OFFICE OF THE LEADER OF THE OPPOSITION

ALTERNATIVE MINISTERIAL POLICY STATEMENT

MINISTRY OF HEALTH

FY 2022/2023

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SHADOW MINISTER OF HEALTH

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Contents

EXECUTIVE SUMMARY

In accordance with Section 6E (4) of the Administration of Parliament (Amendment) Act (2006), Rules 14(4) and 146 of the Rules of Procedure 2017, this Alternative Policy Statement for the Health Sub-Program articulates policy directions of the Opposition in Parliament.

Sector Overview

Health Service delivery in Uganda is undertaken under the auspices of the Ministry of Health Strategic Plan, 2020/21-2024/25 which builds on the Human Capital Development Component of the National Development Plan III and lays a foundation for movement towards Universal Health Coverage.

In spite of an overall improvement in the national health indicators over the last five years, they remain unsatisfactory and disparities continue to exist across the country. Seventy-five percent of the disease burden in Uganda is still preventable through health promotion and disease prevention. The COVID-19 pandemic has strained health systems and disrupted essential health services in Uganda leading to reversal of some of the health gains in the last 5 years especially in the areas of teenage pregnancy, HIV/AIDS management and mental health.

Key Emerging Issues

1. Management of covid-19 following full re-opening of the economy. With positivity rate below 2% and about 50% of the eligible population vaccinated, what next?
2. There is continued prioritization of curative approach over preventive approach to health care even when there is an appreciation and recognition of the need to invest more in preventive and community-based health care.
3. Whereas the bulk of the investment has been going into curative health care system, the health care infrastructure is inadequate, ill equipped and nonfunctional. Most of the facilities are functioning below expected standards due to lack of basic equipment and utilities.
4. There is an inadequate health ambulance system. Out of the 460 ambulances required, only 120 are available. There is no national

standard ambulance coordination center and even the 911 medical emergency functional number is nonexistent.

5. There is high population growth rate with fertility rates at 4.82% and an unmet need of 28%. Uganda has registered an unacceptably high teenage pregnancy rate of 25% with over 30,000 teenage pregnancies registered monthly between January and August 2021.

6. Uganda continues to grapple with the challenge of limited human resources for health with staffing levels at 73%. The few are not well motivated hence constant industrial actions of strikes.

7. There is inadequate public spending on health and high out of pocket spending on health making many Ugandans face challenges access health in the absence of inclusive and affordable health insurance schemes.

Alternative Policy Proposals

1. Government should focus on making available health infrastructure functional instead of investing in non- functional, poorly equipped health infrastructure. It's better to have the available inadequate health facilities functional than having many structures with poor services.
2. Invest in health promotion and disease prevention. Provision of health care services is not the most important determinant of health. Investing in health promotion would yield better results, given the resource constraints.
3. Amplify role of Community based health care through empowerment of Community Health Extension Workers (CHEWS), Village Health Teams (VHTs) and roll out of The Integrated Community Case Management (ICCM). These should be integrated on the payroll.
4. Increase funding towards prevention of non-communicable diseases: Non-Communicable Diseases (NCD) contribute over 70% of the disease burden in Uganda.
5. Address the critical human resource gaps and motivation issues of health workers. Health workers salaries should be enhanced and the gaps filled.
6. Implement a compulsory National Health Insurance Scheme (NHIS)
7. Increase funding to sexual reproductive health services including sexuality education for adolescents and family planning.

8. Ensure availability of blood for transfusion and building of more blood banks

Conclusion

Government policy on health emphasizes access to high quality health care by all Ugandans as a means of guaranteeing their contribution to the country's socio-economic transformation. In line with Government's commitment to preventive health care other than the curative services – which are costly, more emphasis should be on ensuring expediting passing of the National Health Insurance Scheme, increasing investment in health education and promotion, specifically the recognition, integration and remuneration Village Health Teams (VHTs).

CHAPTER 1: Background to Alternative Policy Statement

1.1: Legal Provisions

In accordance with Section 6E (4) of the Administration of Parliament (Amendment) Act (2006), Rules 14(4) and 146 of the Rules of Procedure 2017, this Alternative Policy Statement for the Health Sub-program articulates policy directions of the Opposition in Parliament for the FY 2022/23.

1.2: Sector Overview

The health service delivery system in Uganda is curative "heavy" even when a quick perusal of the health policy documents shows the recognition and need to increase focus and investment in preventive health care. Uganda, just like all other countries globally, was not spared by the noble covid-19. For the last two years, our efforts as a country have been directed towards the management of the covid-19. The pandemic saw all efforts geared towards its management, sometimes to the detriment of gains made in other areas like mental health (where mental health units in hospitals were turned in to Covid-19 treatment units) and HIV/AIDS which saw the gains reversed as lockdown measures negatively affected prevention and treatment measures. The lockdown also triggered a spike in teenage pregnancies.

The health care system is weak, both in terms of infrastructure and adequacy of human resource. Acute lack of hospital beds, Intensive Care Unit beds and Oxygen shortage came to the fore especially during the second wave of the delta variant. Stories of health workers on the front line lacking basic Personal Protective Equipment (PPE).

