UGANDA
COUNTRY HEALTH BRIEFING PAPER

A paper produced for the Department for International Development by IHSD

Despite strong economic growth, averagingaround 8% per annum over the past decade, Uganda remains amongst the world's 20 poorest countries. Per capita income averages around $240 and the majority of the population remain dependent on subsistence agriculture. Uganda has pursued sound macro economic and social polices which have been supported by, and rewarded with, significant donor support and has been the first beneficiary of the HIPC debt relief scheme with the resultant savings allocated to priority interventions in the social sectors.

There has been strong support for public sector reform – the number of civil servants has been halved, there has been significant decentralization and many industries have been privatised. Uganda remains a one party state although a referendum will shortly decide whether to move to a multiparty system. Poverty is widespread although the proportion of those living in poverty declined from 56% to 46% between 1992 and 1996. On the negative side internal and external conflict and corruption give grounds for concern.

Health Indicators

Health status is poor even by regional standards although this partly reflects the collapse of health services during the Amin and Obote periods. Despite the attention paid to HIV/AIDS in Uganda in the media, malaria remains the main source of ill health.

Key Indicators:

- Infant mortality rate 1997: 97 per 1,000; U5 mortality rate 147 per 1,000; maternal mortality rate 506 per 100,000
- Life expectancy in decline due to HIV/AIDS epidemic; 43 in 1995 – but evidence that incidence in high risk groups (e.g. 15-19 year old females) has declined rapidly
- Total fertility r ate 6.8 (1995)
- HIV Prevalence 14.5% (WHO, 1994)
- Fully immunised children : 47% 1995 – concerns that rates are now going down (removal of allowances for district staff)
- Acute malnutrition 5%
- Contraceptive prevalence rate 15% (all methods), 9% (modern methods)
- Access to safe water c34% (43% urban, 30% rural)
- Access to sanitation – urban 63%, rural 28% (JMP, 1991)
- Deliveries by trained attendants 38% (DHS, 1995)

Health Sector Provision and Financing

Services are provided by a mix of public and private providers (table overleaf). The public sector plays a key role. With decentralisation the districts have taken on the responsibility for delivering district health services receiving block grants from the Ministry of Health. The role of the Ministry of Health is now focussed on providing technical support, supervision and monitoring, setting norms and standards, mobilising resource and donor coordination.

The NGO sector also plays an important role. Traditionally, there has been great antagonism between the Government and the NGO sector but this is disappearing and Government is now providing direct support to the NGO sector. However, the NGO sector remains primarily self financed (average cost recovery from user fees in NGO hospital 55-60% up to 95% for main Kampala based facilities). There has been an explosion in the role of the private sector especially in urban areas. The two tables over illustrate the health facilities available and data on health seeking behaviour.

Health Seeking Behaviour by Income Quartile, Urban/Rural Residence, 1993/4

Type of Treatment Sought N	**Rural**		**Urban**	
	Lowest Quartile	**Highest Quartile**	**Lowest Quartile**	**Highest Quartile**
No medical attention & no medicine used	16%	1%	17%	2%
Home treatment	34%	19%	36%	23%
Out Patient Government Facility	17%	19%	4%	8%
Out Patient Private Facility	25%	45%	39%	62%
Private Doctor	2%	9%	0%	0%
Pharmacy	1%	3%	3%	2%
Traditional Doctor	4%	1%	0%	0%
In Patient Government Facility	1%	0	0%	0%
In Patient Private Facility	0	1%	0%	2%
Other	0	2%	0%	0%
Total	100%	100%	100%	100%

Providers of Health Services in Uganda

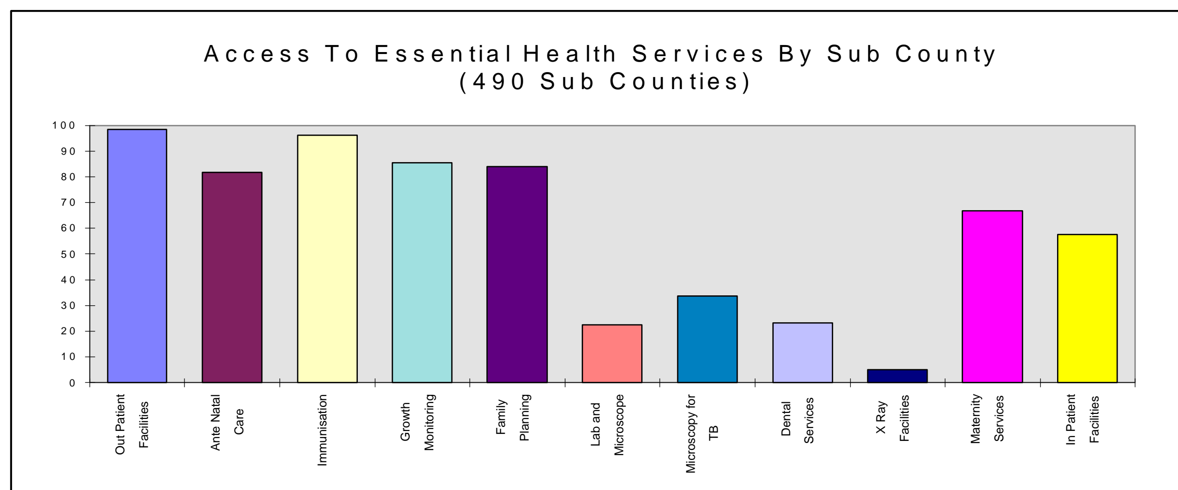
	Government	**NGO**	**Private**	**Total**
Hospitals	55	39	4	98
Health Centres	158	61	4	223
Dispensary/ Maternity Units	80	43	1	124
Maternity Units	211	144	12	367
Dispensaries	525	71	7	603
Sub Dispensaries	43	14		57
Aid Posts	13	11	9	33
Total	1085	383	37	1505

