

# Health System Profile for Uganda

2005

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## Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARI	Acute Respiratory Infections
CDD	Control of Diarrhoeal diseases
CHW	Community Health Worker
DDHS	District Director of Health Services
DHMT	District Health Management Team
DOTS	Directly Observed Therapy
DPT	Diphtheria, Pertussis and Tetanus vaccine
ENT	Ear, Nose and Throat
EPI	Expanded Program on Immunization
FP	Family Planning
GDP	Gross Domestic Product
GOU	Government of Uganda
HC	Health Centre
HIV	Human Immune Deficiency Virus
HMIS	Health Management Information System
HRD	Human Resource Development
HRH	Human Resources for Health
HSD	Health Sub-district
HSSP	Health Sector Strategic Plan
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
MOH	Ministry of Health
MOLG	Ministry of Local Government
NGO	Non-Government Organization
PEAP	Poverty Eradication Action Plan
PEM	Protein-Energy Malnutrition
PHC	Primary Health Care
QA	Quality Assurance
RH	Reproductive Health
STD	Sexually Transmitted Diseases
TB	Tuberculosis
TT	Tetanus Toxoid
TBA	Traditional Birth Attendants
UBOS	Uganda Bureau of Statistics
UNDP	United Nations Development Program
UNEPI	Uganda National Expanded Programme on Immunization
UNFPA	United Nations Population Fund
UNHRO	Uganda National Health Research Organization
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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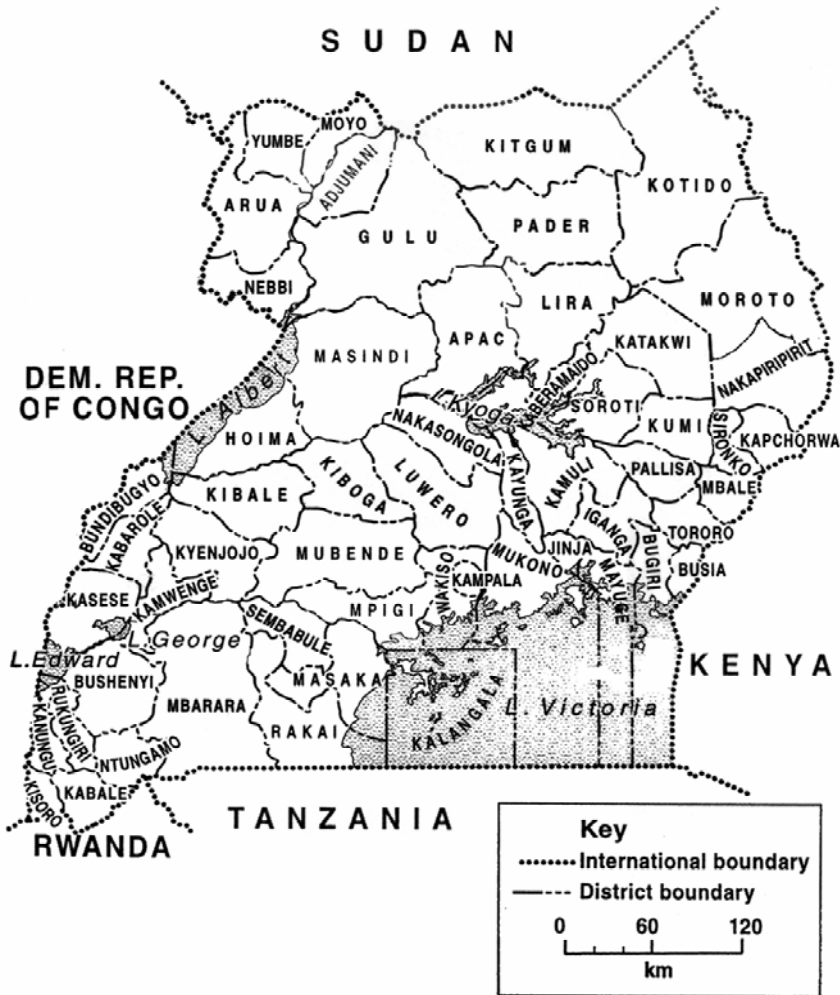
## Foreword

To-date, a number of countries in the Region have been developing their country health systems profiles, albeit in different ways. The information collected in the country health systems profiles is related to the health systems, which consist of all people and actions whose primary purpose is to improve health<sup>1</sup>. In response to the various health sector forms being undertaken in the region, it has become necessary to put in place an instrument that will facilitate systematic monitoring of the progress made by countries. In this regard, a common format for the country profile has been developed, taking into consideration the agreed core indicators and areas for the Region. This will also allow for easy exchange of country health information and for consolidation of health data and achievement of the various goals and targets.

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<sup>1</sup> World Health Report 2000

# Map of Uganda



## Chapter 1: Introduction

### Objectives of the Health Systems Profile

The specific objectives of the document of national health systems profiles are to:

- Readily avail essential country information to national authorities and partners for better planning
- Facilitate the sharing of harmonised information between the countries;
- Contribute to the development of Regional health systems profiles;
- Contribute to the dissemination of country health systems profiles using websites

### General situation and trends

#### General context and demography

Uganda is a landlocked country located in the East African Region. It is bordered by Kenya in the East, DRC in the West, Sudan in the North and Tanzania and Rwanda in the South. Uganda achieved independence on 9<sup>th</sup> October 1962. Uganda enacted a new Constitution in 1995 and decentralized governance under guidance of the Local Government Act (1997). By the beginning of 2001, Uganda had 45 districts. 11 new districts have been demarcated since then. The country currently consists of 56 districts each forming an administrative unit (refer to the Map of Uganda). The 56 districts are subdivided into; 167 Counties, 930 Sub-counties, 4517 Parishes and 39,692 Villages. The village forms the smallest politico-administrative unit.

At the time of the 2002 Census, Uganda had a population of 24.7 million persons with an average inter-censal population growth rate of 3.4% between the 1991 and 2002 censuses<sup>2</sup>.

#### Socio-economic context

Uganda's economy is dominated by agriculture, which contributes more than 60% of its foreign exchange earnings and, 85% of the rural livelihoods. Agriculture accounts for over 40% of the Gross Domestic Product (GDP), 85% of the exports and 80% of the employment sector.

Most of the agriculture sector stakeholders, who are mainly smallholder farmers, account for over 95% of the production. Uganda achieved marked economic growth averaging 7% per annum from 1992 to 1997 and inflation rate was maintained below 10% (approx 5.5%).

The Gross Domestic Product (GDP) realized a modest percentage growth of 7.0% in 1998/99, 5.5% in 1999/00 and 6.0% in 2000/01<sup>3</sup>. GDP per capita in current prices was US\$249 in 1998/99, US\$238 in 1999/00 and US\$ 222 in 2000/01<sup>4</sup>.

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<sup>2</sup> Uganda Bureau of Statistics 2002

Private sector investment increased from 8.6% of GDP in 1992/93 to 14.6% of GDP in 2001/02. Consequently, due to the fluctuation in economic growth rates per annum the percentage of the population living below the poverty line, which had been on the decline from 52% in 1992/93 to 44% in 1997/98 and to 35% in 2000, has risen slightly to 38% in 2003<sup>5</sup>. Poverty continues to be a rural phenomenon, with 96% of the poor living in rural areas in 2000<sup>6</sup>. However, the recent rise in poverty levels revealed a proportionate rise in poverty actually higher in urban areas than in rural areas<sup>7</sup> (MoFPED, 2003). Regional disparities still exist with the north lagging behind most of the country followed by the Eastern region<sup>8</sup>.

The Government of Uganda (GoU) elaborated the Poverty Eradication Action Plan (PEAP) in 1997 with updates/revision every three years - in 2000 and 2003. The PEAP is the overall country development framework which guides the formulation of government policies and particularly allocation of public resources. The goal of the PEAP is to reduce the percentage of the population living below the poverty line to less than 10% by the year 2017 and to improve the well being of all Ugandans (MoFPED, 2001).

Four core challenges for the PEAP are (a) the restoration of security, dealing with the consequences of conflict and improving regional equity (b) restoring sustainable growth in the incomes of the poor (c) human development (d) using public resources transparently and efficiently to eradicate poverty. The PEAP 2004 is grouped under five 'pillars' or components: (1) economic management, (2) production, competitiveness and incomes (3) security, conflict-resolution and disaster-management (4) governance and (5) human development.

In 1998, GoU was granted debt relief under the Highly Indebted Poor Countries (HIPC) initiative. This prompted the creation of the Poverty Action Fund (PAF) in order to channel the additional government funds resulting from the HIPC Initiative and mobilize other donor resources towards the key sectors identified in the PEAP<sup>9</sup>. The PAF budget line is protected from budget cuts within a given financial year and the PAF funds for service delivery are 'conditional' to ensure that they are used on the key programmes in the PEAP. The funding to the priority programmes under PAF has increased from 17% of the total government budget in 1997/98 to 30% in 2000/01 and to 33% in 2002/03<sup>10</sup>.

