

# **YOUNG LEADERS THINK TANK FOR POLICY ALTERNATIVES**

**COMPILATION OF WORKING PAPERS**

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**Topic: Health Policies in Uganda**

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# **ANALYSIS OF POLICIES ON THE PHARMACEUTICAL INDUSTRY, HEALTH INSURANCE, AND CULTURAL & TRADITIONAL METHODS OF HEALTH**

**LOYOLA KAROBWA**

## **SUMMARY**

Uganda has developed several health policies to regulate and improve the delivery of health care services. This paper analyses the policies related to the Pharmaceutical industry and access to drugs and health products, health Insurance and alternative methods of health, the incorporation of cultural and Traditional methods. The major shortcomings in the existing policies are remedied by the alternative options put forward. These alternatives and recommendations are home-grown solutions which if implemented are bound to ensure sustainable development in the health sector.

## **1.1 PROBLEM ANALYSIS**

### **THE PHARMACEUTICAL INDUSTRY AND ACCESS TO DRUGS**

The Pharmaceutical industry in Uganda is restricted and underdeveloped, at best; it may be described as emerging. Drugs account for 6% of the country's total imports. About 90% of all medicines are imported, mainly from India and China, and about 60% are distributed by the private sector.<sup>1</sup> Only 5-7% of the imported drugs are 'branded' medicines, the remaining 93-95% being generic products. Counterfeit drugs are therefore becoming an increasing problem in the country.

There are currently five large and six small scale pharmaceutical manufacturing companies in Uganda. These include; Quality Chemicals, Kampala Pharmaceutical Industries (1996), Uganda Pharmaceutical Industries Ltd, Medipharm, Medical Products Ltd., Karuri Pharmaceuticals Ltd and NEC. The number, if functioning at full installed capacities is capable of meeting the demand for supply of essential drugs in the country. This is not the case due to a number of reasons including; high cost of operations, high cost of energy, and unfair competition from drugs imported in countries which have subsidies.

### **HEALTH INSURANCE**

Health insurance is a relatively new phenomenon in Uganda. The most common trend is for a limited number of corporate companies and businesses to offer health insurance packages as part of the benefits to their employees. There are a number of private Insurance companies providing attractive policies. However, they focus only on the formal sector specifically on the employed. Despite the promotion of Community Health Insurance (CHI) schemes in Uganda since the mid 90's, membership has remained persistently low, with only 30,000 (as by 2007) or so people enrolled in the schemes, comprising approximately 2% of the

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<sup>1</sup> Uganda Private Sector Mapping, Dec 2008

catchment population. Moreover, the total number of schemes has not exceeded thirteen. In addition, CHI schemes have only generated very little additional funding: on average, CHI contributions constitute 2% of the overall recurrent budgets in those hospitals where the schemes have been implemented.

## **ALTERNATIVE, CULTURAL & TRADITIONAL METHODS OF HEALTH**

When it comes to traditional medicine, a large proportion of the population in a number of developing countries, still rely on traditional practitioners including traditional midwives, herbalists and bone-setters, and on local medicinal plants to satisfy their primary health care needs. In Uganda, there is at least one traditional health practitioner for every 200-400 people compared to one orthodox medical practitioner for every 10,000 people. The World Health Organization estimates that traditional midwives assist in up to 95% of all rural births and 70% of urban births in developing countries. Though a traditional medicine bill has been drafted in Uganda, no policy has yet been developed for traditional medicine.

It is necessary to examine the current position of the Government so as to arrive at the ultimate aim of developing the health sector in Uganda in regard to the above mentioned aspects.

### **2.1 EXISTING POLICIES/LEGISLATION**

#### **2.1.1 NATIONAL HEALTH POLICY**

The policy recognizes that shortage of medicines in health facilities constitutes a major problem in service delivery. Poor quantification, late orders, inadequate financing and lack of trained pharmacists/technicians contribute to this shortage. The policy specifically pledges that over the next 10 years GoU shall ensure that safe, good quality medicines and health supplies are available and affordable to the population of Uganda.

The objective of the policy is to ensure that essential, efficacious, safe, good quality and affordable medicines are available and used rationally at all times.

In order to achieve this objective, the Government proposes that it will ensure adequate financing of essential medicines and health supplies in the national budget and gradually reduce donor dependency; strengthen distribution and delivery systems at government health facilities; strengthen the existing regulation and its enforcement in the pharmaceutical sector including setting prices for the private sector.<sup>19</sup> Draft National Health Policy II; ensure that the National Drug Authority conducts pharmaceutical vigilance surveys in order to ensure safety of medicines, including traditional medicines; promote, support and sustain interventions that ensure rational prescribing, dispensing and use of medicines and other supplies; promote regional and international collaboration on medicine regulation and bulk purchasing in line with East African Community and other international initiatives; encourage local production of medicines and ensure compliance with Standards of Good Manufacturing Practices; integrate relevant aspects of private sector activities into the Ministry of Health pharmacy policy framework on issues such as accreditation, standards of practice and

cooperation and collaboration with training institutions and promote and support aspects of complimentary and traditional medicines.

The policy objective regarding the provision of health insurance is to mobilize sufficient financial resources to fund the health sector programmes whilst ensuring equity, efficiency, transparency and accountability in resource allocation and utilisation. In order to achieve this objective, the Government will promote alternative health financing mechanisms other than government budgetary provisions. These shall include national social health insurance and other community health financing.

### **2.1.2 THE NATIONAL DRUG POLICY**

The National Drug Policy, which is implemented by the National Drug Authority, relates to the regulation of the importation, production, distribution, marketing, exportation, and use of pharmaceuticals in the public as well as in the private sectors. It is enshrined in the National Drug Policy Act Cap. 206.

As per the Act, the national drug policy shall be—

- (a) To ensure that essential, safe, efficacious and cost-effective drugs are made available to the entire population of Uganda to provide satisfactory health care;
- (b) To make a continuous review of the needs, knowledge and resources of essential drugs;
- (c) To promote the rational use of drugs both in the public and private sector;
- (d) To improve Government regulation and control on manufacture, production, importation, exportation, marketing and use of drugs;
- (e) To provide systematic public information and professional training and retraining of health workers;
- (f) To improve the registration of drugs and licensing of pharmaceutical premises;
- (g) To intensify research in all types of drugs, including traditional medicines;
- (h) To comply with the international regulations on drugs, including the conventions on narcotic drugs and psychotropic substances under international control; and
- (i) To fight against drug and substance abuse.

### **2.1.3 THE NATIONAL PHARMACEUTICAL SECTOR STRATEGIC PLAN FOR UGANDA (NPSSP) 2002/3–2006/7**

This is basically a plan to operationalize the National Drug Policy of 2002.

Objective 1 Output (Efficient & Effective DRA)

Update existing drug legislation to take account of the changing environment (health policy, decentralization, professional laws) and to generally improve

Governmentt regulation & control of all aspects of drug handling & use, including drug manufacture, import, export, marketing, storage, sale and supply

Carry out systematic review of all current legislation affecting the pharmaceutical sector

The overall aim is to stimulate and improve local production of required essential drugs so that they form a much more substantial proportion of national requirements thus reducing dependence on imports, supporting local industrial enterprise and providing employment opportunities.

At central level: It will be the responsibility of the MoH to advise GoU on the most feasible approaches for stimulating local pharmaceutical production. Based on this advice, GoU will endeavour to institute suitably robust and attractive incentives to encourage investment in this essential industry.

Efforts will also be directed towards providing local pharmaceutical manufacturers with the necessary technical support, guidance and training required to establish the required technical capacity and ensure cGMP standards. NDA will play a leading role in this regard.

The entire provision 3.5 suggests methods to increase local manufacture including Tax incentives and lower tariff rates for electricity and water.

### **3.1 OPTIONS/ ALTERNATIVES**

#### **3.1.1 Local manufacture of drugs**

Drugs should be classified into groups which can be manufactured at home, like anti-malarial; and those which the local companies do not have the capacity to manufacture yet. And then, a total import ban should be imposed on those drugs which can be manufactured locally. Therefore supporting the local manufactures whose production shall increase and because they are local companies, the drugs become more readily available and affordable to the general public.

#### **3.1.2 Liberalizing of the licensing system**

While it is logical to have a strict licensing system so that incompetent, ill-equipped companies do not enter the industry, it is detrimental to have an extremely stringent system. Liberalizing the system shall encourage foreign investors and foreign companies to set up production plants in Uganda. This can be done in two ways;

(a) Foreign investors buying a stake in local manufacturing companies. Such partnerships give the local companies the funds they need to expand and increase production.

(b) International foreign companies building subsidiaries and manufacturing plants in Uganda.

Encouraging more players in the industry creates jobs and increases production of essential drugs.

### **3.1.3 Improvement of health facilities and services**

The poor state of public hospitals is a monster that shall not go away until killed. It should be the first step to solving all the problems in the health sector. The proposed National Health Insurance Policy shall fail if employees are making contributions from their hard earned salaries only to get mediocre attention from doctors, poor bedside treatment, and poor services in filthy overcrowded hospitals.

A compulsory contribution is nothing more than another tax if its purpose is not appreciated. And employees shall not appreciate making this contribution if the health services they are getting are not up to par.

### **3.1.4 Nationalising the Community Health Insurance (CHI)**

The Government should support these schemes and raise awareness for them. This way more families and groups in the villages would join the schemes in their communities.

The Community Health Insurance (CHI) is increasingly being seen as one way of addressing the inequity in access to healthcare that arises from direct payments for healthcare because it has the potential to reach individuals in the informal sector.

It is perceived to be particularly relevant in countries (such as Uganda) that depend a lot on out of pocket payments for healthcare and where a large part of the population is not engaged in formal employment. The major problem of this scheme is a failure to be sustainable. Notably, these schemes are run by Aid organisations and non-profit religious institutions with no funding from Government.

### **3.1.5 Amending NDA guidelines**

The requirements for herbal medicines to enter the market like pharmaceutical name, botanical information are too stringent.

Traditional medicine is a combination of age old remedies and concoctions, the majority of practitioners are not formally educated, and this makes it difficult for them to have such information about their products. The lack of such information like the botanical/ scientific name of a plant does not in any way reduce its effectiveness.

