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"HEALTH FOR ALL" IN UGANDA:
Realistic Achievement through Strong Partnerships and Genuine Collaboration with the Faith-Based Health Sector.

In 1977, the World Health Assembly (WHA) proposed a primary social target for all governments, international organisations and the global community: "To enable all of the world's citizens to enjoy, by 2000, a level of health that would allow them to lead a socially active and economically productive life".
This social target of "Health for All" emphasised the attainment of the highest possible level of health by societies, as a basic human right, and observing ethical principles in health policy making, health research and service provision.

The then World Health Organisation Director General (1973-1983) Halfdan Mahler, defined Health For All as "health, to be brought within reach of everyone in a given country. And in this case "health" meant a personal state of well-being, not just the availability of health services – so Health For All was defined as **a state of health that enables a person to lead a socially and economically productive life**.
This holistic concept implied the removal of the obstacles to health – that is to say, literacy for all, the elimination of malnutrition, ignorance, contaminated drinking water and unhygienic housing – quite as much as it does the solution of purely medical problems such as a lack of healthcare workers, hospital beds, medicines and health commodities and vaccines and it also meant that health was to be regarded as an objective of economic development and not merely as one of the means of attaining it.
Health For All was a symbolic determination of countries to provide an acceptable level of healthful living to all people.

The Health For All concept was concretised in 1978 with the Alma Ata declaration which focused on primary health care as a means to achieving health for all, with a focus on community participation; consideration of community needs and priorities, their values and their vision for a truly functional care system—seen as the guiding principles.
In Uganda the concept was adopted in 1999 by enacting relevant national health policies and strategies, and subsequently, community empowerment for the development of health structures and systems that promised the delivery of community health. The 2001 Uganda Village Health Teams (VHTs) Strategy was a foundational landmark for community health systems, aimed at harmonizing the effective delivery of health programs at the village level. Village Health Teams are Community Health Workers (CHWs), defined by the WHO as "members of the community who are selected by, and accountable to the communities where they work; are supported by the health system; and receive less training than formally trained health workers."

In the years that followed, the concept lost the appeal, fizzled out and lost the push which had been generated in the 70's—and went silent until recently—in the mid-2000s, with the renewed talk of Health For All but now with a broadened concept of Universal Health Coverage (UHC).

In Uganda, Universal Health Coverage (UHC)—i.e. "*all persons in Uganda having equitable access to comprehensive quality health and related services* ***without*** *financial constraints – all delivered through a multi-sectoral approach*", is the new aspiration for Health For All agenda—with achievement commitments by 2030. This implies protection of individuals from financial risk, facilitating access to quality health services, and availability of quality and affordable essential medicines and vaccines for all.

The theme for the year 2023's World Health Day commemorated on the 7th April—is "*HEALTH FOR ALL*"

To achieve the 2030 'Health For All' aspirations in Uganda—while protecting the population and communities from financial catastrophe due to ill-health, **strategic and transformative partnerships with all stakeholders in the health care space are imperative and necessary**. These collaborative endeavours help to coordinate technical expertise and leverage contributions from the private sector who onboard with specialized skill sets and capacities and contributions from the public sector (financial or in-kind) will help to achieve 'Health For All' by 2030. Enhancing partnerships among stakeholders will support enhanced affordable utilisation of health services and leverage the leadership of Faith Based Organisations (FBOs), communities as well as innovative financing opportunities.

Partnerships can also be used to bridge the gap between innovation and scale.

Figure 1: Patients waiting at Out Patients Department

Faith-based health services—e.g. the 298 multi-tiered Catholic Health Facility Network in Uganda— some of which exist in the remotest parts of the country and serve the poorest members of the society, coordinated by the Uganda Catholic Medical Bureau (UCMB), and have existed for over 100 years, have complemented and, in some instances, (i.e. *in some geographies and at certain historical time periods*) provided full range comprehensive quality health services—thereby participating in, and contributing to the Health For All agenda as worthy partners to Governments over the years.

