

# The impact of the World Bank funded Uganda Health systems strengthening project on persons with disabilities:

*A case study of Itojo and Kiryadongo Hospitals*



*Kiryadongo hospital was renovated using World Bank support under strengthening health systems project*

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## **Acronyms**

NUDIPU	- National Union of Disabled Persons of Uganda
WBG	-World Bank Group
PWDs	-Persons with Disabilities
WHO	-World Health Organisation
HIV/AIDS	- Human Immunodeficiency Virus/ Acquired immune deficiency syndrome or acquired immunodeficiency
UNHS	-Uganda National Household Survey
CSOs	-Civil Society Organisations
CRPD	-Convention on the Rights of Persons with Disabilities
BIC	-Bank information Centre
UHSSP	-Uganda Health Systems Strengthening Project
UNMHCP	-Uganda National minimum Health Care Package
MOH	-Ministry of Health
PDO	-Project Development Objective
KIIs	-Key Informative Interviews
FGDs	-Focus Group Discussions
TB	-Tuberculosis
WWDs	-Women with Disabilities
HMIS	-Health Management information System
EA	-Environmental Assessment
HRH	- Human Resources for Health

## **1.0 Executive summary**

NUDIPU is working to influence the World Bank Group (WBG) to ensure that safeguard policies are inclusive of disability issues. This is a deliberate move that would guarantee inclusion in all relevant projects and interventions funded by the World Bank.

To this end, NUDIPU conducts surveys and media advocacy aimed at raising visibility of disability issues in World Bank projects. NUDIPU thus undertook a study to assess the impact of the World Bank funded Uganda Health systems strengthening project on persons with disabilities: A case study of Itojo and Kiryadongo Hospitals.

The data was analysed with regard to project awareness, implementation and effect on the lives of PWDs. The study was concerned with PWDs participation in project design, implementation and monitoring and actual number of beneficiaries.

The findings generally indicate that PWDs are benefiting or will benefit from the Project though PWDs are not direct targets explaining why the monitoring tools do not capture disability as one of the key indicators.

Findings indicated that the project has good aspirations especially in providing Ugandans with a minimum health package. Although there was not specific planning during the project design, the project has been able to adopt and integrate the concerns of PWDs. It can only improve once issues such as data, lack of interpreters, and actual level of benefit are addressed.

The findings, therefore provide insight to the safeguard review process so that the World Bank becomes more sensitive to disability issues, specifically ensuring that disability becomes one of the key indicators in the project design, implementation and monitoring.

## **1.1 Background:**

The WHO/World Bank World Report on Disability 2011 estimates that 15% of the population or over one billion people live with some form of disability worldwide. Among them, between 110 and 190 million “have very significant difficulties in functioning - the equivalent of disability inferred for conditions such as quadriplegia, severe depression, or blindness”. The WHO estimate is up from previously 10%. Women are more likely to acquire disability in their life course than men for reasons such as “poorer working conditions, poorer access to quality health care, gender-based violence and child birth.

In the years to come it is estimated that disability will be of even greater concern due to a rise in the prevalence rate as a result of a number of risks. Infectious diseases like tuberculosis, HIV/AIDS and other sexual transmitted diseases are contributing factors. Increase in chronic health conditions such as diabetes and mental health conditions are other crucial developments. Finally, armed conflict, natural disasters and other forms of humanitarian crisis often generate injuries and trauma classifiable as disabilities. Across the world, PWDs have poor health outcomes, lower education achievements, less economic participation and higher rates of poverty than persons without disabilities – amplified by the barriers experienced by PWDs in developing countries in accessing services.

Although the Universal Declaration of Human Rights provides in article 1 that: “[a]ll human beings are born free and equal in dignity and rights, persons with disabilities continue to face various forms of discrimination in the enjoyment of human rights especially health rights.

**1:2 Disability in Uganda:** In Uganda disability is defined as a “permanent and substantial functional limitation of daily life activities caused by physical, mental or sensory impairment and environmental barriers resulting in limited participations.” The Uganda National Household Survey 2009/2010 from Uganda Bureau of Statistics estimate the population of PWDs to stand at 16% of the Ugandan population aged 5 years and above. Moreover it is estimated that up to 90% of these reside in rural areas, which increases their vulnerability especially in the event of poor service delivery.