The sector is further riddled with poor remuneration and motivation of health workers that has resulted into chronic medical workers strikes. There is a problem of measuring the adequacy of health care by focusing on availability of health infrastructure facilities like Health Centre IIIs at the sub-county level. The determination of sub-counties has of late been a result of Gerry meandering and as it where resources are allocated to construction of facilities rather than delivery of health care. This has resulted in poor diagnosis of Uganda's health care delivery needs as efforts are put on construction of more health facilities even when evidence shows over 77% of Ugandans access a health facility within a radius of three kilometers. This amidst heavy out of pocket health expenditure which stood at 41% in 2020/2021 from 42% in 2019/20. Only 3.1% of

Ugandans access some form of health insurance. This is a drop from 5.1% in 2019/20.[1]

Chapter 2: Situational Analysis of Ministerial Policy Statement

2.1: Health Sector Financing and Budgetary Allocations

The health sector budget as a proportion of the National Budget has stagnated between 6-9% for the last decade. It dropped to 6.1% in 2021/2022 from 7.2 % in 2019/2020. However, in nominal terms the health sector budget increased by 8% from UGX 2,589 billion in FY 2019/20 to UGX 2,788.90 billion in FY 2020/21. This was majorly attributed to additional allocations for interventions related to the Covid 19 pandemic response. Share of GoU contribution to the health sector budget is 57% and external financing is 43%.

Table 1: Overall Health Sector MTEF Budget Proposals FY 2022-23 (UGX, BN)

	PROGRAMME/VOTE	FY 2021/2022 Approved Budget	FY 2022/23 ESTIMATES	Variance
	HUMAN CAPITAL DEVELOPMENT: HEALTH			
014	Ministry of Health	782.75	266.66	-516.09
114	Uganda Cancer Institute	52.71	55.92	+3.21
115	Uganda Heart Institute	28.92	29.15	+0.23
116	National Medical Stores	600.31	601.08	+0.77
134	Health Service Commission	8.13	8.25	+0.12
151	Uganda Blood Transfusion Service (UBTS)	18.80	18.28	-0.52
401	Mulago Hospital Complex	59.99	61.45	+1.46
402	Butabika Hospital	17.31	17.60	+0.29
403	Arua Referral Hospital	10.15	10.15	0
404	Fort Portal Referral Hospital	9.47	9.47	0

[1] Uganda Bureau of Statistics, 2021: Uganda National Health and Demographic Survey, 2019/2020, Kampala, Uganda. p.7

	PROGRAMME/VOTE	FY 2021/2022 Approved Budget	FY 2022/23 ESTIMATES	Variance
405	Gulu Referral Hospital	15.05	15.05	0
406	Hoima Referral Hospital	8.39	8.39	0
407	Jinja Referral Hospital	17.28	17.28	0
408	Kabale Referral Hospital	8.65	8.65	0
409	Masaka Referral Hospital	10.80	10.80	0
410	Mbale Referral Hospital	18.23	18.23	0
411	Soroti Referral Hospital	8.10	8.10	0
412	Lira Referral Hospital	13.81	13.81	0
413	Mbarara Referral Hospital	16.17	16.17	0
414	Mubende Referral Hospital	9.57	9.57	0
415	Moroto Referral Hospital	8.27	8.27	0
416	Naguru Referral Hospital	9.11	9.11	0
417	Kiruddu Referral Hospital	18.74	18.74	0
418	Kawempe Referral Hospital	11.97	11.97	0
419	Entebbe Regional Referral Hospital	5.58	5.58	
420	Mulago Specialized Women and Neonatal Hospital	22.54	22.14	-0.54
421	Kayunga Referral Hospital	-	-	-
422	Yumbe Referral Hospital	-	-	
127	Uganda Virus Research Institute (UVRI)	8.99	9.06	-0.07
612	601-999 Local Governments	734.87	734.87	0
	SUB-TOTAL HEALTH SUB PROGRAM	**7,269.82**	**7,519.52**	**+6,792.7**

Source: MINISTERIAL; POLICY STATEMENT, HEALTH SUB-PROGRAMME, 2022-23

Detailed analysis of the budget figures in the Ministerial Policy Statement was difficult and impossible since it shows that figures for FY 2022/2023 were already approved and goes ahead to even show expenditure by end of December 2022.

However, on pages **xiv** and **xv** of the statement that was laid on the table, there is section titled, "UNFUNDED PRIORITIES FOR FY 2022/23' which gives a highlight of what the Ministry intends to spend on. Under this section, it's important to highlight some of the key allocations. UGX 6 billion has been allocated to community health initiatives to train Village Health Teams. Other preventive health interventions were allocated as follows; Health Education and Promotion (UGX 925,000,000), Reproductive and Child Health (UGX 724,000,000), Non-Communicable Diseases (UGX 579,000,000) and Environmental Health (UGX 1,025,000,000). In contrast, budget allocations to items classified as construction, renovation and rehabilitation is UGX 508,400,000,000 (approx. 30% of the sub program budget). Notable to note is an allocation of UGX 652.000.000.000= for what is termed as the 'Covid 19 resurgence plan.'

The Health sub-program has nineteen intervention areas as per the National Development Plan III. The Budget Frame Work Paper and Ministerial Policy Statement do not show what exactly will be done to operationalize each intervention area. The planning has not been re-adjusted to mirror these intervention areas to ensure that each area has a corresponding program proposal to ensure that some sector interventions are left unattended to.

The National Health Sector Strategic Plan 2020/2021-2024/25 enjoins the Ministry to shift from predominantly disease-oriented care system to a health promoting system, from a siloed, segmented sector specific intervention to multisectoral collaboration with intersections and synergies; from predominantly facility-based care to Primary Health Care (PHC) and population management; and from fragmented and episodic health care to integrated model of health care that continues over time. However, the budget proposals seem to be stuck in the old model of out put based budgeting and isolated planning for health care delivery. For example, there is little or nothing that suggests the Ministry of Health is working with other sectors like energy, education, works and transport, internal affairs to reduce certain out puts like addressing road accidents and injuries which are a key source of admissions in hospitals.

