# Knowledge for action on equity in health in Uganda
# Abstract Book

## National Meeting

**March 27-28, 2008**

**Uganda, Kampala at Hotel Africana**

**Makerere University, School of Public Health**

**and**

**HEPS Uganda – Coalition for Health Promotion and Social Development**

**in co-operation with**

**Regional Network for Equity in Health in east and Southern Africa (EQUINET)**

With support from:
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# Knowledge for action on equity in health in Uganda

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# Knowledge for action on equity in health in Uganda

## Background

Over the past fourteen years considerable effort has been made to restore the functional capacity of the health sector, reactivate disease control programmes and re-orient services to Primary Health Care in Uganda. According to the Ministry of health (2007) there still remain significant challenges in matching need and demands for health services with available resources, making equity or fairness an important issue for advancing national policies for the population as a whole (http://www.health.go.ug/policies.htm) Measures to improve equity in access, like abolition of user fees and investment in primary care and district level services have been a specific and successful response to this challenge. Ensuring that the resources for health fairly reach those with greatest need and that all have fair opportunities for health is not a matter for the Ministry of Health alone, but for all sectors whose activities affect health, and for all sections of society. As a part of this there is a body of work taking place in Uganda in government, academic and civil society institutions to explore, understand and propose options for reducing inequalities in health in Uganda.

## Aims of the meeting

The objective of the meeting is to assess the progress of equity in health in Uganda. We will review gaps and needs in the Ugandan health sector, to feed into and draw from experience in East and Southern Africa. We will develop ways in which networking between people and institutions working in areas relevant to health equity can be strengthened in Uganda to support such work, and widen links with the regional network for equity in health in Uganda. This will involve drawing in people and organisations doing good work on health equity, and making connections with those not yet linked to EQUINET, so it widens networking in Uganda and the potential for support from the regional network. The meeting will discuss options for strengthening communication at country level across those working in equity in health and areas for future research and practice.

## Meeting structure

The meeting involves presentation and discussion of papers of work going on in Uganda around equity in health in key theme areas on health equity identified as a focus in regional and national processes:

- Progress and challenges to health equity in Uganda
- Wider challenges to equitable health systems
- Building equitable health systems: Fair financing for health
- Building people centred health systems
- Equity networking in Uganda
- Regional resources for equity in health

## Regional work on equity in health

The Regional Network for Equity in Health in east and southern Africa (EQUINET) promotes policies for equity in health and supports research, training, analysis and dialogue to strengthen knowledge and to support policy engagement on the implementation of comprehensive, universal, national health systems in the region, centred on the role of the people and of the public sector. (See www.equinetafrica.org). Since 1998 EQUINET has been involved in research, publication, information exchange and dialogue to promote equity in health in southern Africa, expanding to east Africa in 2003.

In 2007, the institutions in EQUINET produced an analysis in east and southern Africa of equity in health in a book, *Reclaiming the Resources for Health*. This analysis provides evidence of three ways in which "reclaiming" the resources for health can improve health equity:

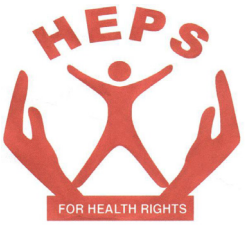
- for poor people to claim a fairer share of national resources to improve their health;
- for a more just return for ESA countries from the global economy to increase the resources for health; and
- for a larger share of global and national resources to be invested in redistributive health systems to overcome the impoverishing effects of ill health.

Drawing on diverse evidence and experience from the region, the analysis describes the comprehensive, primary health care oriented, people-centred and publicly-led health systems that have been found to improve health, particularly for the most disadvantaged people with greatest health needs.

The analysis identified key areas of importance in acting on health equity:

- Ensuring health promoting growth and trade: ensuring that measures for economic growth and trade protect health, reduce poverty and improve human development.
- Building and ensuring access to people centred health systems: that is building comprehensive, primary health care oriented, people-centred and publicly led health systems that have been found to improve health, and ensuring access to these services by the most disadvantaged people with greatest health needs.
- Increasing public financing for health and fair distribution of health resources: Meeting commitment made in Abuja to 15% of government spending on health, excluding external financing and "Abuja PLUS" – international delivery on debt cancellation and a significantly greater share of this government spending to be allocated to district health systems. At the same time reducing out of pocket spending by reducing user fees, and ensuring that government resources are allocated equitably to services with highest impact on health and highest areas of health need.
- Valuing and retaining health workers, by training, retaining and ensuring effective and motivated work of health workers, oriented to support communities acting on health
- Organising people's power for health, working with health systems to empower people, stimulate social action for health and create powerful constituencies to advance public interests in health.

These areas identified across the region as key for equity also have relevance to Uganda. Inequalities in health exist in Uganda between rich and poor communities, urban and rural districts, between social groups and across other social differentials. Uganda has implemented strategies for addressing these inequalities, within and beyond the health sector. This raises the questions what economic, social and health policies and programmes have successfully closed these inequalities in health? What challenges remain for policy and practice to improve equity in health? A dialogue and exchange across those working in health in Uganda provides an opportunity to exchange evidence, strengthen networking within Uganda, and feed experience into regional networking. Towards this HEPS and Makerere are hosting with EQUINET this national meeting of interested individuals and institutions to share and exchange the work taking place, identify lessons learned and gaps for future research and action.




## National Conference on Equity in Health in Uganda

# "Knowledge for action on equity in health in Uganda"

HEPS Uganda – Coalition for Health Promotion and Social Development, School of Public Health Makerere University with

Regional Network on Equity in Health in East and Southern Africa (EQUINET).

