# Yes, citizens have a right to health, but must recognize their responsibilities to achieve better health

Mayora Chrispus

Today December 12 is Universal Health Coverage (UHC) day, commemorated across the world annually. It is essentially an anniversary of the first unanimous United Nations (UN) resolution calling for countries to provide affordable, quality health care to every person, everywhere. Universal Health Coverage (UHC) means that everyone can access the quality health services they need without financial hardship. Universal Health Coverage has now been included in the new Sustainable Development Goals (SDGs) adopted by the United Nations, and countries are expected to achieve UHC by 2030. This year 2017, the UHC day is celebrated under the theme ***"Rise for the right to health"***. It is essentially a call for everyone to work towards ensuring that health is a human right that must be enjoyed by every individual, irrespective of their economic or social status. This theme follows the December 10 celebrations for the international Declaration of Human rights – where calls to translate the Human rights declaration into action, were made.

In Uganda, the Ministry of Health has indeed embraced the pursuit of UHC as the main objective of the Health Sector Development Plan (2015-2020), which is currently under implementation. To ensure the enjoyment of the 'right to health' in Uganda, rights activists and consumer protection organizations have pushed for inclusion of this right into the package of rights in the Ugandan constitution, so that it can explicitly be articulated in the constitution as a way of guaranteeing its enforceability. Indeed, it is always tempting to argue that government has an obligation to provide health care to its citizens. This is because the provision of social services make a case for government taxation of citizens as well as deriving its legitimacy.

These arguments, however, tend to ignore the view that rights and responsibility must be looked at together. The argument of health as a 'right' tends to negate the actions that individuals or households should play in maintaining as well as restoring their own health. In health, some individual level actions can make a very bigger impact to individual and later population health. Recent reports have shown that up to 75% of illnesses can actually be avoided at community level if individuals and communities took responsibility. Malaria for example which contributes the highest out-patient attendances at health facilities can be avoided by sleeping under an insecticide Treated Mosquito net (LLTN). Government has undertaken a lot of effort to distribute LLTNs, but some communities or homesteads do not use them on beds on account of either misinformation or some archaic myths.

Government may only go as far as providing information and distributing such products, but it is the responsibility of individual homes to ensure appropriate use within bedrooms. Other examples such as maintaining better sanitation around your home, eating well, etc., are all micro (household) level actions that have a great impact on health. While the state could influence these actions by means of bylaws, even the implementation success of such bylaws largely depends on if communities appreciate their rationale.

Uganda is currently facing an epidemiologic transition, where non-communicable diseases such as diabetes, hypertension, cancers, obesity, etc., are fast becoming a big problem compared to 'traditional diseases'. The cost of managing and treating these conditions is very high. This cost can however be reduced or avoided completely by undertaking individual level choices and actions, such as physical exercises, eating healthy foods, avoiding sugars, etc.
From a curative care perspective, cases have been reported where individual patients receive medicines (drugs) and never complete dosages or self-diagnose and self-prescribe – and this is now responsible for a new phenomenon 'antimicrobial resistance' where some drugs now can no longer work on certain diseases. Yet, it is essentially a responsibility of the patient or their caretaker to ensure completion of doses. It is a responsibility of individuals to respect and comply with measures adopted for risk prevention, health protection and the fight against threats to public health, such as tobacco, alcohol, traffic accidents and diseases that can be prevented, and to collaborate to achieve these goals.

While it is the duty of the state to create an environment and reasonable measures for its citizens to access health care, it is important that citizens are educated about their 'rights' alongside their 'responsibilities' to health and health care. Minister of Health – Dr. Ruth Aceng, while officiating at the SPEED symposium on Financing Universal Health Coverage, in August, 2017, observed as follows: *"As government does its part of resource mobilization, allocation, and provision of health services, communities and individuals must be told the reality that 'your health is your responsibility'. Eating well, exercising, saying the right things to others to also do it right, etc., is everyone's responsibility. We must be purposeful in our investments to ensure we optimize resource use"*. As we rise for the right to health, we must also together ensure that we take responsibility for individual and community decisions and actions in as far as public health is concerned.