An analysis of the various disability rates of the UBOS census and studies with the international statistics of the WHO and the World Bank, estimates that about 15% of the Ugandan population are PwDs implying about five million people live with some form of disabilities in Uganda. This comprises all types of impairments. The disability prevalence varies across the country: the Northern region has the highest rate while the Eastern and Central regions have the lowest rates. There are also larger numbers of people with physical and sensory impairments at 70% of the population of PwDs according to UNHS 2005/06).

## **1:3 World Bank safeguards on Disability**

The process of reviewing the World Bank safeguards is ongoing. It is a participatory process involving consulting a number of stakeholders including CSOs. For the past 30 years, safeguards have served as an important “foot in the door” for CSOs into international development institutions. While not perfect by any measure, safeguards

help raise community voices in international decision-making, prevent harm from happening, and seek justice from international institutions when harm occurs.

The World Bank's Environmental and Social Safeguard Policies are designed to prevent harm and lessen social and environmental risks associated with World Bank investments. However, as they stand now, the rights of persons with disabilities have not been addressed in these policies. Persons with disabilities, often some of the poorest and most vulnerable people in countries where the World Bank has its projects, are not systematically consulted or considered in the planning and design of projects. The lack of a development policy that addresses the specific needs and vulnerabilities of persons with disabilities can result in harm.

The World Bank must mandate systematic inclusion of disability into World Bank operations, ensuring that all relevant Bank-funded projects are inclusive in design and implementation, and ensuring strong, clear policy language modelled after the United Nations Convention on the Rights of Persons with Disabilities (CRPD) on disability in the safeguards. This is especially important so that no harm is done to persons with disabilities, their families, and communities of support and that the Bank funds projects that are inclusive and that develop supports and services for persons with disabilities and their families.

This however, can only be possible upon inclusion of language on disability rights throughout the revised safeguard policies. Once the safeguards become inclusive, persons with disabilities and disability organizations will have a recourse mechanism available to hold the World Bank accountable to the inclusion of persons with disabilities, their families, and communities of support in Bank projects. When communities believe that World Bank-financed projects have not complied with the safeguards, they can bring their concerns directly to the institution (BIC, 2015).

Since 1993, communities have been able to bring complaints directly to the World Bank's Inspection Panel that investigates whether or not the Bank is following its own policies and procedures. This opens up additional avenues for dispute resolution, particularly when governments are not responsive to communities' concerns. The integration of disability language throughout all relevant safeguard policies will ensure that the Inspection Panel, which previously was not open to complaints on disability because there is no language on disability in the current safeguards, is open to persons with disabilities who have been harmed or not shared in the benefits created by World Bank projects (BIC, 2015).

Assessing the UHSSP is thus of great importance since it provides opportunities to understand how the rights and needs of PWDs have been adhered to. Full participation of the PWDs in the World Bank interventions therefore requires total involvement of PWDs and their families in the project design, implementation and monitoring.

Given that the current safeguards do not provide for PWDs, National Union of Disabled Persons of Uganda (NUDIPU) in partnership with Bank information centres (BIC) are committed to working to ensure the World Bank Safeguards become disability sensitive. Assessing the level of harm or benefit of PWDs with regard to UHSSP is accordingly very vital towards making the World Bank programmes disability sensitive.

### **1:4 Disability and health**

There is global consensus, among both developing and developed nations, that strong health systems are essential to the effective delivery of health services and improved health outcomes. As such government of Uganda with support from World Bank is implementing Uganda Health Systems Strengthening Project (UHSSP) in a bid to build a strong health sector to ensure equal access to health services by all. In spite of the above, the current trends appear to indicate that PWDs are not benefiting. This contradicts the 1995 Constitution providing for enjoyment of the right to health by all under the national objectives. The same law under Article 21, prohibits discrimination against people with disabilities. The Persons with Disabilities Act, 2006, makes provisions for the elimination of all forms of discriminations against people with disabilities and towards equal opportunities. Based on the above, it is imperative to examine how UHSSP is benefiting or harming PWDs, the outcome for which will inform the World Bank Safeguard review process.

