Geneva Challenge 2020

Inclusion for Healthcare access for older persons in Northern Uganda

Ensuring that older persons from Acholi Sub Region of Northern Uganda have access to quality HealthCare: A Community-centred Response

Credit: Daily Monitor, 2019

Credit: Help Age International, 2020

MPAABE EDWIN, SEMUGABI COLLINS, NAKINOBE FLAVIA GLADYS (*Authors*)
Department of Population Studies, School of Statistics & Planning,
College of Business and Management Sciences, Makerere University

The Team

Edwin Mpaabe is a graduate student at the school of Statistics and Planning, Department of Population Studies, Makerere University pursuing a Master of Science Degree in Population and Reproductive Health. He is a Monitoring Evaluation & Learning Personnel and has To-date, Monitored and evaluated projects from Four Key Thematic development interventional areas; Food Security and Nutrition, Water Sanitation & Hygiene, Humanitarian Action and Sustainable Agriculture and livelihoods. Edwin's research interests are in ageing, Reproductive Health, Monitoring and Evaluation and Epidemiology and Biostatistics.
Edwin's Graduate Dissertation focusses on examining "***Factors associated with multimorbidity among older persons in Uganda***". Edwin also is passionate about attainment of the 2030 SDG agenda in sub Saharan Africa and hopes that he can influence policy change and support Governments and the Private sector to foster a feasible Policy environment aimed at improving social service delivery for vulnerable communities.

Collins Semugabi is a graduate student at the school of Statistics and Planning, Department of Population Studies, Makerere University pursuing a Master of Science Degree in Population and Reproductive Health. Collins has been pivotal in supporting the development of the "Ageing Inclusion M&E Strategy" a collaboration between Makerere University, Ministry of Gender Labor and Social Development and the Ageing Initiative. He has also worked at the School of Public Health and trained Public Health personnel and students in geriatric PHC management, development of Health Management Information Systems and use of statistical software (DHIS2 & Open MRS) in health Informatics.
Collin's graduate dissertation focusses on examining "***Covariates associated with compliance to taking of Iron and Folic acids during pregnancy in Uganda***".

Flavia Gladys Nakinobe is a graduate student at the school of Statistics and Planning, Department of Population Studies, Makerere University pursuing a Master of Science Degree in Population and Reproductive Health. Flavia is a Reproductive Health Professional as well as Policy and Advocacy personnel championing for reproductive Health Rights of Adolescents, vulnerable communities and women and girls in Humanitarian settings. She has conducted research in HIV/AIDS, Contraceptive Use, and of recent Ageing. She has developed Research Methodologies working with NGOs and academic Institutions. Flavia is also passionate about SDG realization in developing countries. Flavia's graduate dissertation focuses on examining ***"Factors associated with the increased rates of caesarean section delivery in Uganda"***.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CBSD	Community Based Services Department
CBTs	Cash Based Transfers
CDs	Communicable Diseases
DFID	UK Department for International Development
DHIS2	District Health Management Information Systems
DHO	District Health Offices
HAL	Health Access Livelihood Framework
HC	Health Centre
HHs	Households
HIV	Health Management Information System
HSPs	Health Service Providers
HWs	Health Workers
ICF	International Coach Federation
IDPs	Internally Displaced Persons
IEC	Information and Education Communication
LRA	Lord's Resistance Army
M&E	Monitoring & Evaluation
MEAL	Monitoring Evaluation Accountability & Learning
MIPAA	Madrid International Plan of Action on Ageing
MOFPED	Ministry of Finance Planning and Economic Development
MOGLSD	Ministry of Gender Labor and Social Development of Uganda
MOH	Ministry of Health Uganda
MRS	Medical Records System
NCDs	Non-Communicable Diseases
NDP-III	National Development Plan III
NGOs	Nongovernmental Organisations
NPC	National Population Council
NUSAF	Northern Uganda Social Action Fund
OPD	Outpatient Department
PDM	Post Distribution Meetings
PHC	Primary Health Care
PRDP	Peace, Recovery and Development Plan
PWR	Participatory Wealth Ranking
SAGE	Study on global AGEing and adult health
SAGE-Grant	Social Assistance Grant for Empowerment
SDGs	Sustainable Development Goals
UBOS	Uganda Bureau of Statistics
UNDESA	United Nations, Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
VHTs	Village Health Teams
WASH	Water Sanitation & Hygiene
WHO	World Health Organisation

Table of Contents

Figures

Tables

Abstract

"*The enjoyment of highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political, belief, economic or social condition*".
Dr. Tedros Ghebreyesus, WHO Director General, 2017

Access to healthcare is a key health and developmental concern globally. Subsequently, SDG 3 reflects the need for equitable healthcare access and promoting wellbeing for all ages. This is a global call for action for countries to foster policy change to enhance realization of equity in healthcare access. The Madrid Plan of Action reechoes this call and suggests a bold new agenda to handle ageing in the 21st Century focussed on 03 priority areas; older persons and development, advancing health and wellbeing in old age and ensuring an enabling and supportive environment.

In light of these global calls for action, the team realizes that the elderly persons of the Acholi sub-region of Northern Uganda have been constrained from accessing healthcare. A number of Institutional, Individual, Community, and Facility based factors limit older persons in this region from accessing healthcare.

Our intervention (Inclusion for healthcare access for older persons in Northern Uganda) is thus meant to act as a springboard to enhance healthcare access to older persons in Northern Uganda by adopting Four interventional strategies to include; (a) Health systems approach to support the integration of Age-Friendly Primary Healthcare systems (b) Community integrative approach to eliminate community barriers to healthcare access (c) Advocacy and (d) Cash Based Transfers to enhance access to healthcare. The Initiative is also aimed at supporting the Peace, Recovery and Developmental interventions in Northern Uganda by the Government of Uganda and Developmental partners and fostering the realization of Uganda's NDP III, Vision 2040 and the 2030 SDG Agenda.

SECTION A: PROJECT OVERVIEW

1.1 Introduction and Project Background

The global population is ageing (Bloom, 2011) and estimates indicate that the number of persons aged >60 years is projected to more than double to 2.1 billion persons by the year 2050 (United Nations, Department of Economic and Social Affairs, 2017). Of this statistic, estimates further elucidate that close to 8 in 10 of the older persons will be living in developing countries (United Nations, Department of Economic and Social Affairs, 2017). The World Health Organisation (2010) suggests that this demographic shift in ageing is associated with declined fertility rates and increased life expectancy.

In sculpting the impact of this demographic shift on the health status of older persons in developing countries, two significant concerns have been attested. First "susceptibility" of older persons to detrimental health outcomes (Schatz, Seeley, Negin, & Mugisha, 2018; Wandera, Kwagala, & Ntozi, 2015) and second; The limited access to healthcare for elderly persons (Agyemang-duah, Peprah, & Peprah, 2019; de Carvalho et al., 2017; Dugarova, 2017; Tam & Yap, 2016; WHO, 2004). Ageing populations as a result are subject to a number of chronic conditions and multimorbidity (Agborsangaya et al., 2012; Nguyen et al., 2019). The common morbidities associated with ageing include; hypertension, arthritis, diabetes mellitus, stroke, angina, cataract, cardiovascular disease, chronic lung disease, musculoskeletal disorder, ocular problems, urinary problems and sleeping problems. However, it should be noted that older persons are also at high risk of HIV/AIDS infections (Joint United Nations Programme on HIV/AIDS, 2014; UNAIDS, 2013; Mugisha et al., 2016) , Non-communicable diseases (Morgan, 2017; Nawagi et al., 2018; Wesonga et al., 2016) and Communicable illnesses (Nzabona, 2016; World Health Organization, 2018).

Heightening prevalence of adult multimorbidity has been associated with greater healthcare utilisation (Palladino et al., 2016; Sheridan, Mair, & Quinõnes, 2019), increased polypharmacy (Assari, Wisseh, & Bazargan, 2019; Taylor et al., 2010), worse self-reported health status (Wandera, Kwagala, et al., 2015), depression and reduced functional capacity (Sheridan, Mair, & Quinõnes, 2019; Taylor et al., 2010; Wesonga et al., 2016). This has further propelled increased premature adult mortality (Gallacher et al., 2018), increased care dependence (Bao et al., 2019), significant healthcare budgets (Bao et al., 2019; Taylor et al., 2010) and subsequently affected the quality of life of most adult citizens (Nzabona, 2016; Maniragaba et al., 2018).