### **3.1.6 Integration of traditional methods into mainstream health centres and hospitals**

Many times, traditional cures are almost the same as the orthodox medicines and drugs. Ugandans should be able to walk into a hospital and have a doctor recommend a home remedy before or after drugs have failed.

The integration of cultural and traditional methods can be achieved through the education system. Children in primary schools are taught basic primary health care; this should be supplemented with lessons on traditional cures such as common medicinal plants which are in our environment. This can be extended to higher institutions like Universities and medical colleges.

#### **4.1 Recommendations**

- Training traditional practitioners
- Parliament should pass the National Health Insurance Bill with an affordable rate to be contributed.
- Need to have a regulatory framework of the traditional methods of health
- Increase financing for the health sector
- Encouraging preventive methods other than curative methods such as good nutrition, family planning and personal hygiene and healthy living.
- Knowledge management and research
- Encourage credible alternative methods of staying healthy such as aromatherapy, acupuncture, Yoga, Pilates, meditation, etc... These practices from Asia and the Western world can be introduced into our societies because they have been proven to improve the quality of life and health.

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# AN ANALYSIS OF UGANDA'S RESPONSE TO HIV/AIDS

GATI RHODA

## SUMMARY

World leaders will gather at the United Nations in New York from June 8 to 10 for a high level meeting on AIDS. The meeting comes at an important time in the history of the AIDS epidemic and at a time when prevalence has increased in Uganda. Although Uganda has in the past decade been commended for its efforts in the fight against HIV/AIDS, recent evidence suggests that HIV incidence and prevalence have increased in Uganda. The reasons for this increase have been attributed to the government's shift towards abstinence-only prevention programmes, a general complacency or 'AIDS-fatigue' and a suggestion that antiretroviral drugs have changed the perception of AIDS from a death sentence to a treatable, manageable disease. In order to curb HIV prevalence, Uganda needs to take a serious look at infection trends and behaviour to identify why this rise may be occurring and how to remedy it.

## INTRODUCTION

Uganda is often held up as a model for Africa in the fight against HIV and AIDS<sup>2</sup>. Prevalence rates declined as a result of government policies that promoted the empowerment of civil society, frank discussions of HIV transmission, pragmatic emphasis on comprehensive HIV prevention strategies, and improved access to treatment. However, after sharp declines, recent evidence suggests that HIV incidence and prevalence have increased in Uganda.<sup>3</sup> There are an estimated 1.2 million people living with HIV in Uganda, which includes 150,000 children.<sup>4</sup> An estimated 64,000 people died from AIDS in 2009 and 1.2 million children have been orphaned by Uganda's devastating epidemic.<sup>5</sup>

## BACKGROUND

The first stage of the AIDS epidemic saw the rapid spread of HIV through urban sexual networks and along major highways from its origin in the Lake Victoria region. Doctors in this area had become aware of a surge in cases of severe wasting known locally as 'slim disease'. In 1982, the first AIDS case in Uganda was diagnosed<sup>6</sup> and the link between 'slim disease' and AIDS was clinically recognised. It was not until 1986 that the country had a major HIV prevention

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<sup>2</sup> See Joseph Amon, "Preventing the Further Spread of HIV/AIDS: The Essential Role of Human Rights," *Human Rights Watch World Report 2006* (New York: Human Right Watch, 2006), <http://www.hrw.org/legacy/wr2k6/hivaids/index.htm>.

<sup>3</sup> See Human Rights Watch: Comments to Uganda's Parliamentary Committee on HIV/AIDS and related matters about the HIV/AIDS Prevention and Control Bill.

<sup>4</sup> Government of Uganda (2010, March) ['UNGASS country progress report: Uganda'](#)

<sup>5</sup> UNAIDS (2010) ['UNAIDS report on the global AIDS epidemic'](#)

<sup>6</sup> Serwadda, et al. (1985) ['Slim Disease: A New Disease in Uganda and its Association with HTLV-III Infection'](#) *Lancet* 2(8460):849-852

programme. By this time the country was in the midst of a major epidemic, with prevalence rates of up to 29% in urban areas.<sup>7</sup>

Uganda's first AIDS control programme was set up in 1987 to educate the public about how to avoid becoming infected with HIV. The programme promoted the [ABC](#) approach (abstain, be faithful, use condoms), ensured the safety of the blood supply and started HIV surveillance.<sup>8</sup> Strong political leadership and commitment to tackling the rampaging AIDS epidemic was a key feature of the early response to AIDS in Uganda.<sup>9</sup>

Between 1992 to 2000, the [HIV prevalence](#) fell dramatically, from a peak in 1991 of around 15% among all adults, and over 30% among pregnant women in the cities,<sup>10</sup> to around 5% in 2001<sup>11</sup>.

It is thought the government's ABC prevention campaign was partly responsible for the decline in prevalence. However, as treatment was not widely available in Uganda during this time the high numbers of AIDS-related deaths also contributed to the reduction in the number of people living with HIV.

Uganda has seen the stabilization of prevalence during 2000-2005, and reports of a slight increase in prevalence from 2006.<sup>12</sup> Free antiretroviral drugs have been available in Uganda since 2004. It is thought that the introduction of HIV drugs may have led to complacency about HIV as it is no longer an immediate death sentence. Many experts have also speculated that Uganda's shift in prevention policy away from ABC towards US-backed abstinence-only programmes may also be responsible for an increase in risky behaviour, as comprehensive sex education and condom promotion are no longer mainstream.<sup>13</sup>

The current HIV prevalence in Uganda is estimated at 6.5 percent among adults<sup>14</sup> and 0.7 percent among children.<sup>15</sup> HIV prevalence is higher in urban areas (10 percent) than rural areas (6 percent).<sup>16</sup> An estimated 43 percent of new

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<sup>7</sup> New Scientist (1990) '[AIDS epidemic moves south through Africa](#)'

<sup>8</sup> Ibid

<sup>9</sup> Prevention work at grass-roots level also began in this era, with a multitude of tiny organisations educating their peers about HIV. One of the first community-based organisations formed was TASO, The AIDS Support Organization, which was run by sixteen volunteers who had been personally affected by HIV/AIDS. TASO later became the largest indigenous AIDS service organisation providing HIV/AIDS services in Uganda and Africa, and providing emotional and medical support to many thousands of people who are HIV positive.

<sup>11</sup> STD/AIDS Control Programme (2002) '[Trends in HIV prevalence and sexual behaviour \(1990-2000\) in Uganda](#)'

<sup>12</sup> Aidsmap (2006) '[Is Uganda's HIV prevention success story 'unravelling'](#)'?

<sup>13</sup> Avert; [HIV/AIDS in Uganda](#).

<sup>14</sup> UNAIDS (2010) '[UNAIDS report on the global AIDS epidemic](#)'

<sup>15</sup> Government of Uganda (2010, March) '[UNGASS country progress report: Uganda](#)'

<sup>16</sup> *ibid*

infections occur among people engaged in mutually monogamous heterosexual relationships.<sup>17</sup>

The epidemic has geographic, socio-demographic and socio-economic heterogeneity: women, urban residents and people residing in Kampala and in the central and mid-northern regions are disproportionately more affected. By 2007, the population groups most severely affected had shifted from young unmarried individuals to older and married or formerly married individuals.<sup>18</sup> [Women](#) are disproportionately affected, accounting for 57% of all adults living with HIV. This is attributed to the fact that Ugandan women tend to marry and become sexually active at a younger age than their male counterparts, and often have older and more sexually experienced partners. This (plus various biological and social factors) puts young women at greater risk of infection.<sup>19</sup>

The number of new infections (an estimated 120,000 in 2009) exceeds the number of annual AIDS deaths (64,000 in 2009),<sup>20</sup> and it is feared HIV prevalence in Uganda may be rising again. The most important source of new infections continues to be sexual transmission, which accounts for 76% of new HIV infections. There are many theories as to why this may be happening, including the government's shift towards abstinence-only prevention programmes, and a general complacency or 'AIDS-fatigue'. It has been suggested that antiretroviral drugs have changed the perception of AIDS from a death sentence to a treatable, manageable disease; this may have reduced the fear surrounding HIV, and in turn have led to an increase in risky behaviour.<sup>21</sup>

Despite reaching 42% of the population in need of ART in 2005, the number of those in need of ART continued to grow each year. It was estimated that there were 270,000 PHAs eligible for ART in 2007; this number was projected to reach 332,000 in 2012 – far outstripping system capacity and available finances. The combination of huge increases in the general population (3.2% per annum in 2006) coupled with a high number of new infections made it extremely difficult to stay ahead of the epidemic<sup>22</sup>.

## EXISTING POLICIES

Generally the government response to the HIV/AIDS problem is contained in the National HIV/AIDS Strategic Plan 2007/2008-2011/2012. The NSP aims to reduce the incidence of HIV and AIDS by 40%, expand social support and scale up interventions of care and treatment to make them accessible to 80% of those in need by the year 2012. The plan has three thematic service areas:

- prevention;

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<sup>17</sup> UNAIDS, Uganda AIDS Commission (2009, March) ['Uganda: HIV prevention response and modes of transmission analysis'](#)

<sup>18</sup> The Republic of Uganda (2007), "[National HIV/AIDS Strategic Plan 2007/2008-2011/2012](#)"

<sup>19</sup> AVERT.org

<sup>20</sup> UNAIDS (2010) ['UNAIDS report on the global AIDS epidemic'](#)

<sup>21</sup> AllAfrica (2008) ['Uganda: Stick to condom use'](#)

<sup>22</sup> The Republic of Uganda (2007), "[National HIV/AIDS Strategic Plan 2007/2008-2011/2012](#)"

- care and treatment; and
- social support.

