. Health facilities in the district are scanty and it does not have a hospital; has two health sub-districts (level-four health units/health centre IVs); and 33 lower health units, reflecting a 44% coverage as per the government policy of one health unit per parish. The district has 75 parishes, each of which should have at least one level-two health unit.

2.3 Data types and sources

We employed a qualitative study approach of data collection to effectively solicit community and stakeholder perspectives on the realization of the right to health for everyone, universal health coverage and its indicators. The process utilized an international human rights law (right to health) as the benchmark for analysis. Data collection was conducted between May and June 2014 using focus group discussions (FGDs) with community stakeholders and key informant interviews with respondents from health providers, civil society organisations, local government officials, and local politicians.

2.3.1 Primary data

Focus group discussions

A total of six FGDs were conducted in the three selected districts, with each district having two FGDs from two subcounties. The FGD participants comprised of members of the wider community, representatives of community leaders and members of civil society organizations. The selection of participants was purposive to enable a rich interaction and discussion during the FGD.

Research assistants with experience in qualitative methodology were selected and trained on the study protocol and data collection tools. FGDs were conducted in pairs with one research assistant moderating the discussion and other taking notes. Each session lasted between 45mins to one hour. All discussions were audio recorded and informed consent was sought from participants prior to the discussions. Participants' responses were translated and transcribed verbatim into MS Word.

Key informant interviews

A total of 18 key informant interviews were conducted with different stakeholders from government agencies/departments and civil society organizations in the selected districts. Key informant interviews were conducted with the help of a semi-structured interview guide, covering the indicators presented under the section on FGD.

All FGDs and KIIs were audio recorded with the permission and consent of the respondents. Each KII lasted between 1 to 2 hours, and was conducted in the key informant's language of preference. The interview was later translated (where necessary) and transcribed into MS Word.

2.3.2 Secondary data

The survey team undertook an analysis of available evidence to answer questions in the economic/quantitative realm of the survey issues: a) The achievement of a fixed percentage of Gross National Product on health care; and b) Reduction in the share of out of pocket payments for health care below a fixed percentage.

This analysis attempted to answer the following questions:

- 1) What is the current level of health financing in Uganda (GOU, out-of-pocket, donor) and how does it compare with other countries?
- 2) What has been the trend of GOU total and per capita health financing, in nominal and real terms, over the past 10 or so years? How does this trend compare with growth in the national budget, domestic revenue, GNP over the same period?
- 3) What level of total health financing is needed to achieve universal coverage of the current UNMHCP? At this spending level, current estimates of GDP per capita and level of income poverty, what should be the maximum out-of-pocket spending (absolute and percentage) at catastrophic threshold?
- 4) What has been the health sector's budget utilization (budget performance) level over the past 10 years or so?
- 5) Compare total budgetary allocations/ allocations in budget

framework papers with total annual cost estimates of implementing interventions in the HSSP II and HSSIP (using costs indicated in the two policy documents).

2.4 Data management and analysis

2.4.1 Qualitative data

Thematic content analysis was used to analyse the data. The qualitative data analyst reviewed each transcript from the FGDs and the key informant interviews for content in order to identify codes by indicator and emerging themes organised by the consultation areas defined in the focus group discussion and the key informant guide. An analysis plan was developed based on the consultation objectives (in this case the UHC indicators). Transcripts were read to identify recurrent themes and to develop a code book. Thematic analysis was utilized to match the emerging themes to the key objectives (indicators) and to gain a clear understanding on participants' perceptions about realising the right for health.

3. RESULTS

The findings in this section are deductions from community and stakeholder attitudes and perceptions towards the survey issues. These results are perceptions of the rural communities, local leaders and civil society organisations on issues to consider in the implementation of the new development framework and what they hope the new development goals should achieve. The results also summarize outcomes from an analysis of available evidence relating to health investments in Uganda.

3.1 Community views on the right to health in the post-2015 agenda

The field team sought views of community stakeholders on “*realizing the right to health under the post-2015 development agenda*”. It also sought views on the value of having the right to health in national laws, and other ways to ensure that government provides health care to its people.

Most respondents participating in this process were supportive of the idea of using the post-2015 agenda to realize the right to health, and agreed that an overarching health goal based on the right to health would be important in mitigating the health challenges faced by communities in low income countries. There was a general consensus that Uganda needed realize the right to health for all its people using whatever health goal emerged from the SDG formulation process. Respondents further reported that the right to health framework would form an appropriate guide for actors both in and outside government, and it would important for community empowerment.

“*Realizing the right to health for everyone... yes I think it will be good because it encompasses so many things, like it can deal with HIV, it can deal with children issues like neonatal deaths, and ensure that services reach all groups of people without discrimination*” (Respondent at Baylor Uganda, Kamwenge)

“*When you talk about the right to health for everyone, you need to ensure that all get regardless of physical status. It needs an all round kind of approach. The right to health provides a very good framework*” (Ag LC V Chairperson, Gulu District)

“Of course, if it will enable better health service provision then why not have it as an overarching goal?” (Hospital Administrator Kawolo Hospital, Buikwe district)

“These goals are important as they can act as guidelines to be used by governments to serve its citizens. If well drafted, NGOs can use them to advocate for improved service delivery to communities” (Civil Society, Gulu)

“It is all about unpacking the right to health. It would be good if all Ugandans know their rights. If it is unpacked, the different kind of implementing the other rights too should be very clear. I hope the different indicators can capture maternal health, HIV, child health and people living with disabilities. I would look at having very clear indicators that can be budgeted, implemented and accounted for. It is therefore important to have indicators that we can use to hold government accountable” (GWED-G, Civil society, Gulu district)

Respondents were mindful of the benefits that could come with the pursuit of the right to health for everyone. Majority of respondents suggested that having the suggested goal would be important in bridging the existing gaps in some critical areas of health care especially maternal and child health, disability where more interventions were needed to reduce maternal and child mortality.

“You can realize that there has been a gap in the MDGs, when they talk about improving maternal mortality rates, in our communities, we are not 100% equal, there is the other section of the community that needs special attention, that is persons with disability. How about if in a health unit we do not have interpreters for people who are deaf and dumb, who will translate to the medical people about the complications the woman has.. such a woman deserves the same medical attention like that woman without any disability. This will be addressed if our focus is on the right to health for everyone” (District Chairperson, Gulu district)

However, some respondents noted that the right to health needed to be broken down to address country specific health challenges especially in light of the variations in the level of development, the nature of health

burden and existing health challenges. It was also noted that many low income countries were still lagging behind in achieving the MDGs which are expiring in 2015. A few respondents felt that pursuing the right to health as the ultimate goal without breaking it down may make it difficult to achieve.