Uganda's aged population (>60years) is currently estimated to be 4.1% of the total population and projections estimate it to grow to 5.5million as of 2050 (Uganda Bureau of Statistics, 2007; Wandera, Ddumba, Akinyemi, Adedini, & Odimegwu, 2017). Like a greater part of the world, Uganda is also currently undergoing both epidemiologic and demographic transitions poised with decreased mortality rates and increasing life expectancies (Nawagi et al., 2018).

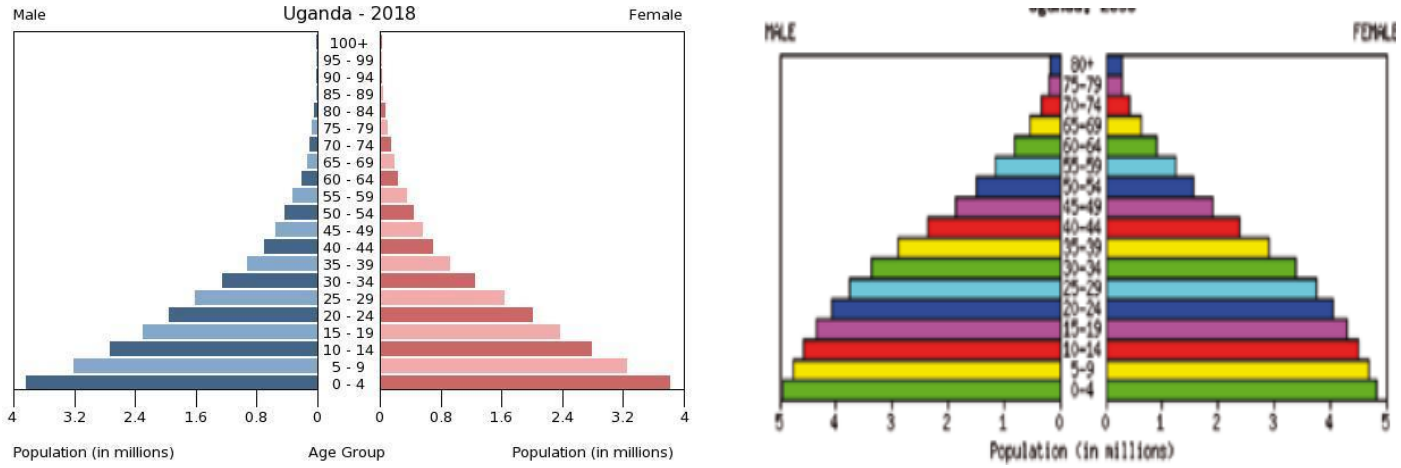


Figure 1.1 (a &b): Uganda's Population Pyramid, 2019 (Source: UDHS, 2016) [Population: 34m (2019) 89m (2050 Projection)]

Uganda's population pyramid is flat-based with 50% of her population youthful (aged <35years) (Uganda Bureau of Statistics & ICF, 2018) which has formed the core of policy action to respond to the needs of this cohort. As a result, less policy attention and focus has directed towards elderly persons (Wandera, Kwagala, et al., 2015). As indicated in Figures 1a and 1b, projections indicate the total population to grow to approximately 89 million persons but with a larger flat base (National Population Council/ MoFPED, 2011). The implication is that the existing policy framework is not adequate to support ageing concerns and this poises the rationale for ageing-specific policy interventions if Ugandans are to live longer and have dignified lives (Nzabona, 2016).

In Uganda, there are no reliable statistics on adult NCDs and multimorbidity prevalence but using proxy ageing studies; prevalence estimates range between 45% to 65% depending on region with the Northern (58.5%) and Eastern Uganda (50.5%) having a higher prevalence of adult multimorbidities and Central Uganda with the least prevalence (40.5%) (Wesonga et al., 2016)

Uganda like other developing countries is grappling with poor healthcare systems, ineffective referral systems, ineffective Health Information Management Framework (Mujasi, Asbu, & Puig-Junoy, 2016), Lack of nationally representative data to inform policy responses (Wesonga et al., 2016), and an inadequate policy framework to mitigate health inequalities which has further fueled exclusion of older persons from access to healthcare.

1.2 Problem Statement

The Acholi sub-region of Northern Uganda (*a Region forgotten*)

The Acholi sub-region of Northern Uganda is one of the most impoverished areas on earth with 43.7% of its population living below the poverty line (MFPED, 2014; The World Bank Group, 2016). For 20 years (1986–2006), the region experienced violent conflict at the hands of the Lord's Resistance Army (LRA) insurgence. The conflict claimed the lives of at least 500,000 people, 20,000 child abductions and close to 2million persons were displaced with most of them living in IDPs (*Armed Conflicts Report Uganda (1987- first combat deaths)*, 2009).

The conflict also had devastating impact on social service delivery (Namakula & Witter, 2014), fractured physical infrastructure subsequently leading to heightening absolute poverty, poor education system (Women's Commission for Refugee Women and Children, 2005), poor healthcare system (Namakula & Witter, 2014), heightening dependence burden (Levine S, 2009), higher HIV sero-prevalence (Ansaloni, Acaye, & Re, 2007), and a disease burden (Advisory Consortium on Conflict Sensitivity, 2013).

Northern Uganda Health Indicator Performance:

Northern Uganda is grappling with poor health indicator performance in comparison with other regions across Uganda. In terms of Health Facility density[1], Northern Uganda has the lowest Hospital/ HC IV density per 100,000 of the population standing at only 0.8 compared to Eastern (0.89), Western (1.04) and Central Uganda (1.08) and way below the National average (0.96) (Ministry of Health-Uganda, 2014). In terms of Per Capita OPD visits[2] in Hospitals; as of 2014, Northern Uganda stood at 0.13 in comparison with Eastern (0.14), Western (0.19) and Central Uganda (0.24) and way below the National average (0.18) (Ministry of Health-Uganda, 2014). This indicator performance indicates significant challenges in meeting the National indicator performance Framework averages (NPA/ UBOS/ MOFPED, 2016) and targets for the National Development Plan III.

The Case of Northern Uganda's Elderly and their access to Healthcare

The elderly of Northern Uganda have also been documented to face significant barriers and limitations to health access. Of the studies conducted, poor health seeking behaviors (Nawagi et al., 2018), preference for traditional medicines, mobility challenges, living alone (Wandera et al., 2017; Wandera, Kwagala, et al., 2015), inadequate income (Schatz et al., 2018) among others (Nzabona, 2016). Other studies suggest that older persons in Uganda experience financial, physical, psychological and legal barriers to healthcare (Nzabona, 2016). A more comprehensive barrier framework is presented in the subsequent section.

[1] **Health facilities density** refers to the number of health facilities per population of 10,000 or the number of health facilities per total population living in a designated area. Health facilities include all public, private, non-governmental and community-based health facilities defined as a static facility in which general health services are offered.

[2] **Per Capita OPD attendance** is the number of outpatient consultations per person per year. Often used proxy indicator for accessibility and utilization of health services that might also reflect the quality of the services.

1.3 Project Justification

Social infrastructure in the Acholi sub-region was significantly fractured during the LRA insurgence, which in turn affected social service delivery leaving the region impoverished. The elderly as a result have been excluded from access to social services and healthcare, which has left them vulnerable to heightening Communicable and Non-Communicable Diseases. Implementing the programme is pertinent to enhancing inclusion of ageing populations to healthcare.

In line with the 2030 SDG agenda, the study is meant to set precedence to achieving Sustainable Development Goal 3 (*equitable healthcare access and promote wellbeing for all ages*) and Pillar Two of the Madrid International Plan of Action on Ageing (MIPAA) solely focused on "*health and wellbeing in old age"* and the Commitments as stipulated in Framework by supporting Government and Civil society actors in fostering for policy change and programming to enhance healthcare access to elderly populations.

The programme is also aimed at supporting Government and developmental partner development, stability and recovery efforts in Northern Uganda. Government of Uganda with support from developmental partners have been vibrant in fostering socio-economic transformation of the Region with a number of Key Developmental Interventions (Policy and Programmes). Firstly "*The Peace, Recovery and Development Plan"* (PRDP 2007-2010) meant to provide a roadmap for Policy Intervention, Infrastructural recovery, Social Service delivery, and support political dialogue for peace and stability aimed at enhancing holistic recovery and development of Northern Uganda post – LRA conflict. Secondly, "The Northern Uganda Social Action Fund Project (NUSAF Phase III)" aimed at provision of effective income support to build the resilience of poor and vulnerable households in Northern Uganda.

