

# **Health as a Basic Human Right: Efficacy of Quality Assurance for Healthcare in Uganda**

“It is my aspiration that health will finally be seen not as a blessing to be wished for, but as a human right to be fought for.”

UN Secretary General, Koffi Annan

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**Dedication:**

This paper is dedicated to Nakato, a three-year-old girl who lost her life due to the shortcomings of the Ugandan medical system. May the health sector learn from her story, and the thousands of stories like hers, to improve health care for all Ugandans.

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## Abstract

Quality of health care is an important aspect of health services delivery because of its ability to maximize outputs within given resource constraints. Quality assurance programs for health care are paramount to the realization of good quality health care because of their ability to identify gaps in service provision. The Ministry of Health and other stakeholders in health care have created quality assurance supervision and support programs for the health sector, yet there is a disconnect between the programs and the operational realities of the sector. The health-related Millennium Development Goals (MDGs) are far from being achieved within Uganda and people are dying everyday from preventable and treatable diseases. Therefore, the research examined the issue of quality assurance from several angles: Government programming and provisions for quality assurance for health, private sector response to the issue of quality assurance, and community perceptions of and involvement in health care.

A variety of methodologies were used during the research including: literature review, key informant interviews, individual interviews, and participant observation. A review of government regulations, policies, and programs was essential to understanding the current situation regarding quality assurance programs for health care, whereas both key informant and individual interviews were used to supplement the theories behind the programs with actual information about their efficiency. Additionally, key informants shared critical information about the actual workings of the health sector, versus the image that is often portrayed to stakeholders and development partners. Finally, participant observation during the Health Sector's Annual Joint Review Mission and a workshop for Senior Health Managers on Neglected Tropical Diseases (NTDs) allowed the researcher to assess the health sector's commitment to quality assurance as well as observe and interact with key health policymakers.

The researcher found that there is, in fact, a wide gap between health sector policies and programs in theory and implementation. Although the Ministry of Health and other key stakeholders have excellent quality assurance programs in theory, they are not being operationally realized within the districts. The Yellow Star Program, consistently mentioned as one of key programs of the Quality Assurance Department of the Ministry of Health, is in actuality only fully implemented in a few districts, and only deals with issues of supervision, not improvement. Although development partners are beginning to fund programs related to this issue, there is an overall gap in private sector commitment to quality assurance policies and programs. There are Civil Society Organizations (CSOs) dealing with the issue of quality assurance; those that are working for health rights often do not have enough funding to make an impact nationally, and instead choose to focus their work in a few districts. Overall community perceptions of health care are low. Communities do not understand the level of quality health care they are entitled to, but also feel that current levels of health service delivery are inadequate. In summary, the quality of health care is still an under examined issue that needs to be resolved for the realization of the right to health and meaningful development within Uganda.

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## **Operational Definitions and Key Terms**

**Rights Based Approach to Health-** Incorporating human rights in the creation of appropriate health policies, programs, and legislation. This approach ensures that both rights holders (consumers) and duty bearers (health workers and government) are aware obligations and responsibilities to ensuring the right to health.

**Right to Health-** The right to good quality health care, not a right to be healthy. It requires governments and other planning authorities to create policies and programs to avail accessible, quality health care for all in a timely manner.

**Health Rights-** Health consumers have a right to be treated by a named health worker; right to confidentiality and privacy; right to treatment; right to non-discrimination; and right to continuity of care, among others.

**Health Responsibilities-** The responsibilities of health consumers to take care of their own lives; provide accurate information when prompted by health workers; comply with instructions from health workers; and support the health care system/ institution, among others.

**Acronyms**

COBES	Community Based Education and Services
CPD	Continuing Professional Development
CSO	Civil Society Organization
DANIDA	Danish International Development Agency
DHO	District Health Officer
DHT	District Health Team
HC	Health Center
HIPS	Health Initiative for the Private Sector
HPAC	Health Policy Advisory Committee
HSC	Health Services Commission
HSD	Health Sub District
HSSP	Health Sector Strategic Plan
IV	Intravenous Treatment
MDG	Millennium Development Goal
MOH	Ministry of Health
MUK IPH	Makerere University Institute of Public Health
NGO	Non Governmental Organization
NRM	National Resistance Movement
NTD	Neglected Tropical Disease
OPD	Out Patient Department
PEAP	Poverty Eradication Action Plan
PNFP	Private Not For Profit Organization
QA	Quality Assurance
RCQHC	Regional Center for Quality of Health Care
TWG	Technical Working Group
UHRC	Uganda Human Rights Commission
UMA	Uganda Medical Association
UN	United Nations
UNDP	United Nations Development Program
UNHCO	Uganda National Health Users/Consumers Organization
UNICEF	United Nations Children's Fund
UNISTAF	Uganda National Injection Safety Taskforce
UNMHCP	Uganda National Minimum Health Care Package
USAID	United States Agency for International Development
YSP	Yellow Star Program

## **1. Introduction**

### *Statement of Intent*

Good quality health care is the single most important factor preventing Uganda from achieving meaningful development. This research examines the quality assurance programs and policies that are supposed to protect health consumers' right to good quality health care, and investigates the reasons for their shortcomings.

### *Location of Study*

The study was conducted in Kampala, Uganda through collaboration with the Makerere University Institute of Public Health and the Ministry of Health. A two-week internship was conducted with the Uganda Human Rights Commission (UHRC), and another two-week internship was carried out with the Uganda National Health Users/Consumers Organization (UNHCO).

### **1.1 Statement of Objectives**

*Main Objective:* To analyze the efficacy of quality assurance policies and programs within the Ugandan healthcare systems so as to determine the protection of health consumers right to good quality healthcare.

### *Underlying Objectives:*

- 1) To examine the issue of health as a human right and its relation to the quality assurance programs within the health care system.
- 2) To assess the policies and procedures used to ensure quality of health care services delivery within the health care system.
- 3) To examine community perceptions of their right to quality health care.
- 4) To determine private sector involvement in assuring quality health care.
- 5) To identify the challenges of quality assurance program implementation within the Ugandan health care system.

### **1.2 Background**

#### *History of the Health Sector*

Before the upheavals of the 1970's and 1980's, Uganda had the best health indices in Eastern Africa.<sup>1</sup> Unfortunately, the rule of President Idi Amin caused the collapse of the health system and created serious gaps within health targets and health achievements. The current National Resistance Movement (NRM) government, under President Yoweri Museveni, is responsible for critical responses to the HIV/AIDS crisis within the country, as well as for several key reforms of the health sector. Although significant reforms had been undertaken, in 2000, accessibility to basic health services, or, the percentage of the population living within 5 kilometers of a health

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<sup>1</sup> Ministry of Health, Health Sector Strategic Plan I, 2000/01-2004/05, (Kampala, Uganda: 1999) iv.

facility, was still estimated to be only 49% nationwide.<sup>2</sup> Additionally, only 42.7% of parishes (every 5,000 people) were found to have any type of health facility, with significant gaps between rural and urban areas.<sup>3</sup>

Poor health is directly related to economic status. The Ministry of Health (MOH) directly contributed to the creation of the Poverty Eradication Action Plan (PEAP), to assist in the reduction in levels of household and absolute poverty. Therefore, the Government of Uganda grounded the 2000 creation of the first Health Sector Strategic Plan (HSSP I) in the already existing framework of the PEAP, in order to improve both health services delivery and poverty levels through health sector policies and programs. The goal of the HSSP I was to “reduce morbidity and mortality from major causes of health in Uganda and the disparities therein, as a contribution to poverty eradication and economic and social development of the people.”<sup>4</sup> The HSSP I was created with the intention of continually monitoring the health sector and evaluating policies to “constantly refine the defined needs of the health sector, modify the national minimum health care package, and update cost estimates and provisions of financial resources for the health service needs”.<sup>5</sup>

During the evaluation of the HSSP I at the end of 2004, several improvements in the health sector were identified. Health resources had been reallocated to lower levels of health units to maximize care for rural areas, and hundreds of new health facilities were built to increase accessibility. User charges for use of government facilities had been abolished, excluding private wings, and new Out Patient Department (OPD) attendance rose from 0.4 visits per person to 0.9 in FY 2004/2005.<sup>6</sup> However, only 30% of the HSSP I was actually funded, which severely limited its achievements. In 2005, there were still significant stock outs of essential medicines, equipment for new facilities was lacking, and there were serious inadequacies in training and provision of health workers.<sup>7</sup>

The HSSP II, for the year’s 2005-2010, notes that the quality of care was a health concern within the HSSP I, however, focus was more on access since many Ugandans did not have

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<sup>2</sup> Ministry of Health, Health Facilities Inventory, (Kampala, Uganda, 2000).

<sup>3</sup> Ibid.

<sup>4</sup> Ministry of Health, Health Sector Strategic Plan I, 2000/01-2004/05, (Kampala, Uganda: 1999) 3.

<sup>5</sup> Ibid 4.

<sup>6</sup> Ministry of Health, Health Sector Strategic Plan II, 2005/06-2009/10, (Kampala, Uganda: 2005) IX.

<sup>7</sup> Ibid IX.



access to basic health services.<sup>8</sup> In the HSSP II, the Ministry of Health reflected on the shortcomings of the initial plan, “HSSP II will therefore further refocus the sector’s priorities so as to achieve the maximum health outputs and outcomes that are possible within existing resource constraints.”<sup>9</sup> In fact, the Ministry of Health specifically states that an internal quality assurance system is necessary at all levels of health services, from the basic Health Center (HC) I clinics to the National Teaching Hospitals such as Mulago.<sup>10</sup>

### *History of Quality Assurance*

The idea of quality assurance arose from the business industry’s dissatisfaction with the quality of products being produced and was not introduced to the health sector of developing countries until the 1990’s.<sup>11</sup> The Ministry of Health defines quality as doing the right thing at the right time, in the correct manner.<sup>12</sup> In a health specific context, this means providing the highest possible standard of health care services using the required medical equipment, from trained medical health professionals. However, there are varying consumer, provider, and manager perspectives on quality, ranging from availability of service, effectiveness of service, to outcomes of the service.<sup>13</sup> These perspectives must be streamlined in order to ensure maximum satisfaction with the quality of health services delivered. Quality assurance therefore, is “that set of activities that are carried out to set standards and to monitor and improve performance so that the service provided is as effective and as safe as possible.”<sup>14</sup>

Quality assurance (QA) was first introduced to Uganda in 1994 as a project under World Bank funding to support recent health sector reforms such as decentralization, restructuring of the health system, integration of services, and coordination of NGOs.<sup>15</sup> In 1998, quality assurance was integrated as a department into the Ministry of Health, whose aim was to “strengthen management of district health services under decentralization, using QA management methods.”<sup>16</sup> The mission of the department is to “cultivate a work culture that

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<sup>8</sup> Ministry of Health, Health Sector Strategic Plan II, 2005/06-2009/10, (Kampala, Uganda: 2005) 89.

<sup>9</sup> Ibid 7.

<sup>10</sup> Ministry of Health, Health Sector Strategic Plan II, 2005/06-2009/10, (Kampala, Uganda: 2005) 89.

<sup>11</sup> Interview with Informant 101. Ally Pregulman. November 20, 2008.

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

promotes excellence and rejects poor quality within health services in Uganda.”<sup>17</sup> The Ministry of Health developed a series of procedures for the implementation of QA within the health sector. Senior management members, District Health Teams (DHTs), and district leaders in the health sector were trained in QA, a training and reference manual on QA was created for health workers, and a system of quarterly supervision visits to the districts was implemented.<sup>18</sup>

According to the Quality Assurance Department of the Ministry of Health,

Poor quality of services can be found at all levels of a health care system. Poor quality reduces the benefit to users of the health systems, frustrates and demoralizes health care workers, and wastes valuable and often scarce resources. Improving the quality of health services is everyone’s responsibility, not just that of the Ministry of Health, the District Medical Officer, or the Medical Superintendent.<sup>19</sup>

The outcomes of quality care will be:<sup>20</sup> improved effectiveness and efficiency of care; increased satisfaction of client with services; increased use of these services; and ultimately, improved health standards of the population.

#### *Implication for Development*

According to a recent BBC report, “over the last 50 years Western governments have paid out more than £400bn of tax payers' money in aid to Africa, but according to figures released by the World Bank this year, half of sub-Saharan Africans still live in extreme poverty, a figure which has not changed since 1981.”<sup>21</sup> Sub-Saharan African countries are receiving enormous amounts of development aid on a yearly basis. In fact, one source suggests, “Uganda has been flooded by so much aid that it cannot even properly use it all.”<sup>22</sup> Resources are obviously being grossly misallocated, otherwise there would have been marked improvements over the last twenty years in the areas of health, poverty, and general development. In fact, “World Bank figures showed that Africa has been the least successful region of the world in reducing poverty, with the number of poor people in Africa doubling between 1981 and 2005 from 200 million to 380 million.”<sup>23</sup> Health care is important to the overall development of a country because the health of an individual determines their ability to function in other capacities such as employment. Therefore, for a country like Uganda, which has 25% of the disease burden, 2% of

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<sup>17</sup> Interview with Informant 101. Ally Pregulman. November 20, 2008.

