Civil Society and its role in monitoring the implementation of comprehensive health policies that guarantee the Right to Health:

Successes and challenges of Civil Society in the performance of Participatory Governance Actions

A new paradigm of Health Systems Strengthening in Africa: A People's Health Movement rights based approach to improved Social Determinants of Health in Uganda

By Denis Joseph Bukenya

Health Rights Researcher and Advocate ***from***

People's Health Movement–Uganda (PHM) and Human Rights Research Documentation Centre (HURIC)

Introduction

This paper highlights the People's Health Movement and HURIC's growing involvement in strengthening the social determinants of Health, through social accountability initiatives such as active civic engagement through civil society organizations' involvement and community participation in the attainment of the highest attainable standards of health to achieve the right to health for all as a new global paradigm in health systems strengthening. This further analyzes the experiences of the People's Health Movement and HURIC in Uganda and explore the challenges and opportunities for the movements' health activists as a leeway of building active volunteerism and synergy between the civil society, private players, health workers and the state capacities to improve health service delivery.

The Social Determinants of Health perspectives in Africa have become a fundamental center of emphasis for the international health community because they are essential in strengthening the blocks of health systems such as access to medicines, technologies, health information systems, health workforce, and health financing. Many of the initiatives, however, embrace a vertical 'top down' approach which has focused on the community governance and development sector that engages operational and bureaucratic interventions with the core aim of promoting health rights, effective and sustainable development of the health sector.

The social determinants of health are economic and social conditions that influence an individual and group differentials in the health status. These are health promoting elements found in one's living and working conditions (such as the income dispersion, wealth, influence, and power). Health governance and financing have a great impact on determining the health system of the country which is predominantly dependent on policy framework, public administration through public financial management and resources at the national and local levels. This influences the availability, accessibility, and acquirebility of quality health services for all social stratas which undoubtedly result in either better or worse consequences on their health and well-being henceforth

greater egalitarian or inequality in the health system of the society. This paper therefore argues for a new paradigm in Health Systems strengthening that operates on an inclusive, horizontal level embracing concepts of bottom-upstream interventions and harnessing community and civil society's active participation.

Our advocacy work as PHM in Uganda has majorly focused on best stratagems to promote investment in disease prevention and create awareness through information to the people as a mechanism to enhance disease burden control and reduce vulnerability exposure of people to it. This is because the external health financing in Uganda has regressively gone down through aid cuts as a result of corruption, unstable fragmented funding and the tight macroeconomc policies of the multi-lateral institutions such as the IMF/World Bank, but Uganda's domestic health financing has remained low amidst the growing burden of disease and weak health system with inadequate human resources for health. This means the burden has been left to the local people thus increasing the out-of-pocket expenditures which is the one of the largest source of funding to health in Uganda.

The Health Sector Development Plan, 2015, shows that households finance is at 37% of healthcare financing in Uganda compared to external health financing mainly from donors and NGOs who finance 46.3% and the government which finances 8% less than the 15% Abuja declaration benchmark. This means that households have to pay a significant proportion to access the health care they need and where they cannot afford to pay for it they will have to go without treatment. The Government expenditure for the last eight financial years has taken a downward trend from 9.6 in FY 2009/10, 8.9 in FY2010/11, 8.3 in FY2011/12, 7.8 in FY 2012/13, 7.2 in FY2013/14, 8.2 in FY2014/15, 7.4 in FY2015/2016 and 8.7% in FY 2016/2017 (vision, 2017) (Health, Uganda Health Accounts, 2012/13 and 2013/14) (Health, National Health Expenditure, 2014/15 & 2015/16) (Global Health Observatory 2017) and (Ssempala, 2017)

Background of disease burden:

Uganda's disease burden is generally dominated by transmittable diseases, which account for over 50% of morbidity and mortality. Malaria, HIV/AIDS, TB, and respiratory, diarrhoeal, epidemic-prone and vaccine-preventable diseases are the leading causes of illness and death. There is also a growing burden of non-communicable diseases (NCDs) including mental health disorders. Maternal and perinatal conditions also contribute to the high mortality. Neglected Tropical Diseases (NTDs) remain a big problem in the country affecting mainly rural poor communities. Furthermore, there are wide disparities in health status across the country, closely linked to underlying socio-economic, gender and geographical disparities. The major challenges affecting the health system are the lack of resources to recruit, deploy, motivate and retain human resources for health, particularly in remote localities; ensuring quality of the health care services delivered; ensuring reliability of health information in terms of the quality, timeliness and completeness of data; and reducing stock-out of essential/tracer medicines and medical supplies. The emergence of antimicrobial resistance due to the rampant inappropriate use of medicines and irrational prescription practices and the inadequate control of substandard, spurious, falsely labelled,

falsified or counterfeit medicines are also key problems in the sector (Global Health Observatory 2017).

