Rehabilitation in Uganda: A Call to Action

Policy Brief

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The urgent and growing need for accessible rehabilitation and assistive technology (AT) in Uganda is clear, but services remain an unfunded priority. Learning, Acting, and Building for Rehabilitation in Health Systems (ReLAB-HS) conducted a qualitative analysis to understand the prioritization of rehabilitation in Uganda and to identify entry points for elevating rehabilitation in national and district health agendas. The study included a document review and 31 key informant interviews with governmental and nongovernmental stakeholders at the national and district levels. This brief provides an overview of our findings and guides stakeholders to strategic considerations for advancing rehabilitation in Uganda's health agenda and advocating for increased resource allocation.

Scope of the problem

Rehabilitation is a category of services aimed at improving functioning across the life course. It has a long history in Uganda through community-based rehabilitation (CBR) programs and via nongovernmental organizations (NGOs) that provide valued services to communities. Participants argued that rehabilitation is considered a part of the health care system and is a priority alongside other types of health care interventions, pointing to the creation of a rehabilitation workforce in the public sector, expanded pre-service training programs, the establishment of orthopedic workshops in regional referral hospitals, and the creation of a Disability and Rehabilitation Division within the Ministry of Health (MoH). However, rehabilitation remains an unfunded priority in the public sector health budget. Lack of prioritized financial investment is driven by both a perception of competing needs from policymakers and international donors' relatively low prioritization of rehabilitation compared with infectious diseases. According to participants, this has resulted in unfilled positions for rehabilitation service providers within the public system, a lack of key equipment to provide services, and considerable geographic and financial barriers to access services.

Barriers to prioritizing and implementing rehabilitiation services

Rehabilitation is perceived as a complex issue requiring collaboration across sectors and the national and district levels. This complexity challenges prioritization in five main ways:

- There are **different views on what and where to prioritize**. Some stakeholders view rehabilitation as a health issue to be resolved with medical care, while others are concerned with improving societal and environmental factors that impede functioning.

- **Many stakeholders are focused on only one condition or element of rehabilitation instead of the entire service category**—for example, focusing on orthopedic conditions, versus visual impairment, versus lifelong congenital conditions. This differing positionality leads to **different policy solutions**—for example, strengthening orthopedic workshops at regional referral hospitals versus improving accessibility of public services for persons with disabilities. These **competing solutions and advocacy objectives have prevented the development of a united rehabilitation stakeholder coalition** capable of making a cohesive "ask" of policymakers.
- Relatedly, there is **no common or multisectoral policy document** to unify rehabilitation stakeholders to advance a single goal. Uganda's National Health Sector Strategic Plan VI minimally includes rehabilitation. Existing policies on CBR are housed within the Ministry of Gender, Labor, and Social Development (MoGLSD) and have been variably implemented since the transition from external to government financing. The absence of a common goal or target has resulted in **fragmented governance arrangements** and **limits the ability to monitor progress or hold stakeholders accountable for results**.
- Existing **rehabilitation services are fragmented between the public sector and different NGOs engaged in service delivery in specific communities**. There is limited evidence on what services are currently provided, how much they cost, and their effectiveness. This **lack of evidence limits advocacy for increased budget allocation and reduces the ability of the MoH and MoGLSD to plan for service scale-up**. Participants suggested that some communities, especially in Northern Uganda, benefit from many NGO services, while others have no services at all, exacerbating **inefficiencies in the use of limited resources**.
- **Lack of rehabilitation-specific population** data further prevents stakeholders from estimating unmet needs for services and advocating for funding for rehabilitation services vis-à-vis competing health budget priorities.

Call to Action: expanding access to rehabilitation services

Strengthening prioritization and increasing funding to align service provision with the unmet need requires collaboration across all levels of the health and social systems. The following are entry points on how to increase investments in rehabilitation to expand access to services.

At the national level: strengthen evidence, planning, and policy frameworks

- **Generate needed data for advocacy and rehabilitation planning:** On the demand side, quantify the unmet need for rehabilitation via a sub-nationally representative population survey to inform service planning and human resource allocation. On the supply-side, ensure integration of rehabilitation indicators into the national health management information system to capture service needs and monitor service usage over time.
- **Build a multisectoral coalition that aligns stakeholders around a common vision:** Leverage the forthcoming rehabilitation strategic plan to increase stakeholder consensus on a unified set of policy solutions across a range of rehabilitation services, build an advocacy agenda around common goals, and track progress against a unified results and accountability framework.

- **Align development partners with the rehabilitation strategic plan**: This plan can be used as an advocacy tool to generate interest in and commitment to rehabilitation from development partners. It can also increase commitment to rehabilitation within donor-prioritized services or programs by, for example, ensuring that development partners consider rehabilitation as part of the care continuum for persons living with HIV, for maternal and child health care, and to respond to the growing burden of road traffic-related injuries.

At the district level: leverage existing structures to strengthen implementation

- **Improve efficiency of resource allocation by mapping private investment:** Mapping all private (for-profit and not-for-profit) rehabilitation service providers in the district, their geographical coverage, eligible populations, and offered services can increase understanding of the existing rehabilitative services provided by the private sector. This can assist in identifying the most urgent service delivery gaps which should be addressed with increased government and/or private sector investment.
- **Strengthen referral networks at all levels:** Rehabilitation service delivery is fragmented between levels of care, across sectors, and across types of providers. Strengthening referral networks—including from community and primary health care to regional referral hospitals; between public and private providers; and between health, education, and social services—is critical to ensuring that patients are identified and supported in accessing existing services. The Parish Development Model and Village Health Teams can be leveraged to strengthen the identification of patients and connect them to services.
- **Increase budget allocation via existing structures:** Rehabilitation is catered for in the structure of the health system but remains unfunded. A clear opportunity is to fill existing rehabilitation professional positions within the public health system, which can be an entry point to expand access to services.

At the frontline: what can NGOs, health care providers, and communities do?

- **Generate evidence to make the case for investing in rehabilitation**: Develop, test, and evaluate new models for integrating rehabilitation into primary health care that demonstrate improved functioning. Conduct cost-effectiveness analysis of these service delivery models to demonstrate the return on investment for rehabilitation.
- **Integrate rehabilitation in other disease areas that are gaining increased attention and funding to broaden the coalition of advocates:** For example, there is growing momentum around addressing the burden of road traffic crashes in Uganda—an opportunity to advocate for rehabilitation as a critical part of post-crash care for traffic crash victims.
- **Empower communities with knowledge to increase demand for rehabilitation services:** Raising awareness on what rehabilitation is, why it is important, and its potential for improved quality of life is important to increasing demand for services. Elevating the voices of service users, including persons with disabilities, and fighting stigma should accompany awareness raising efforts.

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Our partners