Gender balance in governance and service provision is one of the main domains of the 1995 constitution of Uganda. Main features of gender policy implementation varies from the community level whereby community based organizations and local governance councils are obliged by law to have at least 33% (one third) slots specifically for women to legislative representation in parliament where each district has an automatic woman member of parliament to represent women.

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3 Background to the Budget 2002/03

4 Macroeconomics Department MoFPED 2003

5 Poverty Eradication Action Plan 2001-2003 and Uganda National Household Survey 2003.

6 Poverty Status Report 2000

7 Poverty Eradication Action Plan 2001-2003

8 Uganda National Household Surveys 1999/00 and 2002/03.

9 The non Poverty Action Fund (non-PAF) resources are constituted by Government's own resources.

10 Poverty Eradication Action Plan 2001-2003

Even at ministerial level, the government of Uganda recognizes gender participation as a key obligation by having at least 33% women ministers. One of the longest serving vice presidents of Uganda has been a woman. Other affirmative actions for gender mainstreaming include awarding additional 1.5 points to all female entrants to government universities. Enrolment and performance of girls in schools has been rising steadily as well. In Uganda, there is no gender discrimination in employment opportunities; the only yardstick of recruitment is relevant qualification.

## **Environmental health**

Environmental health programme is one of the main components of the current National Health Policy of Uganda as it is evident that environmental factors are major determinants of public health outcomes. The main objective of the programme is to contribute to the attainment of a significant reduction in morbidity and mortality due to environmental health related conditions.

The government programme has been focussing on raising awareness in the population on the relationships between their health and their surroundings. This programme provides health services that aim at alleviating current poor sanitary living conditions and food contamination by providing access to safe water and waste disposal- at household, institutional, and urban and rural settings.

It also addresses health issues related to environmental and/or occupational hazards such as toxic agents and worm infection in agriculture and hazards to health in other occupations. Further, the following are also addresses: maintenance of food and personal hygiene to prevent communicable diseases, adoption of appropriate technology for vulnerable communities including those with special geo-physical conditions, and updating and enforcement of health regulations.

The national targets by the end of the plan period (2000/01 – 2004/05) are:

- To increase access to safe water from 43% to 75% by the end of the planned period;
- All 45 districts will be carrying out regular drinking water quality surveillance activities;
- Increase safe waste disposal including human excreta in 60% of households and institutions in Uganda by end 2004;
- An Environmental Health Act and subsidiary legislation in place and being fully enforced.

The Environmental Health programme through the National Environmental Sanitation Plan and the Kampala Declaration on Sanitation (KDS) is expected to:

- Implement minimum environmental health services package with special emphasis on safe water supply and sanitation as spelt out in the National Health policy and the Kampala Declaration;
- Strengthen collaborative mechanism at various packages with special emphasis on promotion of safe water and sanitation and occupational health;
- Promote proper food hygiene and safety, management of waste (solids and liquid), pollution control, and occupational health and safety in workplaces;

- Promote gender responsive IEC to support community mobilisation on environmental health matters;
- Promote clean and hygienic living conditions at household level;
- Integrated Sanitation and hygiene in school health and educational programmes.

*Implementation Strategy emphasizes:*

- Regular monitoring and awareness campaigns to facilitate all households to have access to safe human waste disposal systems and safe refuse disposal methods
- Legislation to guide safe water and environmental sanitation, pollution control, disposal of industrial and chemical waste, and promotion of public safety in motor vehicles
- Water and environmental sanitation underpin much of the activities envisaged by other technical programs that aim to reduce child and infant mortality, and epidemic prevention and control, especially: IMCI, MCH and Nutrition programs
- Effective implementation of this programme entails involvement of the community on proper sanitary behaviour and practice, and active involvement of NGO and other Government Agencies- particularly, the ministry responsible for the construction work/provision of water systems
- Appropriate environmental measures including anti-worm infestation measures in communities is to be upheld

Some of the indicators of the performance of the Environmental Health programme are in Annex III.

*Policy stewardship:*

The Division of Environmental Health in collaboration with Health Education at the MoH is responsible for policy development, overall co-ordination and guidance on sanitation and safe water services throughout the country, as well as technical supervision and support to District Directors of Health Services. It co-ordinates:

- NGOs, and other Government agencies on the establishment of standards and regulations affecting the program
- Monitoring of delivery of public and private sector sanitation and safe water services throughout Uganda
- At District level, the District Director of Health Services is responsible for the planning, management, monitoring and co-ordination of sanitation and safe water services with all agencies working at the district level.

There are health training institutions and one Government University training environmental health specialists at Diploma and Degree levels, respectively.

## **Healthy lifestyles, food and nutrition**

**Nutrition and Emerging diseases:** The nutritional status of the population, particularly children and women is poor and has been identified as a major health problem in Uganda. In order to control diseases due to nutritional anaemia, protein energy malnutrition, Iodine deficiency disorders and vitamin A deficiency, a combination of strategies including awareness building, care management, rehabilitation, supplementation, food fortification and diet diversification will be employed. The department of community health will use a multi-sectoral approach with other sectors in implementation of strategies to improve the nutritional status.

The main objective of nutrition programme is to contribute towards the improvement of the nutritional status of the population with special emphasis on mothers and children.

The programme will be expected to:

- Provide policies and guidelines in conjunction with the National Food and Nutrition council;
- Support capacity building at central and district levels for reduction of malnutrition;
- Promote nutrition programs at different levels to reduce micro-nutrient deficiency disorders;
- Establish an effective national growth monitoring and promotion system nation-wide;
- Provide support supervision to the district;
- Formulate and enforce nutrition related legislation in conjunction with other relevant sectors;
- Intensify gender responsive advocacy and social mobilisation for nutrition at all levels;
- Provide guidelines for monitoring and evaluation of nutrition interventions;
- Target the school going population through the School Health Programme.

### **Implementation Strategy**

The strategy of sensitising households on balanced diets for children and young adults will be adopted. Upgrading the existing health centres, Implementing Health Sub-District (HSD) and the community health departments of the hospital will ensure effective implementation of Nutrition programs targeting households and communities.

At the national level, the Nutrition unit under the Department of Community Health in collaboration with other technical department, programs, other Government Ministries and agencies, will be responsible for policy development, overall co-ordination and guidance on nutrition throughout the country as well as technical supervision and support to Districts. The Department of Community Health will co-ordinate NGO sector on the establishment of standards and regulations affecting the program. Furthermore, it will create linkages within the Department in the section of nutrition and IMCI community component and other development partners

At the district level, the District Director of Health Services is responsible for the planning, management, monitoring and co-ordination of nutrition activities at the District. Implementation arrangements for Nutrition programme are given in the log frames below.

**Healthy Lifestyles and Mental Health:** Main challenges to healthy life styles mainly affect the youth, and include: influence of mass media, pornography, sexual laxity and alcoholism (closely associated with sexually transmitted infections/HIV/AIDS and unwanted pregnancy), cigarette smoking, eating junk food from chains of junk food restaurants (hence obesity), indifferent attitude to physical exercise, and use of other substances of abuse: Marijuana, Cannabis, Cocaine, Caffeine, Nicotine, Khat (*Mairungi*), aerosol fumes, etc. Uganda still ranks very high in teenage pregnancy rates among the Sub-Saharan African countries. Overall, 31% of teenagers have begun child bearing, with almost 26% having had a child already (UDHS 2000/01).

The concomitant existence of war, internal displaced and externally displaced populations has created psychosocial challenges, and increased vulnerability of these populations to deviant

moral behaviours- especially indiscriminate heterosexual relationships, use of substances of abuse, delinquency, trading off good sociocultural moral values for moral-value compromising western culture, and associated reinforcement of HIV/AIDS spread and persistence in the population.

Several studies in the country have revealed that there is unprecedented high level of mental illnesses of varying types in the country, worsened by wars and displaced populations, high levels of abject poverty, HIV/AIDS and the resultant psycho-social traumas of individuals, families and communities. The current health policy has placed a special emphasis on mental health because of the significant burden of disease, and mortality attributable to mental illness in the country. Current challenges, however, remain inadequate funding and limited availability of appropriate trained service providers to run mental health activities (AHSPR, 2003/04).