2.1: Emerging Sectoral Issues and Proposed Alternatives

Issue 1: Containing further spread of Covid-19 following full re-opening of the economy

Since March 2020, Uganda has been battling the Covid-19 pandemic. Drastic measures including long lockdowns were instituted to contain the spread of the virus. By December 2021, the country was officially into its third wave of the pandemic. Although the positivity rate reached as high as 25%, this was followed by notably low hospital admissions.

Among the interventions looked at as the magic bullet for managing the pandemic is vaccination. Vaccination against Covid-19 in Uganda was launched on 10th March 2021. The vaccination which started off as a ray of hope and caused excitement was hit by a setback of conspiracy theories that so many Ugandans become suspicious of the effectiveness and safety of the vaccines resulting into low vaccination up take. The low uptake was due to inability of vaccines reaching out to all parts of the population. There were long queues at vaccination centers meaning many of the eligible candidates and even priority groups for the vaccine hadn't been able to get their turn — including schoolteachers.

By 31st December 2021, total doses administered then were 11,377,067 and out of this, 3,756,248 million people had been vaccinated fully either with 2 dozes of the various the vaccine types or the one vaccine of Johnson and Johnson. Of the 22 million people, 45% (9,979,206) of the target population had received at least one shot of the vaccine and 17% had been fully vaccinated. Uganda had received a total of 20,658,940 million vaccine types that need two dozes to cover one person and 12,037,500millions of the single doze Johnson and Johnson meaning 21,086,318 dozes had been used and what hadn't been used, had the capacity to vaccinate 8,503,631millions of people or to cover 6.1million people due for second dose. As at 31st December 2021, the country was expecting another 7,319,610 million double doze vaccines, able to vaccinate 3,659,805million people and another 3,691,200 Johnson and Johnson able to vaccinate a similar number.

Proposed Alternative

The Ministry of Health should institute measures of monitoring severity of covid-19 in patients especially children in schools who are known to be asymptomatic to covid-19 and remain with mild illness. The Ministry of Health should consider

procurement of Pulse-Oximeters and distribute them to schools and VHTs along with the necessary empowerment.

It's known that many Ugandans have contracted Covid-19 and recovered. The Ministry of Health reported high positivity rate of the Omicron but low hospital admissions. We therefore contend that local research be done using Covid-19 anti body tests to establish Ugandans who have acquired natural immunity resulting from infections. The findings of the study should then inform the vaccination policy so as to ensure an evidence-based vaccination strategy.

Going by the World Health Organization (WHO) guidelines, all the available vaccines should be for those 18 and above with priority to the elderly and those with comorbidities.

We note that the country has already procured and or received in donations sufficient covid-19 vaccines to administer to the categories of people indicated by the WHO guidelines. We therefore propose that the colossal sums of money being requested for another mass vaccination campaign be invested in the establishment of a minimum care and monitoring package that will ensure early and timely detection of any COVID-19 cases at the community level including schools.

Issue 2: Continued prioritization of curative approach over preventive approach to health care.

In Uganda, like in many other countries, the best way to improve health and well-being remains contested. Policies and investments in health improvement have followed a "care" approach – where communities are expected to receive health services from health installations like hospitals and health centres. Although health promotion has been advanced in the policy discourse, its institutions and structures are diverse and less well understood across development actors.[2] Health investments are usually allocated on the basis of indices related to disease burden and the infrastructure used to restore health. These criteria have institutionalized an unsatisfactory norm among policy-makers and technocrats that privilege the finance of "diseases" instead of financing of

[2] F. Ssengooba, SN Kiwanuka, E. Rutebemberwa, E. Ekirapa- Kiracho (2017), Universal Health Coverage in Uganda: Looking Back and Forward to Speed up the Progress. Makerere University, Kampala Uganda., p.5

good health and well-being of communities.[3] An analysis of the health sector service delivery in Uganda shows that it is predominantly a disease-oriented care system than health promotion and disease prevention.[4]

The focus on curative health care in Uganda notwithstanding, efficient and functional curative health care service delivery system is still a mirage. Nine hundred and eighty-two (982) sub-counties don't have a single Health Center III[5] as by policy, health staffing levels are at 74%[6] and funding gap for essential medicines and supplies for the year 2022/23 is 70.32 billion. Even with all this, the health planners have continued to ignore the option of meaningfully investing in preventive health care amidst evidence that 40% of the disease burden among adults 19-64 is due to preventable non-communicable diseases.[7] Generally, over 75% of disease burden in Uganda is preventable.[8]

In the financial year 2021/2022, a meagre UGX 728,498,000 was budgeted for health education, promotion and communication[9] and even then, only UGX 342,416,000 went to non-communicable disease with UGX 196,616,000 going to staff salaries.[10] The trend has been consistent. In the financial year 2019/2020, the NCD department was allocated UGX 120 million and Health Promotion allocated a sultry UGX 139m respectively for the entire year.[11]

The response to health care in Uganda is to prepare to treat diseases through building of infrastructure and procurement of medical supplies yet the resource

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[3] Ibid, pp6-7

[4] Ministry of Health, 2021: Health Sector Strategic Plan 2021/2022-2024/2025

[5] Ministry of Health, 2021: Ministerial Policy Statement on Health, Kampala, Uganda. p.20.

[6] Ministry of Health Uganda: The Annual Health Sector Performance report, 2020/21

[7] National Planning Authority, 2020: National Development Plan III, Kampala, Uganda. p.70

[8] Parliament of Uganda, 2019: Report of the Parliamentary Committee on Health on the Health Sector Ministerial Policy Statement and Budget Estimates for FY 2019/2020, Page 26.