## March 27 – 28, 2008

## Kampala, Uganda

## PROGRAMME

### March 27 2008

| Time | Topic | Presenter |
|---|---|---|
| 8:00 – 8:30 | Registration | HEPS-Uganda |
| **OPENING PLENARY** | | |
| 8:30 – 9:00 | Welcome and Introductions | |
| | Opening Remarks | Rev. Canon John Kateeba Chairperson HEPS – Uganda |
| | Official opening | Dr. David M. Serwadda Dean School of Public Health, Makerere University |
| **PLENARY 1: Progress and challenges to health equity in Uganda** | | |
| | Chair: Dr. Chris Orach, Makerere University School of Public Health | |
| 9:00 – 9:15 | Changes In Utilisation of Health Services Among Poor and Rural Residents In Uganda | Dr. George Pariyo, Makerere University School of Public Health |
| 9:15 – 9:30 | Accessibility and Utilisation of Health Services for the Poor and Vulnerable in Uganda: A Systematic Review of Available Evidence | Dr. Suzanne Kiwanuka, Makerere University School of Public Health |
| 9:30 – 9:45 | Missing the Target: Challenges of ART Delivery and Accessibility in Uganda | Richard Hasunira, International Treatment Preparedness Coalition, HEPS Uganda |
| 9:45 – 10:00 | Progress and Challenges to Health Equity for Older Persons in Uganda | Kituku Cris Mpweire, Matunda ya Wazee (MAWA) |
| 10:00-10.30 | Discussions | |
| 10:30– 1100 | **TEA BREAK** | |

## March 27 2008 continued

| | | |
|---|---|---|
| **PLENARY 2: Wider challenges to equitable health systems** | | |
| 1100-1110 | Session introduction | Chair: Rangarirai Machemedze, EQUINET/ SEATINI |
| 1110-1125 | Patents and Access to Medicines in Uganda | Author Mpeirwe, IP Consultant |
| 1125-1140 | Impact of Prices on access to medicines in Uganda | Aziz Maija, HEPS-Uganda |
| 1140-1200 | Plenary Discussion | |
| 1200-1215 | Uganda's Policy and Legal Framework for Human Resources for Health. | Mulumba Moses, Faculty of Law, Makerere University |
| 1215-1230 | Health worker retention: lessons and options from regional work in east and southern Africa | Yoswa Dambisya, EQUINET/ University of Limpopo |
| 1230-1300 | Discussion | |
| 1300–14:00 | **LUNCH BREAK** | |
| **PLENARY 3: Building equitable health systems: Fair financing for health** | | |
| 1400-1410 | Session introduction | Chair: Kyomuhendo Swizen, Dept of Social Work and Social Administration, Makerere University |
| 1410-1425 | Uganda's Health Financing from an HIV/AIDS Perspective | Agaba Edgar, HEPS – Uganda |
| 1425-1440 | Local Government Budgeting and its Response to Gender Health Needs: A Study of Mpigi District in Uganda | Kareem Buyana, International Potato Center |
| 1440-1505 | Households' Willingness to Join Community Health Insurance | Dr Martin Ruhweza, Uganda Protestant Medical Bureau |
| 1505-1520 | Equity in the Allocation of Primary Health Care Resources in Uganda. | Erizabeth Ekirapa, Makerere University School of Public Health |
| 1520-1600 | Plenary Discussion | |
| 1600-1630 | **TEA BREAK** | |
| **Group work session 1: Networking for health equity in Uganda** | | |
| 1630-1645 | Session introduction | Chair: Rosette Mutambi, HEPS |
| 1645-1745 | 3 working group discussions on health equity networking in Uganda<br>◆ priority areas of work and policy targets;<br>◆ stakeholders and networking – who, how?<br>◆ co-ordination, communication, next steps | Facilitation: Mulumba Moses, Rosette Mutambi, Christopher Orach (HEPS Uganda and Makerere University) |
| 17:45 | **CLOSE OF DAY** | |

## March 28 2008

| Time | Topic | Presenter |
|---|---|---|
| 8:00 – 8:30 | Administration, posting flip charts, report back on group discussions | |
| **OPENING PLENARY** | | |
| 8:30 – 9:00 | Welcome, Recap of the previous day | Participant |
| **PLENARY 4: Building people centred health systems** | | |
| 09.00-0910 | Session introduction | Chair: Rene Loewenson, EQUINET/ TARSC |
| 9:10 – 9:25 | Health Systems and Ethical Analysis Compliance | D. Nsubuga Moses Kakyama, Compliance Health Ethical Alignment and Policy Center |
| 9:25 – 9:40 | Integrating Refugees into the National Health Framework and Action Plans | Irungu Peter, Pan African Development Education and Advocacy Programme |
| 9:40 – 9:55 | Implementing the Village Health Team Strategy: Experience of UNACOH in Kyenjojo and Masindi Districts | Dr Deogratias Sekimpi, UNACOH |
| 9:55 – 10:25 | Discussions | |
| 10:25- 10.55 | **TEA BREAK** | |
| **PLENARY 5: Building people centred health systems, continued** | | |
| 1055-1110 | Effective Health Communication Campaigns for Community Empowerment for Health in Uganda | Wilson Okaka, Kyambogo University, Uganda |
| 1110-1125 | Reaching out of School Adolescents with Reproductive Health Services | Henry Nsubuga, Straight Talk Foundation |
| 1125-1140 | Community Empowerment and Participation in Maternal Health in Kamwenge District, Uganda | Aaron Muhinda, HEPS-Uganda |
| 1140-1215 | Discussion | |
| 1215-1330 | **LUNCH BREAK** | |
| **PLENARY 6: Equity networking in Uganda** | | |
| 1400-1410 | Session introduction | Chair: Yoswa Dambisya, EQUINET/ U Limpopo |
| 1410-1455 | Feedback from the three working groups | |
| 1455-1530 | Discussion and recommendations on the way forward | |
| 1530-1545 | **TEA BREAK** | |
| **PLENARY 7: Regional resources for equity in health** | | |
| 1545-1615 | Session introduction and summary of the meeting recommendations | Chair: Rosette Mutambi and Mulumba Moses |
| 1615-1645 | Reclaiming the resources for health in east and southern Africa and regional networking | Dr Rene Loewenson, EQUINET Steering committee |
| 1645-1715 | Remarks and Launch of the EQUINET book | Dr. Emmanuel Otaala, Minister of State for Health (PHC). |
| 17:15 | Close of the Conference | |
| 1730 | **RÉCEPTION**<br>**Dancing and Drama -** KISA Production | |