### **1:5 Uganda Health Systems Strengthening Project (UHSSP)**

The World Bank provided the government of Uganda with financial support under the Uganda Health Systems Strengthening Project (UHSSP) amounting to US\$150m. The project commenced in May 25, 2010 and is expected to conclude by June 30, 2017.

UHSSP supports renovation of hospitals, improved management of health workers, and strengthened leadership in the sector. It also provides reproductive healthcare, including family planning services (World Bank2010). UHSSP funds the renovation of selected health facilities to ensure basic functionality of the facilities and scaling up services for maternal care among others.

The development objective is to deliver the Uganda National Minimum Health Care Package (UNMHCP) to Ugandans, with a focus on maternal health, new born care, and family planning through improving human resources for health, physical health infrastructure, and management, leadership and accountability for health service delivery.

The project's cost breakdown is as follows; Improved health workforce :( Cost \$5.00 M), improved health infrastructure of existing facilities :( Cost \$85.00 M), Improved management and leadership: (Cost \$10.00 M), and Improved maternal, new-born and family planning services :( Cost \$30.00 M).

### **1:6 UHSSP implementation status**

The Government of the Republic of Uganda received financing of SDR 85.7 million equivalent to US\$130 million from the International Development Association (IDA) of the World Bank towards the cost of the Uganda Health Systems Strengthening Project (UHSSP). The Project Development Objective is to deliver the Uganda Minimum Health Care Package to Ugandans, with a focus on maternal health and family planning<sup>1</sup>.

The credit agreement for this project was signed in August 2010 and the project was declared effective on 11 February 2011 following which implementation started. The

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<sup>1</sup> <http://health.go.ug/projects/uganda-health-system-strengthening-project-uhssp-0>

Project was to initially end on 15 July 2015 but was given a no cost extension and will now close on 30 June 2017 (MOH 2013). The project has four specific objectives as outlined below: i) To improve infrastructure of existing health facilities; ii) To improve development and management of the health work force; iii) To strengthen management, leadership and accountability for health service delivery; and iv) To improve access to and quality of maternal health, new born care and family planning services.

### **1:7 Progress of Project Implementation**

Under Health Infrastructure one of the main outputs of UHSSP was to renovate 2 Regional Referral Hospitals, 17 General Hospitals and 27 HCIVs. The General Hospitals included: Anaka, Nebbi, Moyo, Kiryandongo, Masindi, Apac, Mityana, Nakaseke, Iganga, Bugiri, Entebbe, Itojo, Bukwo, Buwenge, Kawolo, Pallisa and Kitgum, (MOH 2013).

The Regional Referral Hospitals included: Mubende and Moroto. The HCIVs were as follows: Kasanda, Kiganda, Ngoma, Mwera, Kyantungo, Kikamulo, Kabuyanda, Mwizi, Kitwe, Rubare, Aboke, Aduku, Bwijanga, Bullisa, Padibe, Atyak, Obongi, Pakwach, Buvuma, Budondo, Ntenjeru-Kojja, Buyinja, Nankoma, Bugono, Kiyunga, Kibuku and Budaka.

Due to budget constraints, the available funds were committed to renovating the first set of 9 Hospitals and 26 HCIVs. It is the intention of Government to mobilise additional resources to renovate the remaining Hospitals. Under the first phase, the following hospitals were considered: Anaka, Nebbi, Moyo, Kiryandongo, Nakaseke, Iganga, Entebbe, Moroto and Mityana (MOH 2013).

According to the implementation status report, the project is making good progress toward achievement of the Project Development Objectives (PDO), including; Improved health workforce: (Cost \$5.00 M), Improved health infrastructure of existing facilities. :( Cost \$85.00 M), improved management and leadership: (Cost \$10.00 M), Improved maternal, newborn and family planning services: (Cost \$30.00 M).

The report further indicates an increase of People with access to a basic package of health, nutrition, or reproductive health services from 274900.00 to 170900.00. Deliveries taking place in Government and PNFP Health Facilities have increased from 34.00 to 41.00. Health facilities constructed, renovated, and/or equipped stand at 230.00 %. Approved positions filled by qualified health workers stands at 69.00 from 63.00.

