Knowledge for action on equity in health in Uganda

National Meeting Report

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:
IDRC (Canada) and SIDA

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1. Background

Over the past 14 years, considerable effort has been made to restore the functional capacity of the health sector, through increasing public health spending, reactivating disease control programmes and re-orienting services to primary health care in Uganda. However, as the Ministry of Health admits, there still remain significant challenges in matching need for health services with available resources, making equity or fairness an important issue for advancing national policies for the population as a whole (Uganda Ministry of Health 2007, http://www.health.go.ug/policies.htm). Inequalities in health exist in Uganda between rich and poor communities, urban and rural districts, between social groups and across other social differentials. Ensuring that those with the greatest need have fair access to resources for health and fair opportunities for health should not be left only to the Ministry of Health, but should be a matter for all sectors.

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.

Towards this 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 comprehensive, primary health care oriented, people-centred and publicly led health systems 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:
- 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.

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. HEPS focuses on advocacy for better health care and community outreach on 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 (http://www.heps.org/)

Makerere University is one of the oldest and most prestigious Universities in Africa, established as a college in 1937. In 1974, the department of preventive medicine evolved into the Institute of Public Health, and was granted full autonomy in 2000. 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 (http://mak.ac.ug/makerere/)

As part of its bid to promote policies for equity in health, the Regional Network for Equity in Health in East and Southern Africa (EQUINET), in partnership with HEPS-Uganda and Makerere University School of Public Health organised a National Meeting to review the body of work taking place in Uganda within government, academic and civil society institutions to explore, understand and propose options for reducing inequalities in health in Uganda. The meeting provided an opportunity to exchange evidence, strengthen networking within Uganda, and feed experience into regional networking.

The meeting aimed to assess the progress of equity in health in Uganda. It reviewed gaps and needs in the Ugandan health sector, to feed into and draw from experience in East and Southern Africa. It aimed specifically to:

- review the gaps and needs in the health sector in Uganda, to feed into and draw from experience in the East and Southern Africa region;
- 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 to widen linkages with the regional network for equity in health in Uganda
- To discuss options for strengthening communication at country level across those working in equity in health and areas for future research and practice.

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

- 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

2. Opening session

Ms Rosette Mutambi welcomed participants; introduced the background and objectives of the meeting; and gave a brief about HEPS Uganda. Formed in 2000, HEPS is working in five districts, where runs three programmes: Health Policy Advocacy at national, district and community levels; Community Outreach, training the masses in health rights and responsibilities; and Health Rights Complaints and Counselling. She outlined the collaboration between HEPS-Uganda in EQUINET for two years and with Makerere University School of Public Health over the past three months. She explained the background process for selection of the many abstracts in the six thematic areas of the meeting and urged for participants to actively input into the meeting discussions. She expressed appreciation for the organising and technical support from EQUINET through Training and Research Support Centre (R Loewenson and R Pointer) and its partners SIDA (Sweden) and IDRC (Canada). She also thanked the local organising committee of the meeting: Moses Mulumba of Makerere Faculty of Law; and Gertrude Nakanwagi and Rosette Mutambi of HEPS; and Dr Christopher Orach.

The meeting was officially opened by the Dean of Makerere University School of Public Health, Dr David M. Serwadda. He welcomed the collaboration with civil society organisations (CSO's) on public health. The School of Public Health has done a lot of work on equity issues in urban and rural areas, part of which was to be presented in the course of the meeting. Uganda, as a developing country, still has weak health systems and faces challenges of access to ARVs, especially poor people. He requested the meeting organisers to disseminate the proceedings of the meeting widely, so as many stakeholders would benefit from the outcome of the deliberations.

R Mutambi, Dr D Serwadda, Dr C Orach at the opening, Source: TARSC 2008

3. Progress in and challenges to health equity in Uganda

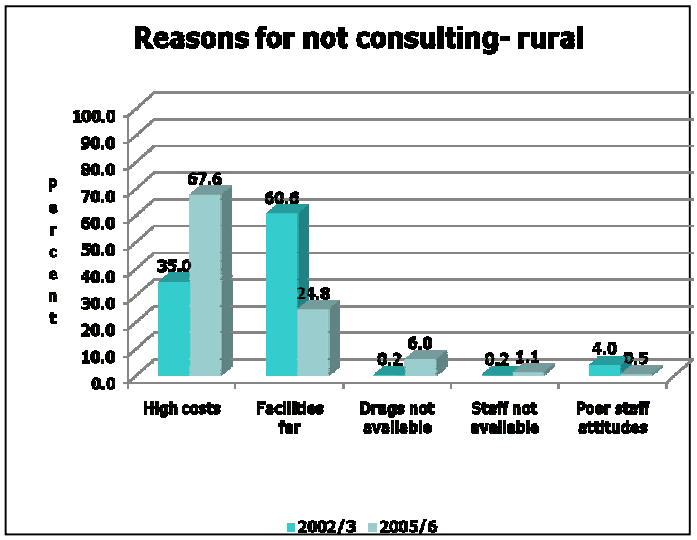
3.2 Changes in Utilisation of Health Services among Poor and Rural Residents in Uganda

Elizabeth Ekirapa, Future health Systems Study, Makerere University School of Public Health

Uganda has in the 1980's implemented a series of health sector reforms to make services more accessible to the entire population, including .abolition of user fees, introduction of public-private partnership in service delivery, and decentralisation of health services to district and lower local government levels. An empirical assessment was made of the impact of these reforms in terms of changes in utilization of health services that have occurred among poor and rural communities between 2002/3 and 2005/6. Secondary data analysis was carried out on the socio-economic component of the Uganda National Household Surveys (UNHS) 2002/03 and 2005/06 using univariate, bivariate and multivariate techniques. Wealth quintiles were constructed using an asset-based index derived from Principal Components Analysis (PCA). The probability of choice of health care provider was modelled using multinomial logistic regression.

Between 2002/03 and 2005/06 there was a significant reduction in the influence of distance as a barrier to seeking health care for illness among the rural residents (OR 0.61, 95% CI 0.50-0.75). There was also a significant decline in the use of self medication among both the most poor (OR 0.11, 95% CI 0.08-0.15) and rural residents (OR 0.17, 95% CI 0.14 – 0.19). Although the majority of respondents

still used private for profit providers, there was a reduction in use in 2005/6. In addition, for severe illnesses those in rural areas were more likely to use PNFP (private-not-for-profit) or public facilities than private facilities in both 2002/3 and 2003/4.



High costs as a reason for not seeking care increased. Cost and distance were found to be important barriers to seeking health services for poor and the rural residents. The researchers propose that government services be strengthened since most of the poor seek services from government, that public private partnerships be broadened to increase access to quality health services among vulnerable communities and policy makers develop more targeted subsidies to poor and rural populations.

3.2 Access to and Utilisation of Health Services for the Poor and Vulnerable in Uganda: A systematic Review of Available evidence

Dr Susanne Kiwanuka, Future health Systems Study, Makerere University School of Public Health

A qualitative systematic review of relevant published and unpublished literature was presented covering English language studies identified from PubMed, Popline, African Index Medicus and the World Wide Web, grey literature of formal reports from studies done in Uganda by government, bilateral and multi-lateral agencies, and university graduate students and faculty. These sources provided information on the distribution of illness, access to and utilisation of health services for people belonging to different socio-economic and vulnerability groups. Forty-eight studies met the study criteria and indicated that:

- Geographical access (within 5km of facility) improved- 49-57% between 1990 & 2000 (UDHS 2002). Abolition of user fees in 2001 improved access of the poor to health services (Burnham, 2004, Xu, 2006, Nabyonga, 2005).
- The poor and vulnerable experience a greater burden of disease but have poorer access to health care than the non-poor. A study in three districts showed the poorest quintiles were 2.4X more likely to suffer ill health than the richest quintiles (Odaga, 2004). Infant & child mortality are twice as much in the poorest population quintile compared to the richest (UDHS, 2000-2001). The poorest and marginalised were most affected by HIV with more than 50% of all people living with HIV as well as the newly infected are women (World Bank, 2005).
- The poor and vulnerable have poorer access to health care than the non-poor and are more inclined to treat themselves. Poor, low educated, assetless women, were less likely to receive family planning, less likely to attend antenatal clinics or deliver in health facilities & more likely to have malnourished children *(World Bank 2005, UBoS, 2001).* Health knowledge, transport, communication, food, water and sanitation worse off for poorest quintiles *(Vella 1995, Wamani, 2004).*
- The barriers to utilisation of health services come from both the demand and supply sides. From the demand side are: perceived poor quality of services; cost of care; lack of knowledge; long distance; mothers' young age; lack of time/ long waiting times; negative staff attitude and rural residence; complaints of abuse/neglect; negative cultural beliefs. On the supply side are: shortage of drugs; late referrals; shortage of skilled staff; and negative health worker attitudes.
- The poor/vulnerable are more affected by user-charges and their abolition in Uganda has largely been perceived as pro-poor.