Source: 1996 Health Services Inventory, Health Planning Department

Referral hospitals remain under the MoH. District hospitals were decentralised in July 1998. Supervision is now the responsibility of the district administration (Chief Administration Officer/District Medical Officer). To date the MoH has continued to carry out a monitoring function; resource allocations are still made on the basis of advice from MoH. Thus, no change is yet discernible. However, many districts see the hospitals as overfinanced and would like to access some of these funds. MoH has set guidelines though these relate largely to how resources should be spent. No specific service standards are in place.

Access To Health Services

There are significant barriers to access by poor people. Quality of services, distance from health services and the cost of using services present major obstacles. Only 49% of the population live within 5km of a health facility.



Source: Health Planning Department, HMIS

Health expenditure accounts for around 6% of GDP. Recurrent health spending is over $12 per head although public expenditure accounts for only around $3 of this. Out of pocket expenditure accounts for around 70% of total expenditure; 75% of this is spent on drugs. There is a high degree of donor dependence with donors covering around a third of recurrent spending and around 90% of capital expenditure

Recent Trends – Allocation of Public Health Expenditure

- Reduction in allocation of resources to centre and hospitals
- Reallocation of resources from Government to NGO hospitals
- Large increases in resources channelled to PHC through PHC Conditional Grant
- Introduction of lunch allowances for lower level staff – to create incentives for staff to work productively at lower level units (previously only enjoyed by hospital staff) and support for lower level NGO units

Human resources are not well distributed. Most medical staff are in the hospital sector and in urban areas and productivity tends to be low.

GOVERNMENT HEALTH POLICY

Health services in Uganda collapsed during the troubles of the 1970s and for most of the 1980s. The 1993 Health Policy clearly set out consolidation and rehabilitation as the main strategies. This is cur rently being updated and Government has entered into negotiations with donors with a view to implementing a sector wide approach.

MoH has produced a 5 Year Health Policy and Plan. The underlying theme of this is to increase access to a minimum essential package of health services. This allows for limited expansion of the health infrastructure.

Areas of Refor m

- refining the role of the Ministry/organisational restructuring
- developing tools to influence the performance of district health services
- shifting towards a sector wide approach
- greater autonomy
- reallocation of resources and other health financing reforms
- further decentralisation including the introduction of the Health Sub District approach
- improved human resource management

DFID STRATEGY and PORTFOLIO

DFID's strategy as set out in the Country Strategy Paper is "improved health outcomes, especially for the poor". The focus is on:

- ıongoing health policy/strategy dialogue
- explore possibility of direct budgetary suppor t (in context of SWAp)
- continue support in current districts – focus on rehabilitation, strengthening management systems and improving quality of services especially sexual and reproductive health
- advocacy – encouraging politicians to place higher emphasis on health
- continued support for EPI and polio eradication
- supporting the 2000 population census

SECTOR-WIDE MANAGEMENT

- Process of developing sector wide approach has been built around MoH development of 5 Year Health Plan
- WHO has played a catalytic role; SIDA, DANIDA, DFID have played key roles; others are less a ble or unwilling
- Donors (SIDA, Holland) have already begun providing budgetary support to MoH (through the Poverty Eradication Fund). Some concerns about how these funds have been spent.

Role of Donors

Traditionally there has been a lack of donor coordination. With the encouragement of the Ministry donors have often developed their own districts. Over the last 3 years, however, significant steps have been taken towards a sector wide approach.

Activities by Main Donor s

- World Bank – District Health Services Project – aims to implement the basic health package in all districts plus capacity building in selected districts
- USAID – DISH project focusing on reproductive health in a number of districts
- DANIDA – essential drugs, support for MoH,
- DANIDA, Italy, Irish, German y, DFID, EU – district based programmes
- EC – blood transfusion, HR development
- AfDB/F – rehabilitation of Mulago hospitals/other hospitals
- WHO – coordinating SWAp approach

KEY DOCUMENTS

- DFID Uganda Country Strategy Paper
- DFID Health and Population Strategy
- 5 Year Health Policy and Plan
- Donor Expenditure on Health

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