# March 27

## Session One: Progress and challenges to health equity in Uganda

**9:00 - 10:30**

### 1.1 Changes in Utilisation of Health Services among Poor and Rural Residents in Uganda

***Authors:*** *Dr George Pariyo, Makerere University School of Public Health*

**Introduction:** Uganda has implemented a series of health sector reforms to make services more accessible to the entire population. An empirical assessment of the likely impact of these reforms is important to inform policy decision making.

**Objectives:** This study describes changes in use of health services that occurred among the poor and rural residents between 2002/3 and 2005/6.

**Methods:** Secondary data analysis was done on the socio-economic component of the Uganda National Household Surveys 2002/3 and 2005/6 using univariate, bivariate and multivariate techniques. The poor were identified from wealth quintiles, using an asset based index derived from Principal Components Analysis. Multinomial logistic regression was used to model the probability of choice of health care provider.

**Results:** From 2002/3-2005/6 the influence of distance as a barrier to health care among rural residents (OR 0.61, 95% CI 0.50-0.75) fell significantly. But, high costs were a increasing reason for not seeking care. Self-medicating dropped significantly among the most poor (OR 0.11, 95% CI 0.08-0.15) and rural residents (OR 0.17, 95% CI 0.14-0.19). Use of private-for-profit providers also dropped in 2005/6. For severe illness rural residents were more likely to use private not-for-profit or public facilities than private facilities in 2002/3 and 2003/4.

**Conclusions:** Cost and distance are still key barriers to accessing health care for the poor and rural residents. Public private partnerships should be broadened to increase access to quality care among the vulnerable. Rather than simply continuing general subsidies, policy makers should consider targeted subsidies for poor and rural populations.

### 1.2 Accessibility and Utilisation of Health Services for the Poor and Vulnerable in Uganda

***Author:*** *Dr Suzanne Kiwanuka, Makerere University School of Public Health*

**Introduction:** Inequality and inequity in the utilisation of and access to health care among people of different socio-economic backgrounds has been reported in Uganda. This review explored published and unpublished formal studies in Uganda.

**Objectives:** To locate and appraise socio-economic differences in morbidity, access to and utilisation of health care in Uganda.

**Methods:** Systematic review of relevant published and unpublished literature in English sources identified from PubMed, Popline, African Index Medicus and the internet, grey literature from studies done by the Ugandan government, bilateral and multi-lateral agencies, and university graduate students and faculty.

**Results:** Of 678 identified documents, 48 met the study criteria. The poor and vulnerable experience a greater burden of disease, but have poorer access to health care than the non-poor. Barriers to use of health services include drug and staff shortages, late referrals, health worker attitude, cost of care, lack of knowledge, distance and poor quality services. The poor/vulnerable are more affected by user-charges; their abolition in Uganda has largely been perceived as pro-poor.

**Conclusions:** The poor still experience a greater burden of disease, and have poorer access to health care than the non-poor. Distance to service points, perceived quality of care and availability of drugs are key determinants of use. Rather than just continuing general subsidies, policy makers should consider targeted subsidies to the poor and vulnerable.

## 1.3 Missing the Target: Challenges of ART Delivery and Accessibility in Uganda

***Author:*** *Richard Hasunira, International Treatment Preparedness Coalition, c/o HEPS Uganda*

**Introduction:** In Uganda, more than half the people who need anti-retroviral therapy do not get it and it is feared that by 2012, people in need of ART will have doubled. Government capacity to respond to needs of PLAs is outstripped by the demand.

**Objectives:** To establish the status and trend of the national HIV treatment effort and identify barriers to ART scale-up in Uganda. Specific objectives were to: assess balance between ARV demand and supply; evaluate the Prevention of Mother-to-Child Transmission program; study the burden of HIV-TB co-infection; assess national ART program in terms of funding and availability; document availability of and access to ART by marginalised groups; identify what is working in HIV treatment and the specific barriers to ART delivery and accessibility.

**Methods:** Data was collected from government institutions, the private sector, civil society and individual PLAs and ART providers through a literature review, structured questionnaires and interviews.

**Results:** Treatment increased due to the free ARV program, yet demand continues to outstrip supply, and the gap is widening. PMTCT does not adequately address pregnant women's treatment needs. HIV-TB co-infection is rife; while TB treatment has risen, programme reach is limited by travel distances, inadequate training and poor community awareness. A severe financing shortfall and corruption undermine ART delivery, aggravated by shortages of health care facilities, laboratories, equipment and doctors, nurses and counsellors.

**Conclusions:** More funds for health and ART, especially for human resources and infrastructure, better drug procurement, supply and delivery systems are needed, as well as collaboration between public and private sectors, and a campaign to tackle stigma. Systems and accountability for HIV-related funds should be strengthened.