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 utilisation. The Uganda National Minimum Health Care Package (UNMHCP), which is only available in HCIV's and hospitals, needs re-prioritisation and rationing within the package should

be carefully examined to ensure that it does not result in further inequalities. The formulation of specific performance indicators with regard to the UNMHCP is needed in order to target the poor and vulnerable.

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

Richard Hasunira, International Treatment Preparedness Coalition (ITPC) and HEPS Uganda

There has been a significant increase in antiretroviral treatment delivery in Uganda over the past few years, thanks to a free ARV programme supported by the Global Fund, PEPFAR, and other donors. According to the Ministry of Health, 70,000 people living with HIV/AIDS (PLWAs) out of an estimated 150,000 people in need of antiretroviral therapy (ART) were accessing ART from 173 health facilities by June 2005. the latest estimates show that 85,000 PLWA access ART from 220 accredited centres. The ministry estimates that the number of PLWA who need ART reached 234,500 at the end of 2006. however, more than half the number of people who need ART do not get it and it is feared that by the year 2012, PLWA in need of ART will have doubled. The government capacity to respond to the needs of PLWAs is outstripped by the demand.

This study was conducted to establish the status and trend of the national HIV/AIDS treatment effort and to identify specific barriers to ART treatment scale-up in Uganda. It assessed the balance between demand for and supply of ARVs in Uganda; the performance of the national Prevention of Mother-to-Child Transmission of HIV (PMTC) programme; the burden of HIV-tuberculosis co-infection among PLWAs; and the availability of and access to ART by marginalized groups. Primary and secondary data was collected from government institutions, the private sector, civil society as well as from individual PLWAs and ART providers through the review of published and grey literature, standard structured questionnaires and personal interviews.

It found that:

- Uganda has been able to set up communication channels to reach the population with sensitization messages through the mass media, community health systems, religious institutions, schools, public dialogues, open testimonies
- Many players, partners and stakeholders contribute to the prevention, treatment and support services; and are sharing information and other forms of resources
- Uganda has infrastructure for scientific and socio-economic research into HIV/AIDS, and is an active participant in clinical trials of treatment and preventive medicines that under development
- ARVs are provided free of charge and ART services have in principle, been rolled out to HC III level. There are currently 220 centres accredited to provide ART countrywide

There remain barriers to access to ART, particularly among the most poor and vulnerable groups:

- Demand for treatment continues to outstrip supply, including in PMTCT services. About 60% of the people who need ART cannot access it
- Access to TB treatment services has increased, but travel distances, insufficient provider training, and inadequate community awareness limit outreach.
- ART delivery is undermined by financing shortfalls, problems reported with abuse of funds, inadequate health care facilities, laboratories and medical equipment, and of doctors, nurses and counselors.

The study recommends:

- Increased government funding to the health sector and ART services
- Government to strengthen management and accountability systems for HIV-related funds and investments in human resources and infrastructure
- A public education campaign to address stigma and encourage community support systems
- Greater collaboration among public and private service systems
- Improved drug procurement, supply and delivery system to ensure supply matches demand in quantity and constitution of consignments, and
- Donors to support consistent availability of medicines and other logistics and minimize possibilities of abuse of (cash) resources.

3.4 Progress and Challenges to Health Equity for Older Persons in Uganda

Kituku Cris Mpweire, Matunda ya Wazee (MAWA)

Older persons need health care, but in many cases they are neglected and left in poverty isolation and boredom, and are prone to disease, including eye cataracts, brain deterioration, spinal problems, dentral problems and diseases related to diet. Some of the challenges in health care of older persons include:

- Inaccessible service: transport and distance to health services, poor communication and health workers negative attitude.
- No money for treatment and drugs while drugs for chronic illness are often inadequate and not a priority.
- Heath workers lack skills in health needs and treatment of older persons and there is lack of training in Geriatrics and social Gerontology.

Older persons are entitled to the health rights that other people are entitled to, such as medical care, a healthy and safe environment, security and safety, confidentiality and privacy, redress, medical information and prohibition of discrimination. However, they have limited capacity to demand for their health rights due to low awareness. Equity in health is this important for marginalized senior citizens. It is stated in the United Nations Principles for older persons that ”older persons should have access to health care to help them to maintain all regain the optimum level 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 (MAWA) NGO’s cardinal goal in as far as older persons in Uganda are concerned. We call upon government, CSOs, private sector and all stakeholders to come out and support equity in health for older persons of Uganda

3.5Discussions

In the plenary discussion facilitated by the session Chairperson, Dr Chris Orach University of Makerere, Institute of Public Health, the cost of care and high price of medicine was given focus as factors affecting access. It was observed that community health insurance schemes can augment public health spending, with a caution that existing community health insurance schemes do not seem to be sustainable. It was also raised that while decentralisation had increased utilisation of public facilities in rural areas, people in urban areas prefer to go to private because of quality concerns in public facilities.

Delegate discussions at the meeting Source: TARSC 2008

The burning of plastic waste by the public was noted to result in some of the diseases, with long term exposure to plastic fumes leading to health problems, especially for elderly people. Plastic waste may be used as a substitute to wood fuel, and it was noted to be important to raise awareness on its dangers.

4. Wider challenges to equitable health systems

The session chairperson, Rangarirai Machemedze (EQUINET/SEATINI) referred to the cost barriers raised in the previous session and noted that it was important to understand the drivers of high costs. In 1995, WTO was formed to regulate trade between and amongst countries. As a member Uganda has to ensure that its policies are in conformity with the principles of WTO. Agreements such as TRIPS, GATS and the Agreement on Agriculture affect health, availability and accessibility of drugs or may make them expensive and thus difficult to access. The cost of health care has gone up as a result of liberalisation and privatisation, with subsidies cut and user fees introduced. The questions for the presenters on this theme are: what potential benefits and costs or threats come from economic and trade policies and agreements? Do they allow our countries to prioritise service provision and public health? Can we manage these issues in a way that is beneficial to health?

4.1 Patents and Access to Medicines in Uganda

Author Mpeirwe, Intellectual Property (IP) Consultant

Like many other WTO least developed member states, Uganda is involved in 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 right to health. International intellectual system is aimed at rewarding the people who have invested their intellectual energy to produce tangible goods. The TRIPS Agreement is based on the principle that inventors have a right to exploit their investments, i.e. inventions. The obligation of WTO members is to reform national legislation to conform to TRIPS.

Equitable access to health care requires:

- Availability of medicine at a price affordable to both the poor and the rich
- Achieving equity in access to medicine is a deliberate action
- Government has to make particular interventions to ensure access to medicine by all

The controversy on patents and access to medicine has set protection of public against individual interests – represented by health consumers (developing countries and civil society) and pharmaceutical industries respectively. Availability (supply) and affordability (cost) are key elements of access to medicine. Thus, high costs due to monopoly rights and low supply against manufacturing capacity stand as barriers to equitable access to medicine. The effect of patents is to affect supply quantities and prices.

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. Patent Law reform process is underway in Uganda. There are concerns 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 for most poor Ugandans. The IP Bill is at cabinet level but a number of provisions need redrafting. The challenge is determining how to draft legal provisions that allow the government maximum flexibility, deal with foreign interests, and competing regional processes. Therefore, CSO's 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 rice of medicine. International consensus suggests that a flexible patent regime should afford greater access to medicine and so improve health.

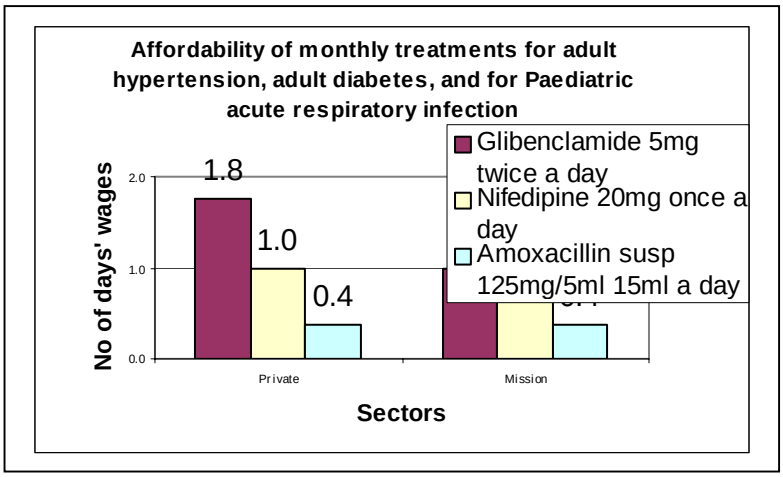
4.2 Impact of Prices on Access to Medicines in Uganda

Aziz Maija, Medicine Advisor, HEPS Uganda

Access to medicines is a human rights issue and the main reason people seek health are. Therefore, periodic monitoring and assessing medicine prices is important to determine if medicine is available and affordable at different levels in the distribution chain. The medicine price monitoring surveys are conducted by the Country Working Group, which includes WHO, Ministry of Health and HEPS Uganda (on behalf of HAI Africa). This survey aimed to inform policy makers, implementers and health consumers of medicine prices, to document availability and price variations of selected medicines in the private-not-for-profit (mission/NGO) and public sector facilities and the affordability of treatment for a

selected list of common diseases, when comparing prices to international reference prices. The project used a standardised WHO/HAI Africa medicine price monitoring tool. Forty key (regularly prescribed and dispensed) medicines were selected for price survey (lowest priced generic versions) and availability. The survey was conducted in four regions (Eastern, Central, Western and Northern) and three sectors per region (public, private and mission).