SECTION B: REVIEW OF LITERATURE

2.1 Theoretical Framework and Healthcare access and utilization

To examine Healthcare access and utilization among older persons in Northern Uganda, the study is ground on two theories (a) The Andersons Healthcare utilization Model and (b) Obrist Health Access Livelihood Framework of 1967.

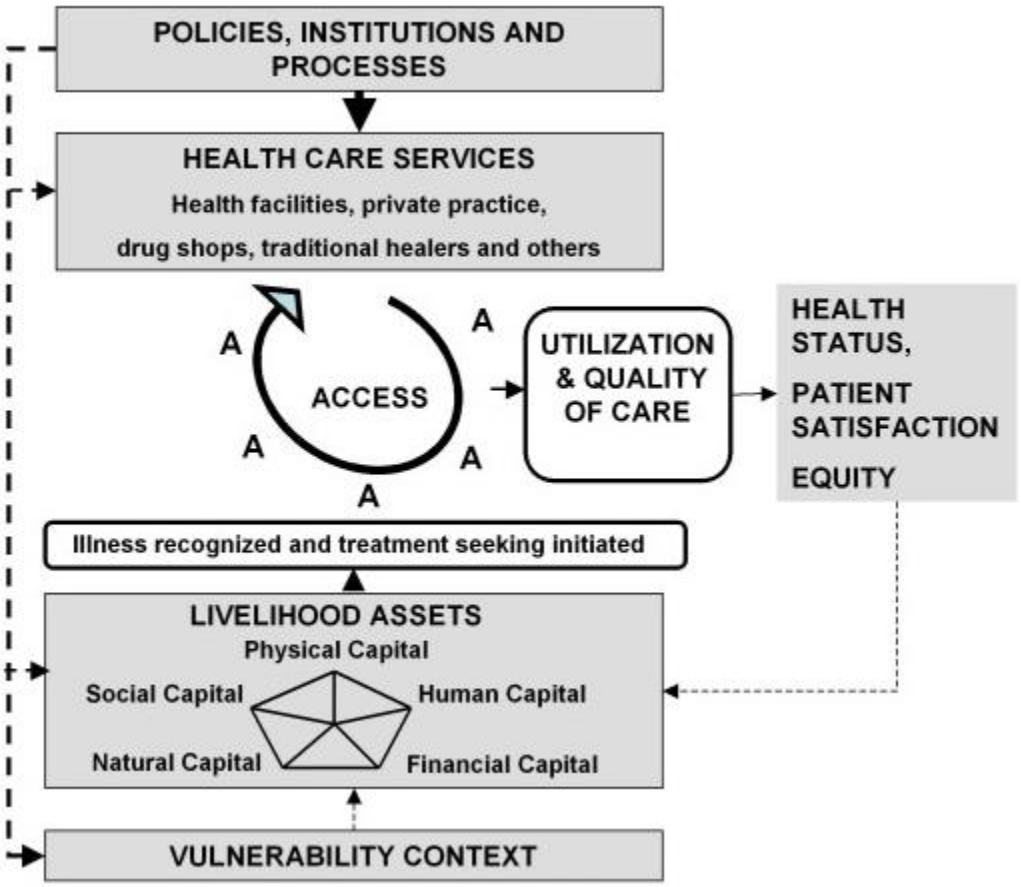
2.1.1 Andersons Healthcare utilization Model

Originally developed by Ronald Andersen in 1968, the Andersen Healthcare utilization model is pivotal in explaining healthcare access and utilization. The model purports that health service utilization is a progressive and conditional function of three sets of factors to include; predisposing (demographic and social) factors, enabling (economic) factors, and need (health outcomes) factors. Predisposing factors reveal the individuals' inclination to use health services, enabling factors are the resources that facilitate access to healthcare, and the need factors signify intended need for healthcare such as self-perceived health, chronic conditions, and restricted activity (Jang, Chiriboga, Allen, Kwak, & Haley, 2010)

Table 1.1 Integrative Review of Literature using the Anderson's Model

Factors associated with healthcare utilization	Author(s)	Type of study	Study	Risk Factors associated with Healthcare utilization	Study Findings
Predisposing Factors	(Wandera, Kwagala, et al., 2015)	Cross sectional	Determinants of access to healthcare by older persons in Uganda	Age; Marital status; Place of Residence; Sex and Living arrangements	Access to healthcare increased with being married, male, living in urban areas and not living alone but decreased with age progression (aged >70 (RR = 0.90, 95% CI: 0.83-0.98))
	(Razzaque, Nahar, Akter Khanam, & Kim Streatfield, 2010)		Socio-demographic differentials of adult health indicators in Matlab, Bangladesh: self-rated health, health state, quality of life and disability level	Age Sex	All four indicators of health were better for males and health deteriorated with age progression
Potential Health Needs	(Wandera, Kwagala, et al., 2015)		as above	Disability status Self-reported NCDs	Self-reporting of NCDs was associated with higher likelihood of access to healthcare (RR = 1.09, 95% CI: 1.01-1.16) whereas mobility limitations was associated with less access (RR = 0.84, 95% CI: 0.75-0.95)
	Lima-Costa et al., 2003		Socioeconomic circumstances and health among Brazilian elderly	Self-rated health Physical functioning	Poor self-rated health and worse physical functioning was associated with less frequent use of medical and dental services
Enabling Factors	(Wandera, Kwagala, et al., 2015)		as above	Educational level, employment status, Insurance and Health infrastructure	Access to healthcare increased with having higher years of schooling, employed (RR = 1.08, 95% CI: 1.00-1.15), but decreased with being from poor household (RR = 0.91, 95% CI: 0.83-0.99)
	(Lima-Costa et al., 2003)		as above	Wealth-quintile	access to healthcare for older persons reduced in the lower quintile per capita household income

2.1.2 Health Access Livelihood Framework



doi:10.1371/journal.pmed.0040308.g001

Figure 2.1: The Health Access Livelihood Framework

Access to healthcare is explained by three perspectives; health-seeking behavior of ill persons, utilization rates and livelihoods approach (Obrist et al., 2007). The framework combines health service and health seeking and to inform access to healthcare using with the view of vulnerability. Five dimensions to health seeking are suggested; availability, accessibility, affordability, adequacy and acceptability.

Policy and institutional processes influence provision and accessibility to healthcare services. In terms of vulnerability, in access to livelihood assets will act as a significant barrier to health utilization. The framework thus suggests that "*improved access and health care utilization have to be combined with high quality of care to reach positive outcomes*" (Obrist et al., 2007)

2.2 Barriers to healthcare access for older persons (*closer look at Northern Uganda*)

Building on the Theoretical (presented above) underpin, we have developed a barrier analysis framework to explain limitations to healthcare access for older persons in Northern Uganda.

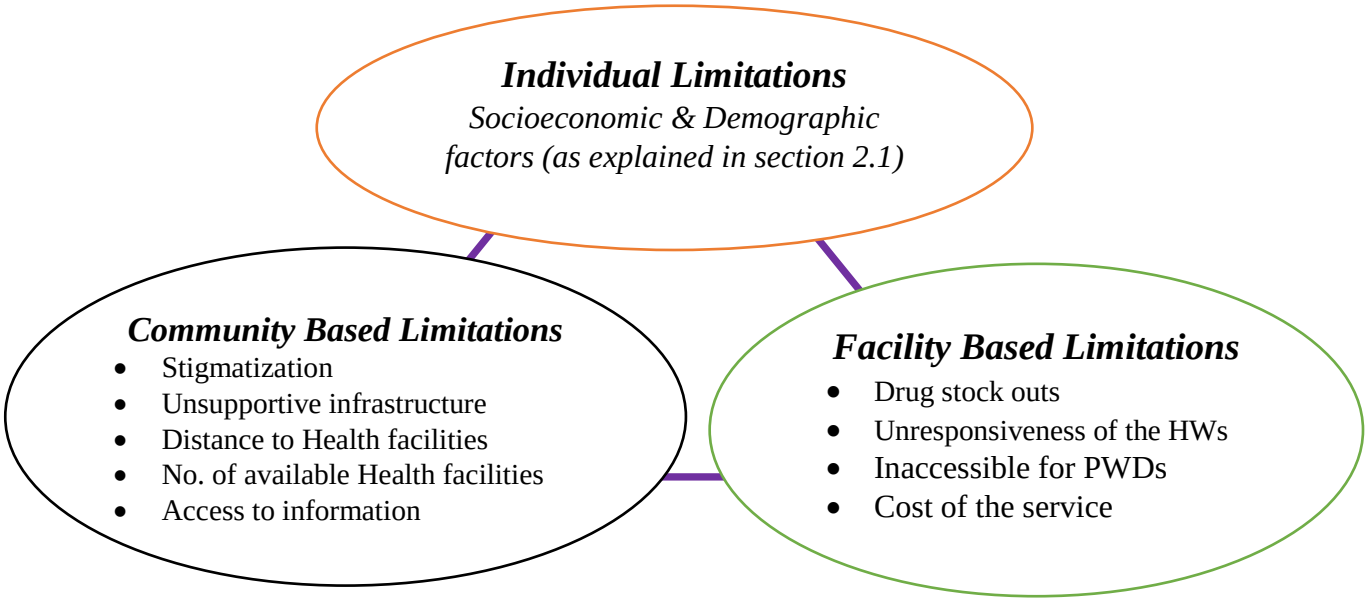


Figure 3.2: The barrier Framework to healthcare access for older persons

After a thorough literature scan and situational analysis of limiting factors to healthcare access for Northern Uganda's elderly, the team has deduced that an interplay of individual, community and Facility based factors explain in access to healthcare.

