BETTER HEALTH FOR THE PEOPLE OF UGANDA
Consolidating Sector Programs and Focusing on Community Participation

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INTRODUCTION:

Let me start by congratulating UNACOH on their 20th Anniversary and at the same time pay tribute to the individuals in the group who have over the years shown exceptional commitment in spending their personal precious time and money to keep this association alive. It is this type of professionalism that we want to encourage across all professions and that gives us all hope for the future of the people of this country. It is this level of commitment to professionalism that has enabled other societies and countries to prosper.

DR. MATTHEW LUKWIYA:

This lecture is an annual event in memory of one of the greatest Community Health Workers that this country will ever see. Dr. Matthew Lukwiya gave his own life to save the rest of us from the frightful Ebola Hemorrhagic fever that gripped this country, struck fear and caused panic for several months at the end of 2000 and beginning of 2001. Dr. Lukwiya was in Kampala and not Gulu when the first suspected cases of the strange disease were identified and he quickly left his family here and rushed to Gulu where he took charge of things and together with the District medical Officer of Gulu, sent an alert to the Ministry of Health on 8th October 2000. Commendation is due to the Ministry of Health Surveillance and Emergency Preparedness and Response Team because despite 9th October being the Independence Day public holiday, they were still able to send a team to Gulu on that day to look at the situation and to obtain blood samples that were sent to South Africa and on were used to confirm the diagnosis of Ebola hemorrhagic fever. On the basis of the information that we had on 9th October, Hon. Dr. Crispus Kiyonga who was Minister of Health convened an emergency meeting with the WHO Country representative Dr. Oladapo Walker, Dr. Mukoyo was detailed to search the web for information on hemorrhagic fevers which we studied and we prepared to go to Gulu the next day. At that time there was a police helicopter which proved to be of immense value in our work in the fight against this disease and it is what Drs. Kiyonga, Walker and I used to travel to Gulu the next day. Upon our arrival at Lacor Hospital, we found that Dr. Lukwiya and his team had already put in place very advanced arrangements for managing the out break. An isolation unit with universal precaution facilities was already operational. We did not enter this ward and observed the patients through the windows of the ward. There were also suspected cases at the Gulu Regional Referral Hospital which we visited and found that isolation arrangements were not yet properly established. In retrospect, Dr. Kiyonga and I took a great risk in boldly entering this ward, talking to the patients and giving advise on how to institute universal safety precautions. My past experience in open heart surgery and intensive care units proved useful in giving instructions to the very brave and dedicated staff at Gulu Regional Referral hospital.

Thereafter, we travelled to Gulu by helicopter every week, visiting the camps all over the district and working closely with the district authorities. On one of those trips, we went to deal with strike by nursing staff at Lacor Hospital. The leadership qualities of Dr. Lukwiya truly shone on that day. After we had held discussions with the nurse leaders and persuaded them to go back to work and after Dr. Kiyonga and I had finished addressing a general meeting of the nurses and all staff, Dr. Lukwiya asked that we close the meeting by singing the Nurses Anthem, which was done. This lifted every body's spirits and ended the strike.
Later we learnt the terrible news that he had been infected in trying to restrain a fellow member of staff who was already down with the disease and had become violent. Deep in the night not long after, I got a phone call from Dr. Isaac Ezati with terrible news that Dr. Lukwiya had passed away. I called Dr. Kiyonga but he had already received the news. The next morning we flew to Gulu and upon reaching Lacor, Dr.Kiyonga called me aside and told me how we should conduct our selves as leaders who are well controlled portraying a stoic and brave yet sympathetic posture. In other words I understood him to say that we should not breakdown and cry. When we entered Dr. Lukwiya's house and found there a crowd in mourning, first my nose started to run and as I was reaching for a handkerchief in my pocket, tears were already rolling down my face. I did not look in the direction of Dr. Kiyonga but later my tears dried up and I have never regretted that my emotions had taken the upper hand.