The 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 mission facilities, and medicines in private sector and mission facilities were unaffordable for the lowest paid government worker.



Source: MoH Uganda, WHO, HAI Africa and HEPS Uganda 2008

The research suggests that analysis of the medicine procurement system in public sector facilities is needed 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.

4.3 Uganda's Policy and Legal Framework for Human Resources for Health

Moses Mulumba, Faculty of Law, MUK

The workforce is the single most valuable asset in the health system, which can ultimately influence the success or failure of the health system. This paper seeks to review the existing policy and legal frameworks with implications on the human resources for health. In Uganda, the National Health Policy addresses a number of factors affecting the national human resources for health such as constraints of inadequate numbers and inappropriate distribution of trained health personnel. Uganda has several other scattered national polices and laws with provisions that have influence for addressing challenges for human resources for health in Uganda:

- Human Resource for Health Policy (2006)
- The National Health Policy (1999)
- The Health Sector Strategic Plan II 2005/06-2009-2010 (2004).
- The Constitution of the Republic of Uganda – 1995
- The Allied Health Professionals Act Cap 268
- The Medical and Dental Practitioners Act Cap 272
- The Nurses and Midwives Act Cap 274
- Occupational Safety and Health Act
- The Code of Conduct and Ethics for Health workers (2002)

To varying extents, these laws and policies address aspects such as: the education and training of health workers; the procedure for recruiting, terms and conditions of work; safety; and internal and external migration of health workers in Uganda as well as provisions for incentives for health workers.

The Human Resources for Health Policy comprehensively addresses various aspects of Human Resources for Health in Uganda. It provides a framework and guidance for ensuring that there is adequate and appropriate capacity to implement the National Health Policy and includes training and education, in-service training, and policies aiming at resolving national and regional gaps in staffing levels and skills and national development policies The policy framework is however not backed by a sound legal framework, an area that needs review for support of policy processes aimed at addressing problems of human resources for health in Uganda.

4.4 Health worker retention: lessons and options from regional work in ESA

Yoswa Dambisya, EQUINET/University of Limpopo

East and southern Africa (ESA) faces a critical shortage of health workers. There are less than 2.5 health workers per 1000 population. There are also critical gaps to service delivery: there were 55% vacancies in doctor posts in Zimbabwe in 2005; 10 districts in Malawi were not having a Ministry of Health doctor in 2005; and more than 50% of health services are provided by the private sector, and children under one year from the richest households are 1.6 times more likely to be immunised than the poorest in Uganda. Much of this shortage is due to emigration of health workers at a time of new demands on health personnel, due to e.g. AIDS epidemic. Health migration takes two forms: internal (losses from rural areas) and external (losses from public sector to overseas). Health migration constitutes a drain of public investment and a subsidy to high income countries.

EQUINET in co-operation with ECSA-HC have a programme supporting knowledge for health worker retention in ESA involving University of Namibia; Health Systems Trust SA, the EQUINET Secretariat (TARSC), University of Limpopo, ECSA, IOM, WHO, SADC, institutions in Canada, UK and Australia with support from SIDA.

Financial and non-financial incentives are used in ESA to try to address retention and migration of health workers:

FINANCIAL	NON FINANCIAL
Salary top ups	Career paths and recognition
Differential salary levels for health vs other civil servants eg Tanzania	Training opportunities: scholarships, study leave, skills enhancement, research opportunities
Scarce skills and rural allowance	Assistance with housing, schooling, transport, child care, food
Permitting dual practice	Working conditions: Improved facilities, conditions of service, security
Reasonable access to loans	Health coverage: ART, insurance
Per diems, sitting allowances	Management: Strategic planning
	HRIS, open appraisal systems, supervision

There is 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 and general budget support rather than donor-driven vertical programmes. Issues arising from retention schemes in ESA show successful schemes:

- Consider targeting areas of most critical shortage in a context of universal application of incentives across grades
- Consult the workforce (between cadres; between facility type)
- Set up systems to support incremental expansion: planning, management, monitoring, adjusting
- Build on existing and working (district-level) initiatives
- Use simpler unambiguous systems
- Are consist with wider HR and health sector strategies

Clear signals needed that health workers are valued

"How does one care for someone when we do not care about ourselves? Health care workers have kept silent for so long. Do you know what is silence? Silence is the absence of sound. Sound is when you make an impression and from us as nurses there is no sound or impression. That is why the government can make legislation without asking the health workers"

South African health worker IHRG 2006

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.

4.5Discussion

In the discussion it was pointed out that the pricing of medicines tends to have a disproportionate effect on women due to their natural gender role of caring for children. By putting in time and effort, women play an unpaid nursing role and “spend” more on child health than men and in so doing “subsidise” paid and unpaid health care.

The legislative provisions that regulate herbal medicines was queries together with the packaging of these medicines. It was noted that herbal medicines are supposed to be regulated by the National Drug Authority (NDA) who regulate and coordinate research into herbal medicine, but that there may be shortfalls in quality and packaging enforcement. A policy was being drafted to deal with research into herbal medicine. It was noted that many poor people resort to herbs because they cannot afford medicines.

A further problem was raised of some unqualified health personnel reported to be practice in some suburbs of Kampala and of patients are being charged for services and drugs in government facilities that should be free. Such practices were noted to be illegal and should be reported to police. CSO’s were urged to take up the matter and create public awareness and advocate for tough police action on illegal practice.

Another participant asked whether it was possible for Uganda to follow the path of India, defying the TRIPS Agreement to make cheap generic AIDS drugs available. In response, the presenter noted that it is not necessary to violate the TRIPS Agreement, because it has flexibilities that least developed countries like Uganda could exploit between now and 2016. He however pointed out that Uganda still does not have an IP legislation and has limited capacity to manufacture drugs. Besides, Uganda is already bound by TRIPS Agreement; India was not yet bound when it went into the manufacture of generic drugs.

5. Fair financing for health

The session was chaired by Dr Yoswa Dambisya, University of Limpopo / EQUINET.

5.1 Uganda’s Health Financing from an HIV/AIDS perspective

Edgar Agaba, MUK Population Studies Department and HEPS Uganda

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 of ART (MoH, 2006) currently access treatment, while there is upward appreciation in HIV prevalence rates of 6.4% (MoH, 2006).

The study reported aimed to monitor and evaluate health sector financing from an HIV perspective to produce policy recommendations for effective health service delivery in Uganda. It examined the level of government commitment to HIV funding; identified priority given to different aspects of the fight against HIV; assessed per capita spending on AIDS drugs; and assess sustainability and harmonisation of HIV financing mechanisms. The methodology involved a review of relevant documents and key informant interviews with HIV policy programmers and communities. The study was done in four districts: Soroti, Lira, Rakai and Kamwenge.

On the positive side, Uganda was noted to acknowledge health as a right for all citizens, and has be applauded in fight HIV/AIDS. It has signed my covenants; UN declaration on HIV/AIDS, MDGs, African Union Abuja Commitment (15% of budget for health), WHO 3/5 ART targets, among others. There has been a significant increase in HIV/AIDS funding (including from Global fund, MAP-World BANK,

PEPFAR). Central government funding for health has been rising, moving from 5th in budget allocations from the government treasury to 4th in 2004/5. In FY2004/5, out of US$210m total budget for health, government sent US$53.4m to districts for primary health care (MOFEP, 2004): US$5.7m district hospitals and US$9.7m to NGO hospitals.

Nevertheless, public health spending is below the level needed to realise the targeted 2.5 health treatments per person per year, with some Health Centre II receiving about Ushs 70,000 (US$40) per month. Although health expenditure is about 6% of GDP, drug supply remains inadequate compared to demand. The immediate shortfall in HIV funding is about Ushs 200 billion. Local government contribution is low, e.g. in 1998/9 they contributed US$0.04 to health financing, which reduced to US$ 0.03 in 1999/2000 and no allocations are made in districts budgets for HIV/AIDS activities. The health sector entirely depends on PHC funds, donors.