[9] Government of Uganda, 2021: Approved Estimates of Revenue and Expenditure (Recurrent and Development), 350

[10] Ibid, 367.

[11] Parliament of Uganda, 2019: Report of the Parliamentary Committee on health on the Health Sector Ministerial Policy Statement and Budget Estimates for FY 2019/2020, Page 26.

envelope is inadequate. The estimated cost for construction and equipping is UGX 70bn per hospital and total cost for 74 hospitals is UGX 5,180 billion. The recurrent costs, including wage, non-wage recurrent and medicines required per hospital per annum is UGX 3.8 billion. Should government construct all the 74 General Hospitals, it will translate to UGX 235.3bn recurrent costs per annum.[12] This cost leaves out other levels of health infrastructure like Health Center IIIs, IVs, Regional Referral Hospitals and the attendant costs for running them. With a total annual budget of average 3 .5 trillion, it would take Uganda over half a century to attain the required standard of health infrastructure to provide adequate curative care for its citizens.

Proposed Alternative(s)

i) ***Amplify role of Community based health care through empowerment of Community Health Extension Workers (CHEWS), Village Health Teams (VHTs) and roll out of The Integrated Community Case Management (ICCM).***

The recognition for a need to develop a health care delivery system in Uganda designed to improve the health status of households, with their full participation, using local technologies and resources is well documented.[13] The government of Uganda has experimented with a number of community-based health initiatives including the Village Health Teams launched in 2001[14], Community Health Extension Workers (CHEWS) being piloted since 2014 and Integrated Community Case Management (ICCM). Evaluation of the VHT strategy by the Ministry of Health in 2014, expectedly found that the VHT system had not been effective in reducing the disease burden since it has been hinged on volunteerism as the main pillar. The Ministry of Health has gone ahead, based on the findings of the assessment, to propose scrapping of the VHT strategy and substitute it with the CHEWS which is based at the Parish Level.

The Ministry of Health has been experimenting with the ICCM in 67 Districts and 11 cities. The ICCM is an extension of Integrated Management of Childhood and Illness (IMCI) to the community level. This approach facilitates prompt, low-cost, evidence-based lifesaving treatments for the most common causes of

[12] Ministry of Health, 2021: Ministerial Policy Statement on Health, Kampala, Uganda. p.17.

[13] Ministry of Health, 2018: Community Health Extension Workers National Policy.

[14] Ibid

childhood mortality and morbidity to children closer to home. The UN-led Child Health Epidemiology Reference Group estimates that access to community-based treatment could reduce child deaths from malaria by half, deaths from pneumonia by nearly two-thirds, and deaths from life-threatening diarrhea by up to 90%.[15]

The existing Community Based health care initiatives should be amplified by adopting VHTs on the Ministry pay roll and have one CHEW at the parish level to supervise the VHTS. The VHTs should then be empowered to provide ICCM but also other health care and prevention packages.

Uganda has 70,512 villages/cells/zones and 10,595 parishes/wards. The proposal is to have two VHTs per village and 1 CHEW per parish. Each VHT should be paid UGX 70,000 per month and 250,000 per month for each CHEW. This will require a total investment of UGX 150,242,160,000/=.

ii) Invest in health promotion and disease prevention

Provision of health care services is not the most important determinant of health.[16] *Investing in health promotion would yield better results, given the resource constraints. Health promotion is the process of enabling people to increase control over and to improve their health so as to reach a state of complete physical, mental and social well-being. It has three overlapping spheres, namely health protection, health prevention and health education.*[17] *Investing in disease prevention and promotion is a sure way for improving health outcomes in Uganda. All the leading cause of disease burden in Uganda as per the 2020/2021 Health Sector Annual Performance Report are preventable with malaria contributing 29.1% of all Out Patient Department (OPD) attendances.*[18] *The same report recognizes the need for effective communication and*

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[15] Ministry of Health, 2021: The Investment Case for Integrated Community Case Management of Childhood Illnesses, p.4

[16] Ssengooba, SN Kiwanuka, E. Rutebemberwa, E. Ekirapa-Kiracho (2017), Universal Health Coverage in Uganda: Looking Back and Forward to Speed up the Progress. Makerere University, Kampala Uganda., p291

[17] Ibid

[18] Ministry of Health, 2022: Annual health Sector Performance Report for Financial year 2020/2021

community engagement to influence and ensure behavior change at individual and community level.[19]

Health promotion contributes to disease prevention, which reduces the amount of sickness in the population, thereby reducing the number of hospital visits and, presumably, lowering the costs of health care.[20] *There is a substantial evidence base suggesting that many health promotion and disease prevention interventions, delivered within the health system as well as in partnership with other sectors, are highly cost-effective. A 2017 Ministry of Finance and Planning briefing showed that using the cost based on the expenditure on curative services in regional referral hospitals, Uganda stands to save over UGX 44 billion if it scaled up health promotion and preventive activities.*

The Health Promotion and Education Division of the Ministry of Health should therefore be supported to undertake robust multimedia Behavior Change Communication (BCC) campaigns that will involve both mass media and inter personal communication approaches utilizing Community Health Extension Workers (CHEWs) and Village Health Teams (VHTs).The UGX 925,000,000 that was allocated to the Health in Education and Promotion Budget for FY2022/23 is a drop in the ocean and we propose at least UGX 5 billion for this financial year.