### HIV Prevention in Uganda

Uganda is often cited as a rare example of success in a continent facing a severe AIDS crisis. The country is seen as having implemented a well-timed and successful HIV prevention campaign, which has been credited with helping to bring adult HIV prevalence down from around 15% in the early 1990s to around 5% in 2001.<sup>23</sup> However praise for Uganda's prevention efforts has waned in recent years, with particular criticism levelled at US-backed abstinence campaigns. There are indications that Uganda's HIV prevalence may once again be on the rise.<sup>24</sup>

The approach used in Uganda has been named the ABC approach - firstly, encouraging sexual Abstinence until marriage; secondly, advising those who are sexually active to Be faithful to one partner; and finally, urging Condom use, especially for those who have more than one sexual partner.<sup>25</sup>

#### *Abstinence*

Abstinence is the most controversial area of Uganda's HIV prevention campaign. Although it has always been part of the country's prevention strategy it has come under scrutiny since 2003 following significant investment of money for abstinence-only programmes from PEPFAR<sup>26</sup>, the American government's initiative to combat the global HIV/AIDS epidemic. It is felt that PEPFAR has shifted the focus of prevention in Uganda from the comprehensive ABC approach of earlier years.

UN Special Envoy for HIV/AIDS in Africa, Stephen Lewis said that PEPFAR's emphasis on abstinence above condom distribution is a "distortion of the preventive apparatus and is resulting in great damage and undoubtedly will cause significant numbers of infections which should never have occurred".<sup>27</sup>

#### *Be faithful*

Being faithful to your partner-or 'zero grazing'-was the dominant message of early HIV prevention campaigns led by President Museveni. The term 'zero-grazing' comes from the agricultural practice of tying livestock to a post, restricting them to a zero-shaped section of grass.<sup>28</sup>

Models of the epidemic and surveys from the late 1980s to 1990s show that encouraging fewer sexual partners was effective - the World Health Organisation

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<sup>23</sup> STD/AIDS Control Programme (2002) 'Trends in HIV prevalence and sexual behaviour (1990-2000) in Uganda'

<sup>24</sup> Aidsmap (2006) 'Is Uganda's HIV prevention success story 'unravelling'?'

<sup>25</sup> AVERT.org

<sup>26</sup> The U.S. President's Emergency Plan for AIDS Relief

<sup>27</sup> New York Times (2005) '[U.S. Blamed for Condom Shortage in Fighting AIDS in Uganda](#)'

<sup>28</sup> AVERT.org

reported that between 1989 and 1995 the number of Ugandan men reporting three or more non-marital sexual partners fell from 15 percent to 3 percent.<sup>29</sup>

Unfortunately, the early emphasis on avoiding casual sex appears to have lost its impact in recent years. A 2006 study by the Ugandan Ministry of Health found an apparent increase in multiple partnering. The proportion of sexually active Ugandans who reported having had two or more sexual partners in the previous 12 months increased from 2 to 4 percent between 2000-01 and 2004-05 among women, and from 25 to 29 percent among men.<sup>30</sup>

### *Condom Use*

Condoms were not heavily promoted and distributed during the early years of the AIDS epidemic in Uganda, as the president felt they offered false hope that the epidemic could be stopped without curbing multiple sexual partnerships. It was not until the mid-nineties that condoms were widely distributed. The number of condoms delivered and promoted by international groups rose from 1.5 million in 1992 to nearly 10 million in 1996.<sup>31</sup>

The momentum of condom distribution was lost in 2004 when the Ugandan government issued a nationwide recall of the condoms distributed free in health clinics, due to concerns about their quality. Millions of condoms were incinerated, and by mid-2005 there was said to be a severe scarcity of condoms in Uganda, made worse by new taxes which made the remaining stocks too expensive for many people to afford.<sup>32</sup>

In June 2006, the Ministry of Health announced it had, with assistance from the World Bank, imported 80 million re-branded condoms for free distribution.<sup>33</sup> However, in 2010 another shortage of free condoms was reported which a Ministry of Health official blamed on the long procurement process, erratic delivery and lack of storage space for condoms.<sup>34</sup>

Conflicting messages and problems with distribution appears to have had an effect on the number of people using condoms. UNAIDS found that condom use during sex with non-regular partners was reported by 20%, 39%, 47% and 35% of women in 1995, 2000, 2004–2005 and 2006, respectively, and by 35%, 59%, 53% and 57% of men.<sup>35</sup>

### *HIV/AIDS Testing*

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<sup>29</sup> Bessinger and Akwara (2003) 'Sexual Behavior, HIV and Fertility Trends: A Comparative Analysis of Six Countries Phase I of the ABC Study', USAID

<sup>30</sup> Uganda Ministry of Health (2006) '[Uganda: HIV/AIDS Sero-Behavioural Survey: 2004-05](#)'

<sup>31</sup> The Washington Post (2007) '[Uganda's Early Gains Against HIV Eroding](#)'

<sup>32</sup> AllAfrica (2006) '[Engabu's Second Coming](#)'

<sup>33</sup> *ibid*

<sup>34</sup> UNAIDS (2007) '[Sub-Saharan Africa: AIDS epidemic update Regional Summary](#)'

<sup>35</sup> *ibid*

Recognising the vital role that testing plays in preventing the spread of HIV, Uganda was the first country in sub-Saharan Africa to open a voluntary counselling and testing (VCT) clinic.<sup>36</sup>

In 1999 the Ugandan Ministry of Health started a voluntary door-to-door HIV screening programme using HIV rapid tests in an effort to reduce the spread of HIV. This effort was intended to make HIV screening services accessible to more people, especially in rural areas where there were neither modern laboratories nor electricity to run standard HIV tests.<sup>37</sup>

Uganda has also begun to implement routine or 'opt-out' testing (whereby anybody who enters a healthcare facility is tested for HIV unless they specifically ask not to be) in some healthcare settings. Trials of routine testing had overwhelmingly positive results, showing that this style of testing identified those infected at an earlier stage of their infection (before they were symptomatic) and therefore increased their survival rate.<sup>38</sup> A study in two large Ugandan hospitals with a high HIV burden found a high rate of routine testing uptake with only 5% of people refusing the test.<sup>39</sup>

In 2007, HIV testing and counselling was available in 554 of health facilities in the country. By the end of 2008, this number had risen to 812 and increased further to 1,215 in 2009.<sup>40</sup>

### *Education*

PIASCY (Presidential Initiative on AIDS Strategy Communication to Youth) is a national holistic programme designed to provide all school going children and teachers with information on HIV/AIDS, both to cope with the disease- for those infected and affected-and to prevent further infections. The implementation of the programme has been more idealistic than practical. For example, it is noted that whereas 'Talking compounds' have been created in schools with messages aimed at preventing AIDS, there is not tangible impact on the target populations. The compounds have ended up as mere accountability tools than realistic prevention tools.

### *Alternative policy recommendations*

Uganda needs to revive and adapt its HIV prevention programme, moving away from abstinence-only initiatives to a comprehensive programme that incorporates not only abstinence, fidelity and condom use, but also HIV testing and the prevention of mother-to-child transmission of HIV.

### HIV/AIDS treatment and care

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<sup>36</sup> Moodie, Rob et al. (1993) '[Confronting the HIV epidemic in Asia and the Pacific: developing successful strategies to minimize the spread of HIV](#)', AIDS, 7:1543-1551

<sup>37</sup> Ibid

<sup>38</sup> Aidsmap (2006) '[Routine or opt-out counselling and testing: findings from the 2006 PEPFAR meeting](#)'

<sup>39</sup> WHO (2008) '[Acceptability of routine HIV counselling and testing, and HIV sero-prevalence in Ugandan hospitals](#)'

<sup>40</sup> WHO/UNAIDS/UNICEF (2009) '[Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector](#)'

The Ugandan Ministry of Health began offering a free prevention of mother-to-child transmission (PMTCT) service in a small number of antenatal clinics in January 2000. The trial PMTCT programme included counselling and rapid testing for all women attending antenatal clinics and treatment for both mother and child following a positive diagnosis.

The number of PMTCT service delivery sites was expanded between 2005 and 2007 with emphasis on providing services to rural populations. The number of health facilities providing routine HIV counselling and testing for pregnant women increased, raising the uptake of HIV testing to 80% of all women attending antenatal clinics.<sup>41</sup> The proportion of HIV positive pregnant women receiving anti-retrovirals for PMTCT increased from 12% in 2005 to 53% in 2009.<sup>42</sup>

According to the latest figures, 18% of new HIV infections in Uganda occurred through mother-to-child-transmission, although this figure may be higher as many births in Uganda take place outside healthcare facilities.<sup>43</sup> In Uganda's 2010 country progress report, PMTCT has been placed high on the agenda with a target of halving mother-to-child transmission by 2012.<sup>44</sup>

It was not until June 2004 that Uganda began to offer free ARV medication to people living with HIV as part of a five-year pilot programme. The initial consignment was funded by the World Bank, with future drugs to be paid for by a Global Fund grant of US\$70 million and large grants from America's PEPFAR initiative.<sup>45</sup> The momentum of scaling up HIV treatment in Uganda was put in jeopardy following the suspension of funds from one of the country's key donors. In August 2005, the Global Fund to Fight AIDS, Tuberculosis and Malaria suspended the disbursement of money to Uganda after financial irregularities were discovered.<sup>46</sup> It was found that management of Uganda's grants was generally poor, and that significant sums of money had been diverted to activities not related to combating HIV/AIDS.<sup>47</sup>

Uganda aims to relieve the drug supply problems by producing its own generic drugs. In 2007, the Luzira factory opened in the capital Kampala, in partnership with the Indian pharmaceutical giant Cipla. However, it did not start manufacturing drugs until 2009. In March 2010, the factory received qualification from WHO to market and distribute drugs internationally. It is hoped that the factory, which has the capacity to produce at least 2 million tablets per day, will reduce the cost of drugs as well as the likelihood of stock-outs.<sup>48</sup> However, AIDS activists have expressed concern that trade-related laws

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<sup>41</sup> UNGASS (2007) '[Uganda: UNGASS country progress report](#)'

<sup>42</sup> WHO/UNAIDS/UNICEF (2009) '[Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector](#)'

<sup>43</sup> Government of Uganda (2010, March) '[UNGASS country progress report: Uganda](#)'

<sup>44</sup> Government of Uganda (2010, March) '[UNGASS country progress report: Uganda](#)'  
[see all references](#)