The key recommendations from the study are for:

- commitment from state funds essential for longevity with strong political commitment
- harmonization of different funding mechanisms
- improved tracking of funds and greater transparency mechanisms on budget allocations
- priority to be given to per capita funding to essential drugs at district level
- equity in service delivery and comprehensive services to enhance physical and psychosocial wellbeing

5.2 Local Govt budgeting and its response to gender health needs: a study of Mpigi District in Uganda

Kareem Buyana, International Potatoe Centre

The study area, Mpigi District is located in central Uganda covering 3,714.9 square kilometers. It is occupied by a total of 88,654 households with a population of 407,790 people (204,279 females and 203,511 males). The district has three counties namely; Butambala, Gomba and Mawokota. These counties are further divided into 17 sub-counties. This study examined the extent to which local government budgeting responds to gender health needs in Mpigi district. Mpigi's local health care system is characterized by persistent drug stock-outs at sub county and village level; stressed health user-provider informal relationships; stigma from local health workers at PMTCT centers; lack of cheap public transport to participate in community health activities; and inability to comprehend health information at HCs, among other things.

The local government administration has set a number of objectives (priorities) e.g. increasing immunization coverage to 90%, PMTCT, malaria control, provision of ARVs, and improving HIMS. These priorities do not reflect the broader understanding of health as perceived by the community. Prioritization is based on disease measures of ill health, thereby ignoring social economic indicators. Therefore the priorities set in the health sector partially respond to gender health needs.

This study used key informant interviews with district and sub-county technical staff and local council officials; focus group discussions with the community; face-to-face interviews with households at the village level; and extensive documentary review of the local council budget (2005/06), budget framework papers and the district development work plans.

Gender health needs in Mpigi District are diverse ranging from health care concerns about household welfare to constraints met within the local health care system. Both women and men have a broader understanding of health needs, including not only common disease infections but also socio-economic needs that affect the quality of life. The District Council however sets budget priorities using a narrow definition of gender health needs within the community, using only the burden of disease. A more holistic approach using a rights-based framework should be the basis for setting budget priorities in local government budgeting. This needs to take cognisance that people have one meal a day; women have no control on productive resources and lack command over distribution of health resources. Fertility decisions are taken by men; the pills are given to women who don't take them because they could one divorced; and quite often women are blamed for sickness of children.

The Local Governments Act (1997) provides for the inclusion of gender concerns in budgeting calling for a Local Governments Gender Budgeting Framework that integrates gender disaggregated information on the BoD and on socio-economic needs, and that provides tools for analyzing the gender implications of priorities set. .

5.3 Household willingness to join community health insurance in Jinja

Dr Martin Ruhweza, Uganda Protestant Medical Bureau

Developing countries carry 90% of the global disease burden but spend under 10% of total health resources. In Uganda, the health sector receives just 9% of the budget, total health expenditure per capita is $18. This calls for innovations in health financing. Health insurance has not been fully exploited; Social Health Insurance is planned to initially target individuals in formal employment, which will leave out the majority of Ugandans. Community Health Insurance (CHI) is increasingly being seen as one way of addressing the inequity in access to healthcare that arises from direct payments for healthcare because it has the potential to reach individuals in the informal sector. It is perceived to be particularly relevant in countries (such as Uganda) 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. This study investigated the willingness of households to subscribe to CHI schemes in Jinja District as an alternative to current methods of payment for healthcare. It used using quantitative and qualitative methods and included 384 households in a cross sectional survey.

About 81% of the households expressed willingness to enroll in CHI schemes. They were willing to contribute on average Ushs.5,977 (USD 3.4) per person per year. This 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. Up to 26% of households had had someone admitted in the year that had preceded the study and up to 77% of them had been making direct payments for healthcare whenever someone fell ill.

Healthcare needs among households were high and majority of the 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 so as to join. The district health team and Ministry of Health (Uganda) should introduce CHI in Jinja District and identify extra funding sources to supplement the meager contributions that households are willing to make in order to join. The study recommended that the DHT

- take steps to shield households from the effects of direct payments for healthcare and help them deal with the high healthcare needs they face
- take advantage of high willingness to enroll, to initiate CHI
- identify other sources of funds to supplement the small household CHI contributions.

It also suggests that CHI Scheme managers to ensure common health problems are included in the benefit package.

5.4 Equity in allocation of primary health care resources in Uganda

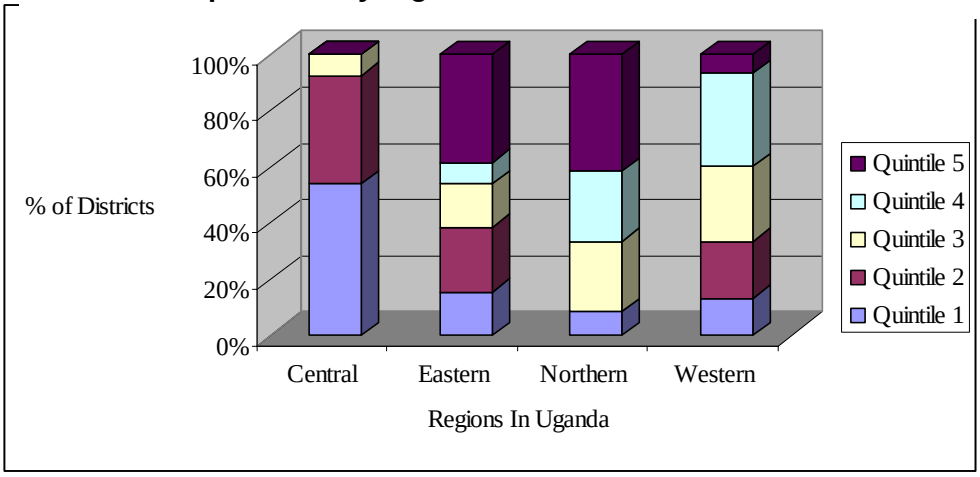
Dr Elizabeth Ekirapa Kiracho, Makerere University School of Public Health

There are significant disparities in health outcomes and health service delivery across the different regions in Uganda. For example, the infant mortality rate is much higher in rural areas compared to the urban areas; and also higher in the Northern region compared to the Central region of the country. These disparities reflect varying levels of need across geographic areas and the need for an equity-oriented resource allocation process for the health sector. However, available research reveals that the resource allocation mechanism in the health sector does not sufficiently address the varying health needs of different geographic areas. The aim of this research was to assess the extent to which PHC financial resources to the districts are allocated according to need in Uganda.

The study assessed the extent to which Primary Health Care (PHC) financial resources to the districts are allocated according to need in Uganda, and identifies health districts with the greatest need. A cross-sectional analytic study was implemented using quantitative and qualitative data. Data from key informant interviews and review of government publications provided information about the resource

allocation process for primary health care grants. The secondary data included expenditure on Primary Health Care and socio demographic and household's characteristics information obtained from the census. The extent of vertical equity was assessed by constructing a deprivation index by health districts, using principle component analysis. These were then compared with per capita primary health care expenditure across health districts using regression analysis. Variables used for constructing the deprivation index included poor quality floor materials, lack of access to piped water, lack of electricity for lighting, use of firewood for cooking, lack of access to a flush toilet or VIP latrine, living in a rural area and lack of employment. Lastly a resource allocation formula was constructed by weighting the deprivation index by district population.

Levels of deprivation by region



Financial resources are allocated by the Ministry of Finance with guidance from the cabinet. The health sector assesses the health needs of the country prepares a plan showing the priority areas of the health sector. PHC resources are given as a conditional grant. The formula has 5 broad components: health needs, project funding, poverty level of the district, presence of IDP camps and cross border flows (considered in the population inflator), and population that is not served by the district and regional hospitals. The resource allocation formula is used alongside an incremental budgeting system. This has watered down the ability of the formula to result in the equitable distribution of resources. One of the limitations of this study was that it assessed only the primary health care financial resources for the districts.

The key conclusions are:

- Deprivation in Uganda is concentrated mainly in the Northern region.
- Resource allocation process for PHC grants does not appear to result in the distribution of resources according to need.
- Resource allocation process combines the use of the formula with incremental budgeting.
- Some of the components of the formula are measured using objective means while others are measured subjectively
- This has affected the extent to which the formula can accurately measure need.
- The other constraints lack of sufficient skilled staff, insufficient funds for PHC, lack of a complete database quantifying donor contributions, reliable data

The study proposes that Ministry of Health and Finance ensure that the resource allocation formula is the primary determinant for the allocation of PHC recurrent resources, with objective measures used to measure the variables included in the formula. External factors influence the allocation of resources such as lobbying by politicians for districts which are not deprived, and need to be managed.

5.5Discussion

Participants queried whether Mpigi district allocates any funds to traditional healers, herbalists and birth attendants given that many people seek their services, but it was noted that the district does not allocate any money to them. The willingness to pay for health insurance in Jinja was queried in relation to quality of services deteriorating, and it was noted that health insurance concept is more sustainable when it has many members pooling risks more than on the basis of willingness to pay, and thus depends

Plenary discussions of papers Source:TARSC 2008

more on the design and management of schemes. It was noted that systems promoting transparency in resource management are needed to inform the public on use of public money. The current allocation of resources was heatedly debated. While some attention was given to expenditures on expensive vehicles, it was noted that vehicles are capital/development expenditures, and there was a need to ensure that recurrent expenditure take into consideration equity issues. The overall low funding to health was observed as health financing had shifted from being needs-based in the 1970's to a more liebralised competitive approach, with demand to show "returns" and effectiveness. This has led to reduced funding for social services.