“Having the right to health as the only goal would make it difficult to achieve because health is wide and has many components. It’s not practical enough because we have maternal health and that alone is huge; we have HIV/AIDS and other areas that need serious attention so putting all of them into one goal will make some areas lost into others” (Political leader, Paicho Subcounty, Gulu district)

“Looking at development goals, these should be applied to all countries but the methodology should vary from country to country as countries differ in terms of development and set up. Since health is a serious issue that affects everyone regardless of country of origin, we need to set the right to health for everyone as the ultimate goal regardless of the location” (Civil society leader, Gulu district)

Respondents were also asked whether the new goals could be applied to all countries. The responses were mixed, but a majority of respondents agreed that the health goals could be applied to all countries since all countries needed health. They argued that although all countries needed health and the right to health was relevant for everyone regardless of where they live, even when health needs may vary.

“Definitely it should apply to all countries because everyone needs health, regardless of where they live” (Health Centre In-charge Nyabaani, Kamwenge district)

“It should apply to all countries because all of us need to be healthy; much as some countries are more developed, all of us need health” (KII, Kamwenge, DHO)

“They should be set at international level such that they should be binding to all states regardless of whether poor or rich, every country. (It) should be at international level such that it’s binding whether you’re in which country or what.” (District Chairperson, Gulu)

“These goals look at development. There is no way development can apply to certain countries and not others. It works in an inter-related way as the middle class are supported by the developed ones” (Hospital Administrator, Kawolo Hosp, Buikwe)

A few however, felt that the differences in the levels of development were strong enough to warrant different goals for different countries. They felt that the right to health should be more relevant to low income countries than developed countries. They argued that low income countries such as Uganda were still grappling with elementary health needs which were no longer an issue in developed countries. Some few respondents felt that the new development framework and the health goals in particular should be able to address this disparity.

“We cannot compare development in all countries because countries are at different levels of development and so the sustainable development goals should be specific to different countries considering the levels of development and other factors for development” (Local Council Chairman, Paicho Subcounty, Gulu district)

“The goal should apply to under developed countries because developed countries as you say have already realized that it is not something that is coming readily but uhh would make any difference in any week but for us here when you bring up something like gradual, it is a process for people to what? To own that part...” (Baylor Uganda, Kamwenge)

It was noted that the right to health is comprehensive and includes all the required health components yet recognizant of the different stages at which countries are in achieving UHC would be more achievable. Respondents suggested that it was important that these observations are taken into consideration whilst formulating the new goals.

“These goals should be applied to all countries but there should be emphasis on some issues in different countries depending on the hierarchy of needs. For example in low developed countries, issues of women and children should be handled carefully” (Vice Chairperson, Nyenga Subcounty, Buikwe district)

3.2 Legal mandate for the right to health in Uganda

At the moment, the right to health is not explicitly provided for in the Uganda Constitution. Our field work sought community awareness on the right to health and their views on the added value of having it incorporated in the national laws. The process also sought their experience with health laws at the national and local levels.

3.2.1 Right to health in national laws

Findings from the survey of communities in Gulu, Buikwe and Kamwenge districts in Uganda, suggest that majority of participants were aware that health is a right they are entitled to. However, they noted that they currently face a lot of barriers in trying to realize it. The barriers come in form of poor quality services at public (government run) health facilities which respondents feel are ill-equipped. Similarly, participants mentioned a number of rights violations when they try to access health services at government facilities. They report that the laws in place to protect the masses are not always implemented and as such health workers get away with criminal negligence among other unethical behaviors.

“We have laws (that do not conform to human rights) for example it is a must to go for testing as a couple to test for HIV/AIDS especially where a woman is pregnant” (FGD, Kamwenge district)

Similarly, respondents reported that some vulnerable groups, particularly the elderly and disabled, being refused access to health care were also mentioned by participants as an example of violation of the right to health.

“...an old woman or man of about 70 years of age may go to the hospital, when he arrives at the hospital, he is not considered as someone who has come for treatment especially if you are above 80 years; they will not care about you and to the extent that his or her right has been taken away just because he is old” (FGD Buikwe district)

“I personally agree that health is a right because I think around the right based approach. The problem is that the population does not understand the fact that health is a right which causes a challenge of how these people will demand for their rights” (GWED-G, Civil society, Gulu district)

Majority of respondents mentioned that they thought the right to health already existed in the national laws even though they were unable to specifically mention what the law is or under what section of the Constitution the right to health was.

“Yes we have the laws like the Constitution of Uganda has provisions especially regarding children’s health... the entitlements include health care. A parent has to immunize the child or face a punishment under the law” (FGD, Kamwenge)

The discussions and interviews with community members and civil society representatives also revealed that there was a general agreement that the right to health should be for all and should be enshrined in Uganda’s Constitution and other relevant laws. The respondents overwhelmingly reported that it would be helpful to have the right to health in the national Constitution and other laws.

They said it would be binding and it would be a recognition on the part of government that it has obligations to ensure its realization, with the citizens feeling that they can claim their entitlements in case government defaults. In addition, it would facilitate advocacy. At least one respondent suggested that the process of amending the Constitution should be an opportunity to not only incorporate the right to health but also to incorporate the new global health goals and the indicators.

“If it is put in our Constitution and it’s binding, it will help. If someone is trying to go against it, you say no, our Constitution guarantees us this, why deny us” (Acting District Chairperson, Gulu district)

“The right to health should be a constitutional right so if it’s not there then that was a deliberate oversight and that’s why we’ve been failing to meet our targets. If our government puts it as a constitutional right then

it would provide the necessary infrastructure and resources to make sure that people realize it” (District Health Officer, Gulu)

“It would be very, very helpful. It would make sensitization and advocacy easier because there will be a reference. Without good health there cannot be development” (Health Facility In-charge, Nyabaani Kamwenge)

“The Constitution is among the most respected tools in the country. If it states that Ugandans have a right to health this will guide health workers and other health implementers who are duty bearers in ensuring they meet their obligations. This will even act as a catalyst to help the marginalized” (Vice chair Nyenga Subcounty, Buikwe district)

“It would be better if the health indicators are well streamlined and a complete clause talking about these indicators. This will make the right to health to become an advocacy platform that we can lobby and demand for it globally” (GWED-G, civil society, Gulu)

Some respondents were of the view that realizing the right to health will only be possible if government aggressively tackled corruption and other evils prevalent in the health system and the government bureaucracy.

3.2.2 Experiences with health laws

Respondents were asked about the existence and efficacy of health-related by-laws in their communities. Majority of respondents mentioned that they were aware of existing by-laws in their communities. They reported that the existence of by-laws had played an important role in promoting health in their communities. Participants mentioned that they were aware of by-laws that addressed protection of water sources (bore holes), cleanliness in the home (having a rack for drying utensils) and each household having a pit latrine for fecal disposal.