The report notes that renovation of the hospitals is on-going in nine hospitals (Anaka, Nebbi, Moyo, Kiryandongo, Nakaseke, Iganga, Entebbe, Moroto and Mityana) and the medical equipment procured by the project was distributed to a total of 230 health facilities. The Government Handed over the 26 Health Centre IV to the contractors to commence renovation. The number of pregnant mothers accessing antenatal is at 32% not far from the target of 65%. There is timely procurement of drugs by National Medical stores, World Bank, 2015.

The implementation of the scholarship program and training of hospital managers is going on, and the training and mentorship of front-line health workers in provision of

emergency obstetric care and long term permanent methods of family planning as well as the roll-out of maternal and peri-natal death reviews have picked up pace. The reviews document number of mother who die while giving birth including pregnancy losses of at least seven months' gestation and deaths to live births within the first seven days of life. At least 75% of the target manpower has been trained and 69 percent of vacant positions have been filled, World Bank (2015).

The development of client charters for Regional Referral Hospitals and guidance notes for the development of client charters for General Hospitals and lower level health facilities have been completed and disseminated to the facilities.

The report indicates that the Government was expected to request a restructuring and extension of the project to allow time for completion of the civil works for the hospitals and start renovation of the 26 Health Centre IV.

The project restructuring involves: (a) revision of the project development objective (PDO) for improved clarity; (b) revising the results framework; (c) introducing output based aid financing under the improvement of maternal, neonatal, and family planning services component; and (d) extending the project closing date from July 31, 2015 to June 30, 2017.

This would mean getting additional credit to cover the funding shortfall for the renovation of the health facilities selected under the original project. It is hoped, with the adoption of output based aid, UHSSP will ensure basic functionality of the facilities and scale up services for maternal care.

It is further hoped that the project will promote results-based and demand-side financing in the sector, and contribute to improved utilization of safe delivery services in rural and underserved areas.

## **2:0 Problem analysis**

According to WHO, over a billion people are estimated to live with some form of disability. This corresponds to about 15% of the world's population. Between 110 million (2.2%) and 190 million (3.8%) people 15 years and older have significant difficulties in functioning. Furthermore, the rates of disability are increasing in part due to ageing populations and an increase in chronic health conditions. According to the Uganda National Household Survey of 2009/2010, disability is estimated to be at 16 per cent of Uganda's then 30.7 million population, Oyara, (2014).

Disability is extremely diverse. While some health conditions associated with disability result in poor health and extensive health care needs, others do not. However all people with disabilities have the same general health care needs as everyone else, and therefore need access to mainstream health care services. Article 25 of the UN Convention on the Rights of Persons with Disabilities (CRPD) reinforces the right of persons with disabilities to attain the highest standard of health care, without discrimination.

## **2:1 Unmet needs for health care**

People with disabilities report seeking more health care than people without disabilities and have greater unmet needs. A survey done by WHO<sup>2</sup> of people with serious mental disorders, showed that between 35% and 50% of people in developed countries, and between 76% and 85% in developing countries, received no treatment (WHO 2014).

People with disabilities are particularly vulnerable to deficiencies in health care services. Depending on the group and setting, persons with disabilities may experience greater vulnerability to secondary conditions, co-morbid conditions, age-related conditions, engaging in health risk behaviours and higher rates of premature death. People with disabilities encounter a range of barriers when they attempt to access health care including the following; Prohibitive costs, Limited availability of services, Physical barriers, and inadequate skills and knowledge of health workers.

Whereas access to health by persons with disabilities was guaranteed under the 1995 constitution of the Republic of Uganda, access to health care by PWDs still remains a chance. The World Bank's decision to finance the Uganda Health Systems Strengthening project is rather spot on because it is hoped the output will cater for all Ugandans. Understanding how the project affects the lives of PWDs thus provides opportunities of ensuring access to a minimum health package is achieved as envisaged by the project. Equally, the findings shall provide a benchmark for review of the World Bank safeguard process, especially that the current policies are still far from being disability sensitive.

## **2.2 General objective**

To assess whether Uganda Health Systems strengthening project caters for the health needs of persons with disabilities.

## **2.3 Specific objectives**

- To find out how the Uganda Health Systems strengthening project provides for the health needs of PWDs
- To find out whether the health centre being renovated cater for PWDs
- To find out the challenges the project faces.