According to the Ministry of Health Annual Report FY 2021/2022, Of the 44.43 million Total Out-Patient Attendances registered in the country, the UCMB network contributed **6.4%** of the OPD attendances—The UCMB network registered a 11.24% increase in the total OPD attendances from the previous financial year, the network accounted for **13.8%** of Total national Admissions—which was a **7.2%** increase from FY 2020/21 and the network accounted for 8.86% of Total national Deliveries—a 7.37% increase from FY 2020/21.

The UCMB health facilities counselled, tested and gave HIV results to a total number of 437,846 individuals, 2.4% of whom tested positive for HIV and 93.4% were linked to HIV care. UCMB-accredited health facilities contributed **7.7%** of total people tested for HIV in the country.

In the FY 2021/22, the UCMB network of health facilities maintained a total of 128,498 patients on Anti-Retroviral Therapy (ART), 32.2% of them being men—translating into **9.53%** of the total country ART caseload. This is an increment from 126,073 in FY 2020/21 for clients maintained on ART.

In some local government districts—e.g. Zombo, Agago, Ibanda, Kalungu, Mpigi, Napak, Oyam Mayuge districts and Maracha district (*In FY 2021/22, 39% of the maternity admissions were referrals from LLUs in the district*)—these UCMB hospitals are the only referral health facilities—providing significant critical health service output contributions, while some UCMB health centre IVs & IIIs are referral centres in other areas due to their location, quality of care services and accessibility.

These health output contributions are partly due to efforts of the Ministry of Health (MoH) financial subsidy (i.e. The Primary Healthcare Grant (PHC)-Non-Wage Recurrent for PNFPs) to 90% of the UCMB network health facilities despite accounting for 7.5 - 10% of the total financial revenue.

The MoH financial subsidy greatly supports, and contributes to the availability and affordability of Essential Medicines and Heath Supplies (EMHS)—ensuring a dispensing rate of 98 – 100%--a quality measure of clinical care, as well as supporting institutional quality of care processes in the health facility. It is envisaged that additional financial and non-financial support—e.g. medical equipment and human resources for health (HRH), to the network would facilitate greater and predictable outputs—especially for certain critical clinical services not normally provided by the public health sector facilities.
A significant majority (60 – 75%) of the financing of health services in UCMB network health facilities is derived from patient fees—mainly at the point of service, and these patient fees have increased by 15% in the last 3 financial years in the UCMB network.
Patient Fees at the point of service are a major impediment of access to quality care, and diminish the social aspirations of provision of holistic, affordable and quality health care by catholic health facilities, as well as impairing the expression for social justice by the health facilities for all those who suffer inequity in health care services, and so, it is noteworthy that this unfortunate instance occurs within the ecosystem of limited alternative financing mechanisms for these health facilities. With sufficient financing support, efforts to subsidise and assure accessibility for even the most vulnerable would be assured—in order to remain consistent, the Gospel aspirations of health care for the poor.

Stronger partnerships by Government of Uganda and Development Partners as well as genuine collaborations with Non-State Health Actors—and particularly with Faith-based health service providers and their respective networks, will enhance and facilitate movement towards the achievement of the Health For All goals and Universal Health Coverage in Uganda.

The achievement of the Health For All goal, calls for dramatic changes, and a social revolution in health development.
It should aim at bringing about a change in the mentality of people, restructuring of health system—including a reliable and sustainable financing mechanism, and reorientation and training of health workers/professionals.

HEALTH FOR ALL in Uganda should be proactively supported by the reduction of existing imbalance in health services—this requires a concentration of more on the rural health infrastructure support—including faith-based health facilities—and this is realistically possible through partnerships that work and genuine collaboration, the provision of legislative support to health protection and promotion, research into alternative methods of health care delivery and low-cost health technologies, and greater coordination of different systems of medicine.

The return of investment in health is long term but requires proactively strong and broad partnerships and effective coordination with all actors to leverage on multiple complementarities.
For Every $1 that Uganda invests in health today, it can produce up to $20 in full-income growth within a generation. When health care is accessible and affordable, families can send their children to school, start a business and save for emergencies.
In times of distress, health minimizes the shock to lives and livelihoods.
In times of calm, health promotes community cohesion and economic productivity.

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