<sup>18</sup> Ibid.

<sup>19</sup> Ministry of Health. Manual of Quality Improvement Methods. (Kampala, Uganda) 5.

<sup>20</sup> Ministry of Health. National Supervision Guidelines for Health Services. (Kampala, Uganda, 2000).

<sup>21</sup> Sorius Samura "Addicted to Aid." BBC. 24 November 2008.

<sup>22</sup> Interview with Informant 100. Ally Pregulman 10/26/2008.

<sup>23</sup> Sorius Samura "Addicted to Aid." BBC. 24 November 2008.

the health work force, and 1% of the government budget, improving the quality of health services delivery should be of the utmost importance.<sup>24</sup> Uganda will never realize the Millennium Development Goals (MDGs) or achieve meaningful development without improving access to quality health care. So where is the money going? Why aren't quality assurance programs effective?

## **2. Methods**

### **2.1 Methodology**

The study used qualitative methods of data collection, as well as supplemental literature review. These included individual interviews, key informant interviews, and participant observation. Due to time constraints, statistical information and surveys conducted by other organizations relevant to the study were used to supplement qualitative information collected. Although there are many organizations working in the health sector in Kampala, this research focuses on four key areas:

#### National Autonomous Institutions

- Uganda Medical and Dental Practitioner's Council
- Uganda Medical Association

#### Government Bodies

- Health Services Commission
- Makerere University Medical School
- Ministry of Health
- Health Policy Advisory Committee

#### Civil Society Organizations

- Uganda National Health Users/ Consumers Organization

#### Private Not for Profit Organizations

- Uganda Catholic Medical Bureau
- Health Initiative for the Private Sector

These organizations were specifically chosen because they represent the different actors involved in the provision of quality health care. Based on literature review and background information research prior to the start of the research period, the researcher was able to determine a sample of organizations ranging from government controlled to private organizations involved with quality assurance. The literature review was conducted of current and past policies and programs of the health sector, scholarly articles, and newspaper articles.

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<sup>24</sup> Interview with Informant 106. Ally Pregulman, November 26, 2008.

Interviews were conducted with stakeholders of the health care system and included doctors working in medical schools, medical school students, employees of civil society organizations (CSOs), employees of non-governmental organizations (NGOs), and employees of government organizations, including Ministry of Health employees and health policy advisors. All interviews were conducted and transcribed by the researcher. The researcher informed the interviewee about the details of her research and the purpose of the study prior to beginning the interview. Due to the sensitive nature of the subject, many interviewees were initially hesitant to participate. Therefore, the researcher chose not to record interviews, choosing to hand-write respondent's questions instead. The researcher chose to keep all quotes and statements anonymous to protect the privacy of the informants. All interviews were conducted on an individual basis; key informant interviews lasted for longer periods of time and often were carried out over several sessions. Individual interviews were used to verify information mentioned in key informant interviews and were often shorter, more narrowly focused interviews.

Participant observation was carried out through the attendance of the Health Sector Joint Review Mission and a workshop conducted by UCRC for Senior Health Managers on Neglected Tropical Diseases (NTDs). In addition to hearing lectures on key issues facing the health sector, important insights were gathered through participation in and discussion with various attendees of these meetings.

### **2.2 Obstacles and strategies**

One of the major obstacles was the reluctance of certain informants to discuss information relative to the health sector. Although care was taken to assure informants of confidentiality, some informants refused to answer several key questions regarding finances and negligence. Additionally, the researcher was constrained by a six-week time limit for her research. Conducting two internships for the duration of two weeks instead of a single four-week internship was an undesired consequence of initial poor selection of internship location. However, participating in the work of two separate organizations in different areas of the health sector allowed for a first hand comparison of the efficiency of different organizations.

### **2.3 Biases**

The researcher attempted to limit her preconceptions, however, being personally involved in the nature of the study as a health consumer may have created certain biases. Although both health consumers and providers have health rights and responsibilities, the researcher mainly focused on the rights of health consumers. Additionally, due to time constraints, the researcher

was unable to individually survey communities regarding their perceptions of health care, and had to instead use surveys collected by other organizations, which may have had different objectives.

### **3.0 Justification of Objectives**

Health is a fundamental human right paramount to the fulfillment of other basic human rights because the health of an individual determines their ability to function in other capacities. The international community first recognized the right to health in the preamble of the World Health Organization's 1946 Constitution and defined the right of "the enjoyment of the highest attainable standard of health" as one of the "fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition."<sup>25</sup> Since this first definition of the right to health, the concept has been further defined through several international charters and declarations, regional charters, and even the Constitution of Uganda. The right to health however, is not a right to be healthy, but a right to have access to good quality facilities that provide access to appropriate healthcare. Governments therefore are not required to ensure the health of their citizens but are instead obligated to provide health facilities and conditions necessary for the realization of good health. On its most basic level, the right to health requires health services, goods, and facilities within a country to be 'available, accessible, acceptable, and of good quality'.<sup>26</sup>

From the first implementation of health care policy within Uganda up to the present, the health sector has seen many improvements in access to and variety of health care services. According to the Ugandan Ministry of Health, 72% of the population of Uganda in 2005 lived within 5 kilometers of a healthcare facility.<sup>27</sup> However, simply living near a healthcare facility does not ensure that the patient will access and receive good quality care from a qualified healthcare professional. The right to health is a basic human right and the Ugandan Constitution, Ugandan government, and Parliament have committed to ensuring that there is not only access to health care, but also access to good quality healthcare.<sup>28</sup> The Ministry of Health along with the Government of Uganda has created several policies, programs, and departments to deal with the issue of Quality Assurance. However, there is a disconnect between the policies of the health sector and the operational realities of the situation of health within communities. Quality

<sup>25</sup> World Health Organization Constitution, 1946.

<sup>26</sup> Uganda Human Rights Commission Right to Health Toolkit.

<sup>27</sup> Ministry of Health, Health Sector Strategic Plan II, 2006/07-2009/10, (Kampala, Uganda: 2005).

<sup>28</sup> Uganda National Healthcare Policy, HSSP I, HSSP II.

assurance has only been a priority within policy and not implementation. In theory, there are several organizations and review boards in place to ensure that there is not only access to health care, but that the services being provided are of a good quality. The operational realities of quality assurance programs for effective health care however are an under examined issue. Therefore, this research aims to identify the causes of the gap between policy and implementation of quality assurance programs within the health sector.

#### **4. Research Findings and Discussion**

##### **4.1 Issue of Health as a Human Right and its Relation to Quality Assurance Programs in the Health Care System**

The rights based approach to health incorporates human rights in the creation of appropriate health policies, programs, and legislation that incorporate caring for the most vulnerable populations, including women and children.<sup>29</sup> Although the right to health is not a right to be healthy, governments are still required to provide appropriate, good quality health services to their country. The issue of health as a human right directly relates to quality assurance programs for health because in theory, quality assurance programs ensure the deliverance of good quality health services by trained health workers in well-maintained facilities with the appropriate equipment and medicines. In practice however, quality assurance programs have had limited success in their implementation and improvement of health care standards, which directly violates the basic human right to health care.

The rights based approach is paramount to the realization of improved health care because health needs become health rights, with obligations to the state to protect these rights. This approach also empowers communities on how to claim their health rights. The comprehensiveness of the rights based approach makes it an effective approach to strengthening health care delivery systems.

##### **4.1.1 Health as a human right in Uganda**

According to United Nations High Commissioner for Human Rights Mary Robinson, The right to health does not mean the right to be healthy, nor does it mean that poor governments must put in place expensive health services for which they have no resources. But it does require governments and public authorities to put in place policies and action plans which will lead to available and accessible health care for all in the shortest possible time. To ensure that this

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<sup>29</sup> World Health Organization (WHO): 25 Questions and Answers on Health and Human Rights. Geneva, Switzerland: 2002.

happens is the challenge facing both the human rights community and public health professionals.”<sup>30</sup>

The rights based approach to health is not currently integrated into the policies and programs of the health sector. Several key informants involved in health policy were unable to define the right to health. According to one informant at the Ministry of Health, “I think we are trying [to implement the right to health within our programs] but we are not achieving it. It’s what we’re striving for. The policies are there but what have we achieved?”<sup>31</sup> The rights based approach needs to be fully ingrained within the health sector from both a consumer and provider perspective in order for meaningful policies and programs to be developed to improve the quality of life for Ugandans. According to one source at the Ministry of Health, “in Uganda, there are high levels of unsatisfactory compliance by health workers with ethical and human rights standards in the health care of vulnerable and disadvantaged groups.”<sup>32</sup> It is therefore of the utmost importance that the government of Uganda focus on the protection of health as a human right.

#### **4.1.2 Quality Assurance programs**

Current Quality Assurance programs are largely run through the Ministry of Health and take a variety of forms. The major government programs include the Yellow Star Program (YSP) and Support Supervision. However, there are also government policies, Acts of Parliament, and several non-governmental organizations that also deal with the issue of quality health care. QA is truly a multi-sectoral issue, with national and international organizations in both the public and private sectors focusing on this issue.

### **4.2 Policies and Programs Ensuring Quality of Health Services Delivery**

Both the Ministry of Health and the private sector have created policies and programs to ensure quality of health services delivery. These policies and program cover various aspects of quality assurance; some are guaranteed by law, others are not.

#### **4.2.1 Policies ensuring quality of health services delivery**

##### *Health Sector Strategic Plans I and II*

The program output goal for support services in the HSSP I included a goal of creating and implementing quality assurance programs for health services delivery regulation. According to the HSSP I, quality assurance programs need the capability to enforce standards in health care

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<sup>30</sup> World Health Organization (WHO): 25 Questions and Answers on Health and Human Rights. Geneva, Switzerland: 2002.

<sup>31</sup> Interview with Informant 101. Ally Pregulman. November 20, 2008.

<sup>32</sup> Ministry of Health, Presentation “Public Health, Ethics, and Human Rights”. October 28, 2008.

delivery through supervision and quality guidelines.<sup>33</sup> More specifically, the strategic plan required periodic evaluation of health care facility performance through the use of supervision guidelines and the creation of reports on adherence to quality assurance standards by facilities at all levels.<sup>34</sup> Unfortunately, only 30% of the HSSP I was funded,<sup>35</sup> which meant that although the quality of care was a health concern, “focus had to be more on access since many Ugandans did not have access to basic health services.”<sup>36</sup> The HSSP I increased access to facilities, however, evaluations found that there was a “mismatch between construction of HCII’s and the speed at which resources were made available for their operationalization. Therefore, new facilities remained closed for lack of staff, basic equipment, and drugs.”<sup>37</sup> Additionally, the overall staffing gap for HCII through HCIV and general hospitals in 2003 was 1082, meaning there were 1082 unfilled positions.<sup>38</sup> The 2003 gap between required HSSP I norms and staff for all district and regional referral hospitals was 4909 unfilled positions, revealing a huge gap in human resources for health.<sup>39</sup>

Therefore, given the relative success and failures of HSSP I, the HSSP II has “given people the opportunity to rethink approaches to better health in the country and assess prevailing strengths, weaknesses, opportunities, and threats to success.”<sup>40</sup> In the HSSP II, the Ministry of Health reflected on the shortcomings of the initial plan, “HSSP II will therefore further refocus the sector’s priorities so as to achieve the maximum health outputs and outcomes that are possible within *existing resource constraints*” (emphasis placed by researcher).<sup>41</sup> In fact, the Ministry of Health specifically states that an internal quality assurance system is necessary at all levels of health services, from the basic Health Center (HC) I clinics to the National Teaching Hospitals such as Mulago.<sup>42</sup> Therefore, the HSSP II aims to develop and disseminate quality health services to all health services delivery points using regular supervision systems, facilitating the establishment of internal quality assurance capacities at all levels of the health system, and involving the community in quality of care.

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<sup>33</sup> Ministry of Health, Health Sector Strategic Plan II, 2006/07-2009/10, (Kampala, Uganda: 2005) 64.

<sup>34</sup> Ibid.

<sup>35</sup> Ibid xi.

<sup>36</sup> Ibid 89.

<sup>37</sup> Ibid 7.

<sup>38</sup> Ibid 51.

<sup>39</sup> Ibid 51.

<sup>40</sup> Ibid i.