## **2.4 Scope of the study**

The scope of the study was limited to the inclusiveness of the Uganda Health Systems strengthening project taking lessons from selected hospitals of Kiryandongo and Itojo. It focused on project implementation strategies as well as review existing policy documents.

## **2.5 Rationale**

With the increasing unmet health services needs for PWDs, the project has fallen short given inadequate planning and allocations of resources to disability issues. The

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<sup>2</sup> <http://www.who.int/mediacentre/factsheets/fs352/en/>

situation is compounded by the negative attitude towards PWDs and inadequate knowledge on disability issues.

### **3.0 Methodology**

**3:1 Design:** This study was conducted using qualitative techniques of data collection. Specially, key informative interviews (KIIs), Focus Group Discussions were used to generate data. In addition, the study also reviewed secondary data relating to the Uganda Health Strengthening Project. The qualitative approach was used in order to maximise the contextual benefits of UHSSP to PWDs in regard to the design of the program, implementation and monitoring. 50 respondents were interviewed. These included PWDs leaders, Hospital managers, Contractors, district authorities, health workers, beneficiaries and Implementers.

### **3:2 Sampling and Data Collection:**

The study used sample frame of Hospitals implementing UHSSP – where two hospitals were intentionally selected as a case study. The study was conducted in the Itojo and Kiryandongo hospitals. These hospitals were chosen as subject of study because they are part of the hospitals being renovated under the UHSSP.

### **3:3 Data collection and Analysis:**

Primary data collection was done using FGDs and Key informant interviews. FGDs were held with the PWDS leaders. Informative Interviews (KII) were held with project implementers who included; hospital administrators, health workers, contractors, and the beneficiaries.

The field transcript data was analysed using project's systems functional conceptual framework. These were then summarised into themes. During the analysis, the researcher identified relevant systems structures, capabilities and functioning, coordination and feedback mechanism as well as contextual facilitators and inhibitors to effective benefit of UHSSP.

### **3:4 Ethical Consideration:**

The research team members were fully aware that anything that could compromise adherence to ethical standards equally compromises the validity of the study findings. The researchers sought informed consent from respondents prior to the interviews. The interviews took place in socially approved settings and were conducted in consideration and honour of community values and norms. Respondents were assured of confidentiality of their responses and that information would not be used for anything else other than the purpose for which they are interviewed. In respect of confidentiality, individual identifications have been removed from the findings.

### **3:5 Challenges:**

There were some challenges experienced during the fieldwork. The researchers could not easily find data on how the UHSSP is impacting the lives of PWDs. In all places visited, no concrete data on how PWDs are benefiting from the UHSSP was made available. Not even estimates were made available. The challenges, however, did not have substantial effect on the validity of the findings.

#### **4:0 Findings**

The Health Systems Strengthening Project for Uganda envisages to deliver the Uganda National Minimum Health Care Package (UNMHCP) to Ugandans, with a focus on maternal health, new born care, and family planning. In Uganda, the minimum health package services typically include preventive services such as childhood immunization, health promotion and education as well as treatment and control of common and infectious disease such as malaria, HIV/AIDS and TB.

As such the project sought to offer components such as renovation of hospitals, enhancement of reproductive health services, improvement of management of health workers and strengthening of the health leadership. With funding from the World Bank, nine hospitals were originally selected to benefit from the project. The hospitals were initially constructed in 1960s by the Apollo Milton Obote's government. The study randomly selected the two hospitals to examine the impact of the project on the lives of PWDs.

Given the project seeks to deliver a National Minimum Health Care Package to all Ugandans, the use of MHCP presupposes three main issues: 1) that government has a good estimate of the resources that are going to be available for health service delivery, 2) that the delivery system has the capacity to deliver the package of services, and 3) that the costs of the services to be delivered and their benefits to the population are available<sup>3</sup>.

Section: 7 of the PWDs Act 2006, provides that Persons with disabilities shall enjoy the same rights with other members of the public in all health institutions including general medical care. The findings therefore, are benchmarked on the above provisions, with specific focus on PWDs participation in the project implementation (before and during), accessibility, data, and actual service provision. The findings, further provide insight to the safeguard review process so that the World Bank becomes more sensitive to disability issues, specifically ensuring that disability becomes one of the key indicators in the project design, implementation and monitoring.

