SUPPORTING POLICY ENGAGEMENT FOR EVIDENCE-BASED DECISIONS (SPEED) FOR UNIVERSAL HEALTH COVERAGE IN UGANDA

Every year on December 12th, the global community marks Universal Health Coverage (UHC) Day. Universal Health Coverage is one of the goals in the Sustainable Development Goals (SGDs). This year's theme of UHC Day is "It's Time to Act with Ambition".

According to the World Health Organisation, "Universal health coverage (UHC) means that all people receive the health services they need without suffering financial hardship when paying for them. The full spectrum of essential, quality health services should be covered including health promotion, prevention and treatment, rehabilitation and palliative care".

The Supporting Policy Engagements for Evidence-based Decisions (SPEED) for Universal Health Coverage in Uganda is a 5 year partnership supported by EU to strengthen the capacity for policy analysis and advice at MakSPH and partner organisations through hands-on policy analysis and health systems research.

According to the World Health Report 2013, research has the ability to answer a wide range of concerns/questions about how UHC can be attained thereby providing solutions to improve human health, well-being and development. The SPEED partnership seeks to engage policy makers with contextually adapted evidence for health policy and systems changes to advance UHC and to support policymakers to monitor the implementation of vital programs for the realization of policy goals for UHC. Consequently, SPEED feels it's part of its mandate to provide policy debate leadership in the area of Universal Health Coverage and what can possibly be done to provide momentum for its implementation.

Publication of these articles was made possible by the generous support of the EU through the SPEED Project. The views expressed in these articles does not reflect the views of the European Commission or the views of the European citizens.

Leaving no-one behind: Rethinking private sector engagement for Universal Health Coverage in Uganda

By Mayora Chrispus

December 12, 2016 is world Universal Health Coverage (UHC) day. This year's UHC day is celebrated with a call to "Act with Ambition". While the UHC concept is not entirely new, it has however been explicitly included in the new Sustainable Development Goals (SGDs) agenda, specifically SDG3. For Uganda, the theme for the Health Sector Development Plan (HSDP 2016-2020) is to "to accelerate movement towards Universal Health Coverage". While it seems clear the focus, the 'how' this can be realized has continued to be a subject of discourse among policy makers, academia, researchers, implementing agencies and funders. It is important to ensure that all stakeholders including citizens – the ultimate beneficiaries – are included in this discourse particularly around rethinking better frameworks for delivering health services to all.

This discussion must extend to redefining roles and responsibilities of actors, and rethink the 'traditional' approach to health service provision as largely a mandate of the state. Two issues emerge from this redefinition; namely, (1) how to empower citizens or communities to actively participate in producing or even financing their own health, and (2) a stronger engagement with non-state actors as complementary rather than competitive actors. For this article, we focus on the later. The non-state actors or simply the private sector includes private and private-not-for profit, and Non-Government Organizations For starters, in terms of health service delivery (infra) structure, in 2015, about 58% of hospital level facilities in Uganda were non-government owned and operated. For lower level facilities that include private clinics and drug shops, the proportion is even higher. This trend will likely continue over the coming years. Over 50% of health service provision in Uganda happens through the private sector.

The rapid expansion and proliferation of the private sector in health in Uganda owes itself partly to inefficiencies in the public sector delivery system. As population continues to grow and a middle class emerges from improvements in income, the demand for health services and of good quality is certainly bound to increase. This will likely provide ground for the private actors to expand even more both in size and role. Working closely with non-state actors is no longer an option, but a necessity. The focus should now be on what models could be adopted to best utilize this rapidly growing sector to ensure the engagement works in the best interest of the population particularly the poor and vulnerable communities.

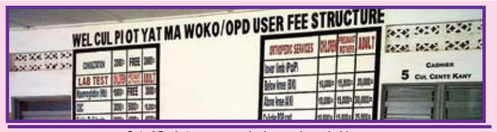
The framework for engagement should take due consideration of the current structure and incentives that influence private sector behaviour in health service delivery. Three issues – with a bearing on Universal Health Care – must be reflected on; 1) Private facilities are more in urban than in rural areas, yet majority of population lives in the rural area. This poses an equity and access challenge, 2) the private sector is traditionally driven by profit which raises concerns about the cost and financial burden of access to health care, and 3) the private sector often focuses on services that generate high return on investment, which raises issues of how services of public health importance (such as public health education) should be delivered for the greater good of society. Both the state and non-state actors must act with an ambition of ensuring expanded coverage for high quality and affordable health services.