Using a sample of 5,888 participants aged 65years and above, Fitzpatrick et al., (2004) established that a combination of the three factors were pertinent to limiting access; unresponsiveness from the physician to the patient, ineffective transport, no supplemental insurance, being female and age progression were significantly associated with limited access to healthcare among older persons.

In Portugal, the barriers to health access included; the prevailing economic crisis and pension cuts, increased user fees in PHC, hospital care service limitations, increased medical expenditures, waiting time at facility for elective surgery and inhabitable housing (Doetsch, Pilot, Santana, & Krafft, 2017).

Older persons in Uganda experience financial, physical, psychological and legal barriers to healthcare access (Nzabona, 2016).

SECTION C: OUR RESPONSE (PROJECT INTERVENTION)

Having expounded on the dire need for access to healthcare for older persons in the Acholi sub region of Northern Uganda, the programme intends to adopt a twofold model hinged on Institutional and Policy response to front for healthcare access for older persons in the region. These two will provide for operationalization of Four interventional strategies to include; (a) Health Systems Approach: *adoption of an Age-Friendly Primary Healthcare approach* (b) Community Integrative Approach (c) Advocacy and (d) Cash Based Transfers. These strategies are tailored towards enhancing inclusion, accessibility, affordability, acceptability, adequacy and availability of healthcare for the older persons of Northern Uganda.

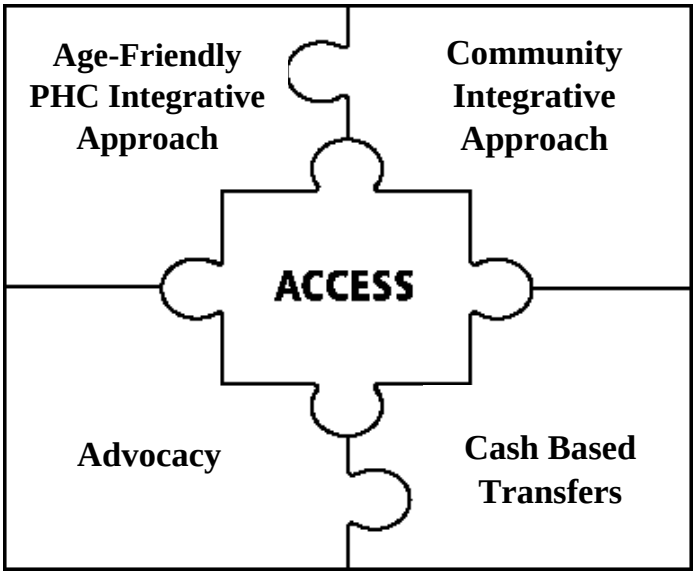


Figure 4.1 Access Framework

Interventional Strategy 1: Health Systems Approach: Enhancing an Age-Friendly Primary Healthcare approach

Strategic Objective 1: To design and adopt an Age-Friendly Primary Healthcare approach to enhance healthcare access for older persons

In line with The WHO's "age-friendly" primary healthcare Framework, the project aims to sensitize and educate PHC providers about the specific needs of their older clients. This is meant to improve on three key areas (i) improve attitudes, education and training of healthcare providers to manage geriatric patients (ii) streamlining PHC management systems to meet the needs of older persons and (iii) making physical access easier for geriatric persons.

Activity 1.1: Stakeholder Inceptions Meetings

Two (02) meetings will be held combining stakeholders. Firstly, with the national institutional framework (Ministry of Health, and Ministry of Gender Labor and Social Development) and Secondly; the Health Sub-District (District Health Offices, Community Based Services Department, and Medical Directors at the selected Health Facilities) in the 04 selected districts in the first months of the project implementation. Stakeholder inception meetings will be conducted to serve as a multi-stakeholder interface and orientation meeting. These meetings will emphasize the stakeholder roles as well as partnership roles of engagement. The meetings will also act as a platform to advocate for the programme tenets as highlighted in Table 2.1 below.

Activity 1.2: Training for Health Workers (HWs) and Health Service Providers (HSPs) in geriatric patient management

As part of the capacity building strategy in managing geriatric patients, HWs and HSPs at the selected facilities will undergo Quarterly Trainings in a myriad of relational concepts to geriatric patient management. The trainings will be conducted with support from the Ministry of Health, Help Age International, the World Vision and Makerere University, School of Medicine. The trainings will be held in line with the standard protocols for Health Workers' Training as per the Ministry of Health Guidelines and training assessments will be conducted at Bi-annual intervals to assess Training impact and need.

Activity 1.3: Training of Village Health Teams (VHTs)[3] in geriatric patient management, Referrals and Minor Case Management

Twenty Eight (28) training sessions (14 on an annual basis) will be conducted for the VHTs to build their capacity in geriatric case management and referrals. The programme intends to tap on the experience of these VHTs in dealing with the rural communities as a front to engaging older persons to healthcare access. VHTs are significant since they make regular visits and being members of the community, they will be pivotal in fostering communication and coordination of healthcare access for the older persons. VHT training will also follow MOH guidelines for Health

[3] *VHTs are part of the Ministry of Health PHC structure known as Health Centre 1s (HC I) whose principal role is linking rural residents with healthcare and often operate on a volunteer basis*

Service providers' training and protocols. Training IEC Materials and other training materials designed and schedules will be in line with the HW Training framework of the MOH.

Activity 1.4: Training of Data Clerks, Records Personnel and Health Workers in incorporation of ageing Health Data in the MOH data management framework

Four (04) bi-annual trainings will be held with data personnel aimed at building their capacity in capture and management of geriatric and health data. The personnel will also be trained in use of Health Management software (DHIS-2, EMR and Open MRS) for effective reporting, Monitoring and Evaluation purposes. This will be pivotal in having an effective data management framework with adequate geriatric data to inform policy response. It's also aimed at supporting the National Health Management Information System (HMIS) backbone, informing national policy response as well as monitoring adult disease prevalence to adopt effective prevention strategies.

Activity 1.5: Construction of accessible infrastructure and refurbishment of selected Health facilities to ensure that they are accessible for older persons with Disabilities

Northern Uganda has 54 Health Facilities under the MOH structure, and of these only Four (04) health facilities two of which are Health Centre IVs, 1 HC III and HC II meet the required accessibility standards as per the Building Act of 2013 (accessible with ramps, walkways or a lift). With funding from the Rotaract Club of Gulu and other probable sources, we intend to construct accessible walkways in the thirteen (13) selected health facilities as well as build a ramp at Angaya HC III and Awach HC IV in Gulu and Kitgum Districts respectively.

Activity 1.6: Periodic health facility visits and supervision

These will be held on a quarterly basis in the four selected districts across the 15 Health facilities. An observational checklist will be developed and used as a tool for monitoring the facilities. Facilities will be checked for whether they meet the required accessibility standards, receipt of older persons, and generally able to manage older patients.

Interventional Strategy 2: Community Approach to Healthcare access for older persons

Strategic Objective 2: To implement a community healthcare approach to enhance healthcare access for older persons

Eliminating community barriers (*Push factors*) to healthcare access and putting in place structures (*Pull factors*) and systems to support accessibility, affordability and availability of healthcare is pertinent in supporting inclusion for healthcare for older persons. The following activities will be implemented;

Activity 2.1: Community stakeholder Inceptions Meetings

These will be six meetings held with community stakeholders (community leaders, VHTs, opinion leaders and clan elders) in the 04 selected Districts to introduce the programme, the project team and share insight on how effective the initiative can be best implemented. These will act as community entry, consensus building meetings and an effective advocacy platform.