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

# A 'Rights-based Approach' to health and citizen empowerment with information are critical to achieving Universal Health Coverage in Uganda

Health is a fundamental right that is a precursor for other rights and overall the quality of life. To Rights Based Approach (RBA) to health - a human rights framework for development, assessment and addressing the human rights implications of any health policy, programme and legislation. The Rights Based Approach (RBA) is aimed at safeguarding human dignity with particular consideration to the most vulnerable in society, increasing safety nets and ensuring universal access for individuals, equality and non- discrimination and recognizing gender and social cultural factors that influence the health behaviors of individuals, families and communities in order to promote equity and achieve the universal health coverage aspirations. A rights based approach would therefore be an effective approach to achieve Universal Health coverage (UHC), because it impresses upon the state, the legal responsibility to provide quality health care to all. The RBA would bestow on the state a level of accountability for available resources in the delivery of health care. There has been efforts in Uganda to move towards the rights-based approach to health. For example in 2009 the Government of Uganda adopted the patient's charter and followed this up with the clients' charter. These charters clearly spell out patients' rights and their responsibilities. Unfortunately, these remain largely unenforceable because there has not been much effort from government to ensure their operationalization. There is another additional challenge to this – the population (community) has not been sensitized about the existence of these charters, which are essentially a 'package' of their entitlements as committed by government. This is an issue of lack of information. The dictum in law that *"justice aids the vigilant not the indolent"* essentially implies that, without enough information, individuals may not have capacity to demand, let alone enjoy what is due to them. Information is power. To this effect, it is critical that patients and the wider population are empowered with knowledge or information on their rights, but also their own responsibilities to allow for a stronger voice of citizens demand for accountability for actions of the state and its agents – the health care providers. If citizens understood their roles and responsibilities and worked towards holding government accountable, they would be able to influence prioritisation of health resources and investments, to ensure they benefit the wider society. Beyond this however, an understanding of individual or community responsibilities ensures that patients take charge of their health, through behaviour change and disease prevention action. A framework should be created, which enables patients or clients to participate as primary and equal partners in all stages and processes that aim at improving their own health. The current missing link that should bring the health providers and users together, needs to be established. This link offers a platform for health service users to define the local needs and aspirations to health care. It also offers opportunity for government and providers to understand service delivery from the perspective of the user and customise their provision to ensure they meet these user aspirations. As we celebrate the world Universal Health Coverage Day, December 12, we appeal to government to adopt the RBA approach, as a mechanism to achieving UHC. We ask government to broadly address outstanding health system governance questions and expedite legislation already before Parliament, and strengthen accountability mechanisms for better health.

***This article was written by Robinah Kaitiritimba and Moses Kirigwajjo of Uganda National Health Consumers' Organisation***

# Key questions remain on integrating the Informal sector and Community Based Insurance Schemes in Uganda's Proposed National Health Insurance Scheme (NHI): First meeting on Community Based Insurance

**Dr. Aloysius Ssennyonjo**

There is a buzz about introduction of National Health Insurance in Uganda. Over the last couple of months, I have participated in two big meetings on how to involve the informal sector in the proposed NHI. The first meeting convened by Ministry of Health (MoH) and HealthPartners Uganda (an NGO) held in mid-October 2017. This National Stakeholders Workshop on Health Insurance for Informal Sector focused on integrating this big segment of Uganda's population into the NHI. The participants included MOH officials (led by the Commissioner Planning and Senior Planner in charge of NHI) and representatives from various non-state agencies. The meeting looked into scaling up community-based health insurance (CBHI) as a vehicle to incorporate the informal sector into the NHI. During this meeting, it was noted that the current NHI Bill is not explicit of the role of these schemes as it considers CBHIs among "other schemes" along with the Private health insurance schemes (PHI). Another key observation was that there are multiple models- diverse in aspects like membership requirements and entitlements. Participation is voluntary and most schemes have limited geographical scope. This beg a question on what model to scale up. Additionally, the CBHI schemes have concentrated in the western and central parts of Uganda. There are regions like the East and North that have not implemented CBHIs. It was recommended that the feasibility of implementing CBHI in these regions be explored. More so, a national model that considers the existing decentralized political administrative systems should be adopted for scale up. In essence, what will be the role of- for example districts- in the NHI Scheme?