iii) Increase funding towards prevention of non-communicable diseases

Non-Communicable Diseases (NCD) contribute over 70% of the disease burden in Uganda.[21] *An NCD investment case*[22] *done by the Ministry of Health in 2021 showed that an investment of UGX 4,300 billion over a 15-year period which translates to UGX 286 billion annually, would see government save UGX 477 billion in direct health expenditures and UGX 4,793 billion annually in enormous productivity losses (indirect costs). Action on NCDs is even more urgent now as Covid-19 and NCDs are exacerbating each other. An allocation of UGX 579,000,000 to NCDs for the FY 2022/23 simply shows how unprepared we are to*

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[19] Ibid, Page xiii

[20] Ssengooba, SN Kiwanuka, E. Rutebemberwa, E. Ekirapa-Kiracho (2017), Universal Health Coverage in Uganda: Looking Back and Forward to Speed up the Progress. Makerere University, Kampala Uganda., p293

[21] Insert Source...

[22] An **NCD investment case** is a quantitative analysis providing the economic arguments for investing in the prevention and control of NCDs.

do the right thing even with all the evidence before us. Instead, money is being allocated to prepare for treatment of NCDs in the Cancer and Heart institutes yet a reasonable investment would render unnecessary the need to go to the same facilities we are funding to unsatisfactory levels.

Issue 3: Inadequate and ill-equipped health infrastructure.

Health infrastructure refers to "buildings, plants, equipment (medical devices, other equipment for health facilities and IT equipment), transport and health care waste management."[23] The health service standards provides for seven levels of health care infrastructure points which include Specialized Hospitals, National Referral Hospitals, Regional Referral Hospitals, General Hospitals, Health Center IVs, Health Center IIIs and Village Health Teams. Government is in the process of phasing out Health Center IIs and ensuring that each sub-county gets a Health Center III and each Constituency a Health Center IV. Out of the 353 constituencies, 135 constituencies do not have a Health Center IV. Many of the Health center IVs have inadequate infrastructure and require upgrade to enable them function fully.[24] Out of 2,184 sub-counties 982 sub-counties do not have a single Health Center III. The distribution of these facilities is also biased with more facilities located in urban areas.[25] Existing health facilities have inadequate accommodation for the staff which exacerbates absenteeism of health workers.

Most of the facilities are functioning below expected standards due to lack of basic equipment and utilities. According to the findings of the 2018 of National Service Availability and Readiness Assessment conducted in 166 health facilities across the country, 18% of health facilities lacked a power source, 27% did not have improved water source, mean availability of functional medical equipment was 37%. Up to 47% hospitals do not have X-ray machines and even those that have, over 70% are obsolete.

Proposed Alternative

Focus on making available health infrastructure functional instead of investing in non- functional, poorly equipped health infrastructure.

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[23] Government of Uganda, *The Second National Health Policy*. 2010, Kampala: Ministry of Health.

[24] Ministry of Health, 2021: Ministerial Policy Statement on Health, Kampala, Uganda. p.18.

[25] F. Ssengooba, SN Kiwanuka, E. Rutebemberwa, E. Ekirapa- Kiracho (2017), Universal Health Coverage in Uganda: Looking Back and Forward to Speed up the Progress. Makerere University, Kampala, Uganda. Page 240

Government should improve the health coverage (range of services provided and the population covered) by re-focusing on functionalizing the existing health facilities. In the short to medium-term, the public health sector should focus on ensuring functionality of existing facilities by making sure that at least each Health Center IV has an Ultra Sound Scanner and X-Ray to support the utilization of theaters.

i) *With 353 Constituencies, and each Ultra Sound Scanner costing approximately UGX 35 million, we require approximately UGX 12,355,000,000. We propose that this money be sought to procure these machines for each Health Center IV to address obstetric emergencies. The management structure of Health Center IV does not provide for a Sonographer. Therefore, an additional 2 billion should be found for in-house training for at least two midwives per Health Center IV on how to use and interpret the Ultra Sound Scan results. This will save government the salary burden had it employed a sonographer. To achieve this, a total of UGX 14, 355,000,000 is needed.*

ii) *Of the 353 constituencies, only 218 have a Health Center IV. Knowing that each X-ray machine costs UGX 170 million, we will need a total of UGX 37, 060,000,000 to equip each Health Center IV with one to address surgical emergencies. The current structure at Health Center IV does not include Radiographers hence the need to recruit Radiographers whose salary scale is U5 (UGX 3 million) will require an annual wage bill of UGX 7,848,000,000=. To achieve this, a total of UGX 44,908,000,000 is needed.*

Construction of health facilities is meant to reduce on the distance people have to travel to access health care facilities. Seventy-Seven percent of the population in Uganda has access to a health facility within a 3-kilometer radius[26] with this percentage going up to 86% within a radius of 5 Kilometers[27]. Availability of health infrastructure therefore does not seem to be the issue. Instead, unavailability of medicine at 83%, long waiting time at the facility at 50% and limited range of health services at 47% seem to be the challenges hindering universal access to health care.[28] Continued investment in the

[26] Uganda Bureau of Statistics, 2021: Uganda Demographic Health Survey 2019/2020, Kampala, Uganda. p.44

[27] Ministry of Health, 2021: Ministerial Policy Statement on Health, Kampala, Uganda. p.4.

[28] Uganda Bureau of Statistics, 2021: Uganda Demographic Health Survey 2019/2020, Kampala, Uganda. p.44

infrastructure therefore is unlikely to result in the desired outcome in respect of the targets set in the NDP III.