“Yes but they depend on each subcounty. For example, in Kanara, every person must have a kitchen, a rack to dry utensils, a pit latrine, and every one must participate in keeping the well clean and clear so that we have a safe and clean environment” (FGD, Kamwenge district)

“...yes we have them especially on sanitation and cleanliness in a home is important if the leaders find you don't have a toilet or latrine in your home or place for rubbish then you will be imprisoned or fined” (FGD, Kamwenge district)

“We have a by law that ensures children are taken to school and if the parent doesn't then the parents are arrested. It is an important by-law that ensures children are taken to school so that they get an education” (FGD, Kamwenge district)

“One of the bylaws is the Health and Sanitation bylaw which prohibits disposing rubbish in a home without cleaning it” (FGD, Kamwenge district)

“A bylaw on clearing water sources, clearing bushes around wells; we have a water source committee” (FGD, Kamwenge)

Despite the presence of these bylaws, some respondents reported that in some instances, the bylaws were not properly enforced and were politicized. Respondents mentioned instances where a member of the community defaulted on compliance and was not punished due to the fear of local politicians not being elected back into office. This, respondents argued, marred the enforcement and implementation of the existing bylaws and this undermined their effectiveness.

“The laws would be working but most leaders because of politics fear to arrest the people because of politics and since they want to be re-elected they will not do anything” (FGD, Kamwenge)

“...the laws are there but the leaders do not enforce them because of politics, they do not bother getting the people who do not have them at home” (FGD, Kamwenge)

“The number of children falling sick because of diarrhea diseases has decreased, water sources are guarded well and we are able to get clean water; the infestation of body lice has reduces because personal hygiene has improved” (FGD, Paicho, Gulu)

3.3 Health financing

Achieving UHC will call for “substantial increase” in health investments. Some approaches, such as the Abuja Declaration, have focused on a specific share of government expenditure to be devoted to health. But there is also emerging evidence that the ability to deliver UHC is associated with a state’s ability to raise direct taxation. Results presented in this section are from community representatives as well as from an analysis of secondary data from Government of Uganda documents mainly from Ministry of Health (MOH), Ministry of Finance, Planning and Economic Development (MOFPED) and the Uganda National Household Survey.

3.3.1 Government’s level of financing for health

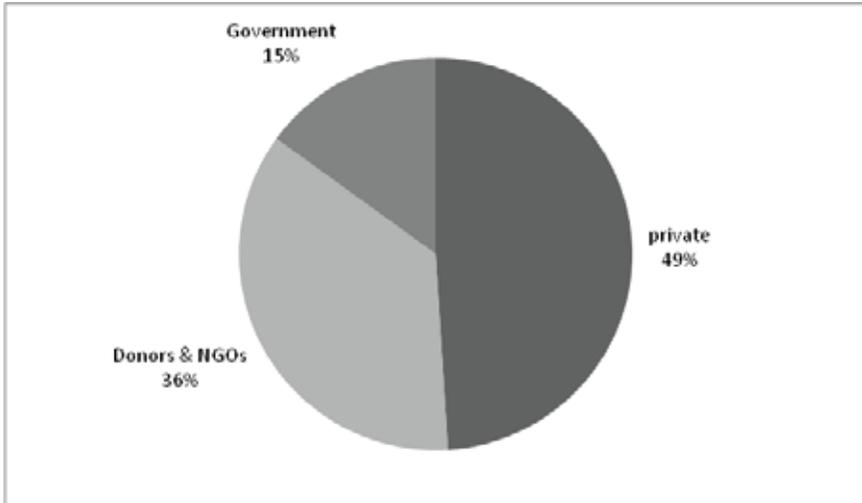
According to Uganda’s most recent National Health Accounts (NHA) survey (MOH 2013), Uganda spent UGX 3, 234 billion (\$1.59 billion) on health in FY 2009/10. This total health expenditure comes from three main sources: public/government, private, and donors/firms. The NHA estimated that in 2009/10, the public sector contributed 15% to total health expenditure, while donors and NGOs contributed 36%, and the private sources contributed 49% (Figure 1).

Households, through direct out-of-pocket payments, were the most dominant private source constituting 87% of all the private sources in 2009/10. Put differently, household contributed UGX 1,372 billion which represented 42% of total health expenditure in 2009/10. Total per capita health expenditure was \$52 in 2009/10, with public per capita health expenditure equaling to \$11.2 (which is half of the household per capita expenditure of \$22).

Government spending on health as a proportion of total national spending is indicative of how well the health sector is prioritized in any given country (McIntyre and Kutzin 2011). Currently Uganda allocates about 7.8% of its total budget to the health sector. Table 1 shows that “Road Construction” was allocated the largest share (15.2%) of the national budget in FY 2012/13 followed by education, energy and mineral development, public sector management, security and then health. The current allocation of national budget to health (7.8% in 2012/13) is very low compared

to what the government committed itself to allocating (i.e. in the Abuja Declaration where Heads of States committed themselves to 15% of total government spending). (see Table 1)

Figure 1: Sources of health expenditure in Uganda



Source: (MOH 2013)

Results from field data suggest that the majority of respondents feel that health does not receive a fair share of government expenditure considering the shambolic state of infrastructure, the critical shortage of human resources for health and frequent medicine stock-outs. They suggested that government prioritize health for its citizens and comply with international treaties to commit more resources to health.

Table 1: Percentage allocation of Government of Uganda budget (FY 2012/13)

Sectors	Billion (UGX)	Percent
Roads	1,652	15.2%
Education	1,619	14.9%
Energy and mineral development	1,483	13.6%
Public sector management	1,021	9.4%
Security	925	8.5%
Health	849	7.8%
Interest payments	840	7.7%
Accountability	591	5.4%
Justice, law and order	519	4.8%
Agriculture	379	3.5%
Water	355	3.3%
Public administration	235	2.2%
Parliament	222	2.0%
Tourism, trade and industry	72	0.7%
Social development	58	0.5%
Lands, housing and urban development	27	0.3%
Information, communication technology	16	0.1%
Total	10,862	100%

Includes recurrent, domestic development and external development

Source: (MOFPED 2013)

“No, it is too small. Because if you look at the drugs we have just received now, you find a box containing only one tin of tablets and they are calling it a carton. Today is 11th (of June); these drugs cannot not even last until the end of the month, and yet we don't expect any other supply until August. You even find a good number of essential medicines missing, meaning that people will be bound to buy. If you look at the payments to the health worker, the motivation is so low” (Health Facility In-charge, Nyabaani Health centre III, Kamwenge)

“It is not fair. I don't think the national budget is taking care of the health services in this country. The international community has set standards, that for us to achieve MDGs, that will need an increase in the budget for the health fund. And the funding for health, the 15% of the budget, Uganda has never met that target. So definitely it'll reflect the standards of service to the health services. Let's provide the funds, the human resource and the capacity to manage the funds properly. That percentage of the national budget that we need, it'll not only go for infrastructure but also human resource, we must be able to train well skilled staff who are well motivated, so that's why we are not meeting the country's goals” (District Health Officer, Gulu)

To gauge their own sense of priority, respondents were asked which sectors should receive less funding than they are currently receiving in order to free up more resources for health. Respondents suggested budget cuts for defense, agriculture, the President's office and State House. Others cited were allowances for parliamentarians and government ministers.