<sup>41</sup> Ibid 7

<sup>42</sup> Ibid 89



### *Medical School Curriculum*

Ethics is an integral part of the curriculum taught in Medical schools. There are 5 medical schools within Uganda, but one of the most well known and respected is the Makerere University Faculty of Medicine. In 2003, the Makerere University Medical School switched from the traditional curriculum of lectures, practicums, and examinations found in medical schools around the world to a new method of teaching called the Community Based Education and Services (COBES) approach, which uses problem based learning. Due to time constraints, this study focused on the Makerere University Medical School curriculum because of its new and supposedly innovative approach to teaching medicine.

The COBES approach uses a combination of overview lectures taught by medical professionals, tutorials, and problem solving to train its medical students. An administrator in the Makerere University Institute of Public Health (MUK IPH) adds, “the students are only given overview lectures by subject experts. They are then given problems within their tutorial groups, and everyone must contribute. If the problems are done properly, the method is successful.”<sup>43</sup>

Ethics is taught during the first course unit in the first year, as part of a unit on biomedical ethics, encompassing confidentiality issues, rights of the patient and health worker, and medical legal issues such as abortion.<sup>44</sup> Through subsequent training in bedside manner and forensics, medical students are exposed to issues of ethics three times throughout their medical training. However, according to an administrator at MUK IPH, the COBES approach focuses on problem solving, and therefore, ethics is studied and discussed in many of the different problems given to students throughout their time in medical school.<sup>45</sup>

### *Health Services Commission*

In the past, all civil servants were recruited and appointed by the Public Service Commission, however, medical professional bodies felt that the commission was not properly handling the issue of human resources for health. Therefore, the Health Services Commission (HSC) was started in 1998 to specifically deal with the issue of human resources for the health sector. Act 15 of Parliament formally established it in 2001, as Article 170 of the Constitution. The HSC advises the President on the appointment of health professionals for key positions, including heads of Ministry of Health departments and the Director General of Health Services. The

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<sup>43</sup> Interview with Informant 115. Ally Pregulman. November 13, 2008.

<sup>44</sup> Interview with Informant 105. Ally Pregulman. November 11, 2008.

<sup>45</sup> Interview with Informant 115. Ally Pregulman. November 13, 2008.

President however, has the ultimate power to accept or reject the suggestions. Additionally, the HSC is responsible for the appointment, confirmation, and promotion of health workers in the two national referral hospitals, Mulago and Butabika. Finally, the HSC is involved with training and quality of health by creating and publishing the “Code of Conduct and Ethics for Health Workers,” and serving as an advisory body as necessary for disciplinary purposes. If necessary, the commission can act as a supreme court for disciplinary cases. According to one source at the HSC, “anyone causing problems can be brought to the health services commission, since we are the ones who appointed them in the first place.”<sup>46</sup> However, the Uganda Medical and Dental Practitioner’s Council normally handles disciplinary cases.

*Uganda Human Rights Commission, Right to Health Unit*

The Uganda Human Rights Commission was created in Act 52 of the Constitution. The function of the commission is listed as the ability to “investigate, at its own initiative or on a complaint made by any person or group of persons against the violation of any human right.”<sup>47</sup> The Right to Health Unit at the Uganda Human Rights Commission was originally set up in 2006, following a recommendation of the United Nations (UN) Special Rapporteur to establish a unit to “monitor and ensure accountability, in furtherance of the right of everyone to the enjoyment of the highest standard of physical and mental health, with special attention to neglected diseases.”<sup>48</sup> The unit serves to initiate and support programs that include a human rights based approach in relation to policies and programs that affect both the general right to health and specifically, NTDs. Additionally, the right to health unit creates and implements strategies to promote health as a human right and to support sensitization and advocacy on health related rights in line with Uganda’s international, regional, and national human rights obligations.

*Regional Center for Quality of Health Care*

In 1999, at the request of the Quality Care Network for Africa, the Makerere University Senate created the Regional Center for Quality of Health Care (RCQHC) to improve the quality of health care in Africa. The mission of the RCQHC is to “provide leadership in building regional capacity to improve quality of health care by promoting evidence based practices through networking, strategic partnerships, education, training, and research.”<sup>49</sup> The center

<sup>46</sup> Interview with Informant 104. Ally Pregulman. November 21, 2008.

<sup>47</sup> 1995 Constitution of Uganda, Article 52.

<sup>48</sup> Uganda Human Rights Commission website, <http://www.uhrc.co.ug>.

<sup>49</sup> Interview with Informant 108. Ally Pregulman. November 25, 2008.

focuses on three main areas: training, research, and improvement of the health sector. Short and long term training programs teach quality of care for health workers and medical students, with an emphasis on the performance improvement approach, which stresses the importance of learning best practices from peers. The RCQHC conducts research on quality of care to develop new tools and approaches to assess the quality of care status around Africa. Finally, the center tries to promote and improve health systems as a whole through financing, decentralization, and working with various health ministries to increase quality of care.

The RCQHC also has significant involvement with the Ugandan health care system. In 2001, the center conducted a study of the quality of Uganda's health care system, conducting both a technical assessment and a survey of the user perceived quality of Uganda's health system. Perceptions of quality ranged from 5-30%, varying by district and socio-economic status of the user surveyed. According to the director of the RCQHC, health care has not changed much since then. Additionally, the RCQHC works with the Ugandan Ministry of Health to implement quality assurance programs, such as the YSP. However, this partnership is no longer very active because "quality assurance is not a high key activity within the Ministry of Health because of a lack of funding."<sup>50</sup> One source at the RCQHC clarifies that they would like to work with the Ministry of Health on quality care issues, but funding is a major constraint. Once new funding is provided, the partnership will resume.

#### *Health Policy Advisory Committee*

The Health Policy Advisory Committee (HPAC) is the highest policy organ at the national level for health policies. It is comprised of members from the Ministry of Health, Ministry of Finance, Private Not for Profit Organizations (PNFPs), and Civil Society representatives. The HPAC is chaired by the permanent secretary of the Ministry of Health and is supposed to oversee policy implementation and integration. Additionally, the HPAC reviews health policy issues and make recommendations. The Technical Working Groups (TWGs) of the Ministry of Health submit status reports to the HPAC on their various issues, which range from the Uganda National Minimum Health Care Package, to Monitoring and Evaluation. The TWGs also have to submit their budgets for approval to the HPAC, which allocates funding and approves new programs for the sector. In the past year, the HPAC has commissioned studies on client satisfaction with health services and a review of the health situation vis-à-vis the rights based approach. More

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<sup>50</sup> Interview with Informant 108. Ally Pregulman. November 25, 2008.

specifically, the committee has also approved quality assurance standards on various issues, including injection safety.

#### **4.2.2 Procedures ensuring quality of health services delivery**

##### *Yellow Star Program*

The Yellow Star Program is a program created by the Ministry of Health to motivate districts and district health officers to be more self-evaluative of their health facilities. According to a Ministry of Health presentation, the public perceived the quality of care to be poor, and in fact, quality of health services was found to be lacking in some areas. Therefore, the program was created to “improve quality of healthcare services through a system of supervision, certification, and reward.”<sup>51</sup> The Ministry of Health created basic standards to be met by the health facilities, covering six key areas that address the requirements of the Uganda National Minimum Health Care Package (UNMHCP), a program outlined in the HSSP I to deliver basic, necessary services to all Ugandans within the given resource constraints of the sector. These areas are: infrastructure standards, infection control, management systems, technical competence, and client services.<sup>52</sup> Specific requirements include the proper disposal of sharps and medical waste, well-kept medical records, a clean and protected waiting area, and receiving clients and patients in a respectful manner, among others (Appendix A).<sup>53</sup>

The Health Sub-District (HSD) supervisors are supposed to monitor each health facility quarterly and evaluate its progress in meeting the basic guidelines. If a health facility meets all of the guidelines for two quarters, the facility is awarded a Yellow Star. Additionally, three outstanding health workers in each HSD are supposed to be given the Star Health Worker Award every quarter. The first phase of the program, in six districts, was implemented in 2001, and the program was supposed to be continually scaled up on a yearly basis. The Ministry of Health used a sensitization campaign aimed at District Health Teams and district and community leaders to educate and gain support for YSP and enlist advocacy support for the program.<sup>54</sup> In addition to district sensitization programs, the MOH also created a provider campaign, targeting all health workers to change their attitudes and practices through education and dissemination of information about the YSP.<sup>55</sup> The program was created to address important quality gaps in

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<sup>51</sup> Ministry of Health. Presentation, “Yellow Star Program”.

<sup>52</sup> Ibid.

<sup>53</sup> Ministry of Health. Yellow Star Program: Improving Quality of Health care. 2006.

<sup>54</sup> Ibid.

<sup>55</sup> Ibid.

health care services, including inadequate interpersonal skills of health workers, lack of inventories, and inadequate infection control.

*Manual of Quality Improvement Methods*

The Manual of Quality Improvement Methods is a publication of the Quality Assurance Department of the Ministry of Health, which is intended to assist in the education of health workers and managers in order to achieve improved quality of health care. According to the Ministry of Health, “it is evident that in the public sector in Uganda, the quality of health services provided leaves a lot to be desired, and there are many examples...Unfortunately, this poor quality of services is sometimes accepted as the norm...People simply shrug and say, ‘this is Uganda, what do you expect?’”<sup>56</sup> This manual however, aims to change the way the health sector approaches health care, with the hope that “this culture of quality will become the basis upon which health services provided will continuously improve and result in a better health status for Uganda.”<sup>57</sup> The Manual of Quality Improvement Methods is not a strategic plan for improving the quality of the health care sector. Instead, it is an educational tool for the health sector to better understand the intention of quality assurance programs so that they can better advocate for and support their implementation on national, district, and local levels. The manual explains that quality assurance is not a new method, but

What is new is the emphasis on continually improving the quality of services by examining and improving the process by which they are being delivered, rather than inspecting the outcome only. It differs from traditional methods of improving health care by transferring the primary responsibility for improving quality to the health workers themselves.<sup>58</sup>

Therefore, for specific information on how to improve the quality of the health care system, the Manual of Quality Improvement Methods directs health workers to other documents such as the National Supervision Guidelines for Health Services, the Yellow Star Program, and the Code of Conduct and Ethics for Health Workers.

*National Supervision Guidelines for Health Services*

The National Supervision Guidelines for Health Services were introduced by the Ministry of Health in order to fulfill the local government act of the Constitution (1997) which states “for the purposes of ensuring implementation of national policies and adherence to performance standards on the part of Local Governments, Ministries shall inspect, monitor, and shall where

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<sup>56</sup> Ministry of Health. Manual of Quality Improvement Methods.

<sup>57</sup> Ibid.

<sup>58</sup> Ibid.

necessary, offer technical advice, support supervision, and training within their respective sectors.”<sup>59</sup> These guidelines help to ensure the efficacy of quality assurance programs for improved health care by requiring continual supervision and monitoring of all levels of health services. The supervision guidelines specifically outline the requirements for “integrated support supervision of community health services and programs,”<sup>60</sup> which District Health Monitoring Teams are required to follow. The monitoring teams are required to visit each district on a quarterly basis to provide support supervision and monitoring services to improve the quality of health services delivery.

*Code of Conduct and Ethics for Health Workers*

The Health Services Commission, the professional medical councils, and the Ministry of Health created the Code of Conduct and Ethics for Health Workers in 2001. It is a legal instrument under part IV of the HSC Act of 2001 and therefore its implementation should have legal force.<sup>61</sup> The code of conduct outlines the standards of behavior and discipline for health workers, encouraging them to adhere to the standards required of medical service. Among other regulations for taking leave, work habits, and pay packages, the code requires:<sup>62</sup>

- ❖ **Responsibilities to the patient or client**, including respect towards the patient, provision of information, obtaining informed consent from the patient, respect of patient to doctor confidentiality, and not asking for or accepting bribes; and
- ❖ **Responsibility to the community**, including promoting the provision of effective health services; and
- ❖ **Responsibility to the health unit or place of work**, including abiding by set rules and regulations and conforming with the expectations of the institution; and
- ❖ **Responsibility to law and profession**, including observing the law, upholding the dignity and honor of the profession, not engaging in discrediting activities, exposing those engaging in illegal or unethical conduct, respect confidentiality of information of patient, participate in continuing professional development (CPD) programs, not performing duties under influence of alcohol, not indulging in dangerous lifestyles such as drug addiction, and not associating with or supporting occult or unscientific health practices; and

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<sup>59</sup> Ministry of Health. National Supervision Guidelines for Health Services. 2000, iii.

<sup>60</sup> Ibid.

<sup>61</sup> Health Services Commission. Code of Conduct and Ethics for Health Workers. 2002.

<sup>62</sup> Ibid.

- ❖ **Responsibility to colleagues**, including cooperation with colleagues and respecting their expertise; and
- ❖ **Responsibility in Research**, including not participating in health research that does not conform with stated with guidelines.