## 1.4 Progress and Challenges to Health Equity for Older Persons in Uganda

***Author:*** *Kituku Cris Mpweire, Matunda Ya Wazee*

**Introduction:** Older persons need health care but often they are neglected and left in poverty isolation and boredom. Some challenges include: transport and distance to services; inaccessible services; poor communication; and health worker attitudes. Older persons often have no money for treatment and drugs; drugs for chronic illness are often inadequate and not a priority. Heath workers lack training in health needs and treatment of older persons, Geriatrics and social Gerontology. Specific problems include cataracts, poor eyesight and hearing loss, brain deterioration causing senile dementia, tremors, poor coordination, Parkinson's disease, epilepsy; prolapsed disks, curve in spine, Arthritis; dental caries, gum disease; constipation; endocrine-menopause for women and prostate problems for men; diabetes; hypertension; heart and kidney disease; anaemia; low calcium; no one to prepare food and not able to feed self, etc.

**Results:** Low awareness of their rights, limits older persons' capacity to demand their rights to medical care, healthy and safe environments, security and safety, confidentiality and privacy, redress, medical information and prohibition of discrimination.

**Conclusion:** Equity in health is important for marginalised senior citizens in Uganda. Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent all or delay the onset of illness. Advocacy for ageing with dignity and the right to a dignified death is Matunda Ya Wazee NGO's cardinal goal. We call upon government, CSOs, private sector and all stakeholders to support equity in health for older persons of Uganda.

# Session Two: Wider challenges to equitable health systems

**11:00 - 13:00**

## 2.1 Patents and Access to Medicines in Uganda

***Author:*** *Author Mpeirwe and Rosette Mutambi, HEPS – Uganda*

Like many other WTO least developed member states, Uganda is involved reforming intellectual property laws to conform to the minimum standards of the TRIPS Agreement. The reform process has been taking place in a mire of international debate on the impact of patent protection on the enjoyment of the right to health.

The protection of public health in view of patents can only be guaranteed by making full use of TRIPS flexibilities intended for member states that need more access to affordable medicine due to low level of economic development. TRIPS flexibilities were a result of the realisation that patent protection for pharmaceutical products and processes could put medicine beyond reach of many people in least developed countries given their low per capita income and low GDP. The challenge for countries has been how to make full use of TRIPS flexibilities to secure affordable medicine for their poverty stricken populations.

Affordability is a key determinant of access to medicine: higher prices mean less people can afford the medicine. Therefore, some people die because they cannot access a life saving medicine because it is beyond their means.

In Uganda there are concerns that the current draft patent law does not make full use of some TRIPS flexibilities and this is likely to prejudice Uganda's interventions in making medicine affordable most poor Ugandans.

Therefore CSOs must increase advocacy to ensure that the link between trade policies and health are clearly understood by policy makers and particularly the effect of patents on the price of medicine. International consensus suggests that a flexible patent regime should afford greater access to medicine and so improve health.

## 2.2 Medicine Price Monitor: Towards Fair Medicine Prices in Uganda

***Author:*** *Aziz Maija, HEPS – Uganda*

**Introduction:** Access to medicines is a human right issue and the main reason people seek health care. Therefore periodic monitoring and assessing medicine prices is important to determine if medicine is available and affordable at the different levels in the distribution chain.

**Objectives:** To inform and update policy makers, implementers and health consumers of the situation and influences on price. We also aimed to: document availability and price variations of selected medicines in the private-for-profit, private-not-for-profit (mission/NGO) and public sector facilities; document and monitor availability of selected medicines in public sector facilities and the affordability of treatment for a selected list of common diseases; inform consumers, policy makers, development partners and other stakeholders on a quarterly basis on the cost of selected medicines; and monitor procurement prices in the public sector and compare them to international reference prices.

**Methods:** We used a standardised methodology, co-developed by WHO and HAI.

**Results:** Surveyed medicines were most available in Mission facilities and least available in public facilities. In public services, there was no difference in availability of medicines between rural and urban facilities, but in the private and mission sectors, medicines were more available in urban facilities. Prices of medicines in the private sector facilities were higher than in mission facilities, and medicines in private sector and mission facilities were unaffordable for the lowest paid Government worker.

**Conclusions:** An analysis of the medicine procurement system in public sector facilities is needed and government should live up to its commitment to ensure essential medicines are available in these facilities. Low availability of first line anti-malarial medicine in the private sector can undermine proper malaria case management and should be investigated, as well as Mission sector pricing mechanisms to ensure medicines are affordable to the people they serve.

## 2.3 Uganda's Policy and Legal Framework for Human Resources for Health

***Author:*** *Mulumba Moses, Faculty of Law, Makerere University*

Despite growing recognition of the crucial role of Human Resources for Health and related functions in health service delivery, little attention has been given to the role of policy and legal frameworks in Uganda. In this paper we review the implications of existing policy and legal frameworks on the human resources for health.

The workforce is the single most valuable asset in the health system, which can ultimately influence the success or failure of the health system. In Uganda the National Health Policy addresses a number of factors affecting the national human resources for health such as inadequate numbers and inappropriate distribution of trained health personnel. The policy proposes several government measures to strengthen Human Resources management at all levels. Several other scattered national polices and laws have provisions that influence the challenge of addressing human resources for health in Uganda.

This paper focuses on provisions in the policies and laws that address: education and training of human resources for health; procedures for recruiting health workers; terms and conditions of work for health workers; health worker safety; migration of health workers within districts and from Uganda to other countries; and provisions on the optimum incentive structure for health workers in Uganda.

There is a need for a holistic approach to address the issues of human resources for health in Uganda. A review of the existing policy and legal frameworks is needed and the implications must be assessed so as to influence future policy processes regarding human resources for health in Uganda.

## 2.4 Health Worker Retention: Lessons and Options from Regional Work in East and Southern Africa

***Author:*** *Yoswa Dambisya, EQUINET/ University of Limpopo*

**Introduction:** East and southern Africa faces a critical shortage of health workers. EQUINET in co-operation with ECSA-HC have a programme supporting knowledge for health worker retention in ESA.

**Objectives:** To establish which non-financial incentives are used in ESA.

**Methods:** A review of available literature on non-financial incentives in 16 ESA countries was commissioned, supplemented by input from a regional meeting on HRH.