The story of the Ebola out break here in Uganda needs to be fully written up. Some scientific papers have been published in journals but there are many aspects of the events that took place that need to be recorded for posterity and for learning. Just two short anecdotes: One is on the power of money. The outbreak spread to Masindi district and caused a lot of panic. Dr. Sam Zaramba who was the Director for Clinical and Community Health went to camp and live in Masindi to take charge of the situation there. He sent us a massage that there were eight bodies in the hospital mortuary and no one was willing to touch them. I discussed very early one morning with Dr. Kiyonga and he suggested that I go to Mulago hospital mortuary and persuade some people there to go to bury those bodies. I met with Mr. Sebuliba in the Director's office together with some of his colleagues and at the right price; they went to carry out those burials. In Masindi, the Hospital staff had become stigmatized in their communities and many did not come to work any more. So we put advertisements for jobs for Nurses and Doctors to go to work in Masindi at certain daily rates, we had an overwhelming number of applicants. The second anecdote is on international cooperation and attention to detail. Hon. Max Omeda then Minister of State General Duties travelled on this same helicopter to Masindi with Dr. Alex Opio where they found that some Kenyans had come to the funeral of the patient who brought the disease from Gulu to Masindi. Dr. Opio called me from Masindi at about seven p.m and I was still at my desk and gave me the names and addresses of the Kenyans who had returned home after attending the burial. I called my counter part from Kenya immediately with details and by 3 a.m. that night all these twelve people had been rounded up and taken for isolation at Busia district hospital where two of them tested positive for Ebola.

HEALTH AND DEVELOPMENT:

To day, there is a major global push and movement to correct the inequalities in the lives lived by the wide array of communities of human beings who populate the world. Never before in the history of mankind have there been sufficient knowledge, science and technology as well as the wealth that could provide basic health for all the peoples of the world. On the other hand, while some populations are living longer and longer enjoying pain free life, others are living, shorter and shorter lives in misery, with declining life expectancy. The phenomenon of declining life expectancy has never before been experienced in human history: over decades the life expectancy of some populations is declining right in front of our eyes. These paradoxes have touched the conscience and the morality that is innate in our humanity and has triggered a global movement and global action. Just two weeks ago for example in London Prime Minister Gordon Brown of the UK together with Prime Minister Stoltenberg of Norway with high level representatives from France, Germany, World Bank, the Gates Foundation launched the International Partnership for Health whose key objective is to improve the performance of health systems in developing countries. Before that at every recent G8 meeting, the health conditions of African populations has been on the agenda, the UN General Assembly has held two special sessions on just one disease namely AIDS, special funds have been established exclusively to address health and examples include, the GFATM, GAVI, UNITAID and indeed the global funding available for health in low income countries has doubled over the last five years alone. The Millennium Declaration with the Millennium Development Goals is yet another example of this global movement to address the embarrassing inequalities among the various human communities that live on this planet today. Human rights activists and advocates are everywhere and you have seen how these people find their way to make their point to the G8 meetings however hard security forces try to keep them away. These are all real signs that the human conscience has been touched and that inequalities among the people of the world have become intolerable. There is a crop of new global leaders who have come on the stage and are enthusiastic about correcting these inequalities between the world's peoples which gives me personally much encouragement and the energy to play my small role in contributing some technical inputs into this global movement.

The right to life and the right to health are looked upon as equals. There is no point being alive if you do not live a productive life. Health is seen not as an end in itself but as a means to living and enjoying a socially and economically productive life. The quality of human life which can be enhanced through health, education, a secure social and physical environment are the ingredients for fulfilling the WHO definition of health as a state of physical, social and mental well being and not merely the absence of disease. Indeed the health sector is no longer looked upon as just consuming resources but as an essential input needed for economic growth and social transformation. Even in religious terms, those of you who can recall the Christian catechism which we crammed as children, the first question asked is "who made you?" and the answer is "God made me" the second question is "Why did God make you?" The answer is "To be happy in this world and to be with him later in heaven". I put it to you that it is virtually impossible to be happy if you do not have health and in any case, nature has already taken preventive measures on this because if you try to laugh when you have pain anywhere in your body, the pain simply gets worse and stops you from laughing!