<sup>45</sup> BMJ (2008) '[Ugandan patients don't get the AIDS drugs they need](#)' 336(7640)

<sup>46</sup> Global Fund Press Release (2005) '[Global Fund Suspends Grants to Uganda](#)'

<sup>47</sup> The Lancet (2006) '[Uganda is learning from its Global Fund grant suspension](#)', 366(9500)

<sup>48</sup> Pharmaceutical Technology.com '[Quality Chemical Industries, HIV Drug Plant, Uganda](#)'

which enforce intellectual property rights might make it illegal for Uganda to produce, import and export generic drugs in the future.<sup>49</sup>

Currently just over 200,000 people in Uganda are receiving antiretroviral treatment, an estimated 39% of those in need, according to the latest WHO guidelines (2010).<sup>50</sup> The latest guidelines recommend starting treatment earlier and have therefore increased the number of people estimated to be in need of treatment. Under the previous guidelines, treatment coverage in Uganda would be 53%.<sup>51</sup> Targets have been set of 240,000 people on treatment by 2012,<sup>52</sup> and 342,200 by 2020. When setting treatment targets Uganda must think about sustainability, as 95% of the ARV programme is currently donor funded, mainly by PEPFAR.<sup>53</sup> This support is under threat; PEPFAR funding has flat-lined, and the US government plans to cap funds to Uganda until at least 2011.<sup>54</sup>

In 2009, HIV activists in Uganda protested against the diversion of earmarked funds from the purchase of antiretroviral drugs.<sup>55</sup> This was closely followed by a recommendation by parliamentarians that Ministry of Health spending on HIV/AIDS increase from 6 percent to 15 percent of the national budget in order to effectively deal with the epidemic.<sup>56</sup> However, increasing demand and reduced donor funding already have an adverse effect on the provision of HIV treatment. In March 2010 Peter Mugenyi, the Director of the Joint Medical Research Centre in Uganda, spoke of turning away 'desperate patients' on a daily basis due to funding shortages.<sup>57</sup> Such difficulties in providing treatment are echoed by other health facilities in Uganda who have placed an informal ban on the enrollment of new patients.

#### *Alternative policy recommendations*

Already existing policies on treatment and care need to be implemented. In particular attention should be paid to:

- supporting and expanding the provision of home based care and strengthening referral systems to other health facilities and complementary services;
- increasing equitable access to Anti Retro-viral Treatment to those in need;

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<sup>49</sup> Consultancy Africa Intelligence (2010, May 14th) '[Uganda's Luzira Drug Factory: Quality generic ARVs versus patents and their promoters](#)'

<sup>50</sup> WHO/UNAIDS/UNICEF (2010) '[Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector](#)'

<sup>51</sup> WHO/UNAIDS/UNICEF (2010) '[Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector](#)'

<sup>52</sup> Uganda AIDS Commission (2008) '[National Strategic Framework for HIV/AIDS](#)'

<sup>53</sup> BMJ (2008) '[Ugandan patients don't get the AIDS drugs they need](#)' 336(7640)

<sup>54</sup> MSF (2009), '[Punishing success? Early signs of retreat from commitment to HIV/AIDS care and treatment](#)'.

<sup>55</sup> PLUS NEWS (2009, 10th August) '[Health ministry diverts ARV money](#)'

<sup>56</sup> New Vision (2010, 16th February) '[Sh60b set aside for treatment of people living with HIV](#)'

<sup>57</sup> Mugenyi, Peter N., (2010, March 11th) '[Testimony to Congress: House Committee on Foreign Affairs, Subcommittee on Africa and Global Health](#)'

- scaling up HIV counselling & testing to facilitate universal access to treatment;
- integrating prevention into all care & treatment services;
- Increasing access to prevention & treatment of opportunistic infections including tuberculosis and others;
- with the realization that the life of a child and a mother has the same value irrespective of whether he or she is born and lives, pregnant women living with HIV need to have access to the best possible treatment regimen to protect themselves and their children; and
- Uganda ought to embrace the benefits of Treatment for Prevention, an option that should be available for all people living with HIV. However this should not have to come at the cost of those eligible and waiting for treatment for their immediate survival.

### Social Support

Social support is the third thematic area of the NSP. The goal of the NSP is to mitigate the social, cultural and economic effects of HIV and AIDS at individual, household and community level. It is notable that there are no tangible strategic steps in place to realize the thematic goal of social support. In the 1990s, when a lot of progress was made in the handling of the HIV/AIDS epidemic, the disease was handled with a community-based approach. Churches and other community institutions were active in reacting to the disease. This has however eroded with time and with the increased commercialization of ARTs and other interventions which has led to negligible and no social support in some cases, in the long run leading to high prevalence rates.

#### *Alternative policy recommendations*

We recommend a community-oriented approach to the epidemic. This will require leaders in village and urban communities and capitals to break the silence about HIV and AIDS and act boldly, with conviction. Specific recommendations include:

- legal and appropriate social and community safety nets persons made vulnerable by HIV and AIDS are put in place;
- quality psychosocial support to people living with and or affected by HIV/AIDS;
- enhancement of livelihoods & economic empowerment of affected communities & households;
- promotion and support for sustained formal and informal education, vocational and life skills development for people living with and or affected by HIV/AIDS;
- increase in access to basic needs for people living with and or affected by HIV/AIDS; and
- There should be space for community dialogue and social transformation. Violence against women and girls, inter-generational sex, homophobia, gender inequity and criminalization of people living with HIV, people who inject drugs or sell sex must end.

## Criminalizing transmission as a policy approach

With the promulgation of the HIV and AIDS Prevention and Control Bill 2010, Uganda's legal response to HIV and AIDS is worrying. The Bill criminalizes a wide and ill-defined range of conduct for example attempted transmission of HIV<sup>58</sup>; intentional transmission of HIV<sup>59</sup>; breach of confidentiality<sup>60</sup>; obstruction or prevention of any activity related to implementation of provisions in the Bill; and breach of safe practices of HIV prevention<sup>61</sup>.

Criminalizing such a wide range of actions not only opens the door for Government to prosecute people in selective and abusive ways, it also adds to the already huge backlog of cases in Ugandan Courts. Further, it has been argued that there are no data indicating that the broad application of criminal law to HIV transmission will achieve either criminal justice or prevent HIV transmission. Rather, such application risks undermining public health and human rights.

## Circumcision as a policy option

Recent studies have increasingly recommended circumcision as a potential policy option. Circumcision however does not reduce any chance of transmission to one's sexual partner. There is also a possibility of circumcision encouraging reckless sexual behavior among men.

## CONCLUSION

Uganda is at an important crossroad in the history of its AIDS epidemic. After a dramatic reduction in HIV prevalence following an early comprehensive HIV prevention campaign, there is evidence that the number of people living with HIV in the country is on the increase.

In order to avoid this, Uganda needs to take a serious look at infection trends and behaviour to identify why this rise may be occurring and how to remedy it. Experts believe that complacency and the 'normalization' of AIDS may be leading to an increase in the risky behaviour that early prevention campaigns sought to reverse.

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<sup>58</sup> Clause 39 of the Bill.

<sup>59</sup> Ibid Clause 41

<sup>60</sup> Ibid clause 40

<sup>61</sup> Ibid Clause 42 of the Bill. The wording of the Clause would mean that for example a patient who fails to take his or her dose of medication would be found criminally liable.

## MENTAL HEALTH

**EUGENE PACELLI OKELLO AND BERNARD MUKHONE**

### **1.1 Abstract**

Mental health is an integral part of our health. Mental health cases in Uganda are not as alarming as other cases not so much because it is not a problem but because there is not much research and data about the same, however it is important that government moves to finalise the mental health policy and strategic plan and align it with the WHO standards as well as address the causative factors like automobile pollution that could blow out of proportion if not checked. These together with training and strengthening multi sectoral collaboration will help prevent, control and mitigate future mental health related cases.

### **Introduction**

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity<sup>62</sup>. From this definition it is clear that mental health is an important aspect in defining the entire health of a person. Mental health refers to the balance between all aspects of life - social, physical, spiritual and emotional. It impacts on how we manage our surroundings and make choices in our lives - clearly it is an integral part of our overall health<sup>63</sup>. Mental Health is far more than the absence of mental illness and has to do with many aspects of ones life including: how the individual feels about him or her self; about others and how individuals are able to meet the demands of life<sup>64</sup>.

Article 12 of the ICESCR establishes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” The Constitution

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<sup>62</sup> Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference,

New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the

World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

<sup>63</sup> <http://www.nehb.ie/youthhealthne/mental%20health%20definition.htm>

<sup>64</sup> *ibid*

of the World Health Organization (WHO), adopted in 1946, first enunciated a right to health and mandated WHO to promote that right<sup>65</sup>. The Convention on the Rights of Persons with Disabilities adopted by the United Nation is a pertinent international instrument on the rights of persons with mental disabilities which crosscuts almost all the rights of persons with disabilities. This right to the highest attainable standard of mental health entails a right on the part of people with mental disabilities to services that are (a) available (b) accessible (c) acceptable and of (d) appropriate and good quality. To be appropriately available, services must be provided in “sufficient quantity” by “trained medical and professional personnel.” The requirement that services be “acceptable” means that they must be provided in a manner that is culturally appropriate and respectful of medical ethics. For services to be of appropriate quality, they must also be culturally acceptable, medically appropriate, and provided in a safe and clean environment.

Worldwide, there is a significant gap between the level of mental health needs and the availability of quality services to appropriately address these needs. In low- and middle-income countries, in Africa as elsewhere, it is estimated that between 76% and 99% of people with serious mental disorders do not have access to the treatment they need for their mental health problems<sup>66</sup>.

Mental health policies and plans are essential tools for setting strategic priorities, coordinating action and reducing fragmentation of services and resources. They are more likely to achieve the desired effect when they reflect a

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<sup>65</sup> General Comment No. 14 (2000)(E/C.12/2000/4) on the right to the highest attainable standard of health (art. 12

of the International Covenant on Economic, Social and Cultural Rights), adopted by the Committee on Economic,

Social and Cultural Rights at its twenty-second session in April/May 2000.