#### **4:1 Participation project design, implementation, and monitoring**

From the findings, it is evident that the level of beneficiaries' participation in any development process plays significant role in determining how much one is or will actually benefit from the project. The Key informative interviews and focus group discussions indicate that the level of involvement of all stakeholders including PWDs, in project design was limited only to a selected few district and hospital leaders, but their participation was limited to site selection. Much of the decisions like determining which contractor could deliver on the renovations, on which design to adopt, target beneficiaries, were exclusively done at the ministry of health.

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<sup>3</sup> Uganda's minimum health care package: rationing within the Minimum? <http://www.bioline.org.br/pdf?hp04005>

In Ntungamo district (where Itojo hospital is located), KII indicated that no consultation was conducted. PWDs leaders specially said no consultation was conducted in respect of the planned project although they acknowledged having been briefed about the project during one of the district council sessions. By the time of this study construction work at Itojo hospital had not yet commenced.

*“Prior to the commencement of construction project, it would have been good if the project design is presented to council to give chance to leaders representing PWDs to determine whether our people will benefit or not. As we speak right now, we are in darkness— we have no idea what the project has for us,” a male councillor representing PWDs said during the FGD.*

The absence of consultation is not only affecting the World Bank funded projects, but also other development projects such construction of staff quarters at Itojo hospital that was funded with from European Union.



### **Participants of the FGD held in Ntungamo**

Because no consultation was conducted, KII said the structures are not accessible to PWDs. In Kiryandongo (where construction is almost complete), the situation is a little different. Although consultation did not involve locals, the design work was adjusted to meet the needs of PWDs in terms of accessibility.

The bottom up approach in development was roundly missed out, more so the PWDs and community members. This has implication on the level of benefit or harm on PWDs. It may also bring about shoddy work since target beneficiaries have little attachment to the project which gives chance to the implementers to provide sloppy service. The beneficiaries easily shy away from monitoring the process. One respondent from Itojo hospital, (where construction work has not yet taken place), said that even the procurement process was concluded by the ministry officials.

'Our involvement is limited to minor issues such as provision of the site and other onsite issues,' he said. This is, however, a trend in most procurement processes undertaken by government through the relevant ministries.

The consultations become even more relevant when it comes to inclusion issues of PWDs, since the majority of project implementers have little or no knowledge of disability. For instance, in both Itojo and Kiryandongo hospitals, it was noted that the health management unit committees don't have representatives of PWDs. It is almost certain that the voices of PWDs may not be present in consultations since those sitting on the committees have limited knowledge on disability, as such the project has presented key gaps, such as lack of wheel chairs, absence of sign language interpreters and accessible deliver beds. One important issue that came through FGDs was the conspicuous absence of orthopaedic services that PWDs thought would be included in the project if they had a chance to present their views.

*"We are lacking orthopaedic and physiotherapy to conduct corrective treatment. We move long distance from Kiryandongo to Masindi to access such services," participant said during the FGD in Kiryandongo.*

Although participation may or may not determine or guarantee the level of benefit, it is crucial to PWDs specifically so because they understand issues that affect them more than the project implementers.

In Kiryandongo Hospital where the beneficiaries have been included in the process the results are positive. The site manager of Complant engineers at Kiryandongo hospital, a Chinese construction company renovating the hospital, notes that consulting with the target beneficiaries (PWDs) is very important because it adds value to the work done.

"The exercise here has been very consultative. The design is inclusive now. Whenever we realise the need to make changes, we are often keen to make those changes to meet the needs of the beneficiaries. You see; it is you who know what you want. We may not know what you need," the contractor notes, adding that disability concerns have fully been catered for.

This revelation clarifies concerns from some of the respondents from the hospital who noted the need for the project to accommodate everyone's concerns more for people with disabilities. Practice has it that where PWDs have been consulted the services tend to be inclusive than when the PWDs are not consulted. Kiryandongo hospital is a clear manifestation of what consultative development process can mean. This was possible because the district leaders are keen on issues of disability.

#### 4:2 Accessibility:



L-R Accessible toilets and a ramp for PWDs at Kiryandongo Hospital

The study notes that whereas physical accessibility has been taken care off by the ongoing renovation process at Kiryandongo hospital, access to information still remains a challenge. All the structures have ramps, the toilets have rails, urinals are lower, and the doors are equally accessible. It was noted that this was only possible due to advocacy lobbying efforts by the leaders of PWDs at the district. However, there was no sign of accessible beds for women with disabilities.