Authors from several schools of thoughts in the Global South are vocal in the need to develop radical development approaches and critique the conventional mainstream approaches of 'conceptual conservatism' in tackling health issues of the society to curb the disease burden. However a new paradigm of community health and participation is emerging, not least in creative responses to these issues within Africa itself. The People's Health Movement and HURIC are such a group: a global South network bringing together grassroots health activists, civil society organizations and academic institutions from around the world, particularly from low and middle income countries (LMIC) to represent the vulnerable groups from the low income settings to promote the right to health.

Government intervention is often ineffective because of gaps between the provision and access of services. These gaps, such as a knowledge deficit due to the imperfect flow of information and lack of awareness among the local people at all intensities, are the gist of the problem. We argue that community involvement, education through sensitization, mobilization and participation in health development is significant in these communities. Their role is analyzed using **an evidence based human rights inclusive model** which has been applied by PHM and HURIC in Uganda through multi-stakeholder support and engagement, this has encompassed a number of players such as the Civil society, private players, government, health workers, and the communities as described below.

Civil Society,

Conventionally, struggles to address the challenge of accountability to ensure effective policy implementation as a way of strengthening the right to health have inclined on improving the "supply-side" of health systems and governance using methods such as periodical checks and balances through supervisory measures, administrative rules and procedures, vigilance commissions, and auditing requirements. However these "top-down" accountability promoting mechanisms have met with only limited success in the global south nation-states.

In order to fill the vacuum above, PHM in Uganda through its right to health based inclusive model has anchored a number of community and civil society inclusive engagement pro-accountability "demand side" strategies on different health programmes and access to medicines. This has encompassed demand for investment in health, clearer procurement processes and procedures in Uganda to reduce the medicine stock-outs in Uganda and demand for the national formulary to ease the registration of both the patented and generic drugs to trim down the counterfeit medicines plight in Uganda. This has been done through engaging other civil society coalition groups such as the Uganda Coalition On Access to Essential Medicines (UAEM).
PHM-Uganda together with HURIC and PHM East and Southern Africa analyzed and advised the World Health Organization in its 68th WHO AFRO RC Session in Senegal on how best to strengthen their points of recommendations towards achieving Universal Health Coverage, and prevention and treatment of both communicable and Non-Communicable Diseases in Africa

through best buys interventions such as regulation on the medicine premiums, national health insurance schemes, creating more awareness among the populations through proper information systems and training the health workers on the basic treatments, regulating multilateral foreign food coorporations, and proper transparent systems that involve close monitoring and tracking of procurement processes to minimize wastage of funds through unscrupulous deals like kick-backs in Africa. https://docs.google.com/document/d/1hjI7nHecRkBnfmKHKCiEL0BLkgivZq4h0xfyLwa8cOw/edit

https://docs.google.com/document/d/1hXSASKC-oTX_Z8CjBH80I7Zv0k3MBhleJNVtPAC4Uj8/edit

Participating in the budget advocacy in the health budget monitoring and demanding for an increased fraction of GDP expenditure towards the health sector from the current 7 per cent to 15 per cent as reflected in the 2001 Abuja declaration, this is one of the ways we are evaluating our domestic health financing and the gaps in it.
Additionally, engaging in assessing and monitoring of the external health financing. PHM, HURIC in unison with the Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) coalition in Uganda have been assessing the performance of the Global Financing Facility (GFF) project of the World Bank Group in the districts in which it was implemented. This has been through designing the score card to gauge the improvement in RMNCAH and designing the guidelines for the region hubs in the GFF regions of Uganda to guide the RMNCAH region groups in the assessment, monitoring and accountability of the RMNCAH Projects.

Government,

In order to make government's effectiveness in policy implementation more eminent, civil society's role in accountability is significant to remind the policy makers their obligation as power-holders to account for or take responsibility for their actions. PHM is closely monitoring and assessing projects that have been implemented by the government these include the new health centres which have been constructed by the government through donor aid or external borrowing, such as the Mulago Specialized Women and Neonatal Health (MSWNH) Kampala whose construction was funded through a loan the government of Uganda obtained from the Islamic Development Bank. The construction was intended to decongest Mulago Natioanal Referral Hospital and enhance treatment of women with difficult reproductive health complications to reduce referrals abroad for certain specialized treatment in reproductive and neonatal health category. However, the government later intercepted women's access to this health facility through heavy fees on the reproductive health services which was an interlope to promoting Primary Health Care and the right to health. PHM stomped on the ground and opposed this capitalistic mechanism through writing a number of statements to the Ministry of Health and engaging with officials from the government to revert this policy.

Health Workers

Health workers' role is so significant in coordinating the blocks of any health system and PHM has been in a number of engagements with the health practitioners and civil society to anchor the efforts of advocating for improvement in the performance of health workers include the quality of their work, the technical skills they use, the care they deliver, and the impact of their work on health outcomes because the health workers' performance and productivity is vital to improving health care delivery. However, our emphasis as PHM has been on the best ways possible to lobby for an improvement in their working conditions (such as medical equipment to use and accommodation), remunerations, clear and proper terms of reference in their work to enhance an increase in their recruitment and retention for proper achievement of PHC in the attainment of the right to life.