Another factor that has elevated health in the global development and economic agenda is the emergence of new diseases and the ease with which they spread across the globalised world. You may recall how SARS emerged out of nowhere and caused a big economic upheaval in the east and shook up the whole world. Then followed Avian Flu which posed a frightful global threat with the projection of scores of millions of predicted deaths. The world is now seeing on average, one new disease per year and health as a global security threat has taken a front seat in world affairs. For example the World Health Report for 2007 will be exactly on this topic of Health Security. For the world to deal effectively with these global health threats, effective health systems in each and every country are a basic requirement for very government. There is also a stream of work on "Health and Foreign Policy" led by Norway and involving about eight countries which will eventually end up at the UN General Assembly. As they say, the proof of the global commitment to health is that fact that the richest people in the world through philanthropy are making major donations to global heal, examples among many include Melinda and Bill Gates, the Mexican who is said to have overtaken Gates as the richest person, Doris Duke Foundation and the Clinton Global Initiative is driven by philanthropy.

THE UGANDA HEALTH SYSTEM:

So how is the Uganda health system prepared to play its rightful role in providing basic health care to its populations and playing her role as a responsible member of the international community? Historically, before the upheavals that rocked the country for two decades during the seventies and eighties, the country had one of the best performing health sectors in the region and among developing countries in general. The health indices were the best in the sub-region and were said to be better than those of some of the Asian tigers who are very advanced today.

The upheavals left the health system and indeed the economy of the country in a sorry state and with previous gains reversed. However, the entry of a new NRM government in the mid-eighties brought in a new effort and new thinking so that today, Uganda has once again regained her position as a leader in health system development in comparison to other sub-Saharan African and some other low income countries. I can say this with a degree of certainty because I have been on the ground here. I have also been active internationally for some time even before I left the country and now implementing a global program on human resources for health, I have had the opportunity to see what is happening in other countries similar to Uganda. The National Health Policy and the two consecutive five year Health Sector Strategic Plans that are being implemented provide a sound basis for moving forward. The laws and structures for implementation are in place and each of the technical programs have developed policies and implementation plans based on the best technical global knowledge with targets and indicators for performance measurement.

The Annual Performance Reports since HHSP I have shown remarkable achievements a few examples include raising Immunisation coverage from 48% to 86% with virtual disappearance of measles, utilisation of health facilities from 0.4 to 0.9, access within 5 kilo meters of populations to health facilities from 49% to 84%, achieving the WHO 3X 5 target of access to ARVs well ahead of time being one of the only two African countries to hit the target, Uganda is also a global model for drug distribution for the

so called neglected diseases of poverty, guinea worm has been eradicated; the list is long. These achievements of HSSP I have been vindicated by the results of the 2006 UDHS which has shown indicators which had stagnated and registered significant improvements during HSSP I. For example, in infant mortality from 88 to 75 per 1000 live births; under five child mortality from 152 to 137; and maternal mortality ratios from 504 per 100,000 to 435 . The performance of the Ugandan Health System is often quoted by a variety of health leaders for example at the recent regional Committee of WHO African Health Ministers, Dr. Margaret Chan, Director General of WHO complimented various aspects of Uganda's work several times, President Bill Clinton told the annual Clinton Global Initiative meeting in New York last year that "if you want to get results go to Uganda", PEPFAR is very proud of the performance of their programs in Uganda. Uganda is also quite open and is serving as global laboratory to many studies and a few current examples include the study on Task Shifting for Universal Access to HIV prevention treatment, care and support, the FIND has recently signed an MoU with the MOH to pilot some of new diagnostics in the country, there are AIDS vaccine studies in progress and we were among the first, again the list is long. It is important that some of the bad publicity that the health sector has suffered in the recent past should not obliterate its achievements. Some of the negative publicity should be seen as credit to the country for the open and transparent manner in which public affairs are handled.