An already existing model to partnership in Uganda – the provision of subsidies to PNFPs and some PFPs – should be the starting point and this needs to be streamlined and even scaled up to cover more facilities. A criteria for selection for beneficiary facilities should take into account for example location in a hard-to-reach area with limited access to a public facility. This must be followed by a strong monitoring and supervision mechanism to ensure the subsidy translates into reduced cost of services. The second model could be for the state to contribute to infrastructure development and deployment of personnel at private facilities to reduce cost of service provision and hence lower access costs. Thirdly, the state could fully contract out certain services to the private sector and only focus on financing. This could be through a performance or results-based financing approach, so that in areas where public facilities are inexistent, an already existing private player may be contracted by government to provide those services. Most importantly however, is to recognise the challenges that come with private sector engagement, and thus provide for a certain degree of regulation to ensure that health care – a public good – is delivered to all. Further, it is important to recognise certain aspects of health service delivery where private sector capacity may be limited, making it apparent for government to come in.

Ultimately, none of the sectors – public or private – can fix the constraints of health service delivery in Uganda, but rather both must complement each other and harness each other's capacities, if Uganda is to achieve Universal Health Coverage.

The writer is a Lecturer & Health Economist – SPEED Project – Makerere University School of Public Health

Moving from selling family property to finance health care: UHC demands a shift in approaches



Out of Pocket expenses cripple poor households

By Dr. Elizabeth Ekirapa-Kiracho

I recently met a man who has diabetes. You could see worry written all over his face. He had already sold his two cows to pay for his medication. Now he had nothing else to sell. If he failed to get his medication his health would suffer and he would probably die early from complications arising from his illness. His family would also suffer immensely since he is the sole bread winner. I wished I could help him, but I could not. Perhaps if I was Bill Gates or maybe Mellinda Gates since I am female.

This is the reason why it is important for us as a country to have adequate financing for Universal health care coverage (UHC). Stories like this are very common in our country. Households provide approximately 37 % of the money spent on health care, while government provides only 15% and donors 45%. In this situation, the poor pay even more for health than the rich. UHC aims at ensuring that everyone has access to essential health care at an affordable cost. This set me thinking about the actions that we need to take as a country to ensure that we have adequate financing for UHC. First of all our government needs to allocate more money to the health sector. The proportion of the national budget that was allocated to health in the 2016/2017 budget was 7%, less than half of what was agreed to at the Abuja declaration. Secondly, we also need to embrace the concept of insurance. Insurance allows us to contribute small sums of money and to pool this money together, so that we use it for treating those members who fall sick.

When we do this those who are healthy are able to support those who are less healthy, those who have more money also support those who don't have or who have less money. This concept of insurance allows our money to go a long way. You might be wondering what about those who cannot pay? What happens to them? Government and other partners can set up funds that can support such people a kind of "good Samaritan fund" so that our insurance fund does not run bankrupt because we have too many people who cannot pay.

Eighty percent of our population are in the rural areas and many have no formal jobs. However Government cannot pay for all these people, it should pay for the most poor. We must invest in equipping the majority of them, so that they can earn some money that they can use to pay for their insurance. Some of them can join these saving groups that people refer to as "village savings and Loans associations" others call them saving groups or burial groups. These groups are found almost everywhere in the country. They can enable them to save and to contribute towards insurance. You might be asking yourself but why all this when health care services are free in Uganda? My response is they are not free, government has to pay for these services and because government does not have enough money, sometimes we do not have all the requirements that are necessary for providing quality services and so we end up running to private providers and drug shops to buy drugs I think Government should speed up the creation of the National Health Insurance. Lastly am sure you know the common saying "prevention is better than cure" we need to put more effort into increasing funding for preventive care, most of our funding (62%) still goes into curative care. Government can focus on prevention as insurance focuses on curative services. Prevention should be aggressively and ambitiously emphasized at household, community and national/ government levels.