The temptation to attempt to construct a hospital per District, a Health Center IV per Constituency and a Health Center III per Sub- County as per the policy is real. Indeed, as per the Health Sub-Program Ministerial Policy Statement 2022.23, construction, renovation and rehabilitation is expected to consume 30% of the budget. However, there is no evidence to show that if the health infrastructure development is halted or only done in very exceptional circumstances in the short and medium term, that the consequences will be negative. We shall instead be "ticking boxes."

Issue 4: Inadequate and scattered National Ambulance System

In Uganda emergency field is dominated by private companies who run ambulance services, and clinics which organize their own ambulances. According to the Ministerial Statement to parliament on the status of public health service delivery in Uganda, laid before parliament in September 2021, establishment of a functional ambulance system is one of the priorities of the Ministry of health. However, the same report confirms that out of the 460 ambulances required, only 120 are available. There is no national standard ambulance coordination center and even the 911 medical emergency functional number is nonexistent.

Proposed Alternative

The National Emergency Medical Services Policy should be implemented and fast tracked. Considerable resources should be allocated to these critical services to streamline emergency response services in the country, and reduce avoidable mortality, morbidity and disability, by ensuring all people in need of emergency care access it. There should be an ambulance for each constituency that is easily accessible and readily available for those in need. As per the policy, over 508 billion is needed to implement this over a period of 20 years but this can be done in a much shorter period.

Issue 5: High Population growth rate and a high unmet need for family planning.

Fertility rates in Uganda, have over years witnessed a steady reduction, but still remain some of the highest rates globally at 4.82%[29]. In 2012, the Government of

[29] https://www.google.com/search?channel=nrow5&client=firefox-b-d&q=uganada%27s+fertility+rate

Uganda made commitments to increase equitable access and voluntary use of modern contraceptive methods for all women and couples; and increase funding for adolescent sexual and reproductive programmes according to Uganda Family Planning Commitments 2030. Still, unmet need for family planning remains high at 28 percent.[30] The young people have limited access to sexual related information due to limited access to youth friendly services and centres. Evidence from Uganda's Health Management Information System indicates that disturbingly, over 30,000 teenage pregnancies were registered monthly from January to August 2021. Besides that, Uganda had registered unacceptably over 350,000 teenage pregnancies in the last couple of years since 2018. The magnitude of this problem could be higher than reported, considering the estimates are based on records from first-time antenatal care visits.[31]

Proposed Alternative

Increase funding to sexual reproductive health services including sexuality education for adolescents and family planning.

Sexual and reproductive health care encompasses a broad range of services that ensure women can decide whether and when to have children, experience safe pregnancy and delivery, have healthy newborns, and have a safe and satisfying sexual life. These services are important investments both because they enhance individual well-being and allow people to exercise their sexual and reproductive rights, and because they have far-reaching benefits for societies and for future generations.[32]

Uganda's population dynamics can be turned into a valuable demographic dividend if it emulates the policy roadmap followed by the East Asian Tigers—against which the country benchmarks itself in its long-term strategy, Vision 2040. The demographic dividend refers to the economic benefit a society enjoys when fertility and mortality rates decline rapidly and the ratio of working-age adults significantly increases relative to young dependents. The dividend is not automatic—it depends on investments and reforms in three sectors: family

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[30] Ministry of Finance, Planning and Economic Development, 2021: The State of Uganda Population Report 2021.

[31] Ibid

[32] Sully EA et al., *Adding It Up: Investing in Sexual and Reproductive Health 2019,* New York: Guttmacher Institute, 2020, https://www.guttmacher.org/report/adding-it-upinvesting- in-sexual-reproductive-health-2019.

planning, education, and economic policy. First, a country must undergo a steady decline in fertility to achieve a structure concentrated in the working ages. Voluntary FP programmes play an important role in reducing fertility desires and enabling couples to realize their reproductive preferences, thereby shaping a country's demographic path while simultaneously improving health and increasing savings across development sectors. If only modest investments in family planning and education are made along with aggressive economic and governance policies, gross domestic product (GDP) per capita in Uganda is projected to reach $6,084 USD by 2040 (up from $506 USD in 2011).[33]

Whereas the benefits of investing in family planning services is not contested, there is little commitment when it comes to financing these interventions. A package of care that would meet all women's needs for modern contraception, pregnancy related and newborn care, and treatment for the major curable STIs would cost $10.6 per capita (that's approximately UGX 40,000 per capita). Ministry of Health contributed 7.5% of the total FP funding in 2017; an indication that the Government of Uganda needs to increase resource allocation to the provision of FP services in the national budget.[34]

A costed family planning implementation plan that was supposed to be implemented between 2015 to 2020 recommended an annual investment of USD 39 million (Approximately 140 billion UGX) for 5 years.[35] *We therefore propose that Government of Uganda sticks to this plan and dusts it from the shelves and commit these funds to achieve the objective.*

Issue 6: Limited and inappropriate human resources for health

Uganda continues to grapple with the challenge of limited human resources for health[36] and contestations about salary enhancement. In the 2022/23 budget

[33] [33] Ministry of Health, Uganda. 2014. Uganda Family Planning Costed Implementation Plan, 2015–2020. Kampala: Ministry of Health, Uganda. p.5.

[34] Uganda Bureau of Statistics (UBOS) 2019. 2018 Resource Flows Survey on Family Planning in Uganda – Main Report, Kampala, Uganda, p.21

[35] Ministry of Health, Uganda. 2014. Uganda Family Planning Costed Implementation Plan, 2015–2020. Kampala: Ministry of Health, Uganda, page xiv

[36] Ministry of Health Uganda: The Annual Health Sector Performance report, 2020/21

framework paper, wage enhancement remained one of the unfunded priorities amounting to 47.9Bn shillings. According to the Annual Health Sector Performance Report, 2020/21, only 74%[37] of the approved staffing norms have been filled against the target of 80% of the approved positions filled by the end of 2020. The same observation was made by the Committee on health in 2021.[38] In addition, the distribution of health workers around the country favors the urban areas as most rural areas are under served according to the Health Sector Development Plan 2015/16- 2019/20.[39] During the strike by health workers in November/December 2021, one of their key demands was that government fills all approved staffing positions to enable them effectively execute mandate.