<sup>66</sup> World Health Organisation World Mental Health Survey Consortium: Prevalence,

severity and unmet need for treatment of mental disorders in the World Health

Organization World Mental Health Surveys. Journal of the American Medical

Association, 2004, 291(21):2581-2590.

clear commitment from governments, are well conceptualized, are consistent with the existing evidence base and international standards, and reflect a broad consensus among key stakeholders

### **Problem description**

Mental health services in Uganda were decentralised in the 1960s and mental health units built at regional referral hospitals<sup>67</sup>.

According to the World Health Organisation (WHO) report on mental health policy and service provision 2010, mental health units that were built at regional referral hospitals resembled prisons and were manned by psychiatric clinical officers.

WHO says the services were plagued by low staff morale, a chronic shortage of drugs and no funds for community activities. “Most people had little understanding of mental disorders or did not know that effective treatments and services were available. Up to 80% of patients went to traditional healers before reporting to the health system,” the report states.

To date, upcountry mental health units have very low numbers of medics in the field of psychiatry, making them as good as useless.

### **Description/analysis of the current (governmental) policy**

The mental health programme at the Ugandan Ministry of Health was initiated in 1996, for coordination of mental health services in the country. Existence of a public health and primary health care framework for the achievement of the health care goals facilitated the inclusion and integration of mental health into Primary Health Care (PHC). In accordance with the health sector reforms and plans, a draft mental health policy was developed in 2000, and still remained a draft by the year 2006.

The following WHO-AIMS items/components are addressed in this draft mental health policy:

- Developing community mental health services

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<sup>67</sup> <http://www.newvision.co.ug/D/9/34/715142>

- Decentralization of mental health services
- Integration of mental health services into Primary Health Care.
- Human resources
- Involvement of users and families
- Advocacy, education and promotion of mental health
- Human rights protection of users
- Equity of access to mental health services across different groups
- A monitoring system

The WHO-AIMS items/components not addressed in this draft mental health policy are:

- Financing for mental health activities
- Quality improvement
- The relationship between mental illness and poverty
- The role of allied health service providers such as psychologists and social workers
- Provision for welfare benefits for people with mental illness
- Research and policy evaluation
- Child and adolescent mental health issues are mentioned, but not strongly addressed.
- Issues of conflict and mental health

### **Uganda's draft mental health policy**

The Uganda's draft mental policy include the following components: (1) developing community mental health services, (2) downsizing large mental hospitals, (3) developing a mental health component in primary health care, (4) human resources, (5) involvement of users and their families, (6) advocacy and promotion, (7) human rights protection of users, (8) equity of access to mental health services across different groups, (9) Monitoring system. Financing and quality improvement are not addressed as these are assumed to be integrated into general health services. In addition, a list of essential medicines was present. These medicines included all categories of psychotropic drugs (i.e. antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs).

## **Comparative analysis**

### *Mandate, level of approval and official dissemination*

In all the countries considered, mental health policy received a high level mandate. However, the level of approval of the policy differed across countries. In Ghana, the 1994 mental health policy was mandated and approved by the Director General of health services. The Minister of Health had nominated the chief psychiatrist at the time as advisor and had been kept involved all through the process. In South Africa, the 1997 mental health policy guidelines were mandated by the Minister of Health and approved at a meeting of the Health Minister, the heads of health departments at provincial and national levels, and the nine provincial Members of Executive Councils (MECs). However, the 1997 South Africa mental health policy guidelines are not recognized as a formal policy by the current national Department of Health because they did not follow more recently adopted policy development protocols and were not formally published for dissemination. In Uganda, the 2000- 2005 draft mental health policy, although mandated by the Ministry of Health senior management, did not receive formal approval. However the policy was informally used to guide the Mental Health programme and activities nationwide. Finally, the 2005 Zambia mental health policy was mandated and approved by Cabinet. In all cases the policy had not been sufficiently disseminated.

### *Evidence base for policy development*

The use of evidence for policy development varied considerably between countries. In Ghana, South Africa and Uganda no formal situational analysis or needs assessment was conducted. In Ghana, the policy was developed based on the personal experience of and information gathered through regional visits to psychiatric services by two senior health officials involved in psychiatric care and policy development in the country. Policy drafters in Uganda and South Africa also used their personal knowledge of the mental health situation in their countries, as well as unsystematic reviews of available small- scale local studies on the mental health situation in those countries to inform the policy process. In Zambia, the policy was informed by a four year situational analysis of the level of

needs and services required in the country (1998-2002) conducted by the Ministry of Health in collaboration with an international consortium<sup>68</sup>. Data on general and mental health social and policy environment, health stewardship, mental health burden and stakeholder needs, and the human and financial resources both available and required were examined as part of the comprehensive country level profile. This information supplied drafters with key data needed to provide the necessary services at all levels of care in the country<sup>69</sup>.

The director of mental health, actively involved in the development of the South Africa policy, was in contact with other countries such as Chile, Cuba and Zimbabwe in order to extract lessons learned for their policy development. Ghana, Zambia and Uganda reported having reviewed policies and experiences of other countries prior to drafting but did not report any type of formal exchange.

### ***Consultations***

***The majority of consultations were held within the mental health sector for all countries. In Zambia and Ghana, the health sectors was consulted more broadly and only in South Africa were consultations extended to other ministries, such as those of social development and finance. Consultations, in general, were reported to be minimal in Uganda in comparison to the other countries. From a human rights perspective, it is interesting to note that Zambia was the only country that consulted service users. In South Africa, the policy drafters had expected the South African Federation for Mental Health, a national mental health non-governmental organization to provide service***

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<sup>68</sup> Mayeya J, Chazulwa ;, Mayeya P; Mbewe E, Magolo LM, Kasisi F, Bowa AC: Zambia

mental health country profile. International Review of Psychiatry, (Feb-May 2004), 16

(1-2): 63-72.

<sup>69</sup> Global Network for Research in Mental and Neurological Health (url <http://www.mentalneurological->

[health.net/browse\\_tree.asp?ct=9&c=6&fid=98&fc=006](http://www.mentalneurological-health.net/browse_tree.asp?ct=9&c=6&fid=98&fc=006).

***user input for policy development; however the input they provided was based solely on provider views.***

### *Vision, principles and objectives*

Only the Zambian policy presented a clear vision. Values and principles underlying the policies are clearly spelt out in three of the four countries. The Ghanaian 1994 mental health policy was structured around a list of objectives or areas of actions. Both the Ugandan and Zambian policy documents had clearly defined objectives. In the case of Uganda these were consistent with the goal ('general objective'), values and principles whereas in the Zambian policy, objectives were only partly consistent with the 'guiding principles', the vision and the mission statement. For example, while the mission statement focused on the will "to provide all Zambians with equity of access to cost-effective, quality mental health care as close to the family as possible through use of comprehensive promotive, preventive, curative and rehabilitative mental health services", none of the five policy objectives listed covered curative aspects of treatment. The 1997 South African mental health policy guidelines did not set clear objectives. Community care and integration of mental health care were the most strongly supported values by all MHaPP countries. The need for evidence-based practice was consistently acknowledged but only strongly in the Ugandan policy. Focus on human rights issues was relatively light, except for the Zambia policy, and was absent from the Ghana document. Intersectoral collaboration and social inclusion were mentioned by most countries but not as strongly as the other key values. None of the MHaPP countries raised equity of mental health care with physical health care as a key value.

### *Areas for Action*

'Areas for action' referred to as 'key priority areas' in the South African policy, 'policy measures' in the Zambian policy or 'policy areas' in the Ghanaian policy were somewhat included in all policy documents reviewed. However, in the South African policy, 'key priority areas' were not sufficiently elaborated to give precise policy directions. In the Ugandan policy, policy directions in each of the main domains (e.g. human resources, essential medicines, information systems,

human rights protection and promotion) were discussed together with broader concepts, values and principles under the 'guiding principles' section, blurring the boundaries between aspiration and actual commitment to action. In the Zambian policy, measures were quite comprehensively developed. The important interrelationships between the different areas for action were not described in any of the policies.

#### *Coordination and management*

Three of the four mental health policies stated the need to establish a coordinating position/body for mental health but only Ghana clearly specified membership, their terms of reference and functions. In the case of South Africa, coordination and management issues were addressed in the South African White paper on Health but not specifically mentioned in the 1997 mental health policy guidelines. The White paper on Health was a document that set out the structure for reform of the health system in the post-apartheid era and included a chapter on mental health. It is meant to be read in conjunction with the 1997 mental health policy guidelines.

#### *Financing*

All mental health policies did not systematically specify sources and levels of funding required to finance the implementation of the mental health policy. For example, financing is not addressed at all in the Ugandan policy. The Zambian policy broadly mentioned that the financing of mental health activities is related to the basic health care package and Sector Wide Approach but did not clearly present any financial sources and mechanisms to support implementation of the policy. The South African policy also noted the need to redistribute budget allocations, following the logic of the shift from institutional towards community-based services, but did not provide any further financial specifications in order to concretely support this policy shift.

#### *Legislation and human rights*

The need to promote and protect the human rights of people with mental health conditions is briefly referred to in three of the four policy documents and, in the

case of South Africa, the White Paper on Health specifies a national responsibility to “review and evaluate legislation relating to mental health and substance abuse to safeguard the human rights of all service users”.

However, with the exception of Uganda, a significant number of key elements of a human rights approach such as *accessibility, acceptability and affordability* of care, equality, freedom from discrimination, involvement and empowerment of users and their families were omitted. Both the *Zambian* and the *Ugandan* policies highlighted the need to revise their current mental health legislation, with the latter clearly stipulating the need for monitoring mechanisms such as periodic reviews of the legislation and the establishment of a mental health board whose mandate included the investigation of complaints by patients.

#### *Organization of services*

A clear focus on community-based services can be found in all the mental health policies analysed, except for South Africa which did not spell out the community-oriented approach as strongly as the other countries did. Integration of mental health into general health care is also clearly highlighted in all countries, except for *Zambia*, with a particular focus on integration at the primary care level for *Ghana* and *Uganda*. Deinstitutionalisation is omitted in all four policies.