The writer is a Lecturer and Health Economist at Makerere University School of Public Health

Governance for Community Health Improvement in Uganda: Community perspective

Communities should be encouraged to participate in improving their health

By Robinah Kaitiritimba and Moses Kirigwajjo

As we join the rest of the world to celebrate the Universal Health Coverage (UHC) day, under the theme "Act with Ambition", Uganda National Health Consumers Organisation (UNHCO) adds the community voice for health production and service utilization as governance issue for community health improvement in Uganda Communities perceive health as a service that should be provided entirely by the state. In contrast, UHC agenda underpins the benefits of community inputs and responsibilities to generating and utilizing health services. Communities can be mobilized and sensitized on their rights and responsibilities to produce health at households and family level through community participation which is the collective involvement of local people in assessing their needs and organising strategies to meet those needs plays a pivotal role in health production by the community.

Community participation in health basically means that communities take responsibility for their own health through: adoption of good health behaviors to prevent and treat diseases such as good sanitation, hand washing at critical moments, seeking medical attention early from the nearest health facilities, avoiding self-medication, proper nutrition, proper use of mosquitoes nets etc; ceffective participation in disease control activities including bulungi bwansi-general cleaning of the environment and homesteads; contribution to the design, implementation and monitoring of health programmes and provision of resources for health through community trusts, existing informal groups, social enterprises and independent sector providers increasing access to equitable health care.(WHO, 2009). Health will then be viewed by community members as a right as well as a responsibility that promote the general wellbeing of society as product not only as health outcome. Therefore community participation and prevention should inform priority setting in UHC agenda because the biggest burden of morbidity and mortality whether from communicable or non-communicable diseases can be prevented.

Limitation in realising community participation and prevention of diseases has raised household out of pocket expenditures and clinical investment by government. A changed orthodox approach to more collaborative relationships among partners, individuals, families, citizens, patients, care takers, consumers and health care professionals will be required for engagement and streamlining governance. Governance in health is mainly about people and how they live and create health in the context of their everyday lives (Ruger, 2010). Therefore communities can also exert their collective voice to influence policy, strategies, and expenditure priorities at different levels of policy making; which through systematic tracking of processes and activities,

individual community members and groups can ensure timely and quality services that address their needs and respond to their expectations through Good governance and Accountability. Involving communities in the governance of their own health awakens their "sleeping power" and empowers them to point out shortfalls in governance. Working with the duty bearers improves responsibility and ownership of programmes, but also follow up and sustainability which restores community confidence in the service providers

The current struggle to guarantee Universal Health Coverage (UHC) to citizens is partly due to the rising levels of household out of pocket expenditure and huge clinical investments by government. Community participation and disease prevention will guarantee community ownership and appreciation to continuous generate their health for good wellbeing.Achieving UHC is a political process that involves continuous negotiations among stakeholders with varied interests. A change from a state-centered model to a collaborative one, in which governance and health is co-produced by a wide range of actors will promote equitable access and financial protection which is the focus for UHC.

The Writers work with Uganda National Health Consumers' Organisation

Contact: Dr. Freddie Ssengooba, Associate Professor & Principal Investigator SPEED Project
Email: speed4uhc@gmail.com , Website: http://speed.musph.ac.ug/ Twitter: @SPEED4UHC

SUPPORTING POLICY ENGAGEMENT FOR EVIDENCE-BASED DECISIONS (SPEED) FOR UNIVERSAL HEALTH COVERAGE IN UGANDA

Let us use Universal Health Coverage day to promote antenatal screening among Ugandan mothers

Mothers at Kawempe Health centre being educated on FP

By Denis Akankunda B

Following the first National Universal Health Coverage Symposium in Uganda, organized by the SPEED Project in August 2015, efforts have been ongoing pushing for policy actions and reforms to make health care coverage for all a reality in Uganda. Universal Health Coverage (UHC) means everyone can access the quality health services they need despite their financial social-economic status. The World Bank Group and the World Health Organization (WHO) have identified UHC as a top priority for sustainable development.