**The 2nd national conference on Community health financing**

Fast forward, I attended the 2nd National Conference on Community Health Financing held 1-2nd November 2017 at Imperial Royale Hotel. The conference was organized by Save for Health Uganda and multiple partners. The focus still was on integrating the informal sector into the proposed NHI. This meeting was graced by the State Minster of Health (PHC), Dr. Joyce Kaducu and the Senior Presidential advisor on health, Dr. Specioza Kazibwe among other prominent delegates. The discussions were rich, stimulating and equally thought-provoking.
One topic related to defining what the informal sector is. The distinctions between formal and informal sectors were notably blurred. The implication of this is that we may not be able to clearly determine who should belong to which insurance category. The other topic concerned raising premiums from the informal sector and enforcing exemption for indigents as proposed in the NHI. I was privileged to participate on a panel that discussed this topic. The submissions highlighted several pertinent issues regarding CBHI implementation in Uganda. First, is there a common appreciation of the contribution of health insurance among key sectors of government to drive a multisectoral agenda? For example, the representative of the Ministry of Gender, Labour and Social Development insisted in his view health insurance should be looked at as one of the initiatives under the social protection and safe net agenda being championed by his Ministry. It is important to consider how this view compares with that of the MOH spearheading the NHI. Other submissions from a prominent implementer highlighted several benefits of CBHI like reducing at point-of-use fees that are usually exorbitant for the service users. He however, noted that most CBHIs face challenges of inequities, management and sustainability capacity. These schemes being voluntary in nature attract those who can afford and perceive their risk of falling sick higher but leave out others who may need the services but cannot afford the premiums. Implementing multiple schemes as standalone initiatives introduces disparities between these schemes which in itself threatens equity and sustainability of these models.


*Source: www.equitesante.org*

*Community Based Health Insurance Schemes should be designed and implemented in such a manner that they address key issues of equity, sustainability and affordability*

On the positive note, there are ongoing efforts among CBHI implementers to confederate several CBHI networks under one-umbrella organization. This should be leveraged as we move towards the NHIS as insurance survives on big pools. Maximizing risk sharing among fragmented schemes is a known challenges facing NHIs with multiple models. Relatedly, the participants agreed to design and pilot a district-wide model of CBHI. Luwero District Local government leadership pledged to support this initiative as the Pilot district. This effort needs to be supported and have a learning agenda imbedded. Lessons from Ghana show that it is easier to integrate district-wide insurance schemes into national insurance scheme. This further addresses the need to involve the local governments alluded to earlier.
Relatedly, the participants raised question on how to determine and raise contributions from the informal sector. One proposed model has been building on voluntary savings and credit groups (SACCOS) were discussed. The main benefits would be that there already exists solidarity among members and financial management capacities. Limitations of saving groups regards the size and fragmentation of pools-sometimes several groups within the same village. The cost of establishing and maintaining these SACCOs is not fully known. The conference participants agreed that irrespective of the CBHI models adopted by the country, determination and enforcement of the premiums and exemptions were expected to become considerable challenges if CBHIs were to be scaled up nationally.

**Parting thoughts….**

In brief, these meetings are deliberate efforts to design a NHI scheme that takes into account Uganda's population profile. These issues require further refinement by the architects and proponents of the proposed NHI. Participation at these fora by key actors in the health sector and government at large bodes well for these efforts. We also need to manage expectations about benefits of NHI and support designing process. I agree that we cannot start with a perfect design but we need to have from the start a NHI model that is malleable to change as we generate lessons from implementation. Some models may commit us to a path that we cannot change in the future, as -once started- changing from initial model is a very political process and cannot be easily done. Lastly, engaging in such deliberations remain a core interest of the SPEED Project as we pursue our advocacy objective of highlighting the preconditions necessary to establish a successful NHI in Uganda.

Whatever model will be adopted by the country, it is critical that the right to access quality health care services and building the capacity of communities to be responsible for their own health, are important elements to consider.

***The writer is a Project Manager Supporting Policy Engagement for Evidence-based Decisions (SPEED) for Universal Health Coverage***

# Malaria Elimination is Critical to Achieving Universal Health Coverage Aspirations in Uganda

**By Dr. Aloysius Ssennyonjo**

Malaria is the leading cause of ill-health, death, and years of life lost among Ugandans, according to the current burden of disease statistics. Four out of ten outpatient visits (40%) at health facilities are due to malaria. This also implies that Malaria consumes much resources from the health sector including health workforce time. The adverse effects of malaria goes beyond the individual patient, and extends to their families, community, and government as well. Malaria is the leading cause of death among children, and can cause complications including brain damage (in case of cerebral malaria) and anemia, which may adversely affect the quality of life for the victim. For households, a malaria episode robs the family of resources (money and time) that could have been spent on other needs. Sick children lose school time thereby affecting their performance, caretakers lose time for work while attending to sick family members, thereby affecting the production and productivity at workplaces. At the macroeconomic level, the effects include reduced revenue for government due to reduced productivity. Thus, malaria control efforts can generate broader cost savings at individual, household, community and government level. To achieve these economic and social benefits, however, calls for concerted efforts from all stakeholders