*Patient's Charter*

UNHCO and other civil society organizations created the Patient's Charter, a document outlining the health rights and responsibilities of patients and health workers. The draft charter was given to the Ministry of Health in 2006, with the intention of submitting it to Parliament to become law. The draft Patient's Charter includes the following health rights:<sup>63</sup>

- ❖ Right to medical care
- ❖ Prohibition of discrimination
- ❖ Right to participate in decision making regarding health
- ❖ Right to a healthy and safe environment
- ❖ Right to proper medical care
- ❖ Right to treatment by a named health professional
- ❖ Right to voluntary participation in research
- ❖ Right to personal safety
- ❖ Right to receive visitors
- ❖ Right to informed consent
- ❖ Right to refusal of treatment
- ❖ Right to continuity of care
- ❖ Right to confidentiality and privacy
- ❖ Right to be referred for a second opinion

The draft Patient's Charter also includes the following patient health responsibilities:<sup>64</sup>

- ❖ Responsibility to provide one's health care provider with relevant and accurate information for diagnostic, treatment rehabilitation or counseling purposes
- ❖ Responsibility to comply with prescribed treatment
- ❖ Responsibility for actions if he/she refuses to receive treatment or does not follow the instructions of the provider

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<sup>63</sup> Uganda National Health User/Consumers Organization. "CSO Draft of Patient's Charter." 2006.

<sup>64</sup> Ibid.

- ❖ Responsibility to respect the rights of other patients and health providers and for helping to control noise, smoke, and the number of visitors.
- ❖ Freedom to advise the health care providers on his or her wishes with regards to his or her death

#### *Uganda Medical and Dental Practitioner's Council*

The Uganda Medical and Dental Practitioner's Council was created by an act of Parliament in 1998. The council is comprised of various stakeholders in the health sector, including representatives from the Uganda Medical Association, a practitioner representing private health sector, and the Director General of Health Services.<sup>65</sup> CSOs and community members are not represented. The main functions of the council include:<sup>66</sup>

- ❖ To monitor and exercise general supervision and control over and maintenance of professional medical and dental educational standards, including continuing education;
- ❖ To promote the maintenance and enforcement of professional medical and dental ethics;
- ❖ To exercise general supervision of medical and dental practice at all levels;
- ❖ To exercise disciplinary control over medical and dental practitioners;
- ❖ To protect society from abuse of medical and dental care and research on human beings.

The council is supposed to maintain records of all practicing medical doctors, both for the public and private sector, issue renewal of medical licenses after requirements have been met, and ensure practitioners have appropriate licenses to practice. Finally, all disciplinary cases against doctors in cases of malpractice or general lawsuits are supposed to be conducted through the council, who has the ultimate power of removing a doctor from the medical register and preventing them from practicing.

#### *Uganda Medical Association*

The Uganda Medical Association (UMA) serves as an umbrella association of all medical associations. It started in 1964 as a branch of the British Medical Association, and its main purpose is to promote medical practice in Uganda and promote health sciences, including education of medicine.<sup>67</sup> The UMA has approval from the Medical and Dental Council to conduct Continuing Professional Development (CPD) courses, which are required workshops to educate doctors on new developments within their fields. Additionally, the association invites

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<sup>65</sup> Constitution of Uganda, Chapter 272.

<sup>66</sup> Ibid.

<sup>67</sup> Interview with Informant 106. Ally Pregulman. November 25, 2008.



medical students to attend and participate in their conferences, although they are not involved in the development or regulation of medical school curriculums. One of the current main focuses of the UMA is the rights of health workers, or, “caring for carers”. The association believes that health care for health workers is being neglected, since many are suffering from the same diseases as their patients, including HIV/AIDs. The UMA is working with other organizations on the Uganda National Injection Safety Taskforce (UNISTAF) to improve regulations for injection safety. Finally, although they have a representative on the Medical and Dental Council, the association is not particularly involved with disciplinary issues.

#### **4.2.3 Redress**

Recently, in a well-known private hospital in Kampala, there was a serious breach of quality assurance in a case that involved substantial medical negligence and disregard for the rights of a patient. A patient was taken into surgery for removal of a dysfunctional kidney, but instead, doctors stole his other, well functioning kidney. Neither the patient nor his wife was aware of this violation of medical rights. The man’s condition persisted, and he flew to South Africa to seek better treatment. The surgeons found that the man had only one kidney, a serious medical-legal issue. The man later died, and his wife wanted to bring the case to court. However, the case never appeared in public because administrators at the Ugandan hospital silenced it. In fact, the informant adds, “many more [medical] incidents are occurring that not even the medical community is aware of.”<sup>68</sup> Regardless of the efficacy of redress mechanisms, it is impossible to deal with issues of medical negligence and poor quality if cases are not brought to the attention of the appropriate authorities.

Although there are several legal documents in place, including the HSC Code of Conducts and Ethics for Health Workers, to ensure that doctors are performing according to certain ethical and professional standards, they are not being followed. According to one source at the HSC, “just as all people read the bible but not everyone follows it, we know that not many [doctors] are abiding by these rules.”<sup>69</sup> Technically, the Medical and Dental Practitioner’s Council is supposed to deal with medical-legal cases. According to a Daily Monitor article, the “Uganda Medical Association does not deny that there have been cases of doctors acting unprofessionally but insists that every case of unprofessional conduct reported in the press or by a patient is investigated by the relevant medical council and appropriate disciplinary action is taken,

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<sup>68</sup> Interview with Informant 106. Ally Pregulman. November 25, 2008.

<sup>69</sup> Interview with Informant 104. Ally Pregulman. November 21, 2008.

including deregistration.”<sup>70</sup> However, doctors question the efficacy of a council so closely linked with the Ministry of Health. According to one source, the aim of the medical council is to protect both the consumer and the provider. However, they are “biased, close to the head of the Ministry of Health, and bend toward the provider and service,” instead of fairly assessing the situation.<sup>71</sup> One of the council’s most common punishments is stripping doctors off of the medical registers, an act that does not prevent them from practicing, only from legally practicing. With medical ‘clinics’ on every corner, there is no possible way for the council to ensure every practicing ‘doctor’ has the appropriate credentials.

An expectant Nanyonga went to Namirembe hospital on October 7, 2003. Unfortunately the doctors found the baby was dead. Nanyonga was successfully operated on three days later and discharged from the hospital. After a few days, Nanyonga went into labor again. Her sister helped her to deliver- the rotting foot of the baby. Apparently the “successful” operation had left parts of the baby inside her womb. They put the foot in an envelope and rushed back to the hospital. She was ignored because the doctors claimed they were all too busy. Eventually she went to Mulago where a doctor discovered other parts of the baby left in the womb and this time successfully operated on her. Finally the birth that started on October 7 ended on October 19.<sup>72</sup>

Consumers of the health care system are being grossly neglected, and yet there are few effective mechanisms for redress. Simply taking legal action results in wasting valuable time and financial resources dealing with the court system, and often does not prevent doctors from practicing within the private sector once they have been removed from the registers.

### **4.3 Private Sector Involvement in Assuring Quality of Health Care**

#### **4.3.1 Development Agencies**

International donors play a large role in financing projects within the health sector. Several donors, including the United States Agency for International Development (USAID), also implement their own programs, such as initiatives within the Health Care Improvement Project, in order to study and improve upon quality assurance programs for health. In the last year alone, “the international community has given Uganda's healthcare sector over half a billion dollars,”<sup>73</sup> accounting for about 34% of the entire sector budget.<sup>74</sup> For fiscal year 2007-2008, for example,

<sup>70</sup> Daily Monitor. January 11, 2004.

<sup>71</sup> Interview with Informant 102. Ally Pregulman. November 4, 2008.

<sup>72</sup> Daily Monitor. January 11, 2004.

<sup>73</sup> Sorius Samura "Addicted to Aid." BBC. 24 November 2008.

<sup>74</sup> Ministry of Health. Annual Health Sector Report 2007/08. Annual Report. Kampala, Uganda, 2008.

donor projects funded over 151,961,631,000 billion Ugandan shillings for the Medium Term Expenditure Framework of the HSSP II.<sup>75</sup> More specifically, United Nations Children’s Fund (UNICEF), USAID, and the Danish International Development Agency (DANIDA) have funded supervision visits in several districts for the Yellow Star Program. USAID for example is funding the Health Initiative for the Private Sector (HIPS), in addition to their worldwide Quality Assurance and Health Improvement Projects.

#### **4.3.2 Civil Society**

##### *Uganda National Health Users/Consumers Organization*

The Ugandan National Health Users/Consumers Organization is a CSO formed in 1999 that is working “to realize a health sector involving meaningful health consumer participation in the promotion of sustainable access to affordable quality healthcare services, based on mutuality of the rights and obligations of both consumers and providers of health services.”<sup>76</sup> UNHCO empowers both health consumers and providers to participate in creating responsive and sustainable health services through sensitization about their health rights and responsibilities. Nationally, UNHCO is involved with health policy advocacy: conducting research to contribute to policy development and monitoring of service delivery.<sup>77</sup> UNHCO has also been instrumental in the formulation of the patient’s charter, a document detailing health rights and responsibilities of both patients and health workers. According to a Ministry of Health official, “the patient’s charter is really UNHCOS’ child. We took it on because by looking at institutional advantages, we are better placed to drive it forward.”<sup>78</sup> Through representation on HPAC, UNHCO provides a voice for CSOs working on health rights. Although UNHCO only works within a few districts due to limited funding, they have had substantial impacts within their targeted communities. After a UNHCO intervention in a community, one health worker commented, “in 8 years I have been at this health unit I have never seen any one who gathers us together with consumers to know our rights and know what to do.”<sup>79</sup> According to a UNHCO employee, “those who know

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<sup>75</sup> Ministry of Health. Annual Health Sector Report 2007/08. Annual Report. Kampala, Uganda, 2008.

<sup>76</sup> Uganda National Health Users/Consumers Organization (UNHCO): Final Evaluation of the UNHCO Health Advocacy Program. Kampala, Uganda: 2008.

<sup>77</sup> Uganda National Health Users/Consumers Organization (UNHCO): Improving Maternal Health and Utilization of PMTCT Services Through the Rights Based Approach in Nakaseke, Kamuli and Mbarara districts, Baseline Report. November 2008, Kampala, Uganda.

<sup>78</sup> Uganda National Health Users/Consumers Organization. Final Evaluation of the UNHCO Health Advocacy Program. April 2008, Kampala, Uganda.

<sup>79</sup> Ibid.

their health rights don't know how to access them.”<sup>80</sup> The work of UNHCO is paramount to sensitizing communities about their health rights and responsibilities so that they may better advocate for quality health services.

#### **4.3.3 Private Not for Profit Organizations (PNFPs)**

##### *Uganda Catholic Medical Bureau*

The Uganda Catholic Medical Bureau (UCMB) provides the best quality health care for money provided, according to several sources. Additionally, the UCMB is considered to have an “outstanding supervision and monitoring system to ensure quality provision of health services.”<sup>81</sup> Every year, each UCMB facility is cleared to ensure conformity to the rigid standards of the Catholic Medical system. This was considered to be a strain on facilities with limited resources and monitoring was therefore switched to a bi-yearly process.<sup>82</sup> However, monitoring and supervision visits still ultimately occur on an annual basis. Additionally the UCMB is considered to breach important service gaps and minimize the inequity of health services, especially in areas where government facilities are not present or providing even a minimum standard of services. The UCMB “gives quality [health services] despite a lack of funding. Donors know that UCMB gives the best value for their money.”<sup>83</sup> According to one doctor has previously worked in government health facilities, the UCMB has the “best health management system in the country.” UCMB uses the following broad components to measure for quality within its health facilities:<sup>84</sup>

- ❖ Technical competence of staff and effectiveness of care;
- ❖ Proportion of qualified staff;
- ❖ Patient satisfaction;
- ❖ Access to services;
- ❖ Continuity of care;
- ❖ Safety of care; and
- ❖ Management processes for quality improvement.

The Yellow Star program is focused on obtaining basic standards for health care such as proper disposal of sharps and medical waste, whereas the UCMB is concerned with maternal death rates, deaths from infection, and overall patient satisfaction with services provided. The UCMB system is far superior to that of other monitoring systems within the country.

##### *Health Initiative for the Private Sector*

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<sup>80</sup> “Patient’s Charter to Protect Health Rights Out Soon.” East Africa Business Week. July 24-30 2006.

<sup>81</sup> Interview with Informant 100. Ally Pregulman. 10/23/2008.

<sup>82</sup> Ibid.

<sup>83</sup> Ibid.

<sup>84</sup> Uganda Catholic Medical Bureau. UCMB Guidelines for Hospital Care Quality Measurement. November 2005, 6.