This December 12th, 2016, the world will be celebrating the Universal Health Coverage day, whose theme this year is, "Act With Ambition". This year's UHC doubles as the 12th is the anniversary of the first unanimous United Nations resolution calling for countries to provide affordable, quality health care to every person, everywhere. In fact UHC has been included in the new Sustainable Development Goals adopted by the United Nations.

My message for this year's UHC theme is to remind all Uganda's development partners and local healthcare practitioners that we should not despair before assuring universal health coverage for our expecting mothers who continue to die in labour at unacceptable rate. I wish to rally support around promoting antenatal screening and assuring quality clinical capacities throughout Uganda's health system.

Utilization of antenatal screening in most developing countries including Uganda faces challenges such as, high cost of health care, long distance to health facilities, limited transportation means, a lack of knowledge for the importance of ANC screening among couples, poor clinical capacities, inadequate technical personnel, and lack of independence by women to make health care decisions. Although Uganda has witnessed a decline in maternal mortality ratio from 435 to 410 per 100,000 live births from 2004 to 2011, the number of mothers dying in pregnancy is still unacceptably high. Maternal and child health conditions that include anaemia, sepsis, pneumonia, and malaria have continuously been reported to carry the highest disease burden in Uganda.

Benefits to antenatal screening include among others, improved awareness of maternal and newborn health needs and self-care during pregnancy, learning healthy lifestyles and dietary practices like iron supplementation, safety and injury prevention, learning preventive lifestyles against malaria through use of insecticide treated mosquito nets, emotional and physical preparedness for birth and baby care especially preparing for early and exclusive breastfeeding, and learning postnatal decision-making like use of family planning for birth spacing. More than 100 low- and middle-income countries, home to almost three quarters of the world's population, have already rolled out UHC. As a nation, we should strive to invest in the health of our people by offering UHC particularly to expecting mothers and all Ugandans overall.

The SPEED Project under the Makerere University School of Public Health is positioned and committed to providing policy analysis technical support to both government and other stakeholders in developing policies for Universal Health Coverage. The initiative is an EU-funded partnership with African and European institutions.

Denis Akankunda Bwesigye (PhD), is a Postdoctoral Research Fellow on the SPEED Project at Makerere University School of Public Health

Malaria Control is the Best Path to Universal Health Coverage.

By Dr. Freddie Ssengooba

Universal health coverage – one of the sustainable development goals that Hon Sam Kutesa steered while serving as the President of the United Nations General Assembly, is to be achieve within the resource envelop of each country. In short, Universal Health Coverage (UHC) requires that everyone can access quality health services without financial hardship. Providing quality services to 34 million people is a tall order for Uganda's economy. Drawing from the Ministry of Health Development plan, it will cost government at least Sh.130,000 per person per year to provide all that the government has promised to deliver in the next five years. At the current rate, Uganda is spending on average about Sh. 35,000 per person per year. So, how are poor countries going to achieve UHC goals while relaying on low revenues and low priority of investing in the health of their people? Dr. Agnes Soucat, the Director Health Systems, Governance and Financing at WHO while presiding over the session about UHC2030 in Vancouver last month said: "there is evidence now to support domestic financing for the attainment of SDGs. Universal health coverage is in fact a social contract that governments have with society - to leave no one behind".

In the attempt to "leave no one behind", many are dispensing advice to increase the coverage of good quality services. Many are pushing for social health insurance – where we all make compulsory payments annually to common basket. Those that get sick use the basket as the insurance to pay for treatment. Another proposal has been to insist that governments increase their financial allocations for health care provision – hence keep the government as the main insurer for all citizens. In this case the national tax system continues to generate the money and technical and political authorities make allocation decisions – i.e. how much to spend on health programs. These two positions provide the main pathways to UHC in the global dialogues.
Savings from inefficient use of current resources is another option that deserves attention. While launching the report on Health System Financing for UHC, The Director General of WHO Dr Margaret Chan said: "20% to 40% of all health spending is currently wasted through inefficiency [……]. Investing these resources more wisely can help countries move much closer to universal coverage without increasing spending".