The current health sector staffing structure is archaic and obsolete and does not reflect the changing socio-economic realities of Uganda and it does not address the current staffing needs as it makes it difficult to appoint some cadres like graduate nurses and laboratory staff.

Whereas the Health sector had planned to gradually improve the staffing levels to 80% by end of 2020, it was reported that staffing level against the approved posts declined to 73% in FY 2019 12020 from 76% in FY 20181 19.

Proposed Alternative(s)

Address the critical human resource gaps and motivation issues of health workers

Government should address the issue of staffing gaps especially in the lower-level health facilities.[40] It's true there have been significant progress in staffing levels from 70% in 2015 to 76% in 2019.[41] Understanding how Resources for Health (HRH), is a critical element of the health system that is required to deliver health services and to drive the UHC agenda, a staffing gap of 24% is still

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[37] The Ministry of Health Uganda: The Annual Health Sector Performance Report, 2020/21

[38] Parliament of Uganda, 2021: Report of the Parliamentary Committee on health on the Health Sector Ministerial Policy Statement and Budget Estimates for FY 2021/2022, p.15.

[39] Ministry of Health Uganda: Health Sector Development Plan 2015/16- 2019/20

[40] Economic Policy Research Centre (EPRC), 2017; Universal Health Coverage in Uganda: The Critical Health Infrastructure, Healthcare Coverage and Equity, Kampala, Uganda. p.6.

[41] Ministry of Health, 2021: Ministry of Health Strategic Plan, 2020/2021-2024/2025, p.24.

deplorable. The identified HRH gaps can be attributed to various reasons, including a mismatch between the availability of health professionals and the demand for health services, inadequate funding for recruitment to meet staffing norms, and poor retention and motivation of staff, especially in rural areas. There is need to attract and retain health workers (including super-specialists) through continuous improvement of pay, working environments, housing and other motivational aspects. Specifically, we propose that the Ministry does the following;

i) Adopt a policy of tying promotions based on years served in settings considered rural and hard to reach as follows: A medical officer special Grade serving three years in a rural setting should be promoted to Consultant, A consultant serving for 3 years in a rural setting gets promoted to Senior Consultant.

ii) To decongest Mulago and put in place an effective referral system, we propose that the Ministry considers having the e following staffing structure at the various levels: Health Center IV-a Medical Officer, General Hospital-Medical Officer Special Grade and Senior Pharmacist; Regional Referral Hospitals- Consultant and Senior Consultant. This will ensure that at every level there is no unnecessary referrals and decongest regional referrals and national referrals. The measure will also help government to attract super specialists since this enables the new entrants to attain a consultancy remuneration.

iii) The Results Based Financing (RBF) project being implemented under the Ministry of Health as a project should be domestically financed and maintained as evidence from other countries like Rwanda shows how a performance-based financing system drastically turned around the Country's health coverage and reduced maternal mortality rates from an alarming 476 per 100,000 in 2000 to 107 in 2011.[42] At the moment, there is no time cap as to when the incentives under the RBF are released. We propose that a time cap of payment the 15th day of the quarter be put in place to ensure that the health workers get the money in time to facilitate planning and operations.

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[42] Economic Policy Research Centre (EPRC), 2017; Universal Health Coverage in Uganda: The Critical Health Infrastructure, Healthcare Coverage and Equity, Kampala, Uganda. p.21.

iv) ***Waive off taxes on cars for health workers in emergency care. The issue of insufficient accommodation for health workers is well documented. Many health workers live far away from the health facilities yet they have to be on call to attend to emergencies but generally commuting between their homes and work places is a challenge since many of them do not have normal working rotas. We propose that they be allowed to import tax free cars as follows; Salary Scale U% be allowed cars of below 2000cc, U4 be allowed up to 3,500 CC and U3 up to 4,500*** CC.

Issue 7: Inadequate blood supply

Maintaining a safe and adequate blood supply is crucial to ensuring positive outcomes of patients in both emergent and non-emergent situations. Uganda has an estimated population of 45,903,545 people which means the country needs to collect 1% of its population as per the WHO guidelines translating into 459,035 units of blood per year. In the Ministerial Policy Statement of FY 2020/2021, Uganda Blood Transfusion Services pointed out that 300,000 units of blood were collected; this is less the amount recommended by WHO and certainly insufficient compared to the demand.

Haemorrhage continues to be the leading cause of maternal death, contributing 42% of all deaths reviewed, with postpartum haemorrhage contributing to 90% of all haemorrhage cases reported. 36% of maternal deaths occurs among young mothers under 24 years who should have been in school, contributing up to 10% of all maternal deaths.[43] A total of 63% Health Centre (HC) IVs conducted Caesarean section without blood transfusion services and 31% HC IVs did not provide any emergency obstetric care services in FY 2020/21, down from 38% in 2019/20-21. As such, the NBFP FY 2021/22 projected that by FY 2022/23, 60% of the functional HC IVs would be offering caesarian and blood transfusion section. However, up to 50% of Health Centre IVs do not provide blood transfusion services and newly up graded health centre IVs lack staff and equipment.