6. Building people centred health systems

6.1Health Systems and Ethical Analysis Compliance

D. Nsubuga Moses Kakyama, Compliance Health Ethical Alignment and Policy (CHEAP) Centre

Ethics refer to behaviours, beliefs, personal efficacy (worth/usefulness), etiquette (manners/customs), and needs and priorities (precedence/main concern) that people hold and practice in their professional fields. The factors that impact on ethics include, but are not limited, to: culture and gender issues, way of life, political rhetoric, nepotism/favoritism, poverty, corruption, social background, etc.

This work monitored compliance with ethics is three sectors: public health institutions, private health providers, and civil society organisations. It used ethical analysis to identify patterns of demand and priority areas for interaction. The paper examined the specific case of public- private partnerships.

It found challenges facing private-public partnerships in ensuring ethical practice in:

- delays in disbursement of funds
- lack of awareness of the needs and requirements of the partnership
- lack of Telemedicine Systems
- lack of clinical analytical platforms in communities.
- heavy taxation on some supplies e.g. gloves
- conflicting views on care needs and delivery

To strenghten ethical practice the author recommended

- establishment of a mediation system for partnerships.
- training providers in health ethics, maximizing team work and promoting ethical behavior
- establishing health-based peer review mechanisms
- widening public and provider health knowledge at all levels.
- improving public relations between health providers and consumers.

6.2 Integrating Refugees into the National Health Framework and Action Plans

Irungu Peter, Pan African Development Education and Advocacy Programme

Uganda hosts about 257,256 refugees (2005) from the neighbouring countries such as Sudan, Rwanda, the Democratic Republic of Congo, Somali and Burundi. Majority of them reside in rural settlements in areas such as West Nile and western Uganda. The United Nations High Commissioner for Refugees (UNHCR) is internationally mandated to cater for their basic needs. Article 23 of the Refugee Convention of 1951 stipulates that refugees should enjoy access to health services equivalent to that of the host population. Under international law, everyone has the right to the highest standards of physical and mental health (Article 12, International Covenant on Economic Social and Cultural Rights, 1966). According to an official of the Directorate of Refugees, Office of the Prime Minister, refugees are supposed to enjoy the same health rights as Ugandans. A study by the Refugee Law Project in 2005 found that refugees in Kampala had access to health care on a par with Ugandans.

Even then, refugees may extra problems due to language barriers, lack of awareness of their rights, retrogressive customs (e.g. among some refugee community sex talk is a taboo and exclusion from primary health care (PHC) and HIV/AIDS interventionists. Refugee health services set up and provided separately by UNHCR and international, regional and local NGOs operated in parallel to that of the host

community, with minimal interface between the two systems. Refugee health services both first line and referral in government gazetted refugee settlements were better funded, better equipped and had more skilled personnel than the local, government supported health delivery systems.

In 1999, UNHCR and the Uganda government developed a strategy to improve refugee self-reliance and integrate their health services into host systems in refugee host districts. This

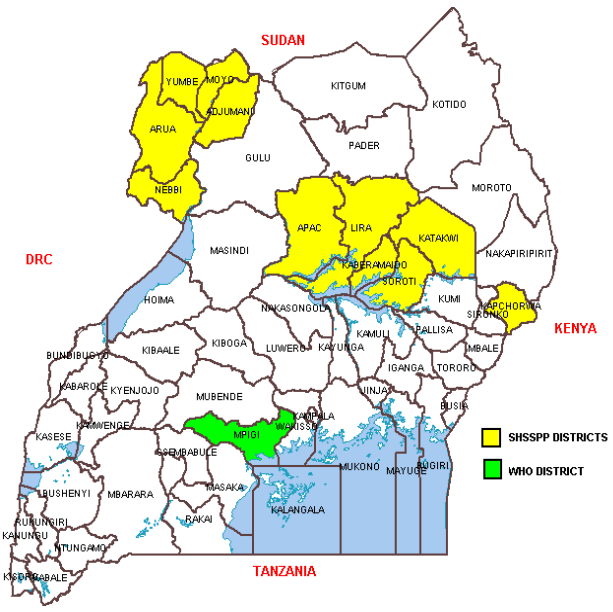
- Gave access to additional resources
- Avoided creation of parallel services and systems, while reducing costs of health services for local populations and refugees
- Improved local health care services
- Removed barriers for providing services
- Reduced discrimination and stigma

The strategy does, however, not cater for urban refugees, who are estimated to be between 20,000-50,000. As integrating refugees into the national health framework work has assisted to integrate them into Ugandan society and avoid duplication of services this gap in urban refugees was noted to be of concern.

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

Dr Deogratias Sekimpi, Uganda National Association of Community and Occupational Health (UNACOH)

In line with the National Health Policy (NHP) of 1999, the Health Sector Strategic Plan I (2000/2005) spelt out the role of Community Empowerment and Mobilisation for Health (CEMH), as an element of the Uganda National Minimum Health Care Package (UNMHCP). The Village Health Team (VHT) Strategy was identified as the means of achieving Community Empowerment and Mobilisation for Health, nationwide. By 2005 the VHT Strategy had been implemented in a number of districts, but not at all in others against a target of complete implementation by 2010. The Annual National Health Assemblies in 2006 and 2007 (with representatives from all 80 districts of Uganda) urged the Government to avail resources to roll out the Strategy to all districts.



Districts in Uganda that had fully implemented VHT programme by July 2006

In its collaboration with government, UNACOH) established Village Health Teams (VHT) in Masindi and Kyenjojo districts to improve people's participation in health; improve people's utilization of existing health services/programmes and promote the keeping, reporting and utilization of community based health records through orienting or training of stakeholders in a systematic and integrated way to motivate health promotion.

The programme in Kyenjojo and Masindi districts began with briefing of District Top Leaders, training of district and sub-county trainers, briefing of sub-county executive committees and a sensitisation of public health workers. VHT members were then selected one per 25-30 households and trained by sub-county trainers.

The programme has involved stakeholders from international to household levels, reducing the burden of health in development . It has established a Community Based HMIS.

VHT programme mobilises communities for immunisation (above) and health campaigns
Source Sekimpi 2008

Many community members are very enthusiastic to participate in health programmes, even on a volunteer basis as in VHT, although some cannot easily accept giving or contributing and do not easily accept a system where they can themselves pro-actively promote health and prevent diseases. The above notwithstanding, the long-term health and poverty eradication benefits of the VHT Strategy were presented as worth pursuing. The main challenge was seen to be resistance to change by most stakeholders (central and local governments, health workers, various leaders, and some community members) not lack of money. Inverted thinking about development also impedes progress: as many people think of what they can get from the economy, rather than what they can contribute to make the economy grow. Many people prefer to reap than to sow!

6.4 Communication Campaigns for Community Empowerment for Health in Uganda

Wilson Okaka, Kyambogo University

Uganda has a well crafted national health policy and the strategic health sector plan with significant progress despite surrounding constraints. Effective health communication campaigns are important to policy awareness and to promote health. This means organising people's power for health, including promoting information and communication technologies [ICTs] to facilitate the diffusion of information.
This paper was based on current research and professional practice, existing literature review of relevant health communication models, and change theories of communication, national health policy, and health sector strategic plan, the current training programmes, and participatory communication models.

It was found that the mass media is the most effective and efficient channel in effecting attitudinal change toward a new health behaviour, moreso if supported by raised, developed and sustained community empowerment. ICT's, mass media, communication strategy, and the "Diffusion of Innovations" Theory, can empower the key health sector strategic stakeholders but these actors need to be well informed about the attitudes, level of knowledge, listening and message comprehension abilities, social and cultural background of the target audiences for effectiveness of their campaigns.

6.5 Reaching out of School Adolescents with Reproductive Health Services

Henry Nsubuga, Straight Talk Foundation

Straight Talk Foundation (STF) started the Community Outreach Project in 2005 with the aim of reaching out-of-school youth. The project reported aims to bring health services closer to the people

through health fairs carried out in different localities with in a district. Through health fairs, remote communities are informed of the health services within their reach. Straight Talk's local language health magazines are distributed.

In a new district, Community Outreach Officers meet the different district health stakeholders like NGOs, CBOs, health workers, politicians and discuss the intention of the project and invite them to a district advocacy meeting where roles and activities on reproductive health are shared and actions planned. Prior to holding a health fair, sports activities are carried out in the venue to inform people to attend the health fair, and announcements are passed on the local radios. During the health fair, local service providers offer services to the people, people are made aware of services available in their area and access free VCT, information especially reproductive health information; donated blood and family planning services. Partnerships between the different stakeholders are created.

While the health fairs are successful in overcoming information and access barriers, mobilisation and event costs are expensive making this less sustainable. It is recommended that challenges to access like roads, health facility costs are addressed, community/district health partnerships are supported to discuss and act on barriers and such models of partnerships are replicated across districts.