The Health Initiative for the Private Sector (HIPS) is a USAID funded program that works with the private sector to promote health services for employees of private companies, their families, and communities within the catchment areas of the companies.<sup>85</sup> Since not many people within Uganda have health insurance, several private companies provide health care services to their employees for free or for a nominal fee. HIPS works to improve the quality of health care provided in company clinics by helping the clinics to create or improve upon a menu of services which includes providing HIV/AIDs testing, free Anti-retroviral therapy (ART), and counseling services.<sup>86</sup> Many of the large corporations in Uganda are in rural areas, where access to quality health services is extremely low. The main focus of the project is the company clinics, however, HIPS also encourages the companies to allow the surrounding communities access to the health services. In some instances where companies do not have clinics, HIPS has worked with community clinics to improve services offered. In the past year, HIPS has actively worked with 30 companies and 22 community clinics to expand and ameliorate the health services offered in the private sector.

#### **4.4 Community Perceptions of their Right to Health**

Although they are the consumers of the health care system, community members often are not particularly involved as stakeholders in their health care. Many programs and policies are created and implemented nationally, without the input of communities. Organizations such as UNHCO are working to sensitize communities about both the requisite quality of health care and their health rights and responsibilities, but are only working in a few districts. Overall, there is a lack of education about both the right to health and quality of health care.

##### **4.4.1 Perceptions of quality health care**

Communities are relatively unaware of their specific health rights and responsibilities. According to a student at Makerere University Medical School, “Most Ugandans do not know about quality and do not know their [health] rights. Patient’s don’t know their health rights and rights as a patient and doctors take advantage of patients not knowing [about their rights].”<sup>87</sup> A UNHCO baseline study conducted in three districts found that “consumer awareness of quality issues averaged 13.5% on the basis of tracking for three quality aspects (time taken before

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<sup>85</sup> Interview with Informant 113. Ally Pregulman. 11/25/2008.

<sup>86</sup> Ibid.

<sup>87</sup> Interview with Informant 105. Ally Pregulman. 11/11/2008.

service is received, drug stock outs, and ethical conduct by health workers).”<sup>88</sup> Additionally, UNHCO found that only 5 out of every 26 community leaders, 19.2%, were able to understand and acknowledge the importance of quality maternal health and Prevention of Mother to Child Transmission of HIV/AIDs (PMTCT) services, meaning that only 19.2% were aware of the importance of the provision of quality health services.<sup>89</sup> However, a study on Client Satisfaction with Health Services in Uganda commissioned by the Ministry of Health and the HPAC found that 51% of patients expressed complete satisfaction with services provided, 25% were mostly satisfied, and 10% were not satisfied with health services provided.<sup>90</sup> It can therefore be inferred that although patients are somewhat satisfied with the health services provided, the overall awareness level of the quality of services that should be provided is extremely low. Patients are therefore generally satisfied with poor quality services.

Although patients cannot specifically articulate their health rights and responsibilities, some have a general awareness of what constitutes gross neglect by health workers. One woman informed UNHCO, “the health workers are never there on time and they take a very long time to act, thus women find it better to visit the traditional healers.”<sup>91</sup> One community member added, “I went to a health center and spent five hours in the seat when nurses were just roaming about, passing by us. After three hours I decided to come back and bought some drugs from a clinic.”<sup>92</sup> Unfortunately, as detected in various studies by UNHCO and the Ministry of Health, awareness levels about health rights and responsibilities, or, the requirements for provision of quality health services, remain low.

In September 2008, a little girl by the name of Nakato accidentally danced backwards into a pot of boiling water and sustained severe burns on 80% of her body. Her family, misunderstanding the severity of her situation, brought her to a medical clinic. There, the doctor on duty put her on a bed and left her to die, without even providing painkillers or removing her burnt skin. Nakato’s family was unaware that she needed emergency medical attention and left

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<sup>88</sup> Uganda National Health Users/Consumers Organization (UNHCO): Improving Maternal Health and Utilization of PMTCT Services Through the Rights Based Approach in Nakaseke, Kamuli and Mbarara districts, Baseline Report. November 2008, Kampala, Uganda.

<sup>89</sup> Ibid.

<sup>90</sup> Ministry of Health. Study of Client Satisfaction With Health Services in Uganda. 30 October 2008. Kampala, Uganda.

<sup>91</sup> Uganda National Health Users/Consumers Organization. Final Evaluation of the UNHCO Health Advocacy Program. April 2008, Kampala, Uganda.

<sup>92</sup> Ibid.

her in the clinic for three days. Once outside friends intervened, she was brought to a hospital in Kampala, where she waited to be seen for several hours. A doctor finally brought her into the surgical theatre to care for her burns, but since it was a Friday, there was not an anesthesiologist on duty. The doctor proceeded to rip off her burnt skin without provision of any painkillers, immune to her cries of anguish. Although outside friends tried to intervene, he relentlessly proceeded. Once finished, nurses tried unsuccessfully for two hours to insert an intravenous treatment (IV), causing Nakato additional pain. Doctors routinely refused to continue to provide treatment unless they were paid, often forcing the family or friends to buy medical supplies and even drugs. The hospital did not provide food or blankets for Nakato; the family had to use already meager resources to provide them. After three and a half weeks of enduring negligence from doctors and nurses, spending hundreds of thousands of shillings on her care, and holding her hand, trying to calm her agony, Nakato died, due to complications from her burns.<sup>93</sup> Had Nakato's family been more educated about basic medical care and requisite quality of health services, they might have been able to save her life. However, even educated communities often view doctors as omniscient and are fearful to intervene in their medical practices.

#### **4.4.2 Perceived quality of care**

Overall, community members lack confidence in the quality of the health care system. In a 2007 opinion-editorial in the Daily Monitor, one health consumer discusses the horror of bringing his three week old child, who had a slightly elevated fever, to a doctor who claimed she had meningitis and wanted to immediately start an IV treatment with a needle bigger than the child's largest vein! After calling the family doctor for a second opinion, the consumer discovered "He [the doctor] was shocked at his [co-worker's] insensitivity and interest in money rather than the toddler's life. It later turned out that on top of my child not being sick such a heavy treatment could actually have cost her life."<sup>94</sup> Sadly, this health consumer is not alone in his opinions of the quality of the health care system. There are at least two articles daily in both the New Vision and the Daily Monitor addressing issues related to corruption and the global fund, essential medical drug stock outs, and preventable disease outbreaks.

A study conducted by the RCQHC in 2001 found that user perceived quality of care ranged from 5-30% for users believing that care was of good quality, and was highest (20-50% feel

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<sup>93</sup> Interview with Informant 114. Ally Pregulman. December 1, 2008.

<sup>94</sup> "Lust for Cash is Ruining the Medical Profession. Daily Monitor. September 1, 2007.

receiving good quality care) in rural communities where care is mainly for outpatients.<sup>95</sup> An informant from the RCQHC further commented, “Not much has changed since then. The care being provided in Uganda is not of good quality.”<sup>96</sup> In fact, quality of care is so poor in government facilities that many patients are seeking more traditional methods. In a New Vision article on June 1, 2008, the Honorable Minister of Health Stephen Malinga said “Mothers have abandoned hospitals and resorted to delivering in villages and going to witchdoctors because they are scared of being abused by the nurses.”<sup>97</sup>

Even President Museveni goes abroad for his medical care, claiming Ugandan doctors will deliberately try to hurt him and “while many good doctors have been trained under the NRM government, who we trust will serve mankind as all doctors should, we still have some wrong doctors.”<sup>98</sup> There are plenty of talented, trustable doctors within Uganda perfectly capable of treating the President, however, he does not trust them. In an article by the Daily Monitor, the President tells a story about two soldiers receiving medical care in Uganda. “One was declared dead by a doctor, but the commanding officer was not convinced. A second opinion pronounced him alive, and he still is. Another soldier was slightly injured but the doctor declared the urgent necessity of amputation. The soldier resisted and walks very ably with both his legs today.”<sup>99</sup> When even the President of Uganda refuses to use the health services within the country, it becomes painfully apparent that regardless of statistics, consumers have very little faith in the quality of their health care system.

#### **4.4.3 Community involvement in improving quality of care**

Once community members are educated about their health rights and responsibilities, they are able to advocate for improved quality of care. However, most communities are unaware of their health rights and responsibilities; they are not particularly involved in improving quality of care. Those health consumers and community members aware of quality issues may be afraid to advocate for better services. A September 2006 New Vision article suggests, “with an estimated population of 27.821 million people, the health worker-patient ration is so pathetic that many are likely to feel too needy to complain over any violation by health workers.”<sup>100</sup> While

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<sup>95</sup> Interview with Informant 108. Ally Pregulman. 11/25/2008.

<sup>96</sup> Ibid.

<sup>97</sup> “Nurses Beat Pregnant Women- Minister.” New Vision. July 1, 2008.

<sup>98</sup> Daily Monitor. January 11, 2004.

<sup>99</sup> Ibid.

<sup>100</sup> “Patient’s Charter to Protect Health Rights.” New Vision. September 6, 2008.



working in the districts, UNHCO found that “people in the community know the rights but they asked, ‘do you want the health workers to hate us,’ [when discussing advocating for better health rights].”<sup>101</sup> In fact, in 2000, the Ministry of Finance said, “A poor person does not have a voice in the community. No one will listen to him.”<sup>102</sup> Not only are community members afraid to advocate for their health rights, but also even government ministries believe that they will not have an impact. UNHOC and other CSOs have programs to sensitize communities about their health rights and responsibilities, but further actions must be taken to allay consumer’s fears about challenging the health system before changes will be made on a community level.

#### **4.5 Challenges of Quality Assurance Implementation within the Health Care System**

##### **4.5.1 Government challenges**

*Good governance.*

Political corruption is the single biggest issue facing the health sector. The Ministry of Health has sound policies and programs in theory, but they are not being properly implemented. When asked about the biggest challenges facing the health sector in provision of quality assurance programs for health care, every informant immediately mentioned issues of good governance.

One student at the Makerere University Medical School adds,

“President Museveni said that the health care system and the hospitals are non-productive so why should they need money. Health isn’t a priority for this government. Health care is basic, it needs to be there, but so much is ignored. Health centers are empty, designed but poorly implemented and sustained. I’m not sure if financing is the only issue. The Ministry of Health had over 80 billion shillings laying redundant, so is money really the issue?”<sup>103</sup>

A recent BBC article examined the issue of aid in Uganda, which “Western donors say is the success story of development aid in Africa.”<sup>104</sup> According to the article, “staff at Mulago Hospital said they struggle to get even the most basic supplies, such as gloves and the analgesic Paracetamol. But a trip to the car park at Uganda's Ministry of Health shows that money is being spent - just on other things. The ministry has bought 1,800 4x4 vehicles for its staff, but only four ambulances for Mulago Hospital.”<sup>105</sup> A Ministry of Health official issued a rebuttal to the article, claiming “Mulago hospital has four operating ambulances, will procure one more this

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<sup>101</sup> Uganda National Health Users/Consumers Organization. Final Evaluation of the UNHCO Health Advocacy Program. April 2008, Kampala, Uganda.

<sup>102</sup> Ibid.

<sup>103</sup> Interview with Informant 105. Ally Pregulman. November 11, 2008.

<sup>104</sup> Sorius Samura "Addicted to Aid." BBC. 24 November 2008.

<sup>105</sup> Ibid.

financial year and two next financial year. The Ministry of Health has 217 vehicles of different sizes and capacities and not all of them are 4x4. Only 10 of these were purchased using the Ministry budget. The rest came in through project support.”<sup>106</sup> Obviously there is a huge discrepancy between the Ministry of Health statistic and the BBC statistic regarding the purchase of vehicles. Unfortunately, this is not the only questionable health statistic produced by the health sector.

There are serious discrepancies between Ministry of Health statistics and statistics produced by the non-state actors within the health sector. According to one doctor working in health systems supervision and management,

The Ministry of Health doctors statistics, if they are not favorable, in order to please the President. If statistics were as good as the Ministry of Health presents them to be, then there would be substantially more progress in health care. Even the latest Uganda Demographic and Health Survey, published in 2006, took longer to publish the maternal mortality ratio because the Ministry of Health wanted to doctor [the statistic]. Therefore, donors take the Ministry of Health statistics with a pinch of salt.<sup>107</sup> Both the Ministry of Health and the donors are turning a blind eye to the obvious discrepancies within the health sector. How is the health sector supposed to improve the quality of health services delivery when the quality of even the statistics produced is in question? Why are donors turning a blind eye to the innumerable issues within the health sector?

The total government expenditure on health as a percentage of the overall country budget for 2007/2008 was 9.6%. During the Abuja Commitment, President Museveni committed to providing 15% of the overall budget to the health sector. That was in 2006. One source working in health policy and management laments, ““I wish there was some kind of trick to increase the health sector budget to 15% but Museveni won’t do it.”<sup>108</sup> Many informants suggest that the only way to see meaningful improvements within the health sector is to have a change in political leadership. A student at Makerere University Medical School is “not hopeful for the future of the health care system as long as this government is in power because there is no priority on health care.”<sup>109</sup> The technical advisors working within the Ministry of Health and the health sector are

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<sup>106</sup> Sorius Samura "Addicted to Aid." BBC. 24 November 2008.