“We no longer have any internal wars to justify heavy spending on defense. Therefore some funds should be reduced from defense to health. We should also look at facilitating agriculture and infrastructure, this will improve health. Also, this should be a priority area for government” (Acting LC5 Chairperson, Gulu district)

“The proportion of the budget to health is not fair. Money should be reduced from other sectors, like the military and defense sectors. We have no war now so there is no insecurity; hence there shouldn’t be an increase to the defense budget when even the wars we are fighting are not ours” (GWED-G Civil Society, Gulu)

“There are three major sectors in this country which get money and you wonder what they are spending that money on. That is the security and defense department, state house, and the president’s office. The spending on administration spending and cabinet allowances should be reduced” (Hosp Admin, Kawolo hosp, Buikwe)

“It is difficult to tell which sector has enough money, but if I were to put more resources in health, I would pinch from defense... I think their budget is somewhat flexible” (District Health Officer, Gulu)

3.3.2 Costing UHC in Uganda

We use the UNMHCP as a benchmark for assessing financing requirements for UHC. The national health financing strategy for FY 2001/02-2012/13 estimated that Uganda needed US\$28 per capita, excluding pentavalent vaccines, to deliver a basic package of health services (MOH 2008); and the revised costing of the minimum service standards conducted during the second health sector strategic plan (HSSP II) estimated the needed per capita expenditure of \$41.2 in 2008/09 raising to \$47.9 in 2011/12⁸ (MOH 2010).

The resource needs estimated for the delivery of UNMHCP in the current health sector strategic and investment plan (HSSIP) are estimated at US\$51 per capita (2004/05), assuming full staffing and salary improvement.

8 The difference in the estimates for delivery of services in the health financing strategy and the revised estimate of delivering the minimum service standard could be explained by differences in what was included in the package of services.

Respondents in the field survey were asked to suggest priorities for funding in the health sector if it were to receive more funding. The suggestion ranged from recruitment and remuneration of health workers, infrastructural development including staff accommodation, equipment and supplies. Also cited were health promotion and patient follow-up, specialized services and emergency preparedness of the health system. Respondents also suggested that the government does more to follow-up on its health programs to ensure they reach the people in most need of the health services.

“The major issues affecting health care apart from supplies is the poor conditions in which the health workers do their work. Instead of forcing people to be patriotic, let them be remunerated and they will love their jobs and country automatically” (Vice chairperson, Nyenga Subcounty, Buikwe district)

“...the number of doctors to patients is below the standard ratio, government should recruit more medical workers and give them fair treatment, like a police officer in Uganda is supposed to handle 505 but at the moment it's 705, it made the government carry out recruitment. Therefore in order to promote the right to health, the government has to recruit more” (Local Government Chairperson, Gulu district)

“When plans and programs are made, there should be effective follow-up and close monitoring to ensure that what government has committed to do is actually done” (Health Facility In-charge, Nyabaani, Kamwenge)

3.3.3 Government's ability to finance healthcare

Some approaches, such as the Abuja Declaration, have focused on a specific share of government expenditure to be devoted to health to improve health financing. But there is also emerging evidence that the ability to deliver universal health care is associated with a state's ability to raise direct tax revenue and the level of national income. Accordingly, this also analyzed government financing as a proportion of GDP and tax revenue.

GDP is the market value of all goods and services produced within a given country by the various sectors in a given period. A country's GDP is representative of the size of the economy in terms of activities taking place and could also be indicative of the resources available within the country to invest in various sectors. Linking such an indicator to health care expenditure indicates the ability of the country to pay for health care through domestic resources. Uganda's recent NHA survey puts the proportion of health expenditure to GDP at 9% in 2009/10.⁹

Increasing resources for the health sector through government tax needs to be cognizant of the need to maintain fairness of contribution to health care financing. The evidence from Uganda (HealthNet Consult 2012) with regard to progressivity of tax is in agreement with that reported for low income countries in a similar setting such as Tanzania, Ghana, Zambia and Kenya (Mills, Ataguba et al. 2012), which has shown that taxes are progressive and that countries could increase their fiscal space for health by increasing the tax base or improving revenue collection without necessarily putting the burden on the poor. (see Table 2)

Respondents participating in the field survey were asked whether they thought government was able to cover all health care expenses and still be able to provide quality services. Some respondents felt that government would not be able to provide all health care services and that the most sustainable approach is cost sharing. There was a feeling that citizens had a responsibility to prevent disease to minimize the need for costly treatment.

⁹ Projections for 2012 by World Bank estimate health care expenditure as a proportion of GDP to be at 8%

“People should put in their own effort in order to be given a quality service.... They can cater for a few things because we provide them with free treatment. If there is a stock out they should be prepared to buy it (DHO, Buikwe)

Table 2: Comparison of revenue for selected countries in Sub Saharan Africa

Country	Revenue (US\$ billion)	Taxes & other revenues as %GDP
Ghana	9.28	23.8%
Kenya	7.42	18.0%
Ethiopia	6.39	15.2%
Tanzania	5.57	19.7%
Botswana	5.51	31.3%
DRC	5.01	28.3%
Mozambique	4.32	29.6%
Zambia	4.26	20.7%
Uganda	3.10	14.8%
Rwanda	1.67	23.1%
Malawi	1.03	24.5%
Burundi	0.77	31.0%

Source: <http://www.indexmundi.com/>

“I think sometimes the government gets over whelmed. I think it should look for which areas it can render support in and request patients too to pay something to improve the health System. This can be in terms of patient examination, laboratory services, and primary health care” (Vice chairperson, Nyenga Sub County, Buikwe district)

“Offering free services is not possible because the government cannot fund health for its entire population; therefore there is unavailability of equipment, medicines and medical workers. Partial payment will empower us to speak with authority to health workers to give us proper care and treatment” (FGD, Paicho, Gulu)

Some participants also mentioned that they felt it was not possible to be able to access all services at public health centers.