However, there are challenges, among which I might briefly mention just three: the challenge of driving and sustaining implementation capacity both at the central Ministry of Health and in the decentralised district services. I always found this to be a permanent struggle to drive a team of staff who are underpaid and overworked across the entire system. This also includes the role of district leaders at all levels. The pet name Hon Dr. Kiyonga and I gave this challenge is "keeping the foot on the throttle". I might recommend two instruments for addressing this challenge. One of them is the Quality Assurance Program which was designed exclusively for ensuring continuous performance improvement in the sector. If this program is supported and guided to perform to its terms of reference, it has tremendous potential to drive implementation. The second tool is the use of the solid existing management structures to promote and consolidate a culture of openness and trust, which makes every player down the line feel that they are valued and respected members of the team. I know that you have many excellent and hardworking professionals but such people are also very easy to demoralize.

The second challenge, I refer to is the one of partnership with Development Partners. Related to the increase of the global interest and effort, we are likely to see these relationships intensifying and not reducing. The Paris Declaration and other pronouncements on Aid effectiveness are very clear about the need and respect for country leadership. However, I hear more and more from other country experiences as well that Development Partners with delegated powers in countries are finding it hard to watch action at close range without wanting to get directly involved. There is a tendency by some of them to want to be in charge and take over leadership in various ways, both indirect and direct and to fragment implementation arrangements for various reasons and sometimes to undermine collectively reached decisions which they may not individually support. The government of Uganda and the health sector collectively needs to be vigilant and provide clear and strong leadership on this. Good donors will respect such leadership. Further, some of the aid instruments that exist or

are being developed are very labour intensive to the countries. Yet when we talk about making Aid work better, the agreed principles are to simplify these but in practice this is not happening. Countries still have to handle huge volumes of paper to access the resources when they already have already developed plans jointly with all partners and to prepare separate reports on top of producing annual sector performance reports and abiding by the signed Memoranda of Understanding.

The third and last challenge is the one of financing the health sector plans. HSSP I was costed at $ 27per capita, HSSP II is costed between 11 to 40 dollars per capita over five years. Yet the current funding is only some $8 per capita. If HSSP I was fully funded it could have achieved far more in terms of poverty reduction and in the improvement particularly of maternal and infant mortality ratios. If sector funding is not increased with the rapidly rising population, the gains that have been made are likely to be lost. Further improvements in infant and maternal mortality cannot be achieved without significant increases in health sector spending. But there are still macro economic issues to resolve globally and in the country in respect to increased external resource flows into the sector. There are strong lobby groups who are beating drums and demanding that the poor should not pay for the free market with their lives or as Sam Okwonzi wrote in the Lancet we are "dying for economic growth". On the other hand, there the likes of Martin Brownbridge who argue that the only way forward is to cap social sector spending, allow the private sector to grow and generate the tax base for increased social sector spending in ten to fifteen years time.
I am in full support of private sector led economic growth; however this has to co exist with immediate and concrete actions to address intolerable living conditions of populations. We must also do more to generate resources locally for health. Kenya has a booming private health sector funded mainly by insurance schemes, Tanzania and Rwanda have also started social insurance schemes and surely Uganda has no choice but to learn from and follow these examples. Such insurance schemes could provide funding for secondary and tertiary leaving the national budget for pro-poor community and public health and primary level interventions. I am encouraged by the number of new private hospitals in the country. Government needs to create an environment where private health care can even become a destination for health tourism and a source of foreign income. Uganda has a potential for this. What about the promise of newly discovered oil, how does this fit into this debate?

COMMUNITY LEVEL INTERVENTIONS:

I argued earlier, that health is a fundamental requirement for happiness and a key input into social and economic development of populations. I would also like us to look at health of individuals and communities as a status that is generally pre-existent, except for those who are born with congenital defects. However, health can be lost and be taken away or be reinforced by the way in which we live at home and interact with our environment outside. The concept behind the Alma Ata Declaration on health for all through the Primary Health Care Strategy was to ensure that the pre-existing health that we are endowed with at birth is protected and reinforced through the way in which we organize our house holds and societies. It is holistic covering many sectors such safe water, security of limb and property, education, food security and safety in abattoirs, markets and households, occupational health, travel, you name it wherever we are and whatever we do may affect our health in one way or another and therefore needs to be done in such a way that the pre-existing health is reinforced