## Chapter 2: Country Health Situation

### Health Status and Epidemiological Profile

The health status indices of Uganda are still very poor, comparable with the average for Sub-Saharan Africa. The UDHS 2000 recorded the Infant Mortality Rate at 88 deaths per 1,000 live births, Under-five mortality rate at 152 deaths per 1,000 live births, Total Fertility Rate of 6.9 and the Maternal Mortality Ratio at 505 deaths per 100,000 live births<sup>11</sup>. There are socioeconomic differences in the health outcomes with the IMR at 60.2 deaths per 1,000 live births for the highest socioeconomic quintile compared to 105.7 deaths per 1,000 for the lowest socioeconomic quintile with an inter-quintile ratio of 1.76. Similarly, the Under 5 mortality rate for the lowest quintile is twice as high as that for the highest quintile. The TFR for the highest quintile is 4.1 births per woman while that for the lowest quintile is 8.5 births per woman. Table 2.1 illustrates this with findings from the last 3 Uganda Demographic and Health Surveys for Uganda – 1988, 1995 and 2000/01, compared with the average for Sub-Saharan Africa (SSA) for the years 1995-2000.

**Table 2.1: Health indices for Uganda**

Indicator	Uganda			Average for SSA
	1988	1995	2000-2001	1995-2000
Life expectancy at birth (at birth)		52	47	51
Infant Mortality Rate (IMR) per 1,000 live births	122	81	88	92
Under 5 Mortality Rate per 1,000 live births	203	147	152	151
Maternal Mortality Ratio (MMR) per 100,000 live births	700	506	505	870*
Total Fertility Rate (TFR) children per women	7.1	6.9	6.9	5.6*
Contraceptive Prevalence Rate (CPR)	5%	15%	23%	
Access to safe water		48%	51.8%	62%**

*Source:* Uganda Demographic and Health Surveys 1988, 1995, 2000-2001, Commission on Macroeconomics and Health, December 2001, \*Health, Nutrition and Population, World Bank 1995, \*\*Global Water Supply Assessment 2000 Report – WHO, UNICEF and Water Supply and Sanitation Collaborative Council

The leading causes of morbidity and mortality in Uganda are mainly communicable diseases. According to the Burden of Disease study done in Uganda (MoH 1995) over 75% of the life years lost due to premature deaths are due to ten preventable diseases<sup>12</sup>. Perinatal and maternal conditions (20.4%), malaria (15.4%), acute lower respiratory tract infections (10.5%), HIV/AIDS (9.1%) and diarrhoea (8.4%) together account for over 60% of the total disease burden. The common non-communicable diseases include hypertension, diabetes and cancer, mental illness, chronic and degenerative disorders and cardiovascular diseases.

<sup>11</sup> Uganda Demographic and Health Survey 2000/01

<sup>12</sup> National Health Policy 1999

By 1986 the Health Sector was in a state of near collapse with dilapidated and very poorly equipped public health facilities. Health Workers in the public sector were demoralized due to very low and irregular wages. Public funding for the sector was unreliable and at its lowest at 2.5% of the national budget in 1987/88<sup>13</sup>. Health care costs were only met from out of pocket payments of households as health services were mostly provided by PNFs facilities and the rapidly expanding Private Health Practitioners' sector. These are manifestations of decades of neglect, looting and massive brain drain, which were reflections of the general decay in the country.

This institutional breakdown was worsened by the re-emergence of diseases that had been previously controlled such as sleeping sickness, TB, guinea worm and measles as well as the emergence of HIV/AIDS. Public health policy vacuums became apparent and Uganda's health indicators were among the worst in the region and the whole world. Further, due to the lack of confidence in the existing public institutions, the bulk of the donor funding was managed through projects and Non-Governmental Organizations (NGOs). Donors could determine which part of the country or/and which type of services to fund. The government tended to fund services at health facilities including salaries of health workers whereas the donor projects funded 'primary health care services' and some extension and rehabilitation of infrastructure.

From 1986, Uganda embarked on major reforms both in the health sector and wider public arena. In the health sector, the immediate emphasis was on rehabilitation of the existing facilities to restore functional capacity, and a shift of emphasis to Primary Health Care with a defined Minimum Package of cost-effective services. As in other developing countries, bilateral and multilateral development partners increase funding to the health sector and encouraged alternative mechanisms of financing health services<sup>14</sup>.

In the early 1990's the Ugandan government embraced Decentralization as part of a crosscutting Public Sector Reform whereby the central government mandate remained policy formulation, standard setting and resource mobilization, and local governments mandate was to implement the policies and mobilize additional resources at the local level. Public institutions were restructured and strengthened as part of wider Structural Adjustment Programmes.

During this period, the health, economic and other social indicators were all on the rise - improved access to safe water, improved pit-latrines coverage and better nutrition at the household level all contributed to improvement of health status.

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<sup>13</sup> National Health Policy 1999

<sup>14</sup> Better Health in Africa, World Bank 1987

## Chapter 3: The National Health System

### The National Health Policy and Health Sector Strategic Plan

In 1995/96 the development of a new ten-year National Health Policy (NHP) and five-year Health Sector Strategic Plan (HSSP) was initiated. The NHP was launched in 1999/00 and the HSSP at the beginning of the Financial Year 2000/01. The NHP and HSSP Seek to enhance the health status of the population thru the following approaches:

A minimum package of services comprising the most cost-effective interventions that address the major causes of burden of disease was articulated. The package known as the **Uganda Minimum Health Care Package (UMHCP)** was intended to be the cardinal reference in determining the allocation of public funds and other essential inputs. The UMHCP includes the Control of Communicable Diseases like malaria, HIV/AIDS and Tuberculosis, the Integrated Management of Childhood Illnesses, Sexual and Reproductive Health and Rights, Public Health Interventions like Immunization, School Health, Health Education and Promotion, Environmental Health<sup>15</sup>.

Realignment of structures and definition of roles and responsibilities of the central and local governments in line with the 1995 constitution and the Local Government Act 1997. While the centre assumes stewardship of the health policy the District Health Service delivers the NMHCP to the communities in an integrated manner through specified activity packages across levels within Health Sub-districts.\*

A sustainable broad-based national **Health Financing Strategy (HFS)** geared towards efficient, effective and equitable allocation and utilization of resources in the Health Sector consistent with the PEAP and the Bamako initiative. Stronger Donor Co-ordination institutionalized through the **Sector Wide Approach (SWAp)** and ICC for health development. The basic principles of equity: fair play and justice are expected to be at the forefront.

**Empowering Communities** to take responsibility for their own health and participate actively in the management of their local health services.

**Enacting a Public Private Partnership for Health Policy:** The recognition that the Private Sector has specific advantages in health care delivery which need to be recognized and harnessed – **Public Private Partnership for Health.**

The NHP and HSSP have laid the basis for a framework for strategic Policy Review and Formulation, Planning, Budgeting, Monitoring and Evaluation

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<sup>15</sup> National Health Policy 1999 and Health Sector Strategic Plan 2000

\*The appropriate Health Infrastructure has been drawn up in the Health Infrastructure Development and Maintenance Plan (HIDMP). A Human Resource Development Plan (HRDP) is available for addressing the major constraints of inadequate numbers and inappropriate distribution of trained health personnel.

The drafting of the NHP and HSSP was over a period of 3-4 years (1996/97 to 2000/01). Hence, the NHP and HSSP were a result of stakeholder consensus, since the Policy and Plan were to be operationalised through SWAp. Implementation of some of the concepts was initiated in 1997/98, for example the creation of a Primary Health Care Conditional Grant (PHC CG) channeling funds for the implementation of the UNMHCP in public and Private-Not-For-Profit institutions, and the operationalisation of the Health sub-District concept was initiated in 1998/99<sup>16</sup>. Other key aspects of health system functionality were structural and operational components: establishment of HSDs, identification of health delivery levels and health unit management committees with direct community representation

## **The components of the Health System**

### **The Public Sector**

The Public Health care system has undergone transformation as a result of proactive government policies. There has been expansion of health infrastructure to achieve greater coverage, rehabilitation and upgrading of some existing infrastructure, continued Human Resource Development to improve competences for effective and efficient management of the national and district health system.

The Public Health System consists of a tiered structure of health facilities. There are two National Referral hospitals, eleven semi-autonomous regional referral hospitals, and well established District Health System under the leadership of the District Directorate of Health Services in each of the 56 districts. Another key feature of the decentralization reform in the Health Sector is the establishment of the Health Sub-district as an integral part of the DHS. The HSD is designated to deliver the NMHCP to the community through a hierarchy of health facility levels:

- Health Centre I (HC I)- a satellite health facility with no definite physical structure; it is where health facility out-reach teams meet the community for EPI, Health Education etc activities
- HC II- the closest structural Health facility to the community; it delivers the MAP (Minimum Activity Package of the NMHCP). It is at parish level of the politico-administrative system and serves a population of up to 5000.
- HC III- The facility that delivers the Intermediate Referral Activity Package (IRAP) of the NMHCP It handles referrals from the HC II as well as referring to HC IV. By level, it equates the sub-county level of the Local Government administration.
- HC IV- Is a mini hospital and delivers the CAP (Complimentary Activity Package). It head the HSD which matches the county, equivalent to parliamentary constituency

This reorganization has led to administrative and structural changes in the health care delivery system. It has radically changed the functions of the district headquarters, removing most of their responsibility for service delivery and focusing on providing direction, technical advice and support to the HSDs. The total number of HSD is 214 (*see National Health System Annex II*).