6.6 Community Empowerment and Participation in Maternal Health in Kamwenge District, Uganda

Aaron Muhinda, HEPS Uganda

Maternal health in Uganda has remained poor despite the country's relatively fast economic growth. The proportion of women delivering in health units remains low and there is a gap between the numbers attending antenatal services and those delivering in health services. Kamwenge District has poor maternal health statistics than the national average and a shortfall of health facilities and staffing.

The Kamwenge Community Empowerment and Participation in Maternal Health Project aimed to contribute to the improvement of the health of expectant mothers in Kamwenge Sub-county, Kamwenge District. Through the use of participatory reflection and action (PRA) approaches, it aimed to increase demand for, access to and utilisation of maternal health services by expectant mothers. This work was implemented as part of a multi-country programme on PRA approaches to people centred health systems in ESA in EQUINET. The project involved health workers and community members, including community leaders, expectant mothers, male spouses, and others in Kamwenge sub-county in Kamwenge District and was facilitated by two HEPS Uganda staff members. It aimed to facilitate community members to identify and analyze barriers to use of maternal health services; work with the community to identify, prioritize, and implement actions for overcoming one or more of the barriers to use of maternal services; and promote a cordial and mutual, respectful relationship between health workers and expectant mothers in the sub-county. PRA techniques were used to draw on people's experience, to identify the barriers to utilization of the maternal health services, prioritise where to act and plan and implement actions on the barriers identified. Community leaders and health workers were trained and sensitized on maternal health rights, who then lead mass campaigns in the promotion of utilization of maternal health services in Kamwenge sub-county.

Several barriers to maternal health were identified. At health facility level, these were shortage of staff accommodation; shortage of skilled health workers; lack of basic health care resources like drugs, mama kits and laboratory equipments; and lack of an operating theatre. At community level, poor roads; traditional and culture beliefs; poor communication between health workers and expect mothers; and competition between traditional birth attendants (TBAs) and health workers impede delivery at services. At household level, high levels of deprivation mean that family especially husband cannot afford the basics for maternal health care; multiple roles of mothers; domestic violence stemming from gender inequality (the couple rarely discuss together); and poor knowledge about the need to deliver in hospitals.

By the end of the project, 34 community leaders and 15 health workers had been identified and trained; 450 posters on maternal health rights had been produced and distributed, and a complaints redress mechanism established at six health facilities with each having a suggestion box installed. By the time

the project ended, antenatal attendance by expectant mothers and supervised deliveries had significantly increased at health centres. The relationship between expectant mothers and community improved; while Kamwenge district and partners like UNICEF responded to the maternal health rights campaign by distributing 700 mama kits to the health centres. The challenges during implementation were low male participation in maternal health; and communication between expectant mothers and health workers on PMTC services remained poor.

The work showed that PRA is an effective way of gathering information, planning and acting on challenges facing communities at grass root level, and needs to recognise local history and values for this. Many community members were very enthusiastic to participate in health programmes, even on a volunteer basis as in the Kamwenge project. It's very important to involve decision makers and community leaders in activities aimed at sensing the communities as they have authority and their messages are taken seriously, sustainability of the project is also ensured. This means that community workers need skills in managing expectations from community members to maintain community motivation in supporting and participating in the project

6.7 Discussion

The chairperson of the session, Dr Rene Loewenson TARSC/EQUINET noted how the presentations show that interventions need to be specifically designed to empower people to act and that this cannot be taken for granted.

Issues were raised of the sustainability of the programmes, including the VHT programme and the health fairs. It was noted that sustainability of the VHT programme was a challenge because it is cost and because the bureaucracy is resistant to change, but that this is "people" driven, and if people support it, it will be sustainable. The presenter quizzed: "What is the 'primariness' of primary health care (PHC); is it about health workers? PHC is about involving communities – educated or not – except that we are training people to keep simple records, except in the case of home based management of fever where people are supposed to know how to give anti-malarials to children. Who trains mothers to look after kids? The only academic requirement is that if one has to be a VHT member, they have to be literate, even if in the local language, and that is because they are supposed to take records. The VHT programme is increasing the pool of knowledge. For us it is not an issue that some of them are dropping out. They are already trained to promote health; when they drop out we train others and increase the pool of knowledge".

It was also raised that empowerment approaches need to be rights based, because it is by knowing their rights that the community will demand for them. .

Some issues of clarification were made. It was clarified that Uganda's policy is that all refugees must settle in gazetted rural places, and that this is not unique. Urban refugees are not catered for and fear to come out and demand for their rights because they have legal issues around their status. They are not free to settle and claim their rights; they are not protected. Some refugees in rural areas are also unknown and have settled among communities of nationals and integrated themselves, acquired land, are involved in income generating activities, and have even married among host communities.

Social factors and processes were noted to be central to empowerment. It was noted that a sustained erosion of culture has affected care and social support to ill people. Many men have a negative attitude to reproductive health. Women do not use them because they fear to be harassed by their husbands because decisions about reproduction are taken by men. For example, an example was cited of a programme to fight bird flu in Mpigi that failed allegedly because women refused health workers to kill suspected birds in the absence of their husbands who own all assets in the home –while the men were never at home. It was recommended that reproductive health programmes target men if they are to succeed.

Communication channels are key. Reading materials for out of school youths in local languages are for example supplemented by radio programmes on 36 radio stations across the country, including Karamoja as these reach the target groups.

7. Networking for health equity in Uganda

7.1. Key issues from the sessions

Progress and Challenges to Health Equity in Uganda
The sessions raised a number of areas of policy concern and options to strengthen health equity and address cost barriers that persist, despite fee abolition and service outreach. It was recommended that government service be strengthened and programs strengthen their subsidies for the poorest and rural residents to ensure they have access to health services. This calls for re-prioritisation and rationing within UNMHCP with formulation of specific performance indicators that monitor equity and reach to poor and vulnerable households, including elderly people. At a more general level it was suggested that government further strengthen management and accountability systems, invests more in human resources, and strengthen collaboration between public and private services.

Wider Challenges to Equitable Health Systems
The redrafting of patenting law currently underway needs to take full advantages of the flexibility provisions of TRIPS Agreement to create an enabling framework for drug access and controlling medicine prices. While the country has effective policies for Human Resources for Health, there is need to review and update the laws to give effect to these policies, while the brain drain of health professionals needs to be reviewed nationally to better manage costs to the health system.

Building Equitable Health Systems: Fair Financing for Health
While progress is being made towards improved state funding, there is need for harmonization of different funding mechanisms, for integrating equity into resource allocation to strengthen disbursements to high need districts and primary health care and for improved tracking of and greater transparency in budget allocations to enhance accountability. This equally applies to financing for HIV and AIDS. Local Governments also need to strengthen their own budget framework to integrate gender disaggregated information and respond to identified community priorities.

Building People Centred Health Systems
Building mechanisms and strategies for informing, involving and empowering communities, especially vulnerable communities, is necessary for equity, and possible through approaches that build skills, structures, through participatory processes, and through providing information resources that reflect local culture and issues. However this needs sustained investments, skills and support in those facilitating it. It also needs to overcome bureaucratic blocks and to draw on ethical health practice. Service providers themselves need to be more skilled and informed to manage these processes, to devolve power to local levels, to integrate rights based approaches and to effectively use and evaluate ICT, mass media and communications strategies.

7.2 Group discussions on priority areas of work, follow up and networking

The participants were divided into three groups, each to work on a specific issue of networking and next steps. This section summarises the feedback from these working groups.

Priority equity Issues were identified as

1. Service Delivery Issues: accessibility, affordability, acceptability, utilization (functioning) and health worker/community attitudes
2. Issues of governance – accountability, transparency, responsibility, legal systems
3. Gender and vulnerability issues - decision making, social responsibility, communication to men and considerations of vulnerable groups, e.g. elderly, under-5's, women, youth and PLWHA
4. Burden of disease on population (causes of morbidity and death)
5. Environmental health issues
6. Trade agreement Issues - Lack of consumer participation, impact of agreements, i.e. patents, e.g. TRIPS, GATS and brain drain

In these issues it was proposed to create, raise, sustain & develop awareness (fill information gaps)., ie to carry out studies, lobby and advocate for health rights, form a coalition and hold forums to share information on lessons learned that can be replicated in other communities (best practices); support exchange programmes in special health areas: e.g. Geriatrics, family nursing; establish demonstration centres for new ideas, practices or health care technologies in communities.

Training health workers on effective communication techniques is important, including communication to men and women, and encouraging peer review mechanisms for health workers.

Plenary discussions of group work Source TARSC 2008

To follow up on the work presented at the meeting it was suggested that there be a report, .translation of the message into Uganda languages, quarterly/annual magazines and creation of a website. The table below highlights the target groups and means identified.