A lot of investments and resources have been made in fighting malaria in Uganda, by both government and the development partners. However, the most recent midterm review of the National Malaria Control Strategy reveals that not much had been achieved so far. While there is a reported reduction in the number of deaths due to malaria, the number of malaria cases increased. While this can been attributed to improved diagnostics capacity, it could also mean that Uganda is doing well on the curative agenda but less on prevention. This trend will likely continue to widen the gaps between prevention and curative capacities. Ultimately, as systems capacities get stretched further, the curative agenda will also be compromised. Malaria prevention can significantly reduce the cost to the health system that is occasioned by drugs and supplies, human resources, as well as diagnostics. Focusing on curative services than prevention can be compared to mopping while the tap (source) is still wide open. As a country, we either focus on first closing the tap or may continue mopping forever.

Uganda's malaria control strategy adopted a multipronged approach that includes diverse interventions at different levels. On the treatment side, diagnosis of malaria has improved after the scale up of testing before treatment using Rapid Diagnostic tests (RDTs). On the prevention side, several interventions target the mosquito that transmits the malaria causing organisms. Uganda with support from her development partners especially the Global Fund has conducted several rounds of mass distributions of long lasting insecticide treated nets. Indoor residual spaying (IRS) is another strategy although this has been limited to a few districts in the northern and eastern parts of the country.

As the country grapples with how best to reduce malaria cases, experiences on IRS indicate that it is very effective on reducing malaria cases. Stakeholder consultations by the Makerere School of Public Health SPEED project in November, 2017, highlighted several health systems benefits of using IRS for malaria case control: "Wards became empty, the need for antimalarials drastically and greatly reduced that the discussion changed from drug shortage to expiry of Coartem. Health workers redeemed time to tend to their gardens and supplement their incomes". Families were also able to save money and time for productive ventures. The school also attendances reportedly improved. IRS is not panacea but it is the very effective on reducing malaria transmission. It is essentially "a big mosquito net hanged all the time". However, there has been planning challenges around implementation of IRS such as evidenced by the abrupt halt of the program that eventually culminated into the 2014 malaria epidemic in the northern region – eventually undermining all benefits of IRS initially recorded.

In the spirit of the UHC agenda, the question is how do we scale up such effective prevention interventions to reduce costs of curative services? Opposition to IRS relates the costs of its implementation in terms of the capacity requirements and logistical needs, besides existing concerns about environmental and health effects of chemicals used in spraying. These issues should be squarely analyzed to separate rhetoric from facts. For instance, possibly the major the cost driver of IRS is the inherently expensive project designs with high dependence on (costly) technical teams from Kampala and use of high cost technologies. If so, then, the action could be to design an IRS intervention that leverages resources at the subnational levels and uses cheaper but safe technologies to reduce costs.

Conclusively, malaria is still a big challenge in Uganda and eliminating this single disease would save a lot of resources at individual, household, health system, society, and economy levels. Control and or elimination of malaria would be a very significant step towards attainment of Universal Health Coverage (UHC) goals. Focusing on prevention is paramount in a context where malaria cases are increasing. The preventive interventions should be further scrutinized to weigh their relative costs, benefits and fitness for scale up. IRS is an effective intervention that should be scaled up in Uganda for elimination of malaria. With elimination of malaria, implies freeing up resources to focus on other disease and health system priorities

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# MARKING **UNIVERSAL HEALTH COVERAGE DAY**

## THEME: **Rise for the right to health**

MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH

**The Universal Health Coverage (UHC) Agenda: What does it mean for Uganda?**

The Millennium Development Goals era ended in 2015, and a new global agenda was adopted - the Sustainable development Goals (SDGs) - expected to be achieved by 2030. Countries committed to this new global agenda and are currently implementing different strategies to ensure progress towards achieving the SDGs. Within this new global agenda is a commitment to achieve Universal Health Coverage (UHC) which is enshrined in Sustainable Development Goal (SDG3) that specifically focuses on "Health for all by 2030". Universal Health Coverage (UHC) has been defined as ***"access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost"***. In Uganda, the pursuit of Universal Health Coverage has now been mainstreamed in government policy agenda. Indeed the current Ministry of Health (MOH) Health Sector Development Plan (HSDP 2015-2020) articulates its main goal as ***"to accelerate movement towards Universal Health Coverage (UHC) with essential health and related services needed for promotion of a healthy and productive life"***. The WHO-proposed framework on proposes three tenets, although to this, a fourth tenet has been added emerging from global debate.