During the presentation to the Parliamentary Committee on health about the budget framework paper FY 2020/2021, the Uganda Blood Transfusion Service pointed out the issue of a small pool of blood donors as the reason for inadequate blood supply. They also pointed out the following; inadequate

[43] Ministry of Health, 2021: Annual Health Sector Performance Report, 2019/20

medical supplies and reagents; aged fleet of blood collection vehicles and inadequate staff for blood collection (152 staff out of the 258 approved staff members are recruited.

Proposed Alternative

Ensure availability of blood for transfusion by establishing six more blood banks in regional referral hospitals

Maintaining a safe and adequate blood supply is crucial to ensuring positive outcomes of patients in both emergent and non-emergent situations. The headquarters at Nakasero Blood Bank acts as a reference center for the regional blood banks and other public and private hospitals. Uganda has 7 Regional Blood banks which include Arua, Fort-Portal, Gulu, Kitovu, Mbale, Mbarara and Nakasero. There are Six- (6) blood collection centers in Hoima, Jinja, Kabale, Moroto, Lira and Soroti. We propose that money be allocated to elevate the collection centers to Blood banks.

Uganda Blood Transfusion Services needs to be fully funded to overcome challenges of the small pool of blood donors, inadequate medical supplies and reagents; aged fleet of blood collection vehicles; Inadequate staff for blood collection (152 staff out of the 258 approved staff members are recruited); inappropriate blood usage and accountability and inadequate infrastructure for blood transfusion in refugee hosting districts.

When there are shortages of blood, smaller health centers outside the main urban areas are de-prioritized and almost do not get any blood from Nakasero blood bank. Many patients who need blood transfusion during this time are either put on halt, left to survive on God's mercy or die. In the early months of the total lock down, that is April/ May 2020 many pregnant women died because of lack of blood. Hemorrhage is the number one killer of pregnant women. When there is no blood in a hospital the risk of a woman dying in labor is very high.

Limited access to safe, timely banked blood affects the most vulnerable people health wise who include; pregnant women, children aged 5 years and below, patients with chronic illnesses, those due for surgical operations and trauma victims which also results into a number of deaths. In Uganda, 50% of all blood collected is for treating children with severe anemia, largely due to malaria, intestinal worm infection and malnutrition, 25% of the blood is for treatment of pregnant women with anemia and complications of child birth and 25% of the

remaining blood is used in other emergence medical treatment of anemia, accident and surgical cases.

Issue 8: Inadequate public spending and high out of pocket spending on health

Despite implementing a free healthcare system since 2001, which presumes free access to healthcare services at public facilities, many Ugandans face financial challenges in accessing healthcare services due to high out-of-pocket payments which stand at 42 percent.[44] It has been estimated that household contribution from out of pocket for health care spending is at 42%, government 17% while donors contribute 41%. Health insurance coverage among persons age 15 and above is still low at four percent; this is a reduction from five percent registered in 2016/17.[45] This trend in medical bills has led to about one million people driven into poverty annually. The Uganda National Household Survey 2016/2017 analysis shows that in Uganda, 3 percent of the population is driven into poverty due to out-of-pocket payments (WHO, 2017).

The 10th Parliament debated and passed the National Health Insurance Scheme (NHIS) Bill. The Bill was sent to the President for assent which was never done. Following the ruling by the Speaker of the 10th Parliament that all Bills that were pending by the time of the beginning of tenure of the 11th Parliament, the Bill lapsed and is as good as non-existent.

Proposed Alternative

Implement a compulsory National Health Insurance Scheme (NHIS)

After over a decade of discussions and consultations on the need for and nature of the kind of National Health Insurance Scheme (NHIS) Uganda needs, the 10th Parliament in passed the national Health insurance Bill. The law was to actualize the pooling of health-financing resources for income and health risk cross-subsidization. This Bill was never assented to by the President and was sent back for reconsideration.

According to the 2019/2020 Uganda Demographic Health Survey, 38.6% of Ugandans above 15 years expressed willingness to pay to join a health insurance scheme. There is need to fast track the reconsideration of the

[44] Ministry of Health, 2016: Health Financing Strategy 2015-206-2024/25. Kampala, Uganda.

[45] Uganda Bureau of Statistics, 2021: Uganda Demographic and Health Survey, 2019/2020. p.60.

enactment of the National Health Insurance law to facilitate the implementation of health insurance schemes. Consideration of the law should ensure that Community based Health Insurance schemes are properly provided for to enable inclusion of majority of the people in the informal sector not to be left out. But most importantly, there are already a number of community-based health insurance schemes serving the population that need a conducive regulatory framework to ensure safety of members' savings and expansion of the schemes.

Conclusion

Government policy on health emphasizes access to high quality health care by all Ugandans as a means of guaranteeing their contribution to the country's socio-economic transformation. In line with Government's commitment to preventive health care other than the curative services – which are costly, more emphasis should be on ensuring expediting passing of the National Health Insurance Scheme, increasing investment in health education and promotion, specifically the recognition, integration and remuneration Village Health Teams (VHTs).

There is a declining trend of investment in the health sector. All this is happening as we experience more people added onto the realm of need for health care services as our population growth rate remains static at a fertility rate of around 5%.

There is need to invest in strengthening the health care service system not just the vaccination in a bid to build a robust health care system that will be strong enough to withstand any shocks like was the case with Covid19. The nature of Covid 19 is dynamic and it is difficult to accurately predict what will happen next. What's certain is that we need to focus on equipping the existing health facilities with basic minimum infrastructure and tools to manage not only Covid - 19 but any form of emergencies of a similar nature.