### **The Private Health Sector:**

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<sup>16</sup> Ministry of Health: Health Sub-District Concept 1998

The typology of the private sector described below has been reached after consensus with various stakeholders in Uganda.

### ***Facility-based PNFP providers***

The majority of the facility-based PNFP are religious-based health care providers existing under three umbrella organizations; the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB) and the Uganda Muslim Medical Bureau (UMMB). The Bureaux together represent 78% of the PNFP health units while the rest fall under other humanitarian organizations and Community-based Health Care Organizations.

The facility-based PNFP have a large infrastructure base comprising of a network of Hospitals and Health Centres with a considerable percentage of these units located in rural areas<sup>17</sup>. They provide health services and train health workers.

### ***Non-facility based PNFP providers***

The non facility-based PNFP comprise of local and international organisations working in the health sector commonly referred to as NGOs. Diversity within this category of providers exists by virtue of a large combination of characteristics including size, means of and access to finance, control, expertise and motivation. The non facility-based PNFP providers include for example; the Uganda Red Cross (indigenous) and CUAMM, OXFAM, Save the Children Fund, Action Aid (international).

### ***Private Health Practitioners***

Presently the sector encompasses all cadres of health professionals in the Clinical, Dental, Diagnostics, Medical, Midwifery, Nursing, Pharmacy and Public Health categories who provide private health services outside the PNFP establishment. The Medical and Dental Practitioners Statute (1996), the Nurses and Midwives Statute (1996), the Pharmacy and Drug Act (1970) and the Allied Health Professionals Statute (1996), all provide for licensing and regulating health professionals who wish to engage in private practice.

The Private health practitioners provide mainly primary level services and limited secondary level services. A few urban units offer tertiary and specialist care. Membership to professional associations is voluntary.

### ***Traditional and Complementary Medicine Practitioners***

The practitioners include all types of traditional healers: i.e. Herbalists, Spiritual healers, Bone Setters, Traditional Birth Attendants, Hydro therapists, Traditional Dentists, etc. It does not include people who engage in harmful practices, casting of spells and child sacrifice.<sup>18</sup> There are several associations with registered members at the sub-county and district levels, coordinated by Cultural Officers. Many though remain unaffiliated to any association. Of late, a number of non-Ugandan Traditional Medicine Systems have been introduced into the country.

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<sup>17</sup> Public Private Partnership in Health, 2001

<sup>18</sup> More guidance shall be derived from the legislation on Traditional and Complementary Medicine in Uganda

These include the Chinese and Ayurvedic practiced from China and India respectively. Other systems like Reiki, Chiropractice, Homeopathy and Reflexology are among later practices introduced into the country.

***‘Informal’ Sector***

The ‘informal’ sector refers to those individuals without formal health training engaging in treatment of patients and selling of drugs illegally.

## Physical Resources

### Health Infrastructure

Health facilities act as an interface between the health service delivery and the community. They house equipment and technologies, and act as a springboard from which outreach services are provided to facilitate accessibility to both curative and preventive health services. Effective health care delivery requires a network of functional health facilities, and presently, the coverage in Uganda is estimated at 72%.

The National Health Infrastructure Development and Management Plan (NHIDMP), whose objectives are to analyze and assess the current condition of health infrastructure, and then propose investment options and recommendations for infrastructure development, was prepared through extensive consultations, and detailed generic designs of each of the three categories (II, III, IV) of health centres were developed/ redesigned and costed. The overall objective of health infrastructure development is to ensure each population is within 5kms reach of a functional public health unit/facility. During FY 2003/04, maps for district health facilities were completed and, an updated (2004) health facility inventory is indicated in the table below.

**Table 3.1: Summary of Health Facilities by level and ownership**

Level of Facility	Government	NGO	Private	Total
HOSPITAL	56	45	7	108
HC IV	148	9	3	160
HC III	706	157	10	873
HC II	945	391	257	1593
<b>TOTAL</b>	<b>1855</b>	<b>600</b>	<b>274</b>	<b>2731</b>

Because of the inadequacy and poor distribution of HC IVs in some parts of the Country, 150 Health Centres were proposed for upgrading to HC IV status, and so far in the FY 2003/04, 110 operating buildings have been completed, 68 theatres equipped and all the 150 HC IVs provided with a multipurpose vehicle. In addition, 128 doctors’ houses have been competed.

Private health infrastructure to date is mainly more developed and concentrated in urban centres than in the rural areas where most of the population, including the poorest quintiles lives. Hence, ready access for health services in times of dire need by the rural communities remains a big challenge. It is hoped that the Public Private partnership for Health will foster and enhance community focused service delivery.

## Equipment

The National Policy on health equipment was updated (Medical Equipment Policy, 2000) taking into account the redefined roles and functions of the various levels of health units within the district health system. Whereas a lot of effort has been invested in developing health infrastructure in Uganda the result of which has been a fair increase in the number of health facilities, the biggest challenge remains stocking of the health facilities with necessary medical and non-medical equipment. The equipment need is well portrayed in the table below.

**Table 3.2: Equipment procured for health facilities**

Particulars	Quantity	Gap (Quantity)
<b>Medical and Hospital equipment</b>		
HC IV theatre equipment	10 sets supplies	73 sets
Specialist equipment (ophthalmology, ENT and orthopaedics)	-	8 hospitals
Health Centres (medical equipment)	32 health centres fully equipped	400 HC IIs 100 HC IIIs
<b>Ambulance and Transport</b>		
Hospital ambulances	21	34
Vehicles for HSD activities	11	80
HC IV ambulances	48	102
<b>Communication equipment</b>		
FM radios transmitting stations	10	Nil
Radio call equipment	-	-

The MoH has instituted hospital equipment maintenance workshop, based in each region, to serve all districts equitably. Nevertheless, in spite of having the authority to use up to 5% of the conditional grants for maintenance, health facility contribution towards the operation of the maintenance workshops has been unpredictable and generally slow.

Many districts do not consider equipment maintenance a priority and do not use even the 5% provided regularly for this purpose. However, this may be a reflection of tough opportunity costs health facilities have to bear in the face of very scarce resources that accrue to the health facilities for plant maintenance. In spite of modest improvements in government expenditure on health, overall investment in health remains low; the referral system remains unsatisfactorily weak because of shortages of equipment, especially ambulance and communication equipment.

## Medicines and Medical supplies

Up till 2002 Uganda had never had any documented and specific Pharmaceutical Sector Plan. The first step in the process of the development of the HSSP was the review of the National Drug Policy and Authority (NDP/A) statute 1993. This led to the preparation of the revised, comprehensive National Drug Policy 2001. The National Pharmaceutical Sector Strategic plan (2002/03 – 2006/07) is now in place.

The NDP aims at forming a vital and integral part of the over all NHP and farther aims at contributing to the attainment of a good standard of health by the population of Uganda through ensuring availability, accessibility and affordability at all times of essential drugs of appropriate quality, safety and efficacy, and by promoting their rationale use.

The increased levels of drug expenditure and the improvement from the “pull system” are expected to translate into improved availability of medicines and health unit level, or in a context of unmet demand, and or increased utilization of health facilities. However, the HIMS does not reliably report on medicines availability at service delivery levels due to incomplete reporting by health units, denominator problems, aggregate errors and poor utilization by medical personnel in health planning. Nevertheless, following a survey that was conducted in 6 districts in 2002/2003 and 2003/2004 financial years by the MoH District Medicines Management Programme (DMMP) which involved reviewing of Stock Cards at the sample of 36 Health Units, there is evidence of modest improvement in the HSSP ‘zero tolerance’ availability indicator: 60% of Health Units had a monthly Stock out of any 6 indicator drugs in 2003/2004 compared with 67% of 2002/2003.

Despite the improvement in the HSSP ‘zero tolerance’ availability indicator, routine monitoring, surveys and Area Team visits highlight the following challenges:

- Irregular drug procurement and below target expenditure compared to the indicative cash budget. Under spending may be related to re-allocation of funds, irregular ordering, and / or sub-optimal service levels at National Medical Stores (NMS).
- The Health System is increasingly faced with new and expensive medicines and health products for basic interventions, including artemisinin-based combination therapy (ACT) for malaria case management, anti retroviral (ARV) medicines for HIV medicines for HIV/AIDS, the pentavalent vaccine for universal immunization, and auto-disposable syringes. The observed trend is a return to vertical programming of these interventions using parallel funding, and direct procurement from single source-supplies at fixed high prices.
- Further, there are no district specific adapted essential drug lists in the districts; currently all districts use the untailored national Essential Drug List. Sources of drugs in the country include: The National Medical Stores that serves all public health facilities, The Joint Medical Store (for UCMB and UPMB) that serves most PNFP facilities, private wholesale and retail pharmacies, medical clinics and drug shops. However, the greatest challenge is the inequitable distribution of these facilities with an obvious bias towards urban centres and municipalities.