at best and in any case not taken away. This is the reason why action at the points at which individuals interact with the environment assumes critical significance.
In Uganda, it is estimated that 75% of the disease burden is caused by preventable causes mostly related poor personal, household and community hygiene and poor nutrition. It is therefore stands to reason that we should place the highest priority to action at this level. I have looked at the sections Community participation in NHP, HSSP I and II and also the Annual Sector Performance reports and I find that while the documents contain the intention to place priority at Community level, the implementation is weak. The number of districts that have trained VHTs has been increasing very slowly. The membership and scope of work for VHTs has been defined, however, they are all volunteers and not paid staff! There is no way that we can expect volunteers to devote enough time and effort to this important work. Further, in my research for this talk, I discovered that the Ministry of Gender Labour and Social Development has got a Community Mobilisation and Empowerment Strategy (December2006), with a detailed work plan and deliverables which overlap with those of the VHTs and which will be leading to the enactment of a Community Mobilisation Law to enforce, among others the scope of work of the health sector VHTs.
I would like to recommend that the Ministry of Health considers immediately converting one of the established positions at Health Centre II to that of a Community Health Extension Worker or whatever other name that may be chosen. This officer can then be the link with VHTs who may continue to be volunteers serving for limited periods of time as the local authorities may decide. Secondly, it is also my hope that the strategy that has been developed by the Ministry of Gender Labour and Social Development gets fully implemented. This calls for support from higher levels of government as I know that Inter-ministerial work in most governments across the world is not easy. In Thailand where Primary Health Care and Community participation has been a major success, it the Prime Minister of the country who is Chair of such cross sector health programs.

The global movement for better health that I referred to before is riding on a renewed commitment to Integrated Primary Health Care. Next year will be 30th Anniversary of the Alma Ata declaration on Health for All and also the 60th birth day of WHO and the Universal Declaration of Human Rights which has an article on the right to health. It is also the midway point of the Millennium Declaration. There are very many activities taking place now, all geared towards scaling up Community Health Workers as a realist and practical approach to accelerating the achievement of MDGs and revitalising PHC as originally conceived. I would like to see Uganda as part of the mainstream of this movement. I am convinces that this country can achieve better health and MDGs if we get our priorities right.

MY CURRENT JOB:

Just before I conclude, let me briefly tell you about my current job as it has something to do with this topic. I am the ED of GHWA, a partnership that is administered by WHO and is dedicated to identifying solutions to what is referred to as a global health workforce crisis. This is characterised by wide spread global shortages, mal-distribution within and across countries and poor working conditions. We are developing some tools and guidelines which countries can use to plan and manage their HRH programs, we are developing a master global plan or a Road map to guide

global action in areas such as education and training, migration and financing. In the first week of March 2008 we will convene the first ever Global Forum on the health workforce and I am pleased to inform you that Kampala won the bid to host that meeting.

CONCLUSION:

As I conclude this tribute to one of our heroes, Matthew Lukwiya, I would like to thank Mrs Margaret Lukwiya for continuing to attend these lectures. I want to assure you that by so doing, you are continuing the great work of your husband. I also wish to take this opportunity to make a call to all our people in Uganda and particularly the leaders in their respective capacities. Our people are sick and dying too much from entirely preventable causes. When we go to funerals and burials of small children and mothers dying from complications of child birth, we say that "God has called them", we say that "their day has come". Of course it is not God who has called them, of course it not their day that has come. It is us who are alive that have failed them. When I spoke about this at a lecture to the Association of the Academies of American Medical Colleges, they told me that in their country, all deaths including those of hundred year old people are blamed on the health system. We all in Uganda need to cultivate a national mentality where we reject and do not tolerate premature deaths and unnecessary illness of our people. We should stop blaming God and fate for these deaths and examine in each case what should have been done to prevent the deaths and illnesses. We should be ashamed that we are so much behind other parts of the world when we are endowed with such a rich and beautiful country. Action has to start with each of us as individuals committing to making our own personal contribution. This hopefully will develop into a national movement supported by government, civil society groups such as UNACOH to mobilise households and communities everywhere to live happily in health enjoying socially and economically productive lives rejecting premature death and avoidable illness.