Activity 2.2: Mobilization and sensitization of the community and older persons to support the initiative.
The project team will use community radio messaging and door-to-door campaigns to reach out to the older persons and their caregivers to register with their community leaders so that they are favorable candidates for the intervention.

Activity 2.3: Design and Publish Information and Educational Materials: These will include posters, and banners printed in the local languages (*Acholi, Langi, Madi and Kakwa*) communicating our intervention in the region, activities, and share information on water sanitation and hygiene, nutritional tips and healthy living. These will be shared during trainings, in the communities essentially meant to message health campaigns, fight stigmatization of old persons, aimed at combating the vice of ***ageism*** which is highly prevalent in Northern Uganda.

Activity 2.4: Participatory Wealth Ranking (PWR)[4] and Beneficiary Mapping: Identification of the At-Most Risk Vulnerable HHs will involve consultations with local leaders and VHTs to map out HHs with elderly persons that they consider ultra-poor and vulnerable. The team will then conduct a PWR survey to identify the At-Most Risk vulnerable HHs from the 04 selected districts for the intervention. Other inclusion parameters for vulnerability will include; Disability status of the old person, older person living alone, older person living with HIV/ AIDS as well as older person having no access to land, or assets for livelihood. A Beneficiary Database of the At-Most Risk HHs will be created. The HHs will then have their bio-data captured and enlisted for Cash Based Transfers as detailed in the preceding section.

***Activity 2.5: Mentoring of the VHTs*:** The project team will be tasked with routine mentoring of the VHTs to identify capacity gaps, build on their field experiences and brainstorm on challenges, respond to significant field queries, engage stakeholders and ensure that they are effectively performing to enhance indicator realization of healthcare access. A Mentoring log will be created for the field Monitors to collect mentoring data after each session.

Interventional Strategy 3: Cash Based Transfers (CBT)

Strategic Objective 3: To implement CBTs as strategy to enhance healthcare access for older persons

CBTs have been adopted as a pivotal livelihood access framework for vulnerable HHs and have been successful even in humanitarian context (for refugees and Displaced Persons) (UNHCR, 2015; WFP, 2019). The Programme has thus thought it fit to adopt the CBT strategy as an interventional to enhance inclusion for healthcare access for elderly persons in Northern Uganda.

Activity 3.1: Fundraising: To raise funds for our CBT intervention, the team has decided to conduct street fundraising campaigns, Door-to-Door and Church campaigns to raise funds. The

[4] *The PWR is tool used to target vulnerable HHs* (Wealth, 2014)

fundraising will also be on the Project website and other platforms such as Radio drives and social media campaigns.

***Activity 3.2: Beneficiary Verification*:** Using the beneficiary database created, CBT beneficiaries will be verified on a monthly basis before disbursal of funds. This will be done to ensure that the records provided are accurate and that those meant to receive the transfers are the actual recipients. This will aid accountability and minimize loss of funds.

Activity 3.3: Transfers: monthly CBT transfers of up to US$ 10 (Ugx. 35,000) will be provided to the At-Most Risk Vulnerable HHs (using the Beneficiary Database) to support these HHs access medicines, transportation to Health Facilities, and consultations at the facilities as well as offer a basic living for the older persons.

Activity 3.4: Post Distribution Meetings (PDM): These meetings will be held monthly after the CBT Distribution at least within 14 days from the last day of the CBT transfers. One meetings at each of the 15 Health centres. The meeting participants will be representatives of the elderly persons, community leaders, personnel from the health sub-districts and caregivers.

Activity 3.5: Financial Literacy: Project participants or their caregivers will also be trained in financial procedures and management to ensure that the funds they receive are used for meeting their healthcare needs or household needs.

Interventional Strategy 4: Advocacy

Advocacy has been identified as a powerful tool in enhancing institutional, legislative and policy change and we expect to rely on this success to front for advocacy as an interventional strategy to healthcare access for older persons in Northern Uganda

As part of our advocacy campaign as detailed in Table 1.1 (Advocacy Matrix), we expect to adopt and designate key advocacy messages in line with the delineated messaging (Table 2.1) to reach the targeted audiences and implement the underlined activities poised to support integration of age-friendly primary health care and health inclusion for elderly persons in Northern Uganda.

Table 2.1: Advocacy Matrix

TARGET AUDIENCE	KEY ACTIVITIES	ADVOCACY OUTCOMES
Government of Uganda (GoU)/ Parliament of Uganda/ District Leadership	• Lobbying Meetings • Written Petitions to the Parliament of Uganda • Letter Campaigns • High-Level key meetings • Dialogues with District Leadership • Stakeholder inception meetings	• Increase the National Health Budget from 8.9% to meet the Abuja Declaration of 15% • Feasible policy framework to cater for integration of Age- Freindly Primary Health Care in line with the WHO framework • Social infrastructural development in Rural Northern Uganda • Development of health infrastructure i.e. No. of operational Health facilities, improve Doctor-Patient Ratios, equip the health facilities • Capacity building of Health Workers (HWs) in clinical geriatrics • Scaling up SAGE and the size of the SAGE grant to all districts of Acholi sub region • ***Accessible physical environment***: Policy framework to support accessibility in line with the Uganda's Building Act of 2013
Ministry of Health (MOH)	• Stakeholder inception meetings • Lobbying Meetings • Letter Campaigns • High-Level key meetings	• Operationalize the MOH, 2013 policy framework to cater for integration of Age- Freindly PHC • Capacity building of Health Workers (HWs) in clinical geriatrics • Support Health Sub-Districts in Clinical mappinng of At-Most Risk gereatric persons • Provide the requisite infrastructure (Drug stocks, funds, Training for HWs) in a timely manner • Support effective functionality of the HMIS and Data Management systems to monitor incidence, prevalence of NCDs, referrals to enhance access to health service delivery • Effective Monitoring of Health facilities and HSDs to ensure that they meet the requisite stndards and requirements for gereatric management

		• Support the operationalization of the VHT framework to link communities to care, manage referrals, collect data and minor case management
Ministry of Gender Labor and Social Development	• Stakeholder inception meetings • Lobbying Meetings • Letter Campaigns • High-Level key meetings • Dialogues	• Development of Uganda's social protection system: operationalize the National Social Protection policy to guide delivery of social protection interventions • Support Community Structures; Community Development Officers, VHTs and Local leaders in Mapping vulnerable HHs with At-Most Risk geriatric adults to access the continuum of healthcare • Maintain an Information Management system and Database of Vulernable HHs with older persons for effective case followups, referrals and management. • Support the Civil Society in operationalizing aid intervention to Vulernable HHs
Village Health Teams (VHTs)	• Community Dialogues • IEC activities such as Posters, Brochures and Leaflets • VHT Mentoring • VHT Training in geriatric management	• Case management of minor cases • Regular visits and Follow-ups on geriatric persons • Make referrals • Support Civil society activities in the region • Support Government and Health Ministry campaigns to reach the elderly e.g. Mass screening, immunization campaigns and mobile clinics
Health Service Providers	• HWs and HSPs Training in geriatric management	• Case management of geriatric patients as per the WHO guidelines on • Make referrals as per the MOH guidelines in case management of geriatric patients using the Age-Freindly Primary Health Care Framework • Make followups and visits of geriatric patients
Civil Society Organisations	• Stakeholder inception meetings • Lobbying Meetings	• Platform for donor funding towards to support livelihoods and health access for elderly persons

	• Letter Campaigns • High-Level key meetings • Consortia Dialogue • Radio Talk shows	• Platform for NGOs and developmental actors to support integration of Health service delivery in Northern Uganda • Lobby Government and the International actors to increase budgetary allocations to the Health sector, Policy change aimed at health access for elderly persons
Community Leaders	• Stakeholder inception meetings • Community Meetings • Community campaigns • IEC activities	• Regular visits and Follow-ups on geriatric persons • Support VHTs inn making referrals • Support Civil society activities in the region • Support Government and Health Ministry campaigns to reach the elderly e.g. Mass screening, immunization campaigns and mobile clinics
Heads of Households/ Caregivers	• Community meetings • IEC activities • Mobilization and sensitization campaigns	• Line of communication between the geriatric patients and HSPs on their health situations, treatments and possible side effects and their management • Managing medications, ensuring refills, and reviews on regular basis • Support geriatric patients with follow-ups, medication, • Support with health insurance, SAGE funds collection • Support elderly persons with nutritional requirements, medication, emotional, psychosocial support • Support familial and community activities e.g. communication with loved ones, engaging in community activities like going to Church, friends

SECTION D: PROJECT MONITORING AND EVALUATION STRATEGY

Monitoring will involve the routine collection of data by the programme team. The data will be cleaned, analyzed and interpreted to measure performance of the Output indicators. Monitoring will be essential in measuring progress, identification of programme challenges, and response to the interventional challenges, building capacity of project team using evidence lessons and informing management on strategic decision-making.