- Hence the poorest of the population hardly have ready access to medicines in extreme times of need, but for the medicines Home Based Management of Fever (HBM) programme, which exists in only a few districts.

### **Human resources for health (HRH)**

The most valuable resource for effective and efficient health service delivery is the human resource. In order to effectively implement cost-effective health interventions, there must be an adequate number of health workers who must have the appropriate skills, competencies, training and motivation to do so.

In Uganda, there are more than 20 categories of health workers within the health sector. The MoH has opened a human resource database at the central level for the purposes of updating numbers and categories of human resources for health (HRH). As of July 2003, this exercise had covered only 32 districts and it revealed that among established staff, enrolled nurses are relatively more than any other cadre, particularly in rural areas, followed by the enrolled midwives and then clinical officers. Field experience also shows that most health centre level IIs are headed by either enrolled nurses or enrolled midwives.

Recruitment of health workers has been re-instated under the Health Sector Strategic Plan 2001/01 – 2004/05. By mid 2002, more than 85% of the 3172 health workers funded under the Poverty Action Fund (PAF) had been recruited.

The current proportion of approved posts filled with health workers improved from 33% in FY 1999/2000 to 42% in 2001/2002. The level of increase was not as expected, as districts constructed more health units, which therefore increased the denominator. Infrastructure development under decentralized management has gone ahead of production of health workers.

The Country thus continues to experience a shortage of trained workforce. For instance with a population of 24 million people, Uganda has got only 2209 medical doctors registered with the Uganda Medical and Dental Practitioners' council. Further while the current doctor to population ratio stands at 1:12,000, not all these doctors are actually Ugandans.

About 25% of the doctors registered with the medical council are foreigners and the MoH has no guarantee of how long they can stay in the Country. The most rare cadres in the Country include; Pharmacists whose availability is about 30% of the required number. Others include Physiotherapists, Dental Surgeons, Radiographers, Laboratory technicians and Anaesthetic assistants.

The basic professional training programs in Uganda are well established and produce a steady stream of health workers annually. However, the output of the trained health professionals is not based on the market demand but on the capacity of health training institutions. This is because the Ministry of Health has no direct control over the training institutions. The health training institutions are under the Ministry of Education. Currently there are trained health professionals that would very well fit the current demands of the health services, especially diagnostic professionals and Environmental health professionals.

However, many of these professionals are still unemployed due to the adamant stance of the Public Service against lifting the recruitment ban. This dilemma needs to be sorted out because the disease burden tormenting the country's health system would be appropriately addressed by these professionals. The table 3.3 below summarizes the distribution of different categories of health workers in Public and Private Health sectors in Uganda.

**Table 3.3: Distribution of Health Workers**

Variables →	Total Number	Sector			Area		Year	Source
↓ Category		Total Public	Total Private	Private not-for-	Urban areas	Rural areas	Year of the data	Main sources of Information
<b>1. Physicians :</b>					(%)			
<i>Generalists :</i>	1560	666	97	537	50	50	2003/4	HRH Development Division/MOH district staff inventory
<i>Specialists :</i>	649	434	25	159	87	13		
<b>2. Nurses :</b>								2004 MOH staff pay roll
<i>Registered Nurses</i>	2118	1269	163	493	53	47		
<i>Enrolled nurses</i>	4680	2552	384	1315	25	75		
<i>Auxiliary/ Assistant nurses</i>	8007	4688	662	1933	4	96		
<b>3. Midwives :</b>							2005	Current staff records of the National and Regional Referral Hospitals
<i>Registered Midwives</i>	1060	577	74	291	46	54		
<i>Enrolled Midwives</i>	3104	1775	263	784	18	82	2005	Current staff records of agencies, NGOs
<i>Auxiliary/ Assistant midwives</i>	0	0	0	0				
<i>Traditional birth attendants (TBA)</i>								
<b>4. Dentists :</b>								
<i>Dentists :</i>	117	44	11	27	54	46	2005	Current staff records of Health Training Schools incl. Universities having Medical Schools
<i>Dental technician :</i>	18	17	0	1	100	0		
<i>Dental assistant :</i>	228	151	34	22	21	79		
<b>5. Pharmacists</b>								
<i>Pharmacists</i>	215	30	160	25	96	4		
<i>Pharmacy technicians</i>	438	183	166	49	22	78		
<i>Pharmacy assistants</i>	35	0	0	35	?			
<b>6. Physiotherapist</b>	109	45	27	19	49	51		
<b>7. Medical assistants</b>	0	0	0	0				

<b>8. Clinical officers</b>	2472	1346	322	411	10	90		
<b>9. Laboratory</b>								
<i>Laboratory scientists</i>								
<i>Laboratory technologist</i>	776	216	47??	59??	88	12		
<i>Laboratory assistants</i>	762	252	30	355	10	90		
<b>10. Radiographer</b>	164	70	38	29	60	40		
<b>11. Environmental and Public Health Officers</b>								
<i>Environmental and Public Health Officers Professionals</i>	287	219	0	20	10	90		
<i>Environmental and Public Health Officers Technicians</i>	755	539		0	5	95		
<b>12. Other Technicians and Health Care Cadres</b>	661	297	107	117	40	60		
<b>13. Health Educators</b>	155	142	0	13	6	96		
<b>14. Administrative and support staff</b>			info not available					
<i>Skilled administrative staff</i>	1781	1239	info not available	542	?			
<i>Other support staff</i>	4563	2349	info not available	2214				
<b>15. Others categories specify *</b>								
Anaesthetic Officers & Assistants	375	292	14	69	40	60		
Mental Health Nurses	356	182	39	28	40	60		
H/Related e.g., H/Economist, S/Workers, Nutritionist, Counselors	307	126	info not available	181	90	10		

Criterion for calculations: Combinations of health cadres with similarities

- Registered Nurses included; Registered Nurse + 1/2 of the double Registered Nurse/Midwives + Registered Comprehensive Nurse + Bsc Nurse
- Registered Midwives included; Registered Midwives + 1/2 of the double Registered Nurse/Midwife + Public Health Nurse
- Enrolled Nurse included; Enrolled Nurse + 1/2 of the double Enrolled Nurse/Midwife
- Enrolled Midwife included; Enrolled Midwife + 1/2 of the double Enrolled Nurse/Midwife + Assistant Health Visitor
- Laboratory Technologist included; Laboratory Technicians while a total of 766 registered with the Allied Health Professionals Council, only 283 of them were reported to be C30 working in public, some agencies and PNF
- Anaesthetic cadre included; Anaesthetic Officer + Anaesthetic Assistant
- Other Technicians included; Leprosy Assistants, Occupational Therapists, Orthopaedic Officers, Technicians & Technologists + Vector control Officers + Theatre Assistants
- Clinical Officers included; Clinical Officers general + Ophthalmic Clinical Officers + Psychiatric Clinical Officers

# Health financing

## Health Financing Policies and Objectives in Uganda

The social and political turmoil of the 1970's and early 1980's had significant negative consequences on social services. This resulted in a constrained Government of Uganda budget; low per capita expenditure on health; a high contribution by donor financing; and Households contributing the largest share for health, mostly to the private sector. The uncoordinated donor inflows at the time resulted in fragmented and inequitable health service delivery and non-sustainable gains.

A strategic turning point in the health sector was the elaboration of a 10 year NHP and the 5-year HSSP 2000/01 – 2004/05. And the recognition within the Poverty Eradication Action Plan (PEAP) that the provision of good health is necessary not just to improve the quality of life of an individual (Pillar 4) in terms of his/her general well being, but as an essential input for raising the ability of people to increase their incomes (Pillar 3) at a micro level, thereby contributing to poverty alleviation, and facilitation a productive and growing economy at macro level. Today's Health Financing policies are derived from the broad government framework provided by the Constitution, the PEAP and laid out explicitly in the NHP and HSSP.

The Mission Statement of the Health Sector is ***“the attainment of a good standard of health by all people in Uganda, in order to promote a healthy and productive life”***.