“Usually when we receive drugs and medical supplies, we are overwhelmed by numbers and definitely supplies cannot be enough. If there was cost sharing or a contribution from health consumers of any kind, some of these simple things would not be a problem. Small things like syringes and needles, gloves are small but crucial and if I don't have any of them I will not be able to attend to a patient appropriately” (Health Facility In-charge, Nyabaani HC, Kamwenge)

3.4 Out-of-pocket health spending

3.4.1 Per capita government health expenditure (excluding donor project support)

Government per capita spending on health in both nominal and real terms declined between 2001-06 and then rose between 2007/08-2008/09. However, from 2008/09, it fell in real terms and in FY 2012/13 it was at a lower level than it was in FY 2001/02.

A comparison of the resources needed to provide the UNMHCP and the per capita public expenditure (showing available resource envelop) in the first three years of the HSSIP shows that per capita public health expenditure was below what is needed to deliver the package over this period. Between 2010/11–2012/13, per capita public financing was about one quarter of what was needed to provide the minimum health care package irrespective of the scenario considered. The financing gap varies from \$25.15 per capita to \$38.99 per capita.

Table 4: Comparison of per capita cost of UNMHCP and per capita health expenditure

	2010/11	2011/12	2012/13
Scenario 1: Per capita cost (USD)	39.19	47.17	47.99
Scenario 2: Per capita cost (USD)	34.55	41.9	42.6
Per capita public expenditure	9.4	10.29	9.0
Financing gap			
Scenario 1: Per capita cost (USD)	29.79	36.88	38.99
Scenario 2: Per capita cost (USD)	25.15	31.61	33.6

Source: (MOH 2010)

This means that with the current health financing arrangement and given the trend in growth in public expenditure as shown in the previous section, it is unrealistic to expect Uganda to close the health care financing gap and achieve UHC in the near future using tax revenue alone.

3.4.2 Experiences with catastrophic health spending

Health expenditure is considered catastrophic when it causes a distortionary effect on household consumption patterns, especially when it negatively affects the consumption of other household basic needs such as food, education and shelter. Earlier empirical analysis has shown that household consumption expenditure above 5% will affect the elasticity of demand for the other household commodities (Gertler and Gaag 1990).

This affects the household's effective demand for other household commodities and is thus detrimental to the consumption of other household basic needs. The catastrophic health payments methodology is based on comparing health care expenditure with a predetermined threshold of household living standard (Wagstaff and Doorslaer 2003).

The thresholds that have been used to define catastrophic expenditure have been between 5%-20%. It is important to note that such thresholds and choice of the exact thresholds to use in defining catastrophic health expenditure is arbitrary. And given that thresholds of catastrophic expenditure are arbitrary, fixing a threshold at which one can define catastrophic health payments would be based on the moral argument that a predetermined percentage of the population need not face catastrophic health payments.

To determine what level of household health expenditure would be considered catastrophic, for households in Uganda we generate the mean household consumption expenditure per quintile as a representative of level of income within each quintile. Based on the thresholds that have been widely applied elsewhere in analysis of household catastrophic health expenditure, we apply this percentage to the monthly mean household consumption per quintile of socio-economic status to determine the level of household health expenditure that can be considered catastrophic for households in Uganda within each quintile.

Table 5: Household catastrophic health expenditures at different thresholds (5%, 10%, 15%, 20%)

Household consumption (UGX)	Quintile 1 (Poorest)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (Richest)	Total
Average household consumption expenditure (monthly)*	18,753	31,819	43,439	62,452	172,811	73,090
Average household out-of-pocket expenditure (monthly)*	783	1,761	2,586	4,052	10,797	4,449
5% of household consumption	938	1,591	2,172	3,123	8,641	3,655
% households exceeding threshold	32.9%	36.5%	41.4%	42.8%	39.5%	38.2%
10% household consumption	1,875	3,182	4,344	6,245	17,281	7,309
% households exceeding threshold	16.9%	19.9%	22.1%	24.4%	25.9%	21.9%
15% household consumption	2,813	4,773	6,516	9,368	25,922	10,963
% households exceeding threshold	9.8%	12.0%	13.3%	15.2%	18.2%	13.7%
20% household consumption	3,751	6,364	8,688	12,490	34,562	14,618
% households exceeding threshold	5.7%	7.5%	8.0%	8.9%	12.4%	8.5%

Source: Authors based on UNHS 2009/10; Computation for catastrophic payments done with ADePT and STATA 11.0. *Average household consumption expenditure and out-of-pocket payments are adjusted for household size

Table 5 shows that *average monthly household consumption expenditure* varies from UGX 18,753 for the households in the poorest quintile to UGX 172,811 in the richest quintile (households in the richest quintile consume more than 9 times what is consumed by households in the poorest quintile); with the average monthly household consumption expenditure for all households estimated at UGX 73,090. Average household *out-of-pocket expenditures on health* also follow a similar pattern with the richest households incurring relatively higher payments than the poorest households with an average *monthly household out-of-pocket expenditure* (for all households) being estimated at UGX 4,449.

The average amounts that have to be exceeded by the households for their out-of-pocket expenditures to be considered catastrophic vary by quintile and also depend on threshold considered. At the 10% threshold, monthly out-of-pocket expenditure above UGX 1,875 would be catastrophic among the poorest households, while for the richest households, such expenditure would have to be above UGX 17,281 to be considered catastrophic at the 10% threshold. On average, expenditure above UGX 7,309 would be catastrophic threshold at 10% for all households. When one considers the 10% threshold, 21.9% of Ugandan households exceeded this threshold in 2009/10.

To determine what level of household expenditure can be catastrophic in Uganda, one needs to put into consideration Uganda's level of poverty (24.5% of all Ugandans are below the poverty line which means they spend less than an average UGX 29,306¹⁰ per month) and the country's GDP per capita of \$547 (est. 2012). This means that out-of-pocket expenditure of as low as 5% of total household expenditure has adverse effects on household's consumption for many households. Given that poorer households have a much lower ability to pay, any expenditure they incur is catastrophic.

We asked respondents in the field survey about the expenses they incur in accessing healthcare in the public sector. A majority of respondents cited transport, stationery medicines (from private drug shops), gloves, razor blades, polythene sheets, etc. Respondents noted the limited range of

10 Uganda's poverty line varies depending on region and location. The figure shown (UGX 29,306) is the average poverty line per month. Any person whose expenditure is below the poverty line is classified as poor.

services available at government health facilities. Stock-outs of medicines in public health facilities was a major concern, as was long distances to health facilities, particularly referral facilities.

Accessing care for chronic illnesses was singled out as being so expensive that some households had to sell family assets in order to pay for treatments. Participants reported instances where they had to spend most or all of their savings on accessing health care. This included selling off assets like pieces of land, cattle and other items they considered valuable, leaving them more impoverished.

“Services at lower health centers are limited. There are some services that we do not handle even at Health Center IV, which is at referral level. For instance cancer cases have to be referred to higher facilities.”
(Medical Officer, Gulu District)

Similarly, health procedures like surgeries were also not free of charge and many referral health facilities are not adequately equipped to carry out such procedures. Respondents reported that in such instances, a patient is referred to higher level facilities where they can only access such services at a cost.