Uganda has experienced a fairer increase in the recruitment of health workers though with low retention levels due to high health personnel migration trend to other countries as result of poor conditions of work (such as lack of amenities of life like electricity, piped water, etc. in hard-to-reach and live areas.

Inadequate facilities; medical equipment and supplies including frequent drug stock outs, Limited opportunities for career progression, comparatively low levels of remuneration, understaffing leading to burn-out of health workers, health worker performance barriers like unclear roles and expectations, unclear guidelines, poor processes of work, inappropriate skills mix within the work setting, competency gaps, lack of feedback, difficult work environments and unsuitable incentives) meaning that even where there are no critical workforce shortages, health workers may still fail to provide quality care yet this is so crucial in strengthening the health systems in the attainment of health for all.

The qualified health workforce in Uganda in 2015 stood at 81,982. $^{2}/_{3}$ i.e. (55,206) are Nurses. Medical doctors are 4,811 (6%) of the total health workforce. By 2018 the number is estimated to be at 88,108 qualified health workers. Our doctor – patient ratio stands at 1:25,000 which deviates from the WHO recommended ratio of 1:1000. Patient – nurse ratio is at 1:11,000. *(Report 2014/15 and a report on Surgical Workforce in Uganda –ACHEST 2015) and (intrahealth-Uganda)*

Uganda has chronically continued to lose the few health practitioners it has through health workers' migration. In 2018 alone indication is that from Jan to Aug, close to 167 Medical and Dental practitioners left the country according to the letters of good standing from UNMC data (2010-2018).

PHM, HURIC together with the Amref-Uganda through the Health Systems Advocacy Partnership (HSAP) coalition are developing Health Workforce Migration Policy to help the government regulate the overwhelming exodus of health practitioners Uganda is losing to other countries which has left a gap in human resources for health. The policy being designed also incorporates recommendations and policy options the government can use to improve the working condition of health workers, proper absorption of the health workforce and retention strategies.

Communities.

Empowerment of communities is a people centric mechanism used by HURIC and PHM through Participatory Action Research (PAR) to strengthen the voice and capacity of the citizenry (especially poor citizens) to directly demand greater accountability and responsiveness from public officials and service providers. Enhancing the ability of citizens to engage with public servants and politicians in a more informed, direct and constructive manner is one way service delivery can improve.

This has been through identifying communities (such as Kiboga district of Uganda) with high disease burden and limited access to healthcare due to medicines stock-outs and human resources for health. Besides the demand for accountability as a fundamental principle of democracy for citizens, PHM in Kiboga has been carrying out sensitization campaigns to promote Primary Health Care such as encouraging use of clean water and proper hygiene, proper nutrition, immunization, proper use of drugs, use of RMNCAH services available. This form of awareness has been done through use of the Participatory Action Research which has been applied by collectively organizing and assessing people's experiences, analyzing and reflecting on the patterns of problems and causes and sharing new knowledge to take strong actions and reviewing the course and impact of action and change.

Private players

Our approach for the right to health being an inclusive model, PHM we have as well assessed and engaged with the private players because their role is crucial in health provision though this should be regulated. People in Uganda still struggle to access health, many who cannot afford the required treatment quite often resort to self-medication using traditional herbs and alternative medicines or a resignation to the natural hypothetical amazing ability of the human body to heal itself. In many instances this has left patients with severe and chronic complications as a result of a failure to treat the medical conditions early. Due to the fact that Health care financing in Uganda is unbalanced and highly fragmented, PHM-Uganda is gearing its advocacy momentum towards promoting equitable health policies such as flexible and affordable National Health Insurance that will enhance access to health for all (including vulnerable and indigent people) through affordable preventive and curative healthcare to reduce out-of-pocket medical and post-medical related expenses, and financial hardships that people experience after meeting their medical treatment costs. We have advised the government on how to promote an egalitarian health care financing through instituting mixed public-private pre-payment schemes, and here our emphasis is on advocating for the implementation of the National Health Insurance Scheme in Uganda to enhance cross-subsidization pre-payment mechanisms and creating large risk pools, as part of promoting equity in health care financing. There the government has to strengthen its synergy with the private insurance companies because insurance sector is largely dominated by the private firms in Uganda. To make this effective and benefit all nationals, the state should pay part of the premiums to lessen the burden on the citizens once the policy is implemented.

In conclusion, In order to achieve the full right to health, PHM and HURIC have pointed their advocacy gears towards an inclusive right to health model that encompasses all the stakeholders in addressing the social determinants of health as a new paradigm and bridlepath in strengthening health system components. And our main target has been on community empowerment and creating awareness as a major instrument of disease prevention. Further we have encircled more players in our right to health model in attainment of health for all, that is the health workers, government, civil society and private players whose role in promoting health accessibility and acquirebility is indispensable.