To realize this mission, the sector is expected to address the current disease burden, rationalise health services, regulate the quality and cost of services, and improve equity in the delivery of health services in the face of a modestly growing economy. These challenges call for constant improvement in the efficiency of health expenditure. The Health Care Financing Component of the HSSP seeks to address the challenges through the following key specific objectives:

- Ensure effectiveness, efficiency and equity on the allocation and utilisation of resources in the health sector consistent with the objectives of the PEAP
- Eliminate factors of cost and affordability as barriers to access to essential care
- Attain significant additional resources for the health sector and to focus their use on the most relevant and cost-effective priority health interventions
- Ensure full accountability and transparency in the use of these resources through result-oriented management at all levels

To provide comprehensive data on the state of financing in Uganda, NHA studies are imperative. The first comprehensive National Health Accounts study in Uganda covered the Financial Year 1997/98 and was completed in 2000. This is the second NHA study and covers the period 1998/99 to 2000/01. Three financial years were selected for inclusion

in the study in order to construct trends in health financing in Uganda. The period covering the first and second round of NHA (1997/98 to 2000/01) is a transitional period with significant changes such as:

The creation of the Primary Health Care Conditional Grant (PHC CG) in 1997/98 to channel funds from the central government to local government for the implementation of UNMHCP in public and PNFP units. The grant was made conditional to ensure that it is directed towards the sector priorities, which was not the case when the grant was unconditional and local governments were barely allocating resources to PHC. The funds for the PHC CG are from the PAF.

The stakeholders in the sector agreed to implementation of the HSSP through the sector-wide approach to health development (SWAp) whereby all the donors were encouraged to fund the HSSP through Central Budget Support – providing funds directly to the Government of Uganda Treasury. It was indicated that all partners were expected to move towards central budget support as they wound up pipeline projects<sup>19</sup>.

User Fees were abolished in government lower level units with effect from March 2001, and only maintained in the private wings in the hospitals. An explicit objective of the subsidy to PNFP units has been to improve financial access of the communities to these units, and improvements in quality. These policies were put in place following the increased realization that the poor were facing barriers to health care<sup>20</sup>. Only four months of ‘post abolition’ of user fees are covered by the period of study i.e. March to June 2001.

## **Health services access and utilization**

### **Geographical access to health services:**

The national average for the percentage of people living within 5 km radius to a health facility was 57% as of 2000 when a mapping of all health facilities was done. However, there are variations with access ranging from as low as 7% of the population within 5 km of a health facility in Kotido to 100% in Jinja, Tororo and Kampala districts<sup>21</sup>. Rural communities are particularly affected, mainly because health facilities are mostly located in towns along main roads. Figure 1.1 shows the access for the different districts mapped, with respect to public health facilities.

Private health facilities to date are mainly more concentrated in urban centres than in the rural locales. Hence ready access for health services in times of dire need by the rural communities remains a big challenge.

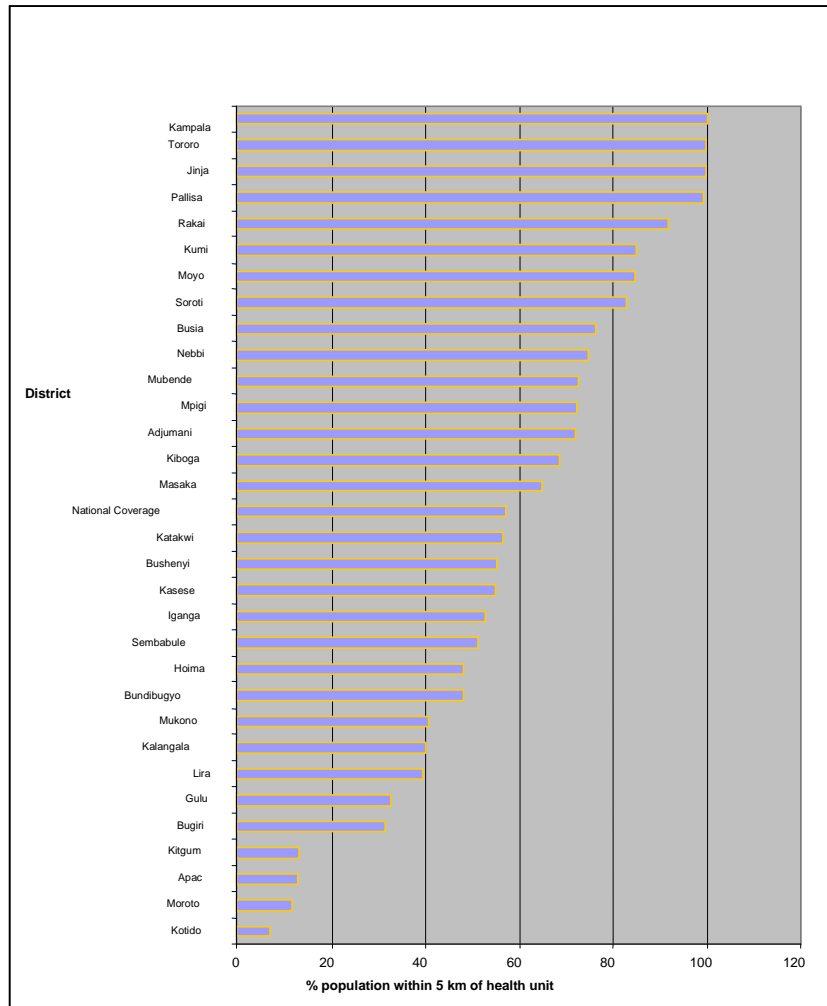
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<sup>19</sup> HSSP I Chapter 6, Page 94

<sup>20</sup> Uganda Participatory Poverty Assessment Project Report 2000

<sup>21</sup> Health Infrastructure Division, MoH 2000

**Figure 3.1: Geographical access to health services in Uganda**



Source: Health Infrastructure Division MoH 2003

## Monitoring and evaluation of the national health system

The implementation of the HSSP is a shared responsibility between the central partners and the district Local governments. Within the districts, the DHT is mandated to support the HSDs and these in turn should support the lower level health units. The central partners on the other hand have the cardinal responsibility of providing guidance and technical support to the district health systems. The HSSP gives a framework for monitoring and evaluation of the delivery of the NMHCP in the entire health system, from the centre to the District Health System (DHS).

## Chapter 4: Conclusion

Coming from economic prosperity in the 1960s, the predominantly agriculture Uganda has passed through a lot of socio-economic and political turmoil / challenges in the 1970s and 1980s. The country has attained relative political stability and commendable economic growth from 1990 onwards.

In 1999, the country enacted a comprehensive health policy (2000/01 – 2009/10) rolled out through two five year term health sector strategic plans. The overall objective of the policy is to reduce mortality, morbidity and fertility, and disparities therein. The strategy is to ensure universal access to health services through national minimum health care package. The key revolutionary features of the new policy are restructuring the health system in line with the decentralization policy and local governance and clear definition of roles and responsibilities of various levels of the national health system.

In effort to increase access to health services by the community, the government embarked on extensive health infrastructure development and furnishing health facilities with the appropriate equipment. Likewise, it is hoped that the health system will achieve significant gains in coverage, access and service range should the policy for Public Private Partnership for Health being established make headway.

Monitoring and evaluation of the health system performance has been implicitly and explicitly built in the HSSP. There exist well defined indicators for monitoring the performance of the health system at all levels. In addition to the HMIS being key monitoring tool, operational research and other tools are used for continuous monitoring and evaluation of the health system performance at all levels. Poor utilization of health data for decision making features prominently throughout the health system.

Whereas health financing by the government and development partners has been increasing significantly, human resource shortfall against recommended staffing norms remains a key challenge. Once implemented during HSSP II, the current health financing strategy coupled with balanced macroeconomic strategies may significantly alleviate the persistent health resource constraints.

Most of the health indicators of Uganda have either had a modest improvement or largely stagnated over the last ten years. Main areas of concern being the maternal and perinatal health, the toll of HIV/AIDS pandemic, low government health expenditure per capita, suboptimal safe water and latrine coverage, poor geographical and functional access for services, poor health resource base, high poverty levels, and disturbingly continued high disease burden of preventable and communicable diseases. There still remain high levels of vulnerable populations attributable to wars in the Eastern and Northern parts of the country, worsened by influx of refugees from the neighbouring countries.

Although community participation in health issues of their own environments through health facility committees has taken root in most districts, higher levels of community participation have not been attained.

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## Glossary

**Health sector reform:** A sustained process of fundamental change in policy and institutional arrangements, guided by government, designed to improve the functioning and performance of the health services and ultimately the health status of the population. Main components include organisational and managerial change, service delivery change, financing change among others.

**The Millennium Development Goals:** The Millennium Development Goals are an ambitious agenda for reducing poverty and improving lives that world leaders agreed on at the Millennium Summit in September 2000. For each goal one or more targets have been set, most for 2015, using 1990 as a benchmark.