#### *Promotion, prevention and rehabilitation*

While promotion was mentioned in all four policies, prevention was clearly addressed only in the *South African* and the *Ugandan* policies. All policies mentioned rehabilitation, which was sufficiently elaborated in the case of *Ghana* and *Uganda* and to a lesser degree for *South Africa* and *Zambia*. *Ghana* had one policy section fully dedicated to 'rehabilitation of the mentally ill in the community'. It strongly stated the need to provide rehabilitation opportunities for persons with mental health conditions in their community, committed both the Ministry of Health and the Ministry of Social Welfare to provide community rehabilitation centres (day care centres, half way homes or hotels) and highlighted the collaboration needed between different relevant Ministries, the Mental Health Associations and NGOs in this policy area. The *Ugandan* policy provided a clear and comprehensive policy description of what will be done for

rehabilitation of people with a mental health condition in the country. The policy listed the components expected to be included in programmes, and emphasized both the need to provide facilities and services as well as the need to encourage full employment and the selective placement of people with mental health conditions in employment. Both the South African and the Zambian policies mentioned in very broad terms the need for rehabilitation to assist people with mental health conditions but did not provide any further details on such interventions.

### *Essential psychotropic medicines*

None of the four policies discussed procurement, distribution and storage of essential psychotropic medicines. The Ghana 1994 mental health policy called for the 'free treatment for the mentally ill' in its policy section 14, but remained totally silent on the strategies to achieve this objective. Each of the other three mental health policies included superficial statements on essential psychotropic medicines: while the Zambia policy committed to improve availability, it did not address accessibility; South Africa policy guidelines clearly stipulated the need to develop treatment protocols and to update the essential drugs list (EDL) but kept a very clinical focus on the use of medicines. Key issues about the distribution of psychotropic medicines directly to primary care and community centres as well as regulations about the type of health care workers able to prescribe and dispense medications were not addressed.

### *Advocacy*

Advocacy in the mental health policies reviewed is generally limited to awareness raising campaigns and fundraising for mental health activities from other ministries and funding agencies. Empowerment of users and families is given variable attention. The South African and Ugandan policies mentioned the need to involve mental health users and families in different stages of the design, planning, implementation and evaluation of services. The Ghanaian policy remained weak in its intended support and empowerment of users' and families' organizations.

The Zambia policy contained an ambiguous statement on the empowerment of users and their supporters which blurs the description of their roles, duties and rights.

#### *Quality improvement*

The need for quality improvement was quite strongly addressed in the Ugandan policy as quality assurance and evidence based services were guiding principles. The three other mental health policies mentioned the need for research on quality improvement (South Africa); quality assurance mechanisms and monitoring/evaluation of services (Ghana); or high quality evidencebased interventions and monitoring/evaluation of services (Zambia). None considered in a comprehensive manner the different aspects of quality improvement for mental health recommended by the WHO, such as alignment of policy for quality improvement, standards development, accreditation procedures, monitoring mechanisms, integration into management and delivery of services, reform of services and review of quality mechanisms<sup>70</sup>.

#### *Information systems*

Information systems for mental health are not addressed by the South African or the Ghanaian mental health policies, while the Zambian policy makes a general statement about the need to develop mental health indicators within the general health information system. Only the Ugandan policy specifies the development of a mental health information system comprised of indicators embedded at each level of care to inform evidence based service development and defined roles and responsibility for its implementation.

#### *Human resources and training*

Human resources and training is one of the most important areas for action in a mental health policy, yet this issue was only comprehensively addressed in the

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<sup>70</sup> World Health Organisation: Quality improvement for Mental Health. In: Mental Health Policy and Service Guidance Package. Geneva: World Health Organisation; 2003.

Ghanaian policy where policy directions were provided for recruitment, training, working conditions, incentives and retention of health workers. The South African policy did not provide any further policy direction than stating the need to maintain a balance between psychiatric and other mental health services in the allocation of human and financial resources, and to develop specific competencies through district based health workers training. The Zambian policy only addressed recruitment and training issues. The Ugandan policy outlined training issues for health and mental health professionals under the description of health services and facilities, level by level. However, as policy choices for human resources and training are diffused throughout the whole Ugandan policy document instead of being incorporated into one solid section, the information appears fragmented and the policy lacks clarity on this important issue.

#### *Research and evaluation*

While the Ugandan policy spells out a process for research and evaluation, in collaboration with a wide range of stakeholders (e.g. teaching institutions, NGOs, private and complementary practitioners, consumers) and provided details on the evaluation tools to be used, the three other policies assessed either did not address research and evaluation (Ghana) or did so only very broadly (South Africa, Zambia). None of the policies stipulated that policy and plans should also be monitored and evaluated. The Ugandan policy specified the development of a research agenda as a policy focus but does not elaborate on this. South Africa's policy noted the need for studies in mental health epidemiology and intervention effectiveness in the South African context, as well as specifying priority areas for research including prevention of substance abuse, violence prevention, the mental health of women, children and youth, and studies on the direct and indirect costs of mental illness in line with the broader national research agenda for the country.

The Zambian policy restricted its mention of research to a need for research focused on epidemiology, to inform service development, for the evaluation of service delivery, and, as in the Ugandan policy, noted the development of a research agenda as a policy priority.

### *Intrasectoral and intersectoral collaborations*

The Ghanaian, Ugandan and Zambian policies spoke in broad terms of the need for collaboration on mental health issues within the health sector while the South African policy focused its attention on traditional practitioners and the private health sector. However, none of the policies detailed the specific roles and responsibilities of the different partners, as well as the nature of the possible collaboration. Similarly, while some of the non-health sectors expected to be involved in mental health service development (e.g. education, justice, housing, labour) are mentioned to varying degrees in all the policies, none of these policies commit to the roles and responsibilities of partners, making collaboration a secondary concern rather than a core and consensual strategy clearly elaborated on the basis of a number of consultations/discussions, with the strong commitment of all partners. This is consistent with the fact that very little consultation around the policy occurred outside the mental health sector.

Integration and consistency with the national policy and legislative environments The 1997 South Africa mental health policy guidelines, while officially not recognized at national level by the current government, has substantially influenced the direction of mental health service development in the country over the past 13 years by informing the content of provincial mental health plans, recently enacted mental health law in South Africa, and the current draft national mental health policy. While people with disabilities are included among vulnerable groups highlighted for attention in South African laws, policies and strategies, and inclusion of people with mental disabilities is specifically mentioned in the Bill of Rights, the inclusion of people with mental health conditions in provisions of other laws, policies and strategies are neither consistently nor explicitly mentioned.

In Uganda and Zambia, mental health has been included in the basic health care package, consistent with the policy direction of integration stated in the two respective national mental health policies. This provides evidence of these governments' commitment to integrate mental health into the overall health system. However there are no development and social welfare policies in these

countries within which to integrate the care and rehabilitation needs of people with mental health conditions, nor have their needs been integrated into the poverty alleviation strategies of these countries.

In Ghana, the 1994 mental health policy contains concepts which are at odds with the more restrictive policy directions being promoted by the current mental health law, the NRC Decree of 1972<sup>71</sup>. There is apparently little collaboration between mental health and poverty reduction or development programmes but a strong role for social welfare in the treatment and rehabilitation of patients in Ghana.

#### *Overall structure, coherence and consistency of the policy content*

Structures of policy documents vary widely between countries but none of the four countries included in its policy the basic key structural elements listed in the WHO Policy Checklist: a clear vision statement associated with consistent values and principles, a clear list of objectives and a detailed description of areas for action. Key values when presented were not always well articulated or organized in the document. In the case of South Africa, the lack of a clear vision statement and objectives reinforced the identity of the document as being general guidelines rather than an official policy.

Although in both the Ghanaian and the Zambian documents the objectives were clearly spelt out, they were not always consistent with the other key policy elements (vision, values and principles).

### **Discussion**

The analysis revealed recurrent gaps in all the policies. Six gaps identified are important enough to raise concerns over the likelihood of these policies having a significant positive effect on the countries' mental health system. These concerns, described below, represent key barriers to effective policy development which are consistent with WHO's extensive experience working with LMICs on policy and service development, in Africa and elsewhere.

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<sup>71</sup> Government of Ghana: The 1972 Mental Health Decree. Accra 1972.

*Lack of internal consistency, both in terms of structure and of policy content:*

None of the countries examined in this study satisfactorily incorporated all or a sufficient number of key policy elements (vision, values and principles, objectives, and areas for action). There were inconsistencies and even at times contradictions between the different elements. Areas for action, which should be the substance of the policy documents, were often loosely elaborated and fragmented throughout the policy document. Inconsistency reduces the strength of the document and introduces ambiguity and uncertainty over the main policy directions. It may reflect lack of commitment of those developing the policy, a degree of superficiality in some of the values being promoted, or a lack of consensus around clear directions, the focus being the production of a policy document at a particular moment rather than achieving true consensus, progressively built overtime through thorough and broad consultations between key stakeholders within the country. These deficiencies may also be related to a more overarching concern, namely a poor understanding of the role and purpose of policy making, and the lack of technical policy development skills amongst policy makers as revealed by semi-structured interviews in South Africa<sup>72</sup>.

Superficiality of key (international) concepts and the predominance of a 'politically correct' discourse over real political commitment to change: Important key international standards, such as human rights protection and promotion, users' empowerment/involvement, or evidence-based approach, were mentioned in policy documents as objectives, underlying values and principles or areas for action. However, these concepts tended to remain at a superficial level without being elaborated in a meaningful action oriented way, giving the feeling of a politically correct discourse not backed up by real commitment to implement these standards. This may reveal a discrepancy between internationally agreed upon standards of best practice and actual

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<sup>72</sup> Draper CE, Lund C, Kleintjes S, Funk M, Omar M, Flisher AJ and the MHaPP Research

Programme Consortium: Mental health policy in South Africa: development process

and content. *Health Policy and Planning* 2004, 24: 342–356.

ideology of national policy-makers, these standards not being really perceived as essential policy directions in the countries. Again, it may also simply reveal the lack of technical skills of those involved in policy-making that, while committed to international standards and good practices were not clear on how to elaborate them into concrete, operational policy directions and strategies.