	ACTIONS								
FOCUS GROUP	REPORT	WORKSHOP	NEWS PULL-OUTS	DEBATE	NETWORK	PBLICATION	BROCHURES	AWARENESS PROG	PRESS STATEMENT
GEN' PUBLIC	✓		✓	✓				✓	✓
PROF' GROUPS	✓		✓	✓	✓	✓	✓		✓
CIVIL SOCIETY	✓	✓	✓	✓	✓	✓	✓	✓	
R&A INST'	✓	✓	✓	✓	✓	✓	✓		
DEV' PARTN'	✓	✓	✓	✓	✓	✓	✓		✓
POLICY MAK'	✓	✓	✓	✓	✓	✓	✓		
MARG'ZED e.g. Geriatrics	Contacted through civil society								

KEY: Prof' groups include medical and health planning professionals Civil Society; includes. NGO's, FBO's and CBOs; R&A Inst = Research and Academic Institutions; Policy makers include politicians and leaders

Actions to strengthen and sustain networking and sharing of information and joint work on health equity in Uganda proposed included

- Collaboration with the mass media through experience and lesson sharing meetings, i.e. at the end of every year.
- Creating a taskforce to identify the need for a multi-health systems equity platform.
- Good communication by improving on publication through for example, journals, research papers, holding workshops on health issues, holding metings, interactive forum, e.g. e-mail lists or a website where the information can be found.
- Promotion of partnership between the academic group, civil service organizations (including the church) and the government
- Through organizing public dialogue on topical issues through public lectures/debates, radio and TV shows in order to be vocal enough.

- Integrate the information through different local languages.
- Enhance collaboration with CBOs such as the Uganda Local Governments Association (ULGA); so they can extend the necessary information to the local person.
- Developing a communication strategy, a database for key stakeholders, and a proposal to support follow up work on the priorities identified by the meeting.
- Establishing a common networking forum, e.g. a website, publications, annual meetings, and a list to serve via e-mailing for continued discussion

7.3 Consolidated next steps for networking on health equity in Uganda

It was agreed that the initiative on network on health equity started at this meeting be sustained, with the issue of health equity a key priority. Rosette Mutambi HEPS presented a consolidated outline of the areas for networking on health equity in Uganda. Participants discussed and made input to this as a shared plan for follow up to the meeting.

R Mutambi, HEPS Source TARSC 2008

The final proposal is shown below.

The meeting set up a task force that they proposed include academics, civil society , ministry of health that would take the work forward. HEPS and Makerere were tasked to continue to co-ordinate this, with members also from the co-ordinators of the different theme areas below.

It was also proposed that a stakeholder reference group be set up involving media, parliament, local govt, international agencies and others who could be brought in for specific areas of work. A database of all those involved in the work and a mailing list for information sharing was proposed (the mailing list has been set up at ugandahealthequity@equinetafrica.org. The network in Uganda will link with other institutions involved in work on health equity and other equity networks, particularly with EQUINET in ESA.

The key areas of focus of follow up work and lead institutions for this were identified as

- Resource mobilisation and allocation – Makarere School of Public Health with HEPS Uganda
- Health in and health care for vulnerable groups – Matuda, Straight talk
- Gender – To be finalised
- Trade and health - HEPS
- Governance in health –To be finalised
- Health rights - UNHCO

The major stakeholders for the work are policy makers, Ministry of health, technical and professional personnel, civil society, media and community leaders and members.

The following specific follow up activities were identified:

- Prepare conference report and brief with EQUINET
- Set up a mailing list for the network of institutions in Uganda – institutions start sharing relevant information
- Include the Uganda institutions in the EQUINET newsletter and mailing list
- Disseminate the report to workshop participants and other stakeholders
- Hold a briefing meeting with Ministry of health
- Prepare a leaflet on the conference proceedings for wider dissemination
- Identify a journal for peer reviewed publication

- Hold a writers workshop for the journal papers and finalise the papers with EQUINET support
- Produce a journal supplement of conference papers
- Within key areas of focus hold follow up activities, eg systematic reviews, position papers, public forums, media dissemination and original research
- Regional and community level dissemination of work
- Organise public dialogues on key issues (target key health days)
- Organise theatre and drama on key issues
- Follow up national meeting in a year to review issues and work

This would be formulated into a workplan and proposal to support action and linkages, including regional networking.

8. Regional networking and learning on equity in health

8.1 Reclaiming the Resources for Health: A Regional Analysis of Equity in Health in East and Southern Africa

Dr Rene Loewenson, TARSC, EQUINET Steering Committee

EQUINET is a network of professionals, civil society members, policy makers, state officials in east and southern Africa that aims to advance and support health equity and social justice through sharing information and experience, research, building critical analysis and skills, and networking and building strategic alliances. It was formed in 1998 covering the SADC region, and extended to east Africa after 2004.

Across the countries of the ESA region, health inequality is stark:

- Infant mortality rate (IMR) ranges from 14 to 154 per 1000, with the highest IMR over 10 times the lowest IMR
- Child mortality rates (CMR) range from 15 to 260 per 1000, with the highest CMR is 17 times the lowest CMR
- Maternal mortality ranges from 22 to 1300 per 100 000, with the highest maternal mortality rate (MMR) 59 times the lowest MMR

Recent DHSS surveys have confirmed improvements in infant and child mortality in 11 ESA countries since 1996, but inequalities persist.

One basis for the inequality is in the poor return to human development and health for the poorest communities from economic growth. Socio-economic inequalities underlie this poor return, as does the impact of AIDS. However at global level ESA countries are also losing significant resources through many routes, such as debt payments, transfer pricing, falling terms of trade, unequal tariff regimes, depletion of natural resources, biopiracy and skills losses through out migration. This weakens the national resources for health. For example health worker outmigration is a subsidy from ESA. In Uganda for example an emigration rate reported in 2005 of 10% nurses and 43% doctors represents a training subsidy of US$220m based on average costs of training personnel in ESA and in OECD countries *(UNCTAD; Meeus and Sanders 2003)* This can lead to stress on PHC and district systems, even while recruiting countries fill marginal posts with high skilled professionals.

Evidence from the region shows that health systems in ESA have significantly reduced poverty and addressed inequalities in health. They have done so when they have increased public spending on health; provided comprehensive PHC oriented approaches; provided public leadership to involve other sectors in health; redistributed resources towards primary care and district services and to major health problems; and invested in the central role of people in health systems.

R Loewenson, EQUINET Source TARSC 2008

Poor-rich differences in the benefits of spending at different levels show that primary level spending benefits poor households. Spending at the local level is more beneficial to poor communities than at central and higher hospital levels.

Hospitals are however more articulate in demanding for resources than community level health centres and command a greater share of healthy resources in many countries. Uganda's redirection of health spending to PHC and district level is thus equity enhancing..

•

Country	% of benefits received from health care services at primary-level facilities		% of benefits received from all curative* health care services at hospital and primary-level facilities	
	Poorest quintile	Richest quintile	Poorest quintile	Richest quintile
Kenya (rural) 1992	22	14	14	24
Madagascar 1993	10	29	12	30
South Africa 1994	18	10	16	17
Tanzania 1992-3	18	21	17	29

Source: Carr 2004 in EQUINET SC 2007

Funding adequate health care at the district level demands adequate public financing as most low income people use public services. The implementation of the structural adjustment programmes however reduced government expenditure on health and threatened equity oriented health systems. As hown in the MacroEconomic Commission on Health, "the majority of studies in Africa, whether theoretical or empirical, are negative towards structural adjustment and its effects on health outcomes" (*Macroeconomic Commission on Health review, 1987-2001 Breman and Shelton, WHO CMH WG6, 2001*)

As a response EQUINET shows from evidence in the region that a framework of universal coverage calls for "ABUJA PLUS", that is meeting the commitment of 15% government spending on health (in 2005 only being met in one ESA country) PLUS debt cancellation, debt resources to health and international support to health systems. It also calls for fair financing, for user fees, threatening equity, to be replaced by progressive tax and social insurance, and for effective use of government resources to offset disparities by resource allocation formulae integrating equity, with increased allocations to primary care levels.

These changes are not simply technical, but call for active public support and involvement. Health systems support empowerment through high level support for participation translated into how systems are organised, funded, provided and reached; orientation of and communication with health workers; functional, resourced and capable mechanisms for dialogue between communities and health systems; and participatory processes that build exchange of experience, reflection, and action between health workers and communities.

Parliaments have for example supported equity through

- ensuring international treaties respect public health obligations, e.g. EPAs,
- ensuring international law promoting health is translated into national law – e.g. TRIPS flexibilities, ensuring equity oriented budgets, eg Zimbabwe, SA, Kenya
- bringing community issues and priorities to national attention and
- monitoring the performance of the executive.

The analysis carried out by EQUINET from evidence in the region points to three major ways in which reclaiming the resources for health can strengthen health equity: for poor people to claim a greater share of national resources to improve their health; for a more just return for east and southern African countries from the global economy; 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. The evidence from Uganda presented in the conference adds weight to the priorities identified in the region, but also adds examples of positive action and policy options for addressing the challenges. This makes regional networking to exchange experience and good practice a key dimension of reclaiming the resources for health and addressing health equity.