Evaluation will consist of periodically conducting Surveys to include; Baseline (prior project inception), Mid-Term (Halfway project implementation) and End-line Evaluation surveys (at Project Exit). The surveys will be designed to measure performance of the Outcome Indicators and will essentially inform the relevance, efficiency and effectiveness of the intervention.

The Logical Framework (as attached in Table 3.1) will be an essential tool in monitoring performance and realization of Output and Outcomes Indicators. The M&E personnel will maintain Programme Databases and will routinely conduct Data Quality assessments to ensure that the Data is Complete, Reliable and Relevant.

Other Field Monitoring activities will include; Quarterly Field Monitoring Visits of the Health Facilities and Quarterly Monitoring and Evaluation Meetings constituting of continuous internal quality checks and reporting mechanisms..

Table 3.1: Programme Logframe

Result Level	No.	SUMMARY	INDICATORS	EVIDENCE	ASSUMPTIONS
Goal		Increased demand, uptake and utilization of health services among older persons in Acholi sub-region	# of older persons in the 4 selected districts and 15 Health facilities of Acholi sub-Region accessing health services increased by 60% by end of year 3	HMIS & DHIS-2 Health Records at the Health sub/District	Timely correspondence of donors Supportive institutional and Policy Framework
Outcomes					
	a.1	Older persons' access to healthcare (including consultation, diagnostic tests and treatment)	% of older persons who report being able to meet their monthly basic healthcare needs after CBT grant disbursement	M&E Databases	Timely correspondence of donors Supportive institutional and Policy Framework
			Proportion of older persons who visited a Health Service provider as defined by the MOH guidelines	Health Facility HMIS Registers M&E Databases	
			Proportion of older persons who accessed healthcare after visiting a Health Service provider/ Health facility		
			Proportion of older persons with presumed minor morbidity(ies) who received appropriate treatment/ case management (disaggregated by place of treatment, Health facility or at home by VHT)	Field Monitoring Data	
			Proportion of Older persons with complex morbidity (ies) recommended for referral. (disaggregated by place of treatment, Health facility or VHT concerned)		
			Proportion of caregivers/ Head of Household who know two or more signs of adult morbidity that require immediate assessment and if appropriate treatment	M&E Databases	
	a.2	Health Systems Strengthening	Proportion of VHTs (trained and active) who demonstrate correct knowledge of management of geriatric patients	Field Monitoring Data	
			Proportion of supported health facilities with Age-Friendly PHC programmes during the day of assessment or last day of reporting period	MOH Health Facility Audit Reports M&E Reports	
			Proportion of supported health facilities reporting complete geriatric data on time to the sub-district/ District level		

			# of supported health facilities utilizing data for decision making according to the national standards		
			# of Health facilities with functioning digital health systems		
			# of HWs that report improved service		
			# of strategic foras/ meetings attended at national level to share results with partners while fostering interoperability of digital health solutions with DHIS2		
			# of HWs with improved knowledge of routine use of video learning episodes		
Outputs	**1.1**	Training of HWs and HSPs in geriatric patient management	# of HWs and HSPs trained in geriatric patient management	Training Reports	
			Disaggregation of Training participants by Gender		
	1.2	Training of VHTs in geriatric patient management, Referrals and Minor Case Management	# of VHTs who demonstrate correct knowledge in geriatric patient management, Referrals and Minor Case Management	Training Reports	
			# of VHTs who've attended all Trainings as per the timetable at end of Yr. 2		
			# of functional VHTs by end of Year 2		
	1.3	Training of Data Clerks, Records Personnel and Health Workers trained in management of ageing Health Data	# of Data Clerks, Records Personnel and Health Workers trained in management of ageing Health Data	Training Reports	
			# of Data personnel who've attended all Trainings as per the timetable at end of Yr. 2		
			Disaggregation of Training participants by Gender		
	1.4	Construction of accessible infrastructure and refurbishment of selected Health Facilities for accessibility for older persons	# of facilities with accessible infrastructure constructed or refurbished at End of Year 3	MOH Health Facility Audit Reports	
	1.5	Periodic Health Facility Visits	# of Health Facility that have received a Quarterly Visit by the Project Team by end of Year 2	Health Facility Administrative Registers	
	2.1	Design and publishing of IEC materials			
	2.2	Mentoring of VHTs	# of VHTs that have been mentored Quarterly by end of Year 3	Attendance Lists	
	3.1	Fund raising for CBT intervention	Proportion of funds raised that are adequate in meeting CBT intervention	Financial Records	Willingness of well-wishers to donate

	3.2	CBT beneficiaries verification	# of CBT beneficiaries verified monthly prior disbursement of funds	Beneficiary Verification Lists	Timely Stakeholder correspondence Supportive institutional and Policy Framework
	3.3	Post Distribution Meetings	# of PDMs held per monthly at least within 14 days from the last day of the CBT transfers	PDM Reports	
			Disaggregation of attendees by gender		
	3.4	Financial Literacy	# of older persons / caregivers attending Financial Literacy sessions		
	4.1	Stakeholder Mapping	No. of Stakeholder Mapped, identified and active in Consortia activities	Administrative Records	
	4.2	Radio Talk Shows	# of Radio Talk Shows held		
	4.3	Community Seminars	# of Community Seminars held		
	4.4	Community Meetings	# of Community Meetings held		
	4.5	Consortia Dialogue	# of Consortia Dialogue held		

4.1 Linking our Intervention to the 2030 SDG Agenda

Table 4.2: Linking our Intervention to the 2030 SDG Framework

2030 SDG FRAMEWORK	SDG GOAL	INTERVENTION STRATEGY	GOALS IN ACTION
		• Age- Freindly Primary Health Care systems • Age- Freindly Community Structures • Advocacy • Cash Based Transfers	• Building capacity of Healthcare providers in clinical gereatrics • Healthcare Management Systems and Refferals for older patients • Supporting gereatric HMIS data management and Reporting at Health facilities • Friendly pshyical enviroment at Health facilities to enhance mobility and access
			• Building capacity of VHTs to manage minor gereatrics and referrals • Establish Familial, Clan and community structures to support older persons
			• Lobby government to scale up SAGE funds in Northern Uganda • Research and Development
		• Age- Freindly Primary Health Care systems • Age- Freindly Community Structures • Advocacy • Cash Based Transfers	• Social infrastructural development in Rural Northern Uganda • Development of health infrastructure • Accessible physical environment • Support Health Sub-Districts in Clinical mappinng of At-Most Risk gereatric persons • Provide the requisite infrastructure (Drug stocks, funds, Training for HWs) in a timely manner • Case management of minor cases • Regular visits and Follow-ups on geriatric persons • Make referrals • Support Civil society activities in the region

		• Advocacy • Cash Based Transfers	• Platform for donor funding towards to support livelihoods and health access for elderly persons • Support Civil society activities in the region • Support with health insurance, SAGE funds collection • Support elderly persons with nutritional requirements, medication, emotional, psychosocial support
		• Advocacy	• Support Civil society activities in the region • Support Government and Health Ministry campaigns to reach the elderly e.g. Mass screening, immunization campaigns and mobile clinics • Support Community Structures • Operationalize the MOH, 2013 policy framework to cater for integration of Age-Freindly PHC • Capacity building of Health Workers (HWs) in clinical geriatrics • Increase the National Health Budget from 8.9% to meet the Abuja Declaration of 15% • Feasible policy framework to cater for integration of Age- Freindly Primary Health Care in line with the WHO framework • Social infrastructural development in Rural Northern Uganda

4.2 CONCLUSION

Preparing for an ageing population is vital to the achievement of the 2030 Agenda (United Nations, 2016). With ageing cutting across the SDG framework; poverty eradication, good health, gender equality, economic growth and decent work, reduced inequalities and sustainable cities, fostering ageing policy response is pivotal in supporting elderly persons to live harmonious and dignified lives.