*Lack of evidence and data on which to base decisions on policy directions:*

For clear decisions to be made, basic information on the existing situation is necessary. Two of the four countries specifically mention the need for epidemiological and other population based intervention studies to inform policy and service planning and development. The need for accurate information systems for mental health is absent in three of the policies, although this is identified as a key need by stakeholders interviewed in all 4 countries<sup>73</sup>. Situational analysis to inform policy development was not sufficiently elaborated in three of four countries, raising concerns on how adequately the policy could really meet the mental health needs of the country and on which basis monitoring and evaluation can be designed. This can also explain the lack of precision in the description of policy actions, for example different aspects of human resources and training or medicines procurement and distribution. The lack of precision is particularly worrying if we consider that none of the four countries had a plan associated with the mental health policy being evaluated. However, having accurate information is not sufficient. Despite the availability of a comprehensive, documented situational analysis, the Zambian policy, for example, does not sufficiently address the key issues requiring attention in the country. Proper use of research to inform policy development requires the development of skills to translate research into policy directions and objectives.

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<sup>73</sup> Omar M, Green A, Bird P, Mirzoev T, Flisher AJ, Kigozi F, Lund C, Mwanza J, Ofori-

Atta A, for Mental Health and Poverty Research Programme Consortium (MHaPP).

Mental health policy process: a comparative study of Ghana, South Africa, Uganda

and Zambia. International Journal of Mental Health Systems 2010 4:24.

Similarly it is not sufficient to simply put in place information systems that collect accurate and timely data without developing the capacity of programme managers, planners and policy makers to use the information in a way that facilitates the monitoring, evaluation and improvement of the policy and plan implementation process.

None of the countries had a built-in process to evaluate the development and implementation of their policy and plan despite these being crucial steps for the development of a comprehensive document achieved through an inclusive process.

Researchers can also support policy development by ensuring that the evidence they generate is made accessible to policy makers and planners, as has been the case with two seminal reports on mental health which clearly and accessibly present sound evidence to inform directions for mental health policy, service development and resourcing, namely the World Health Report 2001, and the newly launched Mental Health and Development Report, 2010 [5] [22].

***Inadequate political support:***

The checklist assessment also revealed an overall lack of high level political support from the Ministry of Health in some instances, and in others, lack of support from key stakeholder groups outside the health sector, with most of them not having been consulted during policy development. Strong support and active participation in policy development from the Ministry of Health and cabinet are essential, first to ensure more consistency of the mental health policy with other current government policies, and second to obtain formal approval and governmental support in implementation. Too often the policy drafting group is restricted to a group of mental health specialists and academics who concentrate their efforts in putting together a 'technically sound' policy document, entirely based on their clinical and/or research experience. Science and personal experience are not valuable enough arguments 'per se' for a government to adopt a policy document, and this approach might result in a shelved policy document which has little if any impact on improving health care in the country. Policy development also requires strong support and

participation from health and mental health care professionals who will be the 'first line' implementers. However, consultations need to be broader than the mental health and the general health sectors if a comprehensive mental health policy promoting integration into the health system and community life (including access to education and employment) is to become a reality [23]. Support, awareness and ownership at all levels are needed for dissemination and implementation to be successful. Users of services and families need to be an important part of the consultation process because these are the groups who are meant to benefit from services [24]. However, consultations in countries did not meet these basic requirements. Political support was lacking because it was not sufficiently and actively built prior to and during policy development. For users and families to be involved, for example, empowerment, collaboration and partnerships must be built beforehand [25]. This explains the unsuccessful attempt in South Africa to get the Federation for Mental Health to provide users' inputs to the policy development process. A mental health policy, to be successfully implemented, requires support from all levels in the country, from users to governments.

***Poor integration of mental health policies in the overall national policy and legislative framework:***

Notably, when there is a degree of consistency and integration of key policy elements into the broader health or development policy of a country the implementation of the mental health policy is more likely to be successful. Integration into the broader development policy allows for a less prioritized programme such as mental health to benefit from the attention given to the development agenda. By optimizing available resources, integration increases the likelihood of mental health activities being implemented (e.g. training of health and social workers in mental health, provision of services), monitored and evaluated (e.g. collection of mental health indicators within health information systems). An example is in the case of Uganda where mental health had been included in the basic health care package and was part of capacity building of health workers at primary care level. [26].

***Lack of specificity for financing the mental health policy:***

Adequate financing is the lifeblood of effective implementation of a mental health policy. Policy development should include activities designed to identify available sources of funds within the health budget and to promote intersectoral collaboration within the budgets of other sectors responsible for mental health related policy actions. Feasible mechanisms for the allocation and monitoring of funds to effect actions prioritised in the mental health policy should be identified and specified in the policy to ensure that implementers have the necessary funds for implementation once the policy is approved. Pilot projects should be designed to assess whether the planned actions specified within the policy can indeed be implemented with available resources, and to identify missed opportunities for financing policy actions when these are scaled up [27] [11].

A report released by WHO indicates that the level of growth and industrialization in the developed and developing countries has brought with it a significant increase in automobiles which emit dangerous fumes that significantly contribute to the causes of mental related illnesses. Studies in Los Angeles, Mexico, Singapore indicate that traffic congestion resulting from the overgrown number of vehicles creates a precarious condition that if not mitigated, will grow out of proportion especially in the developing countries that have no enough capacity to treat the emissions. In almost all the large cities of the world, air and noise pollution from motor vehicles are, or are fast becoming, major problems for the physical and mental health of the people. The industrialized countries, where 86% of the world's vehicles are to be found, have a long standing and extensive experience of the problem. In the developing countries, rapid industrial growth and population increase coupled with rising standards of living are likely to lead to patterns of motorization that resemble those of the industrialized countries. Since the 1960s, the world's motor vehicle fleet has been growing faster than its population. The problems are acute in certain cities in both the developing and the industrialized world and unless controls are applied or strengthened immediately, the damage to public health will become very serious. This can be categorized as one of the leading causes of mental health related illnesses. The most interesting point here is that it is now

possible to reduce the levels of unburnt fossils that are dangerous both to the environment and human beings only if government takes up the initiative to legislate in this direction.

### **Recommendations/policy alternatives**

Considering the WHO-AIMS data and the context given by the situations mentioned above, possible areas of action are:

- i. Finalization of the mental health policy and development of the Mental Health Strategic plan.
- ii. Improvement of training on mental health issues and interaction with mental health services for primary health care workers.
- iii. Strengthen community based mental health services by training Primary Health Workers to promote integration of mental health into Primary Health Care.
- iv. Strengthen multi-sectoral collaboration
- v. Develop training on mental health and human rights
- vi. Review of mental health legislation to bring it up to date with current International Standards.
- vii. A primary health care training program on mental health, spread in all regions in the country.
- viii. Making policies that will help in reducing environment pollution by motor vehicles as well as adopting and encouraging technology that is environment friendly.
- ix. When looking at ways to address the key structural concerns described above, three major strategies emerge: First of all, the capacity of key stakeholders, including policy-makers, in public (mental) health and policy development must be strengthened. Technical policy skills of policy-makers can be improved through a number of strategies (e.g. in-service and outsourced training courses and workshops, post-graduate learning opportunities, peer exchanges and mentoring). In addition, opportunities must be created for members of other key stakeholder groups (users, health professionals, social workers, etc) to develop and

improve their policy skills if they are to significantly participate in policy development in their country.

- x. Second, a new culture of dynamic policy development must be created. Policy making must be understood as a cyclical, inclusive and dynamic process rather than a momentary snapshot in the story of health development in the country. Policies reviewed in this study did not reflect some of the values, principles and practices regarded as standard best practice today, reflecting the impact of the effect of the spirit of the times on policy formulation. The vision, key values and objectives for mental health in the country as described in the policy document must be built with all concerned groups, monitored, evaluated, questioned and redesigned consensually in an ongoing process in order to remain adapted to the level of needs and resources. Policy making must be an inclusive process, blending very diverse experiences and expertises into a national consensus, rather than based on the vision of a very restricted group of experts regarding what mental health care should be. This requires addressing power issues around roles and responsibilities for mental health in the country [23]. Further, policy must be responsive and constantly monitored in order to ensure that the real needs of the population served are addressed. Finally, action must be coordinated, both within mental health and beyond, in order to optimize resources available.
- xi. Good governance is essential to bring about effective coordination of actions in the field of health and mental health, and between health and other sectors, to ensure that both overlaps and gaps in service development and delivery are minimized in pursuit of better health outcomes and overall development.

## MATERNAL HEALTH

### KAVIRI ALI

#### 1. Problem Analysis

**Maternal health;** refers to the health of a woman; before she becomes pregnant, during pregnancy, child birth and in the period following delivery especially the first 6 weeks (post partum period). Health care that ascertains maternal health therefore encompasses health care prior to conceiving, during pregnancy, childbirth during the first 6 weeks following delivery, newborn care is part of health care because ensuring that the baby is born alive and healthy will encourage a mother to make proper reproductive health decisions, especially those pertaining to family planning.

Uganda's population growth rate is at 3.2%<sup>74</sup> making it the highest in the world after Niger and Timor with a fertility rate of 6.9 children for every woman in reproductive age in 2001 and 6.7 in 2006. Out of 100,000 women who give birth every year 435 do not make it out of the labor ward alive<sup>75</sup>. This translates into loss of about 6000 women annually due to pregnancy-related complications, most of whom die from purely preventable causes<sup>76</sup>. Most Ugandan mothers just like from any other developing nation, the majority of who are Young girls under 30 years still do not have access to antenatal care services;<sup>77</sup> walk long distances when going to deliver while others end up dying due to lack of qualified personnel. In fact only 32% of women who give birth in Uganda receive care from trained personnel while the majorities give birth at home or under the supervision of traditional birth attendants. The high prevalence of illegal

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<sup>74</sup> Republic of Uganda 2006a:10

<sup>75</sup> Republic of Uganda 2009a:3)

<sup>76</sup> Daily monitor Saturday, May 28, 2011 | By Evelyn Lirri

<sup>77</sup> Guttmacher institute 2009:1-9

abortion sometimes ends up in deaths.<sup>78</sup> Abortion in Uganda is illegal and is a sign of immorality in society<sup>79</sup>

Health facilities especially in rural areas are not easily accessible due to the poor state of the roads and in addition face drug stock outs, have inadequate equipment and personnel, under skilled workers who are overworked, under paid and the situation is worsened by corruption.