<sup>107</sup> Interview with Informant 100. Ally Pregulman. October 23, 2008.

<sup>108</sup> Interview with Informant 108. Ally Pregulman. November 25, 2008.

<sup>109</sup> Interview with Informant 105. Ally Pregulman. November 11, 2008.

dedicated individuals who genuinely want to see an improvement in health care. Unfortunately, senior managers and upper level government officials are corrupting the system. When asked what needs to be done to improve the quality of health care in Uganda, one source at the HSC immediately answered, “I have sometimes felt that government has yet to give the health system the priority it deserves so I want to see the political will which will invest in the health sector.”<sup>110</sup> A doctor at Mulago hospital adds, “In Uganda, health is said to be a priority but in practice its not. Otherwise we would not be only getting 9% of the [overall] budget.”<sup>111</sup> Until health is a major priority for the government in practice and not just in theory, the quality of the health system will never improve. One source working in the private sector laments, “people in planning implement what the president wants to do and see. If he doesn’t think the sector needs change, the sector won’t change.”<sup>112</sup>

#### *Human Resources*

There is currently a shortage of health workers within the country. The current doctor to population ratio is 1:18,000, and the current nurse to population ratio is 1:3,000.<sup>113</sup> The starting salary for a Ugandan doctor is around 800,000 shillings per month, but doctors often do not receive their salaries on time.<sup>114</sup> However, Kenyan doctors receive a starting salary of 2.5 million Ugandan shillings per month, and Rwandan doctors receive a starting salary of 5 million Ugandan shillings per month.<sup>115</sup> As one medical school student complains, “how can you expect me to stay in the country when I am getting paid so little?”<sup>116</sup> Around 250 doctors graduate every year from Ugandan medical schools, a number that will double this year because of the addition of two new medical schools, Kampala International University and Gulu University<sup>117</sup> however, “at least 70,000 skilled graduates [leave Africa] every year, often trained by Western aid, but unable to stay in the market because salaries are so low.”<sup>118</sup> Those doctors that do stay within the country often seek additional work in private clinics to supplement meager incomes paid by government health facilities.

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<sup>110</sup> Interview with Informant 104. Ally Pregulman. November 21, 2008.

<sup>111</sup> Interview with Informant 106. Ally Pregulman. November 25, 2008.

<sup>112</sup> Interview with Informant 102. Ally Pregulman. November 4, 2008.

<sup>113</sup> Interview with Informant 106. Ally Pregulman. November 25, 2008.

<sup>114</sup> Interview with Informant 105. Ally Pregulman. November 11, 2008.

<sup>115</sup> Ibid.

<sup>116</sup> Ibid.

<sup>117</sup> Ibid.

<sup>118</sup> Sorius Samura "Addicted to Aid." BBC. 24 November 2008.

According to one source working in health policy, the issue of dual employment has been in existence “as long as he can remember,” or, since before the 1980’s and the presidency of Idi Amin.<sup>119</sup> However, one source at the HSC adds, “I have always rejected the issue [of dual employment] as a reason for the poor quality of the health system. [Poor quality] is perhaps a management issue. In the past, both discipline and management were present within the health profession. One made sure that they didn’t cheat the government or the patients by putting in the number of required hours at [their government job] before going to work at their private clinic.”<sup>120</sup> One source from the UMA adds that human resources for health is an issue that is difficult to control.

“There are issues both with internal and external migration of health workers to other sectors. Within Uganda, doctors become politicians, managers, and marketers for pharmaceutical companies because of the low salary levels supplied by the health sector. Even within the profession, there is a shift from working in the public sector to working for NGOs because they pay more. And the doctors there are doing very good work. Why can’t they do good work in the public sector? Because of poor remuneration packages.”<sup>121</sup>

Aside from the satisfaction of providing health care to communities, there are few benefits to working in government health facilities. Doctors are overworked and underpaid, often forced to work long hours as the only medical professional in a facility. An informant working in health policy adds, “ideally one feels that to decide to be a health professional should be a calling where one feels they would like to help people in health need. However, we know that people have joined the health profession because of parents, peers, and because doing medicine is seen as a sellable profession outside of Uganda.”<sup>122</sup> With a lack of human resources for health, few benefits to working in the profession, and many doctors who are in the profession because of outside pressures, it is no wonder that the level of service delivery is low. Doctors have no motivation to provide good quality services, because at the end of the day, they are going to be paid, regardless of how considerate they were to the patient or how effectively they did their job.

### *Financial Resources*

Although many government employees claim that programs such as Yellow Star are not being fully implemented because of a lack of financial resources, this is only part of the problem. There is plenty of donor aid being funneled into the country. Within the last year alone, the

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<sup>119</sup> Interview with Informant 104. Ally Pregulman. November 21, 2008.

<sup>120</sup> Ibid.

<sup>121</sup> Interview with Informant 106. Ally Pregulman. November 25, 2008.

<sup>122</sup> Interview with Informant 104. Ally Pregulman. November 21, 2008.

government of Uganda received over half a billion dollars from the international community.<sup>123</sup> Obviously, the issue is not lack of resources, but adequate management of resources. One medical student claims that last year, “the Ministry of Health had over 80 billion Ugandan shillings laying redundant” in overlapping programs, and questions whether the inefficiencies of the sector were really due to financial constraints.<sup>124</sup> One source at the UMA complains, “of the 8% [of the sector budget], about 4% comes from the government and the rest is donor funded. Money is redirected to other vital ministries and people’s pockets. When it finally reaches the health units, poor planning means poor drugs and poor quality. Maybe 2-3% [of funds] actually reaches the beneficiaries because of corruption, mismanagement, and poor planning.”<sup>125</sup> Many actors within the health sector feel that the government has plenty of money to adequately finance health policies and programs; it simply isn’t being used effectively or efficiently.

#### **4.5.2 Policy and procedure challenges**

##### *National Supervision Guidelines for Health Services*

The supervision and monitoring support systems require quarterly visits to the districts. Although visits are conducted, most district health monitoring teams are accused of ‘parachute supervision,’ or simply visiting the district for the weekend, staying with the District Health Officer, and then leaving without ever having conducted meaningful monitoring or support on a facility level. These monitoring teams are not adequately supervising the districts. Also, the Yellow Star program is not being run concurrently with the supervision visits. Instead, the programs are operating as two separate entities, essentially spending double the money for the same visits. The Yellow Star supervisors and the supervision and monitoring teams need to merge their guidelines, tools, and supervision visits to provide longer, more meaningful visits to improve the quality of care offered in government facilities. Additionally, by streamlining the supervision and monitoring process to include Yellow Star, the human resources available for supervision visits would increase, which would allow for more interactions on a local level, instead of relying on district health teams to provide reports on the individual facilities.

##### *Patient’s Charter and HSC Code of Conduct and Ethics for Health Workers*

In comparing the HSC Code of Conduct and Ethics for Health Workers and the Patient’s Charter, one finds that the two documents are essentially the same. The one difference is that the HSC document has already become law, while the Patient’s Charter is stuck in limbo. Although

<sup>123</sup> Sorius Samura "Addicted to Aid." BBC. 24 November 2008.

<sup>124</sup> Interview with Informant 105. Ally Pregulman. November 11, 2008.

<sup>125</sup> Interview with Informant 106. Ally Pregulman. November 25, 2008.

there are legal mechanisms to enforce the HSC document, actions are not taken against those health workers that are violating the current code of conduct. For example, during November 2008, one doctor was visiting a district in the North and upon entering a health facility he found a drunken surgeon operating on a patient. The patient died and the surgeon was taken to the police station, not because he had been performing surgery while drunk, but simply to deal with the matter of the dead body.<sup>126</sup> No further action against this doctor was taken. The Ministry of Health and UNHCO should focus their resources on gaining political weight behind the Code of Ethics, which ensures patients rights, but simply frames them from the perspective of health workers. Although having a Patient's Charter become law would be a major success for health rights and responsibilities, it is simply not a priority right now for the government. Therefore, the sector should focus on the code that is already law, and seek to better enforce it by creating stronger redress mechanisms.

#### *Uganda Human Rights Commission*

The UHRC was created by an act of Parliament, and is therefore closely linked with the government. The close ties with the government prevent the UHRC from acting autonomously and therefore from meaningfully monitoring and commenting on human rights issues within the country. Many CSOs do not have faith in the UHRC to do an effective job. The right to health unit is funded by the United Nations Development Program (UNDP), but is not using its financial resources as effectively as possible. Additionally, the right to health unit is understaffed and although it has a clear mandate, the employees working within the unit often remain idle or focus on non-health related issues. There is a need for serious reforms within the UHRC both to allow the commission to be completely independent of the government and to more effectively utilize donor funding to ensure the efficacy of the right to health unit. The commission will never be able to effectively monitor the human rights situation within Uganda while still having close ties with the government. Additionally, the right to health unit was created by the recommendation of a UN rapporteur, as an afterthought of the commission, and is currently only staffed by a single person. The UHRC needs to make the right to health more of a priority by allocating more human resources to investigate the claims of medical negligence and violations of the right to health that are made on both a daily basis within the newspapers and within the health sector.

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<sup>126</sup> Interview with Informant 106. Ally Pregulman. November 25, 2008.

*Health Services Commission*

The HSC has an effective program for interviewing and recommending human resources for upper level management positions within the health care system. However, the HSC currently only focuses on top level management positions. Although lower level health workers do not need to be appointed to their positions, the HSC could use its already existing programmatic framework to help deal with the issue of human resources for health. Due to its unique situation of recommending health workers to President Museveni, the HSC could also possibly recommend that he increase funding and remuneration packages for health worker wages, to prevent the issue of the brain drain in the future.

*Yellow Star Program*

The Yellow Star Program is a strategically sound program in theory that unfortunately, was never properly implemented. One source at the Ministry of Health added, “We believe that Yellow Star can improve the quality of the health facilities but it has fallen shy of proper implementation.”<sup>127</sup> Another source adds, “Yellow Star was a good program but it had its head cut off” due to financial constraints.<sup>128</sup> However, financial constraints are not the only reasons for the disappointment of the YSP. A human rights advocate in the private sector blames the failure of the YSP on the attitude of the District Health Officers (DHOs), supervisors, and health workers and their desire for increased compensation for participation in the program. “We are told that the Yellow Star Program was not successful due to a lack of money. However, telling people to properly record [medical] information, keep track of drugs, and be friendly to patients shouldn’t require extra salaries. You don’t need to be paid [extra] for doing your job!”<sup>129</sup> The YSP program itself is a good quality, well thought out program that, when properly implemented, involves community members as stakeholders in their healthcare. However, the Ministry of Health and project donors need to find ways of motivating health workers to strive for the provision of better service without providing monetary compensation. Again, it is not an issue of financial resources, but attitudes towards health care and provision of quality services.

*Medical School Curriculum*

Although the COBES curriculum is in theory more effective for fostering individual learning and motivation to succeed, in actuality, it is full of flaws. In fact, a doctor at MUK IPH

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<sup>127</sup> Interview with Informant 101. Ally Pregulman. October 23, 2008.

<sup>128</sup> Interview with Informant 102. Ally Pregulman. November 4, 2008.

<sup>129</sup> Ibid.

mentions, “the medical school has received a lot of bad press in recent years due to the switch to the new curriculum.”<sup>130</sup> Although overview lectures are supposed to be given by experts within the field, one student within the medical school complains “the first and second year students do not actually have trained professors for their tutorials, in which they are supposed to be learning about the body.”<sup>131</sup> The COBES approach gives medical lecturers working two jobs the ability to devote more time to their private clinics, since there appears to be a lack of monitoring and evaluation within the medical school. Their absence in lectures apparently goes unnoticed, for when they do not show up to teach, the students will in theory simply add the material to the list of subjects they must study independently. In fact, one student at the Medical School claimed, “content experts for overview lectures often ignore the first and second year students and often do not show up to teach. If they do not show up, then students do not have class and must learn on their own.” When asked about the commitment to learning subjects not covered in class, the student added that the onus is on the students to study independently, but many do not.

The doctors in charge of teaching ethics to the Medical School refused to be interviewed. One student of the Medical School comments, “you can understand why they would not want to talk to you after our discussion [on the shortfalls of the medical school ethics curriculum].”<sup>132</sup> In fact, there are many serious issues with the ethics portion of the COBES curriculum. Ethics is initially taught during the first two weeks of the first year of medical school, at a time where one informant claimed professors do not even show up to teach. The curriculum is supposed to teach biomedical ethics, confidentiality, rights of the patient and health worker, and medical legal issues such as abortion. However, the student confirmed that professors “do not go into detail and only teach the basics” due to limited time. Ethics are supposed to be further covered in a section on first aid and nursing, which covers topics such as bedside manner but again lasts for only two weeks. The final exposure to ethics within the COBES curriculum is in theory during the fourth year, in study of forensics. Forensics in Uganda is considered to be an ethical subject, since, according to one source, many post mortem reports are tampered with.<sup>133</sup> However, this section of the course was recently taken off the curriculum for unknown reasons. In response to this deletion, the student commented, “how will we get training about ethics? We won’t.”