In Uganda, huge savings and wellbeing will arise by acting with ambition in malaria prevention. The medicines for treating malaria annually cost far beyond what the national health budget can afford, and yet Indoor Residual Spraying (IRS), which reduces mosquitoes and cuts the malaria burden by more than half, is only provided in 10-15 districts per year. For IRS one does not have to be a doctor, nor does the community need to be paid salaries every month. Many under-employed youth can be trained once or twice every year to support low cost IRS activities). Last year the UPDF sprayed households for free in Kampala. We only need National Medical Stores to procure and distribute the chemicals to spray and the spray pumps.

Malaria control and prevention is best buy

And ultimately government to attract an investor to produce these chemicals and equipment. Communities can provide the labour while the health system can provide the training and supervision twice a year for this effort. It would save the nation thousands of deaths thus improving child survival and labour productivity and reduce school absenteeism for UPE.

With high coverage of IRS, health workers will have more time to attend to other services – thus reducing the pressure to recruit more staff - a relief to the national wage bill. More importantly, Ugandans will enjoy better health and wellbeing – free of malaria and avoiding the situation witnessed in northern Uganda in 2015 when IRS was suddenly stopped- resulting in the largest malaria epidemic Uganda has seen in decades.

Dr. Freddie Ssengooba is Associate Professor of Health Policy and Systems Management at Makerere University School of Public Health. He is the Principal Investigator for the SPEED Project.

Multi-sectoral approach and Coherence in government: Cornerstones for attaining Universal Health Coverage in Uganda

The environment we live in and grow in determines our health outcomes

By Dr. Aloysius Ssennyonjo

Every 12th December, the global health community commemorates the day in 2012 when the United Nations General Assembly resolved to support national and international efforts towards Universal Health Coverage (UHC) hence: the UHC Day! Going through the UN resolution one quickly recognizes the emphasis on multi-sectoral approach to improving population health and achieving UHC.

First and foremost, the UN asserted that health is cross-cutting policy issue and a precondition and an outcome and indicator of sustainable development, therefore improving people's health requires concerted efforts of all legitimate role bearers. To this end, countries were urged to continue to encourage, establish and support or strengthen multisectoral or intersectoral national policies and plans especially in addressing the underlying determinants of health. The health of people is associated with social and economic conditions, the improvement of which is a social and economic policy issue. Put another way, health represents the collective effect of social, economic and physical life conditions. Health disparities arise from the societal conditions in which people are born, grow, live, work and age, referred to as social determinants of health. These factors interact to affect health and disease burden of individuals and populations. This reality points to the fact that achieving health goals in any setting (country/district and even globally) cannot be left to the health sector alone. But to what extent are the other sectors aware of their influence on the health of Ugandans and act in a way to leverage their work to make the required contributions? What are the opportunities and incentives for dialogue among these agencies? A few years ago, the Ministry of Foreign Affairs recommended the exportation Ugandan health workers to Trinidad & Tobago; a decision that caused public uproar especially among stakeholders in the health sector. Apparently, the influence of that decision on the work of the Ministry of Health and negative effect on delivery of health services was not taken into account. About a year ago, there was a typhoid epidemic in Kampala and the President was bitter with the Ministry of Health for not anticipating and adequately mitigating the problem. However, on deeper scrutiny, the problem was that Kampala residents were accessing contaminated water. Of course, you very well know that it is not the health ministry in charge of water in this country. The story goes on. What is common to both these cases, is that actions of "non-health sectors" affect health and with potentially very dire consequences.

However, evidence shows that ensuring sectors work together in a synergistic and coherent manner for population issues is not an easy feat. We need to acknowledge challenges facing efforts to bring sectors together through interministerial committees or sector Technical working groups. These have to be made functional through incentives to stimulate and sustain collaboration. We should also learn from successful multisectoral responses to epidemics, disasters and HIV/AIDS in this country. I contend that we need a shared understanding among government entities on their contribution to health. However, The National Development Plan II highlights that mandates of government entities are often contradicting, overlapping and duplicated. This in turn undermines the comprehensive government efforts to address crosscutting issues such as improving the health of Ugandans. Unless this is addressed, we shall continue to bemoan weaknesses in public sector management and administration as one of the most binding constraints to achieving Uganda's development aspiration including UHC. There is need for deeper reflection on reforms within government to facilitate cross-sectoral approaches. Possibilities include modalities for joint planning, funding and implementation of government programs. We need an ambitious plan and mindset to overhaul the system for better and sustainable approaches and results. To what extent can the National Vision 2040 and the respective NDPs be launch pads for cross-sectoral collaboration for health and UHC in Uganda?