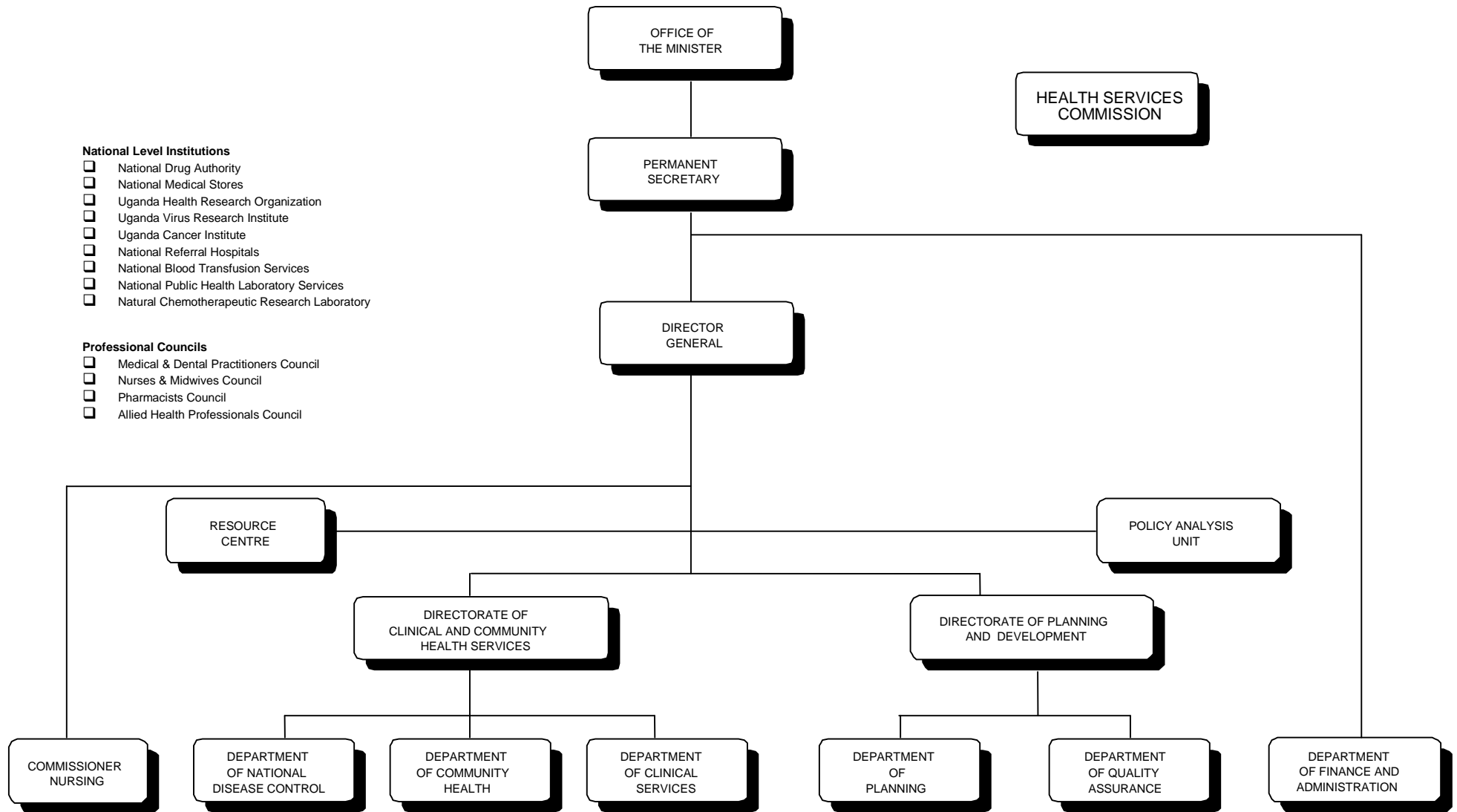
**Primary Health Care:** Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of development in the spirit of self-reliance and self determination. PHC comprises eight elements: (i) education concerning prevailing health problems and the methods of preventing and controlling them, (ii) promotion of food supply and proper nutrition, (iii) an adequate supply of safe water and basic sanitation, (iv) maternal and child health care, including family planning, (v) immunization against the major infectious diseases, (vi) prevention and control of locally endemic diseases, (vii) appropriate treatment of common diseases and injuries, and (viii) provision of essential drugs.

**Stewardship:** It is defined as “the careful and responsible management of the well-being of the population” and has been described as “the very essence of good governance”<sup>22</sup>. It is ultimately concerned with the entire national health system, avoiding myopia, tunnel vision and the turning of a blind eye to a system’s failings.

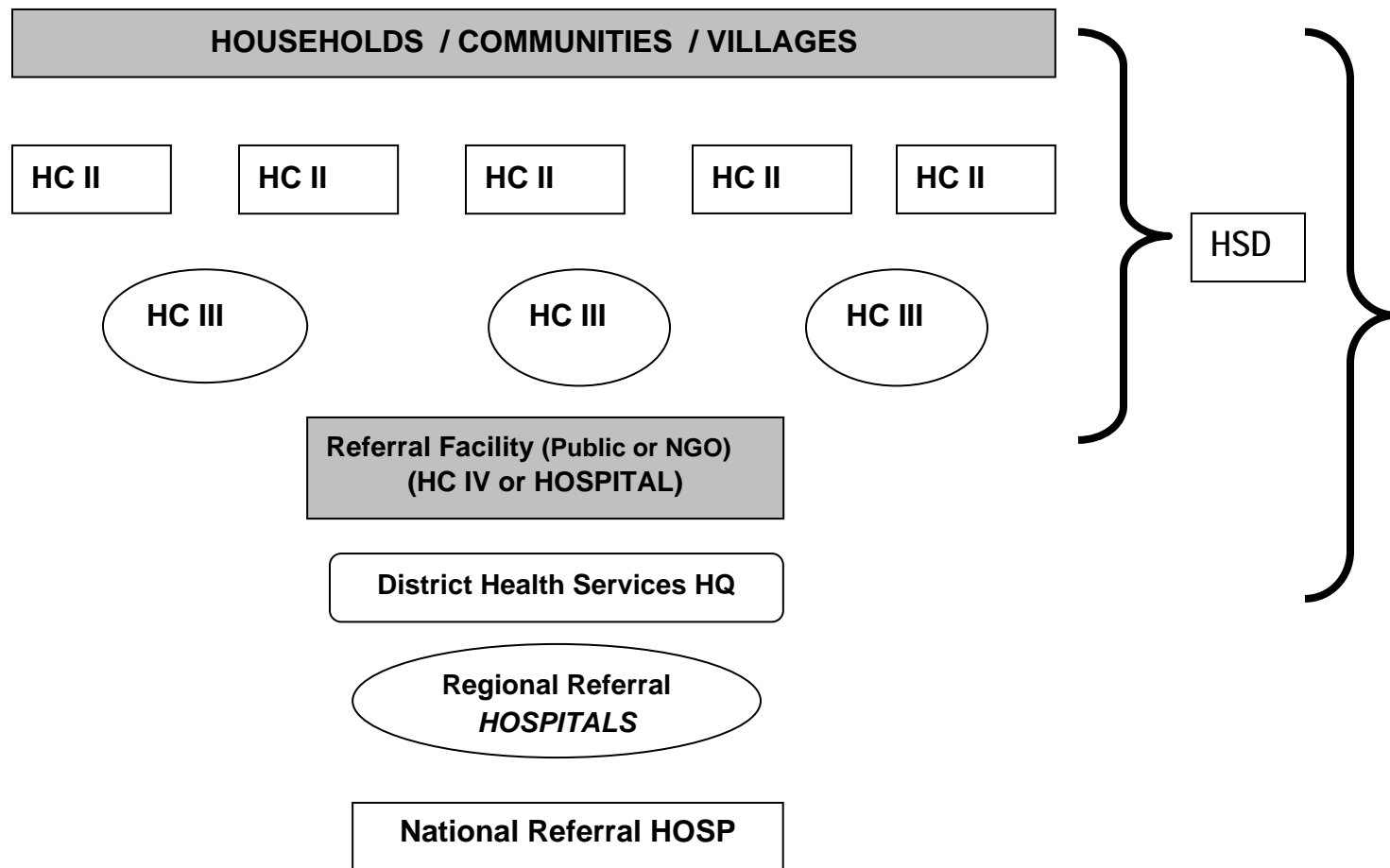
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<sup>22</sup> WHO, World Health Report 2000. Health Systems: Improving Performance. Geneva, 2000.