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<sup>130</sup> Interview with Informant 100. Ally Pregulman. October 23, 2008.

<sup>131</sup> Interview with Informant 105. Ally Pregulman. November 11, 2008.

<sup>132</sup> Ibid.

<sup>133</sup> Interview with Informant 102. Ally Pregulman. November 2, 2008.



There are obviously many gaps within the ethics portion of the COBES curriculum of the Makerere University Medical School. For a school that produces 100 doctors per year,<sup>134</sup> this is a serious issue. The school presumably uses a problem based approach to learning, yet there are no modules covering the right to health, an important issue for doctors-in-training to consider. As one student says, “we are taught to be good doctors but not to give good quality health care.”<sup>135</sup> The gap in requisite ethical knowledge of the future health workers of Uganda’s health care system will ultimately prevent the delivery of quality health care in the future. If doctors are not being trained to provide quality, ethically sound healthcare, the quality of the health care system will never change.

#### **4.5.3 Private sector**

##### *Uganda National Health Users/Consumers Organization*

UNHCO’s programs are extremely effective and have made substantial improvements in health care at a community level. However, UNHCO has a limited budget and is only currently working in a few districts. Community sensitization is paramount to consumer investment in health care and more funding needs to be allocated towards UNHCO programs. There are a few small CSOs working on the right to health, but UNHCO has the strongest voice on a national level. UNHCO needs to collaborate with more CSOs to ensure that civil society is working towards the realization of the right to health. UNHCO also strongly focuses on the health rights and responsibilities of patients. Although health workers are being educated about their health rights and responsibilities, the education is centered on treatment of patients. Currently there are no major organizations working on the rights of health workers.

##### *International Donors*

International donors are turning a blind eye to the realities of the health sector. Why should financing go towards vehicles when money is needed to improve staffing, properly equip facilities, and educate communities? A large percentage of the money donated to the health sector is being pocketed, and yet, donors continue to flood Uganda with development aid. The donors aren’t pushing for good governance or further improvement of the health sector, but are simply turning a blind eye to doctored statistics, corruption, pocketing of money for personal use, and a lack of motivation within the sector. Additionally, quality assurance programs are

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<sup>134</sup> Interview with Informant 105. Ally Pregulman. November 11, 2008.

<sup>135</sup> Ibid.

under-funded because, according to one source, “it is difficult to measure issues of human rights and quality, and donors only want to fund programs with measurable success.”<sup>136</sup>

#### *Health Initiative for the Private Sector*

HIPS has a targeted program that focuses on company clinics. However, the program itself could easily be expanded to improve more rural clinics. The framework of the program already lends itself to improving services offered by clinics, and HIPS already has partners to supply educational materials and medical supplies. However, a representative from HIPS mentioned, “we are working initially with companies but to get targets, we have moved to working with private clinics. We don’t work as much with PNFPs because they do not cost-share [in the clinics] as much as major companies.”<sup>137</sup> The organization is funded by USAID, among others, and could easily be expanded to work with PNFPs and other not-for-profit organizations. However, HIPS seems reluctant to work in areas where they would have to provide the bulk of the financing.

#### *Uganda Catholic Medical Bureau*

The UCMB supervision and monitoring system is without a doubt, the best in the country. However, if the system is effective, why isn’t it being shared with other organizations? If the goal of the UCMB is to improve health services delivery to Ugandans, why can’t the organization share its successes in quality assurance with other organizations and the Ministry of Health? Why isn’t there more inter-sectoral collaboration?

#### **4.5.4 Community**

Aside from the communities that have been sensitized about their health rights and responsibilities by UNHCO, there are few consumers actively participating in the reform of health services delivery. Levels of awareness regarding quality issues are low and communities are unaware of the ways or unwilling to lobby for improved health care. According to one source, “community members are just being given programs instead of being asked whether they want them. There is no meaningful participation by community members [within the health sector]. Communities can monitor, supervise, do awareness, and do advocacy if trained but they currently are not a part [of this]. People claim that it is too expensive to involve the community,”<sup>138</sup> however, it is too expensive not to involve the community. Community members could play an important role in advocating for meaningful reforms within the health

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<sup>136</sup> Interview with Informant 102. Ally Pregulman. November 4, 2008.

<sup>137</sup> Interview with Informant 113. Ally Pregulman. November 25, 2008.

<sup>138</sup> Interview with Informant 102. Ally Pregulman. November 4, 2008.

sector through expressing their dissatisfaction with poor quality health services both at a local, district, and national level. However, “in Africa, people don’t know how to challenge their leaders. People need to challenge their leaders; it needs to start from the lowest person. But governments are leading ignorant people. Community can change even private clinics for once they go to these clinics; they will be empowered to know what they deserve. If the woman getting care from a clinician taking notes on a newspaper didn’t know her rights, do you think she would have spoken up?”<sup>139</sup> The first people responsible for their health rights are individuals. Communities must be empowered to take a larger role in the protection and realization of their health rights.

## 5. Conclusion

Despite the obvious shortcomings of the health sector, one source working in the private sector believes that Uganda is making “beautiful steps to progressive realization of the right to health”.<sup>140</sup> At one point in its history, Uganda had the best health services delivery system in East Africa and arguably within sub-Saharan Africa. Although the problems in the 1970’s and 1980’s can be blamed to a certain extent for the failures of the health system, the government should be doing more to improve the current system. The policies and programs that have been created to deal with the issue of quality assurance and supervision and monitoring are strategically sound, financially feasible, well thought out programs. However, they are not being fully implemented due to mismanagement of resources, poor attitudes and motivation, and a lack of good governance. Ugandans have so little faith in the health sector that some would rather seek the services of traditional healers than chance treatment in a health facility.

The issue of quality health care is not just going to go away if not dealt with properly. Instead, the problem will exacerbate itself and prevent the country from realizing the MDGs or meaningful development. The Ministry of Health is supposed to play a stewardship role to assist districts in planning and health systems development. This is not happening. The current human resource challenge for health is unacceptable. The Ministry of Health says that facilities are currently staffed at 60% of the staffing norms, however, they are actually staffed about 30%.<sup>141</sup> Health workers lack motivation for providing quality health services and there are constant stock

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<sup>139</sup> Interview with Informant 102. Ally Pregulman. November 4, 2008.

<sup>140</sup> Ibid.

<sup>141</sup> Interview with Informant 100. Ally Pregulman. October 8, 2008.

outs of essential equipment and medicines. The current government allocation to health is inadequate. In 2006/07 the government allocated \$7.84 per person per year for health.<sup>142</sup> The actual allocation today is about \$8 per person per year.<sup>143</sup> The current government priority is not health but maintaining the political and defense systems, which is a direct violation of their commitment to protecting the right to health. The defense budget is a classified expense that does not even have to be approved by Parliament, and therefore, gives no justification for its spending.<sup>144</sup> The biggest challenge to the Ugandan health sector is the management of the country. The challenges in the health sector are no longer social, but political issues. Without an improvement in the political atmosphere of the country there will never be quality health care.

## 6. Recommendations

- ❖ The international community needs to immediately push for good governance reforms within the country.
  - All government budgets must be declassified and submitted for approval by Parliament.
  - Stringent measures need to be taken by donors to ensure the immediate allocation of 15% of the annual country budget to health care, as stipulated in the Abuja Commitment. Sanctions and political action should be taken as needed.
  - Donors need to evaluate their programs and financial allocations within Uganda to ensure they are being effectively utilized and managed. Care should be taken to ensure the maximum utilization of resources before providing more money to the sector.
  - Donors need to push for the production of accurate statistics by the Ministry of Health.
  - Donors need to allocate funding for right to health and quality assurance programs, which are currently under funded and unable to be fully operational and effective.

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<sup>142</sup> Interview with Informant 100. Ally Pregulman. October 8, 2008.

<sup>143</sup> Ibid.

<sup>144</sup> Ibid.

- ❖ Re-financing for health worker salaries and remuneration packages needs immediate attention. Addressing the issue of the brain drain is paramount to ensuring improved health services delivery.
  - Salaries for Ugandan medical workers should be made competitive with those in other East African countries.
  - Stronger guidelines and redress mechanisms need to be implemented for doctors working in dual-employment that do not fulfill their obligations to their government postings.
  - The HSC should work with the Ministry of Health to address the lack of human resources for health by creating programs to target young students to become doctors, as well as to encourage medical students to specialize in areas that need additional workers, such as forensics.
- ❖ Parliament and non-government bodies, with the assistance of international donors, need to assess the current finances of the health sector to ensure proper management of resources.
  - Additional resources need to be allocated to the Department of Quality Assurance to fully implement the Yellow Star Program and improve supervision and monitoring visits to the districts.
- ❖ The Department of Quality Assurance needs to conduct training for its supervision and monitoring teams to ensure they are performing their tasks according to regulation. If necessary, the teams should be monitored and put on probation if found to be conducting “parachute supervision”
  - Districts health officers and health workers need to be trained in the importance of the Yellow Star Program. Communities also need to be further sensitized about the importance of the YSP.
    - Communities can act as supervisors and watchdogs for quality of health in local facilities if properly trained.
    - The Ministry of Health should work with UNHCO on this issue by providing funding for the expansion of current UNHCO programs into every district.

- Supervision and monitoring should be conducted on an ongoing basis, not just once a quarter. District supervision and monitoring teams should be spending more than one weekend in the district.
- The YSP needs to be integrated within current supervision and monitoring frameworks instead of being run as a parallel program. There is plenty of funding for supervision and monitoring, which would allow for full realization of the YSP.
- The UCMB needs to share their successes in supervision and monitoring with the Ministry of Health.
  - UCMB should train current Ministry of Health supervision and monitoring teams and educate the Department of Quality Assurance about their successful methodologies and frameworks.
- ❖ The Uganda Medical and Dental Practitioner's Council is currently too closely linked with the Ministry of Health. It needs to become more autonomous.
  - The Council needs to give stronger punishments than simply striking a name from the register of practicing doctors. Stronger systems need to be in place to prevent unqualified doctors or discharged doctors from practicing.
- ❖ The UHRC needs to become autonomous from the government and allocate more staff to the right to health unit.
  - Immediate investigations into daily cases of medical negligence and the violation of the right to health are needed.
- ❖ A separate study needs to be completed on the regulation of quality health care in the private sector. There is currently gross mismanagement of health care in the private sector and this issue needs to be addressed immediately.
- ❖ UNHCO, the Ministry of Health, and the HSC should work together to submit the Patient's Charter to become law. However, in the interim, they should work to more effectively regulate the HSC Code of Conduct and Ethics for Health Workers by creating and enforcing stronger punitive mechanisms.
- ❖ HIPS has the framework to improve the menu of services offered for all rural clinics and should either expand their program to do so, or provide funding for another

program to improve rural clinics. Not wanting to work with PNFP or government clinics because they do not cost share is not a valid reason for overlooking the poor service provided in rural areas.

- ❖ Communities need to be empowered to realize their right to health.
  - YSP should sensitize community members to serve as regulators for local clinics to ensure quality services are provided.
  - UNHCO, with the assistance of the Ministry of Health, needs to expand its work into all districts within Uganda.
- ❖ The Ministry of Sports and Education, along with the Ministry of Health, needs to critically evaluate the MUK COBES curriculum to ensure it is producing well-trained doctors capable of delivering ethical, quality services.
  - MUK needs to regulate its lecturers to ensure that they are teaching their assigned classes.
  - The RCQHC and MUK should review the COBES ethics curriculum to ensure that all areas are effectively covered.

## Appendix A: Yellow Star Guidelines for Health Facilities

### *Infrastructure and Equipment*

- 1) Is there a reliable and clean supply of water from a protected water source?
- 2) Does the facility have clean latrines or toilets?
- 3) Does the facility have a rubbish pit for disposal of refuse and medical waste? Does the unit have a placenta pit?
- 4) Does the facility have a functional examination couch? For a facility carrying out deliveries, is there a functional delivery couch? For the in-patient wards, are there beds with mattresses in good shape?
- 5) Does the facility have basic examination equipment?
- 6) Are men's and women's in-patient wards separated?

### *Management Systems*

- 1) Do client registers exist and are they well kept and up to date?
- 2) Were monthly summary report forms completed approximately over the last 3 months?
- 3) Are there updated stock cards at the facility store (register books) for at least five randomly selected products?
- 4) Were the following drugs/ contraceptives available during the past 3 months at the facility: chloroquine, Fansidar, etc?
- 5) Does the Health Unit Management Committee meet once every quarter?
- 6) Does the facility have the guidelines and standards required for management of clients/ patients?