The majorities of women in Uganda are subordinate to their male partners and therefore lack decision-making power and thus cannot decide the number of children they should bear, negotiate for safer sex measures, contraceptives or child spacing. It is largely when men agree to limit the number of children that a woman can go for contraception. Only 18.5%<sup>80</sup> of Ugandan women use modern contraception methods, the unmet need stands at 41%; the highest in Africa<sup>81</sup>. The major causes of maternal mortality and morbidity in Uganda include severe bleeding, high blood pressure, unsafe abortions and obstructed labor<sup>82</sup>.

The Ministry of Health has tried to set up interventions to fight maternal mortality by scaling up to attain the MDG 5 by increasing skilled attendants at birth, access to Family Planning services in order to avoid pregnancies that occur at an early age, "too frequent" or too late in the reproductive age of a woman, prevention and management of pregnancy related complications by increasing access to Antenatal care and Postnatal Care.

The government has tried to integrate reproductive health programmes with malaria control programmes specifically with the inclusion of intermittent preventive treatment (IPT) as part of the antenatal care package. There is promotion and provision of free or subsidized insecticide treated nets (ITN) to pregnant mothers and children under the age of five. There are also ongoing

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<sup>78</sup> Singh et al 2005:183-191

<sup>79</sup> Sibbald 2007:244-245

<sup>81</sup> Republic of Uganda 2006a:11

<sup>82</sup> Daily monitor Wednesday, June 8 2011

efforts to upgrade and equip health centers with the necessary drugs and attendant equipment to manage emergency obstetric care, blood transfusion and post abortion care.

## **2. Existing policies**

Uganda has been one of the pioneering countries in undertaking health sector reforms within the framework of decentralization. This has definitely scored many achievements such as reduction in infant mortality rate (IMR) from 88/1000 live births in 2001 to 76/1000<sup>83</sup> live births in 2006 (**UDHS 2006**). Similarly, the under five mortality rate (UMR) decreased from 152/1000 live births in 2001 to 137/1000 live births in 2006. There has been a decline in maternal mortality rate over the years that is from 527/1000 live births in 1995 to 505/1000 live births in 2001 and 435/1000 live births in 2006. Maternal mortality however, is still below sector strategic plan (HSSP11) target of reducing maternal mortality rate 505 to 354 per 1000 live births.

Primary health care (PHC) and Minimum Health Care Package (MHCP) were also introduced and have significantly contributed to improving the health of the population. Resultantly, there has been an improvement in a number of input and output indicators. In particular patient department and immunization coverage exceeded the Poverty Eradication Action Plan (PEAP) and the Health Strategic Plan 2004/05 set targets.

Despite these reforms, the health and poverty indicators in Uganda remain some of the worst on the continent. The performance of primary health care is generally poor as compared to the end of HSSP 11 2005 target of 68%. Physical access to PHC services registered a huge improvement with 72% of the population being within the kilometers of the health facility. However, the improved physical access to PHC services reported above, does not reflect the full picture of persisting inequality in access with coverage ranging from 7.1% Kotido to 100% for Kampala. The government of Uganda has tried to come up with a number of policy interventions to improve reproductive health in Uganda

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which seek to reduce fertility rate, maternal morbidity and mortality by promoting informed choice, service accessibility and improved quality of care. These include:

a). The Uganda National Reproductive Sexual and Reproductive Policy is the roadmap to reduction of Maternal and Newborn mortality, but both policies clearly state type of services expected at the different levels of care while the National Health Policy and the Health Sector strategic Investment plan prioritize maternal health or current period up to 2015.

. b) The Uganda Gender Policy intends to empower women in decision making processes as a key to development.

C). The Adolescent Health Policy intends to promote adolescent friendly services, sex education and building life skills. In addition, the Adolescent Health Policy sets the minimum age for marriage at 18 years to counter the high rates of adolescent pregnancy. The governments with the help of the Millennium Development Goal implementer (UNDP) are working harder to achieve Universal Primary Education and in future this will help on the improvement of maternal and reproductive health indicators.

D). The Safe Motherhood programme and it is the major promotion of maternal Health in Uganda. This has helped the civil society organizations to come on board. For example MJAP (**Mulago-Mbarara Teaching Hospitals' Joint AIDS Program**) does outreaches for Home Based HIV Counseling and Testing, Integrated Community Based Initiative does Prevention of Mother to Child Transmission (PMTCT) thus helping a rural woman to know her status and at the same time reducing on maternal mortality.

Despite the above interventions, the following still remain unresolved issues as far as maternal health is concerned and as such form the basis for Alternative proposals and recommendations.

- The provision of high quality, voluntary family planning services,
- Enhancing access to safe abortion where it is legal,

- Working to improve the status of women and girls; sufficiently integrating HIV treatment into maternal health,
- Implementing targeted interventions, such as providing Magnesium Sulfate and improving transport for pregnant women at risk, while aiming to strengthen health care systems and supporting financial investments that will improve the strength of health systems and increase access to skill attendance at birth.

### 3. Policy Options/Alternatives

The table below describes different alternatives and policy proposals that would strengthen already existing efforts by different state and non state actors to improve the Access to Maternal health care services in Uganda. It draws from lessons of other developing countries and projects which are very applicable in the Ugandan context. The table also looks at the advantages and disadvantages of these proposals and informs the recommendations in the chapter following.

Alternatives	Advantages	Challenges
<ul style="list-style-type: none"> <li>▪ Strengthen access to more wholesome reproductive care facilities. That target mothers and their partners.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensures a collective action and concern on issues of maternal health.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Cultural barriers which inhibit men from getting involved and supporting maternal health issues</li> </ul>
<ul style="list-style-type: none"> <li>▪ Invest in research on alternative knowledge on maternal health such as traditional birth attendants to improve the services rendered by the traditional birth attendants.</li> <li>▪ Provide for a legal framework to regulate the work done by the Traditional Birth</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensures that more inclusive policies are formulated.</li> <li>▪ Helps to integrate indigenous knowledge into internationally recognized practices.</li> <li>▪ Ensures procedures in herbal or alternative healthcare are</li> </ul>	<ul style="list-style-type: none"> <li>▪ There is limited accessible knowledge on alternative knowledge and these sources of information must be created</li> </ul>

Attendants(TBA)	standardized.	
<ul style="list-style-type: none"> <li>Invest massively in human capital development of community health workers. E.g. nurses, clinical officers and midwives.</li> </ul>	<ul style="list-style-type: none"> <li>Reduces Doctor/midwife to expectant mother ratio</li> <li>Increases the Human Resource base for maternal healthcare</li> </ul>	<ul style="list-style-type: none"> <li>Limited training facilities for nurses and midwives nationwide</li> </ul>
<ul style="list-style-type: none"> <li>Government should rehabilitate dilapidated structures and improve public health infrastructure.</li> </ul>	<ul style="list-style-type: none"> <li>Improves access to maternal healthcare services as services are brought nearer to the people</li> </ul>	<ul style="list-style-type: none"> <li>Limited resources allocated to the Health sector in the National Budgeting process</li> </ul>
<ul style="list-style-type: none"> <li>Government should devise means of monitoring and evaluating health programs that improve access to maternal and reproductive health.</li> </ul>	<ul style="list-style-type: none"> <li>Improves accountability and checks corruption.</li> <li>Strengthens government's capacity to monitor the effectiveness of programs.</li> </ul>	<ul style="list-style-type: none"> <li>Strengthen community monitoring of Public funds initiatives</li> </ul>
<ul style="list-style-type: none"> <li>Government should revive and strengthen primary health care facilities with components of reproductive/ maternal health to reduce maternal mortality occurring from purely preventable causes.</li> </ul>	Significant reduction of maternal mortality e.g. PMTCT	<ul style="list-style-type: none"> <li>Limited resources allocated to the Health sector in the National Budgeting process</li> </ul>

#### 4. Recommendations

If Uganda is to hit the MDG target, what should be in place? Are the resources allocated to safe motherhood programmes sufficient, and who is responsible for ensuring that women of Uganda do not die due to complications of pregnancy and child birth? The following analysis proposes some alternative policy recommendations for consideration.

- There is need to invest in training and retaining health care personnel especially those who provide maternal health care services and allocate adequate resources to the health sector with a view of improving maternal and child health.
- Provision of an attractive salary package for professionals to work in their country to prevent them from moving to developed nations in search of greener pastures
- Monitoring and evaluation of health programs by the Ministry of Health to ensure value for money and improve the quality of services delivered. The sector should also ensure that drug supplies dispatched from central medical stores reach the intended districts and health facilities.
- Budgetary allocation needs to be stepped up and specific budgets have to be created to address not only the health (safe motherhood) but also the socio-economic and cultural dimensions of safe motherhood.
- Health service providers and Ministry of Health must cease to consider safe motherhood as “an add-on” program and should institute budget line for the purpose with meaningful allocations for reaching wider communities.
- There is need for decentralization of drug management and distribution mechanisms to improve on the timely distribution of drug so that health units at levels have sufficient drugs to serve the population at any given time.
- Health personnel should undertake refresher courses/trainings to enable them have a “human face” and to adopt the ethics of handling expectant mothers as well as having a positive attitude towards them.

- Government needs to allocate resources to address issues of gender based violence, promotion of adolescent reproductive health to match with the gravity of safe motherhood concerns.
- There is need to construct health centers in every parish so that pregnant women do not walk more than 5km to access maternal services. This should be accompanied with the procurement of “Mama Kits” which must be compulsory at district levels to promote safe motherhood concerns.
- Allocation of sufficient resources for implementation of government commitment made under the Abuja Declaration on health, the AU commitment on the campaign on accelerated reduction of maternal mortality and the National roadmap on maternal health.

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