Dr. Aloysius Ssennyonjo is the Project Manager for the SPEED Project, Makerere University School of Public Health.

The greatest medicine of all is to teach people how not to need it: towards achieving universal health coverage in Uganda.

By Dr. Suzanne Kiwanuka

Almost three centuries ago, Benjamin Franklin said, an ounce of prevention is worth a pound of cure. This makes even more sense today as we embark on Universal Health Coverage where cost-effective interventions and strategies are the best buys for a low income country like Uganda. After all, why spend more for less when you can spend less for more? And why does the average African government continue to spend the bulk of its resources treating the sick, while battling a mostly preventable disease burden?

In Uganda crowd funding for overseas care has increasingly become a popular but alarming solution to the flaws in our health care system. Again one wonders why it is acceptable to ship patients (money) abroad for treatment, while our own system ails? At the global level, the failure to attain set targets is addressed by renaming and setting even more ambiguous targets. Challenges in the public sector have pushed people from the formal providers of health care to the even more costly private and informal sectors. Can we honestly continue doing things the way we have always done them but have the optimism to expect different results?

Dr. Margaret Mungherera (former President of the World Medical Association), once said that; "to achieve our health sector targets in Uganda, a paradigm shift is what we need." This shift requires a radical change from investing in treating disease to investing more in preventing it. Disease prevention encompasses all efforts to anticipate the causes of disease and its progression to clinical manifestations.

Although disease prevention has always been a central tenet of the health care reform in Uganda, most efforts to expand prevention have been continuously thwarted by a system biased towards treating disease. Since the colonial days the health system has prioritized treating the sick thereby marginalizing illness prevention and the wellbeing of the public. Moreover, this medical model is characterized by high costs of technology (equipment, drugs and supplies) and economic interests. This paradigm shift needs to overcome these obstacles by changing approaches to medical education, re-organising service delivery. But how can we do this?

Hippocrates said, "the greatest medicine of all is to teach people how NOT to need it". Medical schools need to emphasize prevention strategies alongside treatment approaches, and educate communities with a focus on lifestyle modification in addition to prescribing medications to the sick. Medical school curricula should emphasize health, in addition to disease and diagnosis, provide training in the science and practice of cost-effective health promotion. Incentives should be provided for medical schools to provide more training in community settings to emphasize health-enhancing behaviors, and not in hospitals – filled with the sick and dying. We have to educate our communities on the many factors that generate health and well-being. Tackling the causes of ill-health including poverty, sanitation, malnutrition, lack of education and poor environment will require a well coordinated multi-disciplinary team approach, a "health in all policies" approach.

More investments need to target activities for promoting health and wellbeing. The US and several European countries already have bike-to-work schemes, with incentives such as tax breaks and financial support for buying bicycles. As people exercise by biking-to-work, health care costs go down, quality of life improves, and they are generally more productive. In Uganda, one could get arrested for "walking to work" and this would actually be a considerate action compared to the hazards one faces as a pedestrian, with limited provisions for walking, compounded by errant boda-boda riders.

Attaining the ambitious goal of universal health coverage will require equally ambitious reordering of our investment priorities. Admittedly the need for medical care will remain, but focusing our meager resources on prevention is the best way to contend with the infectious disease burden while forestalling the emerging pandemic of chronic disease. Ultimately, embedding prevention in the national development plans, training of health workers, organization of social systems like roads, and the delivery of health care will stem the economic burden of treating the illnesses of an ever-increasing population.

The writer is Senior Lecturer at Makerere University School of Public Health and Co-Principal Investigator for the SPEED Project

Contact: Dr. Freddie Ssengooba, Associate Professor & Principal Investigator SPEED Project
Email: speed4uhc@gmail.com , Website: http://speed.musph.ac.ug/ Twitter: @SPEED4UHC