**Tenet 1: Increasing coverage of essential and good quality services.** This implies expanding service packages of good standards, ensuring that priority interventions are scaled up to target populations, and enhancing and strengthening disease surveillance, preparedness and response mechanisms.

**Tenet 2: Expanding population groups that are benefiting from the services.** This is about increasing coverage to the entire population. Either by covering all population groups or by identifying and starting with target groups perhaps based on their vulnerabilities.

**Tenet 3: Protection from financial hardships arising from expenditures on health services.** Financial risk protection means ensuring that, individuals are not impoverished or thrown into 'catastrophic expenditure' due to out-of-pocket expenditures. For those already poor families, it is important that they are protected so as not to drive them into the poverty trap.

**Tenet 4: Building resilient health systems as a basis to sustain coverage.** A resilient health system is one that can absorb the shock of emergencies and at the same time continue providing regular services at a large scale. Building health system resilience implies deliberate and long-term strategies and investments in key health system areas including human resource for health, health information systems (surveillance), health infrastructure, adequate financing, investment in R&D for medicines and medical products, and strengthening the public sector health care delivery system

Based on the above understanding of Universal Health Coverage, it is essential that different players understand their roles and responsibilities. Below we present a summarized multi-level structure of players.

## Priority Actions for Leaders & Individuals to Support **Universal Health Coverage** in Uganda

### Reduce cost burden

**National leaders**
1. Subsidise high cost services, e.g. chronic care;
2. increase funding for medicines and Medical supplies;
3. Allocate more money to health to cover an increasing population.

**District leaders**
1. Prioritise funds for prevention programs;
2. Scale-up outreach to remote communities;
3. Monitor medicine distribution and use to reduce stock-outs.

**Community leaders**
1. Use appropriate channels to educate communities on best service alternatives for their context;
2. Mobilise communities to engage in prevention programs;
3. Encourage SACCOs to begin saving for health;
4. Educate communities on the need for appropriate family sizes.

**Individual**
1. Adopt healthy lifestyles e.g proper nutrition and physical exercises;
2. Plan and have small family sizes;
3. Undertake regular medical check ups and screening;
4. Embrace prevention programs, e.g. vaccination.

### Boost quality of services

**National leaders**
1. Define services to be provided at community level;
2. Establish hospitals for specialised services;
3. Introduce a pay-for-performance system.

**District leaders**
1. Accredit and license health service providers periodically;
2. Monitor services provided at community level;
3. Develop and implement quality improvement plans.

**Community leaders**
1. Strengthen community involvement in health facility management;
2. Participate actively in health facility management;
3. Monitor services provided at community level;
4. Solicit community feedback on quality of services.

**Individual**
1. Provide feedback on quality of services;
2. Adhere to treatment plans and health advice;
3. Desist from self-medication.

### Expand Coverage

**National leaders**
1. Develop coverage profiles for districts;
2. Scale up interventions for prioritized populations;
3. Mobilize funds for scaling up prioritized interventions.

**District leaders**
1. Develop coverage profiles for the district;
2. Plan and implement scale up of interventions for prioritized populations;
3. Budget and mobilise funds for scale up of prioritized interventions.

**Community leaders**
1. Identify vulnerable groups for prioritization;
2. Voice gaps in service utilization;
3. Monitor and address service utilization gaps.

**Individual**
1. Voice utilisation gaps and constraints;
2. Create peer support networks;
3. Participate in wellbeing and sanitation programmes.

### Strengthen the health system

**National leaders**
1. Invest in pre and in-service training, Recruitment & retention of health workers;
2. Regulate the healthcare market;
3. Establish service delivery arrangements that fit system capacity and sustainability.

**District leaders**
1. Deploy, motivate and retain health workers;
2. Strengthen health information systems for decision making;
3. Monitor the performance of health workers;
4. Build partnerships with private sector and communities for wellbeing and health improvement.

**Community leaders**
1. Build capacity for Community mobilization;
2. Strengthen community information systems, e.g. vital registration;
3. Participate in social accountability and decision making fora.

**Individual**
1. Provide information on the health status of household members;
2. Encourage friends and peers about health;
3. Practise what you learn.

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