### *Infection Prevention*

- 1) Does the facility provide adequate infection prevention/ control in the area of handwashing?
- 2) Does the facility provide adequate infection prevention/ control in the area of disposal of sharps and needles?
- 3) Are the injection, dressing and examination rooms clean service environments?
- 4) Does the health unit have facilities for disinfection?
- 5) Is the staff following correct aseptic techniques?

### *IEC/IPC*

- 1) Are health education talks given to clients?
- 2) Do providers use appropriate teaching aides during client counseling/ education?
- 3) Are service providers encouraging clients to actively discuss any problem or concern about their health and treatment during the visit?

### *Clinical Services*

- 1) Does the staff maintain a proper cold chain?
- 2) Are immunization services provided on a daily basis in this facility to as to reduce "missed opportunities"?
- 3) Do all children who visit the facility have their weight plotted correctly on the health card?
- 4) Are providers giving technically appropriate services?
- 5) Are providers giving technically appropriate inpatient care?

### *Client Services*

- 1) Is the facility's waiting area clean and protected?
- 2) Does the facility have a private area for physical examinations and/or deliveries?
- 3) Are patients and their attendants received in friendly and respectful manner?
- 4) Do providers see clients on first-come, first-serve basis?
- 5) Do clients wait one hour or less after arrival at the health facility before being seen by a provider?
- 6) Does provider/ dispenser provide appropriate information to client regarding treatment compliance?
- 7) Does the facility have a plan for emergency cases?
- 8) Does the facility have at least one staff member trained in the following areas in the OPD and MCH departments: IMCI, FP, STD management, ANC/PNC, and Malaria management?
- 9) Does the facility post a list of available services where clients can see them?
- 10) Is there a health provider available at all times?



## Appendix B: Structure and Current Status of the Health Care System

**HCI-** At the village level, the HCI is supposed to provide services for 1000 people. It provides community based preventative and promotive health services and is monitored by the village health committee or a group of a similar status.

**HCII-** At the parish level, the HCII is supposed to provide services for 5,000 people. It provides preventive, promotive, outpatient curative, maternity and in-patient health services and lab services, in addition to the services provided at an HCI.

**HCIII-** At the sub-county level, the HCIII is supposed to provide services for 20,000 people. In addition to services required at lower level health centers, it provides preventive, promotive, outpatient, curative, maternity, and in-patient health services and lab services.

**HCIV-** At the county level, the HCIV is supposed to provide services for 50,000 people. In addition to services provided at lower level health centers, it provides preventive, promotive, outpatient curative, maternity, in-patient health services, emergency surgery, blood transfusions, and lab services.

**HCV-** The HCV is a general hospital and serves 500,000 people. In addition to HCIV services, other general services will be provided. It will also provide in-service training, consultation and research to community based health care programs

**HCVI-** The HCVI is a regional referral hospital serving 2,000,000 people. In addition to general hospital services, special services such as psychiatry, ENT (Ear, Nose, Throat), Ophthalmology, dentistry, intensive care, radiology, pathology, and higher-level surgical and medical services.

**HCVII-** The HCVII is a National Referral Hospital and provides comprehensive specialist services as well as teaching and research.<sup>145</sup>

### Health Resource Indicators

Health Resources Indicators	Data	Year	Source <sup>1</sup>
Number of physicians per 10,000 population	1: 20,000 population	2002	<a href="http://www.UBOS.org">www.UBOS.org</a>
Number of midwives per 10,000 population	1: 15,000 population	2002	<a href="http://www.UBOS.org">www.UBOS.org</a>
Number of pharmacists per 10,000 population	1: 1 0 0 0 , 0 0 0 population	2002	MOH
Number of dentists per 10,000 population		2002	
Number of nurses per 10,000 population	1: 8000 population	2002	<a href="http://www.UBOS.org">www.UBOS.org</a>
Number of Hospital Beds per 10,000 Population		2002	
Total national health expenditure as percentage of GDP	2.4	2003	<a href="http://hdr.undp.org/2003">http://hdr.undp.org/2003</a>
Total government health expenditure as a percentage of total health expenditure	18%	2004	National Health Accounts
Total government health expenditure as a percentage of total government expenditure	9.6%	2004	National Health Accounts

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<sup>145</sup> Ministry of Health, Health Sector Strategic Plan I, 2000/01-2004/05, (Kampala, Uganda: 2005).

## Selected Health Sector Performance (output and outcome) indicators

Indicator	National average	Rural areas average	North Region	West Nile Region	IDPs	Karamoja
Infant mortality rate, per 1,000 births	76	88	106	98	123	105
Under 5 mortality rate, per 1,000 births	137	153	177	185	200	174
Total fertility rate	6.7	7.1	7.5	7.2	8.6	7.2
Women using modern contraceptive methods (%)	18	15	8	11	18	0
TT2 coverage in pregnancy (%)	51	50	55	51	63	53
Births with skilled birth attendant (%)	42	37	31	35	34	18
DPT3 coverage in children 12-23 months (%)	64	64	67	61	84	66
Under 5 stunted children (%)	38	40	40	38	37	54
Under 5 wasted children (%)	6	6	7	8	6	11

(Source: UDHS 2006)

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<sup>146</sup> Uganda Bureau of Statistics (UBOS) and Macro International Inc. 2007. Uganda Demographic and Health Survey 2006. Calverton, Maryland, USA: UBOS and Macro International Inc.

<sup>147</sup> Ibid.

## Appendix C: Interview Questions

*Researcher Note: Not all questions were used in each interview.*

- I. To analyze the efficacy of quality assurance policies and programs within the Ugandan healthcare systems so as to determine the protection of Ugandans right to good quality healthcare
  - a. What is your role within the health sector?
  - b. What are your opinions on the quality of health care being provided today in Uganda? How has the situation improved over time?
  - c. In light of the current state of the Ugandan healthcare system, do you view quality of healthcare as a priority? Or should funding be diverted for other basic programs, such as the Uganda National Minimum Health Care Package or epidemic prevention?
  - d. What policies or programs, if any, are in place to improve the quality of the Ugandan healthcare system? More specifically, is anything being done to address the issue of a lack of human resources for health?
- II. To examine the issue of health as a human right and its relation to the quality assurance programs within the health care system
  - a. How is a rights based approach to health integrated within the quality assurance systems of the health care sector? Is it integrated?
  - b. In your opinion, what could be done to integrate it more within the system?
  - c. Do you think the rights based approach to development is an effective policy towards improving the health of Ugandans?
  - d. Do you think that policymakers and other stakeholders in the health sector believe in the rights based approach to health?
- III. To assess the policies and procedures used to ensure quality within the Ugandan health care system.
  - a. What policies and procedures are used to protect patients against medical negligence?
  - b. Are these policies and procedures effective?
  - c. What is preventing them from being effective?
  - d. Who is supposed to ensure that the patients rights are being protected? IE, which organizations/ government bodies?
  - e. What is preventing these organizations from ensuring these rights?
  - f. On a policy level, how are health workers being cared for? Who ensures that they are performing adequately? Is there an evaluation system in place?
    - i. Who regulates the quality of their medical employees?
  - g. At what stage can a doctor be considered negligent?
    - i. Can doctors in private clinics be held responsible for malpractice?
  - h. Who regulates private clinics?
    - i. Under what conditions can their licenses be suspended?
    - ii. Is this enforced?
- IV. To identify the challenges of quality assurance program implementation within the Ugandan health care system
  - a. What are the main programs being used to ensure quality within the health sector?
  - b. What organizations (CSOs, NGOs, etc) are working to ensure the right to healthcare?
  - c. Do you think these programs are effective? For example, the Yellow Star Program, which the Ministry of Health claims as one of their major healthcare programs, and yet, was only implemented in a few districts and clearly is not being used to its full capacity today?
  - d. How would you change the current programs to better ensure for quality of healthcare?
  - e. What do you think are the main issues preventing the health sector from ensuring quality healthcare?
  - f. What aspects of quality health care are incorporated within the medical school curriculum?
    - i. How is ethics taught?
    - ii. What specifically about ethics and quality of care is being taught?

- iii. Do you feel that the current curriculum adequately covers the issue of provision of quality health care?
    - iv. Does the COBES (problem based learning) approach add to or detract from learning about issues of quality? In your opinion, is it an effective learning tool for medical students?
    - v. Why was the switch to the COBES curriculum made? Who decided to make the switch? What perceived benefits did the switch to the COBES curriculum have?
  - g. Is there any regulation of the process of becoming a doctor in Uganda?
  - h. Do doctors ever have to get their licenses renewed?
- V. To examine community perceptions of their right to quality health care
  - a. Do patients understand the difference between quality and poor healthcare?
  - b. If they understand the difference, do they know their right to quality health care?
  - c. If they do not understand the difference, what programs and policies are sensitizing them to their rights and to the quality of healthcare?
  - d. If a patient determines they are receiving poor quality healthcare, do they intervene and demand better quality healthcare?
  - e. Are there documented cases of this happening?
  - f. What legal frameworks are in place for patients to report poor quality healthcare?
  - g. Are these frameworks being utilized? Are patients aware of these frameworks?
  - h. Do families accompany patients when they receive healthcare?
  - i. Do they feel that they are also stakeholder's within their family member's medical cases?
  - j. Do they intervene in cases if they feel treatment is not adequate? Are doctors receptive to these interventions?
  - k. Are there any documented cases of this happening?
- VI. To determine private sector involvement in assuring quality health care.
  - a. What organizations or governing bodies are in place to ensure quality of care in private medical clinics and centers?
  - b. Is there any collaboration with public sector medical organizations?
  - c. How do issues of quality healthcare in the public sector affect the private sector?
  - d. In your opinion, is the private sector doing a better job of delivering quality health services?
  - e. How much regulation, in actuality, of private clinics is taking place?
  - f. Is there any move to discourage doctors from working in the public sector and owning a private clinic?
  - g. What policies or programs, if any, are in place to combat the issue of a lack of human resources for healthcare?
  - h. What is the international health community's opinion of the quality of healthcare services being provided in Uganda? Is the quality of care seen as improving? Is it even an issue?
  - i. Are quality assurance programs for healthcare in Uganda seen as effective?
  - j. What international programs, if any, are being implemented within Uganda to ensure the quality of healthcare? What programs are currently being funded to ensure the quality of healthcare?
  - k. How do international donors work with the Ministry of Health on the issue of quality of healthcare?
  - l. How is the issue of health as a human right being incorporated into issues of healthcare quality?
  - m. Is the Ministry of Health's program on providing the Uganda National Minimum Health Care Package viewed as effective among international donors? What of the argument that limiting healthcare delivery to a minimum is a violation of people's rights to healthcare? What of the fact that the Ministry of Health cannot even totally finance the Uganda National Minimum Health Care Package?
  - n. Have any studies been done on the quality of healthcare in Uganda?
  - o. What civil society organizations are involved with ensuring quality of care?

**Appendix D: Informed Consent Form**

**Health as a Human Right:  
The Efficacy of Quality Assurance for Quality Healthcare in Uganda  
Informed Consent Form**

**Research Abstract:**

According to the Ministry of Health, 72% of the population of Uganda in 2005 lived within 5 kilometers of a health care facility. However, simply living near to a health care facility does not ensure that the patient will receive good quality care from a qualified professional. The right to health is a basic right, and the Ugandan government has committed to ensuring that there is not only access to health care, but also access to good quality healthcare. The Ministry of Health along with the Government of Uganda has created several policies, programs, and departments to deal with the issue of Quality Assurance. However, there is a disconnect between the policies and the reality of the situation of health within communities. Therefore, this research project will analyze the issue of quality assurance from three angles: Ministry of Health programming and provisions (which includes the standards to be met in Medical School), patient and community conceptions of health care, and finally, the private sector's response to the issue of quality assurance as it relates to health as a human right.

I \_\_\_\_\_ have willingly given my consent to participate in the following interview and/or focus group. I understand that my name will not be used in association with the information that I share during the interview process, and my identity will be protected. I hereby state my understanding of and willingness to have the information shared used anonymously in a formal report at the end of the research period.

I understand that the information gathered is for research purposes only and will not be shared with third parties. Finally, I certify that the research process and purpose has been explained to me in detail. I understand that I can opt out of the interview process at any time should I feel uncomfortable or unwilling to proceed.

I have been given information regarding the study and I understand that if I have further questions I can contact Ally Pregulman through the School for International Training at 077 914 9481. I understand that a copy of the final report will be accessible to the public at the School for International Training Resource Center and that I am free to read the final report, if I so choose.

**Signature of Interviewee** \_\_\_\_\_

**Signature of Interviewer** \_\_\_\_\_

**Date** \_\_\_\_\_

**Location** \_\_\_\_\_

**Time** \_\_\_\_\_

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