“...people are not actually paying for the services – apart from maybe the health center IV, where like the supplies may not be enough and a mother might need a caesarian procedure and she is asked to buy gloves, razor blades and fuel for an electric generator” (Baylor, Uganda)

“Speaking as an administrator I will tell you what we encounter in this facility. Government does not supply all the requirements – medicines, equipment, health workers and other relevant supplies. Sometimes patients are asked to pay some money to fuel the ambulance; some equipment like scan and x-ray machines are non-functional... At times patients are requested to seek services from the private wing” (Hospital Administrator, Buikwe district)

Most of the respondents reported that main services received at these health centers were largely consultative as medicine stock-outs were frequent, with patients being given prescriptions for which they would have to

purchase drugs from private pharmacies and drug shops. Participants also reported that when drugs were delivered at health centers, the stocks run out pretty quickly.

“They do this (give prescriptions) when the drugs have run out because it takes long to provide more drugs from the central Government. But at times the drugs run out and the health workers send them (patients) to clinics to buy the drugs” (LCIII Nyabaani, Kamwenge)

“I had to buy cotton wool, razor blades, a polythene sheet for my wife when she was due for delivery... Sometimes you are asked to buy syringes and medicine. All the doctor does is prescribe medicine” (FGD, Gulu)

“Some health facilities can only afford to carry out examines for patients and prescribe drugs to be bought in private health facilities (FGD, Buikwe, Nyenga Subcounty)

“Public health facilities offer free health care services but the problem is poor quality services which has forced people in the community to go to traditional healers where they actually even pay” (Vice chairperson, Nyenga Subcounty, Buikwe)

Participants also mentioned instances of where people in their communities were unable to meet medical bills.

“Survivors of war, with bullets (in their bodies), and major amputees need care as replacing body parts is very expensive. Most of these people can't afford such bills. One lady who had to be operated to recover her hip cost a donor organization 9.5 million shillings. You find that if it was not for a donor that person couldn't have recovered. Many people have remained with bullets and cannot afford surgery” (Civil Society leader Gulu district)

“Yes, they are quite many. Like there was someone who came requesting me to give them a letter to move around requesting for money close to 4 million (shillings) because they had a heart problem, so on humanitarian grounds, I wrote the letter” (LC V Chairperson, Gulu district)

Respondents were asked to suggest ways in which the new development agenda could shield poor people from being impoverished by catastrophic health bills. Respondents suggested different mechanisms that could be put in place to ensure that health problems do not impoverish people. Majority of the respondents suggested that emphasis should be placed on preventive measures.

“Emphasis must be put to preventive measures such that the rate at which people visit health facilities is limited. They should also emphasize and elaborate on implementation procedures and guidelines to promote working conditions in public health facilities. This should be complement with procedures on how to monitor health activities and nutritional behaviors” (Vice Chairperson, Nyenga Subcounty Buikwe district)

“The best way is to get health centers close to them. If everyone can get a facility within a radius of 3-4km, accessibility can be greatly improved” (Health Facility In-charge, Nyabaani Health Centre III, Kamwenge)

Case of poor healthcare access for disadvantaged population groups

An elderly disabled woman died alone at home. She lived alone and could only get support from well-wishers along the road who could help push her in her wheel chair. However, on the fateful day, she was not strong enough to leave home and by the time the members of the community realized she had had not been seen in a while, it was too late, she was found dead. (Interview with Civil Society Organization, Gulu district)

<i>Table 1 : Examples of out of pocket expenditures incurred by patients seeking care at public health facilities</i>	
OUT OF POCKET EXPENDITURE	ILLUSTRATIVE QUOTES FROM TRANSCRIPTS
Gulu	<i>“I have three children in my family, they suffered flu and fever last Month, and I spent on buying full coartem and cough flu syrups which cost me about Ushs 50,000 this was because the health facility could not provide me the medicines” Gulu FGD</i>
Baikwe	<i>“Our neighbor was forced to sell off his only asset which was a cow when two of their children were attacked by dysentery” (FGD, Nyenga Subcounty)</i>
	<i>“Our child was born with a disability and this has cost us the time to go in the garden as most of the time which concentrate on the child’s health. We are afraid that even those at school will be affected in terms of school fees as most of the money has gone to curing our baby” (FGD, Nyenga Subcounty)</i>
Kamwenge	<i>“My Child was Sick and I took him to ibanda then I transferred him to Mbarara because they had no blood and no medication. My friends lent me money so I paid and later used my goats to pay them and I remained poor (FGD, Kamwenge)</i>
	<i>“Like 3 months ago or two months ago a mother was referred to Ntara health center. And a—the doctors were there but they were drawn out of gloves and things to do with gloves; so they had to send this mother they had to refer again this mother that they couldn’t work on that mother so they had to refer this mother again to Ibanda which was a distance and were looking and if we can imagine it was an emergency for them but somehow they could not work on her without the gloves”</i>
	<i>There are many... for example, there is someone who can be having TB but he is unable to get to the center where TB diagnosis and treatment is done. TB diagnosis and treatment is done at Health Center III at least, and some people are far away from such centers and sometimes the relatives are also not able to help. Such cases are very common (Nyabaani subcounty, health centre III)</i>

Case of out of pocket expenditure – Kamwenge district

Access to health facilities in some rural communities has led to high mortality rates due to costs of transportation to the nearest health facility. In Kamwenge district, Western Uganda, what usually happens is that a person eventually ends up dying because there are many people out there in the community who cannot afford transport to health centers. The few that are able to access health services are those that can afford to walk or to pay transport to a nearby health facility like this one here (Nyabaani Health Centre III). There is a place called Kekubo, in Kanara subcounty; it is near Queen Elizabeth National Park. It is approximately more than 15km from here. Even if one woke up very early, they cannot be here earlier than 11 o'clock and the problem is it separated from this side by River Mpanga, so they have to meander around to get here. It is not easy for people from there to get here therefore many will go untreated and may die. (Interview with Health Facility In-charge, Nyabani Health Centre III, Kamwenge district)

3.4.3 Contribution of donor countries to health financing

It has been noted that donors and NGOs contribute an estimated 36% to Uganda's total spending on health. Respondents were asked about their perception towards minimum donor support to the health of people in poor countries. Majority of the respondents suggested that it would be really helpful if donor countries would commit a minimum level of support to low income countries.