Therefore, while it is essential to address exclusion, vulnerability of and intersectional discrimination against older persons, efforts should also be geared towards supporting their integration in community and national programming. Older persons ought to be recognized as the active agents of societal development in order to achieve truly transformative, inclusive and sustainable development outcomes (Dugarova, 2017). It should be the role of governments and developmental partners in developing countries to push for effective intuitional and policy reforms aimed at addressing the pertinent challenges that exclude older persons from healthcare access to realize SDG 3.

REFERENCES

Advisory Consortium on Conflict Sensitivity (2013). *Northern Uganda Conflict Analysis*. Retrieved from https://reliefweb.int/sites/reliefweb.int/files/resources/ACCS_Northern_Uganda_Conflict_Analysis_Report.pdf

Agborsangaya, C. B., Lau, D., Lahtinen, M., Cooke, T., & Johnson, J. A. (2012). Multimorbidity prevalence and patterns across socioeconomic determinants: a cross-sectional survey. *BMC Public Health*, *12*(1), 201. https://doi.org/10.1186/1471-2458-12-201

Agyemang-duah, W., Peprah, C., & Peprah, P. (2019). *Barriers to formal healthcare utilisation among poor older people under the livelihood empowerment against poverty programme in the Atwima Nwabiagya District of Ghana*. *2*, 1–12.

Ansaloni, L., Acaye, G. L., & Re, M. C. (2007). High HIV seroprevalence among patients with pyomyositis in Northern Uganda. *Tropical Medicine & International Health*, *1*(2), 210–212. https://doi.org/10.1111/j.1365-3156.1996.tb00028.x

Armed Conflicts Report Uganda (1987- first combat deaths). (2009). (January 2009). Retrieved from https://www.justice.gov/sites/default/files/eoir/legacy/2014/02/25/Uganda.pdf

Assari, S., Wisseh, C., & Bazargan, M. (2019). Obesity and polypharmacy among african american older adults: Gender as the moderator and multimorbidity as the mediator. *International Journal of Environmental Research and Public Health*, *16*(12), 2181. https://doi.org/10.3390/ijerph16122181

Bähler, C., Huber, C. A., Brüngger, B., & Reich, O. (2015). Multimorbidity, health care utilization and costs in an elderly community-dwelling population: a claims data based observational study. *BMC Health Services Research*, 1–12. https://doi.org/10.1186/s12913-015-0698-2

Bao, J., Chua, K., Prina, M., & Prince, M. (2019). Multimorbidity and care dependence in older adults : a longitudinal analysis of findings from the 10 / 66 study. *BMC Public Health*, 1–10. Retrieved from https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-6961-4

Bloom, D. E. (2011). 7 Billion and counting. *Science*, *333*(6042), 562–569. https://doi.org/10.1126/science.1209290

Braga, L. D. C., Bittar, B. F., & Lima, K. C. De. (2019). Factors associated with multimorbidity in the elderly: an integrative literature review. *Revista Brasileira de Geriatria e Gerontologia*, *22*(1). https://doi.org/10.1590/1981-22562019022.180154

de Carvalho, I. A., Epping-Jordan, J., Pot, A. M., Kelley, E., Toro, N., Thiyagarajan, otheeswaran A., & Bearda, J. R. (2017). Organizing health-care services to meet older people ' s needs Importance of integrated health care. *Bulletin of the World Health Organization: Type, Policy & Practice*, (i), 1–17.

Doetsch, J., Pilot, E., Santana, P., & Krafft, T. (2017). Potential barriers in healthcare access of the elderly population influenced by the economic crisis and the troika agreement: A qualitative case study in Lisbon, Portugal. *International Journal for Equity in Health*, *16*(1), 1–17. https://doi.org/10.1186/s12939-017-0679-7

Dugarova, E. (2017). Ageing, Older Persons and the 2030 Agenda for Sustainable Development. *United Nations Publications*, 1–26. https://doi.org/10.1016/j.tcs.2014.12.001

Fabbri, E., Zoli, M., Gonzalez-freire, M., Salive, M. E., Studenski, S. A., & Ferrucci, L. (2016). Aging and Multimorbidity: New Tasks, Priorities, and Frontiers for Integrated Gerontological and Clinical Research. *Journal of American Medical Directors Association*, *16*(8), 640–647. https://doi.org/10.1016/j.jamda.2015.03.013.Aging

Fitzpatrick, A. L., Powe, N. R., Cooper, L. S., Ives, D. G., Robbins, J. A., & Enright, E. (2004). Barriers to health care access among the elderly and who perceives them. *American Journal of Public Health*, *94*(10), 1788–1794. https://doi.org/10.2105/AJPH.94.10.1788

Gallacher, K. I., Mcqueenie, R., Nicholl, B., Jani, B. D., Lee, D., & Mair, F. S. (2018). Risk factors and mortality associated with multimorbidity in people with stroke or transient ischaemic attack: a study of 8,751 UK Biobank participants. *Journal of Comorbidity*, *8*(1), 1–8. https://doi.org/10.15256/joc.2018.8.129

Guillaume, K. M. A., Christophe, B. T. J., Christine, K. B., Henock, M. K. J., Anaclet, M. M., Valentin, K. B., … Stanis, W. O. (2019). Factors Associated with Inequalities in Access to Health Care to Mbujimayi (Kasai Oriental/DR Congo). *OALib*, *06*(10), 1–17. https://doi.org/10.4236/oalib.1105666

Jang, Y., Chiriboga, D. A., Allen, J. Y., Kwak, J., & Haley, W. E. (2010). Willingness of older korean-american adults to use hospice. *Journal of the American Geriatrics Society*, *58*(2), 352–356. https://doi.org/10.1111/j.1532-5415.2009.02684.x

Joint United Nations Programme on HIV/AIDS. (2014). *People aged 50 years and older*. 1–12.

Levine S. (2009). *Poverty and Human Development in Northern Uganda: Notes for the Development Partners Group For Northern Uganda Recovery and Development*. (August).

MFPED. (2014). *Uganda Poverty Status Report 2014*. 1–96. Retrieved from http://www.ug.undp.org/content/dam/uganda/docs/UNDPUg2014 - POVERTY STATUS REPORT 2014.compressed.pdf

Ministry of Health-Uganda. (2014). *The Uganda Hospital and Health Centre IV Census Survey*. 224. Retrieved from https://www.who.int/healthinfo/systems/SARA_H_UGA_Results_2014.pdf?ua=1

Moe Dr., S., Tha, K., Naing, D. K. S., & Htike, M. M. T. (2012). Health seeking behaviour of elderly in Myanmar. *International Journal of Collaborative Research on Internal Medicine and Public Health*, *4*(8), 1538–1544.

Morgan, S. A. (2017). *Multimorbidity: its prevalence and impact in middle-income countries. A multicountry comparison using household surveys and qualitative methods*. University of Southampton.

Mugisha, J. O., Schatz, E. J., Randell, M., Kuteesa, M., Kowal, P., Negin, J., & Seeley, J. (2016). Chronic disease, risk factors and disability in adults aged 50 and above living with and without HIV: findings from the Wellbeing of Older People Study in Uganda. *Global Health Action*, *9*, 31098. https://doi.org/10.3402/gha.v9.31098

Namakula, J., & Witter, S. (2014). Living through conflict and post-conflict: Experiences of health workers in northern Uganda and lessons for people-centred health systems. *Health Policy and Planning*, *29*, ii6–ii14. https://doi.org/10.1093/heapol/czu022

National Population Council/ MoFPED. (2011). *Uganda's Transition Towards Population Stabilisation*. 32.