**Results:** A variety of non-financial incentives are used, including: (i) Training and career path-related incentives; (ii) Incentives that address social needs, e.g. housing, staff transport, childcare facilities, free food, and employee support centres; (iii) Improved working conditions, e.g. better facilities and equipment and better security; (iv) Strengthened human resource management and information systems; (v) Workplace programmes for health workers and their families to access health care and anti-retroviral therapy and health worker medical aid schemes. There was, however, little information on the application, funding, sustainability and impact of incentives, as health information and management systems do not always adequately monitor or report on the impact of incentives. Successful application of non-financial incentives is associated with consultative long-term strategic planning, sustainable financing mechanisms such as sector-wide approach or general budget support rather than donor-driven vertical programmes.

**Conclusions:** Managing non-financial incentives can be complex and calls for strategic capacities and information systems, backed by clear guidelines to and consultation with health workers. "Best practices" and impact of non-financial incentives in ESA countries need to be documented and disseminated.

# Session Three: Building equitable health systems: Fair financing for health

**14:00 - 16:45**

## 3.1 Funding the Promise: Monitoring Uganda's Health Sector Financing from an HIV/AIDs Perspective

***Author:*** *Edgar Agaba*

**Introduction:** Health spending in Uganda covers only about a third (US$14) of what is needed to meet minimum health care needs. Only US$5 per capita in health care spending is from the public sector (including donor funding); the remaining US$9 is out-of-pocket payments. Despite inflows of funds for HIV, only 67,000 of 150,000 people in need ART (MoH, 2006) currently access treatment, while there is upward appreciation in HIV prevalence rates of 6.4% (MoH 2006).

**Objectives:** To monitor and evaluate Health Sector Financing from a HIV perspective to produce policy recommendations for effective health service delivery in Uganda. Therefore we aimed to: establish the level of government commitment to HIV funding; identify priority given to different aspects of the fight against HIV to assess per capita spending on AIDS drugs; and assess sustainability and harmonisation of HIV financing mechanisms.

**Methods:** Review of relevant documents and key informant interviews with HIV policy programmers and communities.

**Conclusions:** Public health spending is below the level needed to realise the targeted 2.5 health treatments per person per year. More state funds are essential to the longevity of scale-up programs, particularly treatment. Although health expenditure is about 6% of GDP, drug supply remains inadequate compared to demand, therefore priority must be given to per capita funding for essential drugs. The immediate shortfall in HIV funding is about 200 billion shillings. Continued political commitment is needed to improve equitable distribution with budget reform for districts; a better tracker system and greater transparency on budget allocations to make clear where money is actually being spent on HIV; and better management of HIV funds to increase accountability.

## 3.2 Local Government Budgeting and its Response to Gender Health Needs: A Study of Mpigi District in Uganda

***Author:*** *Kareem Buyana, International Potato Center*

This was a research project for a Masters degree in Gender Studies of Makerere University Kampala funded by the Belgian Technical Cooperation.

**Objectives:** To examine the extent to which local government budgeting responds to gender health needs in Mpigi district.

**Methods:** A triangulation of qualitative methods was used, including: household questionnaire interviews, focus group discussions with local community leaders and key informant interviews with selected officials at Mpigi District Council.

**Results:** Gender health needs in Mpigi District range from concerns about household welfare to constraints in the local health care system. Women and men have a broad understanding of health needs, including not only common disease infections, but also socio-economic needs that affect quality of life. The District Council approach used to set budget priorities narrowly defines the gender health needs of women and men, focussing on the burden of disease and excluding health rights (socio-economic needs). Yet, if service provision is to respond accordingly, a holistic approach using a rights-based framework should form the basis of setting local government budget priorities.

**Conclusions:** Local government budgeting does not respond to gender health needs in Mpigi district. While the Local Governments Act (1997) provides for inclusion of gender concerns in budgeting and service delivery, it has failed to translate this gender equality commitment into meaningful action at local government level.

## 3.3 Households' Willingness to Join Community Health Insurance

***Author:*** *Dr Martin Ruhweza, Uganda Protestant Medical Bureau (UPMB)*

**Introduction:** Community Health Insurance is increasingly seen as a way to address inequity in access to healthcare arising from direct payments for healthcare. It is seen as particularly relevant in countries that depend a lot on out-of-pocket payments for healthcare and where a large part of the population is not engaged in formal employment. Uganda is one such country.

**Objective:** To investigate the willingness of households to subscribe to CHI schemes in Jinja District as an alternative to current payment methods for healthcare

**Methods:** A cross sectional study of households in Jinja District using both quantitative and qualitative methods was conducted. Multi stage sampling was used to select the 384 households that participated in the study.

**Results:** Most (81%) households were willing to enrol in CHI schemes; they were willing to contribute on average Ushs 5,977 (US$3.4) per person per year. Willingness was associated with employment of the household head in the formal sector, location of household in rural areas and absence of children in the household. In up to 26% of households, someone had been admitted in the year preceding the study; up to 77% had made direct payments for healthcare whenever someone fell ill.

**Conclusions:** Healthcare needs among households were high and most households made payments for healthcare whenever someone fell ill. Most households were willing to join CHI schemes but were willing to pay only small contributions per person. The district health team and Ministry of Health should introduce CHI in Jinja District and identify extra funding sources to supplement the meagre contributions that households are willing to make.

## 3.4 Equity in the Allocation of Primary Health Care Resources in Uganda

***Author:*** *Erizabeth Ekirapa, Makerere University Institute of Public Health*

**Introduction:** There are large disparities in health outcomes and health service delivery across different regions in Uganda, but health sector resource allocation does not adequately address the varying health needs of different regions. Therefore, there is a need for an equity-oriented resource allocation process for the health sector.