This presents a big challenge to access to reproductive health services which is a right. The findings also revealed that patients who are deaf have not been taken care of by the project since it does not provide for sign language interpreters let alone training of the health workers on sign language. As a result deaf women are delivering in the villages.

This is contrary to Sec: 7(3) a, b, c of the PWDs Act, providing for introduction of sign language into the curriculum for medical personnel, inclusion of interpreters in hospital structures and pre-brailing the labels on drugs.

It, therefore, becomes difficult for such people to access services. On the other hand, women with disabilities have challenges delivering at the hospitals because of lack of accessible beds. It was also noted that WWDs are experiencing issues of stigma. This has made many WWDs fear visiting government hospitals.

*"I have four children but I have never delivered any at government health centre because health workers have negative attitude towards us WWDs. if you have no money they can't attend to you. So I would rather go to the private health centre and pay money rather than government hospitals. Once I get pregnant it start saving for my hospital bills," Kate Musiime, said during the FGD in Ntungamo.*

*"One of my friends was pregnant and when she went to deliver, instead of being helped she was insulted. Look at her crippled. You don't have money, you have no husband, why do you get pregnant. As a politician I went to their boss and complaint that is when my friend was assisted," said a PWD female councillor during FGD in Ntungamo.*

In many instances, these barriers to service delivery contravenes the project objective of enhancing reproductive health/family planning services. This scenario is not isolated. All the hospitals visited indicate that women with disabilities have not been provided for with regard to accessible beds. As such pregnant mothers with disabilities have to struggle to access beds used by non-disabled pregnant mothers. Some have resorted not to go hospital.

*“Kiryandongo Hospital has no accessible beds. When you go to give birth the health workers insult you, as they drag you to the inaccessible bed. You disabled and you get pregnant? That can't happen,” a woman with disability said during the FGDs in Kiryandongo.*

#### **4:3 Data/service delivery**



#### **Expectant mothers waiting for antenatal services at Itojo hospital**

Although most Ugandans now live within five kilometres of a health centre, significant challenges remain to improve the quality of service delivery and address continuing health status issues such as high infant and maternal mortality. Primary health care remains difficult for some to access, and quality of care is inconsistent. The referral system is not functional, and patients often ignore secondary or tertiary care due to the high costs involved. Stock outs of drugs and supplies and inadequate HRH availability impact service delivery. Lack of financial and human resources adversely

impacts regulation and quality control. Many services, including those related to HIV and tuberculosis (TB), are not well integrated into the general health delivery system and continue to be provided vertically. Evidence-based medicine is not consistently followed and facility based quality improvement initiatives, while they exist, have not been institutionalized uniformly. The system also does not invest sufficiently in prevention and public health services to minimize unhealthy behaviours that lead to increases in both non-communicable and infectious diseases<sup>4</sup>.

Whereas this case study indicates significant level of benefit for PWDs, health service delivery hiccups, as indicated in the World Bank implementation report, it notes further that the implementation report is not explicit on how PWDs are benefiting. This could be drawn from the fact that the project design does not specifically target PWDs. Additionally, the implementers have limited knowledge with regard to disability issues. For instance, the report indicates that the direct project beneficiaries currently stand at 137400.00 without indicating how many of these; are PWDs.

The implementation status report only reports in general terms without disability indicators. Even the data collection tools at the hospitals have do not include disability as part of the variables for reporting. Although the hospitals visited report that they do receive significant number of PWDs seeking health services, there is no evidence in terms of specific data providing for prove that PWDs are accessing the services.

Records of most hospitals visited indicate general data with indicators such as male and female without necessarily indicating disability. Both health management information system forms (HMIS) 105 (for outpatients) and 108 (for inpatients) capture data in general sense. The HMIS have female, male, 0-5 and, 5 and above as variables for data recorded.