“We can just tell them where to support us from and the sectors that need more money like maternal health and persons with disabilities. Everything that has been said is to benefit everyone and where things are not moving on well, there should be assistance from international organizations that have better health systems than ours. I think we can improve especially when we rhyme our interests with theirs and make it specific for us” (LC V Chairperson, Gulu district)

“We can advocate for that, we can even advocate for them come and run our health system or our government for that matter. You see, providing resources is one thing, managing the resource is another. If the resources come and we squander them, even if they are committed, we should be committed as a government to use whatever we have optimally, we should not squander our own resources then ask others to come and assist us. But first of all we must do what we are supposed to do otherwise no.” (District Health Officer, Gulu)

Other respondents were not supportive of a minimum support from donors suggesting that sometimes there were unforeseen events like disasters which would not be easily planned for and the minimum support would not cover such eventualities.

“No, I don’t support that suggestion. They should not put a limit because different countries have different needs, and those needs by reduce or increase, for instance during a disaster” (Health Facility In-charge, Nyabaani Health Centre III, Kamwenge district)

“Sometimes we are not left with a choice as we are just beggars. However, emphasis should be put on allowing the donor community to start following up the projects they set up in our country” (Vice chairperson, Nyenga Subcounty, Buikwe district)

“It is good to advocate for more support form developed countries to support the poorly facilitated indicators in Africa especially in health. This however calls for vibrant leaders who can speak out the inconsistencies in development in all sectors other than those of who talk about what they have done yet the quality of service rendered is poor” (GWED-G, Civil Society, Gulu).

3.4.4 Fair level of contribution to health

Community perceptions about the extent to which government should finance health care were more inclined towards free services. Respondents were asked about what their perceptions on a fair level of expenditure on healthcare. Responses were mixed with most respondents stating that it was difficult to agree on a fair level of expenditure because people had different levels of income. Participants reported that although a small amount may be suggested, there were vulnerable sections of the population who were unable to afford this. Others were of the view that due to different earning capacities and levels of income, it would be difficult to come up with a standard acceptable amount that people could be able to afford to access health services as one respondent suggests below:

“It is wrong to require people to contribute a particular amount of money because we all have different levels of earning. One person can cry for a million shillings while another will cry to just get one thousand shillings. The amount of tax we pay should be enough to cater for these services” (FGD, Kiboga)

“About one million shillings per year that would be minimal for me and people at my level” (LCIII Nyabbani Subcounty, Kamwenge district)

“Most of the people who come here are very, very poor. There are those who cannot even afford an exercise book. But a few can afford to make a small contribution. An average person can contribute at least Ushs5,000 in a month” (Health Facility Incharge, Nyabaani Health Centre III, Kamwenge)

“We need more money for mother and child health, particularly safe motherhood. That is an area where we continue to lose mothers unnecessarily. We need enough antenatal and delivery kits for mothers. We need more money for medicines and better motivation for health workers” (Health Facility In-charge, Nyabbani, Kamwenge)

3.5 National public health strategy and plan of action

3.5.1 The Uganda Minimum Health Care Package

Uganda’s first national minimum health care package (UNMHCP) was developed in 1999 and its implementation started in 2000 within the period when Uganda’s first health sector strategic plan was also implemented.

Respondents were asked about their knowledge of what was included in UNMHCP. Majority of participants were not confident of the composition in the package but were able to mention some aspects of primary health care they knew were part of the package for example Maternal and Child health. Knowledge of the total composition of UNMHCP was limited. Most participants alluded to it but could not specifically identify the clusters contained therein.

“Here in Gulu, Maternal and Child Health is least accessed, Nutrition is completely inaccessible, and when we are handling new born babies, there is always need to provide nutritional supplements for people living with HIV/AIDS” (Civil Society, Gulu district)

Participants were also asked about the universality of the UMHCP, majority of respondents felt that with adequate funds, the package could be universal but at the moment some vulnerable population groups in hard to reach areas could not access it and this was more specific for persons with disability however respondents mentioned that the Village Health Team Structures had allowed for some progress in enabling some vulnerable groups to seek and receive some health services.

“When you are to look at the most problems we have in our hospitals, it’s about mothers dying in health facilities because of poor services and care, I think if we improved that, then we would reduce the numbers of women who die giving birth in our facilities” (LC V Chairperson)

Interviews with local government officials revealed that the minimum health package provided by the government was insufficient and not within reach of the most disadvantaged populations who most need it

3.5.2 Relevance of the Uganda National Health Care Package

Participants who had some knowledge of the UNMHCP stated that it was a good package and they would not exclude anything but could add components to address other disease conditions and important components in the health care system that they felt were not adequately addressed by the current package.

Participants talked of emerging infections which were affecting a large proportion of the population. Nodding disease in the northern region was mentioned as requiring special attention. Similarly, participants reported that they felt non communicable diseases (NCDs) had not been given due attention in spite of their increasing prevalence. Participants reported that medicines for the NCDs were not readily available in health facilities.

Some participants felt that the minimum health package was comprehensive enough and did not require any adjustments made to it as one respondent suggests in the quote below:

“There is nothing to add according to me. Services that should not be part are those that have been caused by people themselves out of carelessness like treatment after aborting, that is very bad, people need to know that killing is bad so those who do it do not need medical treatment. Also people injured from accidents from reckless driving, smoking, taking alcohol, and other things that come from someone’s lifestyle” (LC 5 Chairperson, Gulu district)

However, others suggested that some services like injuries from accidents be included in light of the increased occurrence of road accidents. Similarly, some respondents also suggested that special attention be paid to victims of war who had enduring health problems that were a result of the 20 year war in Northern Uganda. It was mentioned that so many gunshot victims remained untreated.

“Injuries should be included because accidents are common. But abortion is illegal so we don’t need to have services for post abortion complications, unless they legalize abortion” (Health facility In-charge, Health Centre III, Nyabaani, Kamwenge district)

“If it has the promotive, preventive and the curative maybe we can only ad palliative care. If we are talking of the right to health, all the services are important” (DHO, Buikwe district)

“Training of health workers” (LCIII, Nyabaani Sub County Kamwenge district)

“...of course the main one of mother and child health. Another one is nutrition; i.e. how people are supposed to feed and the rest... Of course we need to cater for the general health of communities like HIV, TB prevention and other neglected diseases such as hypertension, diabetes mellitus, elephantiasis and general treatment like treatment of worms. You know people have a lot of worms but they don’t know” (Health facility In-charge, Nyabaani Health Centre, Kamwenge)

3.6 Community participation and accountability

3.6.1 Experiences with community participation

When asked about their understanding of community participation and how they had actively participated, respondents reported that they often participated in government programs like immunization, sanitation and sometimes local leaders by attending meetings and participating in service uptake. However they noted that their participation was often dictated “from above” through forced service uptake.