**Objectives:** To identify health districts with the greatest need, assess the extent to which Primary Health Care resources to districts are allocated according to need and identify factors that constrain or facilitate equitable distribution of PHC resources.

**Methodology:** This cross-sectional analytic study used data from key informant interviews, government publications, and secondary data on household and socio-demographic factors from the census. Using principle component analysis, a district deprivation index was developed and compared with per capita PHC expenditure across districts to assess the extent of vertical equity.

**Results:** No significant relationship exists between per capita PHC expenditure and the deprivation index in 2002/3, 2003/4 and 2004/5. PHC resource allocation is calculated using incremental budgeting and the resource allocation formula, some components of which are objectively measured, but some are subjective due to lack of relevant data. Challenges faced in using the formula include: growing need not matched by more resources; increased infrastructure but no additional resources for recurrent expenditure; lobbying by influential persons, and incomplete records on donor contributions to districts.

**Conclusions:** The Ministry of Health and Finance should ensure that the resource allocation formula is the main determinant for allocating recurrent PHC resources, based on objective measures that include recurrent running costs and donor contributions to districts. Lobbying by politicians for districts which are not deprived should be minimised.

# March 28

## Session Four: Building people centred health systems

**09:00 - 10:15**

### 4.1 Health Systems and Ethical Analysis Compliance

***Author:*** *Dr Nsubuga Moses Kakyama*

In Uganda, the Health service sector has experienced Millennium Development Goals achievements in combating HIV, improved maternal health and child mortality. However, this progress was centred on ethical challenges such as religious leaders who stop patients from taking drugs, as well as food and nutritional insecurity, shunning from medication services, insufficient levels of analysis, capacity to monitor pharmaceuticals, legal and incompliant reporting and poor mediation platforms. Compliance objectives were analysed on three levels: i) Public Health Institutions, ii) Private Health Providers, and iii) Civil Society Organisations. In this paper we discuss the operations of the three levels, progress made and challenges to health equity in terms of performance, community outreach, health economics and planning. The aim was to use ethical analysis to identify patterns of demand and priority areas for interaction. By creating a demand-scenario, legal and compliance reporting, and mediation platforms can be effective in ethically aligning the system. A multi-stakeholder view was taken to examine ethical demands using Clinically Analytical Platforms, medication data, the Ministry of Health database and Annual Awards for Health Care Ethics. Education and Health were targeted as priority community demand-side sectors. A Heath Care Opportunities Point System was applied to each sector based on local conditions and needs assessments; aggregated points then provided an indicator of equity demand and ethical compliance in health delivery at community level. Based on this preliminary work, specific areas can now be targeted for analysis and optimised ethical mediation platforms can be designed to include outreach, health best practices based on rural information asymmetry, significant innovation, and partnering with German Business Ethics Network.

### 4.2 Integrating Refugees into the National Health Framework and Action Plans

***Author:*** *Irungu Peter, Pan African Development Education and Advocacy Programme (PADEAP)*

**Introduction:** Uganda hosts about 257,256 refugees from neighbouring countries like Sudan, Rwanda, the Democratic Republic of Congo, Somali and Burundi. Most of them live in rural areas such as West Nile and Western Uganda. The United Nations High Commission for Refugees is internationally mandated to cater for their basic needs, and they are excluded from national health programmes and policies such as primary health care, immunisation and HIV interventions.

**Objectives:** To lobby and advocate the relevant stakeholders for refugees to be incorporated into the mainstream national health programmes and policies.

**Conclusions:** If the Ugandan government, the UNHCR and its implementing partners and other stake-holders pool resources, equity in health, not only for refugees, but also for host communities will be streamlined and efficiently delivered. Integrating refugees into the national health framework work will help them integrate into Ugandan society. It will also financially benefit all stakeholders since it will streamline costs of health, service delivery and avoid duplication of services.

## 4.3 Implementing the Village Health Team Strategy: Experience of UNACOH in Kyenjojo and Masindi Districts

***Author:*** *D. Deogratias Sekimpi, UNACOH*

**Objectives:** To improve participation in health issues and use of existing health services/programmes; promote community-based record keeping, reporting and use.

**Methods:** Intervention involved systematic and integrated training of stakeholders from international, national, district, health sub-district, sub-county and community level. Trained community members were then deployed to motivate their neighbours, on a continuous basis, to promote health for economic productivity and poverty eradication.

**Conclusions:** In Kyenjojo District, Kyaka HSD, by December 2007, 951 volunteers from 227 villages had been selected, trained and deployed, using seed funding from the Canadian International Immunisation Initiative 2, UNACOH and Kyenjojo District Local Government. By January 2008 in Masindi District, Bujenje HSD communities were selecting volunteers to be trained. The Masindi District intervention is funded mainly by Barclays Bank of Uganda Limited, with focus on Malaria Control. Many community members are very enthusiastic to participate in health programmes, even on a volunteer basis, although some community members and leaders are so used to being paid for attending or participating in programmes that they cannot easily accept giving or contributing instead. Some leaders and Health Workers are resistant to change from conventional facility-based health care to a system where they can pro-actively promote health and prevent diseases. Despite this resistance, long-term health and poverty eradication benefits of the programme are worth pursuing.

## 4.4 Effective Health Communication Campaigns for Community Empowerment for Health in Uganda

***Author:*** *Wilson Okaka, Kyambogo University, Uganda*

**Introduction:** Uganda has one of the most well crafted national health policies in Africa, which with the strategic health sector plan, has made remarkable progress despite objectives being implemented in a social, cultural, economic, environmental, and legal context dominated by poverty. The health burden is aggravated by information poverty among policy makers and implementers, donors, civil society, communities, households and the private sector. Yet, effective health communication campaigns can raise policy awareness and reduce disability, disease, death and mental poverty. Organising people's power for health, supported by new technology, is crucial to health communication campaigns.