# Annex I: Organisation chart of the Ministry of Health



Annex II: National Health System



## Annex III: Country Statistics

Table A1:

<b>NAME OF THE COUNTRY :</b>	<b>UGANDA</b>
<b>Capital City :</b>	Kampala
<b>Official Language :</b>	English
<b>Surface Area :</b>	
<b>Population density - per square km (year)</b>	126 (year 2002)
<b>Ministry of Health Web Page :</b>	<a href="http://www.health.go.ug">www.health.go.ug</a>

Table A2:

Demographic indicators	Data	Year	Source <sup>1</sup>
Population - Total	24,748,977 (26.4m in 2004)	2002	<a href="http://www.UBOS.org">www.UBOS.org</a>
Male	12,124,761	2002	<a href="http://www.UBOS.org">www.UBOS.org</a>
Female	12,624,216	2002	<a href="http://www.UBOS.org">www.UBOS.org</a>
Children aged 0 to 1 year	1,064,000	2002	<a href="http://www.UBOS.org">www.UBOS.org</a>
Children aged 0-5 years	5,000,000	2002	<a href="http://www.UBOS.org">www.UBOS.org</a>
Under 15 years as a % of total population <sup>1</sup>	52%	2001	UDHS, 2001
65 years and over as a % of Total population	3.2%	2001	UDHS, 2001
Life expectancy at birth - Total	44.7	2003	<a href="http://hdr.undp.org/2003">http://hdr.undp.org/2003</a> ,
- Male			
- Female			
Total fertility rate	6.9	2001	UDHS, 2000/01
Annual population growth rate (%)	3.4%	2003	<a href="http://hdr.undp.org/2003">http://hdr.undp.org/2003</a>
Percent urban population	12.2%	2002	<a href="http://www.UBOS.org">www.UBOS.org</a>
Crude birth rate (per 1000 population)	47.3	2002	<a href="http://www.UBOS.org">www.UBOS.org</a>
Crude death rate (per 1000 population)	17	1991	UDHS, 1991
Infant (aged 0 to 1 year) Mortality Rate (per 1000 live births)	88.4	2001	UDHS, 2000/01
Under-5 Mortality Rate (per 1000 live births)	124	2003	<a href="http://hdr.undp.org/2003">http://hdr.undp.org/2003</a>
Maternal Mortality Ratio (per 100 000 live births)	510	2003	<a href="http://hdr.undp.org/2003">http://hdr.undp.org/2003</a>

Table A3

Socio-economic indicators	Data	Year	Source <sup>1</sup>
Gross Domestic Product (GDP) per capita (US\$) adjusted for purchasing power parity (PPP)	330	2003	<a href="http://hdr.undp.org/2003">http://hdr.undp.org/2003</a>
	300	2004	World Bank
Annual GDP growth rate (%)	5.3%	2003	MoFPED, 2001
Adult literacy rate -Male	64.3	2001	UDHS, 2001
-Female	47.5	2001	UDHS, 2001
Percent of population living in poverty	38%	2004	MoFPED, 2004
Human Development Index			

Table A4

Health and Environment indicators	Data	Year	Source <sup>1</sup>
Percentage of population with sustainable access to an improved water source			
- urban areas	62%??	2001	UNICEF
- rural areas	51.8%??	2001	UNICEF
Proportion of urban population with access to improved sanitation			

Table A5

Nutritional Status indicators	Data	Year	Source <sup>1</sup>
Percent of live births weighing less than 2500 grams			
Percentage of underweight children among children under five years of age	23%	2001	UDHS, 2000/01
Proportion of population below minimum level of dietary energy consumption (Indicator reported by FAO only)			

Table 7.2.6

Health Resources Indicators	Data	Year	Source <sup>1</sup>
Number of physicians per 10,000 population	1: 20,000 population	2002	<a href="http://www.UBOS.org">www.UBOS.org</a>
Number of midwives per 10,000 population	1: 15,000 population	2002	<a href="http://www.UBOS.org">www.UBOS.org</a>
Number of pharmacists per 10,000 population	1:1000,000 population		MOH
Number of dentists per 10,000 population			
Number of nurses per 10,000 population	1: 8000 population		<a href="http://www.UBOS.org">www.UBOS.org</a>
Number of Hospital Beds per 10,000 Population			
Total national health expenditure as percentage of GDP	2.4	2003	<a href="http://hdr.undp.org/2003">http://hdr.undp.org/2003</a>
Total government health expenditure as a percentage of total health expenditure	18%	2004	National Health Accounts
Total government health expenditure as a percentage of total government expenditure	9.6%	2004	National Health Accounts
Percent of national health expenditure devoted to tertiary institutions	2		
Percent of national health expenditure devoted to secondary and primary level	49.69%		AHSPR, 2003/04
Percent of out-of-pocket in total health expenditure	54%	2004	National Health Accounts
Percent of recurrent government expenditure going to drugs			
Proportion of population with access to affordable essential drugs on a sustainable basis			

Health Resources Indicators	Data	Year	Source <sup>1</sup>
Amount of international aid received as % of total government health expenditure	27%	2004	National Health Accounts
Total health expenditure per capita (US \$)	38	2003	<a href="http://hdr.undp.org/2003">http://hdr.undp.org/2003</a>
Total government health expenditure per capita (US\$)	2.88		National Health Accounts, 97/98, Household Surveys, 95/96 & 99/00

Table A7

Health services Indicators	Data	Year	Source
Proportion of births attended by skilled health personnel	39	2003	<a href="http://hdr.undp.org/2003">http://hdr.undp.org/2003</a> UDHS, 2000/01
% of women of childbearing age using family planning	23%	2001	UDHS, 2000/01
% of women that have been immunized with tetanus toxoid during pregnancy	41.7%	2001	UDHS, 2000/01
% of eligible population (i.e. infants reaching their first birthday) that has been fully immunized according to national immunization policies	36.7 44	2001 2003	- UDHS 2000/01 - AHSPR, 2002/03
% of infants reaching their first birthday that have been fully immunized against diphtheria, tetanus & whooping cough	46.1 48	2001 2003	-UDHS, 2000/01; MOH, Annual Health Sector Performance Report - HSSP 2000/01-2004/05 Midterm Review (HMIS)
% of infants reaching their first birthday that have been fully immunized against poliomyelitis	33.2	2001	UDHS 2000/01
% of infants reaching their first birthday that have been fully immunized against measles	56.8 61	2001 2003	UDHS 2000/01 <a href="http://hdr.undp.org/2003">http://hdr.undp.org/2003</a>
% of infants reaching their first birthday that have been fully immunized against tuberculosis	78.7	2001	UDHS 2000/01
% of infants reaching their birthday that have been immunized with yellow fever vaccine	46.1 48	2001 2003	-UDHS, 2000/01; MOH, Annual Health Sector Performance Report - HSSP 2000/01-2004/05 Midterm Review (HMIS)
% of the population that have been immunized with hepatitis B vaccine	46.1 48	2001 2003	- UDHS, 2000/01; MOH, Annual Health Sector Performance Report - HSSP 2000/01-2004/05 Midterm Review (HMIS)

Table A8

HIV/AIDS, Malaria and TB Indicators	Data	Year	Source <sup>1</sup>
HIV prevalence among young people aged 15 to 24 years	6.2%	2003	MOH
Condom use rate of the contraceptive prevalence rate			
Number of children orphaned by HIV/AIDS	1,650,000	2001	UBOS 2001
% of AIDS patients with access to ARV	10%	2003	MoH, ART Advocacy strategy
M:F ratio on HIV	1:5	2003	MoH, STD/ACP
Prevalence rate associated with malaria	46	2003	<a href="http://hdr.undp.org/2003">http://hdr.undp.org/2003</a>
Death rates associated with malaria (all ages)	152	2003	<a href="http://hdr.undp.org/2003">http://hdr.undp.org/2003</a>
Proportion of population in malaria-risk areas using			

HIV/AIDS, Malaria and TB Indicators	Data	Year	Source <sup>1</sup>
effective malaria prevention and treatment measures			
Prevalence rate associated with tuberculosis	187	2003	<a href="http://hdr.undp.org/2003">http://hdr.undp.org/2003</a>
Death rate associated with tuberculosis	48	2003	<a href="http://hdr.undp.org/2003">http://hdr.undp.org/2003</a>
Proportion of tuberculosis cases detected and cured under Directed Observed Treatment, Short-course (DOTS)	60		AHSPR, October 2003

Table A9: Not Available

Morbidity and Risk Factors Indicators	Data	Year	Source <sup>1</sup>
<i>Population of the reporting year</i>			
<b>Top ten first causes of Morbidity in absolute number</b>			
1. Perinatal and maternal conditions			
2. Malaria	9,689,739	2003	HMIS
3. Acute lower respiratory tract infections			
4. Diarrhoea			
5. Trauma			
6. HIV / AIDS			
7. TB			
8. Anaemia /Malnutrition and Cardio-vascular diseases			
9. Cancer			
10. Mental health			

Table A10: Not available

Mortality Indicators	Data	Year	Source <sup>1</sup>
<i>Population of the reporting year</i>			
<b>Top ten first causes of Death in absolute number</b>			
1. Malaria			
2. Perinatal and maternal conditions			
3. Acute lower respiratory tract infections			
4. Diarrhoea			
5. Trauma			
6. HIV / AIDS			
7. TB			
8. Anaemia /Malnutrition and Cardio-vascular diseases			
9. Cancer			
10. Mental health			