8.2 Remarks from Fountain Publishers Uganda, co-publishers of Reclaiming the Resources for Health

Fountain Publishers Limited was represented by Sara N. Kahangi, Group Sales and Marketing Manager. She said that Fountain Publishers was honoured to be associated with EQUINET as a co-publisher of the book "*Reclaiming the Resources for Health – a regional analysis of equity in Health in East and Southern Africa*". Fountain Publishers is not only the leading publishing house in Uganda but also one of the most active players in the book industry of East Africa and the Great lake regions.

Part of Fountain Publishers' mission statement is to provide a platform for intellectual exchange of knowledge and information between Uganda, Africa and the rest of the world. So where Fountain Publishers are unable to publish books on pertinent intellectual topics, it has partnered with prominent organisation such as EQUINET as co-publishers. Such other organisations it has co-published with are Oxfam – UK , James Currey - UK , The World Bank, Zed Books, Pluto Press, Ohio State University Press - USA, Indiana University Press -USA, Sterling Publishers India, Mkuki na Nyota - TZ, and E.A.E P - Kenya. This year Fountain Publishers will be celebrating 20 years of publishing success and believes that EQUINET choose to associate with the organisation based on our strong background in the publishing industry. Apart from publishing on specialised topic like this book Fountain Publishers also publishes school books, children's readers, local languages readers, and scholarly books for university and colleges and tourism.

Ms Kahangi congratulated EQUINET on the "very topical book for our health policy makers" and thanked it for partnering with Fountain Publishers. She closed with an anonymous quote: "It's not enough to borrow a book, you should buy a book."

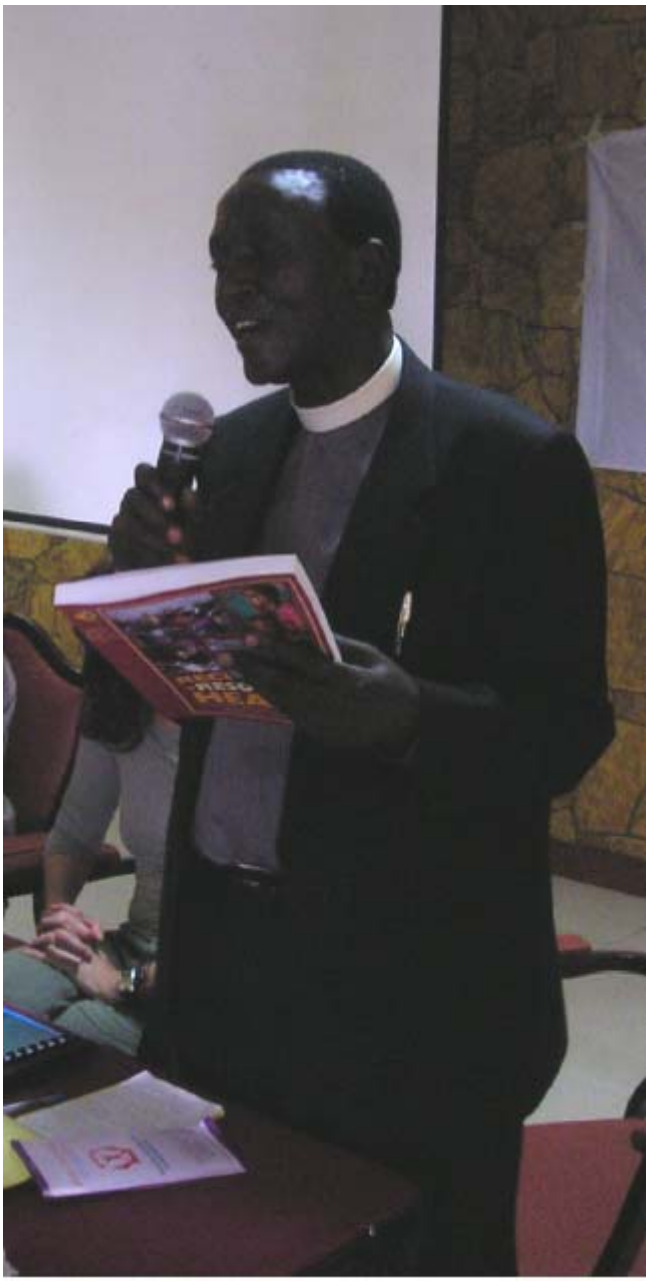
8.2 Closing remarks by HEPS Uganda Chairperson and launch of the EQUINET book

The meeting was officially closed by the Chairperson of HEPS Uganda The Rev. Canon John Kateeba, who also launched the EQUINET book ocally, after its regional launch in Malawi in 2007. In his remarks, he appreciated participants, "the team leader of HEPS" Ms Rosette Mutambi and the organising committee of the meeting, as well as EQUINET. He also thanked God for the distance HEPS has come, "step-by-step".

He noted that the book contained valuable evidence of how resources could be organised to promote health and appealed to the Ministry of Finance to heed the book's message: "Global and national resources should be used for health". He called on all Ugandans to read the book, and to redirect their own resources towards investing in knowledge by buying books.

In launching the book, "*Reclaiming the Resources for Health – a regional analysis of equity in Health in East and Southern Africa*", and the follow up networking on health equity in Uganda he used what he called Jesus' model. "Those of you disseminating health messages (usually) call people to follow you. We thank God that this book is free to institutions working on health equity; please use it. In case we are allowed to translate it, please translate it into local languages because a message in your mother tongue flows better. In the name of the Father, the Son and the Holy Spirit, I launch this book and pray that it makes a great impact in this country."

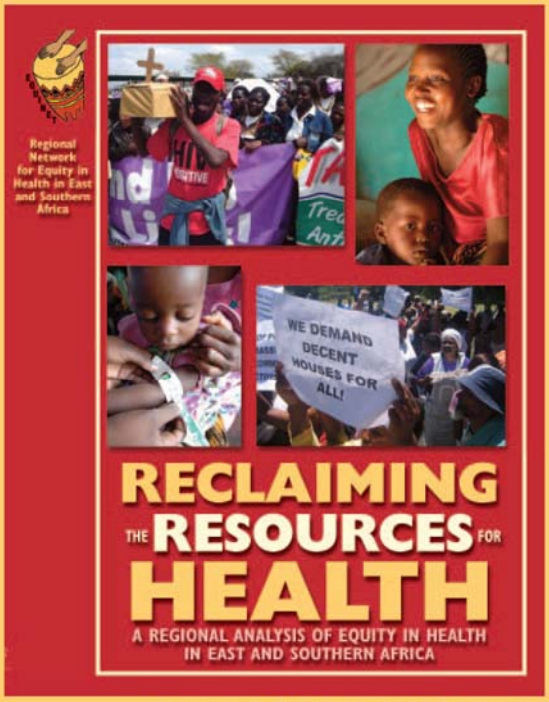
The HEPS' Chairperson finally expressed gratitude to HEPS Uganda's partners, Makerere University School of Public Health, for the technical input into the meeting, including putting together the abstracts of the papers presented during the meeting and to all participants at the meeting, and with this closed the meeting.



Rev. Canon John Kateeba, HEPS Chairperson
Source TARSC 2008

RECLAIMING THE RESOURCES FOR HEALTH:

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



Cover photos © B Goddard, TAC, Indymedia

Authors: EQUINET steering committee
Publishers: EQUINET in association with Weaver Press, Fountain Publishers and Jacana
Format: 200 x 260 mm Extent: 240 pages
ISBNs: 978-1-77922-066-0 (Zimbabwe);
978-1-77009-409-3 (South Africa);
978-9970-02-754-5 (Uganda)

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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.

APPENDIX 1: MEETING AGENDA

March 27 2008

Time	Topic	Presenter
8:00 – 8:30	Registration	HEPS-Uganda
OPENING PLENARY		
8:30 – 9:00	Welcome and Introductions	
	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. G Pariyo, E Ekirapa, 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	
10:30-11:00	**TEA BREAK**	
PLENARY 2: Wider challenges to equitable health systems		
11:00-11:10	Session introduction	Chair: Rangarirai Machemedze, EQUINET/ SEATINI
11:10-11:25	Patents and Access to Medicines in Uganda	Author Mpeirwe, IP Consultant
11:25-11:40	Impact of Prices on access to medicines in Uganda	Aziz Maija, HEPS-Uganda
1140-1200	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: Y Dambisya U Limpopo /EQUINET
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.	Elizabeth 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	Facilitation: M Moses, R Mutambi, C Orach (HEPS, Makerer University)

March 28 2008

Time	Topic	Presenter
8:00 – 8:30	Administration, posting of flip charts reporting 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 (CHEAP)
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		
1330	Session introduction	Chair: R Mutambi, HEPS
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	Launch of the EQUINET book and closing remarks	Rev. Canon John Kateeba Chairperson HEPS – Uganda
1730	**RÉCEPTION** **Dancing and Drama -** KISA Production	

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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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Cover page design : R Pointer TARSC