**Objectives:** To present the most effective communication channels and campaigns for reaching maximum audiences; discuss the relevance of communication strategy, ICTs, mass media, and the 'Diffusion of Innovations' theory in empowering key health sector stakeholders focussing on ordinary Ugandans; and explain the types, methods, and role of health communication campaigns evaluation research in outreach programmes and projects.

**Methods:** The paper is based on a literature review of health communication models, change theories of communication, national health policy, health sector strategic plans, current training programmes and participatory communication models.

**Results:** Effective health communication campaigns driven by theory, ethics and gender ensure maximum audience exposure. Employing ear and eye catching messages for effective health policy implementation, the mass media is the most effective and efficient channel in effecting attitudinal change; and creating, raising and sustaining community empowerment through awareness, knowledge, adoption, and use of health services or products among all stakeholders.

## 4.5 Reaching out of School Adolescents with Reproductive Health Services

***Author:*** *Henry Nsubuga, Straight Talk Foundation*

**Objectives:** Straight Talk Foundation started the project in 2005 to reach out-of-school youth, improve health services and bring them closer to the people, with a focus on addressing challenges facing district reproductive health services. Health fairs were carried out in different localities in districts to inform local remote communities of health services within their reach and Straight Talk local language health magazines were distributed.

**Methods:** In each new district, the community outreach officer meets the different district health stakeholders like NGOs, CBOs, health workers, politicians, etc., explains the aims of the project and invites them to a district advocacy meeting so that stakeholders get to know what each does in the area of reproductive health, they share challenges, pave the way forward and learn about health fairs to be held in various localities in the district. Prior to the health fair, sports activities are carried out in the venue to mobilise people to attend the health fair, and announcements are made on local radio stations. During the health fair, district and local service providers are invited to offer services to the people. District advocacy meetings help Straight Talk Foundation evaluate its performance.

**Results:** People are made aware of services available in their reach and access free VCT, family planning services, information especially about reproductive health; and donate blood. Health-related questions are answered and health providers learn about the challenges in their area, creating partnerships and awareness among stakeholders.

**Conclusions:** Local people come to own the program. Health services are far from the people and sometimes inaccessible, there is a lack of youth friendly services, and commitment levels are low. Poor infrastructure makes it difficult for services to reach people. Health fairs and advocacy meetings are not socially sustainable.

## 4.6 Community Empowerment and Participation in Maternal Health in Kamwenge District, Uganda

***Author:*** *Aaron Muhinda, HEPS-Uganda*

**Objectives:** Facilitate the community to identify and analyse barriers to use of maternal health services; work with the community to prioritise, identify and implement actions for overcoming one or more barriers to use of maternal services; promote cordial and mutually respectful relationships between health workers and expectant mothers in the sub-county.

**Methods:** The project employed participatory techniques to draw on people's experience, identify barriers to use of maternal health services, prioritise, act and follow up on one of the barriers identified and work with the community to address the identified problem. Community leaders and health workers were trained and sensitised on maternal health rights, then lead a mass campaign to promote of use of maternal health services in Kamwenge sub-county.

**Results:** By the end of the project in November 2007, 34 community leaders and 15 health workers had been identified and trained; 450 posters on maternal health rights were produced and distributed; six suggestion boxes were procured and installed at six health facilities in and around the sub-county.

**Conclusions:** PRA is an effective way to gather information, plan and act on challenges facing communities at grass root level. Many community members are very keen to participate in health programmes, even on a volunteer basis. It is important to involve decision makers and community leaders in activities, as they have authority and their messages are taken seriously, so sustainability of the project is also ensured. Community workers need skills in managing expectations from community members to maintain community motivation to support and participate in the project. It's important to understand the social values and history of the target area, to avoid the negative history and values in the target area.

## About HEPS Uganda

HEPS-Uganda is a Health Consumer's Organisation advocating for health rights and responsibilities in Uganda. HEPS-Uganda was established as a not-for profit-organisation in 1999 out of concern for the lack of attention for health consumers in the country. An office with a functional secretariat was opened in 2000. Initially, HEPS focused solely on Health Policy Advocacy. Subsequently, after conducting several advocacy activities on its own, the organisation started the Ugandan Coalition for Access to Essential Medicines in 2002. Members of the coalition include mainly national and international health CSOs and NGOs. The purpose of the coalition is to advocate for better healthcare through combined efforts. To this end, HEPS and the coalition started a constructive dialogue with the government of Uganda, (the Ministry of Health). Besides these Health Policy Advocacy activities, HEPS started a Community Outreach programme in 2001. Outreach has been focussing on education with regard to health rights and responsibilities in rural communities in Uganda. Educating communities about health rights and responsibilities is aimed at ensuring that people make informed choices about health. You can access the HEPS website at http://www.heps.org/

## About Makere University, School of Public Health

Established in 1922, Makerere University is one of the oldest and most prestigious Universities in Africa. In 1937, the College started developing into an institution of higher education, offering post-school certificate courses. In 1949, it became a University College affiliated to the University College of London. In 1963 it became the University of East Africa, offering courses leading to general degrees of the University of London. With the establishment of the University of East Africa on 29th June 1963, the special relationship with the University of London came to a close and degrees of the University of East Africa were instituted. On 1 July 1970, Makerere became an independent national university of the Republic of Uganda, offering undergraduate and postgraduate courses leading to its own awards.