“We do not participate because even activities of VHTs (village health teams) were not as a result of participation. they were just sent “from above” (FGD, Buikwe)

“The decisions and programs come “from above”, however the sub-county secretary called on village members to participate in choosing who would be a VHT in their area (FGD, Buikwe)

“I do not know but community participation is only at LC I level not at LC III level” (LCIII Nyabaani Sub County, Kamwenge district)

“Actually the community has been left out. Because if they are to be involved most of these cases that we receive at the health facility would not occur. That is why we see that people are given mosquito nets for control of malaria and they instead sell them off. It is because someone sat somewhere are decided that what these people need are nets, without even asking them. When people do not participate in making decisions, they will never appreciate the value of an intervention and they may never own it” (Health Facility Incharge, Nyabaani HC III, Kamwenge)

“The community leaders and the elected leaders... because first of all, planning is supposed to be bottom-top, but these days it is top-bottom; whatever is decided from the top is brought down and imposed on the people”(Health facility Incharge, Nyabaani HCIII, Kamwenge)

“Village health teams (VHTs) and Health management teams at lower levels. Politicians should be excluded in such processes. The IGGs office should be involved by having a representative at the lower communities. On the international level, institutions like UNICEF, WHO, and Red Cross” (Vice chairperson, Nyenga Sub county, Buikwe district)

Participants mentioned some small efforts by lower level government structures trying to engage them in dialogue however were unable to follow-up whether their grievances or issues had been addressed at the higher level. The community perceptions were that access to health services did not improve year in year out and in many instances any attempts by local government structures and local politicians engaging the community was often motivated by political aspirations especially in an election year.

Participants were asked about their engagement in decision making and planning for their health. Although responses given are mixed, predominant voices suggest limited community participation.

Participants cited several examples of ways in which their communities had been engaged in planning and budgeting for their health. However they note the approaches have been more of top-down approaches than bottom-up.

“At the district, most times when they send money for sensitization, they don't even bother to come yet ideally, they should be engaging with people, at the moment, information only flows from the district to the community but not the other way round” (FGD, Najja Subcounty, Buikwe district)

“There is limited engagement, if at all as government just implements and yet those implementations are sometimes irrelevant. We are not consulted on what can benefit us before establishing a project” (FGD, Nyenga, Buikwe)

“You look at the quality of services being delivered and if it reflects community needs then you know the community is contributing. Communities participate when their voice is being heard for example when people complained about the road from Kamdini to Gulu and it was constructed, in such instances, we see community participation” (LC V Chairperson, Gulu district)

“Right now in Gulu, we use the community in mobilization, participation in health programs like keeping the home clean, telling them the types of food people need to plant, water, plant trees, mobilization, family planning, all that is community participation.” (District Health Officer, Gulu district)

3.6.2 Monitoring Community Participation

Majority of respondents suggested that community participation could be effectively monitored by external agencies that had no political affiliation and would provide a sense of neutrality in monitoring and ensuring there is accountability.

“The local leaders are supposed to carry out follow ups and monitor activities but due to lack of facilitation they are not motivated, this is hindering development and hence, community participation cannot be realized. Many issues raised by the community are kept locked at the sub county office”(FGD, Paicho Gulu)

“By holding Community dialogue to get feedback from community members on the same. Nongovernmental organizations like CEHURD, international NGOs, Ministry of health and world health organization” (Hospital Administrator, Kawolo hospital, Buikwe district)

“Ideally, the community would be best-placed to monitor... they can tell if they are satisfied with services, empowerment, they know their rights, they demand for services, etc. I don't think another government arm should monitor. WHO should monitor community participation; it should be able to monitor without any bias at international level.” (District Health Officer, Gulu)

Interviews with government officials had contrasting views about who was better placed to monitor community participation suggesting that local government structures at the lower level could be utilized in monitoring for example; Village Health Teams and Health Assistants.

“Village health teams (VHTs) and Health management teams at lower levels. Politicians should be excluded in such processes. The IGGs office should be involved by having a representative at the lower communities. On the international level, institutions like UNICEF, WHO, and RED CROSS” (KII, Vice Chairperson, Nyenga Subcounty, Buikwe District)

“All the planning of the country is done at national level, therefore the best institution would be the National Planning Authority because it harmonizes all the country’s planning” (LC V Chairperson, Gulu District)

“At international level, I think it would be World Health Organization (WHO), their focus is on global health concerns, it makes it the right organization to monitor health concerns at global level” (LC V Chairperson Gulu District)

“These may include, cultural and religious institutions, Civil Society, the special rapporteur for the right to health, UNICEF and UNFPA, AMNESTY and the Human rights Watch” (GWED-G, Civil Society Gulu)

“At the community level, the Church, and community leaders at the village and parish levels, and then at the sub county level could monitor community participation. At the national level, I think this should be the Ministry of Health, because it supersizes the implementation of the national health policy. At the international level, it definitely has to be World health Organization because it oversees all health systems in the world and it connects health systems of different countries” (Health Facility In charge, Nyabaani HCIII, Kamwenge)

4. CONCLUSION AND RECOMMENDATIONS

4.1 Conclusion

Realizing the right to health for everyone will be a challenging undertaking. However, if states and the international community can “ensure healthy lives and promote well-being for all at all ages” by 2030 it will be a major step. A human rights-based approach to health is essential. The right of everyone to enjoy the highest attainable standard of physical and mental health is recognized in numerous global, regional and national treaties and instruments. It underpins action and provides part of the rationale for including health in the post-2015 development agenda.

However, as a precursor to achieving a more sustainable and obtainable goal, commitment from key stakeholders including governments of low- and middle-income countries as well as those of high income (developed countries) will be key in creating in recognizing that health must and should be recognized as a right in and of itself as well as being linked to other development sectors which impact on health for example, poverty and sustainable development.

The findings from community consultations with communities from different regions of the country revealed a hope that governments would not only commit more resources but also enact laws that would ensure the right to health of Ugandan Citizens especially the most vulnerable ones who live in hard to reach areas are unable to access health care services like their urban counterparts.

4.2 Recommendations

- 1) The right to health integrates all major components of health. Whatever the health goal is, or however it is stated or pursued, the end result should contribute to the realization of the right to health.
- 2) Budgetary allocations and funding for health should be prioritized in order to achieve UHC. There is need to improve capacity and functionality of existing health facilities through refurbishing, staffing and provision of adequate essential medicines and other health supplies. Similarly there is need to take care of vulnerable members of the communities like people with disabilities and those with limited proximity to health facilities.
- 3) There is an urgent need to enact a right to health law which will be binding and ensure that the government follows through with its promises to Ugandan citizens in ensuring that every Ugandan has a right to health regardless of their socioeconomic status.
- 4) It will be important for the new sustainable goals to address the need for effective monitoring of community participation in health issues that affect. There is need for governments to put in place for effective mechanisms to ensure local communities are involved in not only implementation of health programs but also planning and budgeting process to ensure their voices are heard.

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