Nawagi, F., Söderberg, M., Berggren, V., Ajambo, A., Nakasujja, N., & Midlöv, P. (2018). Sociodemographic Characteristics and Health Profile of the Elderly Seeking Health Care in Kampala, Uganda. *Current Gerontology and Geriatrics Research*, *2018*, 9–12. https://doi.org/https://doi.org/10.1155/2018/4147509

Nguyen, H., Chua, K. C., Dregan, A., Vitoratou, S., Bayes-Marin, I., Olaya, B., & Prina, A. M. (2019). Factors Associated With Multimorbidity Patterns in Older Adults in England: Findings From the English Longitudinal Study of Aging (ELSA). *Journal of Aging and Health*. https://doi.org/10.1177/0898264319891026

NPA/ UBOS/ MOFPED. (2016). *National Standard Indicator Framework.pdf*. Retrieved from https://budget.go.ug/sites/default/files/Annex 8a-National Standard Indicator Framework.pdf

Nzabona, A. (2016). *Data Assessment Study of Population Ageing in Uganda*. Retrieved from https://www.un.org/development/desa/ageing/wp-content/uploads/sites/24/2019/04/Assessment-Uganda.pdf

Obrist, B., Iteba, N., Lengeler, C., Makemba, A., Mshana, C., Nathan, R., … Mshinda, H. (2007). Access to health care in contexts of livelihood insecurity: A framework for analysis and action. *PLoS Medicine*, *4*(10), 1584–1588. https://doi.org/10.1371/journal.pmed.0040308

Palladino, R., Lee, J. T., Ashworth, M., Triassi, M., & Millett, C. (2016). Associations between multimorbidity, healthcare utilisation and health status: evidence from 16 European countries. *Age and Ageing*, *45*(3), 431–435. https://doi.org/10.1093/ageing/afw044

Razzaque, A., Nahar, L., Akter Khanam, M., & Kim Streatfield, P. (2010). Socio-demographic differentials of adult health indicators in Matlab, Bangladesh: self-rated health, health state, quality of life and disability level. *Global Health Action*, *3*(1), 4618. https://doi.org/10.3402/gha.v3i0.4618

Rijken M (Coord). (2016). *How to improve care for people with multimorbidity in Europe? On behalf of the ICARE4EU consortium What is a Policy Brief?* Retrieved from

http://www.euro.who.int/__data/assets/pdf_file/0004/337585/PB_23.pdf

Schatz, E., Seeley, J., Negin, J., & Mugisha, J. (2018). *"They don'' t cure old age": older Ugandans' delays to health-care access."*

Sheridan, P. E., Mair, C. A., & Quinõnes, A. R. (2019). Associations between prevalent multimorbidity combinations and prospective disability and self-rated health among older adults in Europe. *BMC Geriatrics*, *19*(1), 1–10. https://doi.org/10.1186/s12877-019-1214-z

Singh, P. K., Singh, L., & Mehrotra, R. (2019). Socioeconomic determinants of chronic health diseases among older Indian adults: a nationally representative cross- sectional multilevel study. *BMJ Open*, (e028426), 1–12. https://doi.org/10.1136/bmjopen-2018-028426

Tam, W. J., & Yap, P. (2016). Health Care for Older Adults in Uganda : Lessons for the Developing World. *International Health Affairs*. https://doi.org/10.1111/jgs.14560

Taylor, A. W., Price, K., Gill, T. K., Adams, R., Pilkington, R., Carrangis, N., … Wilson, D. (2010). Multimorbidity - not just an older person's issue. Results from an Australian biomedical study. *BMC Public Health*, 16–18. https://doi.org/10.1186/1471-2458-10-718

The World Bank Group. (2016). *Poverty Assessment Report 2016*. 178. https://doi.org/10.1002/adma.201102804

Uganda Bureau of Statistics. (2007). *Projections of demographic trends in Uganda*. Kampala.

Uganda Bureau of Statistics & ICF. (2018). *Uganda Demographic and Health Survey 2016*. 625. Retrieved from https://dhsprogram.com/pubs/pdf/FR333/FR333.pdf

UNAIDS. (2013). *HIV and Aging. A special supplement to the UNAIDS report on the global AIDS epidemic 2013*. 1–7. Retrieved from http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20131101_JC2563_hiv-and-aging_en.pdf

UNHCR. (2015). *Cash-based interventions for health programmes in refugee settings. A review*. 28. Retrieved from http://www.unhcr.org/568bce619.pdf

United Nations, Department of Economic and Social Affairs, P. D. (2017). World Population Ageing 2017 - Highlights (ST/ESA/SER.A/397). In *World population ageing*. Retrieved from http://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2017_Highlights.pdf

United Nations. (2016). Transforming our World: The 2030 Agenda for sustainable development. *Arsenic Research and Global Sustainability - Proceedings of the 6th International Congress on Arsenic in the Environment, AS 2016*, 12–14. https://doi.org/10.1201/b20466-7

Van Den Akker, M., Buntinx, F., Roos, S., & Knottnerus, J. A. (2001). Problems in determining occurrence rates of multimorbidity. *Journal of Clinical Epidemiology*, *54*(7), 675–679. https://doi.org/10.1016/S0895-4356(00)00358-9

Wandera, S. O., Ddumba, I., Akinyemi, J. O., Adedini, S. A., & Odimegwu, C. (2017). Living Alone among Older Persons in Uganda: Prevalence and Associated Factors. *Ageing International*, *42*(4), 429–446. https://doi.org/10.1007/s12126-017-9305-7

Wandera, S. O., Golaz, V., Kwagala, B., & Ntozi, J. (2015). Factors associated with self-reported ill health among older Ugandans: A cross sectional study. *Archives of Gerontology and Geriatrics*, *61*(2), 231–239. https://doi.org/10.1016/j.archger.2015.05.006

Wandera, S. O., Kwagala, B., & Ntozi, J. (2015). Determinants of access to healthcare by older persons in Uganda: A cross-sectional study. *International Journal for Equity in Health*, *14*(1), 1–10. https://doi.org/10.1186/s12939-015-0157-z

Wealth, A. J. D. (2014). *Participatory wealth rankings as a tool for targeting and evaluation: Do participatory methods successfully identify the poor and measure change in their lives?* 1–14. Retrieved from http://villageenterprise.org/wp-content/uploads/2015/12/Participatory-Wealth-Ranking-and-PPIs_November_2015_AJ-white-paper.pdf

Wesonga, R., Guwatudde, D., Bahendeka, S. K., Mutungi, G., Nabugoomu, F., & Muwonge, J. (2016). Burden of cumulative risk factors associated with non-communicable diseases among adults in Uganda: evidence from a national baseline survey. *International Journal for Equity in Health*, *15*(195), 1–10. https://doi.org/10.1186/s12939-016-0486-6

WFP. (2019). *The potential of cash-based interventions to promote gender equality and women's empowerment*. (February), 1–138. Retrieved from https://reliefweb.int/report/world/potential-cash-based-interventions-promote-gender-equality-and-women-s-empowerment

WHO. (2004). Towards Age-friendly Primary Health Care. *Health Care*, 40.

Women's Commission for Refugee Women and Children. (2005). *Learning in a War Zone : Education in Northern Uganda*. (February). Retrieved from www.womenscommission.org

Annex 1: Letter of Support from the Ministry of Gender Labour and Social Development, Uganda

TELEPHONE:
SWITCHBOARD: 041-4 347854
041-4 347855
PERMANENT SECRETARY: 041-4 343572
FAX: 041 256374
E-MAIL: ps@mglsd.go.ug
WEBSITE: http//www.mglsd.go.ug

THE REPUBLIC OF UGANDA

Ministry of Gender, Labour and Social Development
P.O. Box 7136
Kampala,
Uganda.

In any correspondence on
This subject please quote No. ADM 52/159/01

10th July 2020

The Adjudicators of the Geneva Challenge:

RECOMMENDATION FOR SUPPORT TO THE "INCLUSION FOR HEALTHCARE ACCESS FOR OLDER PERSONS IN ACHOLI SUB REGION OF NORTHERN UGANDA INITIATIVE PROJECT

The Acholi Sub Region of Northern Uganda witnessed Two decades of civil strife from 1986 to 2006 from the LRA insurgence, which fractured Healthcare infrastructure other significant social infrastructure. This adversely affected social service delivery, leaving the region impoverished and subsequently affecting the region's developmental prospects.

The Ministry of Gender, Labour and Social Development , is mandated to empower communities to promote socio-economic growth, skills development and labor productivity while promoting gender equality, labor administration, social protection and transformation of communities. This has been done by developing effective legal and policy frameworks to support Social Service delivery for Older Persons.

The Ministry has also operationalized the Social Assistance Grants for Empowerment (SAGE) under the Expanding Social Protection Program. The Government of Uganda also continues to collaborate with the Private Sector and Civil Society with the aim of supporting the developmental agenda as laid out in the National Development Plan (NDP III) and Uganda's Vision 2040.

We pledge our full support to the cause of "**enhancing healthcare access inclusion for older persons in Northern Uganda**" and to support the Team from Makerere University as they implement their intervention in the region.

Agnes Nampeera
FOR: COMMISSIONER DISABILITY AND ELDERLY

Ministry of Gender, Labour and Social Development