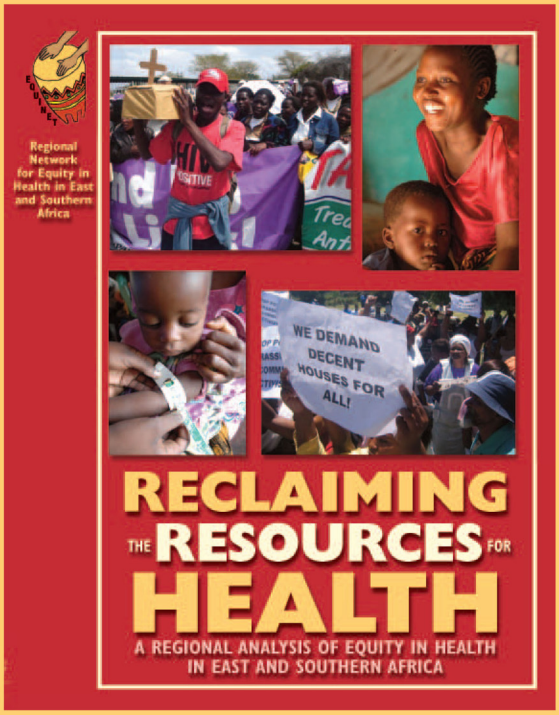
Thirty years after Makerere University was established, preventive medicine was introduced as an academic discipline of health sciences in the medical school's Department of Preventive Medicine. By 1974, the department had doubled in size and scope and eventually evolved into the Institute of Public Health. In 2000, the Institute was granted full autonomy and became known as Makerere University Institute of Public Health (MUIPH). In 2007 the Institute was granted the status of a School and changed the name to Makerere University School of Public Health (MUSPH). The school has five departments: Health Policy Planning and Management, Epidemiology and Biostatistics, Disease Control and Environment Health, Community Health and Behavioural Science and Regional Centre for Quality Health. You can access the Makerere University website at http://mak.ac.ug/makerere/

## About the Regional Network for Equity in Health in east and Southern Africa (EQUINET)

EQUINET, the Regional Network on Equity in Health in Southern Africa, is a network of professionals, civil society members, policy makers, state officials and others within the region who have come together as an equity catalyst, to promote and realise shared values of equity and social justice in health. EQUINET gathers people to overcome isolation, give voice and promote networking using bottom-up approaches built on shared values. We have come together in a spirit of self determination and collective self reliance working through existing government, civil society, research and other mechanisms and institutions in the Southern African Development Community (SADC) region and in southern and East Africa (www.equinetafrica.org). EQUINET is building a forum for dialogue, learning, sharing of information and experience and critical analysis. We do this to build knowledge and perspectives, shape effective strategies, strengthen our voice nationally, regionally and globally and our strategic alliances to influence policy, politics and practice towards health equity and social justice. EQUINET's work covers a wide range of areas identified as priorities for health equity, within the political economy of health, health services and inputs to health, covered in the theme areas shown on this site. EQUINET is governed by a steering committee with representatives from fourteen institutions in southern Africa and is co-ordinated at the Training and Research Support Centre Zimbabwe (www.tarsc.org).

# RECLAIMING THE RESOURCES FOR HEALTH:

## A regional analysis of equity in health in east and southern Africa

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## The background

Global attention to equity and to Africa is growing. In 2006 the United Nations focused on these issues in three key reports and the WHO set up a Commission on the Social Determinants of Health. With Africa as the focus of commissions and special programmes, the WHO Director General declared improved health in Africa a top priority. The 30th anniversary of the Alma Ata declaration on primary health care will bring even greater focus on health in Africa in 2008.

Missing from this heightened focus is a synthesis of evidence and analysis by people within Africa of how to tackle inequalities in health. This book fills that gap.

## The book

This regional equity analysis offers a comprehensive, yet accessible, resource presented through text, tables, figures, case studies, quotes and images. Evidence is drawn from published literature and formal government data, as well as from less commonly documented experience within the region – from grey literature, interviews and testimonials, gathered through participatory processes. It strikes a balance between technical information and terminology and descriptive insight into people's experience of providing and accessing healthcare in the region.

Although the health picture for east and southern Africa is currently quite bleak, the spirit that emerges across the seven sections of the book is one of hope:

- **Section 1: Progress in health** traces the sources of inequalities in health within and between communities and countries in the region, analysing links between poverty, inequality and health.
- **Section 2: Reclaiming the economic resources for health** maps the outflow of resources from Africa, the consequences and the options to address outflows in areas such as food security and access to medicines.
- **Section 3: Building universal, comprehensive people centred health systems** shows the ways in which health systems can make a difference, particularly for those with greatest health needs, and presents lessons learned from primary health care and from the roll-out of prevention and treatment for HIV and AIDS.
- **Section 4: Fair financing of health systems** explores options for increasing the resources for health systems and for overcoming barriers to services for people with the greatest need.
- **Section 5: Valuing and reclaiming investments in health workers** outlines the outflows of health workers from vital health services and discusses the policies and measures to involve, value and retain health workers in the region.
- **Section 6: Organising people-centred health systems** points to the many ways health systems can act to empower people, stimulate social action and build alliances to promote equity-oriented health systems.
- **Section 7: Taking action to reclaim the resources for health** summarises the policy messages presented and proposes targets and indicators to signal progress in key dimensions of health equity, and towards meeting regional and global commitments.

## The audience

This book provides a source of evidence and analysis to support and advance the work of health policy makers, researchers and activists and the diverse academic, state and civil society community involved in health equity within east and southern Africa. It is relevant for policies and programmes within and beyond the health sector in the region and will be valuable to international agencies working on and in Africa, particularly given the current global commitment to and attention on Africa.

## The authors

The book was produced by the steering committee of the Regional Network on Equity in Health in east and southern Africa (EQUINET) (www.equinetafrica.org), a network of professionals, academics, civil society members, policy makers, state officials and parliamentarians. Production was supported by SIDA (Sweden) and IDRC (Canada). It draws on and will feed into the several thousand organisations and individuals involved in EQUINET training, research, policy dialogue and information activities over the past seven years.

**Equity in health** implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.


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