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<sup>4</sup> UGANDA HEALTH SYSTEM ASSESSMENT 2011



#### ***A health worker takes record of the patients at Itojo hospital***

One respondent notes thus, “We have not been recording that ‘thing’.” That thing to mean disability issues. This connotation is reflective of negative attitude to towards issues of disability. The absence of disability indicators means that the needs of PWDs may or may not be fully catered for. This is, therefore, a missed opportunity which affects the impact of UHSSP on the lives of PWDs.

The study further notes that whereas UHSSP support the development of health workers capacities to deliver quality services through provision of scholarships at masters level, the skills acquired by the staff still are devoid of disability knowledge. One of the beneficiaries of the scholarship said the Master’s degree he attained did not tackle any disability knowledge. This means that the hospitals may continue to have deficiencies in planning and providing for PWDs. This also falls short of the provisions of the PWDs Act that seek to ensure inclusion of disability issues in the health curriculum.

#### ***4:4 Discussion on Safeguards:***

The World Bank safeguard policies, aimed at preventing harm in World Bank projects, are triggered in investment lending projects. This project thus triggered the environmental assessment (EA). Environmental Assessment is one of the 10 environmental and social Safeguard Policies that WBG uses to examine potential environmental risks and benefit associated with Bank lending operations, (ESIA report 2010).

From the nature of the project and the fact that project activities would largely entail internal modifications of existing buildings, only policy 1 and 7 were triggered.

Moreover Policy 7 would be triggered only in isolated situations and on a small scale involving displacement of people who obtain primary or secondary livelihood from vending retail goods or services at healthcare premises, (ESIA report 2010).

The report thus provides for possible harmful effects resulting from the project as well as mitigation measures. For instance, it notes that the project will positively impact health of Ugandans through easing access to quality medical care currently non-existent at these facilities. Renovation of facilities and installation of medical equipment will enable currently ineffective healthcare facilities provide new or improved services to patients. A key benefit to mothers will be the opportunity to safely deliver children in a medical environment where existing healthcare facilities did not have maternity wards or capability to handle complicated deliveries through medical / theatre operations.

Additionally, improved healthcare will reduce morbidity; improve labour productivity and household incomes leading to the long-term benefit of improved local economies. Equipping healthcare facilities with modern equipment, enabling provision of new healthcare services and resultant increase in visiting patients may create additional long-term technical and non-technical job opportunities for medical professionals, janitors, security guards. The above benefits are fantastic but quite ambiguous with regard to how specific they impact on PWDs.

The report, meanwhile notes the negative effects associated with the project such as escalation of HIV, environmental degradation, increased accidents, and other health risks. Subsequently, it recognises the need for the implementers to undertake appropriate measures like creating awareness on HIV among the workers, provision of condoms, consulting on the local leaders on waste disposal and identification of authorised sites for collecting construction materials. It also urges for proper management of medical waste involving segregation of hazardous from non-hazardous streams and safe disposal in order to mitigate existing public health risk associated with improper disposal of healthcare waste.

The above are pertinent issues, but it is worth noting that they are only general and do not specifically provide for issues of persons with disabilities. For instance, all the mitigation measures identified by the report are not only silent about PWDs, but that they are inadequate to address PWDs concerns. Because the safeguards are not specific on disability inclusion it is not surprising that even the Environmental and Social Impact Assessment conducted severally falls short of disability issues.

The findings, therefore provide insight to the safeguard review process so that the World Bank becomes more sensitive to disability issues, specifically ensuring that disability becomes one of the key indicators in the project design, implementation and monitoring.

#### **4:5 Conclusion**

By all standards, the findings indicate that PWDs are benefiting in general terms and as a result of lobbying from their leadership. However, there is no deliberate effort to target PWDs even when it is no longer secret that PWDs as much as they are like any other, have specific unique features that require special attention. Consequently,

PWDs are receiving a leap service, which is why the World Bank safeguard review process ought to come strong on issues of disability with regard to the projects it funds.

#### **4:6 Recommendation**

- The ministry of health should ensure that the health management committees have PWDs representatives
- The health management information systems should include disability as one of indicators. This would help in determining how many PWDs actually access services or may need specialised services
- There is need for the ministry of health to ensure that health workers are oriented on disabilities issues including sign language training. This could be through inclusion of disability issues in the health training curriculum
- The World Bank should ensure PWDs are deliberately targeted by the projects they fund. This can be done through deliberate inclusion in the project proposals and safeguard policies.

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